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Acutely ill older people in the corona era

OPINIONS

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The COVID-19 pandemic will affect older people and put health personnel to the test. We wish to draw attention to some main principles in acute geriatric medicine.

Experiences from China and Northern Italy show that many of the oldest among us will face serious illness as a result of COVID-19, and that mortality is highest among patients older than 80 years (1). Among the oldest, the proportion with comorbidity is higher than in younger age groups. A greater number of older people are malnourished and have reduced physiological reserves, or have chronic impairment in one or more organ systems. Both chronic illness and age-related physiological changes contribute to vulnerability among older people and increase the risk of serious illness from influenza, COVID-19 and other infections. In cases of influenza, pneumonia and sepsis, mortality is higher among older than among younger patients. It is not surprising that mortality is also higher among older people with COVID-19.

Older people often have atypical symptoms

Older people with acute illness, especially infections, often have discrete and diffuse symptoms. Common diagnoses at admission to hospital in this patient group include acute functional impairment, falls and delirium. Dehydration and malnutrition may dominate the symptom profile, but these are frequently caused by insufficient intake of fluids and nutrients because of an acute underlying disease. In a quality-improvement project among patients admitted to an acute geriatric ward, we found that one in three had delirium and one in four had fallen in the 24 hours prior to admission (2). These symptoms appear very frequently in acutely ill older patients and will most likely be dominant also for COVID-19. Fever and cough may be absent or less prominent. However, a key clinical sign of COVID-19 is hypoxemia, which can be the mechanism that underlies both delirium and other acute functional impairment (3).

Diffuse symptoms in older patients will challenge our diagnostic assessments. Who should be tested for COVID-19, and who should not? Our advice is that the indications for testing should be very liberal for older people with acute functional impairment, including in the absence of fever. Accurate diagnostics will put us in the best possible position to make treatment decisions.

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Age should not be the only criterion

The question of prioritisation in the health services has become far more relevant as a result of the COVID-19 pandemic. We believe that using age as the only criterion for setting priorities is not appropriate. Older people who belong to the fittest subgroup in their age range may have the same life expectancy as an ill and vulnerable younger person. It is thus essential to assess frailty and comorbidity in the acutely ill in order to determine their treatment level. In geriatric medicine we normally have both the time and resources needed to decide such priorities with the aid of a broad, interdisciplinary geriatric assessment (4). Most likely, we will not have the same opportunity if a large number of older people fall ill at the same time.

Typical characteristics of frail patients are weight loss, cognitive impairment, reduced mobility and decline in the functions of daily living. As an aid in assessing frailty we propose the use of a structured instrument. The Clinical Frailty Scale (CFS) is available in Norwegian translation (5), takes little time to

complete and is already being used to some extent in acute and intensive care medicine. It has proven to be useful both as an aid in making treatment decisions (6) and for assessment of prognosis in emergency admissions (7).

Treatment decisions must be made in nursing homes, in accident and emergency departments and in hospital wards with no access to specialist competencies in geriatrics, or a geriatric team. Some will claim that nursing home patients with COVID-19 should not be admitted to hospital. However, the nursing home population is very heterogeneous. Some are relatively fit older people who are on short-term stay for rehabilitation, while others suffer from severe dementia and need help with all activities of daily living. There is also considerable local variation in the nursing homes' capacity to treat seriously ill patients. Therefore, there may be good reasons to admit acutely ill frail patients, with or without COVID-19, to hospitals, even when they will not need treatment in the intensive-care ward. Individual assessments must thus be made, and we recommend advance care planning for all patients in nursing homes.

End of life care

A decision not to admit the patient to hospital or not to provide intensive care should not deprive the patient of the opportunity to receive good palliative treatment and care. In COVID-19, respiratory failure and dyspnoea are described as the most serious symptoms. The national guidelines for end of life care contain recommendations for symptomatic treatment of dying patients. For patients with dyspnoea in the final stage of life, treatment with opioids should always be considered, possibly with the addition of benzodiazepine for the accompanying anxiety and distress. The guidelines also provide useful input on communication, co-determination and decision-making processes (8). Geriatricians are available in most hospitals, and we wish to help in providing assessments and decision-making support for our colleagues, both in and outside of hospitals.

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