MEDICAL PRACTICE

Today's Treatment

Psychological Medicine

The Elderly Mind

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There is a very high incidence of mental disturbance in old age, particularly in people with physical illness. All types of mental disturbance may be encountered, but depression, confusional states, and dementia are the most common and important forms.

Depression

Depression becomes more common with advancing age and is all too often overlooked as a diagnosis. This is an important omission, as effective treatment is possible. The diagnosis may be overlooked because an elderly person, particularly one with physical illness or disability, may be regarded as having sufficient circumstances in his life situation to account for the observed unhappiness or pessimism. In other patients hypochondriacal symptoms may throw the emphasis on to physical disease, so that the mental diagnosis is missed. Alternatively, very severe depression with withdrawal and apathy may be mistaken for dementia. Many depressed old people may remain unrecognized because they put on a brave front for the doctor and appear cheerful superficially, but specific questioning about mood, appetite, and sleep may show the true state of affairs.

Bereavement is a well recognized precipitant of depression in the old, but physical illness is perhaps even more important. Depression often follows stroke, particularly when there is dysphasia, and is one of the more important barriers to recovery

if not recognized and treated. Drugs may also cause depression, and reserpine is by far the most important example. We are also recognizing by routine biochemical screening a surprising number of patients with hypothyroidism who have depression as the main symptom.

Elderly patients with depression are most often treated with tricyclic antidepressants, such as imipramine or nortriptyline. Monoamine-oxidase inhibitors are far less popular, as they are particularly hazardous in the elderly. Electric convulsion therapy has a valuable place still, and should not be denied solely on the grounds of age. There is probably not much difference in practice between the various tricyclic drugs. They all need to be used with special care in the old because of the risk of side effects. They are potent causes of confusional states, and postural hypotension may lead to giddiness and falls. Atropine-like side effects such as retention of urine, blurring of vision, or dry mouth (sometimes severe enough to lead to acute parotitis) may also be troublesome. Dosage, therefore, needs to be cautious, particularly in frail or ill old people. When agitation is prominent and troublesome, a tranquillizer may also be needed. Promazine or thioridazine is suitable, but these too have atropine-like side effects, which may summate with those of the tricyclic drug. Again, cautious dosage is imperative.

Confusion

Mental confusion is common in old age. It is an unfortunate short-coming if doctors, faced with a confused elderly patient, deal with it only at the level of symptomatic treatment. Mental confusion is in fact an important pointer to physical illness, much of it remediable. It may indeed be regarded as one of the main indicators of acute illness in an old person, often replacing such symptoms as pyrexia, rapid pulse, or pain, which typically herald acute illness in younger persons yet be absent in the elderly.

RECENT ONSET OF CONFUSION

When confusion is of recent onset, it is particularly likely to represent a confusional state due to underlying physical disease. The same, however, is true when mildly demented people show a sudden increase in their degree of confusion. Indeed pre-existing dementia appears to increase an old person's vulnerability to the development of a confusional state. Because of the underlying physical disease confusional states have an appreciable mortality, but if promptly recognized and appropriately treated they have an excellent prognosis in terms of mental recovery.

The causes of confusional state are legion, but among the most frequent are acute infections, particularly pneumonias, respiratory and urinary infections, congestive cardiac failure and left ventricular failure, and carcinomatosis.

Among many other alternatives the possibility should be considered of any drugs the patient may be receiving, especially when multiple drugs have been given. Tricyclic antidepressants have already been mentioned, but many other drugs with actions on the central nervous system may be responsible. Perhaps the most troublesome of all are the drugs used in the treatment of Parkinson's disease, the disease itself appearing to predispose to confusional states. The older atropine-like drugs, such as benzhexol, were particularly troublesome, but the newer drugs have their problems. L-dopa causes confusion occasionally, while amantadine does so rather more often in my experience, and furthermore tends to give rise to florid visual hallucinations. Sedatives, tranquillizers, and antiepileptic agents may also be implicated.

Acute stroke may present as a confusional state, and this may be misleading when neurological signs are inapparent. The acute onset of dysphasia, especially if of "jargon" type, may be sometimes mistaken for severe confusion because the patient is talking "nonsense." Epilepsy may also be followed by a period of acute confusion.

