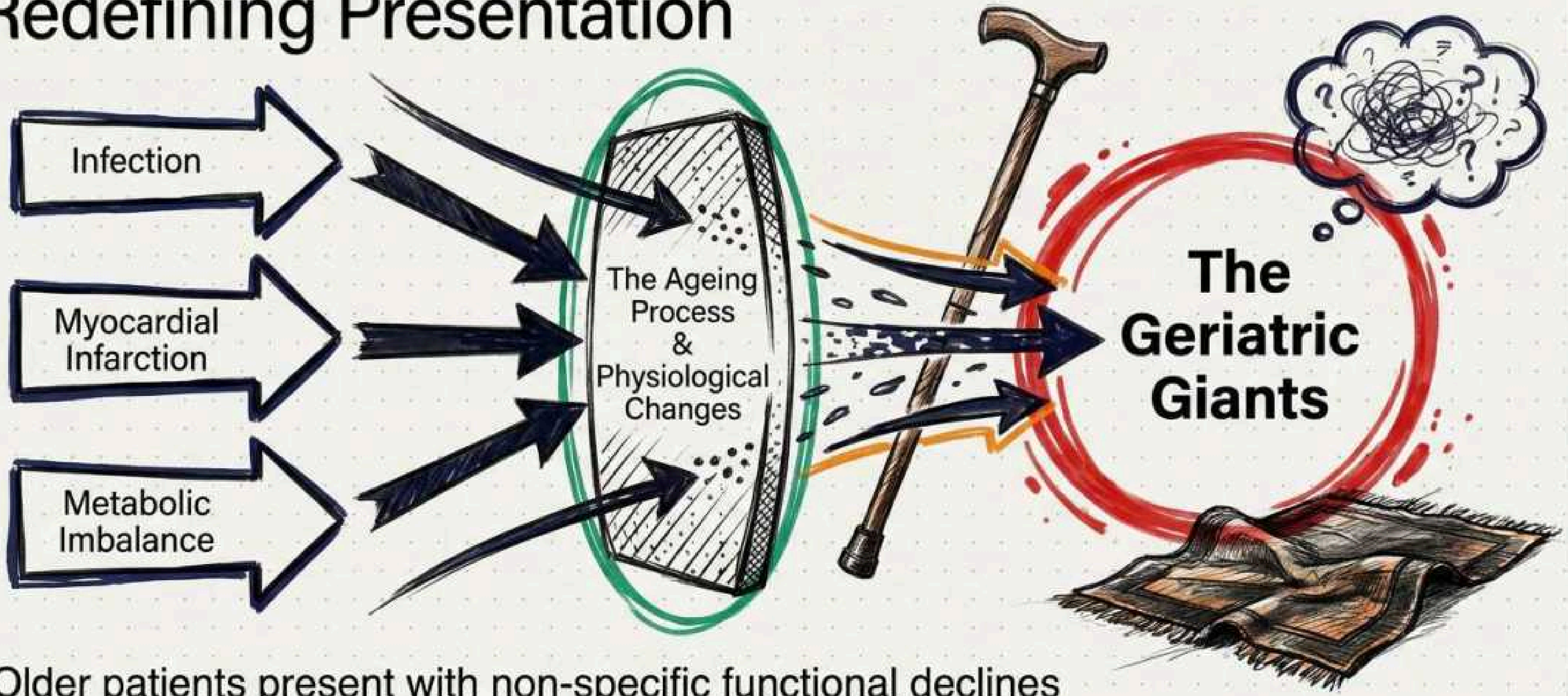
The Ageing Filter: Redefining Presentation

9 5.1



Older patients present with non-specific functional declines rather than classic disease symptoms.

