The Hong Kong Geriatrics Society Newsletter

The Hong Kong Geriatrics Society

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Editorial

We have very interesting articles and local news in the present issues. Besides the current hot topics of prevention of falls, prevention of other accidents in older people is also important as apparently Hong Kong is not a very safe place for older people to live in. We have two important reports published here: the HKGS response on the Advance Directive issue and a conference report on Nutrition. HKGS has developed a number of SIGs and many have function well in the development of knowledge or provision of service in their particular area of interest. Members are welcome to join in and develop them further. Looking forward to seeing you in the annual outing of our Society on 5/12/04.

Mok CK, Editor

President's Message
Integration, disintegration, re-integration
Dr TK Kong

This headline was used in the September 1998 issue of the BGS Newsletter in an article by Professor Grimley Evans in response to the concern of Dr. Arup Banerjee (the BGS President then) that the outcome of the "integrated" practice would be "many elderly patients with complex needs being cared for by physicians not accredited in geriatric medicine."

Structural integration of Geriatrics with Medicine started in 1994 in Hong Kong, and its completion is indicated by such names as "Department of Medicine and Geriatrics", or "Department of Integrated Medical Service." Have we achieved the vision of Professor Grimley Evans, the originator of the integrated model? He argued that the concept of the integrated model was to ensure that the increasing numbers of older people referred to hospital general medical services had immediate access to the full range of modern medicine including geriatrics, and that acute geriatric service should be an integral part of the complete spectrum of geriatric services, including geriatric rehabilitation, day hospital, out-patients, long-stay care and community liaison. However, Professor Grimley Evans lamented that disintegration had occurred when the integrated model was driven by cost-saving incentive, with deprivation of the frail old from the full spectrum of geriatric services.

Are our frail elderly patients missing out in the current service organization? How many of the frail elderly patients hospitalized acutely with the "geriatric giants" have these problems identified and have access to geriatricians? Are the individual rehabilitative needs of frail elderly patients recognized or are they sent randomly to "convalescent" hospitals or aged homes because of bed pressure in acute hospitals? In an interview about the early days of geriatric service in Hong Kong, Dr. Chan Sik, the first consultant geriatrician in Hong Kong and the first President of our Society recalled, "People thought then that geriatric wards were simply convalescent wards for older patients, a place where they waited to recover, or to die." How many are still holding such views? Recently, I heard of the term "acute convalescence."

Since the inception of the specialty of Geriatrics in 1975, the number of specialists in Geriatric Medicine in Hong Kong have risen to 120 in 2004, with a growth spurt for the years 1997 to 2000 (Figure 1). There is however no place for complacency. The growth is retarding. The proportion of time spent in Geriatric Medicine for geriatric specialists working in public hospitals are decreasing: 42% of them work half-time in geriatric medicine, 34% work more than half-time, and 24% work less than half-time; so that the full-time equivalents of geriatric specialist take a downturn in 2004 despite an apparent increase in the number of geriatric specialists. The gap between demand (based on the RCPL/BGS recommended ratio of 1 FTE geriatric specialist to 4000 elders aged over 75) and supply is diverging after the convergence during the growth spurt (Figure 1). How are we going to meet the population challenge in the next 10 years?

Since June this year, I have been voicing out my concern to key managers and policy makers in various committees of the Hospital Authority on the current disintegration of geriatric services in the majority of hospitals, and the consequent undesirable impact on service, trainingand manpower with regard to the care of the frail old.

The four stages of a group are forming, storming, norming and performing. We have gone through the stages of forming and storming (I hope!). The ultimate effective performance of us as a group depend very much on our commitments (norming).