Metabolic causes of confusional states include hypoglycaemic attacks, diabetic precoma, uraemia, and severe electrolyte disturbances. Acute delirium may also occur in myxoedema, B₁₂ deficiency, or hypothermia.

MANAGEMENT OF CONFUSIONAL STATES

The most important part of the treatment of confusional states consists in recognizing the underlying physical cause. General therapeutic measures include the withdrawal of all inessential medication, correction of dehydration or electrolyte imbalance when present, and the minimum use of sedation or, better, its total avoidance. Good nursing is of the greatest importance, particularly if this last requirement is to be met. Quiet surroundings without unnecessary changes of staff are helpful, and there should be positive efforts to assist the patient to orientate himself; keeping the room lit at night may help this. It is helpful if the patient can be kept in his familiar home surroundings, if sufficient care is available. Multiple vitamin therapy in large dosage is often given in confusional states but can rarely be justified on rational grounds. In my view it should be withheld in the absence of a positive indication, such as evidence of malnutrition.

Persistent and Chronic Confusion

Long-standing confusion, particularly if it is progressively severe, is most often due to dementia but can represent a confusional state due to persistent physical disease. The main types of dementia are senile and arteriosclerotic dementia, though dementia in association with Parkinsonism is common in geriatric practice. The dementias, typically, have little effect on the patient's general health until a severe stage is reached, so that when an apparently demented patient is also deteriorating

physically the alternative possibility of a chronic confusional state should be especially considered. Important possibilities include myxoedema, B₁₂ deficiency, "apathetic" thyrotoxicosis, or unrecognized uncontrolled diabetes. These, though not particularly common, are potentially curable causes. A common but generally irremediable cause is malignant disease.

The possibility of other diseases of the central nervous system also needs to be considered—for example, chronic subdural haematoma, and benign or malignant cerebral tumours—while non-communicating hydrocephalus and general paralysis of the insane are important as uncommon but treatable conditions. The possibility of depression mimicking dementia should not be overlooked.

Dementia

There is no effective treatment for the common dementias of old age. There have nonetheless been transient enthusiasms for a succession of ineffective remedies over the years. The current vogue is for cerebral "activators" and vasodilators. Though a number of clinical trials would appear to have demonstrated some marginal effect for some of these, they have not been shown to be of any practical clinical value, and I would not recommend their use.

Sedatives and tranquillizers may be helpful in the management of dementia, as well as in the acute confusional states, but as a general rule their use should be kept to an absolute minimum as side effects are both common and dangerous. Dosages should thus be carefully regulated to the patient's needs and may need to be reviewed as the clinical situation alters. The most important side effect of sedatives and tranquillizers is that they may increase confusion if used inappropriately. Barbiturate night sedatives are held in special suspicion by geriatricians, who generally avoid their use. There is much to be said for giving a very mild hypnotic such as meprobamate 400-800 mg, which is less likely to leave the patient with a hangover the following morning than are many alternative drugs. There are many possible choices of drugs for daytime sedation, but the phenothiazine group are probably the most useful and promazine or thioridazine the most suitable. Chlorpromazine is best avoided in elderly patients because it is prone to cause side effects, postural hypotension, drowsiness, and jaundice being particularly common. Trifluoperazine and prochlorperazine should be avoided as they frequently induce Parkinsonism, often of considerable severity. Depot fluphenazine is best avoided in frail or ill old patients, but can benefit fitter patients with persistent behaviour disturbance, who are unwilling to accept oral therapy. Old people tend to require a reduced dose (12.5 mg), and the injection may have to be repeated only at three- or four-weekly intervals.

General measures are often of far greater importance than drug therapy. Not the least of these is providing advice and sympathetic listening for the caring relatives. A variety of local authority services may be of value. The demented patient living alone may be helped by provision of home help and meals-on-wheels. Where incontinence is a problem, the incontinent laundry service or the provision of disposable incontinence pads may help. Many may be helped by attendance at a day centre. Holiday admission to a local authority home or a geriatric or psychiatric department may give a vital break to the caring relatives. However, such admissions are not without some risk, as the move to unfamiliar surroundings may lead to a temporary increase in disturbed behaviour.

Other useful measures may include supervision by the health visitor, assistance with bathing from the district nurse, or the provision of domiciliary chiropody. These last two may be helpful even when the patient lives with a caring relative, for patients commonly refuse to allow their relatives to bath them or cut their toenails while allowing an outsider to do so.

