EDITORIAL

Treatment decisions in the elderly: tailor-made thinking

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The number of people of 65 years or older is growing rapidly. It is estimated that in Europe 17% of the European population is ≥ 65 years (total 88 million), increasing to 157 million people in 2060 (Eurostat Statistics). However, there is no such thing as 'the older patient'. There is an enormous heterogeneity present in our older patients, as compared with younger, generally more healthy patients. This is contributable to a number of factors.

The biological age of any patient depends largely on their medical history, actual comorbidity, medication use and physical capacity. In the elderly, besides the somatic axis, three more axes are used to describe the patient: psychiatric, functional and social status. In general, older people will have multimorbidity, polypharmacy, cognitive decline and decreased physical activity. Studies show that 55-98% of older patients have multimorbidity, i.e. two or more chronic diseases.[1] More often than not, these problems interfere with each other, making it harder for the clinician to treat each different, in itself simple, condition. With decreased life expectancy due to advanced age, quality of life and taking into account the 'cost and benefits' should play a bigger role in the decision-making process regarding (invasive) treatment options. The positive and negative effects for the patient should be carefully weighed, bearing in mind that most older patients will have an increased risk of complications, such as delirium and will need more time for rehabilitation.[2] That being said, there is a risk of undertreatment of older people if the only thing taken into account is age, with no regard for the status of this unique older patient. Treating an older patient with calendar age as the only criterion is likely to lead to overtreatment of the frail older patient and undertreatment of the biologically younger patient.

More evidence-based medicine (EBM) should be obtained to ensure optimal treatment decisions for our older patients. In their article, Mooijaart et al. explain which measures should be taken to improve EBM in older patients: systematic acknowledgement of the patient situation, generating more scientific evidence and increasing doctors' experience and expertise.[3]

Apart from the need for more EBM for our elderly patients, there is growing acknowledgement of the need for tools on decision-making in treatment options for biologically ageing patients. In their article, Van Loon et al. conducted a survey among Dutch nephrologists to assess the role of cognitive, functional and psychosocial issues regarding dialysis initiation.[4] These issues, and especially cognitive problems, are considered relevant; however, Van Loon et al. concluded that systematic assessment of the above-mentioned three issues is not in the standard care. Screening measurements are used, but it is yet to be determined what their value is with regards to improving decision-making.

We all want to identify those patients, in whom forgoing treatment is the better choice. However, generally doctors are more prone to act, and are reluctant to stop or not initiate treatment. A recently published report by the Royal Dutch Medical Association (KNMG) describes the motivations for clinicians to continue treatments, and the mechanisms installed in our care system that are sustaining this way of practising medicine.[5] It also provides medical professionals with measures to reach a level of appropriative care for our older patients.

As there is no standard older patient, there also is no standard way of treating that patient. In general, guidelines have little to offer for the multimorbid patient. With a patient using multiple medications and suffering from more than two chronic diseases, the clinician has to be able to weigh all the different aspects to reach the best plan of action for this particular patient with this particular combination of problems. In all branches of medicine, colleagues are searching for tools to identify the elderly patient, for whom forgoing treatment should at least be seriously considered.

One of the terms often used regarding this type of older patient is frailty. Frailty is a syndrome, describing a patient with three or more of the following criteria present: unintentional weight loss, self-reported exhaustion, weakness, slow walking speed and low physical activity.[6] However, frailty indexes alone do not seem to suffice in

the triage of patients eligible for invasive treatments such as chemotherapy or surgical procedures.

A factor that is not always taken into account is the opinion of the patient. In our experience, when given adequate information and ample time to think about and discuss the matter with loved-ones, older patients are very capable of making decisions concerning their future, even when it comes to starting, stopping or forgoing medical procedures or treatments. This will, however, require a different approach from the clinician, and a switch from a modus of foremost wanting to 'act' to a position in which not starting treatment is an equally possible outcome as starting one.

Of course, we should not make the patients' wishes the only factor in decision-making. For every suggested treatment or procedure, we as clinicians have the obligation to assess the benefits and risks for our patients. If, based on medical reasons, the risks outweigh the benefits, the decision should be made not to start the treatment or procedure. However, in most cases there remains some level of debate whether a treatment will be more beneficiary or detrimental to the patient. In those cases, frailty indexes or other screening instruments can help to ease the decision-making. Furthermore, in all of the cases in which there is debate about a treatment plan, the point of view of the patient should play an important role.

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