

## Editor's View

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### Cardiovascular health and frailty

I have often wondered at what point the pursuit of a healthy lifestyle becomes futile on the grounds of frailty. Perhaps later than expected if the analysis by Chen et al is anything to go by [<https://doi.org/10.1093/ageing/afac311>]. They used UK biobank data to find a range of frailty phenotypes – non-frail, pre-frail and frail people. They then established whether they had ideal, intermediate or poor cardiovascular health based on the American Heart Association's 'Healthy 7' metrics. This considers the adoption of three healthy lifestyle behaviours, namely not smoking, staying physically active and having a healthy diet, and good control of four cardiovascular risk factors, blood pressure, cholesterol, weight and blood sugar. They found a reduced risk of cardiovascular events in those with intermediate and ideal cardiovascular health across the frailty spectrum, but the risk reduction became progressively greater with increasing frailty. This was an observational study and not a trial, so it is possible some residual confounding could explain the result. It remains unclear if actively changing the behaviour of a frail person with poor cardiovascular health and lifestyle would improve their outcomes, even if that were possible. However, the results show that even frail individuals who are keen to improve their cardiovascular health should be encouraged and helped to do so and this could very well be worthwhile.

### Big data – big messages

The term 'big data' is often bandied about. In a digital world everything seems to be counted and recorded. The potential to harness some of these data to better inform our practice is clearly explained in an editorial by Close [<https://doi.org/10.1093/ageing/afac262>]. By linking large databases together, previously unrecognised patterns can emerge. In many cases, this confirm what is clinically suspected but is difficult to prove. A prime example is the study previously published in our journal by Patel et al [<https://doi.org/10.1093/ageing/afac183>], which found organisational factors, such as discussing patient experience feedback at morbidity meetings, are associated with better outcomes after hip fracture. This can be invaluable in gathering evidence of small, but important, benefits where it may be difficult to do so in an individual study.

### Pain in dementia

Pain is one of the most distressing symptoms that patients report. In dementia, it takes on added significance as people living with dementia can encounter problems articulating their symptoms, requesting treatment and ensuring they are appropriately managed, leading to concerns pain is under-treated in the condition. Moreover, pain itself can precipitate and exacerbate other distressing symptoms, such as agitation and sleep disturbance. Collins et al [<https://doi.org/10.1093/ageing/afac306>] highlight the evidence gap in the management of pain in dementia. Importantly, pain management is increasingly becoming individualised, with non-

pharmacological therapies being more frequently proposed. They make the case for greater use of comprehensive geriatric assessment and existing tools to identify 'pain phenotypes' to better identify and individualise management strategies to improve pain. An added benefit of such an approach is that other unmet needs could be identified and remedied.

### Insomnia

A meta-analysis of trials of a 4-week behavioural therapy intervention for older adults with chronic insomnia found it effective at improving a number of subjective and objective domains of sleep [<https://doi.org/10.1093/ageing/afac333>]. This is welcome given the limited benefits and well known adverse effects of commonly used sleeping tablets, especially when used long term. It is well established that non-pharmacological measures such as cognitive behavioural therapy can improve chronic insomnia, but it remains under-used. This is in no small part due to difficulties accessing specialist treatment. However, the Brief Behavioural Therapy for insomnia (BBTi) studied in this new systematic review was developed to try and overcome this by making the behavioural components more easily deliverable by a range of health professionals. Nevertheless, it is unclear whether sufficient professionals could ever be trained to deliver BBTi at scale and the study has important limitations. With only four studies including 136 patients, all community-dwelling and with a mean age of under 70, it remains to be seen whether such an intervention will become established on the back of the limited evidence to date.

### Futility of treating subclinical hypothyroidism

Negative findings are just as important as positive ones, particularly where there remains any lingering doubt about the value of treatment, as in subclinical hypothyroidism. The latest edition of the journal includes results from two randomised controlled trials of levothyroxine treatment in older people with persistent subclinical hypothyroidism [<https://doi.org/10.1093/ageing/afac326>]. No differences were observed in any of the primary or secondary outcome measures, namely gait speed, hand grip strength and muscle mass. The current trial results add to the growing evidence of futility in the treatment of subclinical hypothyroidism with levothyroxine supplementation, although some guidelines still recommend treatment.

### Reducing demand on hospital beds

Hospitals that are bursting at the seams keep making headline news. The search for sustainable solutions has been ongoing for many years, but has taken on greater urgency. One solution that is frequently mooted is the 'virtual ward'. What better place to find a bed for a patient in need than in their own home? Virtual wards are subtly different from 'hospital at home' schemes in that the former rely chiefly on technology for remote monitoring, whereas the latter involves face to face care within the home, though there can often be overlap. Trying to unravel the evidence base for their effectiveness and worth is tricky but important, as Norman and colleagues eloquently explain in their rapid review of the literature [<https://doi.org/10.1093/ageing/afac319>]. The good news is that they found plenty of evidence for the benefits of 'hospital at home' type schemes, but virtual wards have been poorly researched and there is a clear need to investigate their effects to ensure patient safety and judicious use of stretched resources.

Another attractive option may be to bolster provision of outpatient rehabilitation services to minimise use of inpatient rehabilitation. In a systematic review of randomised controlled trials of outpatient geriatric rehabilitation after an inpatient stay, Preitschopf and colleagues found that outcomes in terms of functional performance matched usual care [<https://doi.org/10.1093/ageing/afac300>]. There was no difference in quality of life or risk of readmission. However, and perhaps most importantly if the idea is to keep people out of hospital, there was insufficient evidence that length of stay in hospital was lower in those given outpatient rehabilitation. Indeed, in most studies where risk of bias was low, there was no effect. With some studies dating back over 20 years, what is unclear is how relevant some studies are to today's highly pressured environment, when patients are increasingly discharged as soon as it is safe to do so, rather than when they approach or reach their maximum functional ability. Perhaps where pressure to discharge is great, outpatient rehabilitation services may yet prove helpful. Alternatively, the moral of the story may be that people will often rehabilitate themselves just as well when freed from the confines and restrictions of the hospital environment.