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Editor – A recent article on acute geriatrics by Conroy and Parker[1] was both clear and relevant.

I was however disappointed (but not surprised) by the first sentence which stated that 'the emergency department is the main portal of entry to emergency care'. The authors also point out that 'geriatricians cannot address the population need alone'.

It is a pity that general practice therefore gets but a passing mention. This is not the fault of the authors but results perhaps from a cumulation of political interference, workforce issues and a near complete fission of primary and secondary care.

A few years ago, as a GP, I developed an interest in acute medicine.[2,3] There are now a number of similar initiatives in different areas, the common qualification of the doctors involved being the desire to dispel the myth that hospitals and the community have different agendas. As Conroy and Parker imply, it is rather important that they don't.

There have been recent discussions between the RCP and RCGP to develop both a skill set and an assessment to accredit such doctors. These discussions have currently been shelved. This is all the more regrettable since, as the authors infer, management should focus on what is appropriate for the individual as opposed to exclusion of the unlikely. This concept lies at the heart of general practice. ■

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The emergence of sarcopenia as an important entity in older people

Editor – The informative article by Offord *et al* highlights the detrimental impact of age-related frailty and sarcopenia on mobility, fracture risk, quality of life, and NHS resources.[1] We were, however, surprised to find no mention of hypogonadism among the recognised causes of sarcopenia (and anaemia) in older males. The anabolic benefits of androgens on skeletal muscle mass are well-documented, albeit also observable with supraphysiological levels achieved by athletes as well as in the context of medically justifiable T replacement.[2] The European Male Ageing study found that hypogonadism affects 2–5% of community-dwelling older men.[3]

Hypogonadism is either caused by deficient testicular function (ie primary hypogonadism) or reduced pituitary luteinising hormone (LH) and follicle stimulating hormone (FSH) secretion (ie secondary hypogonadism). Secondary hypogonadism (low LH, FSH and T) is challenging to diagnose, particularly in the acute setting, as similar biochemical results may be observed in relation to non-gonadal illness, and in healthy men in the evening or post-prandially (T levels have diurnal variation and are suppressed acutely by food intake).[4] By contrast, the biochemical fingerprint of primary hypogonadism is unambiguous, even in the setting of an acute medical or geriatric-rehabilitation ward; serum levels of LH and FSH are elevated, and serum T is low or low-normal. Furthermore, it is important to consider that patients may also present with microcytic anaemia caused by reduced T-dependent haematopoeisis.

T treatment may be given topically or by depot injection. T treatment is not recommended for men with physiological suppression of T secretion as a result of either frailty or obesity of old age.[3–5] However, for older men with true hypogonadism, T replacement is an inexpensive, safe and effective therapy that can reverse sarcopaenia, osteopaenia and anaemia, with expert consensus defining no upper age limit for the initiation of therapy in these individuals.[6]

Thus, when diagnosing sarcopaenia in older men, we urge physicians not to reflexively ascribe this to 'old age', and to also recognise that unexplained anaemia may sign-post hypogonadism. If the patient is subsequently found to have elevated LH and FSH, a trial of T replacement should be considered following an expert review. ■

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