

The Challenges of Managing the Older Persons

G.S. Shanthi

Professor & Head, Department of Geriatric Medicine, Madras Medical College, Chennai

Globally, due to shifting demographics, ageing and associated diseases & disability are increasingly important. The most rapidly growing group worldwide is those 80 years of age and above. Although ageing is associated with an increased burden of multiple chronic diseases and disability, health professionals need to take a focused and measured approach to clinical management and decision-making.

The health status of elderly varies from person to person depending mainly on the morbidity pattern and functional status. The goals for healthy older people are functional independence and autonomy and to remain healthy for the maximum possible extent. Health goals for older people at risk add a specific focus on modifying risk factors in addition to the aim of retaining health and wellbeing. People during acute illnesses or traumatic injury require immediate intensive medical or surgical care. In these circumstances the goal is to recover quickly without suffering any long term functional decline. In people with chronic conditions such as arthritis, diabetes, chronic obstructive pulmonary disease and cardiovascular disease, the focus is on minimising disability arising from these conditions, preventing complications and acute exacerbations of the conditions as well as life style modification to address risk factors. Some older people have multiple chronic conditions, associated disabilities and or cognitive impairment. In such situation, they require assistance and support through coordinated management, treatment and care to prevent complications and exacerbations. In End of life care there is an emphasis on quality of life, and dignity-preserving care. Hence the management of elderly will be need based. Overall, delaying and “compressing the morbidity and disability” is a public health challenge.

In India, the elderly people suffer from both communicable as well as non-communicable diseases. This is further compounded by impairment of vision & hearing, decline in immunity and age-related physiologic changes leading to an increased burden of communicable diseases in the elderly. The Indian elderly most frequently suffer from cardiovascular illness, respiratory diseases (COPD, Pneumonia), degenerative disorders and cancers (NSSO). The cardiovascular disease is the leading cause of death among the elderly.

The Geriatric physicians should categorise the older patients according to the health status of the individual and then plan the management accordingly. Hence it may differ for each category of people, as slight modifications has to be done, keeping in mind the basic medical management. During hospitalisation, one has to decide whether the patient needs an acute intensive care or a sub acute care along with rehabilitation to improve the outcome.

The clinical presentation of illness in elderly varies from young adults due to interplay of physiologic ageing changes in various organs, diseases, medications and social factors. Hence atypical presentation of illness is often seen in elderly. Multiple pathology is common in elderly and multisystem chronic diseases and its complications may alter the presentation. Altered presentation and altered response to diseases is present mostly in ‘frail’ older people. The diagnostic evaluation of elderly depends on their disease status and the physiological reserve of the individual. Invasive diagnostic modalities (eg. Contrast injection for CT scan, conventional Angiogram etc.) may have a high risk, due to decline in renal or hepatic function. Generally non invasive tests and procedures are safe. The risks are based on the pathological status of important organs like heart, kidney, Liver etc. rather than the chronological age. However healthy elderly without compromise of the functions of vital organs are to be actively managed like young adults. Geriatric conditions such as functional impairment and dementia are common and frequently unrecognized or inadequately addressed in older adults. Identifying geriatric conditions by performing a Comprehensive

Geriatric Assessment (CGA) is essential to manage these conditions and prevent or delay their complications.

“Geriatric syndrome” which includes cognitive impairment, delirium, incontinence, malnutrition, falls, gait disorders, pressure ulcers, sleep disorders, sensory deficits, fatigue, and dizziness are common in older adults, and they may have a major impact on quality of life and disability. Geriatric syndromes can best be identified by comprehensive geriatric assessment. CGA is also useful to identify medical, psychosocial, and functional limitations of a frail older person in order to develop a coordinated plan of care including rehabilitation to maximize overall health with aging. The major factors focused in CGA are

- Current symptoms and illnesses and their functional impact.
- Current medications, their indications and effects.
- Relevant past illnesses.
- Recent and impending life changes.
- Objective measure of overall personal and social functionality.
- Current and future living environment and its appropriateness to function and prognosis.
- Family situation and availability.
- Current caregiver network including its deficiencies and potential.

polypharmacy is a major risk factor for hospitalisation in older persons. Elderly are more sensitive to drugs with more side effects and serious sequelae. Adverse Drug Reactions (ADR) related hospital admissions are increasing in elderly and have a high mortality rate. This is due to altered pharmacokinetics and pharmacodynamics. On the contrary, Polypharmacy is commonly seen among the elderly, with prescribed drugs due to multiple pathology and as well as over the counter medications. STOP / START or Beer’s criteria can be used while prescribing for the elderly. In malignancy, the combination of life-threatening illness and toxic therapies is a potent cause of functional decline in the settings of both treatment and of survivorship.

Frail older patients have many comorbidities including both physical and cognitive impairment. Although clinical guidelines and disease management protocols have shown benefit in the general adult population, they are often not applicable to the frail older adult patient. Also frail elderly are at risk of repeated hospitalisation. Other risk factors for rapid rehospitalisation are:

- Age greater than 80 years
- Five or more comorbidities
- Functional impairment
- Past or current diagnosis of depression
- Lack of documented education to the patient and/or family upon discharge
- Inadequate support system

Because rapid rehospitalization is frequent, costly, and often harmful to frail older adults, appropriate care management approaches are essential. A geriatric care plan is a way to help aging individuals ensure continued good health, and improve their overall quality of life, reduce the need for hospitalization, and enable them to live independently for as long as possible. A care plan is developed from CGA that evaluates the medical, social and emotional needs of the elderly. It also coordinates the support from the family, paid service providers and voluntary organizations. This is an important factor to establish a continued care of the older person in the community following discharge from the hospital in preventing disability and to maintain the quality of life.

