Letter to the editor

There is a need once again for a multifactorial assessment and intervention for fall prevention among the elderly

Antonio Caronni¹, Luciana Sciumè²

¹Department of Neurorehabilitation Sciences, Casa di Cura del Policlinico, Milan, Italy, ²Università degli Studi di Milano, Milan, Italy

In their recent work, Chen and colleagues have shown that falls from slipping, tripping, or stumbling were the most frequent cause of fall related spinal cord injuries in the elderly between 2005 and 2014.¹

Within a longer (but partially overlapping) period of time, Jain and colleagues² reported the incidence, etiology and mortality of the acute traumatic spinal cord injury in the United States (from 1993 to 2012). The Authors described a two fold increase in the percentage of the spinal cord injuries associated with falls in the elderly, which passed from less than one third in the 1997–2000 period to two thirds in the 2010–2012 period. Jain and colleagues proposed that the increase in falls related spinal cord injuries “*likely represents a more active 65- to 84-year-old US population currently compared with the 1990s.*”² ICD-9-CM codes identifying an external cause of injury (i.e. E codes) were used to classify the spinal cord injury into three groups (associated with unintentional falls, associated with motor vehicle crashes and associated with firearm injuries). The unintentional falls group included different types of falls, such as falls from ladders (E881) and falls on same level from slipping, tripping, or stumbling (E885).

We believe that Chen and colleagues¹ provide an important clarification of the mechanism leading to

the increase in spinal cord injuries associated with falls in the elderly.²

Different modifiable factors are known to be associated with falls in the elderly (e.g. medication, impaired cognition),³ with balance and mobility impairment consistently associated with falls and injurious falls.⁴ The important data provided by Chen and colleagues underline once again the need for an effective fall prevention program among the elderly. Clinicians should not only suggest the restriction of hazardous activities² (e.g. climbing a ladder), but elderly should be given a multifactorial fall risk assessment by a trained clinician and proper interventions to reduce their fall risk.⁵

References

- 1 Chen Y, Tang Y, Allen V, DeVivo MJ. Fall-induced spinal cord injury: external causes and implications for prevention. *J. Spinal Cord Med* 2016;39(1):24–31.
- 2 Jain NB, Ayers GD, Peterson EN, Harris MB, Morse L, O'Connor KC, *et al.* Traumatic spinal cord injury in the United States, 1993–2012. *JAMA* 2015;313(22):2236–43.
- 3 Ganz DA, Bao Y, Shekelle PG, Rubenstein LZ. Will my patient fall? *JAMA* 2007;297(1):77–86.
- 4 Ward RE, Leveille SG, Beauchamp MK, Trivison T, Alexander N, Jette AM, *et al.* Functional performance as a predictor of injurious falls in older adults. *J Am Geriatr Soc* 2015;63(2):315–20.
- 5 Tinetti ME, Kumar C. The patient who falls: “It’s always a trade-off”. *JAMA* 2010;303(3):258–66.

Correspondence to: Antonio Caronni, Department of Neurorehabilitation Sciences, Casa di Cura del Policlinico, Via Dezza 48, 20144 Milano, Italy. Email: a.caronni@ccppdezza.it