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Slovenská gerontologická
a geriatrická spoločnosť
Limbová 5
831 01 Bratislava

Vedúci redaktor:

Prof. MUDr. Ladislav
Hegyí, DrSc.
Jánošíkova 78
901 01 Malacky
e-mail:
ladislav.hegyi@geriatria.sk

Adresa redakcie:

Katarína Ďuranová
Klinika geriatric LF UK
Limbová 5
831 01 Bratislava
tel.: 02/5954 5232
e-mail:
klinika.geriatric@centrum.sk

Jazyková úprava:

Anglická:
PhDr. B. Weiblová, MPH
Slovenská:
PhDr. R. Palátová

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Charis s. r. o., Ipeľská 3
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Contents

I
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Obsah / Contents

Editorial

- L. Hegyí:
Health care reform and its impact on seniors in SR . 3

Original papers

- H. Zavázalová, K. Zikmundová, V. Zaremba:
Way of life of seniors in the context
of subjectively perceived health 55

- R. Suchanová, L. Tirpáková:
Seniors and leisure time activities 62

- Tibor Marček, Tomáš Marček, Daniela Farkašová:
Efficacy and safety of celecoxib treatment
in patients with rheumatoid arthritis
and acute exacerbation of osteoarthritis.
Results of observational study 68

Review articles

- Š. Krajčík:
Ageing of population and health care 76

- R. Červený:
Preoperative examination of senior patient 80

- O. Škachová:
Physiotherapy in the senium 84

Case report

- F. Németh, A. Slivková L. Šimoňáková:
Diffuse idiopathic skeletal hyperostosis 87

- M. Rašiová:
Syndrome of inadequate - oxcarbazepin
induced increased secretion
of antidiuretic hormone (SIADH) 91

- Book reviews 60, 61, 83, 95, 96

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Health care reform and its impact on seniors in SR

Based on the present knowledge we can state that the actual health care reform has not been implemented yet, there was only a change in the legislation and a change of ownership relations. Public money is flowing in private hands, financial burden of inhabitants connected with health has increased, the accessibility of health care services has decreased, the costs of health care providers has also increased, while their earnings remained unchanged. 4 years after this legislation stage and almost two years of the effect of health care law, it is quite difficult to estimate the exact impact of the reform on the population. Moreover, the original laws have been changed by numerous amendments and it is not known whether the Ministry of Health of SR has published or made any study about the effect of this reform.

We can also state that the health status of seniors is getting worse mainly due to unfavourable social development. The quality and accessibility of health care for seniors are also deteriorating and they are particularly sensitive to all the shortcomings of the undergoing health care reform. The health care reform affects mostly seniors which is seen on their health status. 70 % of people over 70 years suffer from cardiovascular diseases, 50 % of the same group report chronic inflammatory diseases, 20 % of people over 65 years of age show mental disorders and in 30 % of people aged over 60 digestive tract disorders are observed. In a group of people over 80 years 35 % of women and 23 % of men do not leave their homes, 52 % have sight deterioration, of them 12 % severe, 45 % have deteriorated hearing and 42 % have difficult access to health care (2). The most frequent diseases in average male senior population include ischemic heart disease, diabetes, lipid metabolism disorders, joint and spinal column disorders, whereas in average female senior population ischemic heart disease, anaemia, os-

teoporosis and joint and spinal column diseases appear most commonly.

The consequences of multimorbidity in health care system are manifested especially by more frequent visits at a doctor's, by a larger number of consulting examinations - repeated payments, more frequent hospitalizations - i.e. payments for hospital stay, larger drug consumption - which leads to lump sum price in pharmacy, higher co-participation in payment for drugs and health supplies, such as glasses, high financial load is observed in maintaining oral-dental health, e.g. very expensive dental prostheses. The artificial barriers in hospitalization are caused by low bed capacities for this group of people. Home care aggravates the prognosis, if complications occur due to delayed diagnosis and therapy (3). So far, there exist no relevant sources for the evaluation of the reform impact upon the health status of seniors, upon their morbidity and mortality.

