MEDICAL PRACTICE

Medicine in Old Age

Treatment of the "Irremediable" Elderly Patient

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Here is a title as full of questions as a pomegranate is full of seeds. How does one treat the irremediable? If the irremediable is treated, is it irremediable? Is "to treat" less than "to remedy"? And why the contiguity of "irremediable" and "elderly"? Are all elderly irremediable? Are all irremediable elderly? These questions concern attitudes. They are important because attitudes rather than expertise determine the outcome of treatment.

Attitudes

There was a time, before I entered on that state of grace peculiar to the geriatrician, when the phrase "treatment of the irremediable elderly patient" would have concisely defined geriatrics for me. Later, when I began to work in geriatric medicine, I would have indignantly rebutted the implication that anyone or anything old was irremediable; for did we not profess our faith in the liturgical phrase: "an ill old person is ill because he is ill and not because he is old"? Now, after years of the pragmatic practice of my art, I welcome the recognition that we geriatricians, and not we alone, devote much of our activities to the treatment of the irremediable. Few diseases at any age are cured; most whisper to the patient of their continuing presence, long after the ink is dry on the discharge letter. The treatment of the irremediable is both a worthy objective and an accurate description of much modern medicine.

Who Are the "Irremediable"?

First who are they not? They are not, and must not be confounded with, the undiagnosed. They are not the confused, the incontinent, the senile. Confusion and incontinence are symptoms of impaired function of the nervous system and bladder. The words give no information on cause or cure. The term "senility" offends the geriatrician; it requires an effort of will even to write it. In my mind's eye I see the word garbed in a cloak of black, with the blood of ill old people dripping from its lanky fingers. A melodramatic image perhaps; but how often has the attachment of this label to an ill old patient spelt the end of diagnostic and therapeutic endeavour, and condemned him to a slow death by stewing in his own urine?

Every ill person of whatever age has a right to a diagnosis; and only when this has been established is it possible to talk about remediability or irremediability. "Senility" is not a diagnosis; it spells relegation for the patient and abdication by the doctor. I look forward to the day when the word "senility" will have disappeared from acceptable medical terminology, as the word "insanity" has done.

Irreversible Disease

Many pathological processes which are common in old age are at present irreversible. These include neoplasm, atherosclerosis, and neuronal degeneration—one or more of which accompany most old people on their last long journey to the grave. It is among these sadly disabled people that the doctor seeks opportunities for effective intervention; and opportunities abound.

Treating the Irremediable

A man of 69 was seen for the first time two months after the onset of a right hemiplegia, and after failure of a trial of rehabilitation. The patient was bedfast, there was no return of movement to the affected side, he had a catheter in his bladder, and he was unable to speak or to comprehend. He had been

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found picking faeces from his rectum and smearing them on his locker. He disturbed other patients by shouting. He had struck out at the nurses, and given his wife a black eye.

First the wife was interviewed. Who was this man? What kind of person was he? He had been a good husband, a loving father, abstemious, a steady and conscientious worker, a keen amateur gardener, a fit man, proud of his good health and work record, inclined to disparage those less healthy than himself. What did she know of his illness? What did she say to him when she visited? She talked to him; sometimes, she thought, he understood her; sometimes he pushed her away and turned his head away from her. Once he lifted his hand to her, a thing he never did in his life. Did she ever cry? She had gone home and wept to herself every night since his illness began, but hadn't told anyone. Did she think he was going to die? She didn't know, but sometimes she found herself half-wishing that he would, and that made her feel wicked. Had she told this to anyone? Not a soul. Had anyone told her what was likely to happen to her husband? No one.

Next the patient was examined. His tongue was dry, his rectum packed with hard dry faeces. There was a pressure sore on his heel; his urine was infected; his haemoglobin level had dropped. He couldn't speak or understand language, but he could pick up situational clues. He could sing "Tipperary" with the words matching the tune; he could count up to ten if he was started off; he could correctly identify "bottle," "tumbler," "spectacles." He could build toy blocks one on top of the other. He could match dominoes. He had no movement in his arm or leg, but he could sit up in bed with minimal support. Suddenly, out of this irremediable situation, all kinds of opportunities of effective intervention were appearing, like crocuses piercing the wintry soil.

