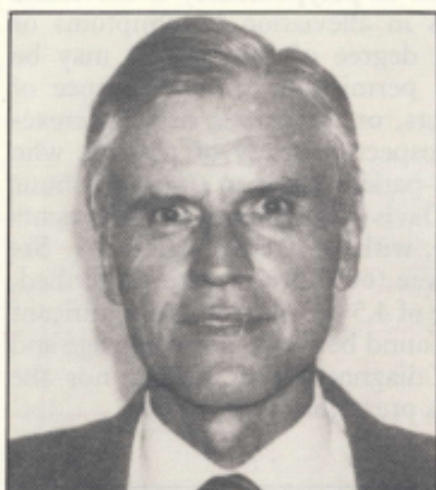


# Pitfalls of practice in the elderly

— P de V Meiring



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## Curriculum vitae

Prof P de V Meiring holds the William Slater Chair of Geriatric Medicine at the University of Cape Town. He obtained his MBChB at the University of the Witwatersrand in 1951; after two years at Baragwanath and the Johannesburg General Hospital, he spent six years in Zimbabwe and Zambia and then proceeded to Britain in 1960 and obtained the FRCP in London, and Edinburgh in 1962. He subsequently held training appointments in Britain, Australia and in Cape Town. In Pietermaritzburg (1966 to 1981) he became interested in the proper care of the aged, carrying out research and community service in this field. His professional interests include planning and provision of geriatric services, preventive geriatrics and retirement planning. He was elected to fellowship of the Royal College of Physicians of Edinburgh in 1972 and of London in 1983.

**C**linical practice among elderly patients is fraught with difficulty for a number of reasons. The aged are known to under-report illness and symptoms generally, as these are ascribed to the natural process of ageing. This is a mistake not confined to patients either, for

*Based on a talk given at SA Academy of Family Practice/Primary Care meeting held in Pietermaritzburg.*

## Summary

*The pitfalls of practice in elderly patients are not readily found in one place in any textbook. This is a discussion of the common problems encountered over many years of clinical experience with the aged.*

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it is commonly committed by the health professionals.

A possibly apocryphal story illustrates the point nicely. An elderly lady consulted a doctor because of a pain in her right shoulder. On learning that she was 84, he asked her what she could expect at her age, at which she tartly asked the doctor — why, in that case the left shoulder was not also painful. In other words, there is a great deal of reversible disability that has the potential for alleviation without any obligation or possibility to cure the underlying chronic pathology. The elderly accumulate pathologies and often get their treatment from several sources for several symptoms.

Moreover, disease often presents atypically in the aged being modified by an interaction of pathologies, drug interactions and the altered homeostatic and other mechanisms in the senescent individual.

Elderly patients are often slow, may give a poor history and be difficult to examine and a number of symptoms and signs from pathology in several systems may compete for attention or at times modify the clinical presentation completely.

A description of the pitfalls of practice in elderly patients is not readily found in one place in any



textbook and must be discovered by sometimes hard won clinical experience. Many experienced general practitioners will undoubtedly be able to add to the pitfalls described here, which are the result of seven years personal experience of geriatric medicine, rather than attempting to draw too heavily upon the published experiences of others.

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### *The aged, and their doctors, tend to under-report illness and symptoms*

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There are obviously many ways, too, to describe these difficulties. But, again from personal experience, they will be presented under the following headings:

1. The influence of multiple pathology; two or more pathologies per patient with conflicts of therapeutic interest.
2. Polypharmacy; attempting to prescribe a pill for every ill.
3. Atypical presentation of disease in the elderly.
4. Poor overall assessment of patients.
5. Lack of knowledge of social, pathological and psychological bases of disease in the elderly.
6. Lack of knowledge of facilities available to deal holistically with the problems encountered; polypharmacy rather than milieu therapy.

### **Multiple Pathology**

Here we sometimes find conflicts of therapeutic interest. For example, the corticosteroids needed to treat a steroid-dependent asthmatic may accelerate the osteoporosis so universal in the

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### *Disease often presents atypically in the aged*

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elderly. The need for anticoagulant therapy for a proven pulmonary embolus may be totally contra-indicated by a gastric erosion caused by treatment with non-steroidal anti-inflammatory drugs which themselves may, by impairment of renal function, make control of hypertension very difficult. For the same reason, severe arthritis and known renal impairment can cause a conflict of therapeutic interest.

Apart from treatment problems, multiple pathology often confuses the clinical issue and a good

example is breathlessness in the presence of both heart and chronic obstructive lung disease. It can be very difficult to decide which organ is primarily responsible and the temptation may be to treat both, without ascertaining for example that either a reversible element of broncho-constriction, or a decline in left ventricular function, are present.

### **Polypharmacy**

A certain amount of polypharmacy is inevitable and if it results in alleviation of symptoms or restoration of a degree of function, it may be looked upon as permissible in the absence of severe side-effects, or dangerous drug interactions. In a retrospective study of patients who attended an out-patient clinic at Groote Schuur Hospital, Dr C Davis (1985) looked at 132 patients aged 70 or over, with an average age of 75. Six hundred and three (603) drugs were prescribed, being an average of 4.5 per patient. No significant association was found between increasing age and the number of diagnoses per patient, nor the number of drugs prescribed.