The level of health care depends on the mutual relation of the three parameters: price - quality - accessibility. While for the health care provider the price, i.e. the amount of costs for the delivered health care is a decisive factor, for the consumer, i.e. for the patient (or the client) quality and accessibility are decisive factors. Higher quality decreases the accessibility and increases the price for the intervention. (5).

Old patient has usually problems with the transportation connected with health care services. These problems are not necessarily associated with his worse mobility but they may result from the fact that health care company as joint-stock company does not conclude contract with a minor health care establishment, or with a particular surgical department of a smaller hospital. Accordingly, the hospital cannot admit the patient no matter how minor his intervention is. Health insurance companies purchase a regulated amount of health services at a specialist. If a specialia-

list exceeds this amount of services, an old patient has to seek another doctor or another hospital. The patient is thus restricted in his legal rights which guarantee his free choice of doctor and health care institution.

The quality also needs adequate financial means (1). The accessibility of a more qualitative service is often associated with financial equivalent, which officially allows the patient to find a surgeon who is going to operate on him. However, old patients are usually deprived of this possibility due to their poverty. Actually, this system induces the violation of the laws of equity in health. The accessibility of services is further diminished by waiting lists. The expected decrease of the quality of delivered health care services will be also caused by free movement of health care workers in seeking jobs abroad.

The most serious consequences involve the growing co-participation of patients in payments for health care. This has increased from 2 milliard Slovak crowns in the year 2002 up to 16 milliard Slovak crowns in the year 2004. In 2006 it may amount to 18 milliard. As seniors spent the largest share of health care delivery, these numbers relate mostly to them. Low pensions lead to the inability of patients to cover the required fees and to the expansion of social non compliance in pharmacotherapy. Social non compliance is caused by poverty, inability to pay for medications and by living in isolation due to age, biological or social causes or lack of control in drug usage.

In the conclusion let me mention the impacts of the health reform from ethical and legal aspects. In December 2004 the Slovak Government's Decree on the prepared health care reform was issued. Besides other facts, the Decree stated that the extent of provided health care services to seniors had to be restricted and the symptomatic treatment has to be preferred over the causal one. The statements of the Minister of Health of SR Rudolf Zajac have markedly contributed to the worsened relations between patients and doctors. The lack of money in the health care sector resulted in decreased health care delivery and the patients' complaints about provided health care services were often justified. Of course, patients do not consider the fact that the reform had an unfavourable effect on health care providers as well. Patients feel that for ever increasing payments they receive a lower amount of health services. On the other hand, health care providers also feel that regulated payments by health insurance companies force them to provide more services, which actually means that they cover the costs of health care services on their own expenses. It has to be admitted that the impacts of the reforms on the patient cannot be quite separated from the reform impacts on health care providers.

It is extremely sad that in modern, civilized and economically developed, society old people as a social group are still being marginalized and this fact is particularly apparent in health care.

Prof. Ladislav Hegyi, M.D., D.Sc.

Way of life of seniors in the context of subjectively perceived health

H. Zavázalová, K. Zikmundová, V. Zaremba

Summary

In a group of 1033 subjects aged over 60 years some characteristics concerning their way of life and subjective evaluation of their own health were followed up. The inquiry was conducted in GPs_ (general practitioner) outpatient departments in the year 2003/04. The group followed up consisted of senior patients who sought GP because of various health problems. 62.9 % of subjects visited a GP due to medical check up and drug prescription. 10.6% of seniors went to see a GP because of preventive check up. Nearly a third of the subjects followed up, evaluated their health status as good, or altogether good, 47% considered it age-related. The inquiry demonstrates some characteristics of the way of life of seniors, such as spending their leisure time, physical activities, way of living.

