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EDITORIAL

Palliative care in the XXIst century

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Palliative care (or more typically hospice) has initially been defined as care that should be provided only for terminally ill patients when cure of the disease was no longer possible. It was largely applied for neoplastic patients and had a sinister and sad meaning. But this definition is no longer true, especially in elderly persons.

There is common knowledge that we face one of the most challenging public health problems – the growth of the population of elderly. This increasing segment of population has different characteristics concerning health problems, quality of life expectations, social and psychological insertion issues and personal opinions about end of life. It is thus obvious that we need to redesign therapeutically approach for this new category of patients.

Maybe this is the reason that a group of geriatricians from Iasi were invited to talk about their experiences in treating old patients with multiple, compelling diseases and, in the same time, to underline the importance of palliative care as an important member of the geriatric team. We shall discuss the personal profile of elderly as a main candidate for palliative care based solely on aging process itself and onset of frailty – a major geriatric syndrome. We shall also emphasize the recent course of palliative care, that has become an interdisciplinary approach, focused both on the relief of suffering and on the achievement of the best quality of life for patients and their loved ones.

Palliative care for elderly patients is different from that of younger adults. We present our personal experience about the fact that frailty, cognitive impairment, multiple comorbidities, various aggravating symptoms that affect not only the quality of life but also the adherence to medical recommendations and even affect the relationship with family members and medical personnel, are issues to deal with for many years. Identification and amelioration of this complex setting is the real target for palliative care rather than, as is typical in advanced cancer and traditional hospice services, amelioration of signs of imminent death. We also present 2 clinical cases which reflect the fact that in response to the unique needs of elderly patients, in response to their need to keep their dignity and serenity towards the end of life, palliative care should become an integrative part of geriatric medicine.
ORIGINAL PAPERS

Can palliative care improve therapeutically adherence in elderly patients?

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Abstract

Objectives: Therapeutic adherence represents the extent to which the patient’s behaviour follows medical recommendations. It is a complex, multifactorial process that strongly influences quality of life.

Material and method: We performed a retrospective study that included 256 old patients (≥ 75 years) admitted in the Geriatric Department in the last year. Patients’ data were recorded in a database that contained demographic and clinical data, the presence of palliative care and information about patient’s current medication. Information about therapeutical adherence was collected for each person by a questionnaire, which consisted in verifying their knowledge about their diet and medication and comparing it with information from past medical records or family members.

Results and discussions: We found several factors that influenced adherence to treatment: the residential area, the number of tablets prescribed by the physician, a strong familial and financial support, and last but not least, the presence of palliative care in the general management of the patient.

Conclusions: Fighting non-adherence should rely upon three complementary directions: a multidisciplinary medical approach, telemonitoring (e-health), and geriatric palliative care.

Key words: therapeutic adherence, palliative care, elderly

Introduction

Therapeutic adherence is a complex behavioral process strongly influenced by the environment in which patients live and the healthcare providers’ practice. Furthermore, non-adherence or “non-compliance” represents the extent to which the patient’s behavior does not follow medical recommendations.

„Non-adherence is not a new phenomenon. The first recorded case took place in the Garden of Eden with dire consequences” (1). Scientific interest into non-adherence started in 1943 (1), but it was only 30 years ago when the seriousness of the problem was fully recognized and research began in earnest. It was noted that the elderly population is particularly vulnerable to non-adherence due to several reasons: physical barriers (sarcopenia, arthritis, tremors), cognitive barriers (memory loss, confusion), polimedicine, polipharmacy and
iatrogeny, insufficient income, familial and social circumstances, and last but not least the nature of the patient–doctor relationship (2, 3).

We are unable to predict patients’ non-adherence at rates better than chance. When any member of the medical team asks about adherence, patients tend to exaggerate (“white coat” effects); therefore, patients’ self-reports usually overestimate compliance by a significant amount.

Recent studies (4, 5) report that up to 60% of all medication prescribed is taken incorrectly, or not at all. 90% of elderly patients make some medication errors, and 35% make potentially serious errors. 40% of all admissions are due to medication-related problems. Non-adherence can lead to treatment failure, further physical or mental health problems, service costs and carrier burden (1, 5).

Non-adherence as a phenomenon spans medical disciplines but research by its nature tends to be discipline specific in outlook, often limited to a specific diagnosis or medication. Recent reviews (5, 6, 7) consider that effective interventions on non-adherence should be complex, combining approaches such as counselling, information, reminders and family therapy; statistically significant positive findings did not however lead to worthwhile improvements in clinical outcome. Most meta-analyses include only papers that are methodologically robust; however, as most research in this area is small scale, adherence is often a secondary outcome measure nested within a larger study, and the quality of papers tends to be poor.

Materials and methods

We performed a retrospective study that included 256 old patients (≥ 75 years old) admitted to the Geriatrics Department of C. I. Parhon Hospital in 2012. Patients’ data were recorded in a secured database that contained demographic informations (age, gender, address, income, whether the patient has any family or is living alone), symptoms (musculoskeletal pain, depression, fatigue, balance disorders, anxiety, muscle cramps, dysphagia), clinical data (elements of frailty and/or sarcopenia, compliance to treatment) and data about current medication. Information about therapeutical adherence was collected for each person by an interview with the patient. The questionnaire consisted in verifying their knowledge about their diet and medication and comparing it with information from past medical records or from family members.

