Influence of kinetic and functional requirements of health outcomes in the functional mobility of elderly people

RESUMO | INTRODUÇÃO: A mobilidade funcional é um fator determinante para promover a independência do idoso, com influência na saúde física e mental. Os testes para avaliar a capacidade funcional de idosos devem ser direcionados a simularem as atividades de vida diárias de locomoção. OBJETIVO: Verificar a influência de requisitos cinéticos funcionais e desfechos da saúde sobre a mobilidade funcional de idosos em uma unidade básica de saúde. MATERIAIS E MÉTODOS: O estudo foi realizado com 88 idosos, que foram submetidos a testes funcionais para avaliação da mobilidade funcional, equilíbrio estático e força muscular de membros inferiores. Além disso foi aplicada uma escala de depressão e coletada variáveis relacionadas a saúde do idoso. RESULTADOS: Os requisitos cinéticos funcionais e a sintomatologia depressiva também foram correlacionados à capacidade de locomoção, todavia a força muscular (correlação de Spearman = 0,52, p=0,000) exibiu uma maior influência na mobilidade funcional. As variáveis que tiveram associação com uma pior mobilidade funcional foram: histórico de quedas (p=0,001), diabetes (p=0,008) e hipertensão (p=0,015). CONCLUSÃO: Nos idosos avaliados, a força muscular dos membros inferiores apresenta maior influência sobre a mobilidade funcional. Ser hipertenso, diabético e/ou já ter caído pode influenciar o desempenho funcional de locomoção.

PALAVRAS-CHAVE: Idoso. Envelhecimento. Funcionalidade. Morbidade. Fatores de risco.

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Original article
Introduction

The development of new technologies and the expansion of knowledge in the health sphere has implied a more effective assistance to the morbidities of the population. The consequence of this evolution is the increase in life expectancy that directly influences epidemiological issues\(^1\). In the first decade of the 21st century, the Brazilian population of the elderly corresponded to 10.8\% \((n = 20,590,599)\) of the total population. Estimates suggest that there are currently approximately 26 million elderly people in Brazil and there is a tendency to increase to 37.9 million in 2027\(^2,3\).

The process of senescence brings about a natural diminution of the physiological functions of the systems of the organism. However, inadequate life habits and genetic propensity make them more propitious to the pathological manifestation of senility, marked by the appearance of Chronic Noncommunicable Diseases (CNCD), reduced mobility and functional limitation. In this context, many factors reduce the functional mobility of the elderly and contribute negatively to the aggravation of the inherent conditions of the natural aging process\(^4\).

The reduction of functions in the cardiovascular, respiratory, nervous, musculoskeletal, endocrine, and other systems, which are expressed by deficits in cardiorespiratory fitness, flexibility, strength and balance, is observed in the elderly. These are called functional kinetic requirements and influence the functional independence of the elderly\(^5\).

Health strategies to reduce the effects and/or development of senility should be increasingly implemented. However, for this to be possible, evaluation tools are needed to track the progression of each process and direct the intervention\(^6\). Functional mobility is a determining factor in promoting independence of the elderly, influencing physical and mental health. The tests to perform this evaluation in the elderly should be directed to simulate the daily life activities of locomotion, since they are performed more frequently and are those of greater difficulty of performance\(^7\).

From these considerations, the objective of this study was to relate the influence of functional kinetic requirements, represented by the evaluation of lower limb muscle strength and static balance, and elderly health outcomes on the functional mobility of elderly in a basic health unit.

Materials and methods

This article is an observational study with a quantitative, transversal and exploratory approach. The sample was intentional, composed of elderly people enrolled in the Ulisses Family Health Strategy (ESF) coverage area, in the urban area of Cocal (PI). Data collection occurred from November 2014 to January 2015.

The inclusion criteria were: age ≥ 60 years, physical and mental autonomy, absence of cognitive and neurological impairment, and independent gait. The exclusion criteria were: presence of sensorimotor, auditory and/or visual impairment, incapacitating them in the performance of the tests.

