Statistical significance does not equate to clinically significant benefit. The magnitude of the benefit is important when applying trial results to clinical practice. For the primary outcome of HYVET,4 absolute risk reduction of stroke was 5.3 per 1,000 patient-years (P = .06), and the number needed to treat per year is 189. For total mortality, absolute risk reduction was 12.4 per 1,000 patient-years (P = .02), and the number needed to treat per year is 81. Whether these results are clinically significant is dependent on individual patients and providers.

Extrapolating benefit from hypertension trials to individual elderly patients can be difficult, and the external validity of HYVET to the target population needs to be assessed. HYVET participants were healthier than the general population of the oldest old. When comparing data from HYVET participants with data from the 2006 National Health Interview Survey from the Centers for Disease Control and prevention,9 the participants in HYVET had a lower prevalence of diabetes mellitus (7% vs 18%), coronary disease (12% vs 26%), and stroke (7% vs 11%) than typical Americans aged 75 and older. It would be interesting if HYVET reported how many patients were screened for the final enrollment.

By design, HYVET does not address isolated systolic hypertension (SBP ≥ 140 mmHg and DBP < 90 mmHg) and mild hypertension (SBP 140–159 mmHg or DBP 90–99 mmHg). Therefore, it is still unknown whether treating the oldest old with isolated hypertension or mild hypertension is beneficial.

That treating hypertension in the oldest old is not simple. Some important outcomes such as quality of life of HYVET participants have not been reported. Drug-related adverse effects are another important consideration. Elderly patients often have orthostatic hypotension, postprandial hypotension, dizziness, and falls. The oldest old might have more symptoms if their blood pressure were lowered to or below 140/90 mmHg, the goal of the Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure.

Overall, HYVET is an important and valid study, but its applicability to most of the oldest old with isolated systolic or mild hypertension is limited. Debates on how to measure the quality of care for this group of elderly patients will continue.10 A new trial that targets isolated systolic hypertension and mild hypertension in the oldest old is urgently needed.

**Dmitry Abramov, MD**
**Huai Cheng, MD, MPH**
**Department of Medicine**

**Division of Geriatric Medicine and Aging, Allen Pavilion**
**Department of Medicine, Columbia University**
**New York, New York**

**ACKNOWLEDGMENTS**

**Conflict of Interest:** Dr. Cheng is a recipient of the Geriatric Academic Career Award from Department of Human Health.

**Author Contributions:** Both authors are contributed equally to this letter.

**Sponsor’s Role:** Not applicable.

**REFERENCES**

1. Mancia G, De BG, Dominiczak A et al. ESH-ESC practice guidelines for the management of arterial hypertension: ESH-ESC task force on the management of arterial hypertension. J Hypertens 2007;25:1751–1762.

2. Gueyffier F, Bulpitt C, Bossel JP et al. Antihypertensive drugs in very old people: A subgroup meta-analysis of randomised controlled trials. Lancet 1999;353:793–796.

3. Bulpitt C, Beckett NS, Cooke J et al. Results of the pilot study for the hypertension in the very elderly trial. J Hypertens 2003;21:2409–2417.

4. Beckett NS, Peters R, Fletcher AE et al. Treatment of hypertension in patients 80 years of age or older. N Engl J Med 2008;358:1887–1898.

5. Guyart GH, Sackett DL, Cook DJ. Users’ guides to the medical literature. II. How to use an article about therapy or prevention. A. Are the results of the study valid? Evidence-Based Medicine Working Group. JAMA 1993;270:2598–2601.

6. Guyart GH, Sackett DL, Cook DJ. Users’ guides to the medical literature. II. How to use an article about therapy or prevention. B. What were the results and will they help me in caring for my patients? Evidence-Based Medicine Working Group. JAMA 1994;271:59–63.

7. Montori VM, Devereaux PJ, Adhikari NK et al. Randomized trials stopped early for benefit: A systematic review. JAMA 2005;294:2203–2209.

