Geriatric Resuscitation

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KEYWORDS

• Geriatric • Ethics • Shock • Coagulopathies • Resuscitation

KEY POINTS

- Do not use age as the sole criteria to perform or withhold any type of resuscitation.
- Early signs of shock may not be apparent in the elderly.
- Do not assume that the cause of shock is apparent. Always keep a high level of suspicion for hemorrhage and obstructive forms of shock.
- Use bedside ultrasound as an adjunct to diagnosis and care.
- Frequent reassessment is necessary to gauge the effectiveness of resuscitation.

INTRODUCTION

The geriatric population is an ever growing demographic in the United States, and thus a significant representation of health care recipients. If 65 years of age is used as the demarcation, in 2010 a total of 13% of the US population was geriatric. Accordingly, by 2030 the percentage is projected to increase to more than 20%.[1] A significant portion of this population will become dependent on the health care system. By the time a person reaches 65 years of age they will have on average three chronic medical conditions and close to a 20% risk for hospitalization per year.[2] According to one source by the year 2050, a total of 39% of trauma admissions will be geriatric patients.[3] Currently, nearly two-thirds of intensive care unit beds are occupied by those greater than 65 years of age.[4] Emergency medical treatment of this expanding population is complicated by their relative fragility caused by nothing more than normal physiologic changes that occur with age. In general, these changes cause the individual to be at greater risk for illness and injury. In addition, many of these individuals have comorbidities that make resuscitation more complex. Trauma, sepsis, gastrointestinal (GI) bleeding, and cardiac arrest have all been shown to have an age-related increase in mortality. Most recent studies show that much of this increase is caused by comorbid disease states and not age alone. Comorbidities can decrease physiologic reserve and alter the body's ability to resist external insults.

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ETHICAL CONSIDERATIONS

Before starting resuscitation a clinician should try to determine the patient's wishes, whether they have advance directives in place, and evaluate the patient's condition for medical futility. This is true in all populations but is more frequently an issue in the elderly. In a perfect world the patient or the patient's agent/proxy would be readily available to express the patient's wishes. More often the patient arrives by emergency medical service with limited information. The advance health care directives or advance directives were developed to provide a practical process for ensuring patient autonomy and self-determination at the end of life.[5] Even though there are distinctions, for this discussion advance directives are used interchangeably with living will, a do-not-resuscitate order, or a Physician Orders for Life-Sustaining Treatment. These directives allow physicians and family to make treatment decisions that reflect the decisions that the patient would have made for himself or herself. Advance directives are not simply about avoiding treatment that would prolong life in undesirable conditions. They have become increasingly detailed and specific, often containing patient preferences for a variety of medical treatments in hypothetical medical scenarios.[6] Most of the advance directives that affect the provider at this stage of resuscitation involve do-not-resuscitate or do-not-intubate orders.

When available and known, most physicians feel comfortable complying with these patient decisions. When physicians fail to comply with a patient's advance directive, the patient or their representative may bring a civil law suit for damages.[7] Unfortunately, the advance directives are often not known or not available at the initial stages of resuscitation. Often a call to the patient's home/facility or a call to the next of kin needs to be made to clarify the proper action. If there is no information available then resuscitation should proceed as the physician deems appropriate. If an action, such as intubation, is taken and later the patient's wishes to the contrary become known, it should be noted that there is little ethical distinction between not initiating care and withdrawing care. When patient's wishes become known the providers should make every effort to apply them. Physicians may override the advance directive, but this should only be done in rare instances where there is evidence that the patient's wishes have changed since the advance directives were written.[8]

Not every patient presenting to the emergency department should be resuscitated. If the medical providers believe that an intervention is futile or that it may only bring harm to the patient, they should choose not to perform that intervention. Arguments against providing care that is futile include potential harm to patients; family members or caregivers with little or no likely benefits; and to a lesser extent, the diversion of resources that might otherwise be used to provide care to those patients who could positively respond to such care. The physician's judgment should be unbiased, and should be based on available scientific evidence, and societal and professional standards. It should include an assessment of the likelihood that a patient could physically recover as a result of treatment, or the likelihood of such treatment to relieve a patient's suffering. The American College of Emergency Physicians has a policy statement that provides some guidance and protection to the physician.[9] The best course of action is to engage the patient and/or their proxies in the decision as to what is best for the patient and continue accordingly.

RESUSCITATION

Once the decision to resuscitate has been made, the emergency physician should act rapidly. There is a tendency to treat older persons less aggressively. However, recognizing illness early and starting appropriate therapy is essential in the geriatric