

Embracing the ageing patient

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INTRODUCTION

"Every flower is a soul blossoming in nature, and everyone is a rose, but even more complex than a mere flower. Everyone is made up of infinitely layered petals, and everyone has something indescribably precious at the heart of their being". (Gérard de Nerval and Mary Balogh).

To carry this analogy further, the petals may be likened to a person's life, with each one representing the different people or activities they encounter. The associates may include their spouse, children, work colleagues, friends, family, medical practitioners, as well as any number of strangers met during daily activities. Activities could revolve around work, family, sports, hobbies, education, social life, health, religion, or leisure.¹ In a young bud the petals are tightly packed with no spaces between them. As the flower ages and opens some of the petals spread apart, and even begin to fall out. By old age there may be very few petals left. Those that remain gain importance as they occupy so much more of the individual's time and thought processes. Medical and dental practitioners are often amongst the last petals to be lost, and may become central figures in the lives of their patients. Visits are often more about the social interaction than the actual provision of treatment.

AGEING IS NOT AN ILLNESS

In the past, *Identulism* (sic) was considered part of ageing along with the other four "I's" often associated with illnesses of the elderly, namely *Incontinence*, *Instability*, *Immobility* and *Intellectual Impairment*.² Old age is not an illness, but is rather the gradual, irreversible and inevitable changes in structure and function, that occur with time. They are not due to disease or trauma, and are often associated with decreased functional capacity.³

Fortunately many of the characteristics once considered as inevitable in ageing are changing. The literature is replete with studies showing an increase in the percentage of the people living beyond 65 years, with an increase in the number of teeth being retained into old age, and an increased desire by patients to retain their teeth.² In industrialised countries, the edentulous rates have decreased due to improved oral hygiene, patient health and dental care, with many people retaining some of their natural dentition into old age. At the same time the total number of edentulous patients has also increased due to falling birth rates and increased

longevity of the adults.⁴

Nevertheless, there are many oral and dental complications which are frequently associated with physiological ageing. The most common, and it is a long list, include: progressive loss of gingival attachment, recession, cervical caries, tooth discolouration, attrition, fracture, interproximal wear, calcification of dentinal tubules, decreased pulpal vascularity, root dentine transparency, increased cementum deposition, thinning of the oral mucosal epithelium, depapillation of the tongue, decreased number of taste buds, fibrosis of salivary glands, altered salivary pH and constituents and decreased salivary volume. Xerostomia reportedly occurs in 30% of adults older than 65 years and up to 40% of patients older than 80 years.⁵ It affects their speaking, enjoyment of food, mucosal healing and denture wearing. It may also be a major contributor to the common disease-related changes in the mouth, notably caries, periodontal disease and oral cancers. The caries may also result from habits such as sucking sweets and frequent sips of acidic drinks to try and relieve the dry mouth, and is a common side effect of medications such as antidepressants, respiratory agents, opiate containing analgesics, and cardiac and anti-hypertensive drugs.⁴ Root caries in particular is prevalent in those with gingival recession, which exposes the vulnerable root surfaces. Over 50% of persons over 75 years have root caries on at least one of their remaining teeth.⁵ Sadly, the annual increase in caries experienced by older people residing in nursing homes is reported to be double that experienced by those living in the community.⁴

DISEASE-RELATED CHANGES, MULTIPLE DISEASE STATES AND MULTIPLE MEDICATIONS

Disease must be differentiated from ageing. Old people are not ill because they are ageing, but because there is some disease process affecting them. Elderly people have fewer reserves of strength than the young, and illnesses that are not serious in youth can be dangerous in old age. The most common age-related conditions, and leading causes of death in those over 75 years are heart disease, cancer, cerebrovascular disease and pneumonia as a complication of influenza.⁴

The elderly tend to suffer from more diseases than the young especially chronic diseases, and may suffer several pathological conditions at the same time. As a result they are more likely to be taking multiple medications. Commonly prescribed medication for the elderly include "statins" for hypercholesterolemia, antihypertensive agents, analgesics, drugs for endocrine dysfunction notably thyroid problems and diabetes, antiplatelet agents, anticoagulants, drugs for respiratory conditions, antidepressants, antibiotics, and those for gastro oesophageal reflux.⁵ The most frequently taken over-the-counter (OTC) medications are analgesics, laxatives, antacids and vitamins.⁵

