The developed world is facing a problem: too many older people and too few younger people to look after them. A powerful case exists to ensure that remediable conditions are not missed and that where possible levels of dependency are reduced, to ensure improvements to the quality of individuals’ lives and the most efficient use of one of the most expensive types of health and social intervention: long-term care.

Challis and colleagues provide welcome additional detailed and comprehensive evidence coupled with an economic analysis, based on a randomised controlled trial.

Skilled assessment of those at the threshold of entry to a nursing home does provide benefits that can be realised through the use of about 1 hour of specialist staff time per case. The authors’ contribution should be required reading for geriatricians and policy makers as they collaborate to meet the challenges of an ageing population and the problem of providing the personnel to deliver care.

TONY LUXTON
Cambridge City Primary Care Trust, Davison House, Brookfields Hospital, 351 Mill Road, Cambridge CB1 3DF, UK
Fax: (+44) +44 (0) 1223 723171
Email: Tony.Luxton@Cambcity-pct.nhs.uk

References

Anaesthesia and the older surgical patient: something old, something new, something borrowed...

In the past eighteen months there have been a number of editorials in major anaesthetic journals on the anaesthetic management of the older patient [1, 2]. In December 2001, the Association of Anaesthetists of Great Britain and Ireland (AAGBI) issued guidelines to members on the perioperative care of the elderly. In particular, the AAGBI called for the appointment of a lead clinician in each anaesthetic department with an interest in the care of the elderly [3]. What has increased the profile of the older patient in the field of anaesthesia and intensive care?

Changing demographics with consequent expansion of resource utilisation is the most powerful explanation. As the elderly have surgery four times more often than the rest of the population, in the near future the majority of patients presenting for surgery and anaesthesia will be aged older than 65 years, with a substantial proportion older than 85 years.

To date, anaesthetic management of the elderly patient has not attracted significant clinical or research interest. Comparison may be made to developments in the field of paediatric anaesthesia, which lead to a greater appreciation of the difficulties associated with patients at the extremes of age, but arguably to a decline in skills among anaesthetists in general.

It will not be possible to ring fence anaesthesia for the older patient. Firstly, by the year 2040 there are expected to be 4.4 million people over 80 years [4]. The elderly patient is found in almost every surgical specialty, with the obvious exceptions of obstetrics and paediatrics! Confining the older patient to the specialty of anaesthesia for the elderly may mean a diminution of skills among anaesthetists of all grades. Continued exposure to the needs of the elderly is vital to our safe practice. Anaesthetists play an integral part
in the perioperative care of the older patient, and would be in a
good position to work within the multidisciplinary framework.

Advances in surgery and anaesthesia have lead to a rapid
expansion of day-case admissions. This has exposed the
individual requirements of this vulnerable group to an even
greater extent. Our preoperative assessment will have to
broaden to encompass issues such as mental state, ability to
offer valid consent, medications on discharge, nutrition and
mobility. If cognitive function can be anticipated to decline
in the postoperative period [5], then who is at home, how
many stairs to the bathroom and who will be managing the
medications become questions to which we need to know the
answers. For many of us, it has been a long time since we asked.

A recent review by Jin et al. reinforced what those working
with the elderly have known for a long time: ageing alters the response to physiological and pharmacological stress [6]. In addition to addressing cardiac and respiratory complications, this review highlights delirium, stroke, malnutrition and hypothermia as significant problems occurring in the postoperative period. Expanding the clinical brief further, the AAGBI’s guidelines emphasise the need for social circumstances and home support to be included as part of the preoperative assessment, particularly for day case surgery. This has certainly not been part of the anaesthetic ‘work-up’ in the majority of hospitals to date.

How should physicians working in medicine for the elderly respond to this wider view on the part of our anaesthetic colleagues?

Increasing the focus of all clinicians, whatever their speciality, on the needs of the older patient is to be encouraged. Efforts in the past to increase links between individual departments such as orthopaedics, with medicine for the elderly have not lead to significant advances in the overall morbidity and mortality of the older patient after surgery. There is little evidence to suggest that mortality due to renal failure or pneumonia in these units has improved, nor that there has been a reduction in the incidence of more ‘trivial’ problems such as pressure sores or cognitive decline [7, 8].

Perhaps with the advent of a broader, cross-specialty approach to perioperative management, combining skills and knowledge found in anaesthesia with those in medicine and surgery, we will see an improvement in patient care, and with time, a reduction in short-term and long-term complications postoperatively. Augmentation of research activity into the response of the older patients to anaesthesia and intensive care would assist practitioners of all specialties involved in geriatric care in better understanding the implications of ageing on postoperative recovery. Collaboration with physicians in medicine for the elderly would provide feedback to the speciality of anaesthesia on problems raised in the early preoperative/late postoperative periods when the patient has disappeared from our view. Working in teams centred on patient care would facilitate identification of particular areas of risk, and allow for implementation of strategies to address these risks to patient safety. It is inextricably linked to the overall aims of clinical governance and is in the interests of both specialities, the admitting institution, the patients and their families.

The appointment of a lead clinician within anaesthetic departments would ideally act as an impetus for this change to occur, producing increased pressure for the provision of additional nursing and technical resources at intensive care, high dependency and ward level.

Suzanne Crowe
Department of Anaesthesia and Intensive Care Medicine, St Vincent’s University Hospital, Dublin 4, Ireland
Fax: (+353) 1 286 8534
Email: crowesuzanne@hotmail.com

References