Clinicial Aspects of Geriatrics

A. Cleland Marshall, '63

Better medicine and prevention create more geriatric problems which are not limited to the elderly, but involve the whole life process from its beginning. Longer life allows more disease processes to accumulate, while increasing debility of the nervous system shields them. Our problem is more one of prevention than of cure. Thus preparation for healthy old age should start in the full vigour of maturity if not at the beginning of the patient's life.

Since medical care of the elderly consists largely of comforting and sustaining, the lack of dramatic cure might be less satisfying to the physician (and bequeathed rewards might even be viewed suspiciously). But successful effort expended over a longer period of time can give rise to greater satisfaction. It is said that general practitioners will not likely limit their practice to geriatrics because many aging people do not like to be considered old and would oppose the idea of going to an "old folks doctor", and the best time to prepare for old age is when younger. It would seem, however, with the increasing understanding of and respect for the older generation and the expansion of gerontology, that greater numbers of GP's will concentrate on this field.

Diseases Important In Later Life

Degenerative diseases and malignant neoplasms have become most important because of the elimination or control of so many infections and the increase in number of older people.

A. Cardiovascular system diseases:

These are the major causes of death, but less terror is associated with them now as more knowledge is acquired. Dr. Paul White, while stressing optimism, said, "Angina pectoris and myocardial infarction are so common that I have come to consider them as almost normal events in the life of the average American male." It is normal for the blood pressure to increase with years of aging.

B. Nervous system diseases:

This is where the most characteristic changes of aging occur. Above 65 years of age there is a sharp increase in the number of first time admissions to mental hospitals. The increasing population age will create a great mental health problem aggravated by a shortage of trained psychiatrists. Therefore the entire medical profession should know more about psychiatric illness and its treatment.

Along with changes in their external environment, the aged must cope with physiological and anatomical changes. There is an increase in time between physic stimulus and somatic responses, due to changes in the central nervous system independent of motivation and personality. Vascular accidents occur in "silent areas", so are overlooked because they do not cause any definite neurological signs. The syndrome of senescence is a vicious somatopsychic-psychosomatic pattern.

Personal deterioration is more psychologic than physiologic. Three main diagnostic categories are of primary importance in the over-60 group:
i) Psychotic reactions, including schizophrenia; affective states such as manic depressive and psychotic depressive reactions;
ii) Acute and chronic brain syndromes resulting from a number of pathological conditions;

iii) Psychophysiologic (or psychosomatic) and psychoneurotic reaction.

Senile brain disease, as a chronic brain syndrome is caused by senile psychosis and the psychosis of arteriosclerosis, which often occur together in the same brain, but usually one predominates. The former is twice as common in females and the latter is three times as common in men.

The family usually brings the patient to the doctor, stating that the patient's behavior is no longer manageable because of delusions, confusion, weakness, and incontinence; and other complaints include slowness, incompetence, dissatisfaction, dependence, conceit, lack of humour, interference, resistance, over-criticism, inaccuracy, suspicion, depression, antiquated ideas and methods and/or slovenliness in dress and posture. There is a gradual fluctuating onset over months or years of these traits, with increasing forgetfulness, failure of efficiency, exaggeration of previous personality weaknesses, deterioration of judgement and personal habits, loss of emotional control, and physical weakness.

Defects in recent memory, and loss of abstract thinking and inability to organize and retain new observations, appear early. The recent memory loss leads to excessve reminiscence of past life and may lead the family to think it demonstrates a keen mind. The reduction in ability to learn new information and to retain previous knowledge is often noticed first by the patient himself, and he becomes concerned about his psychic functioning. Insecurity and fear may also be aroused by reduced efficiency of hearing and vision. When the patient does not realize these internal and external changes he becomes anxious and less adaptable.

Later developments are fabrications, disorientiation, rambling and incoherent speech, poor judgement and hoarding objects of little worth.

Cerebral arteriosclerotic changes (which do not parallel peripheral arteriosclerosis) are more commonly (rather than senile psychosis) associated with prolonged dedizziness, aphasis, apraxias, fainting spells and convulsive seizures. "Silent strokes" are often manifested by a rather sudden onset of upper abdominal distress, followed by faintness or even momentary loss of consciousness, nausea with or without vomit-

ing, and dizziness; subsequently the blood pressure drops; (maybe permanently), there is loss of appetite and a decrease in weight. The patient may note sudden memory failure and easy fatigability. A few recover, but most remain at the lower level with a persistent change in personality. Often they are usually depressed—understandably. Arteriosclertic psychosis is also associated with a history of headache, explosive emotional outbursts and/or cardiac disturbance.

Senile psychosis is shown mainly by personality disturbance. It develops as agradual progressive deterioration of intellectual functions.

Pre-psychotic personality traits may be released, and neurotic trends with hypochondriasis are common.