8. Kostis JB. Treating hypertension in the very old. N Engl J Med 2008;358:1958–1960.

9. Summary Health Statistics for U.S. Adults: National Health Interview Survey, 2006 [on-line]. Available at: http://www.cdc.gov/nchs/data/sr_10/sr10_235.pdf

10. Sutin DG, Rougas S. Are the assessing care of vulnerable elders quality indicators for hypertension wrong? J Am Geriatr Soc 2008;56:1163–1164.

**EFFECT OF PHYSICAL ACTIVITY COUNSELING ON HOME CARE USE IN OLDER PEOPLE**

To the Editor: The high prevalence of disability in older sedentary people increases the need for home care services,1–3 so interventions for postponing disability and related service use are urgently needed.4 A recent randomized controlled trial (RCT) showed that physical activity counseling decreased functional limitations in older people.5 In addition, subgroup analyses showed a reduction in the incidence of instrumental activity of daily living (IADL) disability for those without IADL disability at baseline.6 This letter presents results on the effect of physical activity counseling on formal home care use in older community-dwelling sedentary persons.

**METHODS**

The design and methodology of the Screening and Counseling for Physical Activity and Mobility (SCAMOB) project have been reported in detail elsewhere.7 SCAMOB was a 2-year, single-blind, RCT with 1.5-year follow-up on the effects of individualized physical activity counseling for older sedentary people. The target population consisted of all registered residents of the city of Jyväskylä, Finland, aged 75 to 81 living in the city center area in March 2003 (N = 1,310). After a four-phase screening and data collection process, 632 persons were found to be eligible for the study. The Ethical Committee of the Central Finland Health Care District approved the study.

The intervention group received one individual motivational face-to-face physical activity counseling session with one physiotherapist specifically trained for the task.7 This was followed up by telephone contact every 4 months for 2 years and two annual lectures on physical activity to support adherence and behavior change. The control group received no intervention.
Home care was defined as using publicly subsidized formal home help or home nursing for various activities at least once a month for at least 3 months. Home care activities included, for example, help with IADL and self-care tasks such as bathing, shopping, and preparing food. Hazard ratios and 95% confidence intervals on home care use were estimated using Cox proportional hazards model. Statistical significance was set at \( P < .05 \).

RESULTS
Six hundred thirty-two persons were randomized into an intervention (\( n = 318 \)) or control (\( n = 314 \)) group. Of these, 567 (89.7%) gave written consent to collect data from the city of Jyväskylä health and social service register on home care use during the 2-year trial and 1.5-year follow-up. Three persons who used formal home care at baseline were excluded. Of the 564 (intervention \( n = 290 \) and control group \( n = 274 \)) remaining persons, 59.1% managed self-care tasks such as bathing, getting out of bed, and toileting without difficulty, whereas of the RCT participants that were not investigated (\( n = 68 \)), 42.4% managed the tasks without difficulty (\( P = .01 \)).

Baseline characteristics of the intervention and control groups were comparable, except that 61.6% of the intervention group and 50.7% of the control group lived alone (\( P = .01 \)). In both groups, the majority of participants were women (75.5%). Mean age ± standard deviation was 77.6 ± 1.95, they had on average three chronic diseases, and approximately 68% were able to walk 2 km without difficulty. Fifteen percent of the intervention group and 18.2% of the control group received informal care from a spouse, child, or relative. The risk for home care use was approximately 50% lower for the intervention group than the control group (Figure 1).

DISCUSSION
The current secondary analyses of the RCT data suggest that physical activity counseling may help reduce the need for home care in the long term. It was hypothesized that physical activity counseling would increase physical activity, which in turn, would decrease mobility difficulties, postpone disability, and consequently decrease the need for home care. The current results complement the earlier findings on reduced mobility limitation and the subgroup finding on reduced incident IADL disability and indicate that the trial benefits may extend the entire length of the hypothesized pathway.

