The burden of trauma in the elderly cannot be overstated [7]. A quarter of the elderly population is likely to fall at some time, the incidence increasing with age [11, 13]. Fortunately, only a small proportion will require hospital admission, but the relatively small numbers represent a large group of health service users. Falls not followed by fracture, particularly in the very old, immobile, incontinent and intellectually impaired, may be associated with a higher than expected mortality [16].

If proximal femoral fracture occurs there is also higher than expected mortality, largely within 6 months of fracture. Excess mortality is more likely in the very old, in men, and those admitted from institutions [6, 9, 12]. Elmerson’s report in this issue confirms these findings after 10 years of follow-up. Other associations with excess mortality include progressive conditions which may lead to cardiorespiratory, renal or brain failure, and malnutrition [12]. Such conditions, when severe, are associated with excess mortality per se. A fall or fracture could thus be regarded as a not unexpected component of illness. Such illness can be accelerated or precipitated by ever-present surgical complications such as pneumonia, salt and water disequilibrium and thromboembolism.

Careful preoperative selection might improve the survival figures. Have we the right to deny surgery? Is survival alone an effective measure of care? Leung’s report in this issue looks at social well-being following fracture fixation. Such measurements compliment an often misleading medical outcome. A short time at home, relatively pain-free with some degree of self-determination, might be considered worthwhile. A long time, bedridden in hospital, might not.

More work on measurement of effective care is to be welcomed. If the current fashion of early operation and rehabilitation for all but the very frail is to continue [5], an equally early indication of success or otherwise would be valuable [3]. There are many examples of working relationships between orthopaedic and geriatric departments [1, 2, 8, 10, 14, 15]. Regular visits by geriatric physicians to orthopaedic wards, transfer to rehabilitation units or transfer to geriatric wards expand the capacity of the acute orthopaedic unit. This permits more elective surgery and exposes the more difficult problems to a multidisciplinary team. Unfortunately, no single system stands out, largely because the reports describe different groups of patients and comparison is not possible. It is vital, nevertheless, that the patients’ falls and potential bone pathology are diagnosed accurately and that they, along with the orthopaedic nursing and medical staff, derive maximum benefit from the ‘rehabilitation culture’ of multidisciplinary working.
In conclusion, much good work is being done managing elderly patients with proximal femoral fracture. Unfortunately, such good practice is not universally applied and even progressive units need to look critically at their results. I have not touched on the prevention of falls and bone disease. There are hints of a bright future for prospective osteoporosis victims [4]. This may well reduce the burden of trauma in the elderly.

References