



Facing the 'Geriatric Giants'

By Terry Owen



Dr Greenstein and Dr Abraham, Geriatricians at the Helen Joseph Hospital in Johannesburg, have a passion and zeal for treating the elderly. Mix in a dollop of love for their speciality, and you have the perfect combination to tend to the many complex issues of ageing.

Spending time with these doctors is a wake-up call for me. They remind me to strive for perfection when dealing with the elderly. Often, they become the cast-offs, the forgotten. Doctors Abraham and Greenstein ensure that while in their care at least, this succour becomes a reality as much as possible. Exemplary? Absolutely. The elderly deserve nothing less.

So, we sit down for an hour or so (wish it could be longer but in a big city hospital that's impossible, naturally) and discuss what has been termed the "geriatric giants" – the conditions that are most commonly seen in this population – incontinence, intellectual impairment, instability, immobility, doctor-made (medicine having adverse effects).

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Incontinence

This affects 15-30% of this population. It's a very personal and embarrassing issue and a very common complaint.

There are different types of incontinence, and it can manifest differently between sexes.

UPFRONT –the patient must go to a GP, who will rule out whether there is an infection in the urine, and if there is a need to treat that appropriately, and secondly investigate the case of incontinence. In males, it could be a prostate problem, and this would cause overflow incontinence. In females, as a result of multiple births and labour experienced, they could have stress incontinence.

There are different treatments for the different types of incontinence.

IT IS IMPORTANT for the patients to realise that this is not something they have to live with. There are appropriate treatments and medication available!

The GP may find, upon examination, that the patient may have diabetes or high glucose count that could account for their urinary complaints. An ultrasound may well be needed. The patient could be transferred to a hospital because of infection.

The patient could have been admitted and often upon admission for an elective operation, doctors often find or unearth a minefield of conditions i.e.: pneumonia, kidney failure and other problems that the examiner was unaware of at first.

This is why treatment of geriatrics is a very complex issue!

An often heard saying in this population is "oh, it's just a part of getting old". It must be remembered that this may not be the case at all and could be a condition that can be successfully treated.

Intellectual Impairment

Dementia is not normal! It IS NOT A PART OF GROWING OLD! Forgetfulness could well be a part of ageing, but it is also common in many age groups.

It is when memory problems start impacting on a day-to-day function that it becomes abnormal, and then it becomes dementia.

We first do a comprehensive geriatric assessment where we take a full history. We ask patients everything and delve into social circumstances...the kind of probe that is extremely time consuming (some GP's don't do this). We ask them about their daily functions – what they can do? We touch on subjects like cooking, cleaning, driving, handling finances, medicine, walking, cognitive ability?

This screening takes about an hour and half. After that we do a full physical examination. We screen for depression, cognitive testing, standardised testing, which part of the brain appears not to be functioning. At the end of all that, you have an idea of the diagnosis. Further investigations can be done, and these include blood work or radiology.

Another issue is controlling blood pressure, which is very important in preventing vascular dementia, diabetes and controlling cholesterol.

AS AN ASIDE – there are very few geriatricians in South Africa. In Gauteng, with its massive population, there are just over 7. People are not naturally drawn to it as it is not as 'glamorous' as say, cardiology or orthopaedics and you spend a lot of time talking to a patient which doesn't appeal to many doctors. It's also labour-heavy. Geriatrics encompasses all the problems, of which just one would normally be treated by a specialist!

We may not be able to solve all the 'geriatric giants' but we can optimise the patients purposefully. With many, the diseases have been present for too long. All we can try and do here is improve the situation!

We must ensure that hearing and seeing functions are okay. At the Helen Joseph we have top-class

audiology and optometry departments that conduct thorough checks.

Immobility & Instability

Your patients, if possible, need to be doing some forms of exercise. In a retirement centre exercise classes are held regularly and those that can must be encouraged to attend. Balancing and strengthening muscles must form part of these exercises. You need the elderly to have muscles as strong as possible, so if people tumble, they can right themselves.

THE BIG ONE here is falling and breaking a hip. This is one of the most feared occurrences in this population. Even after falling with no damage, there is the FEAR of falling which cause people to become immobile. A fall is one of the most detrimental things that can happen to the elderly. It's hugely costly and causes psychological and further physical problems.

Immobility is NOT a natural part of illness. People say "oh, I'm just growing old", hence it is okay for me to be in a wheelchair, it's okay for me to be bed-ridden and unable to leave my home. THIS NEEDS RE-THINKING! There are several risk factors for immobility and instability. Sometimes it can just be joint problems, or osteoarthritis which needs attention. Other issues also treatable are foot problems such as gout and arthritis. Physiotherapists and biokineticists can also help with mobilisation.

Too many medicines!

This is a big issue in the elderly. They often see many doctors, have many conditions and are taking multiple medicine regimens. It is a very complex issue. We try and stop superfluous medicine. We take note of everything they take and consider if it is necessary. We discard medicines what are not vital and end up with a core set which consists of medicine they really need. For example, regarding incontinence they are given bladder medication with adverse side-effects, making them dizzy, confused and vulnerable to falling. Certain BP medications can also make patients dizzy by lowering the BP too much, also leaving them vulnerable to falling.

What we do is fine-tune the medicine and ensure they're on the pills they really must be on!

GPs also on elderly CME

There are some GPs that have completed a geriatric diploma and naturally that's very useful. It's an ongoing educational programme for GPs in collaboration with geriatricians. They need to complete an exam at the end of the course. They find that after completing this course, they are far better equipped to handle geriatric problems.

Once a year we have a geriatric conference which is growing, thankfully! It seems the message that geriatric education and care is vital for GPs is booming out loud and clear!

Remember to take vaccines!

The importance of taking vaccines in this population cannot be more vigorously stressed!

Take the flu vaccine every year (and educate that it DOESN'T cause flu!). Take a pneumonia vaccine as this is a very dangerous condition for the elderly. There are a host of vaccines for many conditions available, and this will help the elderly to take control of their health!



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