Clinical Geriatrics

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Edited by

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Preface

Suddenly the geriatric group in our population has assumed a burgeoning importance in medical practice. Many of the strides forward in the care of the young and the middle aged have inevitably led to a marked increase in the absolute number of the elderly, and Medicare legislation has further emphasized the impact of the geriatric group in office and hospital practice. More medical practitioners are discovering that this is one of the most challenging and difficult areas of clinical practice, calling for unusual skills and a knowledgeability not readily derived from standard textbooks of medicine.

When our Department at Montefiore Hospital and Medical Center agreed to give medical care to more than 500 patients in nursing homes and extended care facilities, we found that even our relatively seasoned clinicians were hampered by the absence of textual material that would serve as a guide to their geriatric practice. This text was, therefore, conceived as an everyday aid to the clinician in understanding and treating his elderly patients. To overcome the gaps that sometimes exist between theory, practice and necessity, the many contributors to this book were selected for their special interest in and clinical experience with elderly patients. Because of the importance attached to clinical experience, some of the contributors sought out were clinicians attached to hospitals or to care facilities concerned with the elderly, rather than traditional academicians. It has been equally rewarding from this point of view to seek out chapters from some of our esteemed British colleagues, contributors to the clinical science of geriatrics in a tradition that had its beginnings somewhat earlier than that in the United States. To all these contributors, busy with their practices and other duties, the editor expresses his special thanks.

Those who are familiar with the neat edifices constructed in standard medical texts may encounter new emphases and some seeming assymetries in *Clinical Geriatrics*. This derives from two editorial concerns: the contributors were charged not to repeat the details of familiar material available in standard texts, but rather to accent that which was characteristic or unique in dealing with the elderly. This is exemplified by a chapter such as Brocklehurst's, on The Urinary Tract, which bypasses exposition on the familiar subject of benign prostatic hypertrophy in favor of lesser known aspects such as asymptomatic bacteriuria, the various problems presented by incontinence, the pros and cons of the catheter life and so on. Similarly altered and new emphases are typical of other chapters such as Rodstein's Heart Disease in the Aged, Barham Carter's The Neurologic Aspects of Aging, and Habermann's Orthopedic Aspects of the Lower Extremities, to cite only a few. The apparent assymetry evolves from the nature of clinical practice with the elderly. Many of the major medical problems and some of the everyday threats to this fragile group give new dimensions to diseases and events that may be uncommon or inconsequential in younger persons. Osteoporosis and fractures; loss of ambulation and decubiti; diminished hearing and vision; loss of proprioception; the threat of vertigo; the rising incidence of postural hypotension; the impairment of homeostasis even in heat-regulating capacity, as represented by hypothermia and hyperthermia; these and many

other problems acquire new importance and carry different therapeutic implications. Out of this everyday stuff of geriatric practice emerged the substance of the chapters in this book. The editor and the contributors are certain that those quite familiar with standard texts will find rewarding further reading in *Clinical Geriatrics*.

ISADORE ROSSMAN, M.D.

Contents

PART 1
THE AGING PROCESS

1. THE ANATOMY OF AGING · *Isadore Rossman* 3

Changes in Stature and Posture 3
Span 6
Other Associated Changes 7
Changes in Weight and Subcutaneous Fat 7
Body Hair 9
Facial Changes 10
Arcus Senilis 11
Other Facial Changes 12
Other Contour Changes 12
Changes in Body Composition 13
Conclusion 15

2. DECLINE IN ORGAN FUNCTION WITH AGING · *Ralph Goldman* 19

Cardiovascular System 20
Kidney 24
Respiratory System 27
Gastrointestinal System 29
Endocrine System 35
Nervous System 40
The Eye 42
The Ear 42
Conclusions 43

3. AGING AT THE CELLULAR LEVEL · *Bernard L. Strehler* 49

Methods of Study 51
Causes and Effects 53
Origins 53
Therapeutic Modification 54
The Genetic Origins of Cellular Aging 54
Expression of Genetic Program 71
Reversibility of the Program 80
Summary 81

4. GENETIC ASPECTS OF AGING · *Lissy Jarvik* 85

Hereditary Transmission 86
Genetic Analysis and Life-Span 90
Genetics and Selected Geriatric Entities 98
Conclusions 103

