Geriatric care - a challenge to internists in Saudi Arabia

Sir,

The older segment of society is showing a steady increase in the Kingdom of Saudi Arabia (KSA). There are 3.3% of the population above 65 years and 0.8% above 75 years of age in the city of Riyadh, KSA and this figures is definitely going to escalate.[1] This creates a concurrent demand for increased medical support, mainly primary care physicians and internists, in the absence of qualified geriatricians. A large proportion of general practitioners (GPs) as well as internists have no formal training in geriatrics. Many have not been reading the geriatric literature or attending continuing medical education courses in geriatrics, which are by themselves not commonly available. Care of the elderly is not restricted to treatment of hypertension,[2] diabetes, and falls[3] associated with aging. The geriatric approach is to identify and treat significant problems appropriately, and at the same time, to evaluate and optimize the functional state of the patient and provide a constant support. Old people may avoid medical attention because of faulty subjective health assessment. They may fail to recognize and accommodate to the normal aging process. Continuing to drive a car in the face of a significant visual or auditory impairment is an example of a hazard when senior citizens overestimate their abilities and underestimate the risks. On the other hand, in case of a treatable disease, patients and their families may attribute their infirmities to aging. Such concepts may play a role in the attitude of the physicians as well. It leads to unwarranted conclusions, and consigns patients to a hopeless outcome. The physicians should evaluate clinical problems in older patients rather than to assume that the problems are due to the aging process. A person should not suffer or die just due to old age. In addition to the special subjective factors pertaining to the clinical encounter with aging patients, many diseases may have atypical manifestations. Clustering of diseases may produce alterations in symptoms and clouding of the clinical presentation. Interaction of one disease with another is further complicated by the interaction of medications with disorders. The physician must be alert to discover treatable conditions and institute proper treatment. Urinary retention may relate to physical factors, but anticholinergic effects of medications, fecal impaction or occurrence of sepsis can also produce it. Often, depression is masked, presenting itself as change in sleeping, eating or bowel habits. Claudication may explain why a patient avoids walking. Delirium in elderly patients may be due to septic focus somewhere. Falls may simply be due to poor vision caused by cataracts. A bed occupier may be a Parkisonian patient and a poorly communicative old woman may be a hypothyroid. Pernicious anemia may be discovered only if sought by laboratory tests. Many times, patients are admitted to medical wards with impaired consciousness and in a bedridden state. It is the tendency of many physicians to label them as age related cerebral atrophy, senility or dementia. Careful attention to look for commonly treatable conditions might make a huge difference in this fragile group. Cure is much less common in geriatric medicine than improvements in function, but the latter even when relatively minor, may be equally as gratifying. The establishment of unrealistic therapeutic goals may frustrate the physician who does not appreciate this fact. A patient who has a stroke can significantly improve functional ability by learning to transfer from the bed to the chair or from the chair to the toilet. Below are a list of conditions, which an internist should regularly try to apply to a bed ridden geriatric patient. Diagnosis and management of these conditions may be professionally rewarding and will have a tremendous impact on job satisfaction. Common treatable conditions in the elderly. 1. Gastrointestinal tract (GIT): Constipation and fecal impaction might need an enema and sometimes, manual removal of stools. 2. Urinary system: For urinary retention especially due to prostatomegaly, drugs and so forth, catheterization even for short time might work wonders. Incontinence commonly occurs due to urinary tract infections, but systemic infection and metabolic disorders should also be looked for. 3. Respiratory System: Aspiration pneumonia, especially in patient on Ryle's tube feeding, with pharyngeal paralysis (medullar strokes or pseudobulbar palsy) and those with poor dental and oral hygiene should be suspected. Hypostatic pneumonia, due to poor cough reflex and increased frequency of micro aspirates is seen frequently. Lung abscess and pneumothorax especially in chronic obstructive pulmonary disease (COPD) patients and also pneumonia should be ruled out whenever deterioration occurs in a stable patient. 4. Other infections such as infected decubitus ulcers or intertriginous candidiases and eczema should be looked for specifically. 5. Endocrine system: Disorders like hyperosmolar states may easily be missed and can be life threatening. Similarly, hypothyroid state is commonly missed in these patients. Hyperthyrodidism may present with, atrial fibrillation (AF) anorexia, proximal muscle weakness, withdrawal or delirium. In diabetics hypoglycemia should always be kept in mind and treated immediately when suspected. 6. Dehydration

due to less intake as well as due to fever should be taken care of. Drug induced side effects should be kept in mind because poly pharmacy is common and frequently not reported by patient or relative. 7. Common old age problems such as poor vision, forgetfulness, poor reflexes and delayed physical and mental response may contribute to conditions such as falls, leading to fractured neck of femur, Colles fracture and vertebral compression fractures. 8. Subdural hematoma should always be suspected in any recent onset unexplained neurological symptom, especially waxing and waning of consciousness, even in absence of a clear history of trauma. 9. Pernicious anemia, diabetic amyotrophy and tuberculosis should be specifically looked for and ruled out where relevant. 10. Malignancy occurs more commonly in this age group and should not be out of your mind. 11. Lastly, loneliness in this age when children are leaving and arranging their families may be a source of distress both physical and psychological. Similarly, financial matters may be badly affecting the health of the patient. The tendency of doctors to underestimate the problem and under-evaluation should be strongly checked. The doctor should ask himself, after examining an old man, "Have I overlooked anything?" "Can anything else be carried out for the patient?" Screening methods like stool tests for occult blood or mammography in women or prostate specific antigen in men should be incorporated in practice where relevant. Preventive measures such as influenza vaccine should be administrative yearly, and pneumococcal vaccine should be given to each patient once. Exercise can benefit the elderly but should be tailored to the individual. Constant attention to medications can reduce the high incidence of toxic and untoward reactions. Physicians must remain a resource to the patient and family. Few geriatric problems are short term, and continued access to and compassionate care and support by the physicians is highly valued by the patient and his supporters. Support of the supporters is very important and should always be offered. A couple of days of admission in hospital might give relief to attendants and time to re-organize themselves. In western countries normal sequence is from home to hospice to nursing home to hospital until they die. On the contrary, family and the social care system is still intact and widely available in KSA, patients are taken back to their homes after improvement. This behavior should be encouraged and financially supported as recommended by us previously.[4] Home assessment and follow-up are recommended. However, in view of the fact that most of the physicians are expatriates and multiple socio-cultural barriers such practice is not common here. Even without formal training in geriatrics, internist can learn geriatric precepts and with the basic knowledge they already posses they can effectively use it as a good advantage in practice. They should emphasize on sensitive communication techniques, appropriate screening and preventive measures where applicable, specific prescribing for the elderly, evaluating functional status, and interdisciplinary consultation to broaden the delivery of proper scientific care. With the infusion of geriatric skills, internists could supply the added medical support needed for the care of senior citizens and restore medical specialist's age old and time tested involvement in clinical practice. For most of the GPs, a course of training in geriatric medicine will be needed to update their knowledge and skills. Continuing medical education courses are urgently needed for most of them. However, sooner or later a regular Geriatrician will be required in all hospitals in the KSA.

Latif A. Khan
Sarosh A. Khan
Najran General Hospital
PO Box 5073
Najran
Kingdom of Saudi Arabia

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