Prognosticating Geriatric Frailty

SHELLY GARONE, MD, FACP

ASSISTANT PHYSICIAN IN CHIEF

KAISER PERMANENTE

NORTH SACRAMENTO VALLEY


DILBERT
I'M WELL ON MY WAY TO AN EARLY DEATH FROM OVERWORKING.
www.dilbert.com scottadams@aol.com
I EXPECT A VISIT FROM THE GRIM REAPER ANY DAY NOW.
YOU DON'T LOOK GRIM.
UNLIKE YOU, I LOVE MY JOB.
12/19/02 © 2002 United Feature Syndicate, Inc.

About me

If you could choose….

Where would you prefer to die?

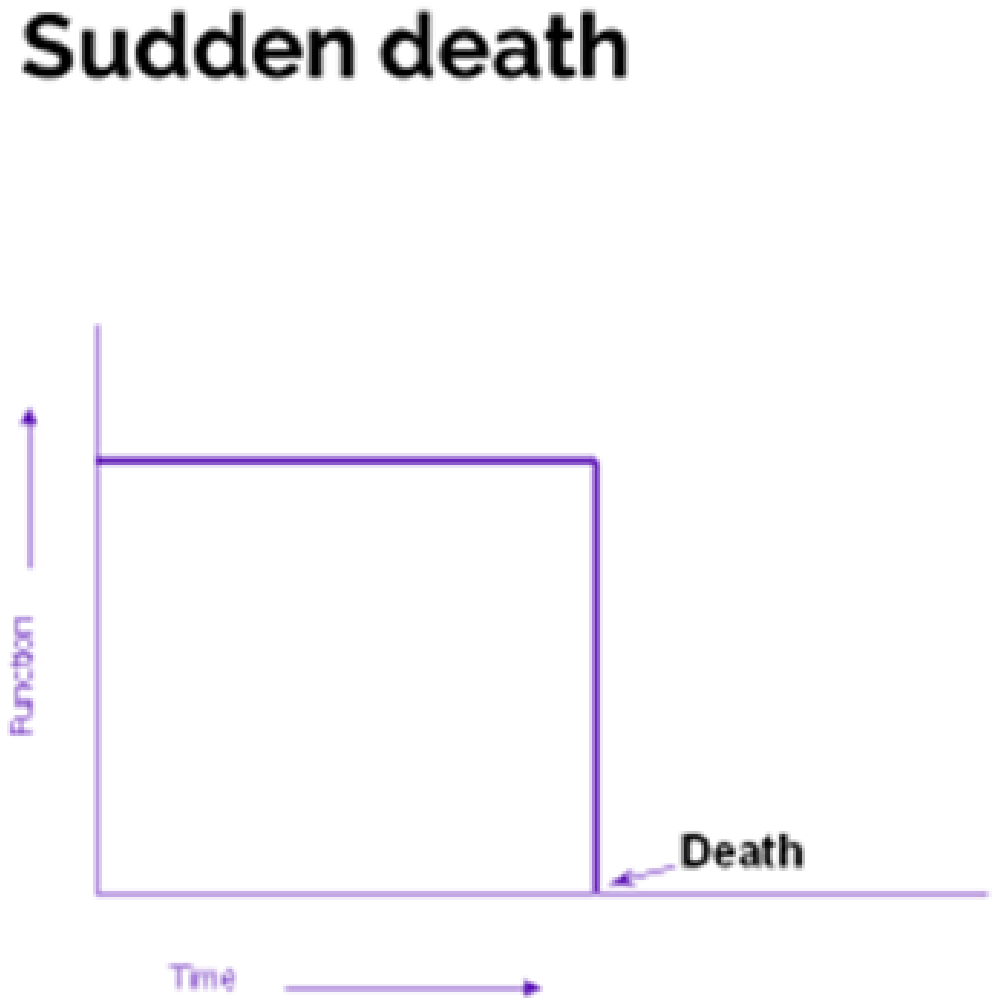
90% of Californians want to die at home

25% of Californians get their wish

If you could choose….