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Polypharmacy brings with it a host of problems. A recent survey in America revealed that over 40% of elderly patients take five or more prescription drugs at any one time.⁶ Drugs can cause adverse reactions, such as stupor, confusion, excitement from sedatives; respiratory depression from narcotic analgesics; peptic ulcers from corticosteroids; and increased cardiotoxicity of digitalis in the presence of diuretic-induced hyperkalaemia. They also show a decreased homeostatic competence, which may magnify these drug responses. Patient compliance is a potential problem in elderly patients who need to take multiple medications. Non-compliance may result from patient error, non-comprehension, financial constraints, cultural attitudes, logistical obstacles obtaining medicine, or even battling to get medicine out of the bottle.

PSYCHOLOGICAL AND SOCIAL PROBLEMS OF THE AGED

With increased age faculties such as hearing and sight are diminished. This makes communication between the dentist and the elderly patient more difficult. In addition, visual and hearing impairment may lead to social isolation and/or withdrawal. This may be compounded in those who have additional social and psychological problems related to their role in life. They may be experiencing "Empty nest syndrome", be newly retired, recently lost a partner, or moved into a retirement home. These situations can impact negatively on their self-esteem. While some adapt well, others may not cope, and can display symptoms of overt or hidden depression. Some patients may not report ill health symptoms to their doctor, or may minimize their severity so as "not to make a fuss". They may also be denying the possibility of disease out of fear, hoping that if they ignore it, it will go away. On the other hand, others may constantly be seeking medical attention and are labelled as "chronic complainers" by their family or caregivers. The clinician needs to be sufficiently sensitive to ascertain whether these patients have a real physical condition, or are merely seeking the company and attention of the practitioner and staff, one of their remaining "petals".

EXPERIENCE INFORMS ATTITUDE

Attitudes develop over time based on previous life events. They reflect where a person has come from, the influence family, friends and experiences have had on their lives, and often dictate how they will proceed with their life in the future. They are thus powerful, long lasting and difficult (but not impossible) to change.⁷ One of the problems with attitudes is that they can blind a person to information inconsistent with the particular attitude. The patients become selective in the way they perceive and respond to issues, and tend to lose objectivity.⁷ In dentistry, clinicians need to consider their patient's attitudes and beliefs, try to identify some of the significant events that have shaped those attitudes, and establish what values and are important to the patient(s).⁷ For example, some patients in their 80s and 90s may have lived through the great depression and World War II and the austerity that accompanied those events. They grew up with a pennywise culture, and were prudent when disposing of items and money. This is in sharp contrast to affluent younger adults who are part of the modern "throw-away generation". The latter are accustomed to having easy access to commodities, are spoilt for choices, eat fast foods from disposable containers, and are familiar with updating devices and appliances as soon as a newer model become available. They may expect the same from their dental treatment and be impressed with / or insist on modern high-tech treatment such as that which promises a "smile in a day". Dentists need to be aware of differing patient attitudes and values, and try to understand the socio-economic history that may have shaped patient opinions. Perhaps the one feature both generations do often have in common, is that neither believe dentistry to be worth what it actually costs.

Although these two examples are broad generalization, the alert clinician, aware of differing patient experiences, attitudes and expectations, may better be able to counsel patients, as well as to effectively manage their oral needs and desires – which don't

always correspond! Thomson also cautioned against believing the stereotypes that "older people are disabled by their accumulated burden of clinical oral disorders", and that they don't place importance on their dental requirements, or have high aesthetic expectations.⁴ He postulated that their "age related stoicism, adaptability, capacity for coping, and ongoing reappraisal of what is important in their lives actually helps them manage well regardless of their physical handicaps".⁴