Finally the patient becomes completely bed-ridden, responding with primitive reflexes and suffering malnutrition, generalized weakness, incontinence, fractures and decubitus ulcers.

Social changes may precipitate a worsening of symptoms. After retirement age the patient finds he is not given responsible roles socially or professionally. He loses authority in his family, even becomes dependent on his children. He loses self-esteem. He becomes suspicious and sulking in protest of being left out, with the rejected attitude seen similarly in youngsters. Financial insecurity affects his health by limiting flexibility in action and social independence. Compulsory retirement deprives him of satisfying activity by removing an outlet for energy and a sense of accomplishment that proves to himself and to society that he is worth while.

C. Other Common Ailments:

Hemiplegia
Arthritis
Cataract
Glaucoma
Gall bladder disease
Ulcer
Diabetes
Cystourethritis
Nephritis
Osteoporosis
Prostatic cancer and hypertrophy
Peripheral vascular disease
Pulmonary emphysema
Parkinsoh's disease

The effect of **trauma** is greater in older people because of loss of elasticity and general degeneration which can lead to more complications. Osteoporosis causes bones to fracture more easily. Psychologically there is a lower threshold to stress. Older people fall more often because of poor coordination, slower reflexes, weaker muscles and failing vision; but they may fall following a myocardial infarction, cerebro-vascular accident, tumor or bleeding. The most frequent fractures are Colles, of the surgical neck of the humerus, and of the hip.

Examing the Older Patient.

The first interview is extremely important in establishing a satisfactory doctor-patient relationship. The doctor will be seeing the elderly patient more often, and this patient's opinion is often less amenable to change. More frequent checks are required because of the increasing number of defects with older age. It is preferable for the doctor to do the interviewing personally, because the reading of a questionnaire or a history taken by someone else does not show the way in which the questions were answered (e. g., hesitantly, too enthusiastically, with tears). A few minutes should be spent to get acquainted (e. g., mentioning a mutual friend, or the weather). Unless the patient is too senile, it is much better if there is no third party present. A check of the history can be made later with someone else. Patients have been found to be more relaxed when they are seated at the corner rather than on the direct opposite side of the physician's desk, which acts as a barrier.

The impersonal part of the history should be taken before the personal life and sources of unhappiness are probed, when one can ostentatiously drop the pencil as if it were "off the record". Respect their extreme modesty but be thorough. Much depends on the examiner's attitude. Any embarassment is likely to be sensed. It is best to procced in the same matter-of-fact manner with which the nose and throat are examined. To be gentle and unhurried is essential. Irrelevant light conversation may help divert the patient's attention.

During the physical examination it is helpful to keep in mind factors which may have affected the particular age group (e. g., World War I veterans were exposed to war gas, older persons were exposed more to tuberculosis). The age as judged by appearance and mental status is better than chronologic age in predicting the physical status.

A good way to start off the physical examination is with the tape measure, measuring the height, and chest expansion (to detect emphysema, spondylitis). Then the blood pressure can be taken on both arms. The second reading varies upward or downward as the examiner appears concerned or surprised, or casual. Fissures at the corners of the mouth may be due to sagging skin, poorly fitting dentures or vitamin deficiency. Tonsils are usually small and hard to find, but an embedded remnant can be a source of recurrent sore throat. Nasal septal deviation is usually found which may or may not interfere with breathing. The eyegrounds are very informative in their reflection of degenerative changes. Wax in the ears is not infrequently a cause of deafness. The hands should be held out extended to be examined for tremor and enlarged joints. With the socks and shoes off the lower extremities can be examined for edema, varicosities, deformities and reflexes (which are often diminished or absent). The man can strip to the waist, for examination of the heart and lungs while he sits straddling a chair. When he is undressed on the table the heart and the rest of the body is checked. There should be another female (nurse) helping the woman undress, and again being present during the examination. It is better to wait until the woman is on the table to examine her chest.

With their initial examination, all these patients should have a chest X-ray and an EKG for future comparison when there is indication for a recheck.

Preventive Measures.

The success achieved in the field of child health supervision has encouraged the promotion by health services, of adult health, with education as the keystone. Periodic health examination has been proposed as a method of attack, but it is questionable how effective this can be. Economic factors have always deterred widespread practice of "presymptomatic medicine". By creating facitilies for the simplest series of tests which would indicate the presence of any of the most important disease entities, using non-medical personnel, large numbers of people can be screened for disease, at low cost. However, proper interpretation of the results requires a knowledge of the history of the patient, his personality and family background. Those (about 96 percent) who emerge with negative results get a false sense of security, not comprehending the little value of negative findings. Thus multiphasic screening diagnostic measures per se should not be set up as a primary public health diagnostic function, but they can be very useful supplementing the physician.

While time can be saved by the screening tests, the doctor's time in relieving the chief complaint, assuaging apprehension, and detailing therapeutic programs cannot be shortened.

