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Pointers

Pain in Arthritis : Probably the most intractable of all pains. Its management with drugs locally and systemically is described, though the patient's approach to life and support he receives from his physician are as important (p. 635).

Po_2 Measurements : Capillary blood taken from ear previously massaged with Trafuril gives values in close agreement with arterial Po_2 (p. 640).

Thyrotoxicosis : Out of 123 patients treated surgically 100 were euthyroid more than five years later. Twenty had some complication attributable to operation (p. 643). Leader at p. 631.

Mites and Dust : Dust mites found to be important in house dust allergies. Desensitization was successful in some cases (p. 646).

Tropical Neuropathy : Cause may be deficiency of sulphur-containing amino-acids resulting from release of cyanide from dietary cassava (p. 647). Leader at p. 632.

Friedreich's Ataxia : Heart failure was cause of death in more than half the patients in a series studied. Nearly three-quarters had evidence of cardiac dysfunction in life, and 23% had diabetes (p. 649).

Synthetic Corticotrophin : Asthmatic patients hypersensitive to animal corticotrophin had no allergic reaction to a synthetic preparation. Depot injection was effective for over 30 hours, compared with 20 hours for corticotrophin-gel (p. 653).

Ehlers–Danlos Syndrome : Lethal complications (p. 656).

Case Reports : Hepatic artery aneurysm after endocarditis (p. 659).

Lippes Loop : Insertion by paramedical personnel found practicable in West Indian study (p. 671).

Chest Radiography : Mobile service for general practitioners much appreciated (p. 674).

Personal View : Dr. William Cowan (p. 677).

G.P. Obstetric Units : Small units condemned by P.R.C.O.G. (p. 678).

Eclipse of the Sun : Leader at p. 633 ; Letter at p. 678.

Czechoslovak Refugees : Offers of help (p. 688).

Annual Clinical Meeting : Cheltenham programme (*Supplement*, p. 107).

Consultant Openings : Hospital posts tabulated by specialty (*Supplement*, p. 110).

Nutrition of the Elderly

A report of the World Health Organization[1] has stated that many people aged over 65 are in a poor state of health, to which malnutrition often contributes, and " The need for a well-balanced and easily assimilable diet in old age is not yet sufficiently recognized either by old people themselves or by those responsible for their care." Unfortunately estimation of the nutritional status of a patient remains for doctors a baffling problem, because satisfactory criteria of adequate nutrition do not exist. In Great Britain obesity is perhaps the commonest symptom of unsatisfactory nutrition, associated as it is with a generally increased liability to illness. The problems of malabsorption in elderly people have not been adequately studied ; partial gastrectomy, however, must be kept in mind as a common cause of it.

Many people eat less as they grow older. For instance, R. B. McGandy and his colleagues[2] showed from a study of 252 men aged 20 to 99 years that the total calorie requirements fell with age. Those men were highly educated and successful, so that the availability of food was not in question. The fall in calorie intake could be accounted for by decrease in basal metabolism and in the expenditure of energy required for physical activity. The diet of these men showed a disproportionate drop in fat intake with age, but the authors did not know whether this was the result of warnings in the popular press about fat or to a change of physiological tolerance. The mean level of total cholesterol in the serum is found to decrease in studies of the male population over the age of 50, and the decrease has often been interpreted as reflecting the earlier mortality of the relatively hypercholesterolaemic men, so that those remaining at later ages are the ones with low levels of cholesterol. But McGandy and colleagues' data suggest that the reduction of fat in the diet could cause a real fall in serum cholesterol. Incidentally, most of the men they studied were taking at least the nutrient allowance recommended by the National Research Council of America.

In Britain symptoms of sufficient severity to induce an old person to consult his own doctor are not often due to malnutrition. But what of subclinical malnutrition ? Many and varied symptoms have been ascribed to deficiency of vitamins. A person, too, may appear to be in a satisfactory state of nutrition but may have no adequate nutritional reserves, so that an illness such as pneumonia may precipitate a state of nutritional deficiency.

Physical or mental incapacity may lead to deficient intake of necessary food substances, and a frequent cause of failure to feed adequately is depression due to bereavement. Nor do old people buy wisely, so that income may be sufficient but spent on inappropriate food. It is extremely difficult to change the food habits of elderly people.

