

Letters to the Editor

Collagenous colitis: a modifiable cause of diarrhoea in older people

SIR—Collagenous colitis is an inflammatory disorder of the colon associated with watery diarrhoea, minimal endoscopic findings and the finding of a pathognomonic subepithelial band of collagen on biopsy. It has typically been described as occurring in middle-aged women. We summarize the case of an older woman with collagenous colitis and propose that this entity be considered in the differential diagnosis of chronic diarrhoea in elderly patients.

An 84-year-old woman was admitted from a nursing home with a 10-day history of 4–5 watery, non-bloody bowel movements per day, as well as vomiting, anorexia, stool incontinence and weight loss. She had experienced three such episodes in the past 2 years. Her medications included naproxen for osteoarthritis, and loperamide.

Examination revealed a cachectic, dehydrated woman who was afebrile and had mild abdominal tenderness. Laboratory examinations included a normal leucocyte count and normal thyroid stimulating hormone. During the 2 weeks in hospital, blood cultures, stool cultures and stool examination for ova and parasites were all negative. However, microscopy consistently showed numerous faecal leucocytes.

The patient's plasma volume and nutrients were replenished. She continued to have 1–2 watery bowel movements each day. Gastroscopy and colonoscopy showed antral gastritis and a pale-looking colonic mucosa. Colonic biopsies revealed mixed inflammation of the lamina propria with rare intra-epithelial neutrophil and eosinophil infiltrates. A thickened subepithelial band was found, consistent with collagenous colitis. The naproxen was discontinued and she was started on loperamide 4 mg three times daily. At 1 month follow-up she no longer required loperamide and was having bowel movements once every 2–3 days. She had regained continence but remained anorexic and malnourished.

Collagenous colitis was first described in 1976 by Lindstrom [1]. Since then, several hundred cases have been reported. Diagnosis depends on colonic biopsy. There is an association with faecal leucocytes [2]. While the aetiology is unclear, there is a relationship with other enteropathies and autoimmune conditions such as thyroid disease [3, 6]. Non-steroidal anti-inflammatory drugs (NSAIDs) may play an aetiological role in a subgroup of patients with collagenous colitis and discontinuing such treatment may improve symptoms [3].

An epidemiological study in Sweden found the peak incidence of collagenous colitis to be in women aged

70–79 years [4] and the disease has been reported in patients over the age of 85 [3, 4, 6]. At the time of diagnosis, most patients have had symptoms for months to years [5].

Several treatments are reported to be effective for collagenous colitis. In one study, aminosalicylates improved symptoms in 50% of patients who could tolerate them [6]. Prednisolone has been reported to be 80% effective, although it is associated with relapse [6]. Successful treatment has also been reported with metronidazole and cholestyramine [5]. A recent publication advocated an 8-week course of bismuth subsalicylate as a successful treatment for collagenous colitis and other forms of microscopic colitis [7]. Riddell *et al.* [3] demonstrated that some patients with collagenous colitis, concomitantly taking NSAIDs, improved within days of discontinuing NSAID use.

Several treatment recommendations have been made. First, NSAIDs should be stopped and the symptoms treated with anti-diarrhoeal drugs such as loperamide. If diarrhoea continues, sulphasalazine can be added. Prednisone should be reserved for severe exacerbations [3–5]. Most patients will have spontaneous resolution or will enjoy long remissions after treatment. Unfortunately, about 25% of patients will require continuous therapy and will suffer persistent diarrhoea if treatment is stopped [8].

In summary, collagenous colitis is a rare but treatable cause of diarrhoea in older people. Clinical clues may include co-morbid autoimmune conditions, long-term NSAID use and faecal leucocytes. Definitive diagnosis is made by colonic biopsy. Treatments are available which promote remission and relief from this disease.

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Declaration of Yuste

SIR—The demographic shift towards an ageing population taking place in Europe, the Americas and South East Asia will increase demands for health care and social support as a consequence of age-related pathology. These demands will make economic impact over the next 10–30 years. Better medical management of diseases in older patients may well limit some of this rising expenditure.

The knowledge, skills and attitudes reflecting a positive approach to older patients by doctors are best presented during undergraduate training for *all* future doctors—be they physicians, surgeons, psychiatrists or in any other speciality. In addition some physicians should be encouraged to develop special expertise at the postgraduate level in the problems of the older patient.

In order to promote these two processes, geriatricians from European countries with active educational programmes in geriatric medicine, along with observers from North and South America, met to develop a common core curriculum in geriatric medicine. This 2-day intensive workshop at the European Academy of Yuste, Spain, received prepared position papers, which were discussed, developed and finally agreed. These core element undergraduate and postgraduate curricula are available from us. In addition they can be found on the internet (www.yuste.org/edugeri.html).

