Gerontology & Geriatrics: Research

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Letter to the Editor

# Geriatric Surgery and Anesthesia: A Plea for Room and Attention in Gerontology & Geriatrics: Research

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## Letter to the Editor

In its nature of scientific periodical, *Gerontology & Geriatrics: Research* is expected to promote a forum for discussion among doctors, researchers and healthcare professionals in all the areas of geriatric medicine. I wish it can act as well as an intercultural tool aiming to promote – together with high quality scientific research – also a team-based strategic discussion regarding the wide area of inter-disciplinarily that currently surrounds geriatric medicine and, mostly, the world of geriatric surgery.

In my position of geriatric anesthesiologist and Past Director of the Geriatric Surgical Department at the INRCA Research Hospital (Ancona, Italy), I feel the responsibility of kindly driving your attention toward this area of interest that has emerged in the last years as a consequence of both general population aging and increased need for surgery among the elderly. As a final result of the combination between those factors and the impressive technological advancements registered in surgery and anesthesia, the percentage of the global surgical population represented by subjects aged 65 years or more currently ranges, in the operating theatres of all the western countries, between 40 and 50. Those patients may have specific patterns of diffused vulnerability while being prone to perioperative complications and at risk of losing, after surgery, part of their functional status and independence.

Despite these data that depict a demanding scenario and high levels of interest from the scientific community, geriatric perioperative medicine still remains a niche subject. What mostly seems to be lacking is a process-based approach to the matter, able to transform parceled researches about "the best anesthetic agent for the elderly" or "the best minimally invasive surgical technique for older people" into an organic, multidisciplinary thinking, with specific focus on organizational aspects, such as preparation to surgery, clinical risk management and patient-centered decision-making.

This is especially true about Europe, where only a little amount of editorial and educational initiatives can be registered in this field. What was achieved in the US following convergent actions from the American Geriatrics Society (AGS) and the American Society of Anesthesiology (ASA) – from whose close cooperation the Society for Advancements in Geriatric Anesthesia (SAGA) was born, together with the definition of a Core Curriculum in Geriatric Anesthesia – is still far from being achieved in Europe. Being an isolated nation-based example, the recently issued Guidelines on Perioperative Care of the Elderly that were edited by the Association of Anesthetists of Great Britain and Ireland (AAGBI), only partially fill the gap. A strong plan of cultural and organizational innovation is required, capable of involving in the same design not only anesthetists, surgeons, geriatricians and nurses, but also healthcare institutions, national and communitarian governments included.

Elderly surgical patients have peculiarities that make them unique: apart from obvious inter-individual differences based on biological age, functional status and clinical history, they have the common pattern of reduced capability to cope with the surgical stress that makes them highly vulnerable to surgical aggression. They present altered response to drugs that make anesthesia administration in all its forms a challenging task. They have a two-folded postoperative complication rate than younger subjects and demand careful risk-benefit analysis, adequate preoperative counseling and effective preparation to surgery.

Preoperative functional level is the main and more precious resource the elderly have: it should be whenever possible enhanced trough targeted pre-habilitation techniques and carefully preserved all along the hospital stay trough multiple bundles of convergent initiatives concerted among the care-team members. To satisfy their needs, dedicated clinical pathways aimed to reduce complications and to preserve functional status should be extensively implemented in public and private hospitals. To respect and satisfy the elderlies' needs, improvements in communication and increased attention toward their lived experience in the field of surgery should be reserved.

Last but not least, ageism in its more subtle forms is far from being defeated, especially in the surgical field where defensive medicine too often drives surgeons toward defeatist choices – inspired by the fear of complications and consequent legal prosecutions – or at the opposite toward excessively heroic, unjustified decisions, aimed more to show the surgeon to be up to the situation than to demonstrate clinical competence, wisdom and equilibrium.

The main obstacle toward the diffusion of high quality geriatric perioperative medicine is probably represented by the pressing need of certainty that evidence-based medicine has induced among operators as a main decision-making criterion. Due to this trend, evidence seems to take the place of common sense in many field, and mostly in the process of decision-making about surgery on old or oldest old patients. In the lack of sufficient evidence, abstention thus becomes a right attitude, even independently from the patient's life expectancy and expected quality of life: but why is evidence lacking? What is the role exerted by a preconceived ageism and by defensive medicine?

As the number of elderly surgical patients enrolled in trials remains low, evidence won't accumulate, either positive or negative.




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To those who are fans of "evidence-based medicine", the consequent lack of evidence will sound as the right answer. But to those who believe in progress and advancements, this attitude will sound as an example of "evidence-biased medicine", capable of excluding, by principle, elderly patients from possible areas of advancement and improvement in the surgical field. But not due to their fault.

These considerations are only a small example of the kind of discussion I cherish to be developed in our journal: medicine "sensustrictu" won't probably sit alone on the sofa of discussion, but for ethics, human sciences and philosophy some more sitting places will be available.




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