Though there is little protein deficiency among the elderly in Britain, A. N. Exton-Smith and B. R. Stanton[3] found in a study of 60 women over the age of 70 living alone that some diets were ill-balanced and also

provided too little protein, vitamin C, vitamin D, calcium, and iron. A striking deterioration in health and nutrition was found in the late 70s in this series. Vitamin-C levels in plasma and leucocytes are lower among the elderly than in younger people. E. F. Bowers and M. M. Kubik[4] found equally low levels in old people living alone and old people in welfare accommodation, but M. S. Kataria and his colleagues[5] reported them to be higher in elderly people living at home than in those living in a hospital and a large welfare home, the hospital levels being higher than those at the home.

Though low levels of vitamin C, vitamin B_{12}, folic acid, and thiamine may be found in elderly people, it would seem from reported surveys that clinical malnutrition may not be evident.[6-8] L. L. Griffiths and his colleagues[9] found abnormally low levels of ascorbic acid and thiamine in elderly people, but no clinical studies were made and these levels cannot be correlated with clinical signs. However, J. Andrews and his co-workers[10] have suggested that vitamin-C-rich fruit and fruit juices should be given as a routine in institutions. These problems are not simple, however, for R. W. Strachan and J. G. Henderson[11 12] have shown that dementia may be found in patients with vitamin B_{12} or folate deficiency, and H. C. Grant and his colleagues[13] described megaloblastic anaemia due to folic-acid deficiency in patients with undiagnosed peripheral neuropathy and myelopathy. Riboflavine deficiency creates a problem in diagnosis, because blood levels of this nutriment cannot be correlated with the patient's clinical state,[14 15] and further investigation will be required to find out if riboflavine deficiency in the elderly exists as a separate entity. Accurate biochemical assessment of nicotinamide and pyridoxine is also difficult.

Potassium deficiency in man can be induced in the normal person by giving a potassium-deficient diet for four to eight weeks,[16] and it has been suggested that the ease with which potassium depletion may be produced in the elderly results in part at least from dietary deficiency.[17]

Osteomalacia due to lack of vitamin D as a result of defective dietary intake and lack of exposure to sunshine may be commoner than has been reported, particularly in elderly women.[18-20] In this disease, as in iron-deficiency anaemia, it is difficult to assess the part played by malabsorption. Exton-Smith and Stanton[3] have suggested that osteomalacia might contribute to the skeletal rarefaction found in old age and recommended that meals designed for the elderly should contain a high proportion of protein with an adequate supply of calcium, iron, and vitamin D presented in such a way that the whole meal is eaten. Vitamin C might have to be provided separately, as food must be kept hot for long periods in a meals-on-wheels service.

Perhaps surprisingly, C. F. Brockington and Susanne Lempert,[21] studying the over-80s in Stockport, found that age as a factor on its own did not significantly affect the diet, nor did recent illness or the dental state. The unaided efforts of old men and women were associated with the worst diet, with men faring appreciably worse than women when cooking for themselves. Married people fared better, but the best results were achieved when meals were prepared wholly by someone coming into the house, paid or otherwise.

At present in Britain it seems that gross malnutrition is not commonly found in elderly people, but minor degrees of deficiency disease may exist, and there may in fact be a phase of subclinical malnutrition in the older person leading to poor health, apathy, and disinterest. For these reasons a random sample of elderly people is at present being studied for evidence of nutritional defects under a research programme organized by the Ministry of Health and the Scottish Home and Health Department.

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"V.D." as a Diagnosis

The term "venereal disease" arouses emotion in most minds, and to the unfortunate patient who is told that he is suffering from such a condition this diagnosis often appears as the ultimate disaster. Because of this attitude venereologists have from time to time sought to substitute other names, such as "genito-infectious disease," "sexually communicable infection," "genito-medical disease," and the like. The substitutes have never been widely accepted, and if they were the probability is that the old stigma would soon be attached to the new names. It is essential that such a diagnosis should never be communicated to a patient unless its authenticity is beyond question, and even then the greatest care and discretion should be used. The legal definition of venereal disease, as laid down in the Venereal Diseases Regulations of 1916 and the Venereal Diseases Act of 1917, comprises three diseases, namely syphilis, gonorrhoea, and soft chancre, and this limitation remains to the present day. There are, of course, other conditions, such as non-gonococcal urethritis and trichomoniasis, which are commonly transmitted sexually, but these have never been stigmatized as due to venery and it is better from the patient's point of view that they should not be so. This does not, of course, free the doctor from the responsibility of investigating the sexual partners of those suffering from these conditions.

Bernfeld[1] has recently described several cases in which harm resulted from the diagnosis of venereal conditions made upon too little evidence and communicated to the patients.

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