

THE SILVER SURFERS: KEEPING THE ELDERLY HEALTHY

Modern health care services in most countries evolved to solve the main problem affecting populations, i.e. acute infective disease of young people.



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In developed countries these acute problems have diminished, while the number of elderly has increased. Modern medicine in developed countries is therefore dominated by the needs generated by chronic disease in older people. Health care systems have required adaptation in terms of the range of services offered as well as the recruitment, training and attitudes of health care workers.

In developed countries there now exists a wide range of care services for older people, targeting both health and social needs.

In South Africa a two-tiered health service exists within the public sector, focusing predominantly on the chief problems afflicting our society, i.e. maternal and child health care, infectious disease and HIV/AIDS. Doctors are trained within this system, which offers little or no specialised care for the elderly. Consequently, our junior doctors exit this system with minimal insight in geriatric medicine. These doctors then enter the realm of practice. Whether they service the needs of the elderly seeking health care at our public hospitals or clinics or whether they enter the private health care sector offering developed health care, insight remains lacking and overall care of the elderly patient remains poor.

In order to provide an adequate level of service several distinct characteristics of disease in the elderly need to be planned for. These include:

- multiple pathology
- nonspecific presentation (falls, incontinence, loss of mobility, functional decline, delirium)
- rapid deterioration if untreated
- high incidence of secondary complications of disease and treatment
- necessity for rehabilitation (preventive or restorative) in all illnesses.
- importance of environmental factors for recovery and return to the community.

These characteristics occur after age-associated loss of biological adaptability. Illness in an older person requires immediate access to a modern service with doctors, nurses and allied health professionals expert in the pathophysiology and care needs of the elderly. Diagnosis of disease is often difficult and care is complicated. A correct and detailed diagnosis (multiple pathology and multiple aetiology of presentation is the norm) is essential, as is appropriate treatment and preventive rehabilitation, if the progress of disease is to be interrupted early and prolonged debility prevented.

In this edition of *CME* several articles address the issue of disease in the elderly. Dr Bouwens introduces the all-important geriatric assessment. As an integral part of geriatric practice, any older person who falls ill should have immediate access to full diagnosis and treatment. It is preferable that this be done by a doctor or a team of health care professionals with insight into the needs of the elderly. Nonspecific disease presentation, including increasing care needs, is common — any change in dependency should lead to a geriatric assessment for a therapeutic intervention before a prosthetic service is imposed. Rehabilitation (preventive in the acute situation, restorative later) is an integral part of health care provision to the elderly. No-one should be permanently institutionalised until all possible alternatives have been explored with a specialist team.

The paper by Czerniewicz and Nicholson explores mobility problems and falls in the elderly. Thirty-five per cent of persons 65 years and older will fall per year, the incidence increasing after age 75 and in those in institutional care. Falls may result in injury, with fractures of the proximal femur being common and often devastating. Twenty per cent of patients will die in the first year; 50% will never regain full function and independence.

Falls may also result in loss of confidence, with consequent decline in mobility and function. Mobility assessment is therefore an essential component of care and management and is best done out of hospital and even in the patient's own home. Hospitals are often poorly designed with regard to the needs of the elderly. Bed rest is encouraged (often forced), independence is ignored and complications (pressure sores, postural hypotension, nosocomial infections, fluid and electrolyte imbalance, sleep pathology) abound. Up to 80% of hospitalised elderly function at a lower level when discharged. Older patients should be assessed and cared for where they wish — relocation should be minimised.

As is emphasised in the geriatric assessment paper a team (doctor, nurse, community services, physiotherapist, occupational therapist and social worker) should be involved. A single person should be responsible for co-ordinating services and should communicate with patient and carers. Acceptable interventions should be clearly defined and realistic goals outlined. Progress towards objectives should be continuously renewed. Interventions should consider the health and well-being of both carers and patients.

Physical and mental health cannot be clearly separated in the elderly. The article by Dr Dora Wynchank addresses the issue of depression in later life, possibly one of the least recognised and most poorly treated diseases in the elderly. In later life physical illness often presents with psychiatric-like

symptoms, such as depression, delusions, hallucinations and acute confusion. An awareness and assessment of depression, delirium and dementia should be routine. Scales for assessment (MMSE, depression scales and functional scales) may be of assistance if used intelligently.

The vexing issue of hormone therapy, pertinent to women of all ages, is addressed by Dr De Villiers. Potential indications for hormone therapy continue in later life (quality of life, vaginal atrophy, vascular risks and cognitive function). Current knowledge of and approaches to this contentious issue are discussed.

A few endocrine disorders are addressed by Professor Ascott-Evans and Dr Kinvig. Atypical presentation of any disease or illness in the elderly is common. In this paper thyroid hyper- or hypofunction is addressed, as is an approach to the management of diabetes mellitus. Osteoporosis is an extremely common illness in older people. Here we often face the end-stages of the disease, including fracture, pain, deformity and loss of mobility. Rehabilitation is often an integral part of post-vertebral fracture (stretches, analgesia, postural exercises) and hip fracture management. Assessment of the elderly patient with osteoporosis is incomplete without a full and detailed *FALLS* evaluation.

Management should be patient specific. In the elderly, for example, calcium and vitamin D supplementation together with a falls prevention programme, manipulation of environment and use of hip protectors may be more appropriate for prevention of hip fractures than initiation of treatment with a bisphosphonate.

Sleep pathology is common in older age. It often accompanies other conditions, such as dementia, delirium and depression. Treatment with older agents (benzodiazepines and tricyclic antidepressants) is often accompanied by significant and severe side-effects and therefore should be initiated with caution. Non-benzodiazepine treat-

ments are preferred. An approach is outlined by Dr Rosman. Lifestyle adjustment is often successful.

Sexology in later life is often not addressed in clinical practice. The elderly have the right and need to love and be loved. Relationships, including those of a sexual nature, should be considered normal. This subject is discussed in the article by Dr Levinson.

We have a long way to go in South Africa. At present training of doctors and allied health professionals in geriatric medicine is sorely lacking. Consequently the assessment and management of the elderly often fall far short of the desirable. Specialist geriatricians and psychogeriatricians are in short supply, as are allied health care workers with expertise in this area. Geriatric service provision and social support is haphazard, poorly co-ordinated and often totally lacking.

Our aim should be to develop geriatric services. These may be provided by three models:

- Traditional model — geriatric medical services run parallel to internal medicine where selected elderly patients are referred to the geriatric service for assessment and rehabilitation.
- Age-defined model — geriatricians provide all medical care, including acute care for patients above a certain age.
- Integrated model — geriatric medicine is deployed like any other subspecialty of medicine, with geriatricians working as members of a multi-specialty team in hospitals, sharing junior medical staff and assessing elderly patients admitted to a single medical or surgical unit.

The physician is the vital link, matching an appropriate service to the needs of the elderly person. Maintaining or enhancing functional well-being is the highest goal of geriatric medicine. For the elderly bed rest is rehabilitation for the grave! In caring for the elderly we should not destroy health in the name of care.