



FEATURES OF THE COURSE OF DISEASES OF THE DIGESTIVE TRACT IN THE ELDERLY

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Abstract

The main difficulties related to diagnosis and treatment of elderly with diseases of the gastrointestinal tract common in general practice are discussed in this article.

Keywords

elderly patient, diseases of gastrointestinal tract, General Practice.

The proportion of older persons in the general population is currently increasing every year [1]. Doctors of various specialties, primarily a family doctor, increasingly have to examine and treat elderly patients. In this case, the doctor is faced with a number of specific problems, not characteristic of patients of other age groups. Often the symptoms of serious gastroenterological diseases, both to the patient himself and to those who care for him, appear to be manifestations of an aging body that do not require examination and treatment. For an attentive family doctor who knows the patient, as well as his living conditions for many years, changes in the well-being and condition of an elderly person will not go unnoticed. But a doctor who recently met with his family may experience difficulties in interpreting the patient's pathological and age-related changes in the body. The doctor begins to experience the difficulty of examining an elderly patient from the stage of collecting an anamnesis.

Excessively active conversation with the doctor does not contribute to the establishment of psychological contact with an elderly patient, as well as an appeal to the patient by last name, or the familiar behavior of the doctor. An elderly patient often gets tired of a long conversation, in this case, the doctor can collect an anamnesis in several stages. If contact with an elderly person is difficult, the doctor may try to collect a medical history and a medical history at the same time, since it's easier for older people to remember significant events from their professional and personal lives, and then what worried about their well-being during this or that period.

The family doctor should not be limited to collecting history data from relatives caring for an elderly person. It is mandatory to conduct an interview with an elderly patient in the absence of strangers, which allows you to clarify the psychological status of the patient, his position in the family. A patient with sensorineural hearing loss is a serious problem to collect history. When communicating with him, the doctor should speak clearly, clearly, calmly, somewhat more slowly than usual, not shout into the patient's ear. The doctor's face should not only express interest and sympathy, but also should be sufficiently illuminated, as the movements of the lips help the hard of hearing patient to understand the issue [1–5].

An elderly patient is often characterized by increased suggestibility and consciously or unconsciously gives answers that he thinks the doctor wants to hear [1, 3, 5, 6]. Therefore, when examining an elderly patient, it is better to ask questions in a form suggesting a negative answer [7]. For example, when locating the location of abdominal pain, it is advisable to ask about the absence of pain in that or another zone. If the answer follows: "No, in this place, on the contrary, there is pain", then such an answer

will be closer to the truth, since the form of the question excluded suggestibility. Gathering an anamnesis, the doctor should avoid medical terms incomprehensible to the elderly person. An elderly patient and a doctor often understand the same words differently [5, 8, 9]. At the same time, many patients by old age have rich experience in medical institutions, consider themselves fairly competent in medicine and, trying to ease the task of the doctor, they begin to list the diagnoses when asked what is bothering. In this case, it is important, without interrupting the patient and not entering into an argument with him, to begin to clarify the symptoms, formulating questions differently in order to form an opinion on the diagnosis [4, 5, 7]. The medical terms used by the patient should not serve as a basis for the doctor to form a holistic view of the patient.

In many cases, an elderly patient overestimates his past treatment experience, which may prevent the family doctor from suspecting, for example, a myocardial infarction in a patient with an attack of abdominal pain, if the patient himself associates this pain with a peptic ulcer for many years [2, 7, 8]. Abdominal pain can disturb an elderly patient with a number of diseases that are not related to abdominal organs pathology: pneumonia, pleurisy, myocardial infarction, hypertensive crisis, acute right ventricular failure, renal colic [6, 9]. Opposite situations are also possible when gastroenterological diseases in elderly patients are masked by the symptoms of diseases of other organs. For example, unpleasant sensations behind the sternum, regarded by the patient as a manifestation of heart disease, may be the first sign of gastroesophageal reflux disease, and sometimes cancer of the esophagus [2, 6]. Shortness of breath, tachycardia, pain in the heart region in an elderly patient with a long-term "cardiological" history sometimes serve as a manifestation of a large diverticulum of the esophagus, gallstone disease [3, 5]. The cause of persistent cough in an elderly patient who is convinced that he has chronic bronchitis may be gastroesophageal reflux disease, cancer of the esophagus [3, 4]. Sudden asthenisation in old or old age, loss of interest in the environment is usually regarded by both the patient and his relatives as a natural manifestation of aging. However, the family doctor is obliged to pay attention to these symptoms, since they, even in the absence of a temperature reaction, often indicate the development of an acute infectious process in the body of an elderly person [1, 2, 6].