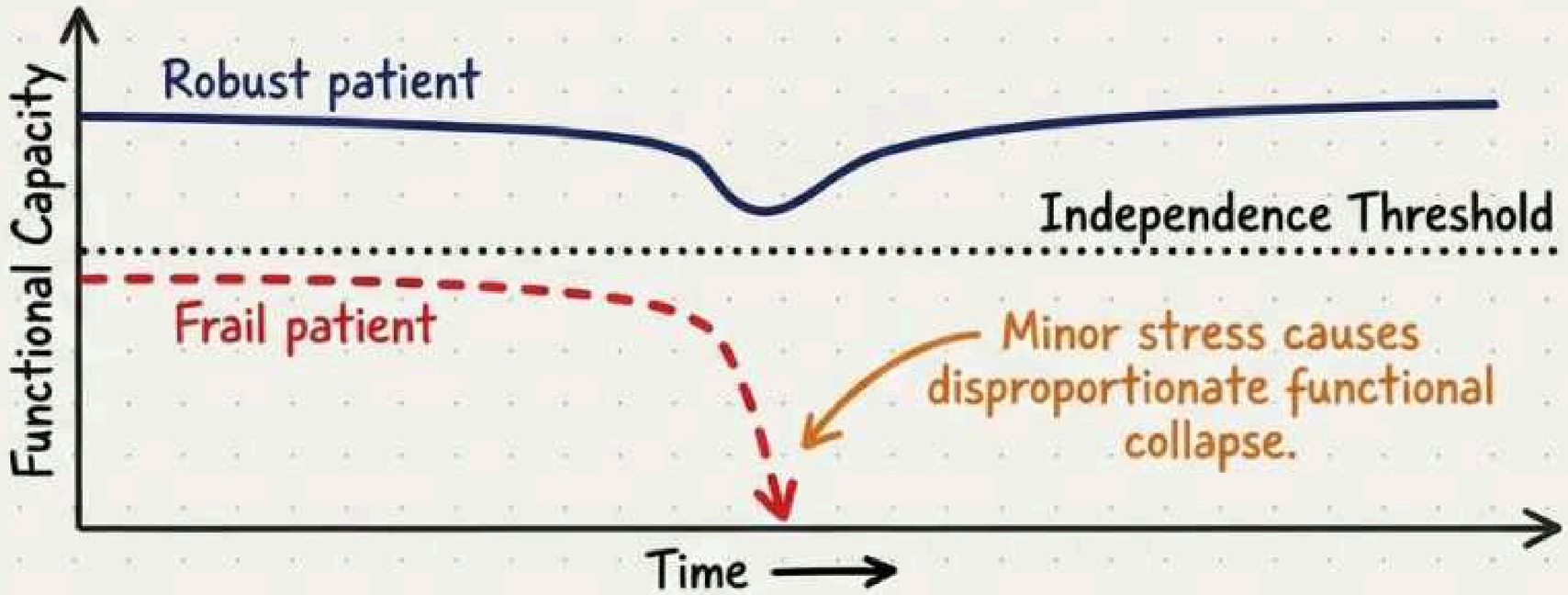
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Frailty Mechanics: The Loss of Functional Reserve

¶ 5.2

Capacity − Minor Stress = Reserve

Assessed via tools like the Clinical Frailty Scale.

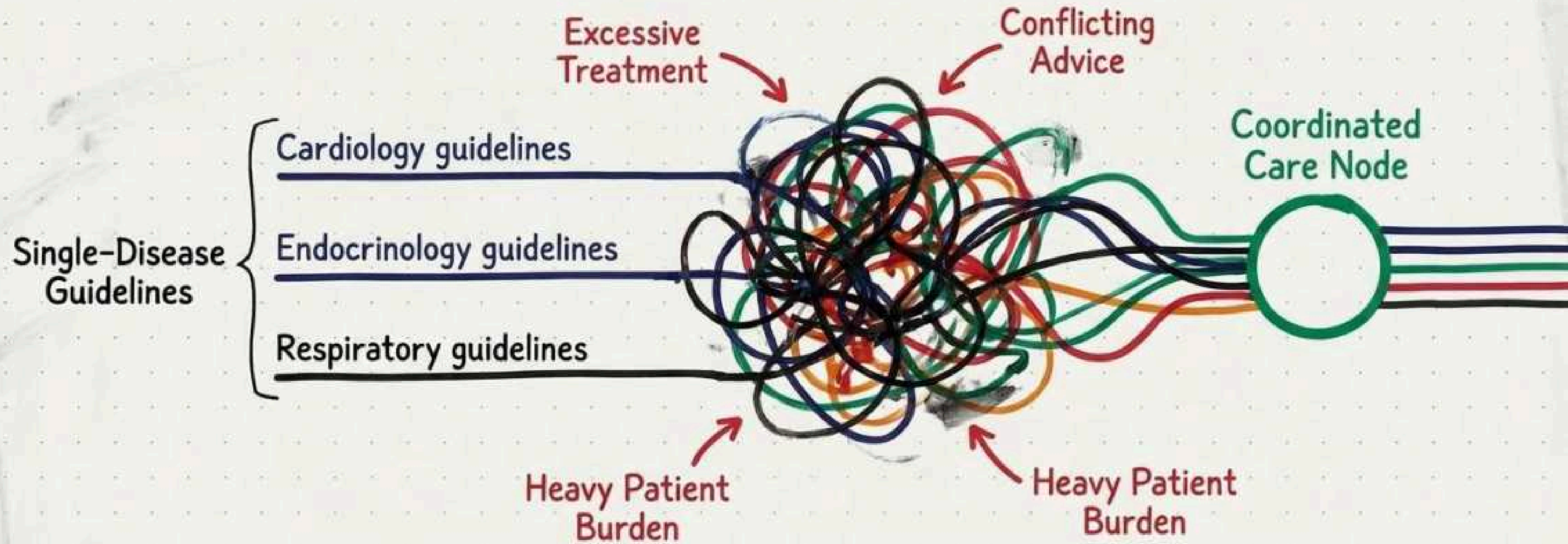


Frailty is a state of dangerously reduced reserve. It predicts clinical outcomes far more accurately than chronological age alone, serving as the primary guide for treatment decisions.

