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AGEING - THE INDEPENDENT RISK INDICATOR

Saba Sohail

KARACHI

The graying of hair at temporal region (from tempes=time) is a harbinger of more than the chronological passage of time. It also announces the anticipation of greater health care and social needs. Majority of these health care situations are expected as part of degeneration processes such as the osteoarticular degeneration leading to joint diseases and hearing disturbances; the atherosclerotic intimal degeneration leading to hypertension, ischemic cardiac diseases and cerebrovascular accidents (stroke); the lenticular degeneration leading to cataract and related visual impairments; Alzheimer's disease, and so on and so forth. However, apart from these chronic and expected geriatric complications, advancing age is increasingly being recognized as an independent predictor of high risk situations for example postoperative atrial filorillation following cardiac interventions,[1] non union of fractures which are so common in the osteoporotic bones of the elderly,[2] and a myriad of evidence based therapies,[3] which are primarily intended to rectify the degenerative complications of the elderly.

The current issue of JCPSP highlights the issue of old age as an independent predictor of post – stroke recovery, wound dehiscence and post myocardial infarction mortality. In all these situations, advanced age i.e. over 50 years was both a primary etiologic factor and an important, statistically significant, variable in the high risk group. This most probably represents a complex interplay of the gravity of the primary morbidity, the background vascular degeneration failing to provide an adequate backup for repair and a decline in the stress coping mechanism required for intrinsic damage control. It is already known that baseline risk for myocardial mortality is 12 times less for the younger (<50 years) than the elder (> 75 years). Yet the risk benefit trade – offs in management decision making have to be carefully considered before negating or denying survival benefits.

The relatively sensitive issue of the 'elderly primigravida' is yet another proposition where the strict definition of old age or rather 'geriatric obstetrics' cannot be applied. With urbanization, career – oriented approach, emphasis on higher education and economical independence, more and more women are opting for late marriages and even later pregnancies. Again the advanced assisted reproductive techniques will lead to expansion of this stratum. The fact that it leads to more maternal and fetal complications and is again a risk – benefit trade off. Naqvi *et al.* have duly identified the exact obstetrical complications which necessitate an extra vigilant antenatal care and preparation for prenatal complications that add up due to the surgical mode of delivery. Here again the complex interplay of stress – coping and chronological degenerations, (leading to fibroids, cysts and angiopathies), superimposed over the intrinsic risk of labor, is brought into force.

The elderly population of world is growing at an annual pace of 2.4%.[4] Indicators are suggesting that developing countries are going to bear an increasing burden of managing the chronic diseases of the elderly as well as the risk attending emergencies of chronic debilitions and surgical awareness, in the future. This is aptly termed as the possible eruption of a demographic volcano.[5] Health planners in Pakistan should rouse to tackle this upcoming challenge. Geriatric medicine has to be developed and promoted although it is also heartening to note that geriatric care societies have begun to develop atleast in the bigger cities.

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