

## EDITORIAL

# Managing elderly patients with musculoskeletal disorders warrants a different approach

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## Introduction

Literature evidence indicates a direct association between advancing age and the incidence of musculoskeletal symptoms and limitation of movement.<sup>1</sup> Elderly subjects, particularly after the age of 60-65, constitute a special category requiring greater attention and care.<sup>2</sup> Various socioeconomic and age-related factors influence the quality of life in this group of subjects. The complexity of caring for elderly subjects could be grouped into three domains: medical complexities, challenges in interpersonal relationship, and administrative domain.<sup>3</sup> The incidence of rheumatic diseases like polymyalgia rheumatica (PMR) is more in this age group. Some of the management challenges confronted are: atypical presentation due to malignancy, increased comorbidities, and variable clinical presentations due to physiological conditions like edema surrounding the inflammatory joint. This editorial for the special issue on 'Geriatric Rheumatology' discusses how the management of rheumatic disease in elderly should differ from the regular approach.

## The role of communication, patient history, and examination

Ambiguity in communication and obtaining detailed patient history are the foremost challenges in the management of elderly. Communication is essential in collecting accurate patient history and in providing necessary instruction on self-management as well as on other aspects of health. The presence of certain factors, either alone or in combination, like moderately impaired memory, delayed communication skill, and reduced hearing influences the process of history taking in senior citizens. The emphatic statements, which are often used by the elderly, should be cautiously interpreted, since confabulation may be misleading.

Age-related changes and comorbidities would alter the clinical presentation of regular symptoms and signs

in geriatric patients. For example, in the presence of neuropathy, the pain in the inflamed joints may be minimal and the edema around inflamed joints might be more prominent than localized swelling, due to the presence of loose skin. Limited mobility, because of ageing, may not indicate the dyspnea early in the course of a lung disease. Such clinical features need greater attention. Hence standard physical examination needs to be modified for elderly patients. Such examinations should focus on assessing the problems interfering regular activities such as gait, bowel and bladder continence, hearing, and vision. Certain patient findings in elderly such as minor deviations in toes, distal phalangeal joint, and nail changes may require different interpretations. The examination should include head and neck, chest, back, abdomen, extremities, skin, mental status, breast and pelvic area in women, and prostate in men.<sup>4</sup>

The third party, who may serve as caregiver, influences the communications and caring of elderly. The third party could be spouse, children or a hired person. In an individual with cognitive impairment or dementia, the collection of history and the details may depend on the third party. The patient communication and the discussion on various problems may be altered in the presence of a third party. The focus of discussion may often change from the core issue. In the presence of a third party, the patient may be reluctant in revealing certain personal issues including alcohol consumption, smoking etc. Thus the communications between a single patient and an additional third party has been often described to be different.<sup>5</sup> An experienced physician may be able to overcome such challenges and gather necessary details about the disease and other perspectives, which are also influenced by the third party. Even the patient may concede some of the symptoms in the presence of a third party. Depending on the circumstances the patients may either exaggerate or understate a few of the symptoms. Some elderly patients who have fear

of curtailing their independence may deny the incidence of giddiness and may try to justify it. Hence, a skillful evaluation is paramount while recording and interpreting the patient history as well the signs and symptoms.

Certain classical signs in rheumatology may need careful consideration. Some of the observed changes in the joints can be considered as a part of aging. But there is no clear consensus on what and how much to be considered as permissible changes due to aging. A wide range of musculoskeletal, endocrine, metabolic, traumatic and psychological conditions may influence the clinical presentation of an elderly.<sup>6, 7</sup> The major challenge is to distinguish the signs and symptoms related to comorbidities, drugs used, and aging process. The ecchymosis can occur as apart of age-related changes or the side effect of anti-platelet drugs used. Senile purpura, dark freckles in lower limb, minor ischemic changes of atherosclerosis, and certain nail changes (the fragmentation and nail grooves), which may be suggestive of a connective tissue disease, could be a part of the age-related changes. The physician should be able to differentiate such changes from otherwise serious manifestations. The senile purpura rashes appear gradually over a longer period and are non-pruritic and hyperpigmented rashes; whereas the pathological rashes are of short duration and symptomatic. Sometimes the differences could be subtle and need a careful consideration.

The edema around the joints, especially around ankle and hands, with minimal pain and discomfort, may be the presentation of peripheral inflammatory arthritis. The reduced pain could be due to peripheral neuropathy or ligamentous laxity. The additional neurological symptoms may complicate the symptoms. The cognitive impairment, reduced mobility, and additional neurologic symptoms may add to the complexity and delay in recognizing the symptoms. In such cases, careful examination and detailed history collection is essential.

The history collection, especially in patients with impaired memory, is a challenge. It is always worthwhile to communicate with the patient's family physician. The improper maintenance of medical records by the patients and physician, especially in developing countries and by the less educated patients, further adds to the difficulty.

### **Rheumatic disease in elderly**

As per survey based on the papers published by ICMR in 2012 and COPCARD studies across India, around

30-45% of patients suffer from several musculoskeletal disorders.<sup>8</sup> Diseases that may be common in elderly and also in patients of around 50 years are: PMR, remitting seronegative symmetrical synovitis with pedal edema (RS3PE), giant cell arteritis, osteoarthritis of knee and hip, and osteoporosis. The elderly population is prone to develop all the autoimmune rheumatic diseases but the clinical manifestations may vary. The late-onset rheumatoid may affect more of proximal joint instead of small joint of hands and may clinically mimic PMR.<sup>9, 10</sup> The systemic lupus erythematosus, with typical presentation of dry mouth, thrombocytopenia and arthritis, may mimic Sjogren's syndrome.<sup>11</sup> Font *et al.* have reported reduced frequency of anti-ds DNA positivity and renal involvement.<sup>12</sup> A few series have suggested no significant difference in the renal involvement. The osteoarthritis, degenerative arthritis, and crystal-induced arthropathy, especially CPPD crystals, are common. One major concern while evaluating elderly is the probability for missing a malignancy. The psoriatic arthritis in elderly is often very aggressive.<sup>13</sup> Since the presentation of rheumatic disease varies across elderly subjects, implementation of a different management approach and customization of treatment strategy is very important.<sup>14, 15</sup>

The treatment planning should commence from the assessment of patient history. The presence of comorbidities like diabetes, hypertension, and the consequent complications strongly influence the drugs to be prescribed. Polypharmacy is a concern and the appropriate segregation of medications for different conditions is necessary. The assessment of improvement in functioning is another challenge, since the disease work-up should be based on the impact of age-related symptoms and impairments. Confronting all these challenges may assist in improving the comfort, quality, and dignity of affected subjects. A meticulous history and examination, with a lot of patience and skillful interpretation of the clinical features and planned investigation, helps in appropriate diagnosis and treatment planning in elderly.

### **Competing interests**

The author declares that he has no competing interests.

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