A simple grading system to guide the prognosis after hip fracture in the elderly

Kellogg Speed described fracture of the neck of femur as "the unsolved fracture," and much work has been carried out to find the surgical solution to this fracture. The problem is not simply a surgical one, however, and the social implications should not be underestimated. Miller suggested that fracture of the hip may be viewed as a disease with a predictable rate and pattern of mortality. The importance of social circumstances and state of general health at the time of fracture in influencing the rehabilitation of elderly patients with hip fractures has been shown. Predictive studies of rehabilitation after hip fracture are scarce, and those which have been published fail to offer a more complicated bedside grading system suitable for routine use at the time of admission. A prospective study of 322 patients we have tested a simple bedside formula for use as a guide to prognosis after fracture of the femoral neck.

Patients, methods, and results

A prospective study of 322 patients over the age of 65 with fractures of the femoral neck (intracapsular and extracapsular) was carried out. Patients were assessed by one of the authors before surgery and allocated points according to social circumstances and medical state. For social circumstances those who were totally independent were given one point, those living alone with help at home, and those living in an institution three points. For medical state those in good general health were given one point, those with satisfactory general health but a history of previous serious illness two points, and those with poor health three points. The scores from both categories were added, giving each patient a possible combined score of two to six. Six months after surgery the patients' circumstances were reassessed by one of the authors. They fell into one of three unambiguous categories: satisfactory (back to original circumstances within six weeks of fracture), poor (still in hospital six weeks after fracture with no immediate prospect of return to previous circumstances), and dead.

Severe cutaneous reactions to alternative remedies

"Alternative" or "complementary" treatments are widely employed by patients, often without medical advice. Three cases are described of severe cutaneous reactions to alternative remedies.

Case reports

Case 1—A 46 year old man presented with erosion and blistering of the mouth, lips, and penis and soreness and redness of the eyes. The appearance was that of the Stevens—Johnson syndrome and he was admitted to hospital, where he required systemic steroid treatment. He gave no history of preceding illness or infection and was taking no medications. He did, however, admit that one week before the onset of the eruption he had visited a health food shop looking for a general tonic; he had purchased two bottles of tablets, one unlabeled, subsequent analysis of which yielded only lactose, and the other called "Golden Health Blood Purifying Tablets": these contained extracts of red clover, burdock, queen's delight, poke root, prickly ash, sassafras bark, and Pustiflora. He admitted that some months previously he had had a similar, but rather less severe reaction a few days after taking these tablets. The patient's condition resolved, but 10 months later he returned with a clinically identical eruption, again after the use of Golden Health Blood Purifying Tablets.

Case 2—A 56 year old man presented with an acute generalised pustular psoriasis. He gave a 25 year history of chronic plaque psoriasis, which had been
well controlled with topical agents until four days earlier, when he had purchased a 1 kg packet of Dead Sea Mineral Salts, which he added to his bathwater. Within two weeks he had become generally unwell and his psoriasis erythematous. He required admission to hospital and treatment with methotrexate and oral retinoids. His psoriasis remained well controlled until two years later, when it was noted to be once again inflamed and unstable; on direct questioning he admitted that he had recently again tried the Dead Sea Minerals, though on this occasion he had used only about 250 g per bath. The stated ingredients of the preparation used (Dead Sea Health Products, Kibbutz Ein Gedi MP, Dead Sea, Israel) included potassium chloride 22.88%, magnesium chloride 30.34%, bromides 0.2-0.4%, and sulphates 0.1-0.2%.

Case 3—A 22 year old woman with lifelong mild topic eczema visited a naturopath, not medically qualified, who recommended an injection of a homeopathic remedy, Nat Mur 200. Within 12 hours she was in an acute erythrodermic state, requiring intensive medical treatment. The mechanism of this reaction was obscure, since homeopathic remedies are not normally administered by injection and are usually in such a highly diluted form as to contain no measurable quantity of the original ingredients.

