Frontiers in Medicine and Health Research
An open access journal
eSciRes
FMHR-1-106
Research Article

Autumn Song: The Decline Syndrome in the Elderly. Crossing the Borders between Treatment and Healing

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Abstract

The syndrome of decline in the elderly or fragility syndrome is the situations that have some patients who do not improve after the appropriate medical treatment or after a specific intervention program. It would be a consequence of the extreme fragility and, therefore, the end-of-life stage, or a clinical condition derived from the various chronic diseases in advanced stages, which would present a final deterioration before death. The syndrome of decline in the elderly or fragility syndrome may represent "the autumn" in the life of some old people. In literature, autumn, figuratively, represents old age. During autumn, the leaves of deciduous trees change and their green turns yellowish and ochre, until they dry and fall aided by the wind that blows with greater force. But, if these patients do not improve with any treatment, what role does the family doctor have? This article tries, through the narration of a clinical example, to reflect on the crossing of borders between the concepts of treatment and healing in general medicine. It is proposed that the sense of healing is qualitative and occurs in a non-dichotomous continuum. It means to facilitate the unlocking of a situation, change or move from one setting to another. It is the result of the action that gives rise to a new scenario; Healing takes place through the encounter of a person with another person, therefore, healing is a "relational" concept, of modifications in the network of relationships, and does not refer conceptually to interventions in the body or mind of the person isolated from his environment. This concept includes the "do no harm", and avoid creating more problems by the intervention itself. Elderly people with frailty are not homogeneous and require a patient-centered evaluation of their situation by the general practitioner and his family to decrease physical and mental deterioration.

Keywords: Frail elderly; Family medicine; Comprehensive health care

"It was the only beautiful thing about becoming old that the trees he knew from childhood were now giants, and while the city and the people were deteriorating, the park was becoming more upright and majestic."

Introduction

The syndrome of decline in the elderly or fragility syndrome is the situation of loss of functions that present some elderly patients who do not improve after the appropriate medical treatment or after a specific geriatric intervention program [1-7]. Frail elderly people represent a major patient group in family practice [8]. According to some authors, it would be a consequence of the extreme fragility and, therefore, the end-of-life stage, whereas for others it would be a clinical condition derived from the various chronic diseases in advanced stages, which would present a final deterioration before death.

Two types of decline syndrome could be differentiated:

- A secondary decline syndrome, related to chronic diseases and an evolutionary stage of many irreversible and life-threatening chronic diseases (severe COPD, congestive heart failure, chronic renal failure), which do not improve despite treatment optimization and an evaluation and integral geriatric intervention.

- A syndrome of primary decline, which would occur in some elderly patients who, without suffering from any acute illness or serious associated chronic diseases, begin a process of progressive functional deterioration, apathy, anorexia and dehydration that leads inexorably to death.

Most of the authors consider this syndrome as a final part of life and difficult to manage, in the patient and his relatives, due to the medical and bioethical implications associated with attending those difficult moments that end life [1-9]. So, if these patients do not improve with any treatment, what role does the family doctor have? How do we understand the concept of healing in these cases? This concept in family medicine is often difficult to explain and understand. Perhaps, this concept is explained better through metaphors. Metaphors enable us to understand something that is unknown in terms of its familiarity.

A prolific number of researchers have chosen to study metaphorical narratives, confirming their usefulness in educational research. The metaphors allow to illuminate the reality, simplifying the expert knowledge, although without ignoring or reducing its complexity, but favouring its understanding. Thinking based on metaphors and comparisons is a way of transforming a concept into something that is so suggestive, interesting, and surprising, that it reaches people more easily [10,11].

In literature, autumn, figuratively, represents old age. During autumn, the leaves of deciduous trees change and their green color turns yellowish and ocher, until they dry and fall

aided by the wind that blows with greater force. The temperature starts to get a bit cold. Autumn is the season of the "end". Bad weather comes, with rain, storms and, soon, snow and cold. In nature autumn is the season when almost everything is over: the forests stop their activity and go out, after a few weeks of flashes of colours. The migrant birds go south or arrive in a hurry to stop at a shelter before the cold reaches them... The syndrome of decline in the elderly or fragility syndrome -a condition of low physical capacity and vulnerability to adverse functional outcomes- may represent the autumn in the life of some old people [12].

