Welcome to the Geriatric Clinic!

The aim of the clinical evaluation of elderly patients is to collect information that will help prevent or treat disease, maintain or restore function, and provide a supportive environment. The purpose of this clinical experience is for you (1) to learn the special features of the clinical assessment of elderly patients, (2) to gain experience in applying these principles in a clinical setting, and (3) to develop approaches to the management of medical and psychosocial problems commonly found in the elderly.

A thorough geriatric assessment encompasses six components: (1) physical health, (2) mental state, (3) functional status, (4) environmental circumstances, (5) social support, and (6) economic situation. Each component interacts with the others, often leading to challenging logistic problems. Standardized assessment instruments can make the process easier and more structured.

Physical health is assessed from the medical history, physical examination, and laboratory tests.

Mental state includes cognition and psychological tone. The mental status examination provides information on cognition. Inquiries about emotional disorders, loneliness, bereavement, depression, anxiety, alcohol use, and mood swings help assess behavioral problems.

Functional status is evaluated by assessing activities of daily living (ADLs) needed for self care and instrumental activities of daily living (IADLs) needed for independent living.

Environmental circumstances that impinge on an elderly patient's health include such things as hazards at home that increase the likelihood of falls and fear of neighborhood crime.

Social support comes from family, friends, and agencies. Social support may determine whether a patient can remain in the community or will be institutionalized.

Economic situation addresses whether financial resources are adequate to meet the personal and medical needs of a patient and not the specific amount of money a person has or receives.

SPECIAL ATTRIBUTES OF THE GERIATRIC PATIENT

Geriatric medicine is based in the principle that elderly persons are different from young and middle-aged adults. The following are some of the important clinical differences:

1. Physiologic reserve is diminished.
2. Homeostasis is more easily disrupted and more difficult to reestablish.
3. Disease in one organ system may present with symptoms in another, weaker organ system. For example, the stress of infection or anemia may present as heart failure if there is marginal cardiac compensation.
4. Disease may present in an altered form, either in an atypical fashion or with nonspecific symptoms (e.g., delirium, falls, urinary incontinence, sleep disturbance, weight loss).
5. Polypharmacy (multiple drug use) may mask symptoms or produce new symptoms.
6. Drug effects are more pronounced due to changes in both pharmacokinetics (handling of drugs) and pharmacodynamics (action of drugs).
7. Biologic variability is greater than in younger patients.
8. Multiple medical, psychological, and social problems may coexist and interact.

Medical Interview
Interviewing the elderly patient is often complex. More time may be required because of slow response, impaired hearing, or a large amount of information. The interview is a continuing process, for a new patient it need not be completed in a single session but can be spread out in more than one visit. However, certain topics need to be covered: current complaints, present medical problems, and medication history (including both prescribing and proprietary drugs).

In caring for the elderly, seek treatable disease. A treatable disease may be missed because it is not looked for or it presents in an atypical fashion. For example, demented patients often have unrecognized coexisting medical problems that when treated may improve cognitive function.

The elderly often attribute changes in health to aging and fail to seek help. Many physicians make the same error and as a result do not treat the treatable. Small improvements in health can make a marked difference in function and sense of well-being.

A directive symptom is one that directs the physician to the organ, system, or part of the body affected by a disease. A nondirective symptom indicates sickness but does not point to the source. Vomiting blood is a directive symptom (bleeding in the upper gastrointestinal tract); fever is nondirective. Because any disorder may present with vague, nonspecific, or nondirective symptoms in the elderly, specific inquires about the presence of such symptoms must be made. Frequent and important nondirective symptoms in the elderly are lethargy and fatigue; falls; new onset of a sleep disorder; unexplained weight loss; newly developed urinary incontinence; acute confusional state (delirium); and a symptom complex that has been termed "being off one's feet" (feeling poorly, losing interest in one's surroundings, and spending an increased amount of time in bed).