EFFECTS OF AGEING AND DRUGS ON NUTRITION

Age related changes in the gastrointestinal system could lead to a significant decrease in the absorptive capacity of essential nutrients. These changes include decreased intestinal blood flow and gastric motility, increased gastric pH, and decreased rate of cell renewal in the intestinal wall, with older cells being less effective in nutrient absorption. The resulting mal-absorptive processes primarily affect fat adsorption which impacts on calcium absorption, resulting in a negative calcium balance that in turn leads to osteoporosis and other disorders. Absorption of essential nutrients may be further impaired due to reactions with ingested medications. Laxatives and antacids adsorb nutrients to their magnesium oxide particles, while vegetable oil laxatives bind and prevent adsorption of fat-soluble vitamins. Vegetable fibre laxatives adsorb nutrients and may contain up to 50% dextrose, which is bad for diabetics, and have a high salt content, which affects cardiovascular patients. As well as impaired absorption of drugs, the elderly have altered distribution of medicines in the body as total body water decreases, while body fat increases. Therefore, water-soluble drugs have decreased distribution, and fat-soluble drugs (e.g. Valium) result in more extensive distribution. Protein-binding also influences distribution. With age, there is a decrease in plasma albumin, which is further decreased by illness and poor nutrition. Therefore, drugs that usually bond to protein will be higher in unbound concentrations where they exert a greater effect, e.g. salicylates, diazoxide, digitoxin, furosemide, indomethacin, penicillin, phenytoin, probenecid, sulphonamides and warfarin. Clearance of drugs from the body is slowed by factors such as decreased hepatic blood flow, decreased glomerular filtration rate, and decrease in liver mass and enzyme activity.⁵

Dietary deficiencies may result in malnutrition or even starvation. Vitamin deficiencies in particular are of importance to the dentist where they may be related to degenerative changes, including painful and/or burning mouth symptoms, while decreased folic acid leads to a smooth, red tongue and inflamed, delicate gingiva, and zinc deficiency leads to decreased salivary flow and also to loss of taste.

Note: Decreased chewing forces that result from wearing dentures may influence the selection of food types, and can make mastication difficult, but poor nutrition is not necessarily the outcome. Often social and economic factors impact more on diet than dental issues. Financial need can result in patients having an inadequate diet, poor nutrition, weight loss, inattention to medical needs, and inability to afford medicines.

HOLISTIC PATIENT CARE

While dentists still need to be familiar with the presentation and management of physiological and pathological age-related conditions in older adults, "care of the aged should be less focused on procedures and be more holistic and patient-centred".² Many of the following examples seem obvious and simple, but are often overlooked. These may include: speaking loudly, clearly and slowly for those who are hard of hearing, while at the same time not sounding patronising or condescending; facing the patients who read lips and making sure the lips are visible by removing your mask; avoid too much background noise for those with hearing aids; gaining the patient's attention by using a light touch or signal before beginning with explanations; avoiding use of technical terms; follow up all verbal communication with written instructions; before starting a procedure inform the patient what equipment will be used, and again alert them when something different is about to

be done; and follow up all verbal communication, especially post-operative instructions, with written notes that they can re-read at home. Remember too, that learning and memory are also affected by age. Understanding, assimilating and remembering new information may be more difficult for older patients. These factors of age, memory and communication are important in conveying facts, obtaining informed consent and giving instruction on post-operative oral hygiene or prescription drug taking.

On a more practical side, the clinician should also consider the mode of transport patients use to get to the clinic, if they are able to travel alone or need to rely on others to take them, if they use public transport, the costs involved and the time of day that is best in relation to the management of their other diseases, medications and meals. They may also consider comfort and technical issues such as keeping large print magazines in the waiting room and use of large print on prescription bottles, have good lighting in areas where patients will be filling in forms, using bright colours on door handles, rails and stair markers, and having a chair that is easy to access or modify (turning the headrest around) for patients who are wheelchair-bound. For patients with physical disabilities such as osteoarthritis, consider how to adjust home care oral hygiene aids such as by attaching Velcro straps or bicycle handle grips to a toothbrush, suggesting use of an electric toothbrush, or providing floss holders.⁵ When trying to determine how much home-care help the patient may need the dentist can also assess their functional status by using an index called the "Activities of Daily Living" (ADL) which measures the person's ability to function independently when performing daily activities such as moving, eating, dressing and bathing.⁸