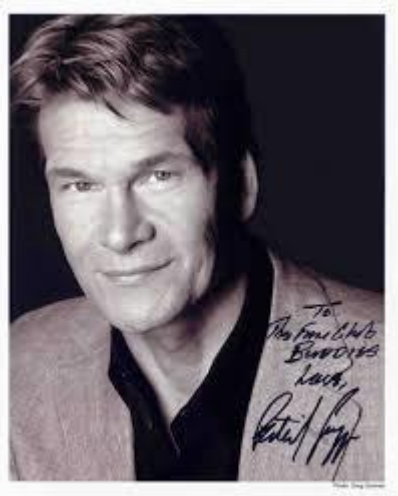
Of what would you die?

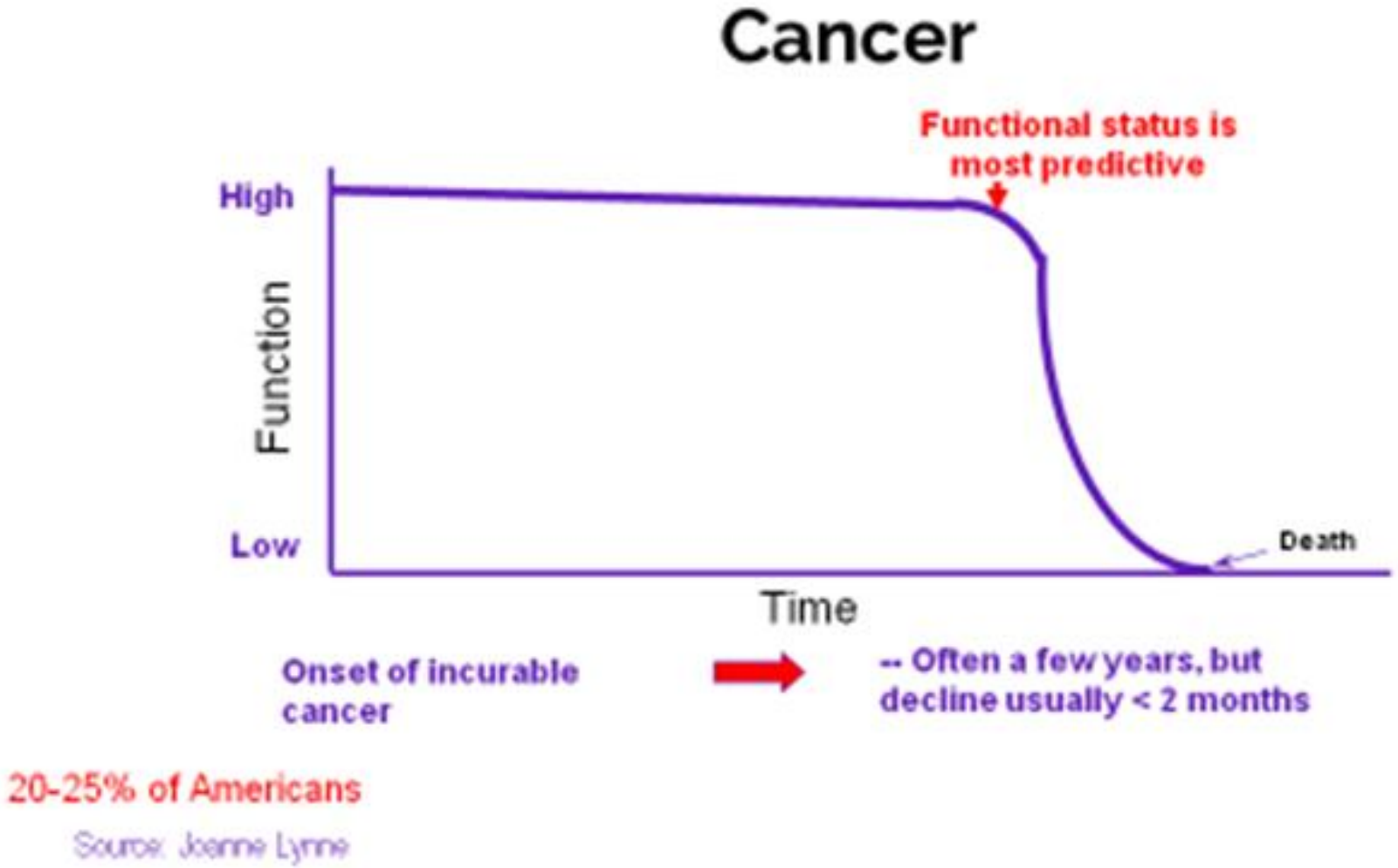
Sony Bono



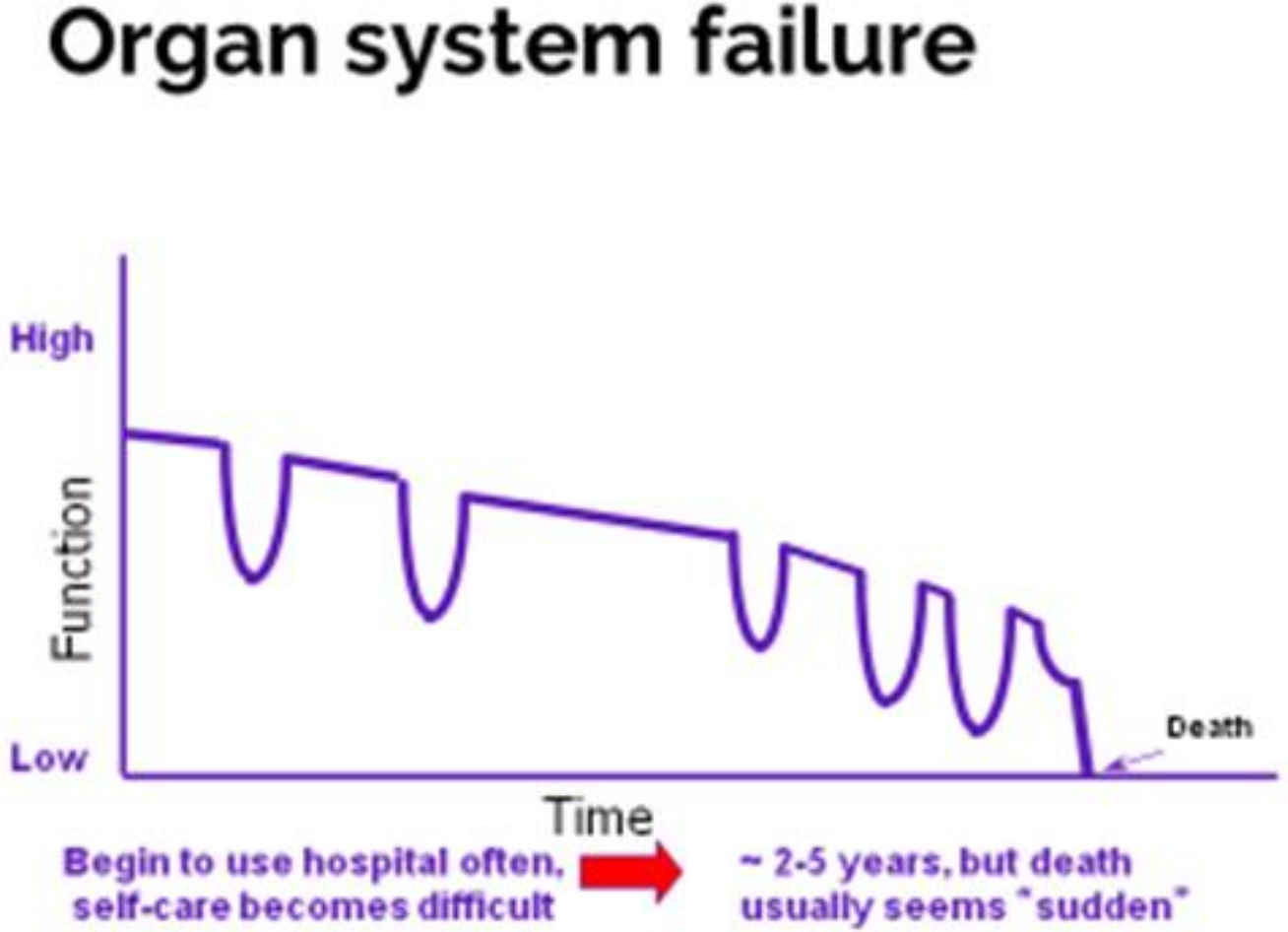
10-15% of Americans

Patrick Swayze





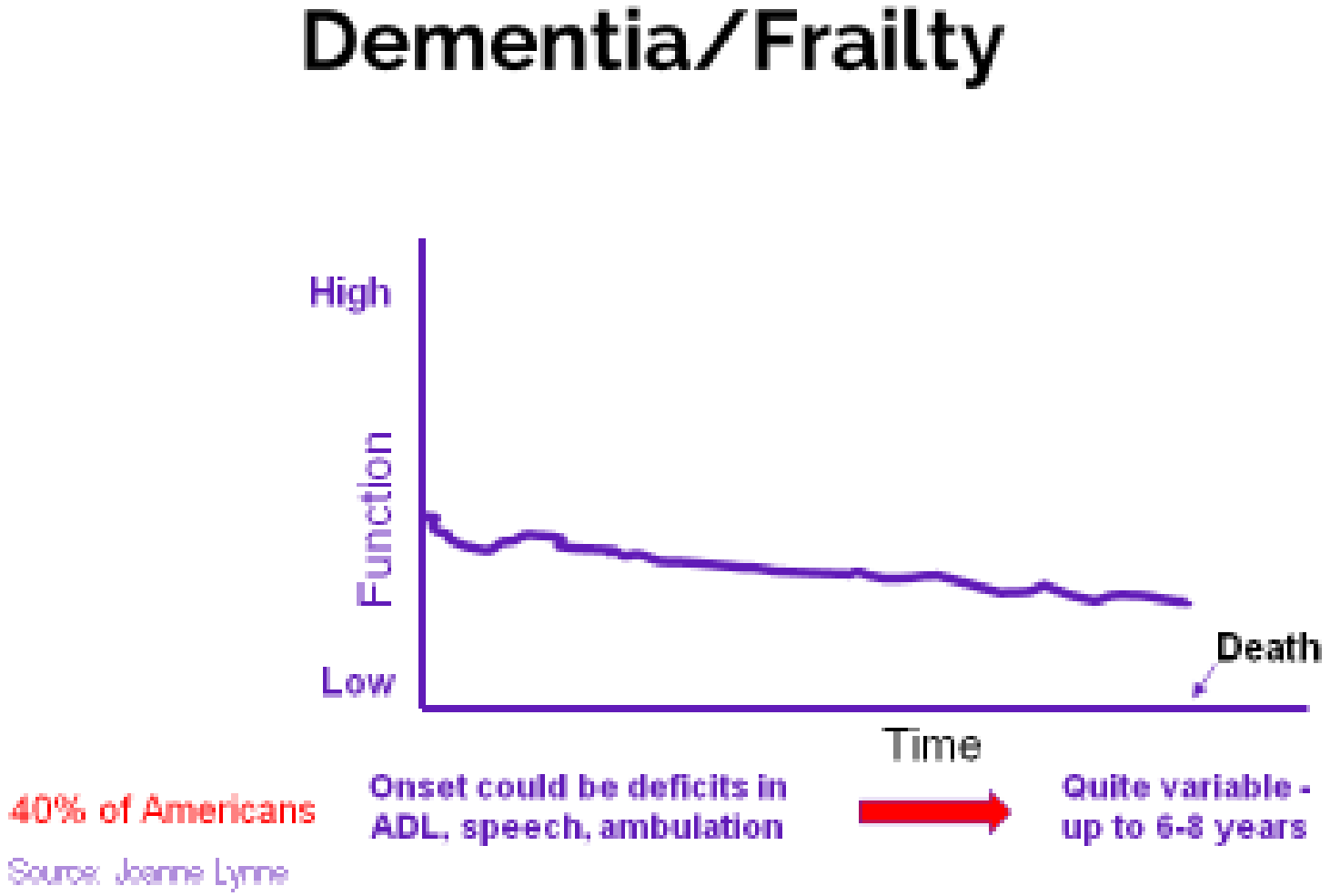
Dean Martin



20-25% of Americans

Source: Joanne Lynne

Ronald Regan



Today

We recognize frailty and related implications in meeting care needs of older adults

We utilize functional status to assess prognosis and guide critical conversations

How might these two elders differ?

How might these two elders differ?

80 y/o sustained a hip fracture after falling off the roof

Repaired with ORIF under spinal anesthesia

Returned home POD #3

80 y/o sustained a hip fracture falling from the toilet

Repaired with ORIF under general anesthesia

To SNF on POD #2

Never returned home

