

# Elderly patient

The [definition](#) of an [elderly](#) patient can vary depending on the context and the field of healthcare, but it typically refers to an individual who is older in age and may require special consideration in medical care. While there is no universally agreed-upon age at which a person is considered elderly, the term is often used to describe individuals who are in the later stages of life, usually at their 65 years of age or older.

In many countries and healthcare systems, the age of 65 is commonly used as a starting point for defining elderly patients for various purposes, such as healthcare policies, social programs, and research. However, it's essential to recognize that chronological age alone does not capture the full spectrum of an individual's health or functional status. Health and well-being can vary widely among people of the same age, so healthcare providers often consider factors such as the patient's physical and mental health, functional status, and the presence of age-related conditions when determining appropriate care and interventions for an individual.

In geriatric medicine and gerontology, healthcare professionals may use different criteria to define elderly patients, often based on the assessment of an individual's physical, mental, and functional health. This approach allows for a more individualized and holistic assessment of a patient's needs and healthcare management.

Overall, the definition of an elderly patient is somewhat flexible and may be influenced by cultural, societal, and healthcare factors. It is more important to consider an individual's specific health and functional status when providing medical care rather than relying solely on a fixed chronological age to determine when a person is considered elderly.

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Elderly patients have been considered at higher risk for surgical complications and poor outcomes compared with regular adult patients, and literature across the surgical disciplines supports this notion <sup>1) 2) 3) 4) 5)</sup>.

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From a chronological viewpoint, medical treatment of the elderly (geriatrics) starts from the age of 65 years old. This definition per se is nowadays certainly not really an adequate definition of an elderly patient and the reason to be treated by a geriatrician. In addition to chronological age, other factors must be considered in order to define the elderly patient. Functional reserves decrease with age, which leads to increased vulnerability. [Frailty](#) as a term describes this situation and can be defined pathophysiologically by a mainly subclinical inflammatory state. Therefore, in 2007 the German Society of Geriatrics (DGG), the German Society of Gerontology and Geriatrics (DGGG), and the German Group of Geriatric Institutions (BAG) have jointly developed a definition of the geriatric patient <sup>6)</sup>.

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Current predictions suggest that the number of persons 65 years of age and older will more than double in the United States during the next 30 years. As a result, the number of elderly Americans could increase from 34 million in 1998 to approximately 69 million in 2030. This increase, combined with the disproportionate rate at which elderly patients use medical resources, will require that

primary care physicians become increasingly knowledgeable about the needs of geriatric patients and increasingly efficient in the evaluation and management of concerns unique to these patients.

The value of performing a comprehensive geriatric assessment appears to be equivocal. Simple screening instruments can be helpful in identifying patients at risk for common health problems and in improving the clinical assessment of a disease course.

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They are sometimes considerably disabled due to [lumbar degenerative spondylosis](#) and may need major spine surgery.

## Neurosurgery disease in elderly patients

[Idiopathic normal pressure hydrocephalus](#)

see [Glioblastoma in elderly patients](#)

## Malignant MCA infarction

Less than one-tenth of candidates with malignant MCA infarction in Japan underwent decompressive surgery, and the vast majority of patients were elderly. Age was not found to be an independent factor for immediate mortality in this study, and performing surgery in the elderly may be justified based on additional evidence of functional improvements <sup>7)</sup>.

## Coil embolization

Endosaccular [coil](#) embolization is safe and feasible for elderly patients with asymptomatic UIAs. Old age itself should not be a contraindication <sup>8)</sup>.

## Geriatrics-surgery co-management program

[Geriatrics-surgery co-management program](#)

# I15189

Title: [Syncope](#) and [Spinal Fracture](#) in a 96-Year-Old Male with Complex Medical History: A Case Report

Introduction: Syncope in elderly patients presents a significant diagnostic challenge, especially in those with multiple comorbidities. This case report describes a 96-year-old male with a complex medical and surgical history, admitted after an unwitnessed syncopal episode. Subsequent imaging revealed bilateral [subdural hygromas](#), a [vertebral compression fracture](#), and a possible hematoma, highlighting the intricate management required for [geriatric patients](#).