Since prevention of degenerative diseases cannot be promoted yet by mass methods,

DOCTOR:

This case of S-M-A is for YOUR baby . . . and we'll send *as many more* as your baby will require.

Sincerely,
Your Wyeth Representative

S-M-A PHYSICIANS' SERVICE

S-M-A is available to physicians, internes and senior medical students—without charge — for the feeding of their own infants. We would like you to observe the superiority of the S-M-A formula in the nutrition of the most important infant in the whole world — your baby.

Thousands of doctors across Canada have taken advantage of this service through the years—years that have brought constant improvement in the S-M-A formula. Today, S-M-A contains all the elements necessary to produce nutritional results surpassed only by mother's milk.

Simply contact your Wyeth Representative or write direct to

Sales Service Department JOHN WYETH & BROTHER (CANADA) LIMITED Walkerville, Ontario

Sound Infant Nutrition

S-M-A
FOOD FORMULA FOR INFANTS

Wyeth
Registered Trademark
WALKERVILLE, ONTARIO

in the light of our present knowledge, it must be done by the physician on an individualized basis. Its chief purposes are to prolong life, to render the life of the mature person freer of chronic illness and disability, and to preserve his mind and body during that period of his life when his ripe judgment and past experience should render him a valuable and productive member of society. Periodic examinations are important as they afford the physician an opportunity to give counsel concerning adjustment to a made of life so that the patient may face the requirements of the approaching aging process intelligently and adequately, and conserve his ability and special talents. The prevention of mental ill health during retirement should be done by encouraging him in mid-life to cultivate friendships, preserve family ties, develop interests outside of his occupation, and develop psychomotor skills that will not be easy to learn later. Steps should be taken to prevent inadequate diet and loneliness that can lead to loss of mental and physical vigour.

Aspects of Management.

In the general management of geriatric patients one should heed Mark Twain, when he says, "Habit is not to be thrown out the window, but coaxed downstairs one step at a time." Make concessions, and give moral support, or more harm can be done than good.

Older people take longer to deal with because they require more time to interview, often have multiple problems, are harder for a younger person to comprehend from personal experience, and may be slowed or fixed mentally requiring more repetition to sell a therapeutic regimen, so one must have patience.

The question arises of whether the patient should be told he has a fatal disease. It is often best to tell the truth, even though the family insists not. The patient usually knows more than he admits, both sides are deceiving, and it is a relief to have the veil of secrecy removed. But "You can at least put a bathing suit on truth". Don't shut the door against hope: Describe cancer as slow growing, cirrhotic liver is now much more amenable to dietary and other therapeutic measures, a cure for leukemia may be found with all the intensive work being done on it just as a cure was found for pernicious anemia when it was thought hopeless.

Management, which is more than treatment, means a long-term doctor-patient relationship, best established over yearly to weekly visits. Attempts are made to anticipate and prepare for, prevent and postpone, the infirmities of old age. Osteoarthritis, diabetes, heart disease and many others are caused or aggravated by obesity, so that proper diet and regular exercise are prophylactic measures as important in later life as are sterile technique and immunizations in pediatrics. Oral hygiene should be encouraged. The treatment of high blood pressure is mainly reassurance, avoidance of potentially harmfull stresses, and of the secondary complications. Wonders have been done with hemiplegia by encouragement and rehabilitation. The word "arthritis" is terifying to most people, so it is important to clarify to a patient that he does not have the rheumatoid, but the degenerative, form which is not crippling. The complications of bed rest must be avoided. Fractures must be treated soon, as little is gained and much is lost by excessive procrastination. There are few contraindications here for surgery, (diabetic acidosis, congestive heart failure). The risks of treatment which causes trauma have to be considered more in older patients since they cannot recover as easily. Here is where it is asked whether the treatment is worth the discomfort with only a short extension of life. Also one must remember that drug therapy changes withe age; e.g. barbiturates often cause unusual reactions in older people.

An important function of the family doctor is to see to the psychiatric management of the geriatric patient. The family can be of great assistance, and they should be led to appreciate the patient's need for acceptance as a useful citizen. There should be tact used in suggestions for retirement. Work routines should be limited within the patient's tolerance. The physical and social environment should be protected with proper diet, simple activities and quiet companionship. High protein diet is advocated. Drugs for insomnia are used sparingly. Avoid immobilization, as it hastens confusion and physical deterioration. Failure of judgement may require a guardian. Guard against risks of falling. Avoid sexual stimulation where difficulties with children might arise, since patients recognize the child's sex but ignore age.

The GP can help patients train themselves to enter old age with dignity, self-confidence and understanding. Help is most valuable when they are physically healthy but becoming emotionally disturbed. The "silent stroke" can be discussed quite frankly with the patient, who is usually relieved that it is not cancer. The GP should advise him to set up trust funds and legal guardianship before the onset of poor business and social judgement.

The older patient needs a doctor who will be truly his "guide, philosopher and friend".