



Elderly: Stay in the Hospital or Go Home

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Editorial

Elderly patients are uniquely vulnerable and particularly sensitive to the stresses of hospitalization and surgery/ anesthesia in ways that are only partially understood. Clearly, there are two major challenges confronting anesthesiologists today: the nuances of gerontologic anesthesia and the safety of day-case surgery. Even “normal” aging results in alterations in cardiac, respiratory, neurologic, and renal physiology that are linked to reduced functional reserve and ability to compensate for physiologic stress. Moreover, the consumption of multiple medications so typical of the elderly can alter homeostatic mechanisms. Clearly, the goal of the preoperative evaluation should be the identification of major predictors of cardiac risk in patients who have a prohibitive rate of perioperative morbidity and mortality, and are inappropriate candidates for elective outpatient surgery. Routine screening in a general population of elderly patients does not significantly augment information obtained from the patient’s history. Additionally positive results on screening tests have modest impact on patient care. So, for preoperative cardiac evaluation, the patient’s activity level, expressed in metabolic units, is accepted as the primary determinant of the necessity for further evaluation, along with the results obtained from history and physical examination. A preoperative assessment of comorbid conditions should be undertaken to detect hypertension, dysrhythmias, previous MI, cerebrovascular disease, and biventricular failure. In patients with intermediate clinical predictors, the invasiveness of the surgery and the functional status of the patient will have major roles in determining the nature and extent of preoperative testing or intervention. No preoperative cardiovascular testing should be performed if the results will not change perioperative management.

Since subtle forms of cognitive impairment can predispose to worsened cognitive outcome postoperatively, a multidimensional approach should include screening for mental status, depression, and alcohol abuse. It should be appreciated that the elderly patient is at much greater risk for long-term functional compromise after the stress of surgery. Appropriate preoperative optimization may well pay dividends in terms of improving functional status after discharge. Many anesthesiologists question whether OSA patients are appropriate candidates for ambulatory surgery. Recently, members of the ASA Task Force on Perioperative Management of Patients with Obstructive Sleep Apnea implied that OSA patients can be safely managed on an outpatient basis, as well as the appropriate time for their discharge time from the surgical facility. However, those individuals with multiple risk factors, most probably will benefit from a more conservative approach that includes postoperative admission and careful monitoring. It is important not to be lulled into a false sense of security simply because general anesthesia is not involved. Efforts to identify the “best” intraoperative anesthetic agent or technique or approach for the elderly continue, but it seems that no anesthetic agent or technique is unequivocally superior for all conditions or circumstances. Therefore, clinicians should strive to maintain homeostasis, to avoid drug cocktails—especially long-acting benzodiazepines and anticholinergics—to administer short-acting drugs, maintain normothermia and euolemia, and provide adequate postoperative analgesia. Because of pulmonary changes, especially when general anesthesia is preferred, it is imperative to appreciate that desaturation occurs faster in older adults and also they are more vulnerable to desaturation-related cardiac events. Advanced age is clearly associated with a reduction in median effective dose requirements for all agents that act within the central nervous system. This reduction in anesthetic requirement is agent-independent and probably reflects fundamental neurophysiological changes in the brain, such as reduced neuron density or altered concentrations of neurotransmitters. Use of bispectral index (BIS) monitoring, can provide more rapid emergence in geriatric patients and keeping the BIS level close to 60 rather than in the 40 range has been recommended. Indeed, neuraxial, plexus, or nerve blocks in the elderly may be associated with an increased risk of persistent numbness, nerve palsies, and other neurologic complications. Monitored anesthesia care with intravenous sedation has become really important in the ambulatory venue and many procedures can be performed with local anesthesia plus sedation. These changes have been in

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the favor of increasing number of geriatric patients with coexisting medical conditions that benefit from minimally invasive surgical and anesthetic techniques. The implications of cognitive decline in elderly are devastating because affected individuals often become dependent and withdraw from society. It has been postulated that pain, sleep deprivation, sensory deprivation or overload, and an unfamiliar environment may contribute to delirium. To overcome the problem early mobilization and appropriate environmental stimuli are encouraged. Because ambulatory patients return home to a familiar environment postoperatively where appropriate stimuli and support are available, one suspects that the incidence of delirium may be less in outpatients than in their hospitalized counterparts. Typically it should be remembered that, pain and post-operative nausea and vomiting are two of the most common reasons for unanticipated admission after

planned outpatient surgery. It is imperative that elderly outpatients be discharged from an outpatient surgery facility only if accompanied by an escort, and a competent individual should remain with the patient for at least 24 h postoperatively. Geriatric patients are at higher risk for drowsiness, confusion, falls, urinary retention, and adverse drug interactions than their younger counterparts. Clinicians should provide the patient and his or her caregiver with clear, written post-operative instructions about administration of medications, activities to be avoided, and the phone number to be called should problems or questions arise. When possible, a case might be made for encouraging ambulatory surgery because of its typically brief duration, relatively noninvasive approach, and its ability to allow elderly patients to recover in their familiar, supportive home environment.