Clinical case: Elena's autumn fall

Helen, 84, was a widow, and living with a single daughter. She was a petite woman and short, with a sweet face, with an important kyphosis, and who was autonomous for the tasks of daily life. She had undergone progressive dyspnea and malleolar edema, which had reached the knee, with exudation of fluid in one of the legs. In last 4 months she had stopped going out and it was getting harder to do the simple homework she had done before.

A similar clinical picture appeared almost two years ago: for several weeks there was an increase in the usual feeling of shortness of breath and tiredness. She had to rest frequently while she was doing little housework; she stopped going out into the street because she had to walk very slowly and needed to sit down because of "fatigue".

For years she had had a feeling of increased shortness of breath in supine position, which now increased; but still when she was sleeping with a single pillow, she used to open the window for breathing better. Occasionally she wakes up with more sensation of lack of air but generally does not had to get up of bed; In addition, she avoids incorporating by "fatigue". At that time, the ECG was shown to be in sinus rhythm at 63 bpm, the analysis had no coagulation abnormalities, no anemia, and normal renal function and ions were normal. Baseline blood gases were PO2 48; PCO2 52. Sat: 87.2. The chest radiograph showed pulmonary fibrosis and large kyphosis. She was diagnosed of global respiratory insufficiency, adding to his previous medication (Atenolol 50 mg per day, Chlortalidone 0.25 mg per day, and acetyl salicylic acid 100 mg per day), Ramipril 2.5 mg per day and home oxygen therapy.

A few days later, an echocardiogram was performed at the Cardiology Service: it showed a growth of right cavities; left ventricle (LV) normal; Light mitral and pulmonary insufficiency; Moderate tricuspid insufficiency; severe pulmonary hypertension.

Among Helen's personal antecedents, they emphasized, pulmonary tuberculosis in youth, treated 43 years ago, and an episode of rapid atrial fibrillation, which led to hospitalization 12 years ago, and was treated with amiodarone and anticoagulation. At that time, a Holter showed a sinus rhythm, with a slightly slow heart rate. An echocardiogram showed an impairment of LV relaxation. Thyroid hormones were normal. Amiodarone was later changed to Atenolol.

One year later she presented another episode of rapid atrial fibrillation that reversed in the emergency room with IV digoxin. She had BP 210/100 at that time in the emergency room. A diagnosis of atrial fibrillation due to hypertensive crisis was made.

In subsequent reviews in cardiology, an echocardiogram showed normal left atrium and normal LV. As she was in sinus rhythm, the cardiologist suspended Acenocumarol, following with AAS 100 mg and Atenolol 50 mg per day. In successive reviews, ECGs continued to show sinus rhythm.

8 years ago, Chlortalidone was added to control blood pressure.

Five years ago she presented post-menopausal metrorrhagia, and an endometrial adenocarcinoma grade II was found that infiltrates myometrium superficially. No extrauterine extension or retroperitoneal lymphadenopathy was found in NMR. A total hysterectomy and bilateral salpingo-oophorectomy was performed. The ovaries showed no alterations in the pathological anatomy, and the peritoneal lavage was negative for malignancy.

Now, the family doctor has changed Chlortalidone to Furosemide and the nurse has bandaged her legs to try to improve the edema. She has to use the house oxygen almost all day, at 1L-2 L / min, for a sensation of lack of air... One afternoon, when his daughter arrives home, she finds Helen asleep on the sofa. She calls to wake her, but Helen only manages to move its arms and emit some syllable... and goes back to sleep... It has not eaten... It does not know what time it is.

Helen is admitted to the hospital. Her gasometry at admission was: PO2 92, PCO2 68, Sat. O2 97%. The ECG showed sinus rhythm at 60 bpm, but onset atrial fibrillation with ventricular response at 165 bpm, and subsequently, when frequency was controlled, frequent ventricular extrasystoles appeared. The echocardiogram showed moderate tricuspid insufficiency, pulmonary artery systolic pressure of 76 mmHg, mild mitral insufficiency, normal-sized left ventricle with mild concentric hypertrophy, and normal systolic function.

