Respect and care for the older person

The utopian image of older people as venerated members of society who have earned respect after a lifetime of work and accumulation of knowledge slipped even further from reality with the publication of the latest National Confidential Enquiry into Patient Outcomes (NCEPOD) report. The report, a review of the care received by elderly patients undergoing surgery, published on Nov 11, adds to the battery of depressing statistics describing how some older people end their lives in the UK. Recent media reports have told shocking stories of neglect of older people by their families or by carers in nursing homes. Now the NCEPOD document tells of how older patients who have undergone surgery are all too often left isolated, confused, cold, and in pain.

The report presents data from people over 80 years old who died within 30 days of operations done between April 1 and June 30, 2008. Data for all aspects of care, from admission to death, were gathered by review of 820 case notes and around 2000 questionnaires completed by the doctors involved in the patients' care. Other data on hospital services were gathered from 280 organisational questionnaires. The patients were operated on in all hospitals in England, Wales, Northern Ireland, the Isle of Man, and the Channel Islands.

The opening sentence, "this report makes depressing reading", sets the timbre of the report, which is littered with the words "disappointing", "unsatisfactory", and "inadequate". As the patients progress through their hospital stays, the report's dry data relentlessly details failures in care. Many patients were not adequately stabilised before surgery. Many had no record of a formal cognitive assessment—especially concerning given the need for informed consent. Many who were likely to have sensory impairment had no documentation of this. Details on the degree of frailty and nutritional status were not optimally recorded. The list of preoperative failures goes on.

However, the report does offer some good news. Many patients were operated on by the appropriate level of surgeon, and many underwent surgery in a timely manner. Nonetheless, in 21% of cases assessors felt that a delay in surgery was clinically significant, and there were a few cases for which the operating surgeon was under qualified.

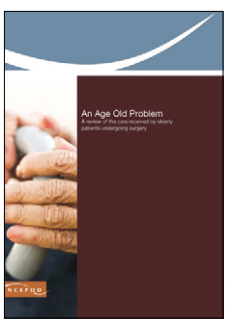
Once out of the operating theatre, though, the litany of errors resumed. Patients prone to confusion were prescribed benzodiazepines, hourly urine output was not measured, temperature was not recorded, and patients were left hypothermic. The end result for these unfortunate patients was death. In only around 40% of the cases did the assessors feel that the patients had received good care.

This is a gloomy picture, but it has to be put into context. This report looked only at patients who had died after surgery, and there are certainly many other occasions when the outcomes for older people undergoing surgery are good. However, we learn best from our mistakes, and the NCEPOD report therefore provides an ideal learning opportunity. What can the medical profession do to ensure that these failings are addressed?

Certainly, implementation of the report's recommendations will go a long way to improve the lot of older people undergoing surgery. This will require a sea change in how care is delivered to these patients. At the heart of the report's recommendations is that "daily input from Medicine for the Care of Older People should be available to elderly patients undergoing surgery". These geriatricians, psychiatrists, and allied health professionals have invaluable experience in caring for people with complex comorbidities, and hospitals need to move away from the ad-hoc, on-call basis by which their expertise is often sought.

At present, around 40% of all surgical inpatients are over 65 years old; this figure will increase as the population ages. To provide daily, optimal care to older people undergoing surgery will require a massive expansion in the number of physicians who care for older people. Additionally, undergraduate and postgraduate training in all specialties needs to focus on the care of older people. Certainly, the short undergraduate courses in the care of older people offered by many universities are woefully inadequate given that most of the patients that doctors treat are over 65 years old. Finally, older people should be much better represented in research trials; only with better outcome data can doctors tailor their care appropriately.

Older people rely on those who look after them to ensure that they have the best care. Geriatricians should now demand that changes are made to make good care the standard. ■ *The Lancet*



NCEPOD

For the **NCEPOD report** see http://www.ncepod.org.uk/2010report3/downloads/EESE_fullReport.pdf

Shortage of streptomycin: time for a change of approach?

