

Respiratory disease in the context of comorbidities and ageing



Speaker **Dr Chris Dyer** *Consultant Geriatrician, Royal United Hospitals NHS Foundation Trust, Bath*

Key learning points:

- One in four people with COPD are frail
- Patients with moderate frailty should receive a comprehensive geriatric assessment
- Co-morbidities such as depression, osteoporosis and heart failure are more common in COPD
- Pulmonary rehabilitation can be suitable for some patients with frailty (must be able to walk 5m and comply)
- Rationalise treatment in frail patients and consider medication concordance

For frail older people what is really important is their quality of life and not necessarily the quantity of life, Chris Dyer told delegates.

He said that although more people are reaching old age the morbidities associated with the later stages of life are not reducing.

Rather than considering a patient's age it is better to think about ageing in the context of frailty. This is a distinctive health state related to ageing in which multiple body systems gradually lose their in-built reserves. This causes slow walking, a lack of energy, loss of strength and an increased risk of falls. About one in 10 people over the age of 65 are frail but around one in four people with COPD are frail.

Comprehensive geriatric assessment

Dr Dyer said that there is a strong evidence base for conducting a holistic geriatric assessment of patients with moderate frailty. It is known that this can reduce the risk of institutionalisation and mortality by about a third and improve quality of life.

The NHS Long Term Plan has identified the need to target frail older people in the community, particularly those with moderate frailty with a view to

implementing preventive measures to try and prevent them progressing towards severe frailty. It recommends that community teams seek out older people with moderate frailty or existing conditions like COPD to offer proactive personalised care.

The electronic frailty index which is linked to the TPP and Emis computer systems can be used to identify patients with frailty and rank them from managing well, moderate or severely frail to terminally ill.

“ Congratulations on another inspirational conference! ”

Conducting a holistic assessment should be a team-based approach. For example in Wiltshire care coordinators work with practice nurses.

An assessment should identify physical problems such as respiratory conditions or arthritis, review medication, identify environmental elements or mobility aspects which could result in a home visit by an occupational therapist to help to reduce falls. It should also consider psychological mood and cognitive function.

Primary Care Respiratory Update

Many patients who are old and frail have respiratory problems as part of a wider condition and therefore the comprehensive geriatric assessment should cast a wider net than might perhaps typically be cast in a patient with COPD or pulmonary fibrosis.

“ It was my first PCRS conference, I found it very friendly and useful. ”

The impact of comorbidities

Multi-morbidity is common in patients with COPD. These include:

- **Heart failure:** This may be increased directly as a result of the COPD or indirectly by smoking. The prevalence of heart failure in people with COPD is 20% - it is twice as common as those of a similar age in the general population. Ischaemic heart disease, atrial fibrillation and hypertension are also more common in people with COPD. Beta-blockers increase survival of patients with COPD with little impact on lung function.
- **Osteoporosis:** This is three times more common in COPD and patients have a 60% increased risk of fractures. Patients should be asked if they have fallen or broken a bone in the last few months. If the answer is yes consider a fracture score or even the DEXA scan. While there is some contention about the effectiveness of osteoporosis treatment it is known that up to the last year of life people probably benefit from taking osteoporosis treatment in terms of fracture prevention.
- **Anxiety and depression:** This is prominent in about half of older adults with COPD and other severe respiratory disorders. It results in high levels of hospital admission and mortality. So screening for this co-morbidity and treating it can pay dividends.
- **Comorbidity and inhaler technique:** Around 40% of older people have a problem with inhaler technique. This may be because of a lack of dexterity, (caused by arthritis, poor vision or muscle weakness) or their mental status.

If struggling with the patient ask:

- Is the diagnosis correct? Look holistically at the older person and consider co-morbidities.
- Are they on optimal therapy and are they taking it? Could the reason they are not taking their inhaler be that they are fed

up and socially isolated? Social prescribing for frail people might offer support and companionship and or a network of support that could include encouragement to use an inhaler or become more mobile.

- Is the patient's cognition, depression or anxiety causing problems?
- What about pulmonary rehabilitation (PR)? Does the patient need oxygen in order to be able to attend PR? Less than one in three people who could benefit from PR are referred but it is never too late to stay active.
- What are the patient's oxygen levels? Check their oxygen saturations.
- Do you need to phone someone else for advice?

NICE offers guidance on multi-morbidity which recommends considering:

- Treatments that could be stopped because of limited benefit
- Treatments and follow up arrangements with a high burden – do they need all these appointments?
- Rationalising medicines with a higher risk of adverse events such as falls, gastrointestinal bleeding, acute kidney injury

“Talk to your patients about these issues and come up with an agreed shared plan then you can rationalise medication and focus on what's really important,” said Dr Dyer.

“ Thought the breadth and depth of sessions this year was excellent. ”

Conclusion

It is important to conduct a comprehensive respiratory assessment of frail older people, involve the patient in shared decision-making and agree a care plan. The key thing is to have a holistic view of the patient and consider comorbidities. Pulmonary rehabilitation should be considered for older people with frailty and should include a mobility assessment with a view to reducing the risk of falls.

Finally it is really important to review medication and to rationalise treatment where possible.