The nurses began first. They put him on a fluid chart, gave him adequate nourishing drinks, talking to him as they did so, telling him what they were trying to do, encouraging him to take the cup and drink himself, trying to find out what he would like—orange juice, milk, tea, beer, perhaps even a glass of whisky. They found his pipe, his false teeth, his razor and comb. They emptied his bowel, they gave him fruit. They put him in the bath twice a day, gave him a support to take pressure off his painful heel. They spigoted his catheter, emptied his bladder every two or three hours for a day or two, then tried him without the catheter, carefully showing him how to use a bottle, and ensuring that there was one where he could reach it on his left side. They sent for his clothes and shoes. They got him up, dressed, shaved, hair brushed, and showed him his image in the mirror. With the help of the physiotherapist they put him in a self-propelled wheelchair and taught him how to use his good foot to drive himself about.

The physiotherapist mobilized his limbs and trunk, stood him up with support to give him the feel of the ground under his feet. The occupational therapist trained him to assist in his own dressing. The speech therapist discovered routes of communication by gesture and situational clues, and taught the relatives and the nurses how to exploit these. The doctor treated the accompanying urinary infection and anaemia, relieved pain, ensured sleep, conferred with relatives and with the therapeutic team. In the end the patient did not fully "recover"—but he regained self-respect and a limited degree of independence. He became much less demanding and frustrated. He was able to go on outings, and could spend an occasional weekend at home. He took up indoor gardening and filled the dayroom with pot plants. We did not "cure" him of his irremediable disease, but we were privileged to watch the tide of his personality begin to flow again over the dry sand of his disability.

Principles

All this required the full geriatric team. In the more usual setting of the patient's home or a general hospital ward the same basic principles apply. These are:

- (1) Listen carefully to the patient. He will tell you what needs to be done.
- (2) Make yourself available to talk to relatives in privacy. They too have needs.
- (3) Information is the fuel of opinion. So do not hesitate to investigate, but keep the investigation relevant to possible treatment.
- (4) No form of treatment should be rejected dogmatically; always the benefits should be weighed against the hazards. To secure comfort in the last days of life risks are justified.

Investigation and Surgical Treatment

The undiagnosed are often the unremedied; so no patient should be denied investigation. Evaluation of the haemoglobin, blood urea, electrolytes, and blood sugar is a minimum. A chest x-ray film may show unsuspected cancer, tuberculosis, or osteomalacia. Sternal marrow examination is well tolerated and should not be withheld on grounds of age alone. Barium meals seldom lead to useful treatment. Barium enemas are more often helpful, but may be frustrated by non-retention or by faecal accumulations. Urine cultures often yield organisms, but their eradication less often relieves symptoms.

Surgery and anaesthesia are well tolerated, and should not be withheld if they offer hope of improvement in the quality of life. Postoperative rehabilitation may be very successful, and old people can learn to use colostomies or artificial limbs.

Relief of Symptoms

Intractable pain is mercifully rare in the elderly. Its adequate control requires timely relief with non-narcotizing doses of potent drugs, a technique which needs organization, but which yields benefits by relieving the fear of having to endure pain.

Dyspnoea is more common and more difficult to control. Good posture is best obtained at home by nursing the patient in a chair. Adequate diuresis is sometimes resisted, because the patient and his relatives become exhausted by frequent potting. A catheter should be used without hesitation. Oxygen usually causes more anxiety and tension than it relieves.

Anorexia is treated by indulgence. Favourite foods and beverages are prescribed; and a glass of whisky or sherry acquires a new and glorious flavour through having been prescribed by the doctor.

Treating dehydration is important, since ill old people do not experience thirst. Their fluid intake should be charted, aiming at an intake of 1,500 ml a day. If they have difficulty in swallowing they should use a straw or a child's feeding cup. Their fluids can be given in the form of jelly or liquidized foods.

Constipation is compounded by lack of roughage in the diet, lack of physical exercise, poor somatic muscle tone and evacuating power, inadequate opportunity, and fear of discomfort, quite apart from any autonomic dysfunction. The provision of a commode which the patient trusts and is prepared to use is as important as the prescription of the correct laxative or suppository. Regular enemas are required; regular rectal examinations are even more important.

Sleep disturbances send the doctor off on a prescription odyssey, sailing from drug to drug in an endeavour to secure sleep by night and wakefulness by day. From time to time one stops all drugs and starts again at the beginning with one aspirin at 9 p.m.—and sometimes this works. The hot milky drink may secure sleep at night, but the full bladder may alert early waking.

