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Editor – A recent article on acute geriatrics by Conroy and Parker¹ 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 haematopoiesis.

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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Sarcopenia, frailty and exercise

Many thanks to Offord and Witham for their article on sarcopenia.¹ They rightly identify low levels of physical exercise as a major cause of sarcopenia and subsequent frailty, dependency and premature death. As they say, exercise has some effect in reversing sarcopenia but by the time that sarcopenia has become a clinical problem it is probably too late to treat. A trial that investigated weight-training in nursing home residents, aged 90 years or older, showed weight training to be clearly beneficial in terms of strength and self-care scores – but, the scores soon fell back to their pre-trial levels after the study ended.² Prevention is what is needed and this means regular exercise for the population as a whole, starting as early in life as possible and continuing throughout life.

Regular moderate to vigorous exercise is not only a protection against sarcopenia but is also the key to prevention of a large number of non-communicable diseases which themselves lead to a further reduction of physical performance – obesity, diabetes, heart disease, osteoporosis, some cancers and many others. Regular exercise lengthens lifespan but, perhaps more importantly, healthspan. The compression of morbidity at the end of life is what we all seek for our patients as well as ourselves. It is regular exercise which lengthens healthspan and reduces the financial, social and health costs which result from an increasingly dependent elderly population. The desirability of decreasing the period of dependency at the end of life cannot be overstated.

Sadly it seems that end-of-life dependency is actually increasing. The Office of National Statistics report in 2012 showed that a 65 year old man could expect to be free from disability and long term illness for a further 10.6 years but by 2014 this had decreased to 10.3 years. For women the figures were 11.2 years falling to 10.9 years.³

Inactivity should be managed as seriously as cigarette smoking. Public education, the provision of better exercise facilities and the promotion of active travel (ie walking or cycling to work) should become political imperatives. And the medical profession should spend a great deal more time and effort in encouraging an idle population to get off its collective backside and start exercising. ■

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Antisynthetase syndrome

Editor – Fallon *et al* report a typical case of antisynthetase syndrome (ASS) responsive to prednisolone and mycophenolate.¹

While the association of the related autoimmune connective tissue disorder dermatomyositis with malignancy is well established, a link with the presence of antisynthetase antibodies

and malignancy is only just emerging. A recent case series reported the development of malignancy in 8/124 patients.²

Both conditions are routinely treated with potent immunosuppressive therapy which further increases this risk of malignancy.

Readers are reminded to monitor for malignancy in patients with antisynthetase syndrome in the same fashion as they currently do with patients with dermatomyositis particularly when using long term immunosuppressives such as mycophenolate or azathioprine. ■

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The hyperacute neurology team

Editor – I enjoyed reading the paper on a hyperacute neurology team¹ which certainly seems to produce impressive results. I was left wondering however, with a consultant-delivered service, about their education and training responsibilities. Does the team have these? If so, how do they impact on the service? If not, how is their expertise transmitted to the next generation? ■

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- 1 Nitkunan A, MacDonald B, Boodhoo A *et al*. A hyperacute neurology team – transforming emergency care. *Clin Med* 2017;17:298–302.

Editor – Nitkunan *et al*'s¹ interesting article outlines some innovative ideas to ensure that patients are promptly seen by neurologists after admission to a district general hospital. They highlight the role of an acute neurology nurse co-ordinator and the advantages of a service being based close to the acute medical unit.

Our district general hospital also provides a 5-day service, with patients being seen on the same day if referred before 2 pm. There has been a similarly marked increase in number of referrals to the team. The number of referrals increased by 38% between the first six months of 2014 and the comparable period in 2015, were static to 2016, but increased by a further 22% in the first half of this year.

In response to this growing demand we introduced another individual who could be considered when constructing a hyperacute neurology team – a neurology clinical fellow. This would typically be an individual who has completed Core Medical Training and who is interested in obtaining further experience in neurology. They can provide an easily accessible