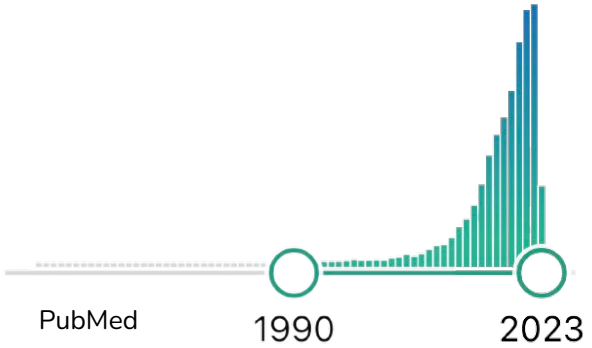
Přechod do geriatrické deteriorace

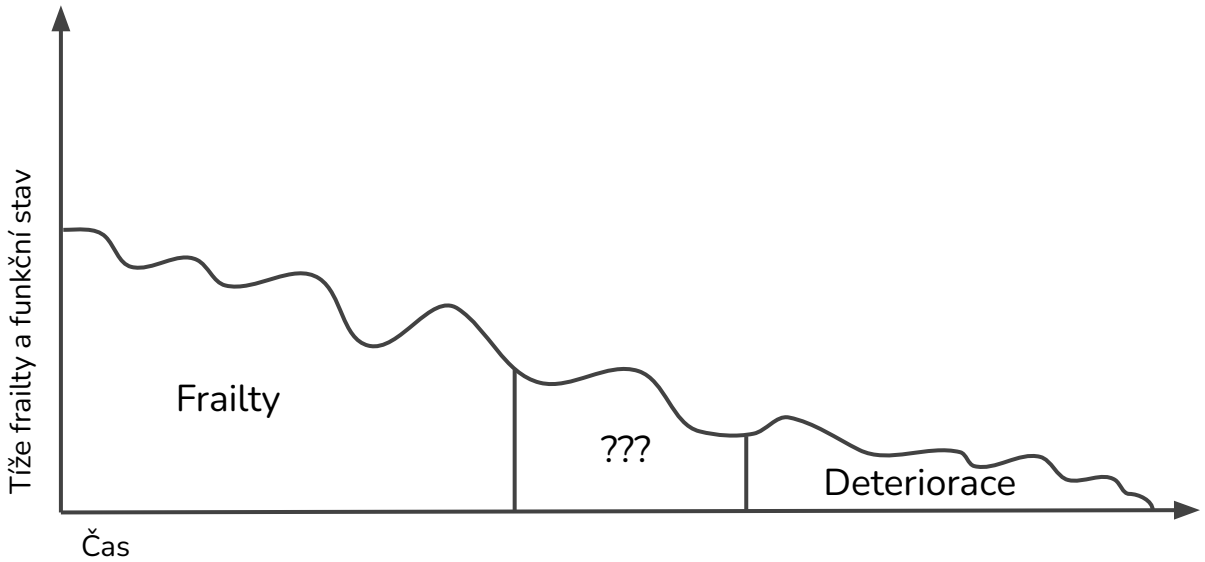
Radovan Kunc

Pojem geriatrická deteriorace

- Geriatrická deteriorace jako samostatný syndrom (failure to thrive, failure to cope, acopia)
- Geriatrická deteriorace jako vágní označení „celkově špatného stavu seniora“
- Geriatrická deteriorace jako vystupňovaná křehkost



Trajektorie frailty



Nástroje k hodnocení frailty

- Klinické vyšetření, event. funkční geriatrické vyšetření (CGA)
- Nástroje k určení přítomnosti frailty, event. pre-frailty (např. kritéria podle Friedové)
- Nástroje hodnotící míru křehkosti v kontinuu (např. Frailty Index)

Edmonton Frail Scale (EFS)

- Screeningový nástroj k měření křehkosti
  - Bez křehkosti (0-5)
  - Zranitelný (6-7)
  - Mírně křehký (8-9)
  - Středně křehký (10-11)
  - Závažně křehký (12-17)

Frailty domain	Item	0 point	1 point	2 points
Cognition	Please imagine that this pre-drawn circle is a clock. I would like you to place the numbers in the correct positions then place the hands to indicate a time of 'ten after eleven'	No errors	Minor spacing errors	Other errors
General health status	In the past year, how many times have you been admitted to a hospital?	0	1–2	≥2
	In general, how would you describe your health?	'Excellent', 'Very good', 'Good'	'Fair'	'Poor'
Functional independence	With how many of the following activities do you require help? (meal preparation, shopping, transportation, telephone, housekeeping, laundry, managing money, taking medications)	0–1	2–4	5–8
Social support	When you need help, can you count on someone who is willing and able to meet your needs?	Always	Sometimes	Never
Medication use	Do you use five or more different prescription medications on a regular basis?	No	Yes	
	At times, do you forget to take your prescription medications?	No	Yes	
Nutrition	Have you recently lost weight such that your clothing has become looser?	No	Yes	
Mood	Do you often feel sad or depressed?	No	Yes	
Continence	Do you have a problem with losing control of urine when you don't want to?	No	Yes	
Functional performance	I would like you to sit in this chair with your back and arms resting. Then, when I say 'GO', please stand up and walk at a safe and comfortable pace to the mark on the floor (approximately 3 m away), return to the chair and sit down'	0–10 s	11–20 s	One of : >20 s , or patient unwilling , or requires assistance
Totals	Final score is the sum of column totals			

CLINICAL FRAILTY SCALE

1 **VERY FIT** — People who are robust, active, energetic and motivated. They tend to exercise regularly and are among the fittest for their age.