Key words: old age - health status - consumption of health care delivery - way of life

Seniors and leisure activities

R. Suchanová, L. Tirpáková

Summary

Activity is an important means of preventing premature ageing in seniors and when talking about seniors' activity we mean the setting in which their personality is manifested. Activities are very important for seniors as they help them how to spend their free time, they affect social contacts, support physical and mental energy, create social status. The adequate physical and psychic activity slows down the ageing process, prevents social isolation and increases the quality of life of seniors.

The goal of our inquiry was to map leisure time activities in seniors residing in old people's homes and identify the most common activities of their leisure time. The results of our inquiry point at a rather passive way of residents of old people's homes in spending their free time. The majority of seniors rarely takes part in the events aimed at their development and education or at physical and working activities.

More favourable results were recorded in their participation in cultural- educational events oriented on communication and development of social relations.

Key words: senior - old age - leisure activities - old people's homes

Efficacy and safety of celecoxib treatment in patients with rheumatoid arthritis and acute exacerbation of osteoarthritis. The results of observational study.

Tibor Marček, Tomáš Marček, Daniela Farkašová

Summary

Objectives: To assess therapeutic regimens, efficacy and safety of celecoxib in patients with rheumatoid arthritis (RA) and with acute flares of osteoarthritis (OA) in Slovakia.

Design of the study: An open-label, prospective, non-comparative post marketing observational study lasting 8 weeks, from June 2001 till December 2002. 2309 patients aged 18 years treated with celecoxib in a dose ranging from 100 to 500 mg daily, were enrolled in the study.

Results: In 66 % of enrolled patients OA, while in 34 % RA was diagnosed. 86.1 % of subjects and 89.4 % of physicians assessed at the end of the study the efficacy of celecoxib either as very good or good and 94.5 % of subjects and 95.1 % of physicians assessed the tolerability of celecoxib as very good or good. More than 71 % of all subjects used celecoxib because of its good efficacy and tolerability. 72.1 % of patients used celecoxib in combination with other medicaments. The preferred dosage was 200 mg celecoxib QD, the mean dosage 202.0 mg (SD 24.3 mg) of celecoxib and 99.8 % of subjects maintained their dosage regimen unchanged throughout the study period. 113 adverse events (AE) were recorded altogether, with gastrointestinal tract disorders being the most common (28.3 % of all AE). There were no serious gastrointestinal (GI) or cardiovascular AE. GI disorders represented also the most frequent reason for discontinuation in the study (0.82 %).

Conclusion: In the submitted study the therapy with celecoxib was safe, well tolerated and efficacious in the treatment of the symptoms of rheumatoid arthritis and acute flares of osteoarthritis. Celecoxib was prescribed in accordance with the recommended therapeutic dosages.

Key words: celecoxib - rheumatoid arthritis - osteoarthritis - geriatric patient

Ageing of the population and health care

Š. Krajčík

Summary

Ageing of the population is the result of improved living conditions and health care that have a positive effect upon the functional state of old people, as well. The increase of birth rate cannot be expected and the society has to cope with the growing number of old and decreasing number of young people (adjustment of pension scheme, building of the system of health and social care aimed at complying with the needs of seniors).

The number of seniors in the following 50 years will double. Especially the number of seniors in the highest age groups will rise. Due to good health care, the number of people who survive despite their diseases, is growing and the functional status of seniors is improving.

Key words: ageing - disability - demography

Preoperative examination of senior patient

R. Červený

Summary

New payment decrees on payment No.550/2005 and No.101/2006 of the Ministry of Health of the Czech Republic effective from 1 January 2006 or 1 April 2006, with the regulative measures stimulated a new wave of various discussions, one of them concerning the extent of preoperative examinations. This situation emerged because the 1997 recommendations do not quite meet the requirements, moreover in practice these regulations are not observed anymore. Preoperative examination is provided in a nonstandard way and with a great variety. Surgical outpatient hospital departments give their patients, who are to be operated on, various recommendations using different modes. E.g. somewhere several year old forms (copied), are given to the patient automatically by an outpatient nurse, elsewhere the patient is given a form with numerous compulsory examinations and conditions (e.g. the date of examination should not exceed 5 days), that has to be fulfilled and if left unfulfilled, the patient will not be operated (disregarding his waiting for this operation for a year). If a GP makes such a complicated preoperative examination, he exceeds the limits mentioned in the above decrees effective from the beginning of this year and consequently he will be fined regardless whether he is to blame or not. This situation is partly caused by surgical departments that order these services in GPs, ignoring thus the currently valid recommendations about preoperative examinations.

