

Aged-care medicine

THE ROLE OF AGED CARE in the practice of medicine is becoming more prominent with the increase in the proportion and absolute numbers of older people in our population. This is associated with an increase in diseases of advanced age — the neurodegenerative diseases, vascular diseases, and musculoskeletal disorders. Over the past five years significant advances have occurred in the management of these diseases and in the organisation of clinical services for older people.

Prevention. Research in the high-prevalence problem areas of dementia and falls has shown that at least one in every 20 people in our population aged 65 years and older will suffer from dementia, with a large burden of care being placed on family members and community and health services. There is preliminary evidence that anti-inflammatory drugs and vitamin E may be protective against Alzheimer's disease, but the preventive role of folic acid (reducing homocysteine levels) and oestrogen is still under investigation.¹

Falls and osteoporotic fractures are common: about 30% of older people fall at least once a year; between 4% and 5% of these falls result in fractures. Exercise, particularly balance, lower-limb strength training and walking (Figure), reduces the risk of both falling and sustaining a fall-related injury.² Hip protectors (pads or shields which absorb, or divert to surrounding tissues, the energy of a fall onto the greater trochanter) have been shown to be effective in reducing hip fractures in older people who live in residential-care facilities.³ Compliance with their use has been variable, and their use in community settings still needs to be evaluated.

The Commonwealth Government's Enhanced Primary Care Initiative, introduced in late 1999, includes an annual health assessment by general practitioners for people aged 75 years and over. While the impact of this initiative is yet to be evaluated, the aim is to prevent illness and improve health by providing patients with a written report and recommendations on staying healthy. Influenza vaccination, another important preventive measure, is encouraged as part of this assessment. This initiative also incorporates the National Falls Prevention for Older People strategy by encouraging GPs to identify and promote best practice in prevention and treatment of falls.

Intervention. Recent advances in aged care have occurred in medication availability and service delivery. The cholinesterase inhibitors are the first medications to provide modest symptomatic improvement in cognition, function and behavioural symptoms for people with mild to moderate Alzheimer's disease.¹ Their use requires a specialist diagnosis and evidence of improvement. As yet, there is no evidence that they alter progression of the disease. However, vitamin E (1000 IU twice daily) has been shown to delay clinical deterioration in established Alzheimer's disease.

For older patients with documented osteoporosis, the bisphosphonates are recommended as a first-line treatment; in these patients they reduce vertebral fractures by about 50%. Raloxifene, a selective oestrogen-receptor modulator, modestly increases bone density and reduces the risk of vertebral fractures.

The newer classes of antidepressants, including the specific serotonin reuptake inhibitors and the serotonin and noradrenaline reuptake inhibitors, have improved the management of depression. While their efficacy is similar to that of the tricyclic antidepressants, their improved side-effect profile means better tolerance, particularly in older people at risk of anticholinergic side effects.

The management of stroke has been improved by the introduction of stroke units, which provide comprehensive, interdisciplinary care from the day of admission, often until discharge. Patients admitted to these units show a decrease in mortality, morbidity and disability compared with those receiving standard care.⁴ The treatment effect appears to be due to the combination of management strategies rather than any one particular intervention.

Another improvement in service delivery for older people is the development of the Acute Care of the Elderly Unit (ACE Unit). Older people who are hospitalised often undergo a decline in physical function and these units aim to prevent or ameliorate this decline. The wards are designed with the acutely ill older patient in mind (good lighting, high-low beds, bedside chairs, rails, appropriate floor covering, ensuite bathrooms), with care provided both by the admitting general physician and the consulting geriatrician, and nursing and allied health staff (particularly physiotherapists and occupational therapists) trained in gerontology. The focus of care of the acutely ill older person is not only on the acute illness, but also on the patient's functional state. Randomised trials of these hospital units have shown improved functional outcomes and a reduction in nursing home placement in the intervention group.⁵

Conclusion. With a rapidly ageing population in Australia, it is important to continue these improvements in aged-care medicine. We need to balance the benefits and harms of new treatments in older patients in whom several disease processes may be operating, and we must evaluate the changes in aged-care service systems.

Susan E Kurrle

Director and Senior Staff Specialist, Rehabilitation and Aged Care Service
Hornsby Ku-ring-gai Hospital, Palmerston Road, Hornsby, NSW 2077
kurrle@bigpond.com

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