How are these two elders different?

Frailty defined

The condition of being weak and delicate

Vulnerability arising from dysregulation of multiple physiologic systems

Syndrome of physiological decline in late life, characterized by marked vulnerability to adverse health outcomes

Probably NOT “weakness in character or morals”

Frailty

Contributes to increased risk for adverse outcomes

- Procedural complications
- Falls
- Institutionalization
- Death

Forerunner to falls, fractures, delirium, incontinence, cognitive decline

NOT defined by age alone

- BUT, 24% age 90-94, 40% age 95 or greater

Physiologic vs psychosocial

Risk factors

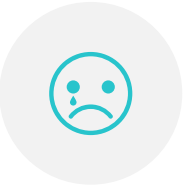
AGING

PHYSIOLOGICAL COMORBIDITIES

LOWER EDUCATIONAL LEVEL

CURRENT SMOKER

SINGLE



DEPRESSION

INTELLECTUAL DISABILITY

Pathophysiology

- Endocrine – decreased HGH, steroid, vit D
- Immune – increased cortisol, CRP, IL6, clotting factors
- Dysregulation of autoimmune system
- Bone marrow failure

Differential diagnoses

- Depression
- Cancer
- PMR
- Thyroid dysfunction
- CAD, CHF, PVD
- CKD
- MDS, anemia
- Vitamin deficiencies
- PD, dementia

How do you decide how bad it is?

Over 67 tools to measure frailty

- Physical Frailty Phenotype
  - Grip strength and walking speed
  - Weight loss
  - Exhaustion
  - Weakness (decreased grip strength)
  - Slow walking speed
  - Decreased physical activity
- Frailty index
  - 20 questions about clinical and functional status

Concordance among the tools varies between none and high

Bottom line?
It depends

An easier tool: FRAIL scale

Fatigue: y=1, n=0

Resistance: y=1, no=0

Ambulation: y=1, n=0

Illnesses: >5=1, <5=0

Loss of weight: y=1, n=0

Have you felt fatigued most or all of the time in past month?

Do you have difficulty climbing a flight of stairs?

Do you have difficulty walking one block?

Do you have HTN, DM, CA, COPD/ILD, CAD, CHF, CVA, CKD, DJD, asthma, angina?

Have you lost more than 5% of your weight in the past year?

Frail = 3-5, Prefrail = 1-2, Robust = 0

Management

- Reverse what can be reversed
- Use it or lose it (body and brain)
- Vit D
- Stop polypharmacy
- Establish goals of care

Can frailty be a prognostic indicator?

- What's "normal"
- What COULD happen
- What IS LIKELY to happen
- What IS NOT LIKELY to happen
- That the "right" decision is the one that feels right
- That we will create a care plan aligned to their carefully considered decision

What do they need to hear?

