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this is likely due to ours being a population-based sample, whereas REACH is a sample of outpatients with preexisting CVD risk.1 Nevertheless, our findings concur with those of Perissinotto et al2 and Udell et al3 that lack of social support, whether it is measured objectively (living arrangements) or subjectively (feelings of loneliness), has a negative impact on health and would be worth addressing in future intervention studies.

**Table.** Association Between Living Alone and Risk of All-Cause Mortality Over 10 Years Among 3486 Blue Mountains Eye Study Participants, Stratified by Age Group

<table>
<thead>
<tr>
<th>Participants</th>
<th>Deaths, No. (%)</th>
<th>Age and Sex Adjusted HR (95% CI)</th>
<th>Multivariate Adjusted* HR (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total sample</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not living alone (n = 2453)</td>
<td>448 (18.3)</td>
<td>1 [Reference]</td>
<td>1 [Reference]</td>
</tr>
<tr>
<td>Living alone (n = 1033)</td>
<td>291 (28.2)</td>
<td>1.25 (1.07-1.47)</td>
<td>1.18 (0.98-1.43)</td>
</tr>
<tr>
<td>Participants &lt;75 y</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not living alone (n = 2051)</td>
<td>233 (11.4)</td>
<td>1 [Reference]</td>
<td>1 [Reference]</td>
</tr>
<tr>
<td>Living alone (n = 689)</td>
<td>103 (15.0)</td>
<td>1.41 (1.11-1.79)</td>
<td>1.36 (1.04-1.79)</td>
</tr>
<tr>
<td>Participants ≥75 y</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not living alone (n = 412)</td>
<td>215 (52.2)</td>
<td>1 [Reference]</td>
<td>1 [Reference]</td>
</tr>
<tr>
<td>Living alone (n = 344)</td>
<td>188 (54.7)</td>
<td>1.12 (0.90-1.39)</td>
<td>1.08 (0.85-1.31)</td>
</tr>
</tbody>
</table>

Abbreviation: HR, hazard ratio.

*Further adjusted education, current smoking, body mass index, walking disability, prior diagnosis of heart disease, angina, heart attack, diabetes mellitus, cancer, poor self-rated health, and 36-Item Short-Form Survey mental and physical component summary scores.

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**Author Contributions:** Study concept and design: Gopinath and Mitchell. Acquisition of data: Mitchell. Analysis and interpretation of data: Gopinath, Rochtchina, and Anstey. Drafting of the manuscript: Gopinath. Critical revision of the manuscript for important intellectual content: Rochtchina, Anstey, and Mitchell. Statistical analysis: Rochtchina. Obtained funding: Mitchell. Administrative, technical, and material support: Anstey. Study supervision: Gopinath, and Mitchell.

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**EDITOR’S NOTE**

The Differential Diagnosis of Living Alone

It is interesting, but perhaps not surprising, that living alone seems to be a stronger predictor of mortality in younger persons than older persons. In older persons, living alone may be a proxy for very different phenomena that have opposing impacts on mortality. On the one hand, persons who live alone are more likely to have limited social support, and limited social support increases the risk for mortality. On the other hand, an older person who lives alone is more likely to have good functional status, particularly independence in the basic activities of daily living that are required to live without assistance. Functional independence is a powerful predictor of survival in older persons. In epidemiologic studies, these 2 factors may cancel each other out, leading to a null impact on mortality.

Epidemiologic studies often are not able to fully identify what is going on with an older person who lives alone. But clinicians should identify what is going on with their older patients who live alone. How good is their social support structure? Is there someone who could help them if they need care? Do they feel that they have someone they can discuss concerns with? And are they developing any difficulties with basic activities of daily living such as taking a bath or shower, getting dressed, or getting out of bed or a chair? Living alone has a differential diagnosis, just like any important sign or symptom in a patient.

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