

GERIATRIA

časopis slovenských
a českých geriatrov

Vydáva:

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a geriatrická spoločnosť
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Sadzba, reprodukcia, tlač:

Charis s. r. o., Ipeľská 3
821 07 Bratislava

Registračné číslo: 1441/96
ISSN 1335 - 1850

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3/2007

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Perspectives of longterm care

The expression long-term care implies the delivery of health and social care over a longer or a long period of time or up to the end of one's life time. As institutional care in health care establishments longterm care has been defined as health care provided to patients with complications resulting from multiple chronic diseases of adult age whose basic diagnoses are known and the status does not require intensive examinations. However, treatment, rehabilitation, nursing and training of routine daily activities are needed. Institutional social care facilities provide mainly social services. The mutual interconnection of social and health services in individual health care establishments is inevitable because it results from the characteristics of chronically ill elderly (Hegyi, 2007). The role of health care facilities for longterm patients has already been clearly defined at the time of establishing of these facilities: *"Health care facility for long-term patients admits such patients in whom no improvement can be expected during the period shorter than 3 months, despite the fact that all the available means and methods of modern medical science have been applied"* (Pacovský, 1981). Mortality in longterm care facilities was later shown to be approximately threefold as against that in hospitals (Kalvach et al., 2004) and a great part of the services provided had nursing character (Busch, 1997).

Longterm care with prevailing social services is provided to seniors in social care institutions, mainly in old people's homes and residential homes.

The most serious problem in old people's homes is lack of vacancies that complicates the activities of longterm care facilities because of limited length of hospital stay. Furthermore, many residents of old people's homes should be hospitalized in chronic health care-oriented departments since old people's homes have no adequa-

te either personnel or material equipment for the treatment of these patients. The solution of this problem can be seen in common financing of home care conducted by home nursing care agencies and by creation of nursing departments (Pflegerheim' (Krajčík, 2000).

Bartošovič found that admissions to Old people's homes are dominated by social causes (63.3 %), followed by health causes (36.7 %), whereas with the increasing age the health indication is elevated, too. Mild or moderate cognitive disorder is present in 49.5 % of residents of Old people's home, in 3.5 % severe cognitive disorder was detected. 59.4 % of residents of Old people's homes showed permanent and severe pain, 34.4 % had giddiness, 28.9 % suffered from dyspnoea, 24.7 % had malaise, 22.8 % insomnia and 25.4 % had grief. (Bartošovič, 2006).

The current system of longterm care in Slovakia does not correspond with the present-day situation in health care. Further development lacks any clear-cut conception. It is evident current health practice does not offer any longterm care for seniors. We can state that the system is functioning in social care facilities under the optimal level of providing health and medical care. One mode of development would consist in larger support of health care services in these facilities.

It has to be considered, on the other hand, that higher quality of life as well as fulfilment of wishes and notions of seniors about their old age rests in the provision of adequate home care if there exist conditions for providing such professional help in home setting. Community medicine offers several solutions of this problem.

The idea of organization of small territorial areas with the aim of providing social and health services for seniors arose in Tyrole (Austria) as early as in 1978. For the period of 20 years about 65 small ter-

ritorial areas were created in Tyrole covering the needs of more than 90 % of Tyrolean communities.

Social and health district is an ambulatory community-orientated establishment. The district workers manage certain social and health problems of senior inhabitants of the coverage area of the district forming thus a network of professional and non-professional auxiliary activities that provide aid promptly and without any administrative restrictions. The district is self-autonomous within the community.

The goals of the district involve delivering ambulatory counselling service, mediating various professional services, creating motivation to self-help and mutual help as well as public activity. General practitioners, other health establishments and non-professionals participate in the district's activities.

The district offers only the services manageable on professional and qualified level. It has no political or religious bonds. The coverage area of one district may take from 3000 to 29 000 inhabitants. The districts provide mainly health care, home nursing, help in the family, help to old people and lonely ones, assistance in households, meals on wheels, drug supply, extending information, etc. Social events may comprise the participation in preventive programmes, the days of health, work in self-help groups, meetings with other providers.

