Medicine and elderly people: over-investigation or under-treatment?

A conference entitled ‘Medicine and Elderly People: over-investigation or under-treatment?’, was held at the Royal College of Physicians on 15 May 1995. The aim of the conference was to review recent medical research and examine current medical practice in three specific areas of elderly care medicine: dementia, cardiovascular disease and large bowel cancer. The presentations that followed fuelled the debate on how best to provide such healthcare for an ageing population, culminating in a review of the important ethical issues raised.

Dementia

Dr D O’Neill (Geriatrician, Meath Hospital, Dublin) reviewed the diagnostic criteria for dementia and its investigation. He emphasised its under-diagnosis in medical practice. ‘At best there is 58% recognition of the condition in general practice and only 30% within the hospital setting’. Difficulties in diagnosis of dementia are due not only to its evolving taxonomy but also to its long time course; and dementia is a neglected topic in the undergraduate curriculum. For the investigation of Alzheimer’s disease, Dr O’Neill outlined a method of structured assessment, taking into account cognitive function, depressive symptoms [1], vascular risk factors, laboratory testing and neuro-radiological investigations, and referred to the potential use of the Apo E gene as a screening tool [2]. The dementia work-up should be clinically based, starting early in the disease process. The approach to investigation and therapy should be multidisciplinary and long-lasting.

Dr J P Wattis (Community Mental Health Team Leader for Older Adults, Leeds) developed the theme of managing dementia further. Quoting Oscar Wilde, ‘We know the price of everything and the value of nothing’, Dr Wattis felt this exemplified society’s attitude towards the demented elderly person. He compared them to the unemployed: ‘Both are like commodities bought and sold for profit, although having little or no purchasing power themselves’. The problems experienced by demented patients are exacerbated by a punitive social environment which is both infantilising and devaluing [3]. His approach in managing the demented individual incorporates adequate investment, specialist nurses, well-informed carers and relatives, and a stable social service base. From this a new culture could arise which values the demented person.

Cardiovascular disease

‘Thrombolysis in myocardial infarction’ was presented by Dr A J Marshall (Cardiologist, Derriford Hospital, Plymouth). He reiterated the findings of the Royal College of Physicians working party, which recommended that non-invasive investigations and thrombolytic therapy should be made available to all age groups [4]. He quoted figures from Lawson-Matthew and Channer who found that only half the cardiologists and geriatricians in the Trent region were aware of the college report and that even fewer had actually read it [5]. His own unit in the Plymouth Health District found a marked difference in the management of coronary artery disease compared with the management of other cardiovascular diseases in the elderly. Angina in particular was more likely to be managed conservatively [6]. Dr Marshall then reviewed the four European trials of thrombolytic therapy. Three of these showed a reduction in mortality in elderly patients when treated with thrombolysis after an acute myocardial infarction [7-9]. The impact of these reports on pre-hospital management of suspected acute myocardial infarction was such that 97% of general practitioners now admit these patients to hospital. However, Dr Marshall cautioned that one-fifth of coronary care units operate an age-related admission policy and two-fifths operate an age-related thrombolysis policy [10]. He conceded that there are difficulties in the management of thrombolysis in elderly patients, mainly because the diagnosis of myocardial infarction is often less clear cut and there is a small but unequivocal increase in the risk of intra-cerebral haemorrhage [11]. An audit of thrombolytic therapy within his own unit resulted in better thrombolytic treatment for this age group, with only infrequent adverse events [12]. He concluded that while age-related policies exist, elderly patients with coronary disease will continue to be under-investigated and under-treated.

Dr I Simpson (Cardiologist, Southampton General Hospital) outlined the medical management of aortic stenosis, stressing the importance of accurate diagnosis. To achieve this he recommended the use of trans-thoracic echocardiography and Doppler, as clinical assessment is woefully inadequate [13]. Doppler quantification and serial monitoring of the aortic valve gradient is important because of the progressive and unpredictable time course of the disease [14]. The physician’s role is to identify suitable candidates for aortic valve replacement surgery. A blank slide summed up the medical management of severe aortic stenosis, making it clear that in such patients surgery is the only safe and effective treatment!