During admission, rapid atrial fibrillation was not controlled with Digital and oxygen therapy, presenting after adding Verapamil, bigeminism. She was switched to Amiodarone who did not control the ventricular response, and was treated only with Verapamil, managing to control the frequency.

In the hospital, Heelen is very discouraged... She does not eat almost, for lack of appetite and for not liking the purees that give her...

"... And it is without salt".

"I feel the work I give..." says Helen to her family.

Some episodes of disorientation appear. She needs help getting up, to go to the bathroom, to move in bed... What little she eats does it unaided, but needs supervision.

Twenty days after admission, she is discharged and returned home, on treatment with Spirolactone, Furosemide, Verapamil, Acenocumarol, Thiopropium, Omeprazole, and household Oxygen. In this environment she was something better..., but need help to move around the house...

The family doctor sees the evolution of Helen, while the leaves of a thousand colors of the trees fall carried by the autumn wind...

Autumn is the most nostalgic and reflective season.... Maybe sad, but beautiful, warm, gentle... Someone said that, as you get older, autumn becomes more autumn and you end up almost installed in that season with short exits and innings in the other three seasons. And in the end, you stay to live forever in the fall.

Discussion

Decline Syndrome in the Elderly. Is it a Case Where There is no Healing? How do Family Physicians Treat?

Helen was a patient as fragile as a butterfly ... like a leaf that is carried by the wind in the fall... She do remembered to me the illustrations of butterflies by Vladimir Nabokov, with those mauve, blue, gray, black or rainbow shades… [13]. There was an intense tinge of sadness, of being dragged along the course of life, so strong that it almost made me want to cry... but also, it was not known why, there was a gust of fresh breeze, which looked like spring in autumn !, wanting to live, to run, to fill the lungs... [12].

If the syndrome of decline in the elderly or syndrome of fragility of the elderly is the situation of loss of functions that present some elderly patients that do not improve after the appropriate medical treatment nor after a specific geriatric intervention program, what is the role of the family doctor? Is the decline syndrome in the elderly "another more" of the problems that does not cure the family doctor? But how does he cure, how does he solve, how does the family doctor treat? [14].

The losses that occur in the patient with fragility syndrome would be reflected in the elderly in three spheres: functional, cognitive-psychic and nutritional. Classically, this term has been used to define patients with chronic diseases who frequently re-enter because of worsening of the general condition, and by proceeding with the usual measures of assessment (physical, analytical, radiological examination), there is no obvious cause. Although treated in a specific way for their basic diagnoses, as in previous admissions, they do not show improvement and usually die in that hospital admission. In many of these patients, a review of their evolution in the weeks prior to admission reveals a progressive decrease in their functional capacity, deterioration of cognitive functions and weight loss, data on malnutrition and, very frequently, it is accompanied by separation from their usual environment [1-9].

Usually, from the biomedical theoretical framework, it is considered that "healing" is a quantitative and dichotomous concept (yes or no; thus, one could say, for example, "90% of cases are cured") and is achieved through pharmacological interventions. But, “healing” has a qualitative meaning in a non-dichotomous continuum. Elderly people with frailty is not homogenous and requires a patient-centered evaluation of their situation by the general practitioner and his family to decrease physical and mental deterioration [15]. The concept of healing must understand, in general medicine, as a way to help unblock a situation; to change or to move from one scenario to another.

It is the result of the action that gives rise to a new scenario. Healing takes place through the encounter of a person with other people (healing is a "relational" concept, of adjustment or change in the matrix of relationships or connections), rather than through interventions in the body or mind of the individual isolated. Healing involves in one way or another return of the part to the whole. The prevalence of frailty within the aging population poses challenges to current models of chronic disease management and end-of-life care delivery. As frailty progresses in the elderly, it is more likely that they will have to face new acute health problems. The ability of health care systems and family doctors to recognize and respond to acute health issues in frail patients using a holistic understanding of health and prognosis will play a central role in ensuring their effective and appropriate care, including that at the end of their lives [16, 17].