Furthermore, we do not consider the rule issued by the legal department of the Czech Medical Chamber that is generally not adhered to. The physician indicating some health services, examination or prescription of any drugs shall provide these services by himself (he shall refer the patient to laboratory tests, ultrasound, X-ray, etc.) and he shall not send the patient to other health care establishment, in most cases to a general practitioner. The health care providers should observe the currently valid recommendations for preoperative examination and they should equally share in the costs connected with such patients according to the valid medical and legal norms. This would prevent excessive examinations of patients and a better human approach should avoid sending a geriatric patient from one doctor to another or cancelling scheduled surgical interventions.

This paper also mentions the regulations published in 1997 Věstník of the Ministry of Health of the Czech Republic as Standards of diagnostic and therapeutical procedures, No. 708-7/1997 Standard -Preanaesthetic examination of patients without concurrent complicating disease - ASA I. and Standards 708/8 - 708/15 - Preanaesthetic examination in patients with complicating disease (ASA II-IV).

Key words: *decrees of the Ministry of Health of the Czech Republic - general practitioner - outpatient surgical hospital department - standards of preanasthetic examinations - ASA I-IV- preoperative examination as a set of interventions - definition of health status of senior patient - consulting examination*

Physiotherapy in the senium

O. Škachová

Summary

The contribution focuses on the rehabilitation of geriatric patient. The demanding complex care for geriatric patients is increased by the restricting factors, such as polymorbidity of seniors, restricted variability of physiological functions, immobilization syndrome, sensory insufficiency, deteriorated physical and mental functions. The motivation and establishing contact with a patient is of great importance. The art of gaining one's confidence requires great patience, ethical approach to the patient and is very significant for the final effect of the rehabilitation. The principal task of rehabilitation is to restore or sustain physiological and psychical functions and to adjust as well as affect the quality of life. In attaining this goal the exploitation of all the available rehabilitation means is necessary.

Key words: *ageing - rehabilitation - ergotherapy - self-sufficiency*

Diffuse idiopathic skeletal hyperostosis

F. Németh, A. Slivková, I. Šimoňáková

Summary

Diffuse idiopathic skeletal hyperostosis (DISH) is chronic systemic skeletal disease of unknown etiology that appears in middle and high age. Its characteristic feature is bone proliferation in a form of calcifications and ossifications of the ligament mainly in the area of ligamentum longitudinale anterior that causes bone ankyloses of anterolateral corners of the spinal column. The affliction of peripheral skeleton is usually manifested by extensive entesopathies. This nosological unit is analyzed in connection with differential diagnostics in a patient hospitalized for chest pain.

Key words: diffuse idiopathic skeletal hypostosis - ossifications - entesopathies

Syndrome of oxcarbazepin induced inadequate increased secretion of antidiuretic hormone (SIADH)

M. Rašiová

Summary

The oxcarbazepin therapy may cause undesirable effects such as angio-edema, Stevens-Johnson syndrome, abdominal pain, etc. These effects of oxcarbazepin appear in 8.2 % of this way treated patients, as against 7.6 % using placebo. Serious undesirable effects involve potentially fatal hyponatremia induced by the syndrome of inadequately increased secretion of antidiuretic hormone - SIADH. It is characterized by the secretion of antidiuretic hormone (central or ectopic) inadequate to the actual serum osmolality. The risk of development of drug induced SIADH elevates with polypragmasy, concurrent treatment with psychotropic drugs and thiazide diuretics. The case report presents a case of drug-induced SIADH.

Key words: SIADH - hyponatremia - oxcarbazepin