On a more sinister note, the dental team are also in a good position to detect elder abuse. The dentist may treat "tell-tale" injuries or notice them elsewhere on the body, while the receptionist and nursing staff may perceive hostile, neglectful or awkward relationships between the elderly patient and their caregiver in the surgery or waiting room. This is commonly referred to as "granny bashing", and is thought of as a recent phenomenon, but actually has deep historical roots. It was so rife in Europe, 200 years ago, that documents were drawn up in farming communities to ensure the rights of elder parents to use the front door of the house and to sit at the family table. Elder abuse may include: physical, psychological and verbal abuse; denial of rights; withholding of personal care; financial exploitation; and active or passive physical and/or psychological or emotional neglect. Abuse is often subtle, knows no social or economic boundaries, but should never be ignored.

AGEISM AND OTHER "ISMS" (AD NAUSEUM)

Are you still reading? Good. Are you smiling? Even better. So then, having got this far, perhaps you are still YOUNG enough to read further. (Notice that first ageism already).

Like most people living in the 2nd decade of the 21-century, you too are probably punch drunk with PC (political correctness), tired of tact, sick of sensitivity, and immured by inclusiveness. So, to add to the torture, let's add ageism to the list.

The term "ageism" was coined in 1969 by geriatrician Robert N Butler who described it as "a systematic stereotyping of, and discrimination against, people because they are old". Two features differentiate ageism from many other -isms: Firstly, most people have probably already been subject to some form of ageism, and, if they live long enough, will all be subject to it. Secondly it is becoming more prevalent and apparent as opposed to many other forms of prejudice, which are decreasing (at least in the public space) following instances of severe social and legal censure – consider racism, sexism and homophobia.

Ageism is of relevance in both the private and professional lives of dentists. highlighted below are a few of the many ways it may manifest itself. Some are subtle, while others are blatant and overt.

Once one becomes aware of such practices, it's easy to see why they may offend older people, be they patients, colleagues, friends or family.

1. Advertising:

Dentists all work, to some extent, in the sphere of facial "aesthetics". Despite the fact that the effects of ageing lie at the core of this issue, the aesthetics industry is one of the worst offenders of ageism. Consider the profusion of age-related advertisements for a myriad of "beauty products and services, guaranteed to restore the appearance of youth". By buying into this and promoting treatment that will create or restore a perfect, bright, white smile, clinicians may be just as guilty of offending their elderly patients.

2. Conversation:

Everyone will have heard conversations along the lines of "Mrs Jones, I see you are 80 years YOUNG", or "Mrs Jones, you look fantastic for an 80 year old". By using patronizing phrase like these, one is accentuating rather than diminishing their person's age, and relaying the message to Mrs Jones that she looks fantastic only because she is 80 years old. It's important to guard against compliments that have hidden negative connotations.

3. Elderly behaviour:

Be wary of giving excessive acclaim to older people because they are behaving as if they are younger (sometimes inappropriately youthful behaviour). One frequently sees praise for a senior who has, for example, run a marathon, climbed a mountain, or parachuted out of an aeroplane. The older lady, sitting in her rocker, battling illness, financial constraints, mobility problems, and loneliness may be far braver but remains never acclaimed.

4. Euphemisms:

This is a bit of a minefield. Surveys have shown that some people take offence at being referred to as "elderly", "elders", "boomer", "senior citizen," or "mature". The most acceptable term seems to be "older person/people" or "senior" (without the "citizen"). All the preceding terms are, however, more acceptable than "golden oldies", "geezer", "retiree", "person of a certain age" or reference to someone being in their "sunset years". Beware also of adding adjectives as in "cute little old lady". Perhaps we should follow the advice of Dumbledore, Harry Potter's wise guardian who counselled Harry with regard to the feared Voldemort: "Call him Voldemort, Harry," he said. "Always use the proper name for things. Fear of a name increases fear of the thing itself."