5. PSYCHOLOGICAL ASPECTS OF AGING · *Robert L. Kahn* 107

Patterns of Behavioral Changes with Altered Brain Function 108
Brief Objective Measures for the Evaluation of Mental Status in the Aged 110
The Aged and Community Mental Health 112

6. THE NATURAL HISTORY OF DISEASE IN LATER LIFE 115
John Agate

Multiple Pathologic Factors 118

PART 2
SPECIALTY ASPECTS OF AGING

7. THE NEUROLOGIC ASPECTS OF AGING · *Alan Barham Carter* 123

Normal Variations 123
Infections 125
Trauma 127
Neoplasms 128
Vascular Diseases 129
Deficiency States 133
Metabolic Disorders 135
Neurologic Diseases of Unknown Cause 136
Neurologic Disorders Due to Skeletal Changes 139
Conclusion 140

8. HEART DISEASE IN THE AGED · *Manuel Rodstein* 143

The Aging Heart 143
Ischemic Heart Disease 143
Hypertension 147
Pulmonary Heart Disease 148
Congenital Heart Disease 149
Rheumatic Heart Disease 151
Murmurs at the Aortic Area 151
Murmurs at the Mitral Area 152
Subacute Bacterial Endocarditis 153
Acute Bacterial Endocarditis 153
Luetic Heart Disease 153

Hyperthyroidism 154
Hypothyroidism 154
Cardiac Arrhythmias and Conduction Disturbances 154
Congestive Heart Failure 159
The Electrocardiogram 161
Summary and Conclusions 161

9. THE PERIPHERAL VASCULAR SYSTEM · *Henry Haimovici* 165

Arterial Diseases 165
Venous Thromboembolism 175

10. DISORDERS OF THE DIGESTIVE SYSTEM · *Bernard Straus* 183

Esophagus 185
Stomach Disorders 187
Upper Gastrointestinal Bleeding 189
Intestinal Disorders 190
Urinary Tract and Gastrointestinal Symptoms 197
Carcinoma of the Pancreas 198
Diabetes Mellitus and the Gastrointestinal Tract 198
Biliary Tract 199

11. SKIN DISEASE · *Alexander William Young, Jr.* 203

The Pruritic Dermatoses 205
Bullous Dermatoses 211
Infections: Bacterial, Viral, and Mycotic 212
Dermatoses of the Leg 212
Skin Tumors 213
General Principles of Treatment 217

12. THE URINARY TRACT · *John C. Brocklehurst* 219

Urinary Tract Infection 219
The Aged Bladder 220
The Neurogenic Bladder 222
Urinary Incontinence 223
Retention of Urine 226
The Treatment of Other Symptoms of Dysuria 227
Nocturnal Frequency 227
Renal Disease in Old Age 227

13. THE EYE IN OLD AGE · *Abraham L. Kornzweig* 229

Vision 229
Cataract 229
Glaucoma 230
Macular Degeneration 232
Vascular Occlusions of the Retina 234
Retinal Detachment 235

Lid Affections 235
Conjunctival Conditions 239
Viral Diseases 240
Corneal Conditions 242
Uveal Diseases 242
Vitreous Disturbances 243
Tumors 243
Ocular Muscle Paralyses 244
Optic Nerve and Central Nervous System Diseases 244
Preventive Ophthalmology 244
Chemotherapy 245

14. AGING AND HEARING · *Robert Rueben* 247

The Transformer 248
Middle Ear Disorders 248
The Eighth Nerve 250
The Central Nervous System 251
Rehabilitation Measures 251

15. HEMATOLOGIC PROBLEMS IN THE ELDERLY · *George O. Clifford* 253

Iron Deficiency Anemia 254
Pernicious Anemia 255
Other Nutritional Anemias 258
Symptomatic Anemias 258
Lymphoproliferative Disorders: Leukemia, Lymphoma, and Myeloma 261
Aging and Hematologic Resources 264