The data were analyzed using 20 SPSS. Patients were divided into two groups according to their therapeutical adherence as rated by the physician (compliant = group A vs non-compliant = group B); a correlation test was performed in order to identify factors that influence adherence to treatment. Those factors were then assessed by means of both parametric and non-parametric tests, according to data type. When possible, Fischer Exact test was employed, for detecting correlations between non-parametric dichotomous data. The statistical significance was defined as p<0.05. Continuous data was expressed as mean and standard deviation (± SD).

Results

There were no statistically significant differences between groups A and B regarding gender (42,3% males and 57,7% females in the compliant group vs 35,4% males and 64,6% females in the non-compliant group) and age (mean age in group A = 77,9 ± 2,9 years, whereas in group B it was 78,5 ± 2,8 years). There was an important difference between the groups regarding income, but it did not reach statistical significancy (1058,1±902,1 RON in group A vs 680,4±318,3 RON in group B), with p = 0,1.

Symptoms that correlate well with non-adherence were: musculoskeletal pain, depression, balance disorders, anxiety; in group A these symptoms were noted in an increased number of patients than group B, but it did not reach statistical significance.
Clinical data was similar in the two groups, with fatigue present in 96 patients (59%) in group A and in 74 patients (52.1%) in group B (p=0.4); a decrease in mobility was noted in 109 patients (62.8%) in group A and 62 patients (66.7%) in group B (p=0.7) and a decrease in muscular force was present in 39 patients (11.5%) in group A and 23 patients (6.2%) in group B (p=0.5).

Among the tested parameters, one of the most important factor that influence adherence to treatment was the area where the patient had residence - living in a rural area seems to increase the probability that the patient will be non-compliant, with p = 0.04 as assessed by Fischer exact test. Of the patients that lived in a rural area, 53.6% were compliant and 46.4% were not as compared to patients from urban area, where 71.9% were compliant and 28.1% were not.

A second factor that influenced adherence to treatment was the number of pills that the patient was taking prior to admission, with an average of 4.79 pills/day in group A and 3.54 pills/day in group B (p=0.02).

Living with family had a statistically significant influence on adherence. In group A, 83 patients (42.3%) lived alone, as compared to 81 patients (64.5%) in group B (p = 0.01).

Discussion

Poor adherence to drug therapies still represents an unsolved problem and is much more severe in elderly. This contingent of population often has numerous co-morbidities that need numerous medical services, aggressive investigations and polimedication, usually prescribed by different specialists. Polimedication means difficult therapeutical schemes, usually with inappropriate drug posology, recommended to patients with cognitive disorders, sensory and motor deficiencies and lack of familial or social support for the possible handicap (8).

The number of seniors increases as an absolute value and as a percentage of the whole population; in USA, elderly population increased from 3 million in 1900 to 35 million in 2000 and the expectancy for 2030 is 40 million (9). Several studies (10, 11) reported that more than 40% of elderly patients takes 5 or more different types of drugs/day and 10% takes 10 or more different drugs/day. It is widely agreed that the use of many different drugs/day is highly associated with therapeutical non-adherence, iatrogeny, and risk for inducing geriatric syndromes such as: falls (orthostatic hypotension) and fractures, urinary incontinence (abuse of diuretics), cognitive impairment (abuse of sedatives, anti-depressants).

Therapeutical non-adherence may take many forms, e.g., not following dietary or exercise recommendations, not taking the prescribed number of pills or taking them at irregular or otherwise nontherapeutic intervals, not refilling prescriptions, and not showing up at follow-up clinic visits.

We believe that the real number of cases of non-compliance might be higher as patients were not entirely truthful in interviews, mostly because they became ashamed of not having followed medical recommendations.

There were no statistically significant differences between groups A and B regarding gender and age. We expected to find an important difference between the two groups regarding monthly income, because we considered that financial support should be a leading factor for non-adherence. We were surprised that there were no statistically significant differences, possibly due to the study design, that allowed patients to state whether or not they agree to including their income in the database. As a consequence, the number of patients for which income information was available was small (23 patients), which definitely influenced the results. However, our results were consistent with other studies (12), where side effects and forgetfulness were quoted as the most important causes for non-compliance.
An important factor for non-adherence was living in a rural area. This observation is in agreement with other studies (7, 12) and have several explanations: longer distances from any medical institution and/or pharmacy, lower degree of education and lower understanding of the importance of following medical recommendations, lower income and impossibility to fulfill elaborate prescriptions, unsatisfactory relationship with the local general practitioner and distrust versus his/her medical advice.

We were surprised to find a statistically significant correlation between a larger number of pills and therapeutical adherence (4.79 pills/day in group A and 3.54 pills/day in group B, p=0.02) and not other way around. It is probably due to the fact that patients that were considered compliant had a better recollection of the drugs they were currently taking, whereas non-compliant patients did not remember what medication they were under, no matter the number of pills/day. This was a limitation of our study as we were not able to find out if all the patients in Group A really followed medical prescriptions, even if they remembered the drugs they were on. Patients with a partial recall of their medication regimen are usually at higher risk for adverse effects than those with no recall at all, possibly because patients with no recall seek assistance more readily due to rapid worsening of symptoms; patients with partial recall are more prone to experience negative side effects due to overdosing the drugs they could remember, such as digoxin toxicity, oral anticoagulants or beta-blockers overdose.