5. Comedy:

Jokes about older people are sure to get a laugh – a fact well known, and so often overused by many comedians. The sort of one line quips such as: "Q: What is the advantage of Alzheimer's? A: You get to hide your own Easter eggs!" Would anyone repeat this joke with regard to a mentally handicapped person? Awareness of potential sensitivity to this is useful in one's social interactions. Because negative humour is so frequent and insidious, it may well be a root cause of the more serious forms of ageism. Perhaps the comedy industry too should be held to greater account by legal bodies, for overstepping socially acceptable boundaries.

6. The "Other -ism test":

How does one judge for oneself what constitutes ageism? A useful way to make a judgement is to replace the age-related factor with another -ism and then make the decision. "Mr Smith, it is amazing that you bungee jump at your age!" Alternately "Mr Smith, it is amazing that you bungee jump as a gay man!" Would this be acceptable? Or once again, "Mrs Jones, you look fantastic for an 80 year old!" Alternately "Mrs Jones you look fantastic for a dentist / lawyer/ second hand car dealer" Acceptable?

There is of course the flip side of ageism (or any other -ism). Not reverse-ism, but what may be termed "boomerang -ism", where the "benefits" of belonging to a cohort are exaggerated and harmful to some members of the cohort. With ageism this is

undoubtedly on the increase, and best demonstrated in older men where pharmaceutical aids to sexual function have brought about the expectation that virile sexual activity and being a “sexy senior” should extend well into the 9th or 10th decade of life. No such pharmaceutical benefit is yet available for women. On the other hand, women are pressured by societal expectations to pursue and conform to stereotypical images of physical attractiveness. There are a myriad of cosmetic and surgical procedures such as “rejuvenating” skin treatments, breast enhancements, and even vaginoplasty being advertised and available to them. Yes, you did hear right – and on that note, even hearing aids are now promoted as “sleek and sexy devices” in colours such as “Champagne Beige, Samoa Blue, Racing Green, Cabernet Red, Sexy Silver, and Negligee black!”

One has to be realistic – with increasing age one is closer to dentures, dribbling, diapers and death. Let’s take a cue from our older friends and family by declaring war on ageism – see if it doesn’t liberate you a little.

CONCLUSION

The increasing number of dentate and edentulous older adults will likely form a larger proportion of dental patients in the future. There will be a greater demand on dentists to manage conditions such as chronic xerostomia, active root caries, progressive recession and periodontal disease and ongoing incremental tooth loss. This may be complicated by physiological age-related oral and general changes, co-morbid medical conditions, regular use of a number of prescription as well as OTC drugs, and declining physical, sensory and cognitive faculties. This final chapter has emphasised the need

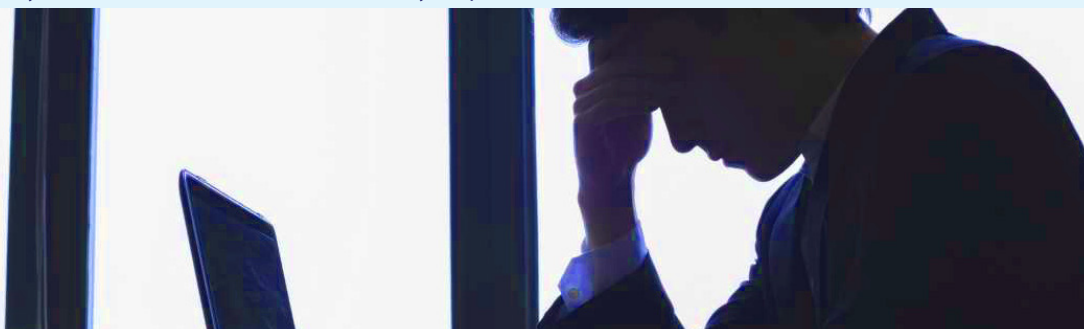
to be more aware of the older patients’ problems, experiences, attitudes and oral health needs, and to identify, develop and test innovative approaches to catering for them holistically.

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Readers will note that we have reduced the number of General Questions to twenty whilst retaining five Ethics based questions. Our allocation of CPD points remains unchanged. There is optimism that this section will continue to provide members with a valuable source of CPD points whilst also achieving the objective of CPD, to assure Continuing Education. **Please note that SADA is no longer offering the ‘CPD via SMS’ service.**

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