16. ROENTGENOGRAPHIC ASPECTS OF AGING · *Fred Winsberg* 267

Skeletal Diseases 268
Skeletal Manifestations of Systemic Disease 272

PART 3
MUSCULOSKELETAL PROBLEMS IN AGING

17. THE SKELETAL SYSTEM 285
Herta Spencer, Juanito Baladad and Isaac Lewin

Osteoporosis 285
Paget's Disease 297

18. RHEUMATIC DISORDERS · *D. A. Brewerton* 301

Widespread Pain 301
Rheumatoid Disease 301

Gout 302
Shoulder-Hand Syndrome 303
Pulmonary Osteoarthropathy 303
Arthropathy Related to Malignant Disease 303
Polymyalgia Rheumatica 303
Suppurative Arthritis 304
Bone and Joint Tuberculosis 304
Calcification 305
Neuropathic Joints and Nervous Disorders 305
Spinal Pain 305
Shoulder Pain 306
Pain in the Elbow 306
Carpal Tunnel Syndrome 306
Degenerative Joint Disease in the Hands 307
Pain in the Hip 307
Pain in the Knees 307
Care of the Feet 307
Rehabilitation 307

19. ORTHOPAEDIC ASPECTS OF THE LOWER EXTREMITIES 309
Edward T. Habermann

Fractures in the Lower Extremity 309
Fractures About the Knee Joint 309
Fractures of the Hip 311
Avascular Necrosis 311
Injuries Around the Knee 312
Osteoarthritis 313
Osteoarthritis of the Hip 314
Osteoarthritis of the Knee 317
The Neuropathic Joint 319
Metastatic Carcinoma to the Skeleton 320
Embolic Phenomena Following Injury or Surgery in the Aged 321
Fat Embolism 322
Sudeck's Atrophy 323
Rehabilitation of the Orthopaedic Patient 323

20. GERIATRIC ASPECTS OF THE FOOT AND ANKLE 327
Melvin Howard Jahss

Common Foot Problems 330
Summary 339

21. REHABILITATION OF THE GERIATRIC PATIENT · *Jerome Tobis* 341

Modalities of Physical Medicine 343
A Therapeutic Program for Rehabilitation 349
Prognosis for Rehabilitation 351
Rehabilitation Services for the Elderly 352

PART 4
OTHER TREATMENT ASPECTS OF THE AGING PATIENT

22. COMMON SYMPTOMS AND COMPLAINTS · *John Agate* 357

Blindness 357
Deafness 358
Fatigue 359
Headache 359
Sleep and Insomnia 360
Dysphagia 361
Anorexia 362
Dyspnea 363
Vertigo 364
Fainting Fits and Attacks 365
Hypotension 367
Postural Hypotension 367

23. PRINCIPLES OF DRUG TREATMENT IN THE AGED 369
A. N. Exton-Smith and A. C. M. Windsor

Changing Concepts of Medical Treatment 369
Therapeutic Hazards 369
Geriatric Prescribing 371
Sedatives and Tranquilizers 372
Analgesics and Antirheumatic Drugs 375
Digitalis 376
Anticoagulants 377
Diuretics 378
Antiarrhythmics 380
Anticonvulsants 381
Antiparkinsonism Drugs 381
Influenza Vaccines 382
Cancer Chemotherapy 383
Antibiotics 385

24. DIABETES IN THE ELDERLY · *Harold Rifkin and Herbert Ross* 391

Diagnosis 391
Clinical Features 393
Management of the Elderly Diabetic 399

25. A SELECTIVE APPROACH TO SURGICAL PROBLEMS IN THE AGED 405
Clarence J. Schein and Herbert Dardik

Hernia 406
Breast Cancer 408
Duodenal Ulcer 409

Gastric Ulcer 410
Gastric Cancer 410
Surgical Problems of the Small Intestine 411
Appendicitis 412
Colonic Polyps 412
Colonic Diverticulosis and Diverticulitis 413
Colon Cancer 414
Rectal Prolapse 415
Rectal Cancer 415
Surgical Problems of the Biliary Tract 416
Pancreatic Cancer 417
Mesenteric Vascular Ischemia 417

26. GERIATRIC ANESTHESIA · *Deryck Duncalf and Edith R. Kepes* 421

Aim of Anesthesia 421
Response to Stress 421
Preoperative Evaluation 421
Preoperative Preparation 422
Choice of Anesthesia 427
Preoperative Medication 427
Anesthetic Management 428
General Anesthesia 428
Muscle Relaxants 430
Regional Anesthesia 430
Subarachnoid Analgesia 431
Monitoring 432
Support of Homeostasis 434
Postoperative Care 435