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The Multimorbidity Knot: Complexity in Practice

¶ 5.3



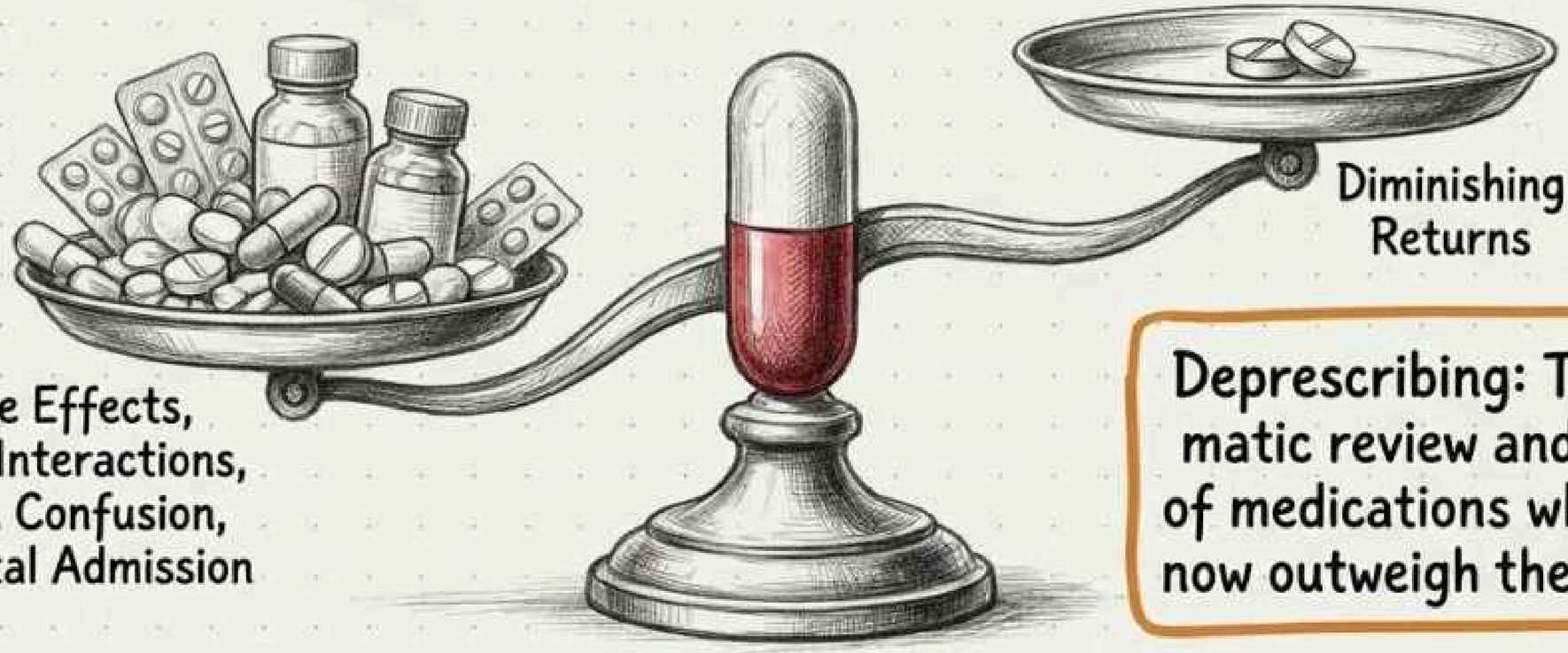
Living with 2+ long-term conditions is the norm. Following isolated, single-disease guidelines in multimorbid older adults results in iatrogenic complexity rather than healing.

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The Polypharmacy Equation: Balancing Risk and Benefit

¶ 5.4

Harms > Benefits → Deprescribe



Deprescribing: The systematic review and cessation of medications whose harms now outweigh their benefits.