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### *Elderly patients often give a poor history; too many systems compete for attention*

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Side-effects necessitating a change of treatment or warranting mention in the notes occurred in 14%, but treatment was assessed as beneficial in 63% of patients. Davis concluded that multiple drug therapy was of benefit to the majority of elderly patients but urged that they must be kept to a minimum, by prioritizing which symptoms really need treatment, and safe by a sound knowledge of pharmacotherapeutics and potential drug interactions.

### **Atypical disease presentation in the elderly**

Common difficulties encountered may be listed and briefly described as follows:

#### ***"Silent" acute myocardial infarction***

In the elderly, inferior myocardial infarction, particularly in diabetics, often presents without pain. This may be true of anterior myocardial infarcts as well, but is less common. Any complaint of syncope, weakness or breathlessness, or a finding of congestive cardiac failure, or drop in blood pressure without an obvious cause,



# Here's the Wellcome one for nasal congestion...



warrants an electrocardiograph and serious clinical consideration to rule out acute myocardial infarction.

### ***Pneumonia without clearcut physical signs***

This is a very common situation. Such patients may present with mental confusion, but without an elevated temperature or the classic signs on physical examination. The only bedside clue may be tachypnoea with or without a flare of the alar nares.

### ***Confusion due to reversible causes***

A mnemonic, DIMTOP, is very useful at the bedside and is interpreted as follows:

- D: Drugs including tranquillizers, hypnotics, antidepressant drugs and a wide range of others including cimetidine, corticosteroids, L-dopa and alcohol.
- I: Infections of many varieties. In geriatric practice the commoner infections include respiratory and urinary infections. In the latter case the only sign, apart from the urine, may be confusion.

M: Metabolic upsets including electrolyte imbalance, dehydration, hyperglycaemia, hypoglycaemia, acidosis, hypothyroidism and renal and hepatic failure.

T: Trauma, Tumours of the brain. In the case of trauma, however minor, one should be ever mindful of the possibility of a subdural haematoma.

O: "Oxygen" — ie Oxygen deprivation to the brain by means of lung pathology, severe anaemia, vascular obstruction or heart failure.

P: Physical causes, eg hyperthermia or hypothermia; psychiatric, eg severe depression, dementia and various reversible organic psychoses.

### ***Masked, atypical or simply, missed depression***

A thick hospital folder with many negative investigations, many referrals and few conclusions should alert the clinician to the possibility of depression. Late onset alcoholism and sleep disturbances are further pointers and then there



is typical depression with most of the DSM III criteria that the clinician simply does not think of. Depression is common enough in the elderly to make a high index of suspicion rewarding.

### **Tuberculosis**

The elderly are a common reservoir of infection and late primary tuberculosis or a thoroughly atypical presentation of reactivated tubercle can easily confuse the unwary. Any unexplained loss of weight, pyrexia, tiredness, malaise should be thoroughly investigated with tuberculosis

### *Polypharmacy rather than milieu therapy*

included in the differential diagnosis. The Mantoux test is unreliable often, the chest X-ray may be misleading and atypical and sputum may be hard to obtain, but no stone including bronchoscopy, gastric lavages and sputum culture, should be left unturned. The subject of tuberculosis in the elderly is one too big to cover

adequately in a few cautionary notes of this nature. Let it suffice to say that it should be considered in a wide variety of clinical circumstances and actively excluded by expert referral if need be.

### **Many and varied drug reactions**

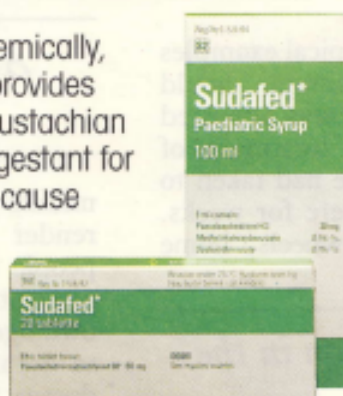
These are too numerous to list in detail in an account of this nature and should be considered in giving rise to a wide variety of symptoms that may be thought to be due to the primary underlying pathology. Common problems have been encountered with hypotensive drugs, oral hypoglycaemic agents, diuretics (beware potassium-sparing drugs in renal impairment), digoxin, anticoagulants, anxiolytics and anti-histamines. In any unexplained illness in the elderly one should ask oneself whether there is any possibility of drugs being responsible.

### **Other pitfalls**

These are many and varied and include cancer and other malignant disorders in their varying presentations, again often atypical in the elderly. It has been said that the elderly often die *with* cancer rather than *of* cancer. Failure to conduct a formal, if brief, assessment of cognitive function

# ...and for eustachian tube congestion.

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often results in missing dementia, which may be disastrous if the patient occupies a responsible position. So-called "social" diseases of isolation, bereavement, poverty and boredom may alter the presentation of disease and no assessment is complete without a social history and an assessment of home circumstances. It has been said that about 10% of all elderly persons presenting to the health professionals have an alcohol-related problem among their spectrum of pathology. A number of us have certainly missed hip fractures in the elderly under atypical circumstances with consequent delay in diagnosis of the true state of affairs.