We would be delighted to receive comments, criticisms and suggestions in order to increase the potential benefits world-wide. We plan to link the agreed curricula to appropriate sites on the internet. We see the development of 'a geriatric educational resource' being helpful to others with similar objectives.

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Air-terminal stress and the older traveller

SIR—The hazards of high-altitude commercial air travel (including hypoxia and venous stasis) [1] are commoner in those with advanced age, chronic disease or mobility impairment [2, 3]. However, most emergencies associated with commercial air travel occur within the airport terminal before or just after flight [4]. The term 'terminal stress' describes mental and physical stresses in the airport terminal, such as pre-flight anxiety and carrying luggage, which may be important in older air travellers. We have made a survey of airport emergencies transferred from Gatwick Airport to East Surrey Hospital over the 3 months between September and November 1998.

Twenty-seven million commercial air travellers use Gatwick each year and, with the exception of patients with suspected infectious diseases, medical emergencies from the airport are usually taken to East Surrey Hospital for assessment and treatment. During the study period, there were 88 emergency transfers of air passengers, of whom 35 (40%) were over 65; 40 passengers (46%) required admission to hospital including 19 (54%) of those over 65. Nineteen admitted patients (48%) became unwell in the departure area, including 12 (63%) of the 19 of the admitted patients over 65. A primary cardiac diagnosis was the cause of admission in nine (75%) of the older patients who were taken ill in the departure area and in most of these, the cardiac problem was an exacerbation or complication of a previously diagnosed cardiac condition.

Over 5 million passengers passed through Gatwick Airport during the study period and, consequently, 40 passengers requiring hospital admission represents a low incidence of such emergencies. However, passengers taken ill on outward bound flights which had left UK airspace would not feature in this survey. A longer study over a 12-month period is necessary to eliminate seasonal influences on the volume and demography of passengers passing through the airport. Nevertheless, our data illustrate that older patients represent a large proportion of the airport emergencies transferred to East Surrey Hospital. The physiological stresses of high-altitude air travel could not have been contributory in cases where passengers were taken ill in the departure area, but terminal stress may have been an important factor. Such stresses within an airport terminal may be similar in most respects to those

which are experienced during other modes of travel (e.g. rail travel). Nevertheless, from the perspective of a hospital neighbouring a busy international airport, the issue of terminal stress is important.

The problems of altitude and air travel in patients with cardiac disease have been reviewed [5, 6] and recent guidelines are available for the assessment of suitability to fly [7, 8]. Clinicians should consider terminal stress as well as in-flight hazards when advising older patients with chronic illnesses (particularly cardiac disease) who are contemplating air travel.

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Agitation and aggressiveness in elderly people at home

SIR—Behavioural disturbances are common in elderly people. Consequences of behavioural disturbances have been investigated in demented subjects and those in nursing homes. Behavioural disturbances affect the quality of life of both subjects and caregivers [1]. They may predict faster decline in Alzheimer subjects [2, 3] and may be related to institutionalization [4, 5] and death [4]. However, there are no published studies of behavioural problems in old people living at home.

We describe behavioural disturbances on the PAQUID (Personnes Agées Quid) Research Programme,

a prospective cohort study of mental and physical ageing people aged 65 years and over living in south-western France [6]. The study population was randomly selected from the electoral rolls, and 3777 subjects (68%) agreed to participate.

Data were collected by trained psychologists. The initial interview included items about demographic and socio-economic characteristics, physical and mental health impairment, disability and several neuropsychological tests. A dementia screen was done using the criteria of the American Psychiatric Association [7]. The subjects were followed-up for 5 years.

Retrospectively, subjects presenting with behavioural disturbances were detected in a two-stage procedure: first, records of subjects having 'impaired judgement' and/or 'personality change' in the DSM III criteria were selected. These were then reviewed, and comments of psychologists were analysed to determine whether the subject was agitated or aggressive.

The prognosis of agitated subjects was analysed by the Cox model with delayed entry [8]. The results are summarized in Table 1.

Of the 3777 subjects [2200 women and 1577 men, mean age 75.4, (SD: 6.9)], 178 (6.4%) had at least one of the two DSM III selection criteria at baseline. Of these, 48 (1.3%) presented with agitation or aggression (both in nine subjects). (Below, the term 'agitation' is used to cover both agitation and aggressiveness.) Dementia was the main factor associated with agitation (logistic regression, $P < 10^{-3}$). Indeed, 18 (17.6%) of 102 subjects who were demented at baseline were agitated, compared with 30 (0.8%) of the 3675 who were not demented at baseline.