An important factor for non-adherence was living alone status (p = 0.01), which was consistent to other studies (13, 14, 15). We believe that loneliness in elderly people is associated with poor health outcome because lonely people do not or cannot perform healthy behaviours, such as medical adherence, physical exercise, good diet and adequate sleep. It appears that people who are lonely have a tendency to see their life circumstances as more stressful, unpredictable, and overwhelming when compared to those who are less lonely (16, 17).

Symptoms that were not necessary linked to the main pathology but were affecting the quality of life and induce non-adherence (musculoskeletal pain, depression, balance disorders, anxiety) required palliative care measures. After we provided palliative care especially for these specific symptoms, the patients developed a new and improved relation with their physicians. They became more opened to doctor's advice and more adherent to treatment. This observation may open a new research for non-adherent elderly patients with a higher need for palliative care (18, 19).

There are numerous studies (20, 21, 22) that have proposed several methods to fight non-adherence. We consider that there are two different, yet complementary approaches to this problem: the first direction should be the medical approach and the second should be telemonitoring and e-health services.

The first line is the multidisciplinary medical approach, due to the complex psycho-social context of the elderly patients themselves. The medical team (geriatrician and general practitioner, psychologist, dietetician, kynetotherapeut, nurses, social services, caregivers) should encourage treatment adherence by clearly communicate with their patients about therapeutic goals and methods to achieve them and by giving legible written instructions after considering the complexity of dosing schedules, expense, and potential adverse effects. Moreover, the patient should be continuously supervised, controlled and encouraged in respecting medical recommendations, and also should be permanently chequed for side effects and/or adverse events that can occur from the medication itself.

Given the importance of the growing need to improve medication adherence, choosing the best intervention represents a challenge for healthcare providers, and we consider that telemonitoring and e-health systems are the most interesting approaches to the elderly
patient of XXIst century. There are many programs that encompass this domain (20,22) but one of the most interesting for our study is the polymedication electronic monitoring system (POEMS), developed by the Pharmaceutical Care Research Group, Department of Pharmaceutical Sciences, University of Basel, Switzerland (22). This system allows reliable and precise measurement of patient adherence to medications by incorporating a microcircuitry into dose-dispensing drug packages of various designs, such that the manoeuvres needed to remove a dose of drug are detected, time-stamped, and stored. The personalized dose-dispensing aid organizes individual oral doses according to their prescribed intake schedule throughout the day and the week. The electronic monitoring of the entire therapy would reveal an intake pattern that would have remained undiscovered with any other device and would allow a personalized intervention to correct an inadequate medication intake behaviour. POEMS may guide health professionals when they need to optimize a pharmacotherapy because of suspected insufficient adherence. Further, knowing the intake pattern of the entire pharmacotherapy can elucidate unreached clinical outcome, drug-drug interactions, and drug resistance (22). In the near future, one could imagine that medication adherence data over the entire therapy plan would be available as soon as the electronic wires are activated, so that a failure to take medication could be detected immediately and intervention could be taken if appropriate.

The results of our study confirm several factors involved in therapeutical non-adherence. These included patients from rural areas, with low income and expensive medical prescriptions, patients with low educational level and sophisticated medical regimens, patients who receive too many drugs, patients with cognitive dysfunction and who live alone, patients who have only partial recall of their medical regimens, smokers and/or alcohol abusers and the symptoms that were not related to the main diseases but were affecting the quality of life. Fighting non-adherence should rely upon three complementary directions: the multidisciplinary medical approach and telemonitoring, in order to assist very old patients in taking their prescribed medical schedule and geriatric palliative care throughout the rest of their life. Geriatric palliative care is becoming an important link in assuring a good quality of life, a good treatment and a dignify ending for elderly patients and we should be able to provide it whenever is necessary, including the cases with non-adherence.

References


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CLINICAL LESSONS

Frail older people and improving quality of life with the help of palliative care

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Abstract

Objective:
Frailty is a clinical state of high vulnerability and reduced ability to maintain homeostasis. Thus, it should have a multi-dimensional approach, involving a variety of psychological, social, emotional and spiritual elements, in addition to the physical ones.

Method:
To exemplify frailty as a geriatric syndrome and the importance of adding palliation early in the management of frail old patient, we have chosen 3 representative clinical cases, of patients hospitalized in the Geriatric Clinic of „Dr C.I. Parhon” Hospital, Iași.

Our first patient is a clinically frail lady with important cardiovascular pathology hospitalized for an acute infectious episode (pneumonia). She recovers well due to simultaneous treatment of both acute episode and frailty. The constant and active family support during recovery was definitely a very important factor in regaining patient’s autonomy. The evolution of the acute pulmonary infection has been influenced more by the degree of frailty than by the pre-existent cardiovascular condition.

The second patient had a more severe class of frailty so her recovery was not as good as in the previous case. It is to be noticed that frailty is a negative predictor in the evolution of geriatric patient and leads to co morbidity aggravation.

The third case represents an obvious frail elderly lady with a series of adverse events (lives alone, has no family) but no major co morbidities. Still, she didn’t cope with this new stressor (urinary infection) despite the correct, multidisciplinary treatment applied and decide in favour to palliation over medication.

Conclusions:
These cases suggest that old age has some particular characteristics: frailty, functional dependence, cognitive impairment, multiple co morbidities, and symptom distress that may be persistent for many years. In the frail elderly, disease-specific treatments may ameliorate disease but are unlikely to eliminate it. Thus, palliative care is centred on the identification and amelioration of functional and cognitive impairment, postpone development of frailty and increase quality of life. In response to the unique needs of elderly, palliative care should be considered an essential part of geriatric medicine.