In an elderly patient, a drop in blood pressure and the appearance of tachycardia may be the only initial symptoms of an acute catastrophe in the abdominal cavity, for example, ulcer perforation [2, 6]. An elderly person who considers himself to be a patient with colitis may suffer from chronic ischemic disease of the digestive system, diverticular disease of the colon, colon cancer, and intestinal dysbiosis [2, 9]. Itching in an elderly patient is more likely to be regarded by a doctor who is familiar with the basics of geriatrics as a manifestation of cholestasis syndrome, rather than an allergic reaction, as the patient himself is often convinced [3, 5]. If an allergic reaction such as urticaria first occurred in an elderly person who is not prone to allergies, the family doctor should be wary of the patient's oncological pathology [6, 8, 9]. An attentive doctor will pay attention to migrating thrombophlebitis in an elderly family member, since this pathology is often the first indirect sign of cancer of the internal organs in the elderly, for example, pancreatic cancer [2, 6]. In general, the clinical picture of most gastroenterological diseases in people of older age groups differs from the usual submissions. All visceral reflexes in the elderly are reduced [2, 4, 6]. The intensity of pain in patients of an older age group does not always correlate with the severity of the disease and its danger to the patient's life [2]. Many diseases are often manifested only in violation of the general condition [2, 6]. Examining an elderly patient, the doctor should remember that the structure of gastroenterological morbidity in older age groups changes: the proportion of functional disorders decreases, the incidence of acute diseases decreases, but their appearance is usually not accompanied by a vivid clinical picture, the likelihood of progression of chronic pathological processes increases, and the risk of developing cancer digestive organs increases. The treatment of an elderly patient also poses additional challenges for the family doctor.

An elderly patient often has his own ideas about the treatment of most diseases of the digestive system: he does not attach importance to the organization of a balanced diet in the family, but he widely uses various biologically active additives, "folk" 328 methods of treatment, uses the advice of neighbors, acquaintances, and others who are far from medicine [3, 10]. An elderly patient more often than a young one trusts the advertising of drugs in the media, independently after reading the instructions or on the advice of friends changes the dosage of the drug prescribed by the doctor, does not use or replaces the drug with

another, more effective, from his point of view. To avoid such shortcomings in the treatment of the patient, the authority of the family doctor in the eyes of an elderly patient should be quite high. Unfortunately, this is not always possible, especially if the difference in age between the patient and the doctor exceeds 20 years. The problem is the widespread uncontrolled use of non-steroidal anti-inflammatory drugs specifically for the elderly to relieve pain, including in the abdominal cavity. The consequences of this “treatment” are well-known: this is not only aggravation of arterial hypertension, but also the appearance of “silent” gastroduodenal ulcers, which are manifested for the first time only by bleeding. Every family doctor knows that constipation is the most common “gastroenterological” complaint of the elderly. But, as a rule, elderly patients do not suspect that the prolonged use of the anthraquinone laxatives they use so often (senna based drugs) contributes to the development of colon and urinary tract cancer. They should be replaced with macrogol, lactulose preparations. Some followers of fashionable “teachings” about healing the body practice prolonged fasting, which is absolutely contraindicated in old age, even during an exacerbation of chronic pancreatitis. High carbohydrate content in the diet, as well as inadequate water intake are the most common mistakes an elderly person should pay attention to by a family doctor. Elderly patients in some cases ignore the medications prescribed by the doctor inside, because consider parenteral administration of drugs, especially intravenous, more effective. However, both intramuscular and intravenous injections are unsafe for an elderly patient, since with aging microcirculation disorders, a decrease in blood flow velocity, changes in hemostasis and the state of the vascular wall appear [3, 5, 10]. Ingestion in the elderly can also be problematic. For an elderly patient with visual impairment, swallowing, parkinsonism, decreased tactile sensitivity, and impaired cerebral circulation, it can be difficult, or sometimes impossible, to remove a tablet from the vial without scattering the others, remove it from the blister, put it in your mouth and swallow it. Often, elderly patients confuse medications prescribed by a doctor, forget the time of the last dose and take it again “just in case”. Therefore, the family doctor faces a difficult task - in detail, in many cases in writing, explain to the elderly patient when and what medicines he should take. Oral administration of the drug in old age may be less effective than in the young, due to a decrease in its absorption in the gastrointestinal tract due to involuntary changes in the digestive system. But, at the same time, in older people more often, than in young people, there are cases of drug overdose due to hypovolemia, hypoproteinemia, slowing the metabolism of drugs in the liver and kidneys. Therefore when prescribing drug therapy, geriatricians recommend reducing by one third the generally accepted doses of medications in elderly patients. In conclusion, it must be emphasized that the above features of an elderly patient suffering from diseases of the digestive system, do not exhaust all the problems facing a family doctor in a given situation. An unequivocal position with respect to a number of tactical moments has not yet been worked out, many of the fundamental issues of managing an elderly patient remain controversial, far from being resolved. The problems of managing an elderly patient with digestive diseases by a family doctor remain open for discussion.

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