Resistance exercises or vitamin D did not improve physical health or reduce falls in frail older people


QUESTION: In frail older people, does a home based programme of quadriceps resistance exercise or vitamin D supplementation improve physical health and reduce falls?

Design
Randomised (allocation concealed), blinded (clinicians, patients, and outcome assessors), controlled, factorial design trial with 6 months of follow up.

Setting
5 teaching hospitals in Auckland, New Zealand and Sydney, Australia.

Patients
243 people admitted to geriatric rehabilitation units (inpatient or day wards) who were ≥65 years of age (mean age 79 y, 53% women), considered frail (≥1 health problem or functional limitation [eg, dependency in an activity of daily living, prolonged bed rest, impaired mobility, or a recent fall]), and had no indication or contraindication for the study treatments. Exclusion criteria included poor prognosis, severe cognitive impairment, physical limitations restricting adherence to the exercise programme, unstable cardiac status, and large ulcers around the ankles. Follow up was 91%.

Intervention
Patients were allocated to resistance exercise (n=120) or attention control (n=123) and to vitamin D (six 12.5 mg tablets of calciferol) (n=121) or placebo (n=122). The quadriceps resistance exercise involved warm up stretches and 3 sets of 8 repetitions of knee extensions using ankle cuff weights in a seated position 3 times per week for 10 weeks. Patients were monitored weekly by a physiotherapist, with alternating telephone calls and home visits. The attention control group received weekly matched telephone calls and home visits from the physiotherapist.

Main outcome measures
Self rated physical health (related quality of life [HRQoL]) using the physical component score of the Medical Outcomes Study 36 item short form questionnaire at 3 months, and falls over 6 months. 25-hydroxyvitamin-D (25-OH-D) concentrations were measured by radioimmunoassay. Adverse events were assessed.

Main results
Analysis was by intention to treat. Resistance exercises did not improve HRQoL or reduce the incidence of falls more than attention control (table). In only 1 measurement (timed up and go) did the groups differ, and the difference favoured attention control (p=0.045). Musculoskeletal injuries were more frequent in the resistance exercise group (18 ± 5 people; relative risk 3.6, 95% CI 1.5 to 8.0). Vitamin D supplementation had no effect on HRQoL or incidence of falls (table), although 25-OH-D concentrations were higher in the vitamin D group than the placebo group (change from baseline to 3 mo ± 9 ± 0 ng/ml).

Conclusions
In frail older people, neither a home based quadriceps resistance exercise programme nor vitamin D supplementation improved physical health or reduced the risk of falls. Resistance exercise led to a higher incidence of musculoskeletal injuries.

### Outcomes Comparison Score Mean difference (95% CI)

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Comparison</th>
<th>Score</th>
<th>Mean difference (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean physical component score of 36 item short form questionnaire at 3 months</td>
<td>Resistance v control</td>
<td>34 ± 35</td>
<td>−1 (−4 to 1)</td>
</tr>
<tr>
<td></td>
<td>Vitamin D v placebo</td>
<td>35 ± 35</td>
<td>0 (−2 to 3)</td>
</tr>
<tr>
<td>Event rates</td>
<td>RRRI (CI)</td>
<td>NNT</td>
<td></td>
</tr>
<tr>
<td>Resistance v control</td>
<td>54% ± 58%</td>
<td>7.9% (−16 to 27)</td>
<td>Not significant</td>
</tr>
<tr>
<td>Proportion of people who fell over 6 months</td>
<td>Vitamin D v placebo</td>
<td>59% ± 53%</td>
<td>13% (−11 to 43)</td>
</tr>
</tbody>
</table>

*Abbreviations defined in glossary; RRR, RRI, NNT, NNH, and CI calculated from data in article.

COMMENTARY

Previous studies have shown the beneficial effects of exercise for older adults,1,2 but no consensus exists on the appropriate quantity, quality, or intensity of exercise necessary to promote improved health and function in this population. Hence, it is difficult to know what would work best for frail older adults. Latham et al and Schnelle et al explore the transferability of what has been learnt in clinical research into the delivery of efficient and cost effective interventions in 2 groups of frail older adults.

