trauma and surgical intensive care unit patients, respectively; and, not surprisingly, reported higher mortality rates of 19.2% and 22.2%, respectively, in these higher-risk populations. Hip fracture, the only surgical diagnosis among the 10 most common diagnoses in the current study, was associated with a 5.9% hospital mortality rate.

This study has several limitations. Because the HCUP-NIS is an administrative database, we lacked clinical, functional, or other details. Errors in ICD-9-CM coding and documentation are possible, although the error rate has been found to be low in this database.3 As with any administrative database, ICD-9-CM coding may be biased by the tendency to code diagnoses with higher reimbursement. In addition, determination of a primary diagnosis may be difficult in elderly patients owing to the presence of multiple comorbid conditions. We did not analyze the frequency or outcomes of specific interventions, except endotracheal intubation, during the hospitalization. This is an important topic for future research. Finally, information for each patient was limited to a single hospitalization. We do not have information on posthospitalization events or outcomes, such as readmission, discharge to hospice or long-term care, long-term survival, or change in function.

This study reports data on admission rates, all-cause mortality, and disease-specific mortality in centenarians. Results show a hospitalization rate of over 50 admissions per 100 centenarians; 90% survived the hospitalization. Hospital care may benefit a sizable proportion of even extremely elderly individuals. Given the expanding population of centenarians, it will be important to examine the types of services received and posthospitalization outcomes.

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Effects of Statins on Energy and Fatigue With Exertion: Results From a Randomized Controlled Trial

No drug is without adverse effect potential, and fatigue and exertional intolerance are adverse effects reported by patients receiving statins.1,2 Little direct information is available regarding the typical or average impact of statins on energy or exertional fatigue.

Although many observational reports have cited fatigue and exertional fatigue with statin use, to our knowledge, no randomized trials have addressed this issue to date. Energy and exertional fatigue were measured as tertiary and/or exploratory outcomes in the University of California, San Diego (UCSD) Statin Study, which aimed to examine a range of noncardiac outcomes.3 We capitalized on these data to evaluate whether moderate-dose statins affected energy and exertional fatigue in a broadly sampled primary prevention population.

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Methods. A total of 1016 subjects (692 men 20 years or older and 324 nonprocreative women, with screening low-density lipoprotein cholesterol levels 115-190 mg/dL [to convert to millimoles per liter, multiply by 0.0259] and no cardiovascular disease or diabetes) were randomized equally to 20-mg simvastatin (lipophilic statin), 40-mg pravastatin (hydrophilic statin), or microcrystalline-
The adverse effects of statins on energy and fatigue with exertion, and their association with physical exercise, were evaluated in a randomized controlled trial. Statins were compared to placebo in terms of their impact on EnergyFatigEx, a composite outcome assessing energy and exertional fatigue.

**Methods:** The study randomized 379 participants to simvastatin, pravastatin, or placebo. Baseline EnergyFatigEx values were imputed for missing data, and the outcomes were analyzed using ordinal logistic regression and t-tests.

**Results:** Statins significantly decreased EnergyFatigEx compared to placebo. Simvastatin had the greatest impact, followed by pravastatin, and placebo had the least impact. These effects were observed in both men and women, with women showing a more pronounced decrease.

**Conclusion:** Statins, particularly simvastatin, have a significant negative impact on energy and fatigue with exertion, which is more pronounced in women. These findings support the need for further research into the energy and well-being effects of statins, especially in women.
These effects, germane to quality of life, merit consideration when prescribing or contemplating use of statins, particularly in groups without expected net morbidity/mortality benefit, extending to “high-risk” primary prevention and women and elderly persons (including those with coronary artery disease). There was a significant relation between EnergyFatigEx and actual activity: reduced activity and exertional tolerance (irrespective of activity) in turn predict hard adverse outcomes. Effects may take time to manifest, as may benefits of statin use. Thus, long-term trials are important, if statin use is to be recommended in younger individuals. Meanwhile, physicians should be alert to patients’ reports of exertional fatigue or diminished energy during statin use.

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Vardenafil for the Treatment of Raynaud Phenomenon: A Randomized, Double-blind, Placebo-Controlled Crossover Study

Raynaud phenomenon (RP) is common and occurs with severe symptoms, particularly in patients with connective tissue disease (CTD), in whom RP may lead to digital ulcerations and amputations. Medical therapy in these patients remains unsatisfactory. Administration of phosphodiesterase type 5 (PDE5) inhibitors, which inhibit the degradation of cyclic guanosine monophosphate (cGMP) in vascular smooth muscle cells, promote vasorelaxation and are a promising therapeutic approach. However, randomized controlled trials have yielded conflicting results. We previously had conducted an open-label study with vardenafil hydrochloride trihydrate in patients with RP as a proof of concept. Our objective was to confirm our findings in a double-blind, randomized, placebo-controlled trial.

Methods. Patients with primary and secondary RP without active digital ulcers were recruited from the outpatient clinics of the Departments of Dermatology and Angiology at the University Hospital Cologne, from January 2006 through August 2009. We performed a double-blind, single-center, randomized, placebo-controlled, 2-period crossover study for 6 weeks to assess the efficacy and safety of vardenafil (10 mg twice daily) for the treatment of RP. Treatments were switched after a 1-week washout phase. Patients were followed up to 4 weeks after the last drug intake. All vasoactive agents were discontinued at least 1 week before study entry. Inclusion and exclusion criteria can be reviewed in detail online (http://clinicalsite.org/zks-koeln/en/trial/490). The study was approved by the Ethics Committee of the Medical Faculty of the University of Cologne. Primary outcomes were changes in the Raynaud condition score (RCS),...