Institutional care may finally become necessary for a minority of elderly demented patients. Where the problem is one of a

simple failure to maintain independent existence even with the full support of social services, but incontinence and mobility are preserved, and there is no significant behaviour disturbance, admission to a local authority welfare home will be appropriate. Old people in need of this may have little insight and may not accept this course. In such cases the social worker's skills will be

needed to gain the old person's acceptance. Where incontinence, behaviour disturbance, or immobility make hospital care the necessary alternative, the choice between psychiatric or geriatric admission will be determined by the balance of behaviour disturbance on the one hand and immobility or associated physical illness on the other.

Surgery of Violence

Report on Injuries Sustained by Patients Treated at The Birmingham General Hospital Following the Recent Bomb Explosions

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Summary

As a result of recent bomb explosions a total of 82 patients were treated at the Birmingham General Hospital, 61 with minor injuries. Bomb injuries may be divided into three main groups due to the blast effect (such as blast lung and ruptured tympanic membranes), the flash (such as burns to the exposed part of the body), and shrapnel (which may cause a wide variety of injuries). The amount of warning of such explosions is usually minimal, and so the prepared accident schemes of most hospitals are inappropriate. If the disaster occurs outside normal working hours much responsibility initially falls on the resident staff. This report gives some idea of the type of injuries they are likely to see.

Introduction

On the evening of 21 November 1974 two bombs exploded in two crowded public houses in the centre of Birmingham. Eighty-two patients were seen and treated in the General Hospital. Of these, 61 were suffering from minor injuries and were discharged after treatment in the accident department. Twenty patients were admitted, one of whom, suffering from extensive burns, was immediately transferred to a burns unit, where he subsequently died. One further patient died in the accident unit.

Of the 19 patients admitted none subsequently died, and the following is an account of their injuries and immediate management.

Report of Cases

CASE 1

On admission this patient, a 21-year-old female, was found to be hypotensive and to have the following injuries: (a) Penetrating wound

left lower abdomen with prolapsing intestines; (b) large wound with marked tissue loss left upper arm; (c) multiple facial lacerations; and (d) multiple shrapnel wounds to leg, scalp, and left upper arm.

She was taken to the theatre after resuscitation and laparotomy was performed. Blood and bowel contents were found in the peritoneal cavity. A large piece of shrapnel had entered the abdominal cavity low in the left iliac fossa and had traversed upwards, ending in the lumen of the stomach. Two perforating injuries were also found in the ileum and in the transverse colon. These were treated by excision and anastomosis. Peritoneal toilet was performed and the abdomen closed with drains. The entry wound on the abdominal wall and the large area of tissue loss in the upper arm were treated by excision, and the wounds packed. X-ray of the leg showed a piece of shrapnel in the upper tibia.

CASE 2

On admission this patient, a 22-year-old female, was shocked and required immediate resuscitation. She had sustained: (a) Open fracture of skull involving the frontal sinus, containing various wood and bone fragments; (b) open fracture of left tibia with extensive soft tissue damage containing much debris; (c) multiple facial lacerations and bilateral perforating eye injuries; (d) flash burns to exposed parts; and (e) additional minor lacerations.

In the theatre excision of her wounds was carried out and the fractured tibia supported in plaster-of-Paris. Some of the wood fragments were removed from her eyes, and the frontal sinus was cleaned and packed. Dressings were applied to the burnt areas.

CASE 3

On admission this patient, a 27-year-old male, was complaining of severe dyspnoea, with pain on breathing and a persistent desire to cough. He was restless with marked tachypnoea. His pulse was 120, and the blood pressure was 90/70 mm Hg. Both sides of his chest were moving equally, with good air entry in all areas without added sounds. He was also suffering from superficial flash burns to both lower legs and the face, the former being grossly contaminated by wood and metal fragments driven in by the blast. At this time it was commented that he appeared more shocked than his injuries suggested, but no other cause could be detected. In particular his abdomen was soft and pain-free on palpation. Chest x-ray showed "blast lung" (fig. 1) injury, and he was curarized, intubated, and ventilated. Hydrocortisone and antibiotics were begun. Two pints (1.1 l) of blood was given. Six hours later his blood pressure, which had recovered initially, showed a fall. This was accompanied by a rising pulse. No

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