Key words: frailty, palliative care, quality of life
Introduction

Frailty is a clinical state of high vulnerability and reduced ability to maintain homeostasis. This vulnerability is not only age-related, but also related to disability and co morbidity. Frailty should have a multi-dimensional approach, involving a variety of psychological, social, emotional and spiritual elements, in addition to the physical ones. (1,2,3,4,5,6,7).

The cornerstone of frailty is sarcopenia and its harmful consequences: loss of muscle strength, loss of mobility, neuromuscular impairment, and homeostatic failure (8, 9). Sarcopenia increases the risk of falls and fractures, it interferes with the nutrition skills (empty refrigerator) and favours the decline of the protein reserve of the body (10). Frailty is a part of all these different "vicious loops" including sarcopenia, neuromuscular impairment, falls and fractures, immobilization, malnutrition, impaired protein synthesis, and decreased protein reserve of the body (8).

In addition to being highly prevalent in elderly population, frailty also exert a substantial impact on quality of life. It is a multifactorial, complex condition in which many risk factors interact and affect different organ systems, influencing clinical presentation, course of disease(s) and outcome of elderly patient. As it is extremely challenging by defying conventional medical wisdom and crossing traditional clinical boundaries, frailty fully qualifies as a new geriatric syndrome (7).

Lang et al. (11) describe 3 stages of frailty. The preclinical stage encompasses the situations when the organism has enough physiological reserves to correctly respond to stressors (acute onset of a disease or aggravation of a previous one) and the recovery should be complete. In the stage of clinical frailty, the functional reserves are insufficient and the recovery is incomplete. The final stage is that of frailty complications, resulting from physiological vulnerability and reduction of functional reserves. This last stage leads to a high risk of falls, disability, polimedication, long-term hospitalizations, severe infections, institutionalization and death.

The clinical diagnosis of frailty is based on a multitude of signs and symptoms, such as weakness, fatigue, weight loss, decreased capacity to maintain balance, low level of physical activity, loss of motor performance, social withdrawal, mild cognitive disorder and growth of vulnerability to stress. There were several approaches to identify frailty. One was developed by Rockwood et al. (12) and consists of measuring deficits across many different types of health conditions: functional, clinical, and physiological. A second approach considers that frailty has a distinct pathophysiology and its own clinical presentation (13). Fried et al. (14) defined a phenotype of frailty with the following features: unintended loss of weight, self-reported exhaustion, decrease of muscle strength (reduced grip strength, less than 20% in dominant hand), slowing down of walking speed (less than 20% for the walking time of 4,5 m), and reduction of physical activity (less than 20% of caloric expenditure). Meeting three out of five criteria define the frail elderly, and one or two out of five criteria define the preclinical form.

Having in mind the functional downwards trajectory towards the end-of-life of the frail elderly, many authors agree to invite palliative care to be an essential part of the complex management of geriatric patient (15).

The difficulty derives from the reduced capacity of the physicians to recognize frailty in spite of numerous diagnosis scales, such as the Canadian Study of Health and Aging (CSHA), Frailty Index, Edmonton Frail Scale, Groningen Frailty Indicator (16). Another problem resides with finding the right moment to initiate palliative care.
Material and method

To exemplify frailty as a geriatric syndrome and the importance of adding palliation early in the management of frail old patient, we have chosen 3 representative clinical cases, of patients hospitalized in the Geriatric Clinic of „Dr C.I. Parhon” Hospital, Iaşi.

- Patient 1 is a 81 years old woman who has been recently diagnosed by the general practitioner with pneumonia and treated at home with antibiotics. The evolution was not favourable and she was admitted in our clinic. She had dyspnoea, cough with muco-purulent sputum, sweating, nausea, weight loss (approximately 5 kg in the last year), and fatigue. She had a history of hypertension, angina with left bundle branch block, and stroke with secondary right hemi paresis. She lives in the countryside with her family and she benefits from family support. The MRC (Medical Research Council) Scale for Muscle Strength for lower limbs and right upper limb = 4/5. The Groningen Frailty Indicator (GFI) = 8/15 points. Comprehensive geriatric assessment showed a high risk of malnutrition (MNA = 16/30 points) and an almost complete need for care for daily activities (ADL) and for instrumental daily activities (IADL). Need for assistance has increased from the moment of aggravation of respiratory disease and the 3-days bed rest. The patient has geriatric frailty syndrome neglected in the last year and aggravated progressively in the last 3-4 days.

Due to the multidisciplinary approach, including palliative care (correct and complete medical treatment, correct diet, physical therapy and adequate family support) she did very well during hospitalization: she acquired autonomy for ADL and decreases the level of assistance for IADL, she started to eat on her own and had a weight gain of 2 kg. She started to walk, first with the support of the family members and with a walker when discharged home. Later reevaluations showed that she maintained a good functional and nutritional baseline.