With the help of the Community Health Agent (ACS) the elderly were invited to attend the Basic Health Unit (UBS), where they were informed about the risks and benefits of the study. Those who met the eligibility criteria confirmed their participation in the study by signing the Informed Consent Form (ICF) and were referred for evaluation. The volunteers responded to a semi-structured questionnaire, which compiled personal data, anthropometric characteristics (weight, height, body mass index (BMI)) and health history: CNCD such as Systemic Arterial Hypertension (SAH) and Diabetes Mellitus (DM), as well as the history of falls in the last year, and functional kinetic requirements, depression index and functional mobility were evaluated.

The functional kinetic requirements were measured from the tests: Functional Reach Test (FRT), which evaluates the static balance through the right upper limb excursion forward; and the lower limb strength test, known as “sit and lift”\(^8\). Depressive symptoms were assessed using the Geriatric Depression Scale with 15 items (GDS-15), where a score between 0 and 5 points is classified as normal symptoms; a score between 6 and 10 points corresponds to increasing depressive signs; and between 11 and...
15 to severely depressed elderly subjects. The functional mobility of the volunteers was estimated using the Timed Up and Go (TUG) test, where the individual must lift from a 3m chair and return to the initial position, while the time to perform the maneuver is performed.

After data recording and storage, an analysis with Stata 15.0© software was conducted. For the descriptive presentation of the data, mean and standard deviation were used. Spearman test was performed to verify the correlation of the TUG test with the other tests of functional kinetic requirements performed and linear regression model to estimate how these tests can influence the functional mobility. The association between the health outcomes of the elderly and the functional mobility was evaluated using Fisher's Exato and linear trend tests, as required by the analysis. A significance level ≤0.05 was considered.

The linear regression model and the Cartesian description of the association between the independent and dependent variables in question, using the formula below:

\[
\text{TUG} = \beta_0 + \beta_1 X_i
\]

The \(\beta_0\) refers to the expected value for the dependent variable TUG when \(X_i\) is equal to zero. The \(X_i\) corresponds to the values of the independent variables of this study (value obtained in the tests). The angular coefficient \(\beta_1\) is the expected variation in the response variable, when the independent variable modifies a unit. The values generated by this mathematical expression create a straight line from the \(\beta_0\) and the angular coefficient \(\beta_1\), which can offer a visual analysis of the associations between the variables.

The study was approved by the Research Ethics Committee of the Unified Teaching Center of Teresina (CEUT), under protocol n° 6,597/2014. The research followed the principles of Resolution No. 466/2012 of the National Health Council (CNS) and all procedures related to the collection and analysis of the data occurred only after approval by the ethics committee.

RESULTS

Of the 163 elderly Ulisses' ESF users, a total of 93 attended the evaluation. The absentees included bedridden elderly and those that the ACS could not contact, as well as those that did not fit the inclusion criteria of the study. During the UBS evaluation process, 5 individuals were excluded because they presented moderate cognitive deficits (n = 2), making it difficult to perform the tests, dependent gait (n = 1) and withdrawal (n = 2). Thus, 88 elderly people composed the sample.

The anthropometric data and the measured values of the performed tests were described in Table 1. The mean TUG test time was 13.96 (± 3.08) seconds. The anthropometric variables age and height had correlation (low) with TUG values, being positive and negative, respectively. Functional kinetic requirements and depressive symptomatology were also correlated with TUG values, however, muscle strength exhibited a greater influence on functional mobility.

Table 1. Anthropometric variables, kinetic requirements and the Geriatric Depression Scale (GDS-15) of the Family Health Elderly (ESF) Ulisses, Cocal-PI.2018

|                      | Mean | SD (±) | R²  | \(P\)   | \(\beta_0\) | \(\beta_1\) |
|----------------------|------|--------|-----|---------|-------------|-------------|
| **Anthropometric**    |      |        |     |         |             |             |
| Variables            |      |        |     |         |             |             |
| Age                  | 68.39| 6.33   | 0.22| 0.035*  | 64.44       | 0.36        |
| Weight               | 57.82| 10.23  | -0.11| 0.292   | 63.82       | -0.41       |
| Stature              | 1.51 | 0.08   | -0.21| 0.041*  | 1.59        | -0.00       |
| BMI                  | 25.23| 3.79   | 0.03| 0.720   | 25.35       | -0.00       |
| **Functional**       |      |        |     |         |             |             |
| Requirements         |      |        |     |         |             |             |
| FRT                  | 17.01| 5.64   | -0.28| 0.007*  | 23.36       | -0.45       |
| MS                   | 17.72| 4.15   | 0.52| 0.000*  | 7.04        | 0.76        |
| **Geriatric**        |      |        |     |         |             |             |
| Depression Scale     | 5.01 | 2.46   | 0.24| 0.021*  | 2.14        | 0.19        |