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**Professor T Treasure** (Cardiothoracic surgeon, St George’s Hospital, London) discussed the surgical management of aortic stenosis: its aim is to relieve symptoms and improve prognosis. In the past it was argued that elderly patients with aortic stenosis and poor left ventricular function should not be considered for aortic valvuloplasty because of the high morbidity and mortality with valve replacement surgery. But data from his own unit showed that among 74 patients who had undergone aortic valve replacement for pure aortic stenosis, there were no perioperative deaths despite poor left ventricular function in 10 patients. He reminded us that symptomatic aortic stenosis has an 80% 2-year mortality, whereas nationally the 30-day mortality for aortic valve replacement approaches 4–5%. Although there is an increased risk of perioperative stroke in the elderly, the majority of his patients experienced better quality of life after surgery [15]. Professor Treasure concluded that aortic valve replacement for symptomatic aortic stenosis in the elderly should not remain a contentious issue. His final slide summed up his experience of operating on elderly patients with a quotation: ‘I am often called to see octogenarians and am told, “This patient is 85 but acts more like 50”. There is nothing like cardiac surgery to bring out a patient’s true age’ [16].

**Carcinoma of the bowel**

**Dr R H Curless** (Physician, Preston Hospital, North Shields) began with an overview of the epidemiology, pathology, symptoms and presentation of large bowel cancer. Its incidence is increasing with advancing age, and in both sexes the 5-year survival figures have remained unchanged for over 10 years. After describing the various presenting symptoms and appraising their positive predictive value, he concluded that their discriminatory power is very poor. This is supported by surveys showing that many elderly patients with carcinoma of the bowel present with non-gastrointestinal symptoms [17,18]. Difficulties in identifying elderly patients with colonic malignancy are also compounded by their reluctance to report symptoms to a doctor. Dr Curless pointed to the role of proto-oncogenes and growth suppressor genes as areas of interest in the future.

**Professor O F W James** (Professor of Medicine, University of Newcastle) reviewed the current medical management of large bowel cancer. The chance of not receiving definitive treatment for any cancer increases with age [19], even though being under or over seventy years of age makes no difference to investigation, staging and adjuvant treatment of bowel cancer. He also found no evidence of ageism in the hospital referral policies of general practitioners or in further hospital investigations. Professor James commented that there is no difference in the biology, disease extent or histology of colonic tumours between the under-and over-seventy age groups, but they do suffer greater morbidity and mortality following colonic resection. Among the screening methods—family history, faecal occult blood and flexible sigmoidoscopy—the last has been shown to have the greatest specificity and sensitivity, leading to an overall reduction in mortality from the disease [20,21]. How often and whom to screen, and the use of aspirin prophylaxis in colonic cancer, still remain contentious issues [22]. Research has shown that in Dukes C disease, combination chemotherapy with fluorouracil and levamisole or folinic acid reduces recurrence and mortality [23,24].

**Mr H Steer** (Surgeon, Southampton General Hospital) outlined the preoperative considerations of surgical treatment for colonic cancer. He includes the nature and prognosis of the disease, and the patient’s wishes, but age alone is not a factor in his decision-making. Determinants of postoperative outcome include the presence of other medical conditions which adversely affect anaesthetic risk and the mode of presentation [25]. Emergency abdominal surgery has mortality rates of 20% or more, compared with elective rates of less than 9%. As a result, Mr Steer recommends prompt surgical referral and early involvement of physicians to optimise medical management of any underlying cardiorespiratory disease. He feels that surgery should only be undertaken by those with experience and a specialist interest in this field.