- Patient 2 is a 77 years old woman from an urban area. She was referred to our clinic by ambulance for fatigue, excessive sleepiness, temporal-spatial disorientation, intense pallor, and weight loss of approximately 10 kg in the last year. She has been living alone in an apartment since her husband died 4 years earlier but she has a caregiver who comes every day. The family noticed depression and loss of appetite, refusing food for the last couple of weeks. She had a history of diabetes, hypertension and anaemia but without any medical records. The very first investigations showed severe macrocytic anaemia which requested several blood transfusions. Comprehensive geriatric assessment was performed after the management of the acute episode. She had a mild cognitive impairment (MMSE = 23/30 points), malnutrition (MNA = 17/30 points) and clinical frailty (GFI = 9/15) but no depression. She did well during hospitalization with the help of the multidisciplinary team: she resumed feeding, initially with the help of the family and caregivers, later on her own. She started to walk under the supervision of the physiotherapist, initially for short distances with bilateral support, then longer distances with the help of a cane. She gained weight, approximately 3 kg. In 6 months time she surpassed her previous functional and psychological baseline, mostly due to correct multidisciplinary approach, including palliative care and increased family support that motivated her to fight frailty and win the battle.

- Patient 3 is a 85 years old woman who has been referred to our clinic by the ambulance for dyspnoea, palpitations, fatigue, oedema of the lower limbs and pain at the same level. She had a history of congestive heart failure, severe degenerative aortic stenosis, severe mitral insufficiency, permanent atrial fibrillation, iron deficiency anaemia, chronic venous insufficiency, chronic kidney disease stage 3, severe hearing impairment and numerous abdominal interventions she could not account for. She lived alone, and could give no information about her treatment. Comprehensive geriatric assessment showed: the MRC for lower limbs is 5/5 (can walk but prefers to stay in bed), slow walking speed, malnourishment
(MNA = 15/30 points), needs assistance for IADL, moderate cognitive impairment (MMSE = 17/30 points), GFI = 6/15 points. We started a complex therapy, including nutritional assistance, physical therapy, adequate medication and psychological support. The cardiac surgeon considered that a valvuloplasty was hazardous and the patient refused surgery anyway. From the first day in the Geriatric Clinic, we associated palliation to our complex medical treatment and it goes without saying that palliative care has had its place in optimizing her quality of life. Pain management, adequate nutrition, constant help in understanding the evolution of her multiple diseases and her choices in medication, affectionate assistance in her daily needs were just part of her complex treatment. Her family’s support was also of great importance in maintaining a good quality of life and a strong motivation to fight all adverse outcomes and keep a serene perspective over the end of life.

**Discussions**

We consider that these 3 cases are illustrative for the frailty syndrome. Even if the three patients had different pathologies, they still had several common features: weight loss, no physical activity, fatigue, different degrees of depression and mild cognitive impairment. All these represent the frailty phenotype observed as being more or less pregnant with the three patients described earlier.

*Our first patient* is a clinically frail lady with important cardiovascular pathology hospitalized for an acute infectious episode (pneumonia). She recovers well due to simultaneous treatment of both acute episode and frailty. The constant and active family support during recovery was definitely a very important factor in regaining patient's autonomy. The evolution of the acute pulmonary infection has been influenced more by the degree of frailty than by the pre-existent cardiovascular condition.

*The second patient* had a more severe class of frailty so her recovery was not as good as in the previous case. It is to be noticed that frailty is a negative predictor in the evolution of geriatric patient and leads to co morbidity aggravation.

*The third case* represents an obvious frail elderly lady with a series of adverse events (lives alone, has no family) but no major co morbidities. Still, she didn’t cope with this new stressor (urinary infection) despite the correct, multidisciplinary treatment applied and decide in favour to palliation over medication.

These cases suggest that old age has some particular characteristics: frailty, functional dependence, cognitive impairment, multiple co morbidities, and symptom distress that may be persistent for many years. In the frail elderly, disease-specific treatments may ameliorate disease but are unlikely to eliminate it (17). Thus, palliative care is centred on the identification and amelioration of functional and cognitive impairment, postpone development of frailty and increase quality of life. In response to the unique needs of elderly, palliative care should be considered an essential part of geriatric medicine.

**References**


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Complex geriatric care of a multi-vascular elderly patient

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Abstract

Objectives:
To find the right comprehensive, multidisciplinary and palliative care in an elderly patient with co-morbidities affecting vascular system.

Material and Methods:
We present for debate the case of a 79 years old patient admitted in the Geriatric Clinic for global heart failure. He has a history of several chronic diseases with significant vascular compound: myocardial ischemia, atrial fibrillation, arteriopathy stage IV and diabetes mellitus with micro and macro angiopathy. Prior to this hospitalization he had an episode of gastrointestinal bleeding and a right plantar ulceration, both due to coumarine overdose treatment. He is bedridden from that moment on. Present clinical examination revealed clear signs of worsening of the vascular condition: local inflammation, infection, and intense pain. We designed a complex, individual and multi-disciplinary treatment that encompassed palliative care as well. The correct management of pain, the correct nutritional intake and constant psychological support decreased depression and increased the quality of life.

Conclusion:
Although this is not a terminally-ill, oncological patient, we proved that other sufferings are extreme in all aspects as well. The case presented is a significant example about the necessity of starting palliative care as an important member of the complex geriatric approach of elderly patients with multiple chronic diseases facing the end of life.

Key words: elderly, cardiovascular diseases, palliative care

Case presentation

We present the case of a 79 years old male patient, hospitalized several times in the past year for numerous chronic diseases with significant vascular compound: myocardial ischemia, chronic atrial fibrillation, chronic arteriopathy stage IV, diabetes mellitus complicated with micro and macroangiopathy, was admitted in the Geriatric Clinic for global heart failure with symptoms progressively worsening in the last 10 days, despite the correct adherence to treatment.