Vaccination in Older Adults

G Usha

Madras Medical College, Chennai

Disease prevention and health promotion are important aspects of health in older individuals. Older adults are at an increased risk of infection due to immune senescence. With increasing elderly population worldwide, especially in developing countries, immunization is one of the most beneficial and cost effective preventive measures. Commonly advocated vaccines in older adults more than 65 years are pneumococcal vaccine, influenza vaccines, tetanus toxoid, herpes zoster. Pneumococcal vaccine can be administered at any time during the year. Influenza vaccine is to be given annually. Tetanus toxoid given once in 10 yrs. Herpes zoster vaccine is to given as a single dose other vaccines recommended by CDC ACIP-2017 are varicella, hepatitis-A, hepatitis-B, meningococcal and *H. influenza* in appropriate clinical settings. There is lack of data on the exact prevalence and rate of complications on these vaccine preventable diseases in our country. Data from developed countries do suggest benefit from vaccination in adults. Considering the increase in older population and the risk of increased susceptibility to infection and complications, increased cost of hospitalisations, policy decisions have to be made in our country with regard to routine vaccination in older adults >65yrs of age.

Post Hospitalization Rehabilitation in Elderly

Y S N Raju

Nizam's Institute of Medical Sciences, Hyderabad

Cognitive rehabilitation is described as any intervention strategy or technique which enables clients and their caregivers to live with, manage, by-pass, reduce or come to terms with cognitive deficits precipitated by injury to the brain. The steps in post hospital rehabilitation are: decision making, contraindications to therapeutic rehabilitation, rehabilitation in general, physical therapy, occupational therapy, recreation therapy, nutrition, speech therapy, intervention by nursing professionals and intervention by social worker. Some of the special areas of rehabilitation are: cardiac rehabilitation, stroke rehabilitation, dementia rehabilitation and fall and fracture rehabilitation. Healthcare professional(s) with the appropriate competencies should coordinate the patient's rehabilitation care pathway. As well as providing information and support, they should: ensure that rehabilitation goals are regularly reviewed and updated; ensure delivery of structured and supported rehabilitation when applicable; and liaise with other relevant settings 2–3 months after discharge.

Long-term Care - Challenges of Caregiving

Arvind Mathur

Director and Managing Trustee, Asian Center for Medical Education, Research & Innovation, Jodhpur

Health care for older persons consists mostly of addressing the problems associated with chronic illnesses. A large number of older persons with physical, mental, or cognitive limitations sufficient to compromise independent living require long-term care. Long-term care is a synthesis of medical and social interventions. It is not the exclusive purview of the medical profession. Most of the long-term care is provided by a host of individuals loosely referred to as informal caregivers - family, friends, or neighbours. Traditionally family has been thought of as the best place for caregiving in India.

“Jodhpur Elder Caregiving Study” a Mixed Methods Study of Caregivers with qualitative interviews and quantitative surveys was undertaken to address various issues of caregiving. Types of household in the study were 98% Joint/ multi-generational and 2% Nuclear families. The average age of caregiver was 50.19 years. In majority women were the primary caregivers and women were the common recipients of care; highlighting “feminization of ageing in India”. Caregiving is a lifespan issue. Age norms, generational position, gender and marital status of care-recipient are the factors that determine who would become the primary caregiver. In general, the person who provides the most assistance with ADL (especially toileting, bathing and help at night) is identified as the primary caregiver. Families navigate elder care by sharing of caregiving activities with multiple informal and formal caregivers. They would negotiate care by dividing and scheduling care according to availability, urgency and proximity of caregivers.

The impact of caregiving on caregiver’s health and wellbeing is of concern. Mental health issues like stress, depression are frequently observed. Physical health problems like hypertension, pain in legs, waist and joints, headaches, lack of rest, and postponing checkups are common. It can also lead to giving up employment or educational opportunities. In spite of significant caregiver burden, the hiring of formal caregiver was rare. Either they do not believe in the use of formal care/ are not aware of formal care. Need for upgrading skill of informal caregivers was felt. A pilot home-based intervention by a team of physiotherapist, nurse, nutritionist and counsellor for skill building training of informal caregivers was successfully undertaken.

Thus there is a high need for assistance for ADL and IADL by the disabled elderly. Informal caregivers have been and remain the backbone of long-term care in our country. Gender and age are significant determinants as to who would care for an elderly with a disability. There is marked heterogeneity in caregiving arrangements. Caregivers have multiple roles. Secondary caregivers are also important partners in assisting caregivers.

A multi-state study is needed, as living arrangements of elderly vary across the country depending on the development trajectory of particular states. There is a need to develop formal service sector because the family cannot be depended upon in the face of changing demographic trends. As a physician taking care of elderly, we realise availability, skill and devotion of caregiver decide the quality of life of the care recipient. Treating physician should always evaluate this aspect and help in strengthening skills and maintaining the well-being of caregivers.