Geriatric Syndromes
For CHO/SN

LEARNING OBJECTIVES

- To know the Geriatric syndromes seen in elderly
- To know how to identify the Geriatric giants

INTRODUCTION

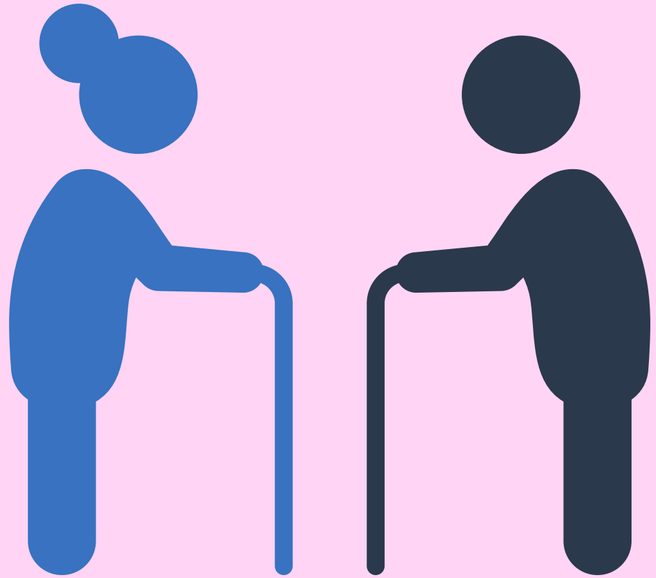
- As people grow old, some degenerative conditions occur. Elderly people are also prone to some diseases.

- Common conditions in older age include hearing loss, blurred vision/ difficulty in reading, back and neck pain, joint pains, diabetes, depression, dementia etc.

- As people age, they are more likely to experience several conditions at the same time

GERIATRIC GIANTS

- Immobility
- Instability
- Incontinence
- Impairment of intellect
- Dementia
- Delirium
- Depression



NEWER GERIATRIC GIANTS

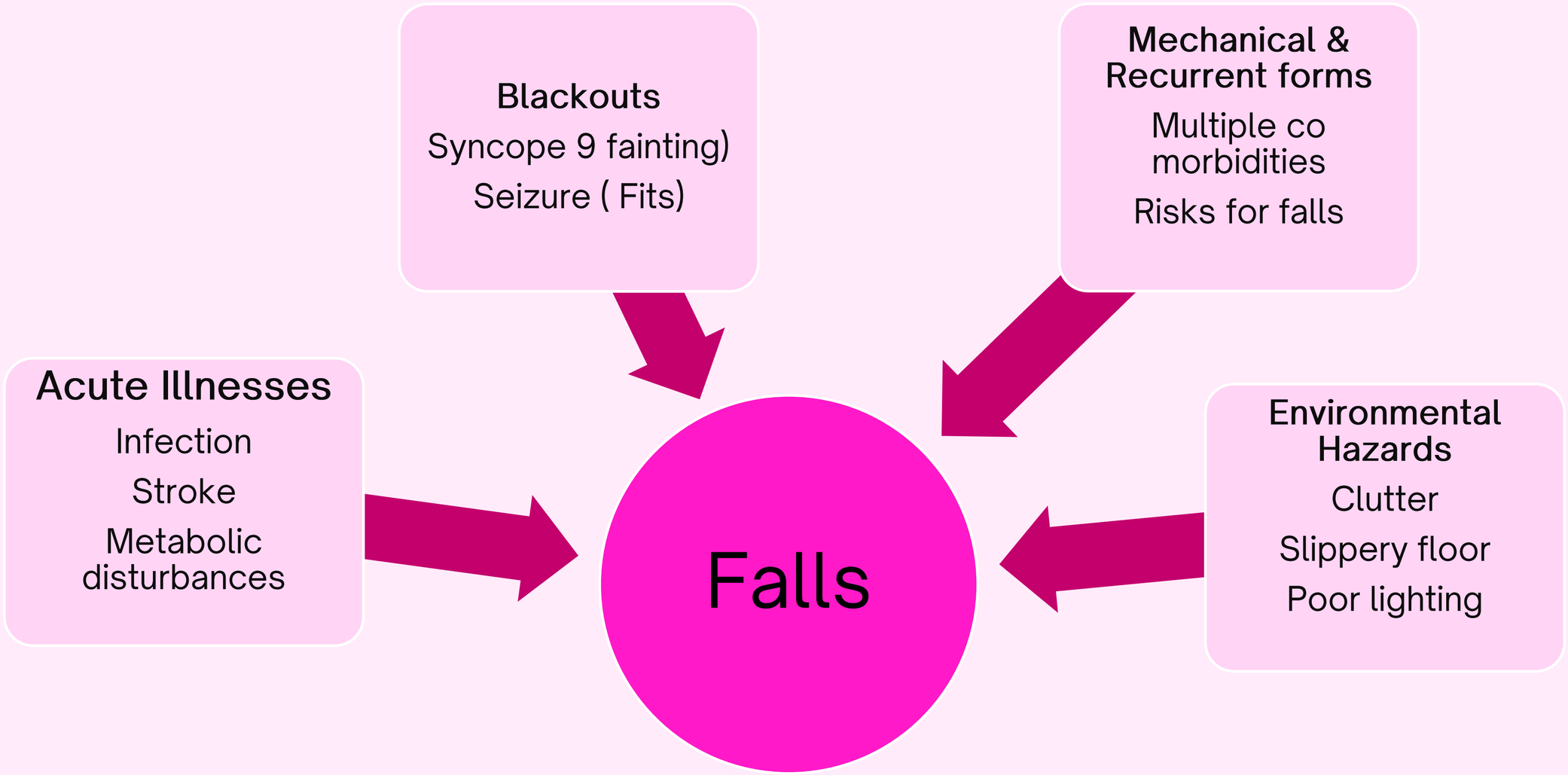
- Frailty
- Sarcopenia
- The ‘anorexia of aging’
- Others : Elder Abuse, polypharmacy,