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### *Inferior MI often presents without pain in the elderly diabetic*

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#### **Poor overall assessment of elderly patients**

A full assessment resulting in accurate diagnosis and hence, appropriate treatment depends on careful consideration of body, mind and social adaptability. Remove any one of the three supporting legs of a cooking pot and it will fall into the fire; more or less the same fate rewards efforts to treat the elderly appropriately if due attention is not paid to the physical pathology, the mental competence and the social support systems of each patient.

Each reader will be able to recall typical examples illustrating this point. An actual example should suffice to emphasise it. A woman was admitted to the Psychogeriatric Unit for treatment of depression on the grounds that she had taken to her bed at home and remained there for weeks. Expensive recourse to meals-on-wheels, home

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### *Depression is very common in the elderly*

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nursing and domestic services and a variety of antidepressant drugs had been of little avail. In the unit she was discovered to be severely osteopaenic with proximal muscle weakness and low serum calcium.

She was in fact suffering from osteomalacia with hypocalcaemic myopathic weakness, with the typical waddling gait of severe osteomalacia and the correct treatment, based upon an accurate

diagnosis, resulted in an ambulant and much happier old lady returning home.

#### **Lack of knowledge of the social, pathological and psychological basis of disease in the elderly**

There is a body of fairly unique and characteristic knowledge being assembled about the elderly and unless the doctor treating these people is prepared to read within this whole field of gerontology, his or her patients will receive less and less optimal management. This is the whole point behind the establishment of Chairs of Geriatric Medicine at Medical Schools. For those who were not exposed to such teaching, self-directed learning is essential and some sources of information are given at the end of this account under suggestions for further reading.

#### **Lack of knowledge of facilities available to deal holistically with problems encountered in the elderly**

It depends very much where one practises as to what facilities will be available. Even in the smallest town there may be married nurses, occupational therapists, physiotherapists and social workers who may be prepared to work part-time for voluntary agencies such as Church organisations caring for the aged in the community. The neighbour, the local schoolchildren,

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### *Any possibility of drugs being responsible?*

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middle-aged housewives looking for services to render in their community and other elderly people are all candidates for mobilisation and motivation to help a community to care for its own aged. It takes enthusiasm and a willingness to organise and co-ordinate these efforts for a doctor to make an impact and thus lighten his and his community's load in keeping elderly people out of institutions for as long as possible.

A file, in which one enters all solutions found to presenting problems, can only make subsequent problems easier.

All pensioner benefits should be explored and made known to your elderly patients and a knowledge of the local old age homes, what facilities they offer and their admission criteria should all be available to practitioners and the local agency for care of the aged should therefore



be encouraged to keep all this information on file, catalogued and available to enquirers.

Proper communication between the GP and all appropriate agencies including the hospitals is essential, and it is to our shame as hospital doctors, that failures in communication are probably more often to our account than to that of our community colleagues. General practitioners should therefore approach local hospital administrators and insistently demand prompt communication about patients who may be returned to their care with delayed or insufficient documentation.

### Conclusion

Some practical pitfalls of practice in the elderly have been briefly described as listed at the beginning of this account.

These include a number of factors intrinsic to the elderly themselves as well as those resulting from interaction between health professionals and patients. Atypical presentation of disease conspires with polypharmacy and a lack of knowledge and expertise in dealing with the elderly in the application of appropriate care to make clinical geriatric medicine extremely difficult to practise well. A professional approach can do much to help many patients by alleviating their symptoms without doing more harm than good, besides being a very rewarding job when done properly.

There has been insufficient space to deal with common problems of deafness, visual impairment, foot care, musculoskeletal disorders and the whole gamut of internal medicine in the organ systems.

It is however, hoped that some of the points raised here, especially if they strike a chord in the reader's own experience, will stimulate further reading in that frustrating, but at the same time fascinating, field of care of the elderly.

### Suggestions for further reading

1. Principles and practice of geriatric medicine. Editor: MSJ Pathy, with many authors. John Wiley & Sons 1985. A comprehensive account of geriatric medicine in great detail and a never-failing source of practical guidance — a *must* for any serious practitioner among the elderly.
2. Caird F I. Medicine in old age. In the Oxford Textbook of Medicine. 2nd Edition, Oxford University Press 1987; 27: 1-9. A succinct and useful account by a leading expert in the field. If you know what is in this chapter thoroughly, you will not go far wrong with common problems.
3. Covington T R, Walker J I. Current geriatric therapy 1984; Saunders & Company. A very practical account. New editions should certainly be watched for with interest.
4. Practical geriatric medicine. Editor Exton-Smith N, with many authors. Churchill Livingstone 1985. A shorter account than Pathy, but practical and almost equally useful to the practising doctor.
5. Journal of the American Geriatrics Society. Official organ of the American Geriatrics Society.
6. Age and Ageing. The official journal of the British Geriatrics Society. For those who wish to become serious about competent practice in the elderly, one or both of the above journals will keep the reader up-to-date with important developments in the specialty of Geriatric Medicine.

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