The changing face of geriatric medicine

Over the past few months, we have wondered whether we are witnessing the changing face of geriatric medicine. Three patients aged over 80 years old stand out.

The first, a heterosexual, Caucasian, English man with HIV, presented with an acute confusional state. Following extensive assessment and investigation, he was diagnosed with Alzheimer's-type dementia with a superimposed delirium unrelated to his diagnosis of HIV.

HIV is now largely considered a chronic treatable condition when diagnosed early and treated and monitored aggressively. With increasing longevity and the advent of improved retroviral therapy, older patients with HIV are likely to suffer from coexistent conditions traditionally managed by geriatricians [1, 2]. Physicians in elderly medicine should maintain an adequate working knowledge of the complications of HIV, the treatments, their side-effects and the interplay between these and the traditional 'geriatric giants'. We should not forget undiagnosed HIV as a cause for unexplained presentations in older patients and should include an assessment of high-risk behaviour [3].

The second case is of a lady who presented via the medical take 'off legs'. Her body mass index (BMI) was 84 and she was hypoxic with peripheral oxygen saturations of 79%. Her subsequent diagnosis of obesity hypoventilation and her profoundly limited functional status presented a considerable challenge to the hospital discharge team. She required hoist transfer using a specialist bariatric hoist and chair and the assistance of six people. There are currently limited community facilities to safely manage a long-term resident with these needs.

The prevalence of obesity in both developed and developing countries is increasing [4]. Physiological changes in older people make defining obesity in this population more problematic. Significant physical, cognitive and psychological implications arise due to this condition. Whilst pharmacological therapy and bariatric surgery may be suitable for selected older obese patients, the mainstay of evidence continues to support a combined programme of diet and exercise [5].

In addition, we are likely to see that acute hospital sites, community rehabilitation units and long-term care facilities will need improved training and equipment to manage this likely increase in the number of dependent obese older patients.

The third case is of a particularly active 81-year-old lady who presented to the orthopaedic surgeons with a dominant hand Colles fracture sustained whilst roller-blading in her local park. It was difficult to label the patient as having suffered a fragility fracture given the mechanism of injury!

Evidence confirms the benefits of moderate physical exercise on physical and mental well-being for older people [6, 7]. The General Household Survey (GHS) [8] in 1996 listed walking, cycling, snooker, bowls, swimming, keep-fit/yoga/dance and golf as the most popular activities for those aged >70.

As geriatricians, we are used to taking detailed social histories regarding patient's activities of daily living to ascertain the need for support services. Perhaps with the increase in active older people coming in to contact with geriatric services, we should widen the context of this section of the history to enquire about driving, occupation and leisure activities.

This potential changing face of geriatric medicine was highlighted recently when Doris Long, aged 95, set a new world record as the oldest abseiler by descending 21 m down a Portsmouth office block! She stated that she will continue to abseil until she retires at age 100 [9]!

Conflict of interest

The authors have no conflict of interest to declare.

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References