Social and functional impact of minor fractures in elderly people

SIR,—The findings of J M Nankhona and colleagues on the social and functional impact of minor fractures in elderly people will not surprise those working in accident and emergency medicine.

A six month study in the accident and emergency department at Charing Cross Hospital showed that 55 of 66 patients (83%) aged over 75 who attended with minor fractures of the ankle, wrist, or humerus could safely be discharged within two hours, during the normal working day of 9 am to 5 pm, if a prospective nursing and social assessment was made by a senior nurse before discharge. The nurse could then liaise with local social services and voluntary organisations to ensure that support was increased from the time the patient was fully assessed and the appropriate services arranged the next day. In our experience, patients rarely need to stay more than 24 hours after their injury while this support is arranged.

A careful social and nursing assessment of elderly patients presenting with minor fractures is as important as the management of their injury itself. By assessing their needs while they are in the accident and emergency department and coordinating the transfer of community services it should be possible to ensure the safe discharge of such patients from hospital while at the same time avoiding their inappropriate admission to hospital.

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1 Intensively conventional insulin treatment and neureropsychological impairment

SIR,—Per Reichard and colleagues conclude that episodes of serious hypoglycaemia did not cause permanent cognitive impairment in diabetic patients in their study.1 For several reasons we suspect that they might have made a type II statistical error.

Firstly, there was insufficient separation between the groups on the basis of the one major cause variable. Although the manipulation of the groups was done on the basis of treatment schedule, the authors made repeated reference to only one causal variable, severe hypoglycaemia. The mean number of episodes per patient per year was 1.1 in the intensified treatment group and 0.4 in the standard treatment group. Further, 29 (56%) of the standard treatment group had one or more episodes of severe hypoglycaemia during the study compared with 34 (77%) of the intensified treatment group.

Secondly, the statistical power of the study was not high. The power of detecting a difference of 0.5 standard deviation between the two groups was about 0.67, and the power of detecting a difference of 0.3 standard deviation was only 0.30. Thirdly, their battery of neuropsychological tests contained some of doubtful sensitivity. The authors claim that their tests were well suited to detecting cognitive deterioration and that some of the tests had proved sensitive to acute hypoglycaemia (their references 28-30). What these references show is that tapping and digit span tests were likely to be insensitive to any effects of hypoglycaemia. The cube test, which is unknown to most neuropsychologists, and the peculiar results of the 1959 paper that were used to support its inclusion in the battery of tests baffled even the original authors; the authors do not state to which this test seemed to be sensitive in the authors’ supporting reference bears no comparison with the subtle deficits that may be expected after exposure to severe hypoglycaemia.

Fourthly, finally, it is too short to afford a clear judgment about the effects of insulin treatment on cognitive functions.

Finally, few contrary positive results were discussed. Using retrospective reports of experience of hypoglycaemia, Langan et al2 showed a significant correlation between a decrease in IQ from premorbid levels and reported severe hypoglycaemia in 100 insulin treated diabetic patients.3 The mantra of “prospective good, retrospective bad” should not lead to this result being dismissed. The retrospective reports proved valid and highly reliable.4 The reports covered a mean of over 10 years, and patients were tested with an extensive battery of cognitive tests, including Wechsler’s adult intelligence scale (revised).

Thus the negative result reported by Reichard and colleagues might constitute a type II error. This important issue has not been settled definitively, and we recommend caution to those who might be tempted to believe that repeated severe hypoglycaemia does not have detrimental cognitive effects.

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Intravenous magnesium in suspected acute myocardial infarction

SIR,—K K Teo and colleagues describe the possible beneficial effects of intravenous magnesium in acute myocardial infarction.1 Magnesium remains an enigmatic treatment. It has been used empirically to treat arrhythmias and began to be used for acute myocardial infarction comparatively recently. Nevertheless, no guidelines exist regarding the salt that should be used, the dose, the infusion times, and the duration of treatment. This is reflected in the different treatment schedules in the overview. At a practical level in different


The first thyroid scan

SIR,—The obituary of Norman Veall credits him with having performed the first thyroid scan. I do not wish to detract from his many achievements, but this requires correction.

To the best of my knowledge I, with J Rotblat, performed the first thyroid scan in Liverpool University's physics department on 10 September 1947. We were able to demonstrate an intrathoracic extension of the thyroid. The original notebook still exists.

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14 December.)

The new disability living allowance

SIR,—I have just attended a seminar run by the Department of Social Security on the introduction of the disability living allowance. I am perturbed at the consequences of what is planned.

In April attendance allowance for the under 65s and mobility allowance will cease to exist and will be replaced by the disability living allowance. Attendance allowance continues in name for those over 65, but the application procedure still follows that for the disability living allowance.

Under the current system a person applying for mobility or attendance allowance has to fill in a short form and send it off. Every applicant is then visited by a doctor (usually a general practitioner), who fills in a four page report which forms the basis of the assessment. Under the new system the customers (as now called) fill in the form themselves, and this is the basis of whether the allowance is granted or not. The form is 26 pages long.

Currently, the report from the doctor is received and assessed by a doctor working for the Department of Social Security. In the new system the doctor assessor is replaced by a lay person, who has been trained in the application procedure but has no medical knowledge. If that lay person does not understand something he or she will consult with a department doctor or write to other professionals concerned; if it is still not clear a doctor (still usually a general practitioner) will be asked to visit. It is estimated that only a fifth of applications will require a visit by a doctor. Visiting doctors are being told to stop using precise medical terminology and use terminology understandable to a lay person.

The money paid to the visiting doctor forms a tiny percentage of even just one year's allowance. I do not understand such a valuable service being abandoned. Also, I am concerned that the 26 page document will form an insurmountable hurdle to many particularly uneducated people, elderly people, and the mentally ill. Applicants are losing the benefit of a consultation with, and a report from, a medical practitioner whereby the often subtle nuances of a disabling condition can be brought out and explained on their behalf. I would very much like this to work as there is too much at stake, but I have my doubts.

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Medicine in Europe

SIR,—The series of articles looking at medical issues in Europe is instructive, but I take issue with the way that Tessa Richards dismisses the activities of the royal colleges and, particularly, the European committee of the Royal College of Physicians. The European committee was not set up as a reaction to anything happening in other colleges, and the one thing it does not do is organise European scientific meetings and exchange visits.1 The BMA has worked long and patiently in Europe, particularly through the Standing Committee of Doctors of the EC, which was established in 1989. But, as Richards stated in a news item and is echoed in the sixth article in the series, 1 “Time and time again [the Standing Committee of Doctors of the EC] has been left shaking its metaphorical fist as directives emerge whose contents have at times been considerably at odds with the best interest of patients and the profession.” Far from the BMA and the royal colleges competing in their activities in Europe, it is essential that they cooperate and complement each other’s efforts. The colleges, however, have to find and pursue their own particular role in Europe, and the conference of colleges must use its organisation to coordinate those activities.

Royal College of Physicians. Europe’s European committee therefore has a major interest in the activities of the monospecialty sections of the European Union of Medical Specialists as well as the Advisory Committee on Medical Training. It is also keen to build up a profile of the various medical, and particularly medical academic, bodies in the various countries so that it can enter into discussion and dialogue with them.

The most difficult problem that the colleges, the BMA, and the Standing Committee of doctors departments is to find ways of influencing the legislative system in Europe. Unfortunately, at present this seems unlikely to be achieved through the European Union of Medical Specialists, the Standing Committee of Doctors of the EC, or the Advisory Committee on Medical Training. If these bodies cannot be made more effective some different structure must be devised. Whichever way, we will certainly need to work together if we are to achieve any success.

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12 October.)