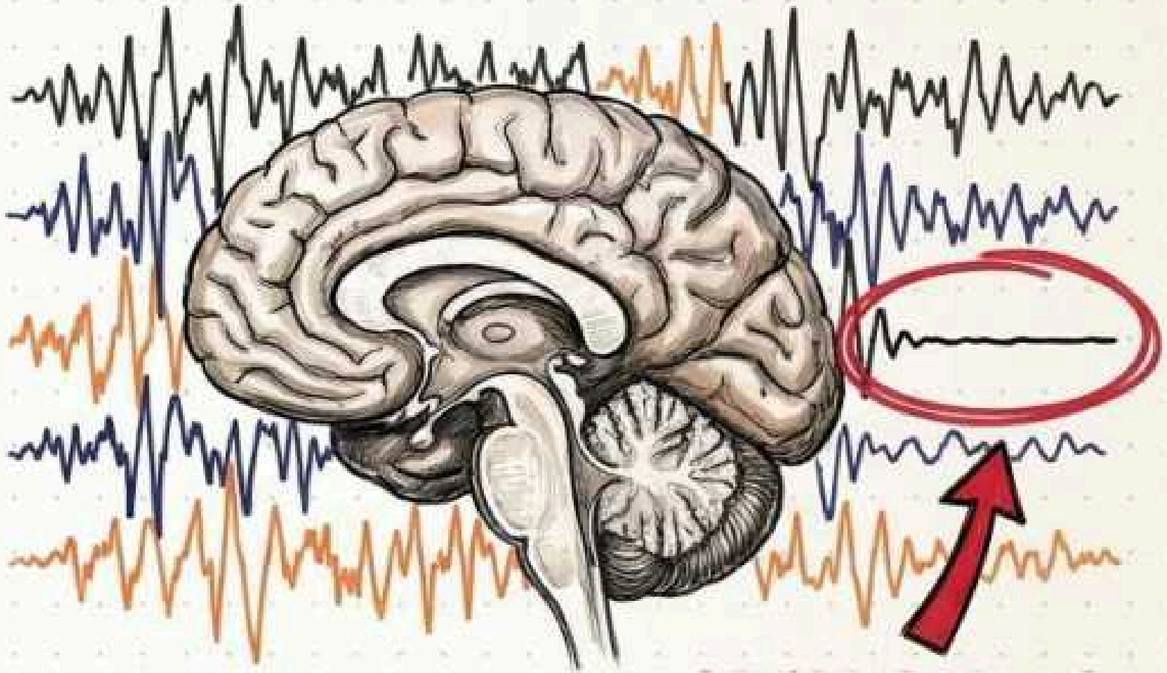
Deprescribing is not just stopping drugs; it is an active, tool-guided process targeting medications that are potentially inappropriate for the ageing physiology.

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¶5.5

Delirium Calculus:
The Cumulative Cognitive Threshold

Sum (Infection + Pain + Drugs + Constipation + Retention) = Delirium



BEWARE: The Quiet Form

Hypoactive, withdrawn delirium is frequently missed on the wards.