2 **FIT** — People who have **no active disease symptoms** but are less fit than category 1. Often, they exercise or are very **active occasionally**, e.g., seasonally.

3 **MANAGING WELL** — People whose **medical problems are well controlled**, even if occasionally symptomatic, but often are **not regularly active** beyond routine walking.

4 **LIVING WITH VERY MILD FRAILTY** — Previously "vulnerable," this category marks early transition from complete independence. While **not dependent** on others for daily help, often **symptoms limit activities**. A common complaint is being "slowed up" and/or being tired during the day.

5 **LIVING WITH MILD FRAILTY** — People who often have **more evident slowing**, and need help with **high order instrumental activities of daily living** (finances, transportation, heavy housework). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation, medications and begins to restrict light housework.

6 **LIVING WITH MODERATE FRAILTY** — People who need help with **all outside activities** and with **keeping house**. Inside, they often have problems with stairs and need **help with bathing** and might need minimal assistance (cuing, standby) with dressing.

7 **LIVING WITH SEVERE FRAILTY** — **Completely dependent for personal care**, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~6 months).

8 **LIVING WITH VERY SEVERE FRAILTY** — Completely dependent for personal care and approaching end of life. Typically, they could not recover even from a minor illness.

9 **TERMINALLY ILL** — Approaching the end of life. This category applies to people with a **life expectancy <6 months**, who are **not otherwise living with severe frailty.** (Many terminally ill people can still exercise until very close to death.)

SCORING FRAILTY IN PEOPLE WITH DEMENTIA

The degree of frailty generally corresponds to the degree of dementia. Common **symptoms in mild dementia** include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In **moderate dementia**, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In **severe dementia**, they cannot do personal care without help.

In **very severe dementia** they are often bedfast. Many are virtually mute.

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Rockwood K et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005;173:489–495.

Možnosti a vlastnosti screeningových testů frailty

- Identifikace rizikových pacientů
- Indikace k podrobnějšímu hodnocení stavu geriatrického pacienta (např. CGA)
- Přesnější proti klinického odhadu

Identifikace křehkého nemocného vstupujícího do závěrečné fáze života

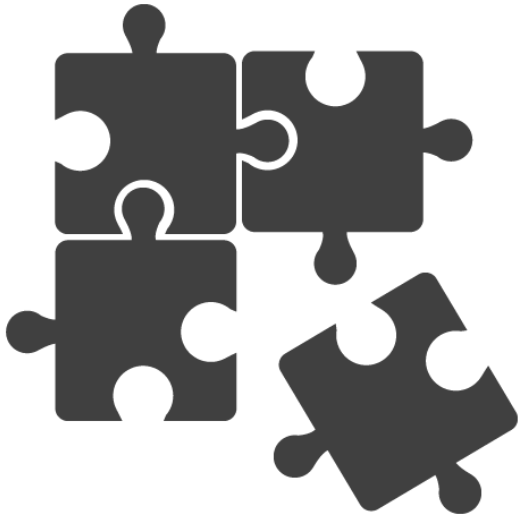
- Cíl identifikace těch, kteří by potenciálně profitovali z geriatricko-paliativního přístupu (CFS, EFS, SPICT, NECPAL)
- Cíl odhadu prognózy
- Nástroj k měření frailty s uspokojivou přesností pro detekci deteriorace neexistuje

Prognostické indikátory

- Závažná křehkost
- Opakované hospitalizace
- Recidivující infekce
- Redukce hmotnosti
- Polymorbidita
- Kombinace křehkosti a demence
- Delirium
- Dekubity
- Opakované pády
- Rychlá progrese křehkosti
- Zvyšující se distres pacienta, rodiny a/nebo zdravotníků
- Preference k redukci intervencí

Identifikace křehkého nemocného vstupujícího do závěrečné fáze života

- Mozaika faktorů
  - Měření křehkosti
  - Komplexní klinické posouzení
  - Hodnotový žebříček a preference pacient a jeho blízkých
- Individuální plán péče
  - Zaměření na potřeby nemocného, nikoli na prognózu
  - Otevřená komunikace



Klíčová sdělení

- Syndrom terminální geriatrické deteriorace je život ohrožující stav
- Je poddiagnostikovaný
- Vysoká symptomová zátěž, odlišné preference
- Screening frailty, individualizovaný plán péče
- V případě nejistoty terapeutický pokus o intervenci
- Budoucí výzkum
    - Stanovení cut-off hodnot pro specializovanou paliativní péči???
    - Automatizované prognostické algoritmy???

Děkuji za pozornost