INVITED ARTICLE

ASSESSMENT OF AN ELDERLY PATIENT

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ABSTRACT

A complete and comprehensive assessment is the first step towards rational management of the elderly patient. The traditional approach of direct response to specific complaints is inadequate. Systemic enquiries for unstated treatable complaints is essential. A full assessment consists of physical diagnosis, mental assessment, functional assessment and social assessment.

Keywords : Complete and comprehensive, unstated treatable complaints, physical, mental, functional and social assessment.

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INTRODUCTION

A complete and comprehensive assessment is an essential prequisite for rational therapeutic options in an elderly patient. It includes physical diagnosis (from history and physical examination), assessment of mental state, a functional assessment and knowledge of the patient's social circumstances (Table I). With comprehensive assessment the following objectives are achieved [1]:

- Accurate and complete diagnosis
- Screening for unreported disease
- Rational therapeutic planning
- Appropriate services usage
- Optimal placement
- Accurate documentation of change.

This approach has been advocated from studies [2-4] which show that the elderly patient often suffers from incomplete and inaccurate diagnoses. The traditional approach of simple direct response to specific complaints is fraught with danger. An approach which relies on a systematic search for unstated treatable complaints and pays attention to functional enquiries and psychological disability is needed [5]. It is hoped that improved diagnostic accuracy will lead to improvement in treatment and a reduction in disabilities through prompt intervention [6].

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(A) Physical Diagnosis

(1) *History*

The quality of information obtained often depends on the level of rapport achieved with the patient. Attention to the patient's ability to see, hear and understand the doctor is vital. A caring, friendly and respectful approach will usually ensure a rich harvest of information.

There will be occasions when the elderly person is unable to provide the necessary information. Further enquiries must then be obtained from the elderly person's carers, relatives or friends. Sometimes, several short history taking sessions may be required instead of one long strenuous one.

Table I
Geriatric Assessment

(A) Physical Diagnosis
- (1) History : Current history
  Past history
  Drug history
  Systemic enquiries
- (2) Physical Examination

(B) Mental Assessment
To assess for (1) Cognitive function
(2) Affective function.
Then search for cause, duration and factors affecting the above.

(C) Functional Assessment
Assessing the result of illness and disability on the patient's functional ability.
- Assessment of mobility status
- Assessment of activities of daily living
- Assessment of activities necessary for self-independence.

(D) Social Assessment
Account and assessment of the social circumstances of the patient.
- Home environment
- Family and other support

Apart from the chief complaints and current illness, the following points in the history are sought :

a. The importance of sequence of events and time scale of symptoms.

b. Systemic enquiries including information on eyesight, hearing, urinary and bowel problems, sleep pattern and dietary habit.

c. Past history, including all past medical diagnoses and surgical procedures.

d. Drug history, including information on both prescribed and 'over the counter' drugs. Information on the patient's knowledge of his medication, compliance, side effect of medication and drug allergies. Enquiries on past medication is also needed.

(2) *Physical Examination*

This is essentially similar as for any individual. The patient has to be told of what is to be carried out. Ensuring adequate privacy and providing a chaperone, when appropriate, is important. Examination would involve all the major systems, however certain points to note include :

a. Sensory modalities with special attention to the special senses (vision and hearing), inspection on the state of spectacles, hearing aids and when they were last assessed. Fundoscopy and examination of the ears should be carried out. Assessment of sensory loss and sensory attention should be sought in all stroke patients.

b. Inspection of oral cavity with emphasis on dentition, health of gums and inspection of dentures. Badly fitting dentures are a common recurring problem.

c. Swallowing ability, assessment of nutritional state and level of hydration are important. Stroke and other acute or chronic illness frequently involve these with surprising swiftness.

d. Measurement of blood pressure in the supine and standing position and the state of the peripheral circulation.

e. Examination of the breast and rectal examination is mandatory for all patients and a per vaginal assessment in those females with incontinence or where malignancy is suspected.

f. Assessment of postural stability involves inspection of sitting and standing balance and gait assessment.

g. Condition of skin especially with regard to evidence of pressure areas and falls. Bruises and broken skin surfaces should be noted.

(B) Assessment of mental state and mood

This involves measurement of both cognitive and affective function. Impairment of intellectual function and depressive states are common and important conditions in the elderly. Cognitive assessment would include testing orientation (to place, time and person), abstract thinking and problem solving.

Several short screening tests have been used for this including the Mini Mental State Examination[7] (a series of 30 simple questions), the Mental Status Questionnaire [8] (a brief 10 items test) (Table II) and the Set test[9] (where the patient is asked to name as many types of fruit, colour, animal and towns or countries as possible).

Assessing a depressive state is more difficult. Apart from the enquiries on the classical symptoms of depression, there are some depression scales in use. Depression quite commonly presents in an atypical manner and a high level of suspicion is required. Occasionally, a trial of anti-depressant may be started to assess response and further aid diagnosis. An example of a depression scale is the Zung Self rating depression scale[10].

Table II
Modified Mental State Questionnaire
(In use by Department of Geriatric Medicine, Tan Tock Seng Hospital)

(1) Name
(2) Date of Birth
(3) Orientation to place
(4) Orientation to time
(5) Address of house
(6) Recall of short term memory ie. 17 Moulmein Road
(7) Recognition of two persons
(8) Date of World War II/Japanese Occupation
(9) Name of Prime Minister
(10) Count backward from 20 to 1

(C) Functional Assessment

This is the assessment of the patient's pre-morbid dependency level. It allows us to assess the functional ability or the result of illness and disability on the elderly patient. This is important as it serves as a guide for therapeutic goals.

Assessment should include[11]:

1. Assessment of mobility. The patients mobility as in sitting and standing balance, walk and gait analysis and ability to use stairs is assessed.

2. Activity of daily living. The activities necessary for daily function such as feeding, eating, bathing, toileting and transferring are assessed.

3. Activity of independent living. Activities which enable the patient to be independent are assessed. Examples of these include use of telephone, knowledge of medication, house keeping skills, ability to go shopping and ability to account for their own finances.

(D) Social Circumstances

Assessment of social function should be given the same importance as physical and psychological factors. It is important to be as objective as possible and an accurate way of assessing social well being in the elderly remains a challenge. The minimum information required should include :

Details of financial situation
Previous occupation records
Place and nature of residence
Family structure
Family relationships (especially with the patient)
Details of the primary care giver
Status of the patient in the family
Other support requirements.

At the end of the assessment, an outline of the problems and how they affect the patient should be compiled. Plans on how the necessary therapeutic approach and realistic treatment goals may then be formulated. Only when the complete diagnosis is known, can adequate therapeutic measures be taken.

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