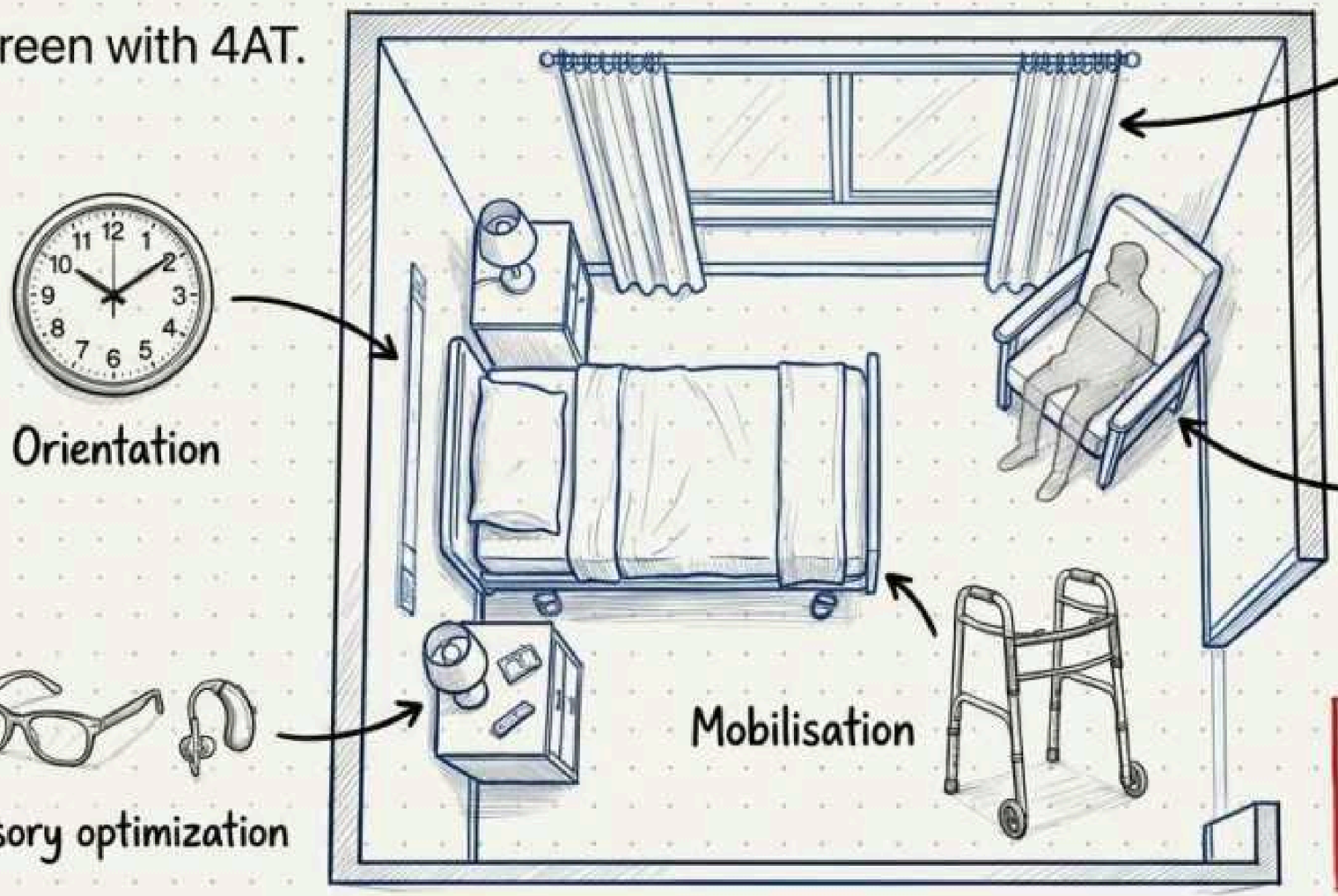
Delirium is rarely caused by a single factor; it is the sum of multiple physiological insults. It directly correlates with longer hospital stays, loss of function, and higher mortality.

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Environmental Engineering: The Anti-Delirium Protocol

¶ 5.6

Step 1: Screen with 4AT.



Sedatives = Only for severe distress/danger

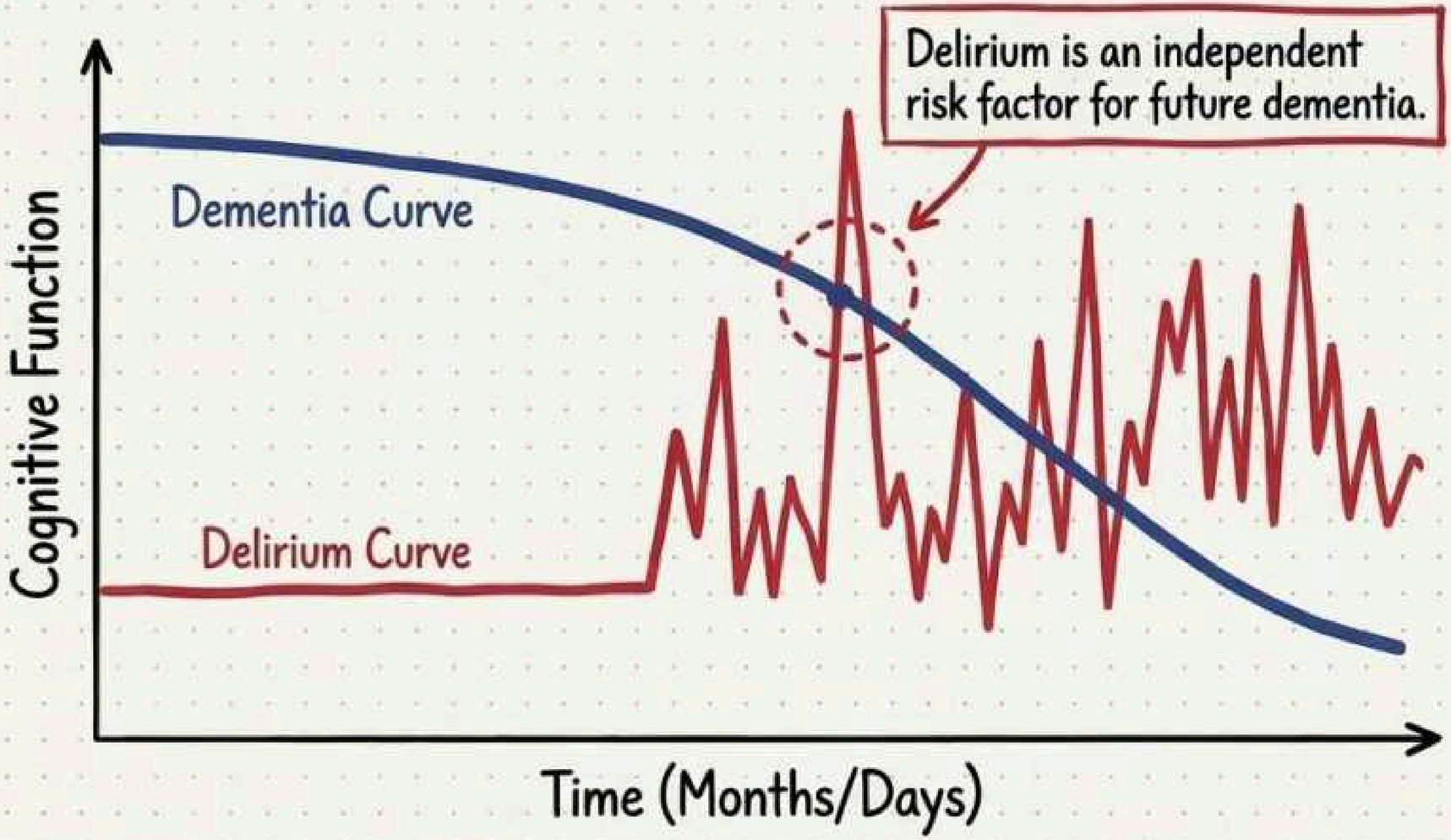
Warning: Sedatives often worsen delirium.