  Nutrition in Older adults

FALLS AND FRACTURES

Elderly people are often at risk of falling.

CAUSES OF FALLS IN THE ELDERLY



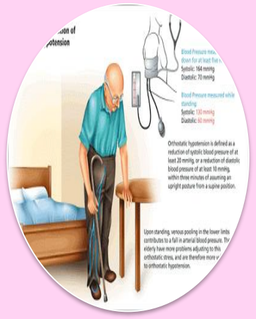
PREVENTION OF FALLS – Multidisciplinary Approach

Balance and Strength training

Tai Chi/ Yoga

Reduce hazards at home

Correct vision- Spectacles



Correct postural hypotension

Rational drug use

- Psychotropic medication

Podiatry

Identify and treat medical conditions causing falls

Use assistive devices

Walking alone does not prevent fall risk

IMMOBILITY

- ***Immobility implies a limitation in independent, purposeful physical movement of the body or of one or more lower extremities***
- Due to physical decline
- Causes
  - Physical (medical illnesses)
  - Psychological (depression)
  - Environmental (i.e. hospitalization)
- Leads to pain, disability and poor quality of life
- Causes deconditioning (decreased functional capacity of multiple organ systems)

IMMOBILITY - MANAGEMENT

- Positioning
- Mattress
- Range of Motion exercises
- Nutrition
- Assistive devices

URINARY INCONTINENCE

Involuntary loss of urine- comes to attention ⟶ severe enough to cause social/hygiene problem

Urge

Due to detrusor over-activity
Results in urgency and frequency

Stress

Women
Weakness of pelvic floor muscles

Overflow

Prostatic enlargement

Functional incontinence It results when an elderly person is unable or unwilling to reach a toilet on time.

- Urinary Infection-urgency
- Severe pain-osteoarthritis, metastasis
- Imbalance , dizziness
- Inaccessible toilets

IMPAIRMENT

- Dementia
- Depression
- Delirium

COMMON SUBTYPES OF IRREVERSIBLE DEMENTIA

Dementia subtype	Early, characteristic symptoms	Proportion of dementia cases
Alzheimer's Dementia(AD)	Impaired memory, apathy and depression Gradual onset	50-75%
Vascular dementia (VaD)	Similar to AD, but memory less affected, and mood fluctuations more prominent Physical frailty Stepwise progression	20-30%
Dementia with Lewy Bodies (DLB)	Marked fluctuation in cognitive ability Visual hallucinations Parkinsonism (tremor and rigidity)	<5%
Frontotemporal Dementia(FTD)	Personality changes Mood changes Dis-inhibition, Language difficulties	5-10%