BMI: body mass index; TAF: functional range test; FM: muscle strength of lower limbs; *statistically significant.
Figure 1 shows the trend of TUG values from the results obtained in the MS test. We can observe a positive correlation between the time spent performing the TUG (Spearman’s correlation $= 0.52, p = 0.000$) and the time spent performing the muscle strength test.

![Figure 1. Correlation between functional mobility and muscle strength (FM)](image1)

Figure 2 shows the trend of TUG values from the results obtained in the static equilibrium test. We can observe a negative correlation between the time spent to perform the TUG (Spearman’s correlation $= -0.28, p = 0.007$) and the distance reached in the FRT.

![Figure 2. Correlation between functional mobility and functional range test (FRT)](image2)
Table 2 shows the functional outcomes of elderly health. The variables that had association with the TUG values were: History of falls, DM and SAH.

Table 2. Functional outcomes of the elderly health of the Family Health Strategy (ESF) Ulisses, Cocal-PI

|                      | N (%)  | P     |
|----------------------|--------|-------|
| History of falls     |        |       |
| None                 | 47 (53,41) |      |
| 1 fall               | 34 (38,64) | 0,001* |
| 2 falls              | 5 (5,68) |       |
| 3 falls or more      | 2 (2,27) |       |
| SAH                  |        |       |
| Yes                  | 42 (46,86) | 0,015* |
| Not                  | 46 (51,14) |       |
| DM                   |        |       |
| Yes                  | 75 (85,23) | 0,008* |
| Not                  | 13 (14,77) |       |
| BMI                  |        |       |
| Low weight           | 43 (49,41) | 0,517 |
| Normal               | 37 (42,35) |       |
| Obesity (Grade I)    | 8 (8,24) |       |
| Income               |        |       |
| Less than a salary   | 2 (2,27) | 0,190 |
| One salary           | 83 (94,32) |       |
| More than a salary   | 3 (3,41) |       |
| Education            |        |       |
| Illiterate           | 59 (67,05) |     |
| Fundamental          | 28 (31,82) | 0,180 |
| Incomplete           | Fundamental Complete | 1 (1,14) |     |

DM: diabetes mellitus; SAH: systemic arterial hypertension; BMI: body mass index; * statistically significant.

Discussion

This study investigated the relationship between functional kinetic requirements, represented by the evaluation of lower limb muscle strength and static balance, and elderly health outcomes on the functional mobility of elderly in a primary healthcare unit. It was observed that the functional kinetic requirements of lower limb muscle strength have a greater influence on functional mobility when compared to static equilibrium; it was also observed that in relation to depressive symptomatology and health outcomes, the variables history of falls, diagnosis of hypertension and DM were associated with a lower capacity for locomotion in functional activities.

Elderly individuals may present deficits in the balance due to the sensory alterations that are due to the natural aging process. This characteristic compromises the Central Nervous System (CNS) in adequately processing the vestibular, visual and proprioceptive signals. The impairment of balance in elderly presented a close relation with the risk of falls and fractures. In the present study, the balance of the elderly was estimated by applying the FRT, the volunteers presented an average of 17.01 (± 5.64) cm, implying that the volunteers presented low risk of falling.

The choice of TUG was based on its ability to integrate functional kinetic requirements such as power, speed, agility and dynamic balance. This evaluation instrument is widely used in the scientific scenario with the purpose of evaluating functional mobility, for representing activities that include getting up, walking, going back and sitting, as reflected in many activities performed by the elderly in the home or social environment.