## Patient Information:

Age: 96 years Sex: Male Social History: Non-smoker, consumes one glass of wine daily. Medical History: Hypertension, hypercholesterolemia, stage III chronic kidney disease (CKD), paroxysmal ventricular tachycardia, benign prostatic hyperplasia (BPH), and depression. Surgical History: Right inguinal hernia repair, bowel resection for intestinal obstruction (2015), bilateral cataract removal, hip prostheses (1998, 1999), with pending oculoplastic surgery for orbital fat prolapse. Medications:

Parapres Plus (16/12.5 mg): 1 tablet daily for hypertension. Simvastatin (10 mg): 1 tablet daily for hypercholesterolemia. Heipram (10 mg): 1 tablet daily (chronic) for depression. Vesomni (6/0.4 mg): 1 tablet daily for BPH. Colchicine (0.5 mg): 1 tablet every 2 days (chronic). Gotaric (80 mg): Half tablet daily (chronic). Ideos (500 mg/400 IU): 1 tablet daily (chronic). Finasteride (5 mg): 1 tablet daily for BPH. Pantoprazole (20 mg): 1 tablet daily. Clinical Presentation: The patient presented to the Emergency Department (ED) after a syncopal episode at home. There were no witnesses, and the patient reported no recollection of the event or any preceding symptoms. He denied any loss of sphincter control. Upon arrival at the ED, he exhibited severe hypertension (BP 202/93 mmHg) but was afebrile (36.9 °C) and had a regular heart rate (71 bpm). Pain assessment revealed a score of 7/10, and neurological examination scored him at 15 on the Glasgow Coma Scale, indicating full orientation.

## Examinations and Diagnostics:

Physical Exam: Cardiac and pulmonary auscultation were unremarkable, with regular heart rhythm and preserved vesicular breath sounds. The abdomen was soft, non-tender, and without palpable masses or peritoneal signs. Lower extremities showed no edema, with palpable and symmetric pulses. Neurological Exam: No focal deficits or neck stiffness were noted. Imaging Studies:

Cranial CT: Compared to previous imaging, subarachnoid hemorrhage in the parafalcine region had resolved. Bilateral subdural hygromas (5 mm on the right, 7 mm on the left) were observed, with no mass effect or midline shift, suggestive of chronic subdural fluid accumulation. Spinal MRI: Showed a compression fracture of T12 with 45% height loss, edema, and a probable acute horizontal sacral fracture. Degenerative changes, including lumbar disc dehydration and canal stenosis, were noted at several levels, with severe foraminal stenosis at L4/5. A septated fluid collection, likely a hematoma, was observed in the right pararenal space, measuring 95 x 35 mm. Management:

Initial Management: Conservative management with a spinal brace was initiated for the T12 compression fracture. Pain control was optimized, and the patient was encouraged to mobilize with a walker. Follow-up Care: Regular blood pressure monitoring was advised, given his hypertensive history and recent elevated reading. Additionally, close renal monitoring was deemed necessary due to his CKD status and potential impact of medication interactions. Outcome and Follow-Up: The patient demonstrated stable cognitive status, adequate pain control, and maintained functional mobility with assistive devices. He was planned for outpatient follow-up with neurology and orthopedic specialists to assess progression and address potential surgical options if conservative management failed.

Discussion: Syncope in elderly patients is multifactorial, often exacerbated by cardiovascular, renal, and neurological conditions. This case highlights the complexities of geriatric care, emphasizing the importance of an interdisciplinary approach. The patient's imaging findings, including bilateral hygromas and [spinal fractures](#), further complicate the case, requiring vigilant follow-up to prevent complications, such as rebleeding or worsening of structural spine changes.

Conclusion: This case underscores the need for thorough assessment and tailored management in

elderly patients presenting with syncope and subsequent spinal fractures. Multidisciplinary care is essential to address the interplay between chronic comorbidities and acute trauma, ensuring a holistic approach to recovery and functional maintenance in a high-risk population.

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