The goal of the study by Latham et al was to identify an intervention that could be easily and inexpensively incorporated into existing home healthcare services. To decrease the complexity and improve the feasibility of the intervention, Latham et al reduced the intensity of exercise necessary to promote improved health and function in this population. Hence, it is difficult to know what would work best for frail older adults.

The results of these studies are relevant to nurses who work in long term care and community settings with frail older adults. The findings increase our understanding of the role of exercise in the treatment of frailty. The studies support the use of exercise as a treatment for frail older adults. However, more research is needed to determine the effectiveness of exercise interventions in frail older adults.

Continued on next page
An exercise and incontinence intervention did not reduce the incidence or cost of acute conditions in nursing home residents


**QUESTION:** In nursing home (NH) residents, does an intervention combining low intensity exercise and incontinence care offset its costs by reducing selected health conditions?

**Design**

Cost effectiveness analysis of a randomised [allocation concealed]*, blinded ([data collectors]* and outcome assessors), controlled trial with follow up at 8 and 32 weeks.

**Setting**

4 NHs in the US.

**Patients**

190 NH residents (mean age 88 y, 85% women) with urinary incontinence who did not have catheters, could follow a simple 1 step instruction, and were not on Medicare Part A reimbursement for post-acute skilled care or terminal illness. Follow up was 91% at 8 weeks and 78% at 32 weeks.

**Intervention**

Patients were allocated to an 8 month exercise programme (Functional Incidental Training [FIT]) (n=92) or to usual care (n=98). The FIT intervention was implemented every 2 hours during the day for 5 days per week and involved prompts to toilet and changing if wet, encouragement to walk (or wheel their wheelchairs), repeat sit to stands up to 8 times, and practise upper body resistance training (arm curls or arm raises) once per day when in bed. Patients were offered fluids after each exercise trial.

**Main cost and outcome measures**

Acute conditions relating to physical inactivity, incontinence, or immobility including conditions of the dermatological, genitourinary, gastrointestinal, respiratory, endocrine, neurological, and cardiovascular systems; and falls, pain, and psychiatric and nutritional disturbances. Costs of tests and treatments were assessed using 1997–98 Medicare and Medicaid reimbursement amounts at a rate of 80%.

**Main results**

The FIT and usual care groups did not differ for the incidence of any acute conditions. Multivariable analyses were done to control for differences at baseline and follow up. When acute conditions were analysed together, FIT showed a non-significant 10% reduction in the number of illness related sickness episodes. Of the acute conditions analysed, only falls showed a significant reduction (odds ratio 0.46, p<0.04) associated with FIT. The groups did not differ for cost of assessment and treatment of acute conditions between baseline and intervention periods (table).

**Conclusion**

In nursing home residents, low intensity exercise plus incontinence care did not reduce the incidence or costs of acute conditions more than usual care.

*Information provided by author.

**Cost of treating acute conditions with Functional Incidental Training (FIT) vs usual care in nursing home residents†**

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Baseline period</th>
<th>Intervention period</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>FIT</td>
<td>Usual care</td>
</tr>
<tr>
<td>Cost per resident per week (1997–98 US dollars)</td>
<td>$30.38</td>
<td>$36.81</td>
</tr>
</tbody>
</table>

†Difference between groups for change from baseline was not significant.

**COMMENTARY—continued from previous page**

such a frail population. The vitamin D supplementation dose was not sufficient to correct elevated parathyroid hormone concentrations that may be responsible for compromising muscle strength. Both calcium and vitamin D in sufficient quantities may be required to achieve the improvement sought.

Secondly, cost of the intervention may not be the most appropriate criterion for adoption into practice. Although it was hoped that the benefits might be gained at no extra cost, this is rarely achieved in health care. Decisions about resource allocation should be made on the basis of information about costs and benefits. The exercise and incontinence intervention tested in the NH clinical trial on which the economic analysis was based resulted in improvement or prevented decline in mobility, upper body strength, and continence in most of the intervention group patients. However, Schnelle et al found that the staffing requirements needed to implement the intervention (1 aide to 5 patients) exceeded the staff resources available in most (92%) NHs and were not offset by reductions in other costly care. Staffing limitations may therefore prevent the successful transfer of this and similar exercise and incontinence interventions to NH clinical practice. The data reported in this study provide evidence that nurses’ aide staffing ratios advocated in recent government studies and by consumer groups’ as necessary to provide high quality NH care are justified.

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