27. CLINICAL PSYCHIATRY IN LATE LIFE · *Robert N. Butler* 439

Overview: Psychologic Problems of the Aged 439
The Dimensions of the Problems 441
Complexities of Old Age 442
Organic Brain Disorders 443
Functional Disorders 445
Evaluation and Treatment 448
Treatment 451
Conclusion 458

28. SPECIAL HAZARDS OF ILLNESS IN LATER LIFE · *John Agate* 461

Special Risks in Bedridden Patients 461
Hypothermia 469
Hyperthermia 471

29. SEXUAL FUNCTION DURING ADVANCING AGE · *Alex L. Finkle* 473

Eliciting History of Sexual Activity 473
Organic Bases for Impotency 474

Extraorganic Influences on Sexual Function 474
Sexuality of Advancing Age 476
Causes of Impotency in Aging Males 477
Aids to Potency in Men 477
Conclusion 478

30. NURSING CARE OF THE AGED · *Doris Schwartz* 481

Where to Get Help 481
Family Agencies 482
Public Welfare 482
Voluntary Health Organizations 482
Medicare 483
The Patient in the Hospital 483
Personal Care In or Out of the Hospital for the Bedbound Patient 483
Diversion 484
The Bedridden Old Person 485
When the Elderly Patient is at Home 488
The Visiting Nurse 488

31. ENVIRONMENTS OF GERIATRIC CARE · *Isadore Rossman* 491

The Hospital 492
Other Hospital Facilities 495
Nursing Homes 496
Home Care 498

INDEX 505

PART 1

The Aging Process

PART I

The Aging Process

1

The Anatomy of Aging

ISADORE ROSSMAN, Ph.D., M.D.

By the time the eighth or ninth decade is achieved, most individuals have undergone a number of progressive aging changes that if not recognized as normal can raise troublesome diagnostic problems. Sometimes, because of loss of sweat glands and hair, with slowed cerebration, hypothyroidism may be suspected. The bloodless aspect of the face may seem to confirm an accompanying anemia. The extensive loss of pubic and axillary hair may suggest other forms of endocrinopathy. Shrinkage of muscles, weakness, and ptosis of the lids, all very common in the elderly, can suggest a primary muscle disorder or myasthenia. Loss of subcutaneous fat and atrophic epidermal changes make the usual tests for tissue turgor useless. Elongation of the aorta can produce buckling of the innominate or carotid artery and present a pulsating mass in the neck (which has been mistaken for aneurysm) or can simulate a tumor in the chest roentgenogram. Thus it is necessary to know geriatric anatomy not only because of its intrinsic interest, but also because it serves as a basis for rational differential diagnosis.

When we judge the age of individuals, we do so on the basis of various criteria for senescence. However, it is advisable to remain skeptical of some criteria. Aging changes that are purely local may indicate only an unusual individual exposure (e.g., wrinkling due to much solar exposure), or that a genetic event has been operative (e.g., early familial graying). Accompanying senescent changes are a number of what might be termed time-related pathological events. The importance of this distinction is indicated by the fruitfulness of research in atherosclerosis and osteoporosis when these disorders came to be considered time-related pathological events, not inevitable consequences of aging. But for descriptive purposes in dealing with the aged, the complexities of pathogenesis can be bypassed. Perhaps many of the changes should not imply inescapable, universal sequences, and it is important to call attention to the existence of variability. The geriatrician is in no sense looking at an unbroken chain of events in the decline and fall of man, and perhaps in those who fall outside the limits of the standard deviations one may seek important clues to constructive therapy.

Changes in Stature and Posture

The physician who works with an elderly population often finds himself stooping while bellowing into the ears of his patients. The geriatric population, with its disproportionately large number of women, is a short group, but other factors besides a preponderance of females contribute to this. Many elderly individuals, in addition to kyphosis, undergo postural changes, among which slight flexion at the knees and at the hips tends to contribute further to diminished stature (Fig. 1-1). A progressive statural decline also seems apparent in the two generations found in the geriatric facility. Women in their 90's are shorter than those in their 70's. Shrinkage in height with aging is well recognized, but its extent has not been quantitated by longitudinal studies of a large number of individuals. The problem is somewhat complicated by the increase in stature occurring during the twentieth century. Records of incoming freshmen in American colleges indicate they are 1 to