STAGES AND COURSE OF DEMENTIA

Early stage: 1-2 years	**Middle Stage:** 3-4 years	**Later stage:** 5 years or more
• Often overlooked • May be overlooked as part of ageing • Features : language difficulties, getting lost in familiar places, mood changes, depression, loss of interest in hobbies	• Pronounced restrictions • Begins to lose basic activities of daily living (ADL)	• Total dependence for all activities. Becomes bed ridden/ chair bound • Risk of death due to complications such as pneumonia/UTI/Decubitus Ulcers/ Malnutrition

BEHAVIORAL AND PSYCHOLOGICAL PROBLEMS IN DEMENTIA

- Depression
- Repeated stories and statements
- Agitation
- Wandering
- Screaming
- Aggression and violence

MANAGEMENT OF DEMENTIA- GOALS

- Early **diagnosis**
- **Optimization** of physical health, cognition, activity and well being
- Detection and **treatment** of Behavioural and Psychological symptoms of Dementia (BPSD)
- **Educating** care giver and providing long term support to them.

MANAGEMENT OF BEHAVIOURAL AND PSYCHOLOGICAL SYMPTOMS OF DEMENTIA

Individualized non pharmacological therapies preferred over drug therapy

Caregiver training

- Improves coping mechanisms
- Cognitive engagement
- No effect on patients ADLs

Pharmacological:

IMPAIRMENT- DEPRESSION

DEPRESSION

- Depression is the **most common psychiatric illness** in the elderly.
- Although common, it is NOT a natural part of ageing.
- The prevalence in community dwelling elders range from 8% to 15%; it raises to as much as 30% of those in long-term care facilities.
- GDS 4 or GDS 15 used to assess depression

MANAGEMENT OF DEPRESSION IN OLDER ADULTS

- Non pharmacological therapy preferred
  - Cognitive behaviour therapy
- Pharmacological therapy
- Needs referral to psychiatrist through the MO
  - If suicidal/homicidal OR refusing to eat/drink
  - if not responding to antidepressants (8-12 week trial at appropriate dose)
  - Uncertain diagnosis
  - Bipolar disorder present

Impairment - Delirium

DELIRIUM

- Acute decline - attention and global cognitive function.
- Often under-recognized & under diagnosed.
- > 50% of hospitalized elderly persons are affected
- Often life threatening and potentially preventable source of morbidity and mortality for elderly patients.
- It is preventable in 30% to 40% of cases.
- Types: Hypoactive, Hyperactive, Mixed
- Delirium prevention is a cost effective strategy, as longer lengths of hospital stay and an increased need for long-term care may be avoided.

CAUSES OF DELIRIUM

Infection

- Pneumonia ,UTI, Sepsis, Cellulitis , abscess

Metabolic disturbance

- Hypo/hypernatremia, hypoglycemia, hepatic encephalopathy, thiamin deficiency

Toxic insult

- Anticholinergics, alcohol withdrawal

Acute neurological conditions

- Acute stroke, subdural haemorrhage

Hypoxia

- Pneumonia , pulmonary edema, COPD/bronchial asthma exacerbation

Treatment of Delirium

- Treat the cause, if you find it
- Do frequent assessments to follow the progress of the delirium.
- Provide supportive care (IV fluids if not drinking, O2 if hypoxic).
- Move the patient to a quiet, well lit room.
- Re orient the patient
- Medications – Only if hyperactive/risk of Self harm

CASE SUMMARY

You are seeing a new patient. He is a 72-year-old retired factory worker brought to clinic by his daughter. He lives with his daughter and her family since his wife died 2 years ago. Daughter is concerned about his poor appetite, trouble recalling conversations and recent falls.

Patient has been silent at home , restricted his activities to staying in the apartment, and he reports no concerns.

He had not seen a doctor for over 5 years until he was hospitalized for pneumonia one month ago when he has altered sensorium for a week .

Since that time, his daughter reports that his memory is worse and he is often agitated at bedtime. Also the daughter reports that there is frequent dribbling of urine.

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ANOREXIA OF AGEING

DEMENTIA

FALL RISK

IS HE DEPRESSED

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DELIRIUM??

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INCONTINENCE

Thank You