

MIND & BODY

DocTalk

FRAILITY MYTHS

Condition is not inevitable with age and should be tackled early

Wong Wei Chin
and Lim Wee Shiong

Madam Sim, who is in her early 80s, used to enjoy regular morning walks, group qigong exercises and travelling on public transport to explore new eateries with her friends.

However, over time, the onset of arthritis and joint pain in both her knees gradually hampered her physical activity.

Madam Sim found it increasingly difficult to board and alight from the bus and train. The pain got so unbearable that she had no choice but to stop using public transport altogether.

As her knee pain worsened, she became more socially withdrawn and eventually stopped venturing outdoors completely.

Things took another turn for the worse when Madam Sim came down with a common cold a few months later.

Feeling groggy and unsteady from her flu medication, she fell while getting out of bed. She ended up at the hospital emergency department with a head injury and was hospitalised.

Madam Sim is a classic example of a frail patient. Arguably, the most significant impact of frailty on a person is the reduced ability to perform normal day-to-day activities as well as a loss of independence, which can spiral into physical or emotional isolation.

Growing frail

Frailty is a common geriatric syndrome that is characterised by diminished strength, endurance and physiologic reserves.

This means even small changes in health, such as a minor infection or change in medication, can put a frail person at significant risk of adverse outcomes.

In the case of Madam Sim, a seemingly minor event such as the common cold caused a disproportionate change in physical and mental well-being.

As geriatricians, my colleagues and I have seen a growing number of elderly folk and their caregivers struggle with frailty.

While there is no single cause for the condition, research has identified several risk factors, including chronic diseases such as



ST ILLUSTRATION: CEL GULAPA

diabetes, cardiovascular disease or chronic lung disease, and physiologic impairments. The condition can result in longer hospital stays, admission to nursing homes and death.

Despite its growing prevalence, there is no gold standard measurement to identify frailty. In fact, there exists different schools of thought within the medical fraternity on how best to identify and measure frailty.

Perhaps the biggest misconception about frailty is that it is an unavoidable consequence of ageing, with caregivers, patients and even medical professionals sometimes attributing weakness or slowness to "wear and tear" or "old age".

As a result of this, opportunities

for timely intervention are often lost.

To help patients and caregivers cope better, we must first help them better understand the condition as myths about frailty abound.

Some common myths include:

1. FRAILITY IS AN INEVITABLE PART OF AGEING

Fact: The risk of frailty increases with age, but it is not inevitable.

In Singapore, research has shown that only approximately 3.5 per cent to 5 per cent of community-dwelling individuals aged 50 and above are frail.

Studies from other countries reveal that up to 25 per cent of community-dwelling older adults are found to be frail.

2. PEOPLE WITH MULTIPLE CHRONIC MEDICAL CONDITIONS AND/OR DISABILITIES ARE FRAIL

Fact: There is a difference between frailty, multiple chronic medical conditions and disability.

Not all those with multiple chronic conditions are frail. It is possible for them to maintain their fitness with proper disease management.

Similarly, while frailty can lead to severe loss of function, not all persons with disability are frail. For example, para-athletes may have a range of disabilities but are just as – if not fitter than – the average adult.

3. FRAILITY IS IRREVERSIBLE AND ALWAYS LEADS TO ADVERSE OUTCOMES

Fact: It is a dynamic condition

comprising a spectrum of non-frail, pre-frail and frail states.

A person's frailty can improve or worsen over time, depending on his preceding state – a weaker person is less likely to improve to a pre- or non-frail state. Frailty should thus be addressed as early as possible.

Prevention or cure?

A comprehensive assessment of a person's medical, functional, psychological and social needs can help to piece together a useful snapshot of possible risk factors of his frailty.

Medical conditions that are potentially reversible, such as occult bacterial infection, can be diagnosed and treated. Medication should also be reviewed by a doctor or pharmacist; drugs that are no longer necessary should be stopped.

Following this, it is important for a frail individual to engage in physical activity, in particular strengthening exercises.

Strength training in older adults does not mean lifting heavy weights at the gym. On the contrary, simple movements such as the sit-to-stand exercise are useful workouts that can be performed at home.

A frail individual should also have a healthy, well-balanced diet. Physical exercise and good nutrition practised early in life will help reduce the risk of frailty later on.

Initiatives such as campaigns to promote exercise and healthier diets in older adults by the Health Promotion Board are helpful. More of such programmes are needed in the community to empower more elderly people to age well.

Madam Sim recovered well after a period of rehabilitation, coupled with a comprehensive review and adjustment of her medications.

Upon her discharge from the hospital, she could walk with a walking aid, although climbing the stairs was sometimes difficult.

With her daughter's encouragement and support, Madam Sim gradually resumed her daily activities, including jaunts to hawker centres – usually accompanied by her daughter. Her story had a happy ending, thanks to the family support and early intervention she received.

Unfortunately, for some patients, frailty is no longer reversible owing to the advanced state or the worsening of their underlying chronic medical illnesses.

In such cases, communication between the frail patients, their families and healthcare providers is vital – not only to discuss treatment goals, but also to help their families cope better with the caregiving challenges that would come their way.

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Helping kids to cope with stress key to a lifetime's well-being

Smita Malhotra

I woke up in an ambulance.

I was in ninth grade practising for my school's choir performance. It was my first field trip in my new home in the United States, and I was nervous. Then, everything went black.

I had fainted, and broke all my front teeth in the process. As the paramedic gently explained to me why there was blood gushing from my mouth, he asked if I had eaten. "Yes," I said. But I was lying.

Shortly after moving to the US, I developed almost debilitating anxiety. On that field trip, I travelled in a bus and the whole time, I worried about making it home safely, and had forgotten to eat.

At the hospital, I had an entire work-up for fainting spells; my paediatrician prescribed anti-anxiety medications. But no one asked what had happened to me and my anxiety continued to hound me. It became a part of me, like an extra appendage I just had to deal with.

Then, an encounter with a patient

in my paediatric clinic changed the way I practise medicine, and my life. A boy I saw looked withdrawn, so I put down the evaluation forms. Instead, I asked him about current or past stress.

He told me his dad had left their family six months ago, and shortly after that, he started having trouble focusing in school. I didn't know it at the time, but I had used one of the basic practices of trauma-informed care, where instead of asking "what's wrong with this child", we ask "what happened to this child". I watched the boy heal with therapy (and without medication).

In 1998, the US Centers for Disease Control and Prevention and Kaiser Permanente published a study that surveyed over 17,000 adults about their history of exposure to childhood traumas, including sexual and physical abuse, emotional and physical neglect and family dysfunction. They labelled these as Adverse Childhood Experiences (ACEs) and developed a scoring system.

Compared to one with a 0 ACE score (no exposure to trauma), someone who scored four or higher

had more than twice the risk of developing liver and chronic lung disease. A score topping seven tripled your lifetime risk of having lung cancer and heart disease. Several subsequent studies showed how different types of childhood traumas can rewire the brain. These children live a majority of their lives in "fight or flight" mode. Their brains are thus overloaded with stress hormones and they cannot focus on learning.

Just as chronic toxic stress can rewire a child's brain, the exposure to interventions that promote resilience (including trauma-focused therapy, proper nutrition, yoga and mindfulness) can help the brain to form new connections, a phenomenon called neuroplasticity.

Now in my work as a paediatrician, I understand that in my work-up for a child's abdominal pain, I must also look at social and emotional determinants of health.

I educate parents about tools to help build resilience, and the importance of having a compassionate and available adult in a child's life.

I counsel parents about how their own childhood experiences and traumas can affect their parenting.

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And those scars can live with our children for a lifetime.

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