Chapter 26
Comorbidity of Medical and Psychiatric Disorders in Geriatric Population: Treatment and Care

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ABSTRACT

Ageing is a universal phenomenon that has not only social but also economic, political, and health-related implications. With the advancement in healthcare facilities and better availability of health services, the geriatric population is gradually increasing. But, this group is at an increased risk of developing both physical and psychological co-morbidities due to age-related factors and changes in the social circumstances. The present chapter proposes the concept and issues related to co-morbidity in the geriatric population. After discussing the issues and consequences of medical and psychiatric co-morbidities, their effective treatment regime and care/management in relation to the geriatric population are addressed.

INTRODUCTION

As worldwide mortality declines, people are living longer with disability and multiple comorbidities, with important implications for global healthcare needs. In developed nations, about one in four adults have at least two chronic conditions, and more than half of older adults have three or more chronic conditions. Elderly individuals (defined here as persons aged ≥65 years) are burdened by multiple concomitant medical as well as psychiatric disorders. The medical comorbid conditions, such as metabolic syndrome, respiratory and cardiovascular conditions, and endocrine abnormalities are common, while with the most common concurrent psychiatric illnesses being anxiety, depression, bipolar disorder, delirium, dementia and substance use disorders (Karlamangla et al., 2007). In older adult (persons aged ≥65 years) populations with depression, the presence of comorbid-anxiety is associated with more severe depressive symptoms, more chronic medical illness, greater functional impairment and lower quality of life (Hegel

DOI: 10.4018/978-1-5225-7122-3.ch026

et al., 2005). There is also evidence to suggest that substance abuse outcomes may be particularly poor among the elderly (Patterson & Jeste, 1999; Langa et al., 2004).

CONCEPT OF CO-MORBIDITY

Feinstein described the term comorbidity as "any distinct additional entity that has existed or may occur during the clinical course of a patient who has the index disease under study." (Feinstein, 1970). In psychiatry, co-morbidity refers to the co-occurrence of two or more medical or psychiatric conditions, which may or may not directly interact with each other within the same individual. The difficulty to define comorbidity emerges from several reasons. One of them is the very nature of health problems involved. Differentiating the nature of conditions is critical to the conceptualization of comorbidity, because simultaneous occurrence of loosely defined medical entities may signal a problem with the classification system itself (Kaplan & Ong, 2007). Another reason for the problems emerged in the conceptualization of comorbidity is difficult to determine the index disease (primary disease) (Schellevis et al., 1993) considering the definition of Felstein, 1970. Depending on the research, different diseases can be considered a disease index. The conceptualization of comorbidity becomes more problematic when considering diseases that might be viewed just as possible complications of other diseases (Valderas, 2007).

Comorbidities are frequently considered in the context of an index disease (e.g., a newly diagnosed cancer); yet, the index disease focus is not sufficiently comprehensive for a general nosology, and may not be suitable for use in primary care settings. Comorbidity is the total burden of biological dysfunction. Traditionally, comorbidity assessments primarily include overt diseases; because subclinical dysfunction and impairments are highly prevalent in older adults and contribute to health outcomes, particularly when they occur in multiple systems. Lifestyle issues, socioeconomic factors, and health care access and quality, genetic factors affect health outcomes and mitigate or accentuate the effects of comorbidity on outcomes. The effect of these factors on health may be captured, at least partially, by measurements of biological processes included in this nosology. Disabilities in activities of daily living representing interaction of an individual with her/his environment are also not included in this nosology.

Older adults generally have multiple medical problems, and no single medical issue can be evaluated and treated in isolation (Van den Akker et al., 1996). In population studies, the prevalence of comorbidities and number of comorbid conditions increase with age (Wolff et al., 2002). In 1999, 24% of Medicare beneficiaries, aged 65 years or older, had four or more chronic conditions. The proportion was 31.4% among those persons 85 years or older (Wolff et al., 2002). Even healthy older adults and those with a single clinically manifest disease are likely to have subclinical pathology in multiple organ systems (Harris, 2003). Moreover, many older men and women experience a gradual decline in physical strength, gait speed, manual dexterity, memory, and cognitive skills, in the absence of a clinically manifest disease process (Fried et al., 2004). Coexistence of multiple such impairments complicates the diagnosis, treatment, and natural course of individual health conditions in older adults. Research has shown that cognitive decline, reaching the threshold for dementia, affects a large proportion of elderly in-patients and is associated with certain alterations, the treatment of which is complicated by the mental state of this segment of the population (Lopponen et al., 2004).

Patients with multiple chronic conditions have on average a higher level of morbidity, poorer physical functioning and quality of life, a greater likelihood of persistent depression, and lower levels of social