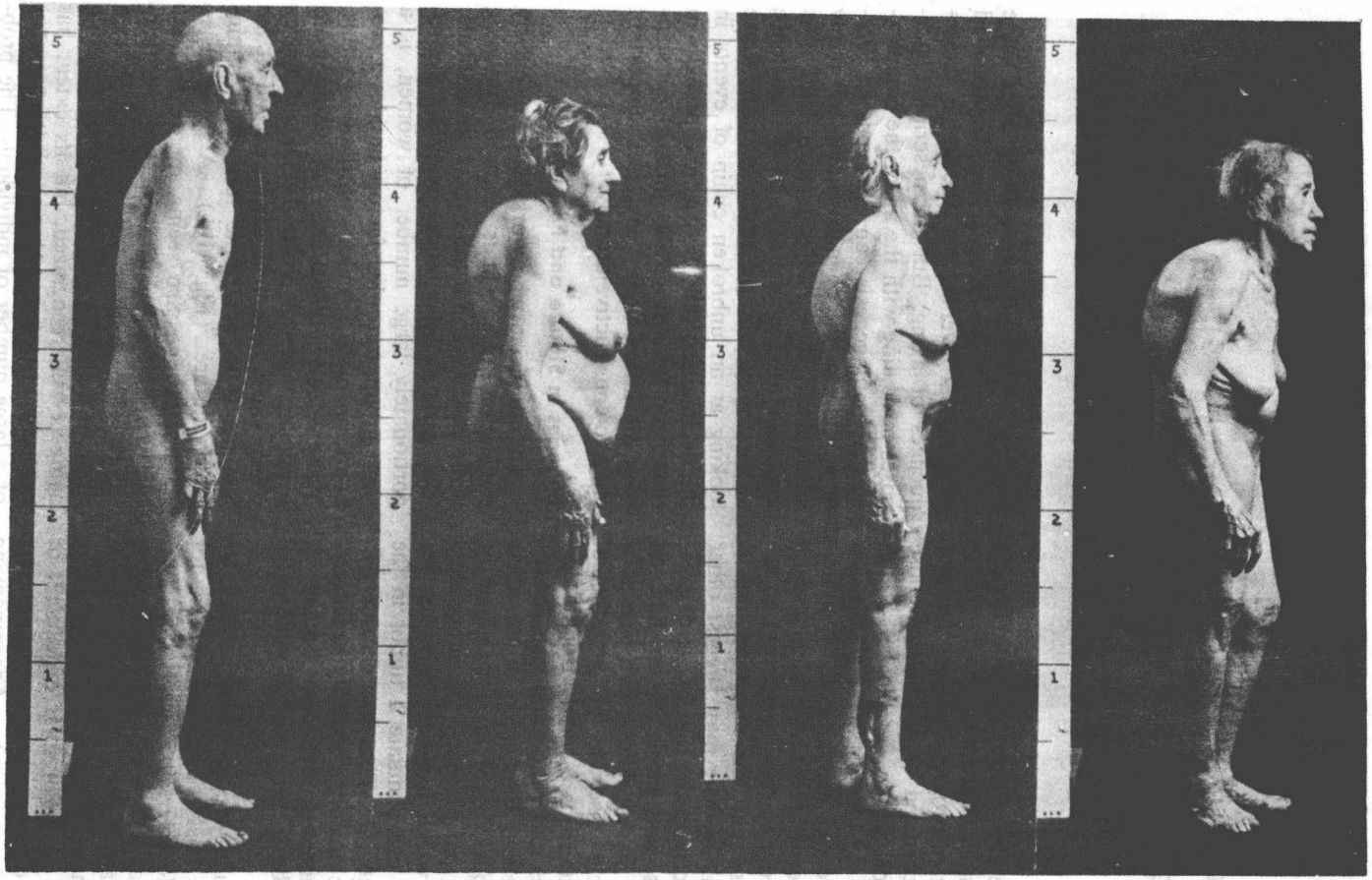

FIG. 1-1. Four randomly selected patients from the ambulatory section of a nursing home, illustrating short stature, osteoporotic kyphosis, and relatively long extremities. From left to right: T. H., age 82, L. B., age 78, A. I., age 79, and A. S., age 94. (Photo from DeWayne Dalrymple)