Certain aspects of the review of systems need to be emphasized in the elderly and inquired about. These include:

1. Nutrition
2. Exercise
3. Vision
4. Hearing
5. Dental problems
6. Falls
7. Urinary incontinence
8. Sleep disorders
9. Immunizations

Functional Assessment:
A functional assessment can provide baseline data, screen for undetected problems, assist in diagnosis, help set goals for rehabilitation and therapy, and monitor a patient's clinical course. Structured assessment instruments are provided on the University of Florida Guide to Geriatric Assessment.

Physical Function:
ADLs and IADLs should be assessed in all new patients.

Cognitive Function:
Healthy elderly persons may show deficits in memory, especially in recall. Age-associated memory impairment is defined as appreciable difficulty in remembering the names of individuals just introduced; misplacing objects; difficulty remembering multiple items to be bought, things to be done, telephone numbers or zip codes; and difficulty remembering information quickly in the absence of signs of dementia, neurologic disease, depression, or drug effects. Many factors can affect memory: education level, impairment of vision or hearing, illness, fatigue, medications that blunt alertness, depression, anxiety, and dementia. Memory is a complex multifaceted function. Disruption of daily activities is the best gauge of the seriousness of memory impairment.

Screening for dementia is not a standard part of a new patient evaluation. But if the patient is brought in for a memory problem or if you suspect cognitive dysfunction from your evaluation, a mental status examination should be performed using the Mini-Mental State Questionnaire.

Emotional Status:
The most frequently encountered emotional difficulty in elderly patients is depression. Depression encompasses changes in mood (sadness, crying, feelings or worthlessness, guilt), cognitive alteration (forgetfulness, loss of interest, loss of initiative), and vegetative symptoms (fatigue, sleep disturbances, change in appetite). The Geriatric Depression Scale is a useful tool designed to assess depression in elderly patients.

Social Support and Economic Status:
A social support system helps a person remain in the community. Social isolation (lack of persons to assist in care) is a risk factor for institutionalization, morbidity, and mortality. The support system is assessed in an unstructured fashion by asking who would the patient call upon if help was needed. Support can come from relatives, friends, neighbors, and social agencies.

Economic status is assessed by inquiring whether the patient has adequate income or funds to cover the expenses of food, transportation, medical care, and other necessities. Because individual lifestyles and spending habits vary, determining exact income is not as important as ensuring that financial constraints are not a problem.

Laboratory Tests:
The reference range of most laboratory tests does not change in old age. For example, there is no such entity as anemia of old age; anemia at any age is abnormal.

However, the erythrocyte sedimentation rate increases progressively with advancing age. Normal values for the Westergren method can be calculated as follows: for men, half the patient's age; for women, half the sum of the patient's age plus 10.

Serum albumin concentrations tend to be lower in the healthy elderly and are usually at the lower end of the reference range. Values below 3.5 g/dL are uncommon in the fit elderly. Hypoalbuminemia, however, is frequently noted as a result of any illness in older patients. Alkaline phosphatase values often are mildly elevated in the elderly; the cause is unknown.

The BUN and serum creatinine concentrations remain unchanged with advancing age, even though the glomerular filtration rate diminishes. Creatinine clearance falls progressively, but serum creatinine values do not rise because muscle mass, the source of creatinine, diminishes proportionately with age.

Although fasting glucose concentrations are unchanged in the elderly, a glucose load produces a higher
maximum serum value, and more time is needed for the glucose concentrations to return to fasting values. This is an example of the elderly's sluggish ability to regain homeostasis. When glucose tolerance tests were performed more routinely, this phenomenon led to the misdiagnosis of diabetes in many normal elderly persons. Nomograms are available to correct for glucose metabolism with advancing age.

Summary:

The geriatric patient is different from the middle-aged patient. These differences need to be recognized and taken into account in the assessment of the elderly patient.

The medical assessment of the elderly patient is a multidimensional process comprising evaluation of physical health, mental state, functional status, environmental situation, social support, and economic circumstances. Multiple interacting problems are often found.

The medical interview of the elderly person is often long and complex. Areas requiring emphasis are the medication history, nondirective symptoms, nutrition history, dental problems, vision and hearing, sleep disorders, falls, urinary incontinence, and immunizations. Improving communication and, in turn, compliance is an integral part of the geriatric medical interview.