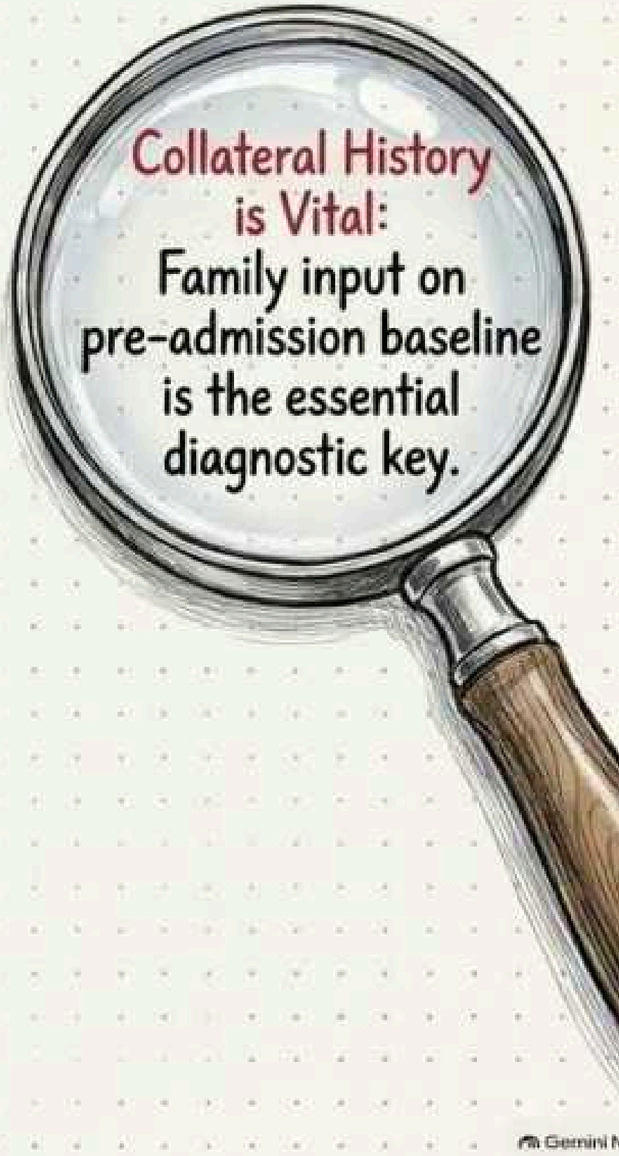
The majority of delirium management is environmental and preventative.
Treat the underlying causes and engineer a calm, familiar space.