Psychological Features

Doctors are often urged to allow old people to die with dignity. I find this very difficult to do, since I associate dignity with black

silk hats, the measured tread, the grave nod of the head—at very least with ambulation, continence, and mental clarity—features which are lacking as death approaches. Near the end of life some old people become undignified, remove their clothing in public, and revile their dear ones with obscenities. Others lose self-control and become irritable, demanding, and selfish; refuse to be left alone; moan repetitively; ceaselessly ask for drinks; or demand to be taken to the lavatory, do nothing, then wet themselves. These anxiety symptoms are hard for relatives to bear; and many have confided to me that the last months of a loved parent's life were the worst they had ever experienced.

These situations test to the utmost the doctor's capacity to

treat the irremediable. He must listen, sympathize, reassure, explain. The relatives require our ears and our time, but the doctor can also give practical help by arranging day hospital care or short-term admission.

Conclusion

Much of medical work is concentrated on the final months or year of life. The curative role of the doctor is being attenuated. But equal or greater professional satisfaction can be found by the skilled and perceptive treatment of "the irremediable."

Occasional Survey

Surgery in Management of Patients with Leukaemia

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Summary

Though leukaemia is not a "surgical" disease, the need for surgery in patients with leukaemia is increasing. Acute surgical problems in such patients present diagnostic difficulties, and accepted surgical principles do not necessarily apply in patients with very abnormal haematological and immunological features. The improved prognosis in some types of leukaemia means that elective surgical procedures, which formerly would not have been considered, may now be applicable just as they would be in patients with non-malignant conditions.

Recent advances in the management of the leukaemias include several surgical procedures—for example, to facilitate intravenous or intrathecal therapy. Splenectomy is of value in chronic lymphocytic leukaemia when the correct indications are present, while early elective splenectomy, when no classical indications are present, may have a useful role in the management of patients with chronic granulocytic leukaemia.

Introduction

Leukaemia has long seemed an example of a malignant disease where surgery has little place. The diagnosis is established without resort to operation. While laparotomy for staging purposes has a role in Hodgkin's disease,¹ and possibly in other malignant lymphomas,² such investigation seems needless in leukaemia, where the disease appears to affect from the outset all those parts of the body which are freely accessible from the vascular system. Leukaemia is certainly not curable by surgery, while the existence of reasonably effective medical treatment does not encourage an investigative surgical approach. Furthermore, thrombocytopenia

and neutropenia, with enhanced risks of haemorrhage and infection, often make the patient with leukaemia an unattractive surgical proposition. Not surprisingly, surgical intervention in leukaemia patients has generally been restricted to urgent procedures, such as the incision of abscesses or appendicectomy for intercurrent acute appendicitis. In the recent past elective surgery even with good indications was often denied to leukaemic patients, particularly those with any form of acute leukaemia, since before the advent of effective antileukaemic therapy the median survival in these diseases was less than three months for both children and adults.³

Advances in the treatment of the leukaemias are altering this picture. In some cases improvements in prognosis have made the indications for elective surgery in a leukaemia patient almost identical with those for the same operation in a patient without leukaemia. Some facets of the medical treatment of the leukaemias can be greatly facilitated or their applicability broadened or their effects improved by various surgical procedures.

Surgery as Part of Initial Treatment

The untreated patient with acute leukaemia is often neutropenic and may have a serious infection at the time of diagnosis. Treatment for the infection is sometimes necessary before embarking on antileukaemic therapy, which in the initial stages usually worsens the neutropenia and may also cause immunosuppression. Surgical drainage of pus or extraction of an abscessed tooth are indicated as they would be in any other patient. If anything, the indications are stronger in the patient with leukaemia, since his ability to overcome infections, even with the aid of antibiotics, is reduced. Sometimes more drastic surgical procedures are indicated before other treatment is begun.

Case History.—A 55-year-old man presented with acute myeloid leukaemia. Eight years previously he had sustained an injury to his left hand. Despite a partial amputation he had a chronic osteomyelitis which discharged occasionally. On examination there were no clinical or radiological signs of activity and the sinus had healed. His leukaemia responded inadequately to initial chemotherapy. Before starting more intensive chemotherapy his

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