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For the **41st Union World Conference on Lung Health** see http://www.worldlunghealth.org/confBerlin/

For the **Global Drug Facility criteria** see http://www.stoptb.org/assets/documents/gdf/drugsupply/GDF%20QA%20Policy%20and%20Procedures.pdf

For more on **drug-susceptibility testing** see **Articles** *Lancet Infect Dis* **10:** 688–98

For more on **multidrug resistant tuberculosis** see http://whqlibdoc.who.int/publications/2010/9789241599191_eng.pdf

As tuberculosis experts met for the 41st Union World Conference on Lung Health on Nov 11–15, a shortage of one of the first effective antibiotics against *Mycobacterium tuberculosis*, streptomycin, came to the fore. WHO's STOP TB partnership estimates that for the next 6 months up to 110 000 people in 41 countries will lack access to this antibiotic. At present, 15 countries are out of stock and 11 more are set to run out before supplies can resume.

Although combination drug regimens have supplanted streptomycin as the first-line treatment for tuberculosis, it remains an important second-line drug. It is recommended to patients returning to treatment with persistent symptoms after defaulting, or relapsing after apparent cure when the pathogenic strain is unknown.

The breakdown in streptomycin supply was precipitated by new Global Drug Facility criteria for quality, which sought to mitigate antimicrobial resistance and toxic effects, but meant that the company that had supplied 80% of streptomycin's active ingredient was unable to meet demand. An improvement in production techniques or switching of suppliers should alleviate the effects and return supply before the experts next convene in late 2011. Nevertheless, the streptomycin stock-out should serve as a useful lesson for those in charge of drug logistics, and provide the impetus to increased use of drug-susceptibility testing (DST). Only around 1% of patients with multidrug resistant (MDR) tuberculosis received a WHO-approved treatment regimen in 2008, and DST could help to increase the number of people receiving appropriate care. Such testing is already advocated by WHO but is far from universal; if it were, any reduction in untargeted drug use it could bring would help national agencies to plan responses to future demands and obviate the need to rely on fall-back options, such as streptomycin.

Policy makers must not become inured to the statistics tuberculosis coughs up—1·7 million dead, 9·4 million new cases, and half a million MDR cases in 2009. Maintenance of high-quality drug supply is crucial, and while supply shortfalls hurt those most at risk, knowledge of which drug to use should help to alleviate their effects. ■ *The Lancet*

Promoting women in science and medicine

Corbis

For more on the **University of Tromsø's gender work** see http://www2.uit.no/www/inenglish

For **genSET recommendations** see www.genderinscience.org

The University of Tromsø in Norway has adopted new recommendations designed to increase the number of female full professors from the current 23% to 30% by 2014. Women spend longer as Associate Professors than men, partly because "men apply as soon as they think they have a chance of promotion, while women tend to wait until they are very confident", according to Curt Rice, Vice Rector for Research and Development at the University of Tromsø. By introducing a trial assessment for women, which simulates the promotion process, Rice hopes that women's confidence will be boosted. Additionally, committees are to search for women qualified for newly advertised positions, with the aim of ensuring that at least 40% of the candidates for any position are women.

Scandinavian countries have long been leaders in gender equality, but in adopting in full the 13 recommendations for institutional action developed by the genSET (gender in science) panel of science leaders, the University of Tromsø has taken one step ahead. Rice was one of the panel members who developed the recommendations; *The Lancet* also took part. Other genSET recommendations include re-advertising positions if there are no women in the applicant pool, ensuring that women receive training in salary negotiation, assessing research quality rather than quantity, setting explicit public targets and action plans to improve gender balance in science institutions, improving the visibility of women within institutions, and encouraging diversity in leadership style. Recognition that gender equality contributes to better science is fundamental to the genSET recommendations.

For *The Lancet*, which is staffed by a majority of female editors (but has yet to have a female Editor), we could do more to commission leading Comment, Seminar, Review, and Series papers from women, and to select women to peer review for us. We encourage women to agree to be profiled, but have had less success in our Lifeline section in persuading women to self-publicise. Raising the profile of women in medicine is complex, but identifying, promoting, and publicising female medical leaders and their contributions to medicine, is a priority. Men rarely hesitate to accept an invitation from *The Lancet*. Women, where are you? ■ *The Lancet*

Aspirin to prevent colorectal cancer: time to act?