Comment

Alternative or complementary medicine is widely used for a range of disorders. Many patients find benefit, and though few of these therapies have been subjected to the same critical evaluation of safety and efficacy as conventional medicines, even the most sceptical of doctors generally regard them as harmless; indeed, it may well be the apparent safety of these forms of treatment which contributes to their popular appeal.

These three cases illustrate severe cutaneous reactions to different sorts of alternative medicines. The prevalence of such adverse reactions is impossible to assess, since there is no central monitoring authority equivalent to the Committee on the Safety of Medicines; furthermore, patients may be reluctant to admit to their doctor that they have employed a non-medical remedy. Alternative medicines are also not subject to the same requirements of standardisation as pharmaceuticals.

Many forms of complementary medicine are of potential value. Nevertheless, it is also important to be alert to their potential hazards. A valuable first step would be a central monitoring body.

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Effect of milk on patients with duodenal ulcers

A diet with a high milk content is often advised for patients with a duodenal ulcer, perhaps because milk is effective in neutralising acid.1 Moreover, epidemiological data suggest that the incidence of peptic ulcers is inversely related to milk consumption.2 In contrast, a diet with a high milk content stimulates significantly greater acid production than a normal diet;3 its value to patients with duodenal ulcers has therefore been questioned.4 The effect of milk on the healing of duodenal ulcers has not, however, been clearly established, so we performed a controlled therapeutic trial on patients admitted to hospital with ulcers.

Patients, methods, and results

Sixty five consecutive patients with duodenal ulcers confirmed by endoscopy were included in the study. On admission to this hospital they were randomly allocated to one of two groups, group I consumed a normal hospital diet, and group II received a diet consisting exclusively of milk (500 ml at breakfast, 750 ml at lunch, and 750 ml at dinner). They were allowed to add sugar according to their taste, and both groups were allowed to consume seasonal fruits. The total daily intakes of calories (1800-2000) and protein (60-70 g) in the two groups were very similar. Both groups received cimetidine 200 mg three times daily and 400 mg at bedtime, making a total of 1 g a day. Treatment continued for four weeks, after which patients underwent endoscopy again. The ulcers were then categorised as either healed, or with residual duodenal ulcers, or not healed (irrespective of size).

Three of 33 patients (9%) in group II developed milk intolerance in the form of diarrhoea and colicky abdominal pain and were excluded from the study. Weekly comparison of symptomatic relief showed no appreciable difference between the two groups throughout the study (table). Endoscopic assessment after four weeks of treatment showed that the proportion of healed ulcers was significantly higher in patients receiving a milk diet (78%) compared with those who consumed only milk (53%) (p<0.05). Serum calcium and creatinine concentrations were within the normal range in both groups before and after treatment.

Comment

In a previous study Doll et al found that a diet with a high milk content and even an intragastric milk drop did not influence the healing of peptic ulcers.5 Their study, however, was based on a barmium meal examination which is not as accurate as endoscopy in assessing ulcer healing, especially in the presence of a deformed duodenal bulb. In our study the proportion of healed ulcers in patients on a normal diet was 78%, which is the usual response obtained with cimetidine. In contrast, there was a significant reduction in the proportion of healed ulcers in patients who received a diet with a high milk content. Pain relief in the two groups was very similar, and this is perhaps why milk has been found to be useful in treating duodenal ulcers.

The precise mechanism by which milk delays ulcer healing is conjectural. One possibility is that the high content of calcium in milk stimulates excess acid production. Extracellular calcium plays a part in gastrin mediated acid production, and patients with duodenal ulcers are more sensitive to this effect than normal subjects.6 Calcium may not be the only factor, however, as even milk that is low in calcium produces a significantly greater increase in acid secretion in patients with duodenal ulcer than in normal subjects.7 We suggest that a diet with a high milk content has an adverse effect on the healing rate of duodenal ulcers and should not be recommended for these patients.

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