The patient was recently discharged from the Department of Infectious Diseases, where he was diagnosed and treated for Clostridium difficile pseudo membranous colitis (vancomycin and metronidazole treatment) for 10 days. Additionally, 3 months previous current hospitalization, the patient experienced an episode of lower gastrointestinal bleeding accompanied by right hemorrhagic plantar ulceration due to coumarin overdose; he is being bedridden from that moment on.

On present admission, the examination of the right leg showed clear signs of worsening of that vascular condition: three ulcers (malleolar, plantar and on the external face of the finger V) with local inflammatory signs, weak pulse present in the femoral and popliteal artery and pulsless in the pedal artery.
Laboratory findings showed leukocytosis (13,900 / mm3), normocytic hypochromic anaemia (probably due to chronic inflammation and poor nutrition), hypoproteinemia with hipoalbuminemia. Cultures of skin ulcers were found to be positive for multiple resistant staphylococcus aureus; currently the cardiovascular balance being stationary compared to previous hospitalization. Initially, the patient had multiple episodes of diarrhoea, the stool exam was negative for Salmonella, Shigella; the symptoms turn to remission after symptomatic treatment (probiotic).

We devised a complex therapeutic approach and initiation of palliative care that comprised: adequate local treatment of ulcers, proper nutrition, intensive treatment of pain, psychotherapy and last but not least, constant discussions with the patient and his family about the evolution of his medical problems and his therapeutic options.

The evolution of peripheral arteriopathy was toward gangrene of finger V. The vascular surgeon considered that the only option should be right thigh amputation, even if surgery would be heavily marked by advanced age and severe co morbidities.

We discussed repeatedly with the patient trying to explain that amputation is the only treatment to preserve life, he refused any other intervention and decided to spend the remaining days of his life in his own home, surrounded by family and dear ones. During this period of intense emotional feeling palliation played an important role for this patient to reach the stage of acceptance of the fatal disease and to decide about future.

During hospitalization we created a strong relationship between patient, medical staff and caregivers (1). We also considered the special needs of the family, strengthening their capacity to cope with the physical and mental degradation process of the loved one during the entire remaining period.

Although this was not an oncological case, its own complex problems are extreme in all aspects. Administration of medication is only part of the therapeutical plan, palliation being an essential adjuvant. Most of the time, correct treatment of pain can improve the physical manifestation of other symptoms, and therefore a repeated review of the therapeutic plan should be considered (2).

Conclusions

Clinical assessment of the severity of the symptoms is highly subjective and is a poor basis for choosing appropriate treatment. Patient by definition means "out of time", so it is sometimes necessary to compromise and postpone medication and avoid unacceptable side effects for the patient and start palliation in order to relieve suffering (3).

According to the principles of palliative care not only symptoms should be controlled, but also emotional, mental, social and spiritual factors that could reduce loneliness, isolation, evolution and duration of hospitalization.

References


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MANAGEMENT

The elderly patient at the borderline between medication and palliation

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Abstract

Palliative care has broadened its reference area and it’s no longer meant exclusively for the terminally ill patient with neoplasia. Aiming for better quality of life, controlling symptoms and providing with necessary care should become an earlier therapeutic target. The elderly are one of the main recipients of this new therapeutically strategy.

We present two clinical cases, with similar pathology but with different family and financial support, in order to prove the need for proper management in palliative care of elderly patients facing end of life.

First case is an elderly woman with disabling pathologies (stroke, neoplasia), without family and financial support. She decided to give up complex medication and turn to palliation. The lack of openings in palliation clinics and the lack of support from social services we performed palliative care in an acute clinic, taking all the risks that come with prolonged hospitalization.

The second case is that of an old patient with a history of global heart failure and who was admitted for generalized oedema and shortness of breath. During hospitalization, he was diagnosed with neoplasia and acute colecistitis. We had several conversations with him about the evolution and prognosis of his diseases and he decided to stop therapeutic measures and start palliative care at home.

Conclusion: As life expectancy of patients increases, more elderly patients should require palliative care at home as well in specialized units, therefore geriatric palliative care is an upcoming concern.

Key words: palliative care, elderly

Introduction

Over time, palliative care changed its reference area. If at first it was designed for the terminally ill, oncologic patient, now palliative care is initiated earlier, trying to insure quality of life by controlling symptoms, minimizing pain and suffering, according to the patients needs and values (1,2,3).

According to World Health Organization “palliative care is an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illnesses, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual”(4).
What is the best moment to start palliative care? What role does family support or social assistance play in palliation? (1,5,6,7) What is the condition of these patients at the borderline between conventional medication and palliative care in Romania? These are questions about proper management and arrangements. We are looking at these issues by presenting two recent situations we encountered in our clinic.

Case 1

We report the case of an 84 year old woman, from the rural area, transferred into the Geriatrics Clinic of “Dr C.I.Parhon” Clinical Hospital Iasi, for deep vein thrombosis in the right leg. The patient has been recently diagnosed with ischemic stroke and right hemiplegia and was hospitalized in the Neurology Clinic where she followed specialized treatment with good outcome. She lives alone and all her family members are deceased.

Upon admission the physical exam revealed obese female, conscious, bedridden, with patent clinical signs of deep vein thrombosis in the right leg.

