Strategies to Promote Successful Aging: Part 1, What Patients Can Do

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What steps can older patients take now to improve their health and quality of life and maintain their independence?

THE CASE: A 65-year-old woman who is a longtime patient comes in for a routine checkup. Her primary problem is hypertension, which is well controlled with atenolol and hydrochlorothiazide. During the past 10 years, her weight has increased from 140 to 165 lb and her height has declined from 5 ft 2 in to 5 ft ½ in. She mentions that at age 79 years, her mother had to move to a nursing home after a hip fracture and was not able to live independently again. The patient wants to avoid a similar outcome. She lives alone, dines out frequently, and is sedentary.

What steps can this patient take now to improve her health and quality of life and to maintain her independence?

In this 2-part series, we focus on strategies to help promote successful aging. Here we discuss areas in which the patient plays the primary role. In a coming issue, we will focus on aspects of care that are managed primarily by the clinician, such as immunizations, screening tests, and osteoporosis prevention.

LIVING LONGER, LIVING WELL

US life expectancy data from 2002 suggest an overall life span of 77 years. A 65-year-old woman can expect to live to age 84 years, a man to age 81 years.1 Increasing numbers of healthy older adults want to live well in addition to living longer. Their goals include freedom from excessive disability or pain, continued ability to manage their daily affairs, and freedom from dependency on their children.

Concern about nursing home placement is well founded. In 1999, 15 million Americans (4.2% of the population older than 65 years) lived in extended-care facilities. The proportion increases dramatically with age: 1% of persons aged 65 to 74 years, 4% of those aged 75 to 84 years, and 20% of those 85 years and older live in such facilities. More than half of admissions to extended-care facilities are short-term (less than 3 months); patients are generally recovering from a hip fracture, stroke, or other traumatic event. The average overall stay in an extended-care facility is 2.3 years.2 The most common cause of death in persons older than 65 years is cardiovascular disease—primarily coronary artery disease (CAD) and stroke. The second most common is cancer (breast cancer for women and lung cancer for men).2

Because the patient in our case history has documented risk factors for CAD and stroke, a vigorous attempt will be made to manage the factors that are modifiable (Table). This includes advice about diet and weight management, exercise, and health habits. Such measures as regular physical activity, maintaining appropriate weight, and not smoking are associated with lower mortality.3 DIET AND WEIGHT MANAGEMENT

Weight reduction. The body mass index (BMI) is frequently used to help identify those who are overweight or obese. The BMI is the weight in kilograms divided by the height in meters squared. This patient's BMI is 32.2 kg/m², which is in the obese range. (The obese range is a BMI higher than 30; the overweight range is 25 to 29.9.) Studies of hypertensive patients show improved blood pressure control with lifestyle interventions that produce weight loss.4 A decrease in this patient's
Bmi will reduce her risk of CAD and facilitate blood pressure control.

**Dietary modification.** The Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (JNC 7) recommendations for a healthy diet include increased amounts of fruits, vegetables, and low-fat dairy products and a decreased intake of saturated fat, total fat, and dietary sodium (see Table). The evidence suggests, however, that most hypertensive patients are unaware of these recommendations. According to data from the National Ambulatory Medical Care Survey (NAMCS), only 35% of patients with hypertension received nutrition counseling. Only 28% of the over-74 age group were counseled. The authors speculated that many physicians may be unaware of the benefits of weight loss for elderly patients. Similarly, many patients may be unaware that sodium restriction is associated with decreased blood pressure and a reduced need for antihypertensive medication.

It is equally probable that physicians are pessimistic about patients' ability to change their habits. Certainly, changing dietary patterns late in life is difficult. Many elderly persons cook only for themselves and no longer prepare well-balanced, nourishing meals. Many rely on frozen dinners or restaurant meals, which are notoriously high in sodium and fat. Others are on a fixed income and consider fresh fruits and vegetables costly.

In a busy primary care office, the most practical approach may be to have a nurse counsel patients about diet. Patient education materials are readily available, both in print and online (see Box, page 471). Patients with multiple risk factors may benefit from formal instruction by a dietitian. Medicare covers dietary instruction for patients with diabetes and kidney disease. Because Medicare has recently recognized obesity as a medical condition, dietary counseling may become more prevalent.