The prognoses of agitated and non-agitated subjects was compared. After adjusting for age and sex, the risk of mortality was significantly increased in agitated

Table 1. Risk of mortality and institutionalization related to agitation/aggressiveness (Cox model with delayed entry, PAQUID 1988-95, $n = 3777$)

	RR	95% CI	P-value
Mortality			
Sex (women/men)	0.53	0.46-0.60	<0.0001
Agitation/aggressiveness	1.79	1.15-2.80	0.011
Institutionalization			
Sex (women/men)	0.51	0.44-0.58	<0.0001
Agitation/aggressiveness	1.22	0.77-1.93	0.402
Dementia	2.89	2.23-3.75	<0.0001
Institutionalization			
Sex (women/men)	1.71	1.22-2.42	0.002
Agitation/aggressiveness	2.77	1.21-6.29	0.015
Sex (women/men)	1.68	1.19-2.36	0.003
Agitation/aggressiveness	2.19	0.94-5.11	0.071
Dementia	2.12	1.19-3.78	0.011

RR, relative risk; CI, confidence interval.

subjects [relative risk (RR)=1.8; Table 1]. The risk of institutionalization was also increased, with an RR of 2.8 (Table 1). However, after adjusting for the presence of dementia at baseline, these were no longer significant (Table 1). In those not demented at baseline, the presence of agitation tended to increase the risk of becoming demented, but not significantly (RR=2.4, 95% CI 0.9–6.5, $P=0.085$).

A major limitation of this study is that we did not use a standardized assessment of agitation, because the sample was so large. Instead, we used the clinical diagnosis reported by the psychologists. In addition, subjects' informants were often present during the interview and could report any agitation to the psychologist. Moreover, an interview is an unusual situation which can provoke agitated behaviour.

As in studies of out-patients from geriatric or dementia clinics, we found agitation to be correlated with both risk of being institutionalized [4] and risk of death [4]. Agitation can reflect an underlying medical or psychiatric condition [9], which may be related to mortality. Moreover, agitation may result in institutionalization when the caregiver can no longer cope.

The prognosis of agitation shows a considerable overlap with dementia. Dementia is underdiagnosed in older people living at home. Agitation may be apparent before the diagnosis of dementia is made. It should alert doctors to the possibility of underlying dementia.

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Anxiety as the reason why previous psychiatric illness is a risk factor for dementia

SIR—The work of Cooper and Holmes [1] is a welcome foil to the genetic determinism that currently seems to be dominating the field of dementia research, and opens the way to more sophisticated psycho-socio-biological explanations of the syndrome.

The authors report a highly significant increase in the risk of apparently unrelated preceding major psychiatric illness in people aged 60 and over with dementia compared with a matched control group without dementia.

There is accumulating clinical [2], epidemiological [3] and biological [4, 5] evidence that anxiety, as the subjective manifestation of the human stress response, may cause neurotoxicity and cognitive decline. Anxiety is very common in all forms functional mental illness. However, in psychiatry we use a hierarchical and categorical method of classification [6, 7] in which anxiety disorders come at the bottom and can only be diagnosed once other disorders have been excluded. Therefore when anxiety does occur, it is not very likely to be recorded as a diagnosis in its own right. Even the symptoms of anxiety may not be recorded in the case-notes if they are assumed to form part of some other diagnostic category. Such under-reporting may seriously weaken any association with subsequent cognitive decline in epidemiological studies (such as that of Cooper and Holmes).

Could anxiety be the causal link between previous psychiatric history and late-life dementia that the authors seek?

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Inappropriate acute admissions from nursing homes

SIR—Further to our letter of 1997 [1], we established an outreach team, composed of a consultant geriatrician and a nurse experienced in the care of elderly people, to try and reduce inappropriate admissions from nursing homes to our acute medical beds. We assessed potential admissions in the nursing homes and managed acute problems there if appropriate, paying full consideration to views of the family and admitting the patient to hospital if necessary.

We now report a pilot study in which the services of the team were offered to eight nursing homes (those with most acute admissions in the original audit). Before starting, we discussed the project with all general practitioners involved in care of residents in those homes, health authority representatives, members of the Nursing Home Association and all matrons.

Referrals were to be made by either the matron or the general practitioner (with the general practitioner informed about any referrals made by the matron). We then applied the appropriateness evaluation protocol [2] to patients managed by the outreach team and to patients admitted from the pilot homes and from homes outside the scheme. The results are shown in Table 1.