The association of FRT and TUG showed a negative correlation between the time spent to perform TUG and the distance reached in FRT, that is to say that the more time spent in TUG execution the less
distance traveled in FRT. Both tests are commonly used in the measurement of these parameters and are reliable for the purpose. For example, a survey conducted in a public hospital used a Proprioceptive Neuromuscular Facilitation (PNF) protocol in the elderly and observed its effects on the volunteers’ balance. The analyses were performed by means of a baropodometer, in addition to the TUG and FRT tests, the baropodometer analysis revealed no differences after the PNF protocol, but there was a decrease in TUG execution and an increase in FRT excursion, reducing the risk fall of the elderly.

In another study performed with 36 elderly women, the functional mobility was evaluated through TUG, static balance using FRT, lower limb strength through the maximal repetition test (1-RM), and the Berg Equilibrium Scale (BES), aiming to verify the influence of the maximum force on the balance of the volunteers. BES was more sensitive to identifying the balance deficits, the 1-RM test identified that muscle strength had direct interference in the TUG results. The authors concluded that lower limb muscle strength is an important predictor of the functional mobility of the elderly.

The present study also investigated the type of relationship between anthropometric characteristics and the patient’s history with functional mobility. Weight and BMI had no correlation with functional mobility, in contrast, age was a factor that contributed to a decrease in performance during the TUG test. This may show that age is a conditioning factor for progressive functional impairment, in association with other factors that arise during the aging process.

A survey conducted in Barbacena-MG evaluated 206 elderly people through questionnaires to identify risk factors, incidence and consequence of falls in the elderly. The majority (54.37%) of the elderly in our study were concentrated in the age range between 70-98 years and the percentage fracture of the lower limbs as a consequence of the fall in this age group was 15.56%, this fact demonstrates the implication of advancing age in reducing the functionality of older people and the consequences it brings. The variables income and schooling had no relation to the outcome, but the history of falls, SAH and DM were associated with worse functional mobility. The previous history of falls generates fear of falling in the elderly and, therefore, restricts and limits them to performing their daily activities.

The association between the risk of falls and the diagnosis of hypertension has not yet been fully elucidated in the scientific literature. The literature evidences a frequency of falls in the elderly with a diagnosis of elevated DM. This fact may be related to the fact that diabetic elderly exhibit impaired balance and mobility due to old age, reduced proprioceptive sensitivity, and lack of balance strategy.

The reduction of functionality implies a greater propensity for the fall event and the consequences that this entails. It is necessary a multiprofessional action capable of detecting the risk of falls in the elderly, since this has a multifactorial cause, such as, drug control, health education, incentive to practice regular physical activity, among others.

Basic care is a field of activities of health education for the elderly, in order to stimulate the functional independence of these individuals and to provide the adoption of healthy habits.

Depression is one of the most prevalent disorders in the elderly, often under-diagnosed and not adequately treated. In this study the evaluation of the depression index in the elderly through GDS-15 showed normal signs and its association as the TUG was statistically significant, this is due to the low risk of the event being found in volunteers. Depression is often related to social isolation and, consequently, functional decline, more markedly in the elderly, because it associates with the specific impairments of the natural aging process.

The research had as limitation the application of the GDS-15 in the form of an interview, the low level of schooling that made it difficult for the command to execute the tests and the reduced sample. The generalizations of this study should be done with attention, because the inferential analysis was performed in a small sample. We suggest future analyzes with representative samples and with prospective evaluations to show the evolutions of the possible functional mobility impairments.
Conclusion

The study allowed us to infer that of the functional kinetic requirements, the muscular strength of the lower limbs presents greater influence on the functional mobility, in a lower magnitude to the static balance. The depressive symptomatology and the health outcomes: history of falls, diagnosis of SAH and DM were associated with less ability to move in functional activities.

Author contributions

Silva LN participated in the study design conception and performed the statistical analysis. Silva JCA managed the data collection and submitted the project for consideration of the ethics committee. Ribeiro MDA participated in the data analysis. Oliveira SB guided the research. All authors participated in writing and critical assessment and review of the article.

Competing interests

No financial, legal or political competing interests with third parties (government, commercial, private foundation, etc.) were disclosed for any aspect of the submitted work (including but not limited to grants, data monitoring board, study design, manuscript preparation, statistical analysis, etc.).

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