The costs for activities are covered by the federal country by 43 %, 22 % is covered by the communities from their own sources, 6 % by social insurance company and 29 % by recipients of help and sponsors.

The district of health and social help in Zierl near Innsbruck covers the area of 5 000 inhabitants. The district has nursing department with 15 beds and 17 beds of Old people's home. It distributes daily 36 lunches for ambulatory recipients, home nursing care is provided to 33 patients. Professional care is provided alternately by 4 general practitioners and 2 nurses. The result of the change in the organization of

health care delivery and social assistance is significant in the reduction of institutional health care and social assistance in attaining higher quality of life of the recipients of these services. (*Hegyvi, 1996*).

The similar model was realized in the USA: PACE (Programs for All-inclusive Care for Elderly), that enables to live in the community covering health services by both general practitioners and specialists and providing nursing care and social care, as well. In 1997 PACE clients showed lower need of hospitalization by 2.3 day than Medicare patients, whereas the mean age of PACE clients was 80 years, the incidence of incontinence more than 50 % and psychic alteration was observed in more than 60 %.

The so called Green House Project is interconnected with the PACE project. It attempts to replace the institutional care by residing in a small community in houses for 6 - 8 persons. These inhabitants are provided professional nursing care for 6 hours daily in average (*Kalvach et al. 2004*). The similar type of residence was realized in the second half of the 20th century in Denmark and other countries.

The implementation of such community projects in our country requires to change the conception of Home nursing care agencies and build up the network of social workers for caring for seniors.

The issue of financial coverage is of crucial importance in longterm care. In my opinion, financial coverage can be solved through legislation: in enacting the law on nursing insurance as known in Western Europe. This law enables to cover nursing of severely ill and those who need such assistance and at the same time the law covers both ambulatory and institutional care. (*Hoffmann, 1996*).

The ageing of the population, the effort to maintain the quality of life in the elderly and finally the economic reasons force us to solve the implementation of longterm care for our seniors by modern and humane way.

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prof. Ladislav Hegyi, M.D., D.Sc.

Are there any age differences in the risk stratification after the past history of myocardial infarction

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3/2007

P. Mikuš, S. Filipová, S. Katina, E. Mikusová, Š Krajččík

Summary

Introduction: Noninvasive stratification of patients' risks after acute myocardial infarction is currently a golden standard in overall care for patients after acute myocardial infarction. Based on this stratification we can identify the patients with high risk of sudden cardiac death and other complications and patients who mostly benefit from additional invasive diagnostics and target treatment.

Aim of the paper: The aim of our paper was to find the differences among the individual risks in the incidence of risk factors for atherosclerosis, in therapy after myocardial infarction, in the risk stratification after myocardial infarction, in interventional therapy after myocardial infarction.

Results: The majority of results coincided with the literature data. The risk factor for coronary heart disease was most common in the youngest age group. In these patients we found a more frequent localization of the infarction on the anterior left ventricular wall- we found no statistically significant differences in the application of thrombolytic treatment, thrombolytic treatment was less common in the oldest group. In the oldest group the use of coronarography and invasive revascularization were less statistically significant. As expected the complications of myocardial infarction were more frequent in the oldest age group. No difference was found in the systolic left ventricular dysfunction and in the incidence of abnormal later ventricular potentials. The prolonged QTc interval most commonly occurred in the oldest age group. Betablockers were the least prescribed drugs in the oldest age group.

Conclusion: We can conclude that every patient regardless of his /her age may benefit from positive finding of cardiovascular risk. There are still reserves in the treatment of old patients after acute myocardial infarction, mainly in the subsequent invasive diagnostics and treatment.

Key words: *myocardial infarction - risk stratification - risk factors - treatment of myocardial infarction - age differences*

Seniors and labour market

L. Hegyi, M. Vladárová

Summary

Motivation to maintaining or accepting employment or becoming independent entrepreneur after having reached the status of a pensioner varies. Besides economic contribution, which is evident especially in pensioners with low income, there is an effort to maintain social prestige, purposeful fulfilment of one's free time, objective need of employers to maintain highly specialized experts as long as possible and the feeling of one's own usefulness.