Of those patients managed by the outreach team, a few were admitted briefly to hospital for investigation or stabilization. Of those admitted to hospital from the pilot homes, early discharge was possible with the aid of co-ordination and support from the team in some cases. The consultant, who carried an electrocardiograph machine and peak flow meter, used the laboratory for simple investigations and carried medications including anti-anaphylaxis drugs, intravenous diuretics, intramuscular and oral antibiotics. The use of subcutaneous fluids (supplied by the hospital) and once-daily intramuscular antibiotics was the main change in management.

After the consultant made the diagnosis and began treatment, he contacted the general practitioner and the care plan was discussed. The first dosage of medication was supplied by the outreach team after which the general practitioner took over prescribing. A discharge letter was sent to the general practitioner after the end of the team's involvement with the patient.

The homes involved in the scheme have been supportive, some using it as a 'selling point' to potential customers. Some nursing-skill deficiencies were identified (for example pressure area care, subcutaneous fluid use and percutaneous endoscopic gastrostomy feeding). These were addressed during patient care but a formal programme of training is

Table 1. Effect of outreach team visits to nursing homes included in pilot scheme, December 1997-March 1998

Home	Patient management	No. of homes	No. of patients			No. of deaths	Median length of contact/stay (days)	Median no. of visits
			Total	Fulfilling protocol ^a	Top three diagnoses			
Pilot	Outreach	8	31	28	Pneumonia (13) Pressure sore (3) ?DVT (3)	6 (5 in nursing home, 1 in hospital)	7	4
	Hospital admission	8	23	23	Fit/collapse (5) Bradycardia (3) Chest infection (3)	6 (3 in nursing home, 3 in hospital)	3	-
Other	Hospital admission	24	54	48	Fits/falls/collapse (16) Chest infection (10) COPD/CCF (8)	8 (in hospital)	5	-
Total		-	108	99	-	20	-	-

DVT, deep vein thrombosis; COPD, chronic obstructive pulmonary disease; CCF, congestive cardiac failure.

^aFulfilling appropriateness evaluation protocol.

needed to improve standards and increase the success of the outreach scheme. The scheme seems to be a success, saving about 190 bed days in 4 months and allowing patients to be managed in the most appropriate setting. For some of those admitted, the scheme has allowed faster discharge. Identification of training needs will help improve formal training and skills of nursing home staff. We intend to expand the scheme to all nursing homes in the area.

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Community hospitals...and district general hospitals

SIR—I read with interest the paper by Cook and Porter on the effect community hospitals had on admissions to a district general hospital [1]. The authors concluded that community hospitals have only a small effect on the use of district general hospital beds. This contrasts with our study [2], in which we found that when a traditional long-stay hospital was transformed into a community hospital and general practitioners were allowed to admit patients directly (following specific consultant-led guidelines) then the local district general hospital bed use declined.

Given the wide variation in community hospitals as described in the accompanying Editorial [3], I am concerned that we draw too firm a conclusion from the hospitals in Oxford as the use of these hospitals may be influenced by local consultant and general practitioner practice.

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SIR—The drive to reduce costs has led to a political imperative to transfer the treatment of some elderly patients from district general hospitals into community hospital or intermediate-care facilities. It has been repeatedly stated, to the extent that it is assumed to be true, that care in community hospitals is cheaper than that in major hospitals [1]. The evidence does not support this.

Unless the patient is mobile and simply waiting for a residential home, the same nurse/patient ratio is required for the more acutely ill patient as for a dependent longer-stay patient needing rehabilitation. The same levels of physiotherapy, occupational therapy and speech therapy are required. Heating, lighting and cleaning costs are the same. There are economies in scale for catering, which is cheaper in the larger district general hospital.

General practitioner time is more expensive than senior house officer time. The same amount of specialist expertise is required whether a ward is in a district general hospital or in a community hospital. The difference in published expense is because a National Health Service costing convention allocates a proportion of the expenses of the 'super' specialties and the large administration overheads to each district general hospital ward.

If a ward were to be detached from the district general hospital corridor, no savings in these overheads would be made and the remaining beds would become more expensive. The only savings which can be made are if there is neglect in the community with reduced levels of nursing and therapy staff. Outcome is improved by a dedicated inter-disciplinary team. The recruitment problems in many areas mean that the full inter-disciplinary approach may be denied to patients in some community hospitals.

A balance is required between ease of access for visitors and the ease of access by the patient to specialist and diagnostic facilities in the district general hospital.

I submit that the cost of a ward is the same whether it is attached to a corridor of a district general hospital or stands alone and is labelled a community hospital. Community hospitals have little effect on hospital medical bed use and, by increasing the overall bed use [2], result in additional expense.

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