**The ethics of health care provision for the elderly**

**Dr N Sterling** (Geriatrician, Southampton General Hospital) analysed the nature of age and people’s perception of it. She looked at how demographic change had affected the provision of healthcare for the elderly. Current practice has changed patient expectations, the majority of elderly patients now expecting to return home following an inpatient hospital stay. Discharge figures from Lymington Infirmary, a local rehabilitation unit to which her patients are admitted, showed that in 1972 only 1% of inpatients aged 65–87 returned home, compared with 70% in 1994. Dr Sterling described how these expectations evolve with time and may have a significant impact on the doctor-patient relationship. She recounted the story of a 96 year old patient with failing eyesight due to diabetic cataracts whom she had first seen in 1985. At that time the mutual conclusion, on weighing up the risks and benefits, was that cataract extraction was inappropriate. However, ten years later the patient was plagued by falls secondary to a peripheral sensory neuropathy. With the restoration of her sight, these falls could be prevented and thus the balance was now tipped in favour of surgery. Despite her 106 years, she underwent cataract extraction without complications and was once again able to lead an independent life.
Dr Sterling therefore stressed the importance of assessing patients’ wishes and needs, with age being one of the many factors that need to be taken into account.

Mr J James (Kensington and Chelsea and Westminster Commissioning Agency), gave an exposé on commissioning the services used by elderly people. How can inequity of access to healthcare come about and what is the commissioner’s role? Initially commissioners establish what the strategy of healthcare provision for the elderly should be. They decide upon the amount of resource investment, and choose the providers. The contractual obligations of the strategy are then drawn up. This sets the framework in which individual clinical decisions are taken and where outcomes are monitored. Auditing of the process allows the strategy to be re-appraised and the sequence of events begins again. An issue to be discussed is whether the strategy should be based on equity of provision or on benefit and value for money; other considerations include health-needs assessment, effectiveness research, demographic modelling and the viewpoints of the users and carers. While this represents the ideal strategy, past legacies also have some influence and therefore flexibility is required. Mr James stressed that the commissioning process comprises many thousands of individual clinical decisions. He looked specifically at contracting healthcare services and highlighted the problem areas of acute care and the social care field. In acute care services for the elderly, access may be restricted by the operation of an age-related admissions policy, while in the social care setting the ‘cliff-face’ between ‘free’ NHS treatment and means-tested provision is bound to cause problems. He emphasised the importance of clinical audit and systematic monitoring of the quality of the service provided.

Professor J M Harris (Department of Social Ethics, University of Manchester) debated the ethics of providing technical services for the care of the elderly. If we believe in equality of healthcare ‘each person must be respected, valued and protected equally’. In such circumstances, where all cannot be treated equally, a fair mechanism of selection must be used. Quality adjusted life years (QALYs) may be used to determine who would benefit from healthcare, and therefore to allocate priorities in the use of services. Professor Harris concluded that QALYs favour younger, healthier people and lessen the priority given to the elderly with their shorter life expectancy. Who decides on the value of life other than the individual concerned? Even if quality of life is poor, the individual’s desire to continue living is the primary consideration. Professor Harris summarised his argument against ageism in medicine: ‘All of us who want to go on living have something that each of us values. This something is the rest of our lives, we each suffer the same injustice whenever our lives are shortened. Therefore elderly people have as much a claim on healthcare as anyone else’. It is only when this precept is accepted, he said, that one can conclude that healthcare policies are not ageist.

Conclusion

The conference was well attended by a good mix of general practitioners and hospital practitioners. It provided interesting views and debate on the current management of several common conditions encountered in the elderly. Speakers and panellists gave well-balanced and unbiased opinions on how best to investigate and treat dementia, aortic stenosis and colonic cancer. If ageist policies were identified within a specialty they should be exposed and addressed by the medical profession as a whole. This was a timely conference in view of current population figures, which show that the proportion of elderly people is increasing. It gives food for thought not only for those who are involved in the provision of healthcare but also for those who are planning for the future healthcare needs of the population.

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