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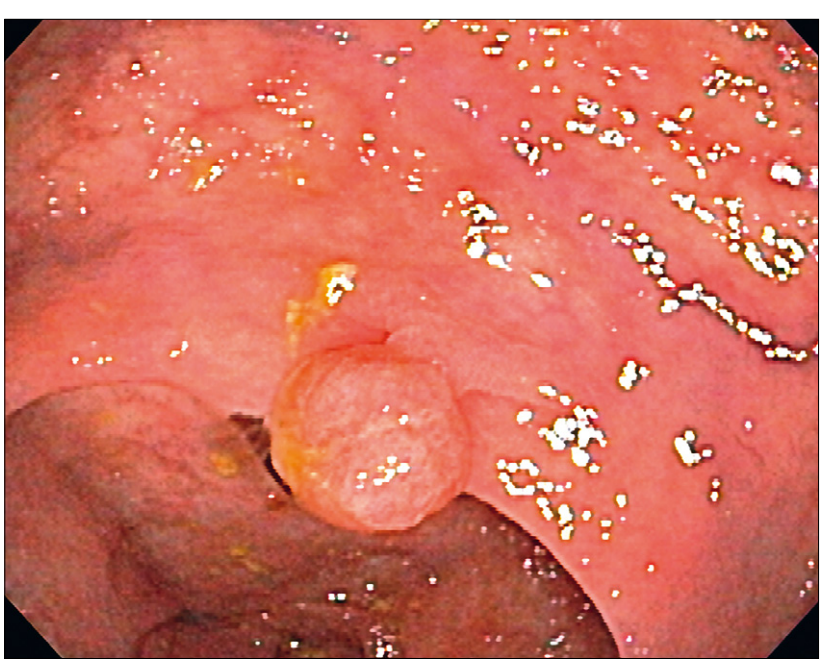
In *The Lancet* today, Peter Rothwell and colleagues[1] present the 20-year follow-up of five pooled randomised trials,[2-6] which assessed the effect of aspirin on colorectal cancer incidence and mortality, and focused on dose, scheduled duration of treatment, and site of tumour. The study of 14 033 patients used data from death certificates in the UK and Sweden, and from cancer registries in the UK. During the 20-year follow-up, aspirin reduced long-term risk of colon cancer (incidence hazard ratio [HR] 0·76, 95% CI 0·60–0·96, p=0·02; mortality HR 0·65, 0·48–0·88, p=0·005) with a latent period of 7–8 years between aspirin intake and its preventive effect. Aspirin doses that were higher than 75 mg per day showed no additional benefit, but doses of 30 mg per day seemed to be less effective. The investigators previously showed a similar effect of aspirin in randomised trials and in case-control or cohort studies, but after only 10 years of use.[7] In today's study, aspirin reduced cancer risk in the proximal colon by 55%, but not in the distal colon. 5-year therapy with aspirin reduced subsequent risk of proximal colon cancer by about 70%.

Rothwell and colleagues' study provides original information. First, it provides an extremely long follow-up (20 years) of patients treated with aspirin for about 5 years in randomised, double-blind, placebo-controlled trials, except for the British Doctors Aspirin Trial[5] (open-control group) or the Dutch TIA Aspirin Trial[6] (283 mg *vs* 30 mg of aspirin, both daily, with no untreated group). Aspirin reduced colorectal cancer incidence and mortality. Data from randomised trials for this issue are scarce. The US Physicians' Health Study[8] randomised 22 071 men to aspirin 325 mg or placebo every other day for 5 years; the risk of colorectal cancer was similar in both groups. In a larger trial, aspirin 100 mg on alternate days did not prevent colorectal cancer in women.[9] Second, the 27% overall decrease in long-term incidence of colorectal cancer by lower-dose aspirin was greater than the 17% reduction in adenomas noted in short-term trials, but consistent with the 28% decrease in advanced adenomas in these trials.[10] Third, by contrast with several case-control and cohort studies, Rothwell and colleagues' study found a similar reduction in colorectal cancer incidence with lower (75 mg per day) and higher (300–1200 mg per day) doses of aspirin. Fourth, the preventive effect of aspirin predominated on proximal cancers, but this subgroup analysis relied on small numbers. Only one randomised preventive study, which was restricted to serrated polyps, showed similarly that the effect of aspirin predominated on proximal lesions (40–50% reduction) with no effect on distal lesions.[11] If confirmed, this original finding might present a strong argument for the addition of aspirin chemoprevention to screening sigmoidoscopy.