The use of other forms of care did not explain the treatment effect. At baseline and follow-up, approximately 10% of the participants in both trial groups reported using private home care services. Informal care did not differ significantly between the groups at baseline or during follow-up. None of the participants were institutionalized at baseline, and during the 3.5-year period, only one person from the control group was institutionalized without prior home care use.

Register-based data was used for investigating the use of publicly subsidized home care, which eliminated the effect of reporting bias. Home care data were available for 90% of the RCT participants, which is why the effect of randomization is uncertain, although the findings indicate that there is a growing need for interventions aiming to increase physical activity for older people with follow-up on the need for health and social services.

Mikaela B. von Bonsdorff, MSc  
Finnish Center for Interdisciplinary Gerontology  
Department of Health Sciences  
University of Jyväskylä  
Jyväskylä, Finland

Raija Leinonen, PhD  
GeroCenter Foundation for Research and Development  
Jyväskylä, Finland

Urho M. Kujala, MD, PhD  
Department of Health Sciences  
University of Jyväskylä  
Jyväskylä, Finland

Eino Heikkinen, MD, PhD  
Timo Törmäkangas, MSc  
Finnish Center for Interdisciplinary Gerontology  
Department of Health Sciences  
University of Jyväskylä  
Jyväskylä, Finland
OLDER PATIENTS HAVE HIGHER CONVERSION RATES FOR LAPAROSCOPIC CHOLECYSTECTOMY THAN YOUNGER PATIENTS

To the Editor: We read with interest the letter by Kaya et al., which compared the rate of conversion from laparoscopic to open cholecystectomy in patients aged 65 and older with that in younger patients. The authors conclude that older patients do not have a significantly higher rate of conversion than younger patients. This contradicts several previously published prospective and retrospective reports that have found advanced age to be an independent risk factor for conversion.2-5 Studies that specifically compared conversion rates in younger and older patients have mostly found greater conversion rates in older patients, one study being an exception.6 Indeed, two studies reported a 10 times greater conversion rate in the 65-and-older cohort.7,8 We have analyzed our own practice over 3 years and similarly found that older people had more than twice the rate of conversion of younger people (Table 1). There are some possible reasons for the favorable conversion rate in the older cohort in the study of Kaya et al. First, their planned rate of open cholecystectomy was 20% in older patients, versus 8% in younger patients, suggesting that their older patient cohort may have been carefully selected for laparoscopic surgery. Data are not presented for the comparative frequency between the younger and older laparoscopic cholecystectomy cohorts of factors that are known to predispose to conversion, such as previous abdominal surgery, common bile duct stones, and inflammation of the gall bladder. These factors are usually more prevalent in older patients, but the high rate of planned open cholecystectomy in the older cohort may have altered the balance. In contrast, our planned open cholecystectomy rate was just 7.5% in older patients (Table 1). Second, the mean age of Kaya et al.’s older group was just 69, with the oldest patient being 80 years old, whereas for example, 18% of our “older patient” cohort was aged 80 and older. Brunt et al. compared laparoscopic cholecystectomy in those aged 65 to 80 and those aged 80 and older and found the oldest group to have four times the conversion rate.9 Similarly, another study found conversion rates in those aged 75 and older to be double those in subjects aged 65 to 79.

Table 1. Demographic Characteristics and Distribution of Cholecystectomy Procedures

| Characteristic | Aged <66 (n = 257, 76%) | Aged ≥ 66 (n = 80, 24%) |
|---------------|-------------------------|------------------------|
| Male, n (%)   | 63 (25)                 | 29 (36)                |
| Planned open cholecystectomy, n (%) | 5 (2) | 6 (7.5) |
| Completed laparoscopic cholecystectomy, n | 229 | 58 |
| Converted laparoscopic cholecystectomy, n (%) | 23 (9) | 16 (22) |