Practice:
86 y/o with COPD

Normal is daily cough, progressive loss of energy and stamina, recurrent exacerbations

Complete respiratory failure could (or could not) happen

Recurrent exacerbations and steroid dependence are likely to happen

Returning to the health enjoyed 10 years ago is not likely

Choices include looking only at exacerbations without context of larger disease “You’ll be good as new” vs planning for progressive decline

92 y/o with frailty

Normal is progressive loss of physiological functions

Slowing of decline could possibly happen

Falls, infections, malnutrition and weight loss will happen

Recovery to pre-trauma state will not happen

Choices include denying underlying frailty and just fixing issues in isolation as they arise, or planning for the next decline

The art of prognostication

Functional decline

Unintentional weight loss

Impaired cognition

Accumulated organ system diseases

Metabolic markers:

- hyponatremia
- serum prealbumin
- blood cell counts (lymphopenia, then anemia)
- cholesterol

What it boils down to

Functional losses occurring over days-weeks portends very short prognosis

Functional losses occurring over weeks-months suggests it's time for hospice

Functional losses occurring over months-years suggest we should create both long and short-term care plans

The rate of decline is pretty constant

So what do you say?

How are you different now than 6 months ago?

What is your understanding of the situation?

What potential choices and outcomes do you have?

What are your fears?

What are your hopes?

What trade-offs are you willing to make? Not willing to make?

All health care workers can speak

You seem less able to do things like you could a few months ago

I'm worried that you're still losing weight

Mr. Jones, your wife's persistent confusion and forgetfulness worries me

Mrs. Smith, the doctor is seeing some lab abnormalities that he does not like

If this does not end up the way we're hoping it will, do you have a contingency plan? What I call Plan B?

Your role may simply be firing the warning shot

This lets patient and family know that we are worried…

and that we CARE

Mandates that we follow-up	• We cannot say, “I’m worried,” and drop it
Acknowledges that our patient / family may not be ready to hear us	• We cannot abandon them • “Can we see how this next week goes and re-address my worries afterward, if I still have them?”
Does NOT condemn the patient to worsen or die	

Starting to talk

Pitfalls

Speaking unintentionally or without thought

Assuming that your listener knows what you mean

Not being aware of your “body language”

Not assessing if patient or family needs a break

Not assessing patient’s impact on yourself

Forgetting that a patient will remember HOW a message is delivered far more than what the message was

- Frustrated care
- Inappropriate care
- Delayed / forfeited progress in the “work of dying”
- Misdirected energy, time, resources
- Misunderstanding, anger, resentment
- Missed job satisfaction

The costs of not prognosticating

96 y/o woman brought to the ED for refusal to eat

Baseline is nonambulatory, but able to transfer to her wheelchair

- Refused an offered hip replacement at age 87

New decub on contralateral hip

Tells me she hurts too much to eat

- “Why bother living this way?”

Mrs. L

Mrs. L

We changed her from 100mcg of fentanyl patch to methadone 2.5mg every 8 hours

She was moved from a B&C to a senior ALF with more activity and socialization

Within 6 weeks, she was out of bed, chatty, eating, happy with her pain control

Ms. P

86 y/o retired RN with early vascular dementia

- FAST 6 – fluent in language, retained humor

Stopped walking 10 months ago after a hip fracture

Baseline is transfer to a chair

Admitted for sepsis, found to have PCM, abnormal weight loss

Sent to SNF for rehab

Ms. P

Ornery enough to graduate from SNF

Back in her ILF, now refusing to go out for meals

Newly incontinent

Labs corrected

Ms. M

90 y/o with chronic systolic heart failure

Irritated that she gets short of breath doing her ironing

Goes out to manicures every other week, daily lunch dates

Wanted to know when she would be hospice appropriate

Ms. M

At my 2 month check in, she reported “tough Christmas” but was back to normal activity of lunches and manicures and daily house chores

Daughter called me 13 days after that check-in to report patient has been down for 10 days

Hospice?

We die as we live

- Feisty independence does not transform into docile receipt of care
- The more stubbornly independent, the faster death seems to come

There is a power bigger than me that determines how long we live

- I only get a say in how well

Having no conversation at all when aging is obvious just frustrates everybody

The world according to Shelly

“I could be wrong…”

- www.projectafterforums.com

Comments or questions?