COMMONLY PRESENTING ILLNESSES IN THE ELDERLY

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As the population ages the demand for medical services will increase as the elderly population in general experience greater morbidity associated with the aging process. Consider that with the recent economic crises and the efforts by legislators to curb spending and reduce the deficit, programs such as Medicare may be reduced, placing a greater burden of care on alternative providers. Additionally, allopathic medicine has largely become a managed care system which means that disease conditions are managed, usually by adding more prescription medications, with little emphasis on prevention. Therefore it becomes all the more important that naturopathic physicians be aware of the areas of morbidity in the elderly population as demand for naturopathic services will only increase in a population that already has a high utilization of natural therapies.

Immobility in this population can have serious consequences, and an elderly person who is largely immobile or remains bed ridden is at higher risk for the following conditions.

Contractures are caused by prolonged immobility in a bedridden patient, but sometimes due to tightness of bed sheets. Contractions can occur in a matter of 2-3 days if the joins are not mobilized daily. With immobilization, fibrosis and tendon contracture will occur, which in the elderly, is difficult to treat due to the slower healing times. Contractures may lead to decubitus ulcers.

Pressure Sores are due to prolonged bed rest especially if there is some type of sensory loss as in diabetes. Obesity, anemia, poor nutrition, low blood pressure, poor peripheral vascular flow, skin infections and fecal contamination are factors leading to bed sore formation. Muscle and fat layers are more vulnerable than dermis and so sores may be larger than they seem. Low pressure for prolonged periods is worse than high pressure for a short time and there is a direct correlation between size and prognosis. Areas of higher incidence are the heels, greater trochanters, spine, sacrum, scapular spines and elbows. Vulnerable areas should be kept clean and dry. Fluid loss through ulcers can be considerable and replacement is often necessary. Consider higher protein, vitamin and mineral intakes, especially zinc and vitamin A to help with healing. Special beds or nursing care may be necessary.

Thromboembolism is also of concern in immobile patients as spontaneous thrombosis may occur even in the absence of neoplasm, post surgery or obstruction. A high degree of suspicion for embolus is present if unilateral leg swelling

occurs, but bilateral leg swelling is not unheard of. There may be patients who have no swelling or calf tenderness. Paralyzed patients need to have regular physical therapy and frequent leg and arm inspection is necessary with anyone on prolonged bed rest. It is best to get the person up and walking, do leg exercises and deep breathing when possible. Consider some form of prophylactic herbal anticoagulant therapy.

Dehydration can occur due to prolonged immobility. Common causes of low fluid intake are fear of incontinence, inadequate or difficult-to-utilize bathroom facilities, fear of falling, or loss of drinking habit. Clinically you will see a dry brown tongue, sunken cheeks, inelastic skin, elevated blood urea nitrogen and often electrolyte imbalance. Over use of diuretics, coffee, alcohol or diabetes may cause this condition as can diarrhea or vomiting. Lassitude, weakness and prostration should suggest potassium depletion (< 3.5 meg/l), which can occur due to dehydration.

Constipation from prolonged bowel inactivity may lead to irritation with subsequent passage of large amounts of mucous. Bowel obstruction should be considered. An impacted bowel may cause an elderly person to become mentally confused or disoriented, which will abate after passage of stool. Bowel problems can be avoided by increasing fluid and fiber intake. Fruits and greens are often found to be lacking in the geriatric diet, especially in rest homes.

Incontinence is one of the leading causes of admissions to rest homes. During illness the incidence increases, much to the embarrassment of the elderly patient, but returns to normal afterward. Prolonged bed rest also predisposes to incontinence, especially at night. The person may also be totally unaware of the problem they have with incontinence due to their mental status.

Some causes of **fecal incontinence** are proctitis, cancer of the rectum, prior rectal surgery, anal prolapse and lesions of the spinal cord or cortical region. Most often it is due to chronic constipation which causes diarrhea or looser stools due to irritation. Rectal exam often provides information regarding fecal impaction and helps to clear the problem while several days of enemas or colon hydrotherapy may be needed to get things flowing again.

Independence - For most elderly patients, maintaining their independence as long as possible is a must. For some, it is very easy to give it up and become dependent upon others. For therapeutic and mental health reasons it is probably best to allow an older patient to do as much as possible by themselves. This may require great patience on the part of the family, but it is the best for the elderly.

Hypothermia - A Body temperature of 35 °C or less is considered hypothermic. Hypothermia can be seen at the onset of diseases such as pneumonia, pulmonary embolism, cardiac infarction and stroke. Often it is due to sleeping in cold bedrooms or from having fallen on ice or on the floor and not being able to get up. Complications are pneumonia, pancreatitis, organ infarct and gangrene of the extremities. Death may be quite sudden and unexplained even if the patient seems to be responding. Hypothermia may present as clouded consciousness, slurred speech, no shivering, puffy face, slow pulse, muscle rigidity and very cold skin, especially of the abdomen. They may not appear ice blue but pink. Rapidly re-warming a hypothermic patient is contraindicated as cardiovascular collapse may occur. Re-warm at not more than 0.5 °C per hour along with other support measures such as oxygen etc. The best treatment is prevention.

Hyperthermia - direct sun exposure need not occur in order to become hyperthermic. Environmental temperatures above 38 °C for several days may cause symptoms such as apathy, weakness, faintness and headache. Signs include body temps of 39.5 °C, tachycardia, and dryness of the skin. Electrolyte abnormalities may or may not be present and perspiration is reduced due to less active sweat glands. Treatment with ice water sponging, fans, alcohol sponge baths to rapidly reduce the temperature is desirable. Some IV therapy may be needed but isn't always necessary as fluid loss may not have occurred. As with hypothermia, any medical condition the patient has (i.e., diabetes) may be made worse by this condition and in fact may precipitate an exacerbation.