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Trajectory Analysis: Delirium vs. Dementia

¶5.7



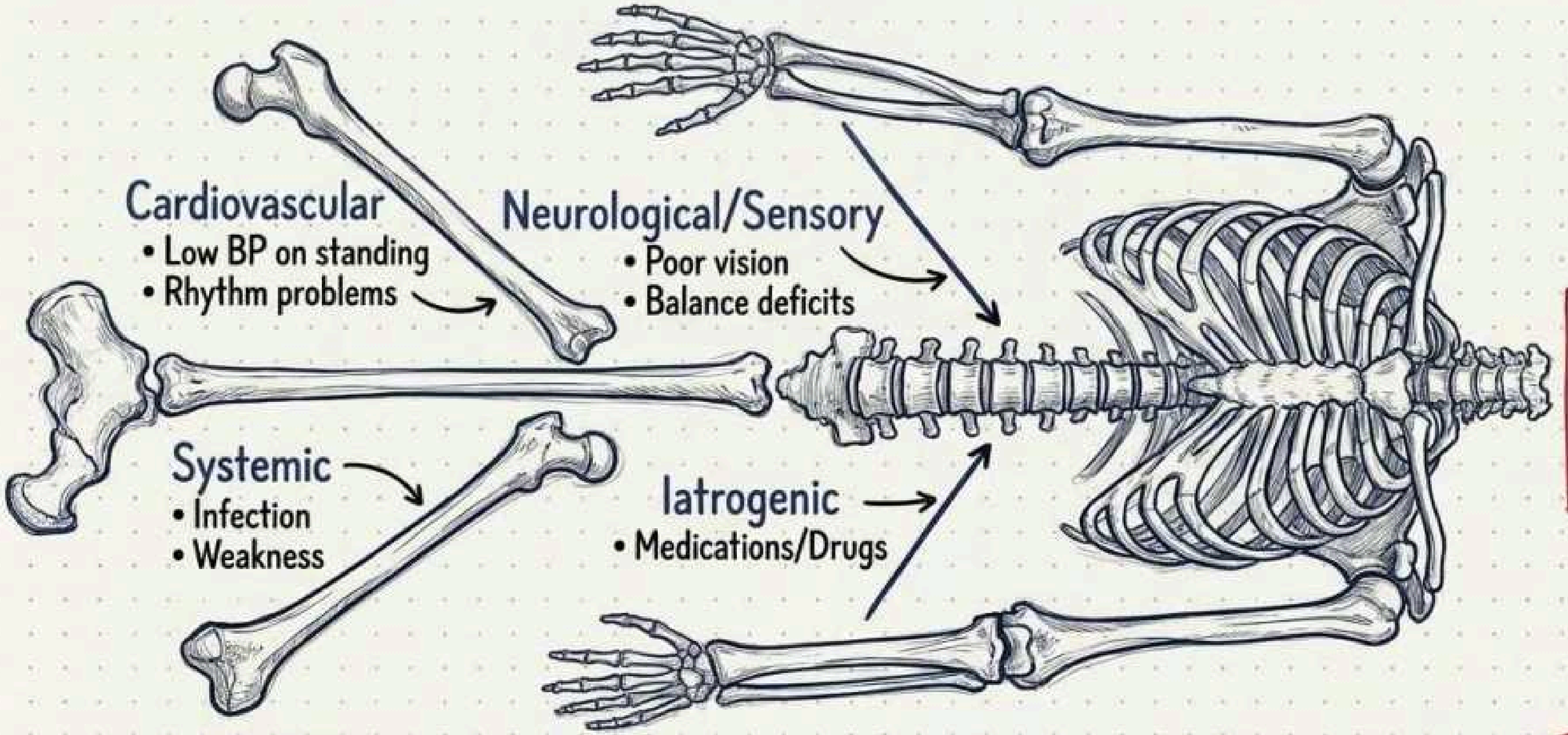


Delirium and dementia frequently coexist, but their timelines and clinical trajectories are fundamentally different.

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Anatomy of a Fall: Systemic Root-Cause Analysis

¶5.8



The Fall
(resulting in fractures, head injuries, loss of confidence)

→ **Mobilisation** + **Attention to Footwear/Toileting** + **Drug Review** = **Fall Reduction**

A fall is rarely just a slip; it is a symptom of an underlying multi-system problem requiring comprehensive assessment.