Today's study has several limitations. First, colorectal cancer was not the primary outcome in any of the trials included. Additionally, the choice of studies seemingly relied more on practical than scientific reasons. Second, the investigators reported specific mortality and not overall mortality, and did not assess mortality related to aspirin side-effects. In a systematic review, aspirin reduced colorectal cancer incidence, especially when used for more than 10 years, but with a dose-related increase in gastrointestinal complications.[12] Whether the digestive-tract complications of aspirin are dose-related, especially from 75 mg to 300–500 mg per day, is still controversial. Third, these side-effects, especially digestive-tract bleeding, might have allowed earlier diagnosis of cancer in aspirin users via additional colonoscopies (the distribution of which was unknown between aspirin and control groups), although such an effect was not observed in Rothwell and colleagues' study. Fourth, there were important proportions of withdrawals in the original



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Colonic polyp, which can be benign, premalignant, or malignant

studies. Such withdrawals seem unavoidable in long-term clinical trials. Fifth, patients in the trials were mostly men with cardiovascular risk (men only in two trials), thus, no conclusions can be made about women and patients with no cardiovascular risk. The mechanisms of colon carcinogenesis might differ between cardiovascular and other patients—eg, because of increased tobacco consumption. Finally, after completion of the randomised periods of the trials, all patients were exposed to aspirin, which would have underestimated its benefits.

No randomised trial is currently exploring the effect of aspirin on colorectal cancer. In a prospective cohort study of 1279 men and women, regular aspirin use after colorectal cancer diagnosis was associated with a reduced risk of cancer-specific and overall mortality, specifically in patients whose initial tumour overexpressed COX-2.[13]

This interesting study could incite clinicians to turn to primary prevention of colorectal cancer by aspirin, at least in high risk-populations. Specific guidelines for aspirin chemoprevention would be the next logical step.

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We declare that we have no conflicts of interest.

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Corticosteroids: short-term gain for long-term pain?

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Although the 1949 discovery of cortisone was a medical landmark, it is still unclear whether this widely used treatment benefits patients with tendon pain. In *The Lancet* today, Brooke Coombes and colleagues[1] evaluate whether corticosteroid injection helps or harms patients with tendinopathies. This question is relevant not only for physicians, but also for other health professionals such as those physiotherapists whose extended scope of practice includes corticosteroid injection. Coombes and colleagues' systematic review examines the outcome of patients with tendinopathy at 4 weeks, 6 months, and 12 months after corticosteroid injections. These important long-term outcomes have been largely overlooked in reports of the efficacy and safety of corticosteroid injections.

Coombes and colleagues show that tendons behave differently at various anatomical sites. Importantly, today's review might discourage clinicians from using corticosteroids in patients who are seeking medium-term and long-term cures. For lateral elbow tendinopathy (tennis elbow), there was a 21% reduction in the relative risk of overall improvement 1 year after corticosteroid injection compared with patients allocated to wait and see (relative risk 0·79, 95% CI 0·69–0·90). When considered alongside the higher absolute risk of recurrence of 63%,[2] this discovery is crucial because it alerts clinicians to the potential deleterious effect of corticosteroid injections that are unrelated to complications of the injection itself.

Conventional dogma has been that as long as corticosteroid injection did not cause an acute complication (eg, subcutaneous atrophy, tendon rupture), it was not harmful.[3] Thus clinicians and patients often considered injection to be worth a shot. For lateral elbow tendinopathy, Coombes and colleagues' analysis implies

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