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Editor's Note

Falls: A Perfect Paradigm for Multifaceted Management

When medical residents rotate through our geriatric service at the University Health Network, we provide a group of seminars on the "Geriatric Giants": confusion, instability and falls, incontinence, geriatric pharmacology and failure to thrive. I have to admit that my personal favourite among the geriatric giants is the topic of falls. I find it to be a perfect paradigm for the clinical practice of geriatric medicine, and thus an excellent tool for teaching the general principles of geriatric care.

What are those principles? I think the first is that any number of problems can result in falls, and that the overwhelming majority of falls in the elderly are not caused by a single factor but by the combination of a multitude of problems. This allows me to demonstrate to the students the various factors that can predispose to falls. These can be intrinsic to the patient (age-related changes or diseases), or external to the patient (environmental factors). The key for the doctor is to determine what factors are operant in a particular patient, and of these, which are modifiable. The next step is to determine which factors can be improved rapidly (e.g., stopping certain medications) and which require long-term strategies (e.g., proximal muscle strengthening). I also emphasize to the residents that there is no such thing as a trivial fall, although some falls only result in trivial injuries. That person's next fall might result in a devastating injury.

The nature of the scientific study of falls in the elderly took an exciting and dramatic turn in the early 1990s, with the article by Mary Tinetti in the *New England Journal of Medicine*.¹ Her study demonstrated that proper attention to falls risk factors in a primary care setting could actually reduce the number of falls these people would have (absolute risk reduction of 12%, number needed to treat to prevent one fall is 8). This demonstrated clearly that with a comprehensive interdisciplinary approach, complex functional issues in the elderly could be systematically approached and improved.

The new issue in falls prevention is how to reach all those at potential risk. With our rapidly aging population, the individual doctor-patient interaction, while very important, is not enough. The next step in falls prevention is the implementation of community-based programs (e.g., exercise programs) that can have a broader impact. These programs have shown clear efficacy in high quality clinical trials, and we now need to determine if they will be effective when introduced into the community at large.

This issue of *Geriatrics & Aging* has been designed to provide the tools for primary care physicians to assess the risk factors for falls in their elderly patients, and to allow them to prevent some of these devastating occurrences. Gabriele Meyer, Andrea Wamke and Ingrid Mühlhauser tackle the general topic of fall and fracture prevention in the elderly, and Dr. Fiona E. Shaw addresses the thorny problem of falls in those with dementia. Drs. Nadine Gagnon and Alastair Flint review one of the crippling consequences of falls, namely fear of falling, which dramatically reduces function and quality of life. Dr. Boyd Swinburn and Richard Sager give some practical advice in their article on the promotion of exercise prescriptions for elderly populations. Dr. Margaret Grant provides treatment strategies for one of the most potent risk factors for falls, orthostatic hypotension, while Dr. Karim Khan, *et al.* present strategies for the optimal delivery of falls prevention programs to the elderly in the community.

Enjoy this issue. ◆

Reference

1. Tinetti ME, Baker DI, McAvay G, et al. A multifactorial intervention to reduce the risk of falling among elderly people living in the community. *N Engl J Med* 1994;331:821-7.



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