Multimorbidity and polypharmacy in the elderly is challenging. Specialist outpatient falls clinics can provide an important service, but GPs also have a considerable responsibility

Tendency to fall in older people

Unsteadiness is a significant problem which reduces the quality of life of many of our older patients. The majority who have these types of symptoms are treated by their GP. GPs have many elderly, multimorbid and multimedicated patients. Requirements for optimal control of hypertension, heart failure and diabetes as well as the use of antidepressants, sedatives and hypnotics increase the risk of adverse effects in the form of orthostatism, conduction disorders and psychopharmaca accumulation. There is a great risk of over-treatment of a patient population that is in essence vulnerable – we know that postural control ability decreases with age in a complicated interaction between sensory signals, central processing and muscle activity (1).

In this issue of the Journal of the Norwegian Medical Association we present a case report (2) and a descriptive study (3) of the first 111 patients at a multidisciplinary outpatient falls clinic at Oslo University Hospital, from its commencement in 2008 until 2011. The study encompasses patients living at home and with a tendency to fall, referred by a GP, emergency department or other hospital departments. Conditions related to the home, such as type of residence, stairs, furnishings, carpets and so on were not investigated. The patients had an average age of 82 years. The majority were women with a high disease burden and reduced walking ability, and almost three-quarters used walking aids when outdoors. All had at least one known chronic disease, and more than one third had three or more. Polypharmacy was extensive, half used psychopharmaca and 70 % used drugs for cardiovascular disease.

Not unexpectedly, orthostatism, vitamin D deficiency and carotid sinus hypersensitivity were found to be frequent causes of unsteadiness. Rare findings of colon cancer, subdural haematoma and normal pressure hydrocephalus were also made. The most frequent interventions were exercise, changes in drugs and pacemaker implantation. The study is descriptive, and the effect of the interventions was not investigated.

The articles provide an update on the boundary between assessment of a tendency to fall in general practice and in the specialist health service. It is commendable that the authors are the first to present a patient population and findings from an outpatient falls clinic. This provides new insight into the problem of unsteadiness among the elderly. The findings are made in a referred, selected patient group, but are nevertheless also relevant for general practice. The phenomena will be much the same, while the prevalence will differ.

The regular GP scheme regulations, Section 25 (4) assign GPs the responsibility to coordinate drug treatment for the inhabitants on their list. The regulations describe in some detail how GPs are to carry out this task, which is a natural and important responsibility. The introduction of electronic prescriptions has provided GPs with a new way of obtaining a picture of which drugs are being used. However, it is a challenge to maintain a full picture and continuously update the list of drugs used, and to provide the patient, municipal partners and multi-dose pharmacies with a relevant list at any one time. GPs increasingly use an electronic tool for medicines reconciliation (5), developed by the Norwegian College of General Practice in collaboration with central health authorities. The tool enables a well-presented reconciliation of medicines in use, for example when a patient is discharged from hospital and changes have been made to his/her medication. But experience shows that this necessary and important work is very time-consuming.

It is, and remains, an absolutely key task for GPs to assess use of drugs in their patients on a continuous basis. When it is known that an elderly person is unsteady, feels dizzy or has similar symptoms, it is the GP's responsibility to conduct a broad clinical assessment of the possible causes. This means reviewing medication, monitoring blood pressure while supine and standing, assessing cardiological, neurological, haematological and biochemical status (including vitamin D status), vision, cognitive function etc. In addition, the GP should work with the municipal home-care nurse, and with the occupational therapy and physiotherapy service with regard to recording of symptoms and implementation of any measures to be taken in the home.

Opinion will certainly be divided with regard to how the specialist health service should align its services with any specialist outpatient clinics, such as the outpatient falls clinic at Oslo University Hospital. Of course we need a specialised health service to deal with patients with the most difficult, complex and rare conditions, and when for various reasons the treatment in the primary health service fails. But an increasingly fragmented specialist health service is a challenge, especially with regard to encounters with the multimorbid elderly. Geriatric departments and outpatient clinics are important broad-based services which are insufficiently developed. According to the description of the work of the outpatient falls clinic, there also appears to be a more coherent approach here than is seen in other specialist outpatient clinics.

The authors conclude by saying that there is no reason to delay offering falls assessment at geriatric outpatient clinics and making referrals for strength and balance training for elderly people who fall. This appears sensible.

However, for my own part it is more natural to propose a challenge for GPs and municipalities: GPs must continuously critically assess medication for the elderly patients on their list, including treatment targets for various risk factors and chronic diseases. This also applies to targets set for medication that is initiated during hospitalisation. The usefulness of various preventive medicines for the elderly is poorly documented. At the same time, good collaborative routines must be developed between GPs and the other municipal health services. Activity and exercise services for the elderly must be further developed, and elderly individuals should, for example, receive specific advice about activity and exercise. Last, but not least, we need more knowledge about the tendency to fall in the population in which these patients are most frequently found, namely in general practice.

Polypharmacy and passivity are a high-risk sport. The height of the fall is not great, but it is still dangerous.

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The author has completed the ICMJE form and declares no conflicts of interest.

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