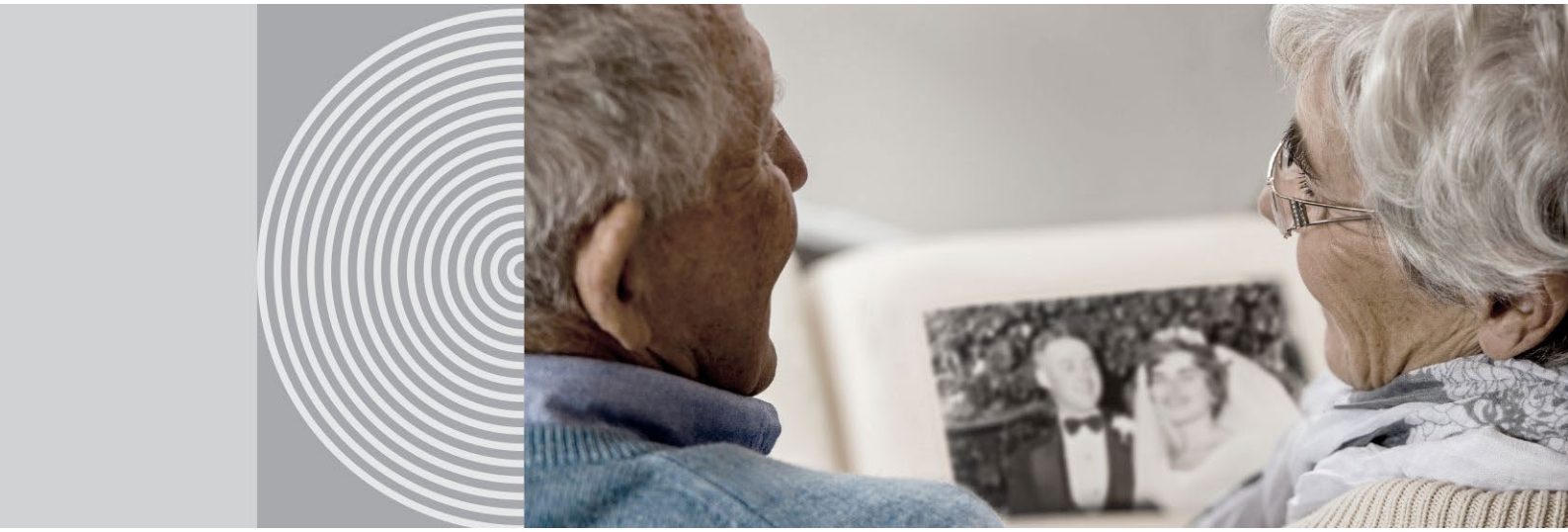
RACGP
Royal Australian College *of* General Practitioners

# *RACGP aged care clinical guide (Silver Book)*

**5th edition**

Part B. Geriatric syndromes



## *General principles*

- The clinical presentation of illness in older people is often atypical, and a coherent, contextual and contemporaneous history may not be available.
- Chronic complex comorbidities add additional challenges and can confound management.
- Descriptive syndrome clusters (ie syndromes) are pragmatic tools that can facilitate mutual understanding between health professionals and patients.
- The Geriatric 5M tool is a simple, practical tool that can be used as a framework by general practitioners in the assessment of the ageing patient.

## *Introduction*

The interaction between physiological changes associated with ageing and illness presentation provides general practitioners (GPs) with unique diagnostic challenges (refer to Part B. Physiology of ageing). In reality, the 'one disease' model of care sits uneasily for most patients, but especially for those who are older.

The clinical presentation of illness in older people is often atypical, which means a coherent, contextual and contemporaneous history may not be available. Often, a collateral description of the patient is the only information available to the GP.

An already atypical disease presentation in older patients is compounded by other comorbidities and individual patient context. Homeostasis also changes with age, which not only contributes to presentation and any future relevant investigation, but also affects pharmacokinetics and therapeutic options.

Any treatment and management of the above patient can therefore be complex and extends beyond the traditional medical model. Additionally, assessment cannot merely focus on the presenting issue; a full reflection of contextual medico-psycho-social assessment is required, including previously documented patient and family expectations.

# Challenges in geriatric syndromes

Reflecting the challenges aforementioned, the term 'geriatric giants' was first coined in 1965 by British geriatrician Professor Bernard Isaacs. His syndrome cluster described four clinical issues:[1]

- Immobility
- Instability
- Incontinence (refer to Part A. Urinary incontinence and Part A. Faecal incontinence)
- Impaired intellect or memory

The four descriptive syndrome clusters above were proposed to enable clinicians to describe the actual 'illness' presentation – a descriptive pragmatic tool to facilitate a mutual understanding between health professionals and patients. Isaacs originally suggested that if appropriate assessments were in place, all common problems in older people would relate to one or other of these four descriptive terms.

By 2017, the nomenclature had evolved and four new geriatric syndromes were proposed:[2]

- Frailty (refer to Part A. Frailty)
- Sarcopenia
- Anorexia of ageing
- Cognitive impairment

A notable absence from the new proposed list of geriatric syndromes was iatrogenic illness.

None of the proposed syndrome types reflect the traditional disease model of care; however, they have significant implications in terms of individual morbidity and mortality, and, indeed, healthcare costs.

GPs' understanding of illness presentation in the older population will continue to evolve, and the nomenclature used will undoubtedly change.

In the current context, GPs are pragmatic and need logical tools to enable optimum patient management. The 5M tool provides a framework that reflects the evolving geriatric giant concept (refer to Table 1):[3]

- Mind
- Mobility
- Medications
- Multicomplexity
- Matters most

**Table 1. Geriatric 5Ms and focus areas**

| Geriatric 5Ms | Focus area |
|---|---|
| **Mind** | • Maintaining mental activity<br>• Helping manage dementia (a decline in memory and other mental abilities that make daily living difficult)<br>• Helping treat and prevent delirium (an abrupt, rapid change in mental function that goes well beyond the typical forgetfulness of ageing)<br>• Working to evaluate and treat depression (a mood disorder that can interfere with all aspects of your daily life) |
| **Mobility** | • Maintaining the ability to walk and/or maintain balance<br>• Preventing falls and other types of common injuries |
| **Medications** | • Reducing polypharmacy (the medical term for taking several medications)<br>• Deprescribing (the opportunity to stop unnecessary medications)<br>• Prescribing treatments exactly for an older person's needs |

| | |
|---|---|
| | • Helping build awareness of harmful medication effects |
| **Multicomplexity** | • Helping older adults manage a variety of health conditions<br>• Assessing living conditions when they are impacted by age, health conditions and social concerns |
| **Matters most** | • Coordinating advance care planning<br>• Helping manage goals of care<br>• Making sure that a person's individual, personally meaningful health outcomes, goals and care preferences are reflected in treatment plans |

# *References*

1. British Geriatrics Society. A giant of geriatric medicine – Professor Bernard Isaacs (1924–1995) Post 1. London: BGS, 2018. Available at www.bgs.org.uk/a-giant-of-geriatric-medicine-professor-bernard-isaacs-1924-1995-post-1 [Accessed 3 June 2019].
2. Morley JE. The new geriatric giants. Clin Geriatr Med 2017;33(3):xi–xii.
3. American Geriatrics Society's Health in Aging Foundation. The 5Ms of geriatric. New York: AGSHAF, 2018. Available at www.healthinaging.org/sites/default/files/media/pdf/HIA-TipSheet%20Geriatric%205Ms.19.pdf [Accessed 3 June 2019].