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The CGA Matrix: Comprehensive Geriatric Assessment

¶5.9

Medical
(Diagnoses, medications)

Functional
(Mobility, activities of daily living)

The Coordinated Plan

Psychological
(Cognition, mood)

Social
(Support network, environment)



Multidisciplinary Process

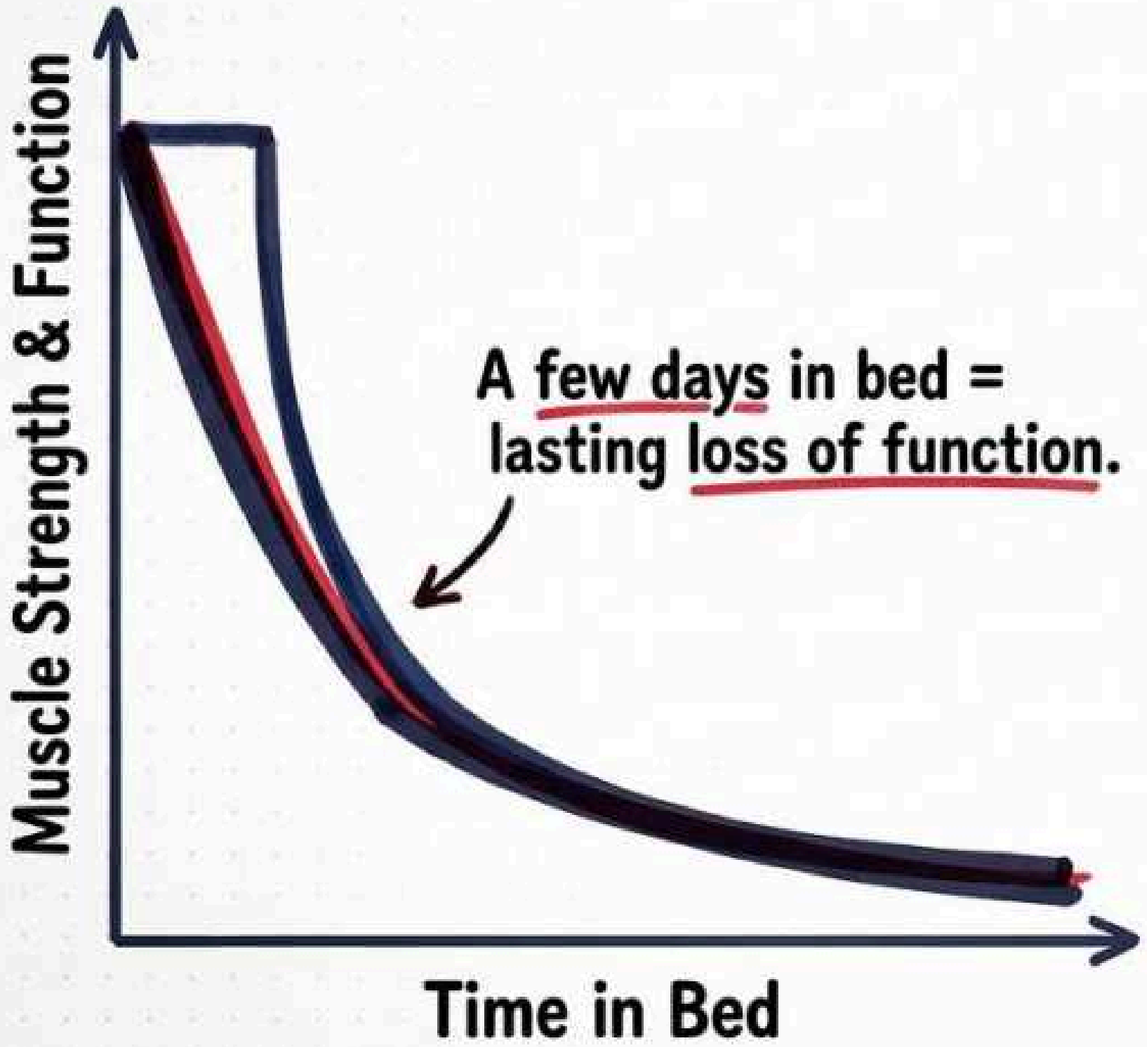
Trials confirm: CGA significantly increases the probability of survival and remaining at home months after an emergency admission.

True geriatric care transcends pure medicine; it requires a multidimensional framework to yield actionable, coordinated care plans.

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Iatrogenic Harm:
The Physics of Pyjama Paralysis

¶ 5.10



End Pyjama Paralysis



Encouraging patients to get dressed, walk, and stay active is not optional; it is essential to preserving independence and preventing hospital-induced frailty. Hospital itself can harm.

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Synthesis:
The Geriatric Paradigm

¶ 5.11

(Frailty > Age) x Coordinated Care → Anticipation & Prevention

- **Axiom 1: Presentation is altered (The Giants).**
- **Axiom 2: Care must be coordinated, not disease-by-disease.**
- **Axiom 3: Delirium and falls must be anticipated and engineered out.**

The comprehensive summary of MED 541 B Lecture 5, locking in the mental models for clinical practice on the wards.

Next Module: Discharge, Chronic Disease, and the End of Life.

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