Often elderly patients that are seen in the office or inpatient settings will present with few symptoms. More often than not they will end up in your office because a caregiver or loved one will have noticed that there is a change in their personality or normal activities of daily living (ADL's). This becomes important because this may be the only sign of an underlying disease process.

Headaches - Periodic or frequent headaches should alert the clinician to the possibility of a space-occupying lesion. This is due to the fact that the elderly generally present with fewer headaches. Temporal headache or facial pain should suggest arteritis and needs to be worked up. Headache due to dehydration is almost never seen as often as it would be in a younger patient.

Sleep/Insomnia – It is somewhat of a myth that elderly people generally requires less sleep than younger. Often an older person will take periodic naps to compensate. If they are sleeping more it may be due to boredom or depression.

Sedative use needs to be considered, as does uremia, heart failure or respiratory insufficiency. Insomnia may also be due to depression or some type of mental upset. An elderly patient may need to urinate more often at night either through habit, bladder disease or use of alcoholic drinks to help them sleep.

Dysphagia - Is often seen and may be due to neurological dysfunction more often than physical obstruction. Conditions that need to be considered are cancer of the esophagus or larynx, Plummer-Vinson Syndrome, diverticula's and hiatal hernia.

Anorexia - Appetites are variable in this age group and it is important to consider how the person ate in the past when trying to assess their eating pattern now. Appetite is probably the last thing to recover from an illness, but anorexia may be the first sign of gastric cancer or other underlying illness. Anorexia nervosa is not found in the elderly but some patients may decide not to eat, as they do not wish to live. It may also be a sign of depression.

Dyspnea - With age, the lung vital capacity decreases, as does the ability of oxygen to diffuse, whereas the residual volume increases. A certain amount of dyspnea may be present, with the elderly person restricting their normal ADL's to compensate. It is also present in obesity as well as anemia. With respiratory disease the respiratory rate will increase and is often the first sign before the pulse and temperature increase. Dyspnea occurs with heart failure and it is important to ask how many pillows they sleep on or it there is coughing at night. Persistent deep, panting respirations in someone who looks sick suggests acidosis. Attacks of breathlessness may be Cheyne-Stokes respiration and is somewhat common or perhaps an acid-base imbalance.

Vertigo - Is a very common complaint with or without a disease process. Causes are anemia, acute GI bleeding, carotid sinus syndrome, postural hypotension, hypertension, cardiac rhythm changes, MI, minor CVAs, wax in the ear, middle ear disease, acoustic neuromas, acute labyrinthitis, sinus congestion, Menieres disease. Also consider drugs such as salicylates, quinidine, beta-blockers, barbiturates, diuretics and antihypertensives.

Syncope - These often present as attacks and cause much anxiety and alarm which may make it difficult to get a history. Concern may arise from the family or spouse as to whether or not the patient is capable of living by themselves or needs to be in an assisted living environment. Etiology can be from minor epileptic fits, stroke, cardiac event or localized cerebral ischemia or plaques. The carotid sinus syndrome can be reproduced by having the person do exactly what caused the attack to see if it occurs again (often neck hyperextension). So-called drop attacks where the

patient suddenly falls and can't get up due to muscle flaccidity may last from minutes to hours. The cause is often unknown and needs a complete work up. Finally the patient may present with hysteria, especially if they are feeling neglected, unloved or are facing a move to a different location. This is often a difficult situation to deal with but needs to be addressed and may require the assistance of a social service agency.

Hypotension - Patients complain of dizziness, limpness, or fainting on standing up. Some will have trouble sitting because they feel ill, or perhaps feel giddy. Usually this is a sign of a severe circulatory disturbance or acute GI hemorrhage or a cardiopulmonary event needs to be considered. MI rarely takes the classic form in the elderly and a low BP may be its first and only sign. A pulmonary infarct, especially if there is a history of being bed ridden, may present the same way. Elderly people on hypertensive drugs are very susceptible to their effects while hypokalemia may cause low BP. In addition, postural hypotension has been shown to be common in those patients with low serum sodium levels.

Blindness/poor vision - Gradually decreasing sight may not be as common as is generally thought and should not be automatically assumed. It may however, be the reason for a decreasing mobility, poor orientation or bizarre visual impressions. Cataract formation may present as direct light causing a glare and the person compensating by sitting with their back to a window or wearing dark glasses while reading. Sudden onset of blindness may mean retinal detachment, hemorrhage, retinal vein thrombosis, giant cell arteritis or an occipital lesion or due to stroke. Quite often the elderly person will be in a state of denial until it is too late to learn Braille.

Deafness and hearing loss is common while impaired hearing isn't. Usually the loss is in the higher tone range but it is not uncommon for the elderly person to hear female voices better than male voices. Being unable to hear, the elderly person will usually withdraw and become less social. If totally deaf, they may respond to questions with a blank stare or smile and may be considered mentally deficient until the question is written out for them. Selective hearing is not uncommon and often results from the person's interest level.

Fatigue - Along with inactivity and a negative outlook, fatigue may be due to depression or boredom. It may also be due to wasting illnesses, anemia, heart disease (especially left ventricular failure), hypokalemia and cachexia. Consider that they are on to many prescription medications, the onset of fatigue often following a medication change or addition. While the vitality level drops off somewhat, if an elderly person is expected by their family or physicians to be fatigued, they generally will be. Following an illness, energy levels will return too normal, but somewhat slower.

Prevention of disease and development of morbidity, one of the primary precepts of naturopathic medicine, is all the more important in the aging population as diseases often do not present with easily recognizable symptoms and the course of the illness can progress rapidly. Awareness of risk factors and recognition of them early on will allow the physician to be proactive to help alleviate the disease as well as its economic burden in this population.

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