The first biologic and imagistic tests revealed leucocytosis, high intensity mass in the upper lobe of the left lung and hypo echoic liver lesions. At this stage the differential diagnosis was: deep vein thrombosis in the right leg, pneumonia and hepatic metastases. Further investigations reveal primary malignant tumor as pancreatic (body and tail) with secondary hepatic dissemination. Oncological consult, considering the hemodynamic and neurologic status of the patient, indicates palliative care as the only option, option that is shared by the patient as well.

We started palliative care while trying to find an opening in a palliative center. Lack of openings made us turn to social services, that were not able to find a suitable formula to ensure home palliative care for our patient.

Case 2

We present the case of an 82 year old man with multiple cardiovascular pathology and a history of toxic hepatitis, who is brought by the family for chronic decompensated heart failure secondary to non-adherence to low salt diet.

Clinical examination revealed dyspnoea, oedema of his lower extremities and light jaundice. Biological assessment revealed macrocytic anaemia (Hb=10.3g/dl), inflammatory syndrome (VSH=90mm/h with elevation in time to 120mm/1h, leukocyte = 12210/mm3). Chest x-ray and echocardiography confirm cardiomegaly and the abdominal ultrasound shows multiple biliary lithiasis and hydrops gallbladder as well as changes of the head of pancreas that suggest tumoral impregnation.

At this stage the diagnosis included: heart failure, dilatative alcoholic and ischemic cardiomiopathy, acute lithiasic colicetistitis with secondary obstructive jaundice and an observation of malignant neoplasm of the head of pancreas.

We considered that managing the colicetistitis was a priority and contacted the general surgery service that recommended a CT scan preoperatory. The scan confirmed the tumor of the head of pancreas. Considering the advanced age, the neoplasia and all the co morbidities, the surgeon postponed any major surgery and recommended conservatory surgery (gallbladder drainage) for the jaundice.

The patient received complete and correct information on risks and benefits of the surgery. The patient decides to stop any further invasive treatment and decides to leave the hospital and initiate palliative care at home, even against his family's wishes.
Conclusions

Access to palliative care is the right of every patient, the problem raises on deciding the right time to initiate palliative care. When complex therapy, further investigations or life threatening major surgery have no benefits, we must consider introducing palliative care that would improve quality of life and the patient’s pain and suffering could be reduced to a minimum (1,6).

The patient is the only one who can decide the moment to give up medication and turn to palliation, as proven in our second case, no matter what are the family’s or the physician’s wishes. To make this option easier, the doctor has to correctly inform the patient on the benefits and also the implications of palliative care.

A healthy social system could make the access to palliative care easier for patients without family support or without financial capabilities. The first case showed that despite all efforts made by the medical team, we were not able to place the patient in a palliation center, situation caused by lack of openings in specialized units but also by the indifference of local city hall and social workers.

References


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COMMENTS, DISCUSSION

The elderly are ideal candidates for palliative care

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In Romania, geriatric palliative care is mainly recommended to patients hospitalized for acute exacerbations of chronic progressive diseases such as chronic obstructive pulmonary disease, heart failure, chronic kidney disease, diabetes mellitus and its complications, worsening of dementia syndrome. The purpose of geriatric management team (including palliative care) should focus more on treating the symptoms of old patients, improving thus their self-esteem and quality of life.

Although there are numerous studies that show the need to include palliative care expertise in the geriatric team, it is widely recognized that non-patient care with advanced malignant disease are suboptimal in Romania.

Old patients are major users of medical services and drugs' consumption due to existing comorbidities, that require numerous inter-disciplinary consultations performed by different specialists who usually ignore each other.

Consumption of drugs (either recommended by physicians or OTC drugs, vitamins, minerals, nutritional supplements, herbal preparations) increases dramatically with advancing age. The elderly patients consume about one third of the global recommended drugs, 46 % of them taking five or more drugs every day.

One of the first studies published in 1997 about polimedication and elderly population reported that 35% of ambulatory patients presented adverse side-effects that required medical assistance; institutionalized old persons reported much higher values that went up to 66% (1). Negative side effects such as: falls, loss of appetite, fatigue or cognitive dysfunction most often were considered as inevitable changes due to old age and not iatrogenic consequences (2).

It is customary to see cases as the one of a 75 years old patient with the following comorbidities:

1. Heart failure cl. NYHA II
2. Atrial fibrillation
3. Chronic anticoagulation
4. Atherosclerotic hypertension
5. Dyslipidemic syndrome
6. Type 2 diabetes mellitus
7. Chronic kidney disease st. 3
8. Obs. Ischemic nephropathy
9. Urinary infection/low prostate adenoma
10. Varicose legs
11. Chronic venous insufficiency
12. Vertebral-basilar circulatory insufficiency
13. Degenerative osteo-articular disease
14. Systemic osteoporosis
15. Gallstones  
16. Partially edentulous  
17. Bilateral early cataracts  
18. Minor cognitive impairment  
19. Anxious-depressive syndrome  

The patient was referred by the family doctor for several consultations: cardiology, diabetology, nephrology, rheumatology, neurology, ophthalmology, psychology, and finally he returned to the family doctor with a total of 30 different drugs, with 49 of administration under the form of tablets, sprays, unguents and eye drops.  

