Dynamic Chiropractic

SENIOR HEALTH

Lend an Ear - Your Elderly Patients Deserve It

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Considering the increasing numbers of elderly chiropractic patients, it would not be much of an exaggeration to say that 50 percent of many practices are comprised of senior citizens. People 65 and over now constitute the fastest-growing segment of our population (well over 12 percent). Projections by the U.S. Bureau of the Census show that the elderly population will expand far more rapidly than the rest of our population. This increase is expected to continue through at least 2030, when approximately 22 percent of the U.S. population will be 65 and older.[1] The 65-and-over population is expected to double from 32.2 million to 64.4 million by 2030.[2]

With the statistical increases in our elderly population, we must keep in mind certain changes that may occur with aging. One of the most important developments carrying possibly the most potentially fatal or life-changing symptoms is *cognitive status*. There are many different types of organic brain syndromes, including: delirium; dementia; Alzheimer's disease; Parkinson's disease; and Huntington's chorea, just to name a few. Except for the "named" diseases, often the etiology of the encountered problem is a reversible one, especially if caught at an early stage.

Every doctor reading this article has had a patient or a patient's spouse walk into the office for some sort of an ache or pain who mentions "my husband doesn't seem to remember things like he used to," or "my wife seems to be getting more forgetful by the day." These phrases should not only concern you, but cause an alarm to go off in your office. Sure, you are a chiropractor and as such are the best qualified to care for the patient's aches and pains. However, don't fall short of your training and discredit yourself by inflicting a *dis*service to your patients. You are a primary "portal-of-entry" physician and are responsible for the *whole* patient, not just the musculoskeletal system and complaints.

When you take an elderly person's history, you may have to compensate for hearing and visual impairments. You should realize that the chief complaint may not be a singular one. You will come to realize that many elderly patients deny themselves medical care for problems which they attribute to perceived "normal" aging. How this phenomenon is perceived by each elderly patient and is made mention of in passing conversation must not be dismissed by the doctor. Remember the credo: *What gets dismissed just gets missed*.

You probably forgot about the problem with cognitive function in the husband and wife example of mentioned several paragraphs ago. However, understand how important it is to *listen* to your patients (elderly or otherwise) and to consider *everything* that they have to say, despite how trivial it may sound.

Many of the cognitive problems that the elderly encounter have a reversible cause if treated early. Elderly patients are generally more fragile than their younger counterparts, and are therefore more susceptible to serious and permanent consequences from otherwise simple conditions. Also, remember

that many things tend to affect the elderly body in different ways than the young - often the effects do not quite match textbook "normal" with the actual pathologic process. There are several differentials for changes in the cognitive state of the elderly patient.

Differential Diagnoses for Changes in Cognition

- dehydration
- anemia
- b-vitamin deficiencies
- electrolyte imbalances
- urinary tract and other infections
- hyper/hypothyroidism
- improper prescription drug doses
- alcoholism
- substance abuse
- depression
- pneumonia
- fecal impaction
- pulmonary embolism
- heart failure
- malignancies
- subdural hematoma
- Alzheimer's disease
- vascular dementia
- normal pressure hydrocephalus
- Parkinson's disease
- Pick's disease
- Creutzfeldt-Jakob disease
- Huntington's chorea

This is by no means a comprehensive list of pathologies that may cause changes in cognition. However, many of the conditions listed have a quite simple remedy and may be easily treated by the chiropractor, once the correct diagnosis is reached via comprehensive history, physical examination and laboratory analyses. However, if the diagnosis is beyond the scope of chiropractic, the correct referral can be made and the patient can be saved from further deterioration.

I can give one excellent example from my own practice of the importance of making the correct diagnosis the first time, in this case not an elderly patient, but a 29-year-old female. She had seen at least six physicians, including a general practitioner, an orthopedic surgeon, an oncologist and two neurosurgeons. Her complaint began in 1995, two years after she was diagnosed as a gestational diabetic. She began to have right hip pain. She became dizzy often and then fell onto her left hip, which also began to cause her pain. She presented with difficulty in ambulating between two points, and her gait was very awkward. She was unable to stand up without her legs feeling as though they were buckling out from underneath her. When these pains were not actively bothering her, she had painful cramping throughout her body and limbs.

All the other physicians she had seen referred her elsewhere, yet none had any answers for this unfortunate individual. According to her, no one else ever *touched* her either - not for a physical, orthopedic, or even a basic neurological examination. She filled out all of my usual paper work and I

took the usual comprehensive history. I asked all the important questions; we covered everything from diet to sexual history. No single diagnosis seemed to fit. All the previous doctors had told her that it was "all in her mind." Then I asked her about her gestational diabetes and the therapy she received. She told me of a resulting potassium deficiency she was diagnosed with in 1995. She had taken potassium chloride 10 mEq, six pills per day, for hypokalemia, for three years. From blood drawn, we found that she was still severely hyperkalemic. No other physician had followed up on this 1995 diagnosis after the medication was administered. I monitored her blood for a month after I took her off the potassium, with full support of her general practitioner, and all of her aches and pains began to disappear. The following month I put her on daily doses of multiple B vitamins. That was four months ago; she is now pain-free and having no problems with walking.

Why am I using a 29 year old as an example in an article about the elderly? The young lady seems to paint the perfect picture of the kind of treatment many of the elderly receive: they're not listened to. Practitioners looked at the outside of the package and saw a pile of puzzle pieces that didn't quite fit together, so they "passed the buck."

Hyperkalemia: Quite a simple diagnosis, once someone asked the right questions and really listened to the answers. If something like this can be missed in an otherwise healthy 29 year old, imagine what can happen to the elderly patient with several separate presenting complaints?

Will you listen, or be just like all the other physicians that this young lady saw? Be the chiropractic physician you were trained to be. Listen to your patients.

References

1. U.S. Senate Special Committee on Aging. Aging America: trends and projections. Washington, D.C., U.S. Department of Health and Human Services, 1991.

2. Zedlewski SR, Barnes RO, Burt MR, McBride TD, Meyer JA. The Needs of the Elderly in the 21st Century. Washington DC: Urban Institute Press, 1990.

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