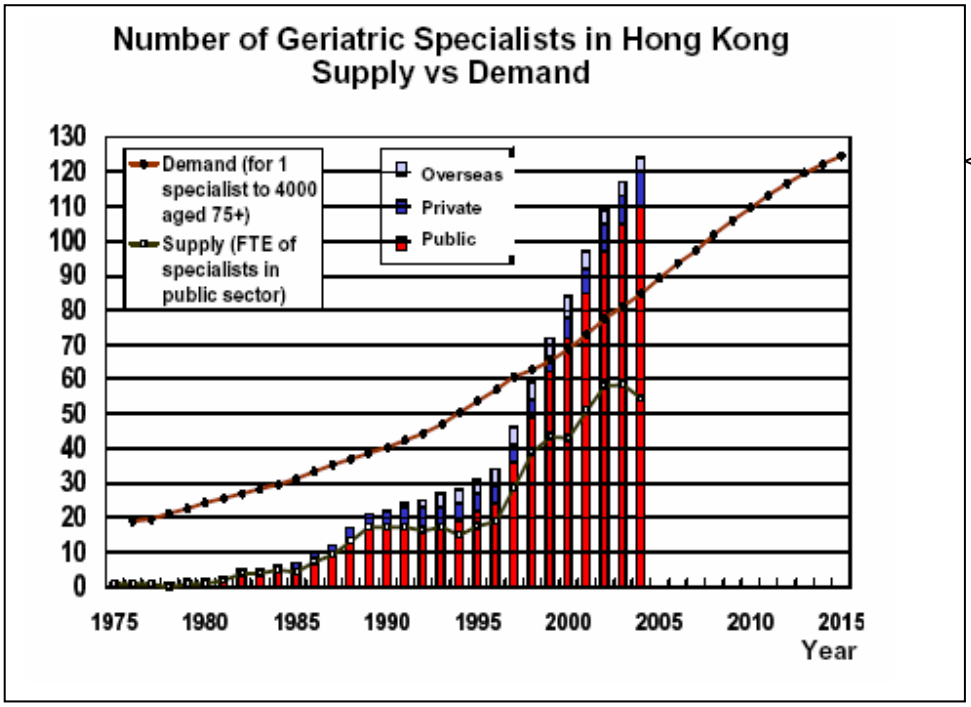

Fig 1

Letter to editor: Report from sponsored meeting PENSA

Ho Wency, Ip CY, Ko CF, Lum CM

We were sponsored by the Hong Kong Geriatrics Society to attend the 10th Parenteral and Enteral Nutrition Society of Asia (PENSA) meeting at Pattaya, Thailand on 27-29 October 2004. The meeting updated the recent advances in nutritional therapy in the past few years. We would like to share our inspiration at the meeting to our colleague members of HKGS.

Because this year is the 10th Anniversary of the PENSA, the conference started with a review on the progress on nutrition support and shone light to the future. In particular, it was stated by Professor Rombeau from the States that one of the foci would be on nutritional support to the elderly. It cannot be over-emphasized on **nutrition intervention to prevent / reverse sarcopenia**. At the other end, obesity is increasing among elderly patients. **Obesity may induce chronic inflammation** and in turn lead to progressive loss of lean tissues and impaired immune function. This may have adverse outcome and is an area to be explored. The understanding of and the possible nutrition intervention on sarcopenia and chronic inflammatory responses are underway.

Much has been presented and discussed on the importance of **early re-feeding the patients**, including patients who had undergone GI operation. Evidence is emerging that enteral feeding is preferred to parenteral feeding in patient outcome. The questions are: how early is early and what / how much to feed? The consensus appears to start re-feeding within 72 hours (48 hours preferred) with glucose solution. As little as 10 ml per day can maintain the microvilli functioning.

A whole session was devoted to **anti-oxidative therapy and trace elements deficiency.** A number of anti-oxidants were discussed. These included: vitamins C&E, provitamin A, N-acetylcysteine and glutathione. Evidence is there that early administration of anti-oxidants supplements reduced the incidence of organ failure among critically ill patients nursed in ICU. It was also highlighted that elderly at long term care facilities was more prone to deficiency of trace elements.

We think that the conference was most appropriate for us. Nutrition is an important aspect in Geriatric Medicine, yet often neglected. Several areas can be developed along the direction:

a) nutrition intervention to **prevent sarcopenia;**
b) nutrition **intervention in aspiration pneumonia**;
c) nutrition **intervention in specific organ diseases** (e.g. chronic renal failure) which are common among elderly;
d) nutrition intervention **against oxidative stress**;
e) nutrition status (in particular, trace elements) and **intervention among elderly at long term care facilities**.

The above can also be potential areas / dissertation topics for our HPTs! Anyone who is interested in the area can contact Dr. C M Lum (lumcm@ha.org.hk) directly for discussion.