**PHYSICAL ACTIVITY**

A regular exercise program is as important to the health of older persons as proper diet. Exercise can decrease the risk of CAD, osteoporosis, hip fracture, and general decline in ability to carry out activities of daily living. In addition, exercise helps prevent depression and promotes improved strength and flexibility, an enhanced sense of well-being, and sound sleep. A moderate exercise program that includes balance training has also been shown to decrease falls. This applies to the "old old" (older than 85 years) as well as to the "young old." The US Surgeon General has said that no one is too old to enjoy the benefits of regular physical activity.

Unfortunately, regular exercise is not actively promoted to elderly persons. In the NAMCS, the overall exercise counseling rate for hypertensive patients was 28%; it was 18% for patients older than 74 years. Reluctance to recommend exercise may be related to a concern for patient safety. However, the contraindications to exercise in older persons are no more stringent than those for younger, healthier adults. Acute illness, unstable chest pain, uncontrolled diabetes, hypertension, congestive heart failure, and/or new musculoskeletal pain all warrant investigation before an exercise program is started. Otherwise, institution of moderate exercise has not been shown to result in significant untoward events, and the benefits may be substantial.

A comprehensive exercise program includes:

- Aerobic exercise--such as walking--to mitigate cardiovascular risk factors.
- Weight training to prevent osteoporosis and general debility.
- Balance training in such disciplines as yoga or tai chi or in specific exercises prescribed by a physical therapist to decrease fall risk.

A goal of 30 minutes 3 times a week for each session of aerobic exercise and weight training is reasonable.

**HEALTH HABITS**

**Smoking.** Cigarette smoking and alcohol use are important counseling topics for health promotion. Encourage patients who smoke to quit. The mortality risk decreases substantially in those who quit, at least up to age 70. Studies show that persons whose physicians actively support their efforts are more likely to quit smoking. If patients show an interest in quitting, a stop date can be negotiated. One-year abstinence rates are highest in patients who use nicotine replacement or bupropion therapy in addition to counseling.

**Alcohol consumption.** Excessive alcohol use is sometimes seen in elderly patients; it may be associated with increased fall risk, malnutrition, memory impairment, and general debility. Advise patients who drink alcohol to do so only in moderation: that is, less than 2 drinks per day for men and less than 1 per day for women.

**QUALITY OF LIFE**

Depression and social isolation are common in elderly persons and are best approached initially with lifestyle changes rather than medication. The need to feel significant and to contribute to society continues long after retirement. In addition, evidence suggests that mental capacity remains sharper.
if the mind is continually challenged. To that end, suggest activities such as participation in church or synagogue activities, volunteer work, joining clubs, or taking classes.

A number of studies have demonstrated a relationship between participation in social activities—including church functions, movies, and games—and decreased mortality. The data apply equally to men and women, although women participate more frequently in structured social events. Many kinds of productive activity—such as gardening, housework, and volunteer work—also are associated with decreased mortality.

Moreover, cognitive function appears to be maintained by certain types of activities, such as learning an instrument or language, playing bridge, and attending social functions. One study found that among older persons who participated in activities such as travel, odd jobs, gardening, and knitting, the incidence of dementia was 50% lower than among persons who did not participate in such activities.

Not surprisingly, social interaction also appears to reduce symptoms of depression. One study that focused on volunteer work found significantly fewer somatic and mood symptoms among volunteers. Social activities have also been associated with reduced anxiety and increased life satisfaction.

Good lifestyle habits not only promote longer life but may also postpone the onset of disability at the end of life. A PLAN FOR THIS PATIENT

The patient has committed to begin a low-fat, low-sodium diet with a goal of 1 lb of weight loss per week until she has lost 20 lb. She intends to meet with a dietitian for consultation and follow-up. She plans to walk regularly in the local mall with a friend to combat both her sedentary lifestyle and to increase her opportunities for socialization. She attends church services and she plans to volunteer to read to children at the local elementary school. She will be followed up by the nurse practitioner in 6 weeks and periodically between regular physician appointments.

References:

REFERENCES:
