

Abdominal Pain in the Geriatric Patient



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KEYWORDS

• Geriatrics • Abdominal pain • Elderly • Emergency

KEY POINTS

- Geriatric patients with abdominal disease or pathologic conditions present to the emergency department atypically.
- There is increased morbidity and mortality associated with geriatric patients who are seen in the emergency department with abdominal pain compared with younger patients.
- Further diagnostics and admission are frequently warranted in elderly patients who present with abdominal pain.

INTRODUCTION AND EPIDEMIOLOGY

Between 2000 and 2010, the population older than 65 years grew at a rate of more than 15% compared with just 10% for the entire population.¹ As the geriatric population increases, so do emergency department (ED) visits by the elderly. According to the last National Hospital Ambulatory Care Survey in 2011, more than 20 million or nearly 15% of all ED visits were by patients older than 65 years.²

After chest pain and shortness of breath, abdominal pain is the third most common chief complaint in patients older than 65 years who present to the ED.² ED clinicians (EDCs) must have a robust understanding of diseases that present with abdominal pain. These diseases are more complex, in both presentation and treatment, in geriatric patients than in their younger counterparts.

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Geriatric patients seen in the ED for abdominal pain have higher rates of admission, up to 60%, as well as longer length of stays in the ED and inpatient units when admitted. Of geriatric patients admitted for abdominal pain, nearly 20% underwent an invasive procedure or surgery.³ These patients generate more charges and cost the health care system more compared with younger patients.^{4,5}

Geriatric patients not only require more aggressive workups and treatment, they tend to fare less well when compared with younger patients. For geriatric patients discharged from the hospital who presented with abdominal pain, nearly 1 in 10 will return within 2 weeks for similar complaints.⁴ Of those geriatric patients presenting to the ED for abdominal pain who undergo surgical intervention, 17% will die, with mortality approaching 40% for patients older than 80 years.^{4,6-8}

PRESENTATION

Physiology

Numerous physiologic changes occur with age. It is necessary for the EDC to have a clear understanding of these changes and how they complicate the workup of abdominal pain.

A fever may be helpful to the EDC when considering the differential diagnosis of abdominal pain in the elderly because its presence may suggest an underlying bacterial infection. Additionally, the presence of a fever is a component of some clinical decision tools (identification of systemic inflammatory response syndrome or Charcot triad) that may help guide further management. However, geriatric patients are less able to mount a fever. In fact, 20% to 30% of older patients with an active infection may have a blunted fever response.⁹⁻¹¹ This blunted response starts with a lower baseline body temperature but may also be secondary to decreased temperature regulation by the central nervous system, decreased response to both endogenous and exogenous pyrogens, as well as decreased conservation of heat.¹¹

Geriatric patients' immune systems are less adept at fighting infections. Although the total number of T cells may not decrease significantly with age, their functionality, specifically their ability to respond to new antigens, does decrease.¹²

Both bowel and bladder functionality decreases with age. Elderly patients have a decrease in colonic motility and transit time, as well as pelvic floor dysfunction, leading to much higher rates of constipation in this age group.^{13,14} Furthermore, the risk of acute urinary retention (AUR), particularly in men, increases with age. For men older than 70 years, the risk of AUR per year is nearly 35% for those who experience moderate or severe benign prostate hypertrophy symptoms. Those with only mild symptoms still have a 10% risk of AUR.¹⁵

Finally, pain perception is also less sensitive in geriatric patients, particularly in abdominal disease or pathologic conditions.^{16,17} This can delay the presentation of serious disease.

Polypharmacy

Of patients older than 65 years, nearly 40% report taking 5 or more drugs within the past month. This can serve to complicate both objective and subjective signs of disease.

For example, geriatric patients are more likely to be on beta blockers that may inhibit tachycardic response in the setting of infection or pain. Nearly a quarter of patients older than 65 years report taking beta blockers.¹⁸ Use of opioid analgesia, which may mask serious pathologic conditions by blunting the pain response, is used by adults older than 60 years at nearly a 50% higher rate than in younger adults.¹⁹

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