Family doctors heal when we are no stranger to the fear of patients, when we have a solid notion of what it means to be a human being. The cure is based on the presence of the doctor (the "doctor as a drug"), more some factors of the patient, like desire to live, positive emotions, etc. The physician-patient relationship model is a "context-creating" element. The doctor-patient relationship has nonspecific effects in medical intervention: the warm and friendly relationship, with shared decisions, is more effective than the very formal and unfriendly relationship [18]. Healing is more about learning to receive a person with "pain." To do heal is to understand that one is involved in helping the other as a person, rather than as a scientist; that family doctor is involved with that person "in the dark." Family doctors heal when we are no stranger to the fear of patients; when we have a solid notion of what it means to be a human being.

What is on the table in the consultation is not the doctor or the patient, but the two together. The physician's task is to achieve and maintain a connection with the patient. Using our experience with suffering beings to connect with those who have crossed the border of what we call normality and try to bring them back to the flow of the human. The only way to overcome suffering and to turn it into joy is therefore to find meaning. Keeping with the patient that connection of the type 'here, right now', in this suddenly great moment. Like a father who learns not so much to hold a crying baby in his arms as to maintain the connection with that crying baby: a being with excessive tiredness, needing to be caught and cradled to sleep, a baby who can discern If the arms that hold it are twisted by anger or just try to control it, or are open and willing simply to be with he or she. If the arms are angry and trying to control it, the baby will fight. If the arms are relaxed and open, the baby will calm down and slide into sleep [19].

It is needed to seeing the patients from new perspectives. To seeing, not only his words, but also something else; everything that surrounds her or him and everything in the space between us, just as in a field of wheat in the summer, that you can almost see the breeze that curls the wheat. Helping people has nothing to do with psychology, but to be human with the one who suffers, to advance with another person as the parts that form a whole.

The successful results are not cure, but to having a function personally and socially in life to the extent that disease allows. The cure is not fundamentally the adjustment between the patient and their environment, but it is a process to restore their ability to face their own problems, or to make decisions about how to act in that particular situation. Healing has to do with self-responsibility and training. A healthy person is not the one who is free of problems but the one who is able to deal with them. The healthy family / community are one that, when there are problems, supports those who carry more distress without blaming others for their difficulties [20].

And if we cannot heal, at least do not hurt; we have to avoid creating more suffering around us. Healing can be to doing nothing. When the patient is a terminal, there are moments where it is best to do nothing: just be there. Cure / palliate: the integration of palliative care and curative treatments are a rational approach to the care of people with advanced diseases and have been shown to reduce suffering, improve satisfaction, reduce costs and facilitate transitions between the different stages of progression of the illness [21, 22]. According to this approach, palliative care is offered as needs develop and before they respond to any other curative treatment [23].

However, the usual situation is that patients receive multiple episodes of curative treatment and a few weeks of end-of-life comfort treatment. The pattern of care is predominantly medical as few of the frail older population use social care [24].

We believe that the fundamental reason for this fact lies in the traditional view of believing that the goals of curing and prolonging life are incompatible with the goal of reducing suffering and improving the quality of life. The dichotomous view of curing-caring means that patients with advanced diseases receive aggressive treatments and do not start treatments with comfort goals until the prognosis is very clear and death is imminent. We need integrates the perspectives of patients, informal caregivers, family physicians and other health professionals [8], in addition to having a bio-psychosocial vision [25].

Family Medicine presents the unique opportunity to detect the transitions or “turning points” in healthcare (life cycle, trauma and stress, and "path" long-term) [26]. But making frailty an integral part of primary care is not without considerable challenges [27].

To fully understand the disabling process, investigators and clinicians must consider the episodic and recurrent nature of disability. Frail patients have highest rates of transition from less to more disability, lower rates of transition from more to less disability, and longer durations of disability [28].

Conclusion

In conclusion, there is a lack of reflection, conceptualization and research on these issues. So, we would do suggestions of research:

1) The concept of healing in Family Medicine (systematization, description, distribution, measurement, etc.

2) Description, prevalence, associated factors, psychological, social, economic and spiritual aspects, clinical aspects, prevention, and public health implications of fragility syndrome in the elderly.

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Received date: May 10, 2019; **Accepted date:** June 13, 2019; **Published date:** June 28, 2019

Citation: Turabian JL (2019) Autumn Song: The Decline Syndrome in the Elderly. Crossing the Borders between Treatment and Healing. *Front Med Health Res* 1(1): 106.

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