

RESPONSE TO DR. STRANDBERG ET AL.

To the Editor: We are grateful to Dr. Strandberg and colleagues for their interest in our article that prompted them to analyze more baseline data of the associations between cytomegalovirus (CMV) serology, functional performance, comorbidity, and health-related quality of life (HRQoL) in their cohort with a mean age of 80.¹ We agree that the apparent lack of association between functional impairment and frailty and CMV serology in our Belfrail cohort with a mean age of 84 may be the result of selection (survival), with many of the participants representing a specific phenotype that is less susceptible to the long-term deleterious effects of CMV.² Consistent with our hypothesis, we would indeed expect similar findings in other equally old populations. To the contrary, in the cohort of Strandberg and colleagues, higher baseline CMV titers were associated with more functional impairment, comparable with findings in younger populations, but their cohort represents a select population of home-dwelling older persons with a history of stable cardiovascular disease. The findings of two recent meta-analyses strongly suggest that CMV infection is associated with a higher risk of cardiovascular morbidity and mortality.^{3,4} There are several plausible mechanisms by which CMV might play a role in the pathogenesis of cardiovascular disease. CMV is able to establish persistent infection in endothelial cells and to cause vascular damage. CMV is also associated with chronic systemic low-grade inflammation, which may also contribute to endothelial damage and the atherosclerotic process. For these reasons, CMV may play an important role in the pathogenesis of cardiovascular disease. In light of this, it seems likely that, in many of the individuals in Strandberg and colleagues' cohort, CMV was involved in the development of their cardiovascular disease. Therefore, it is possible that, in their study, individuals susceptible to the detrimental long-term effects of CMV, but only to the extent that it did not prevent them from reaching an advanced age, are overrepresented.

In our opinion, the contrasting findings between Strandberg and colleagues' and ours are illustrative of the heterogeneity of the CMV-seropositive older adult population. Further research is required to better understand this heterogeneity.

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RISK FACTORS FOR FALLS IN ELDERLY ADULTS: NOT ONLY PHARMACOLOGICAL EFFECTS

To the Editor: We have read with great interest the article by Finkle and colleagues assessing the risk of nonvertebral fractures in elderly persons being treated with benzodiazepines or zolpidem.¹ The article is extremely interesting above all because of the large population included, but our attention was drawn to certain limitations that make it difficult to interpret the results.

The first point that we noticed was that the mean age of this population was well below geriatric age, even though this is the population with the greatest risk of falls, as the authors themselves note. In the basic characteristics of the sample, no reference is made to the standard deviation from the mean.

The authors note that they had no information about the cause of the fracture or the circumstances in which it occurred. The risk of falls is high in people who get up in the night after taking sleeping tablets.² Considering that the population consisted mainly of young people, we suspect that falls are not the only or even the most important etiological factor, because traffic accidents are obviously a major cause. Along similar lines, because we do not know the reason for the prescription, we cannot assess the presence of insomnia, which is itself a well-known risk factor for falls and fractures.³ We do not know the prescribed dose, which is indispensable, because the risk of falls and fractures increases with the dose of benzodiazepines.

We believe that it is wrong to consider only the first drug prescribed in the case of concomitant treatment with zolpidem and benzodiazepines. It is accepted that multiple prescriptions increase the risk of interaction between drugs and raise the risk of falls, and this is even more obvious when more drugs affecting the central nervous system are taken simultaneously. Among the pharmacological aspects that have not been taken into account in the present study, our attention is drawn to the fact that the diagnosis of depression is included, but treatment with antidepressants is not assessed, although this is a well-known risk factor for falls. The use of opiates is not