This is a clear case of polimedicine, polimedication and iatrogeny, with disastrous effects not only on treatment adherence but also on the patient's attitude toward his medical condition. One such patient, in most cases, would become depressed and give up completely therapy; shortly after, the relapse of the cardiovascular symptoms would force him to go to the hospital, where he would become a victim of nosocomial infections and complications of prolonged bed rest.  

The solution in these situations is the proper education of physicians to devise individual therapeutic plans for complex elderly patients with multiple chronic diseases. Individualized regimens, flexibility and understanding of the wishes of the elderly, providing a psychological and emotional comfort to motivate him to maintain constant health, are just a few elements that should be considered when starting treating such patients (3). In this context, palliative care becomes an essential link in structuring multidisciplinary geriatric treatment (4).  

In Romania, geriatric palliative care addresses especially the patients hospitalized for acute exacerbations of chronic progressive diseases such as chronic obstructive pulmonary disease, heart failure, chronic kidney disease, diabetes mellitus and its complications, worsening of dementia syndrome.  

Management of symptoms in elderly patients with co-morbidities is based on the concept of "start low and go slow - but get there" (5, 6). The purpose of geriatric management team (including palliative care) becomes optimizing the physical, mental, spiritual and social condition of the patient (7). One of the most frequent co morbidity is the presence of chronic respiratory diseases with long, chronic, disabling progress, which invalidate the patient by limiting physical activities, progressively worsening fragility, repeated episodes of bronchial infection, and cardiac complications (8). The psychological status is characterized by depression, anxiety, increased risk of cognitive impairment and sleep disorders (9). A holistic approach (including palliative care), should ensure constant medical and emotional support if needed (chronic oxygen therapy, breathing and coughing exercises, psychotherapy) and would improve the quality of life and the disease side effects (10). Although there are numerous studies that emphasize the importance of this aspect, we still don’t apply often enough palliative care in the non-oncological elderly patients (11).  

Most old persons with terminal chronic illnesses spend months or years in need of palliative care based on optimizing the physical, mental, spiritual and social condition (12). Without this kind of help, more and more of them cross the threshold to death on a hospital bed, alone, depressed and humiliated by their diseases rather than wait for this transition in peace, in familiar environment, surrounded by loved ones and serene in the face of destiny.  

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NEW PUBLICATION

Theoretical and practical aspects of palliative care

Gabriela Rahnea Niță (eds), Anda-Natalia Ciuhu, Roxana Andreea Rahnea Niță, Dragoș Eugen Francu
București: Editura Universitară. 2013

A recent book appearance is signed by a group of specialists (oncologists, physical therapist, priest) from the Hospital for Chronic Diseases " Sf.Luca " (Bucharest, Romania) a recognized center for activities in palliative care and the only clinical department of oncology with palliative beds recognized by the Romanian Ministry of Health.

In this book some theoretical and practical aspects of palliative care are presented:
• The principles and philosophy of palliative care
• Pain
• Symptoms other than pain
• Emergency
• The role of physical therapy in palliative care
• Communication with patient
• Communication with family / carers / people that matter to the patient
• Spiritual care

The book addresses the basics of palliative care and is of great use to those who care for terminally ill patients, whether working in the field of institutional structures, or in healthcare in general.

This book is only available in Romanian language and it was free distributed among healthcare professionals in the field.

Dr Constantin Bogdan, President of the Romanian Society of Paliatologie and Tanatologie
NEWS

Top 10 things palliative care clinicians wished everyone knew about palliative care.
Ten things all doctors should know at least!

1. Palliative care can help address the multifaceted aspects of care for patients facing a serious illness.
2. Palliative care is appropriate at any stage of serious illness.
3. Early integration of palliative care is becoming the new standard of care for patients with advanced cancer.
4. Moving beyond cancer: palliative care can be beneficial for many chronic diseases.
5. Palliative care teams manage total pain.
6. Patients with a serious illness have many symptoms that palliative care teams can help address.
7. Palliative care can help address the emotional impact of serious illness on patients and their families.
8. Palliative care teams assist in complex communication interactions.
9. Addressing the barriers to palliative care involvement: patients' hopes and values equate to more than a cure.
10. Palliative care enhances health care value.

The article concludes that palliative care is a multidisciplinary specialty focused on improving the quality of life of patients with serious illness and their families. It is centered on reducing symptom burden, attending to psychosocial needs, and working with patients, families, and clinicians to align care with a patient's goals. Palliative care teams are available to help clinicians care for patients and their families at any age and any stage of a serious illness. Palliative care is of greater benefit for patients and their families when involved early in a disease course. This involvement leads to more effective and efficient care associated with cost savings, not less care.

This ‘News’ has been published in Mayo Clinics Proceedings August 2013.
See http://www.mayoclinicproceedings.org/article/S0025-6196(13)00452-7/fulltext

Marie Curie to lead palliative and end of life care priority setting partnership 16 October 2013

New initiative aims to find out what palliative and end of life care research is most important to public and professionals.
Initiated by Marie Curie Cancer Care, a large number of organisations have come together to form "the Palliative and end of life care Priority Setting Partnership". This means that for the first time, people directly affected will get the chance to have their say in setting research priorities for palliative and end of life care. The partnership is particularly seeking to hear from people who are likely to be in the last years of life, current and bereaved carers, their families, and frontline social and healthcare professionals.

Palliative and end of life care is an under-researched area and requires greater attention and focus. The aim of the partnership is to ensure that future research brings the greatest possible benefit to people at the end of life, and their careers and families, by identifying what questions are of the greatest importance to them.