RCPE Symposium – Managing Complexity and Uncertainty: Medicine for Older People

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The Managing Complexity and Uncertainty: Medicine for Older People symposium was held on 21 March 2018 at the Royal College of Physicians of Edinburgh

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Introduction

Managing complexity and uncertainty is part and parcel of caring for older people, and these patients are increasingly being managed in a wide variety of healthcare settings. This brings with it challenges, including balancing what medical science can do with what is right for the individual. The Medicine for Older People symposium covered an exciting range of topics from community medicine to intensive care, with excellent updates on some key areas of practice.

Session 1 – Managing complexity in the community

The symposium opened with Dr Helen Mackie (Scottish Government) who gave an overview of Realistic Medicine.[1] She asked why clinicians choose less invasive options for ourselves than those we offer patients. Improving health literacy would allow patients to share risk and decision-making, which might, as a side-effect, reduce over-investigation and treatment burden. Dr Jane Haplin (GP, Sunderland) talked about her role case managing complex community patients, with great benefits for GP practices, care homes and the patients themselves. The most important thing is building trust, ideally over tea and cake. Dr Marie Bateman (Sunderland) described the challenges of setting up a community geriatric service to provide proactive management of older people, including in-reach to facilitate discharges and education for professionals and carers. She stressed the importance of developing relationships and evaluating the impact of new services.

Session 2 – What's new in healthcare for older people?

Dr Alisdair MacConnachie (Glasgow) discussed the complexities of Clostridium difficile, including increasing community acquisition and the role of environmental antibiotic exposure. Stool transplant via nasogastric tube can give an 81% cure rate in recurrent disease.[2] He advised against treating asymptomatic bacteriuria or catheter colonisation. Fever in the returning traveller is simple: consider malaria, typhoid and dengue fever. Dr John Baxter (Sunderland) urged promotion of disease stability in heart failure with ABBA: ACE-inhibitors, beta-blockers and aldosterone receptor antagonists. Additionally, prescribing an angiotensin receptor neprilysin inhibitor (ARNI) instead of ACE-inhibitor reduces mortality [number needed to treat (NNT) = 35] and prevents decompensation (NNT = 36).[3] In chronic obstructive pulmonary disease, Dr Richard Stretton (Dundee) explained guidelines have moved from using forced expiratory volume in 1 second (FEV1) to determine treatment, to symptoms of breathlessness and exacerbation.[4] In idiopathic pulmonary fibrosis there are new drugs, but without clinically significant impact yet. However, there are exciting improvements in lung cancer management for those unable to tolerate conventional treatment, including oral chemotherapy and minimally invasive procedures.

Session 3 – Complexity in older people: a trainee's perspective

A medley of fascinating trainee presentations started with evidence that chest X-ray 'slumpograms' predict poorer outcomes in older patients. Next we learned that adding frailty screening to the GRACE score improved identification of non-frail older patients who had better outcomes after myocardial infarction than previously predicted. A lack of multidisciplinary oral healthcare impacts on patient's health, nutrition and dignity. Clinicians should look in mouths and remember dentition when prescribing. Finally, breathing difficulties were the most common reason for admission

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from care homes, which can be challenging to plan for and distressing for everyone.

Session 4 – Frailty and delivery of acute and complex care throughout the NHS

Dr Charlotte Bates (Northumbria) explained that the Clinical Frailty Score[5] is likely to be adopted by emergency departments. We must get it right first time for frail patients with a lower threshold for CT imaging and aggressive early management. Dr Nazir Lone (Edinburgh) considered discussions around critical care. Cognitive impairment and physical disability are very likely sequelae in older patients. Additionally, futile treatment in intensive care can cause significant psychological trauma to relatives and staff. Mr Iain McCallum (Northumbria) explained that over half of emergency laparotomies are for over 70s, and the emergency laparotomy and frailty (ELF) study is looking at improving outcomes. Discussing morbidity rather than just mortality from emergency surgery is challenging but important. Dr Zoe Wyrko (Birmingham) highlighted that 35% of over 85s are not frail and that frailty must not become a proxy for ageism. The panel examined the difficulties of adding frailty screening and comprehensive geriatric assessment to acute pathways – who, when, what and with what outcome?

Take home messages

There are many circumstances where we must provide proactive, evidence-based treatment for older people, while recognising that frailty limits life expectancy and outcomes. Communication and building trust with patients and caregivers is key. Together we must navigate the complexity and uncertainty, in search of a shared, realistic and personalised treatment plan. We need to start talking about functional and cognitive outcomes from interventions as well as mortality. Ideally, this should be early anticipatory care planning involving the patient. If this is not possible, we should find gentle ways of consulting loved ones. Sitting down with tea and cake can do wonders too.

References

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