The possibility of maintaining employment depends - except for employee's wish - on the employee's health status, type of work, demographic changes in the society and labour market alone. With the increasing age a high proportion of the unemployed diminishes the possibilities to find work. The share of working pensioners of the number of old age pensioners has significantly decreased over the past two decades.

Health disorders and health complaints affect the ability to work as early as in middle age. Health problems markedly increase after reaching the age of 45 years in both genders, although the sequence of the complaints reported differs. The symptoms of affected locomotor apparatus, stress and headaches rank as first. Stress increases with the age and is more frequent in men. Low frequency of reported heart problems mainly in men with objectively persisting high number of death from cardiac reasons, is striking. Work-related health problems and complaints are more frequent in working Slovak population in comparison with the initial EU states.

Key words: *seniors - occupational health - labour market*

Fecal incontinence in geriatrics

J. Bartošovič, J. Breza jr.

Summary

A review article is devoted to epidemiology, factors of maintaining continence, causes, examinations and treatment of fecal incontinence in seniors. Fecal incontinence is defined as involuntary leakage of stool. We differentiate between fecal incontinence, gas incontinence and anal incontinence. Its prevalence is not exactly known, it grows with the increasing age, reaching the top in old people residing in institutions and appearing in approximately 25 % of seniors. The age changes alone do not cause fecal incontinence. The authors present physiologic and pathophysiologic factors of fecal continence. The causes of fecal incontinence in the elderly are always multifactorial, the most frequent being functional fecal incontinence, fecal incontinence in concurrent diseases, fecal incontinence from leakage, anorectal fecal incontinence and in diarrhoea. In the treatment of seniors basic nursing procedures, adjustment of way of living, medicamentous treatment and physiotherapy by biofeedback method connected with pelvic muscle exercise, are of great importance.

Key words: *fecal incontinence - seniors - geriatrics - diarrhoea - constipation - loperamide - biofeedback*

Insomnia and its therapy

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J. Dragašek, E. Pálová

Summary

Sleep disorders are dealt with the specialists of various medical disciplines. Despite the frequent incidence insomnia is often underestimated and inadequately treated in old patients. From clinical point of view insomnia's is divided into primary and secondary. As many as 40 % of all secondary insomnias develop in psychiatric diseases. The main principle of sleep disorder treatment is its proper classification according to the cause, elimination of secondary insomnias, adhering to the principles of sleep hygiene and preference of non-pharmacological procedures. In clinical practice we are often faced with dependence on benzodiazepine preparations that affect the sleep architecture. After withdrawal they cause anterograde amnesia and rebound insomnia in seniors. At present geriatrics prefers the hypnotics of III.generation: zolpidem and zopiclone. In the treatment of chronic insomnias newer psychopharmaceuticals can be used, as well. In unsuccessful complex treatment polysomnographic examination is recommended.

Key words: *insomnia - zolpidem - zopiclone - polysomnography*

Infiltrating ureteric carcinoma imitating the dissection of the abdominal aortic aneurysm

P. Ambrošová, P. Weber, Z. Kala, Š. Bohatá, J. Mazanec

Summary

In a case history the authors report about a 79-year old patient with uroepithelial carcinoma of the right ureter imitating the dissection of the abdominal aorta. The clinical picture was dominated by digestive system problems - abdominal pain and vomitus. In the lumbar area there was neither pain nor hematuria which are typical signs of the uropoietic system tumours.

CT of the abdomen showed a large aneurysm of the abdominal aorta with the corresponding abnormal formation having the density of a hematoma. The case was evaluated as suspected dissection of the aortic aneurysm. This formation passed through the right ureter which was depressed and dilated over this formation.

In the next stage ileus developed that was subsequently operated on. The operation revealed tumorous infiltration of the intestines. Pathologic-anatomic autopsy disclosed penetrating ureteric carcinoma as a primary cause.

The authors wish to pinpoint that even though the tumours of the extretory urinary tract (with the exception of the urinary bladder) are rare, they have to be considered, especially in atypic symptomatology of the abdominal cavity organs. Their proper identification is always very difficult and extremely demanding for the attending physician.

Key words: *ureter carcinoma - clinical picture - diagnostics - differential diagnostics - dissecting aneurysm of abdominal aorta*