

# GERIATRIC FAILURE TO THRIVE

## Abstract

Geriatric failure to thrive may be caused by a single, medical condition but in most cases, there are multiple issues, some treatable and some not. Identifying this syndrome is challenging and often clinicians will confuse failure to thrive with the normal aging process. However, they are very different conditions and its critical for failure to thrive to be appropriately diagnosed for a correct prognosis and treatment to be determined. The hallmarks of geriatric failure to thrive are cognitive impairment, depression, impaired physical functioning, and malnutrition. Treatment is individualized and a multi-disciplinary team approach provides the best chance for success.

## Learning Goal:

1. Identify key risk factors of geriatric failure to thrive
2. Describe physical symptoms of an elderly person with failure to thrive.
3. Describe types of treatment available for an elderly person diagnosed with failure to thrive.
4. Provide an example of a condition that might not be responsive to medical and supportive treatment in a case of geriatric failure to thrive.
5. Describe the difference between normal aging and failure to thrive.

## **Introduction**

Geriatric failure to thrive is a complex condition in the elderly that is caused by physical and psychological impairments that slowly decrease an individual's functional abilities over time. Some clinicians confuse geriatric failure to thrive with the normal aging process; however, it is not the same condition. An elderly person who has geriatric failure to thrive is functioning at levels far below what is expected given the person's capabilities. Certified Nursing Assistants (CNAs) and Health Aides need to understand the key identifying feature of geriatric failure to thrive. They should be informed about the causes, signs and symptoms, and treatment of geriatric failure to thrive.

## **National Statistics**

Geriatric failure to thrive is a complex condition that affects millions of the elderly. This condition has also been called failure to thrive in the elderly and adult failure to thrive. These refer to the same concern. It is caused by physical and psychological impairments that over time, slowly decrease an individual's functional abilities. Functional abilities, which are essentially the capacity to perform self-care and maintain a vigorous state of mind, are the skills that keep individuals healthy and happy and when they are lost then a decline begins and failure to thrive occurs. People who suffer from geriatric failure to thrive will often complain that they "just don't feel like themselves," and family members will observe that their relative "doesn't seem the same."

Failure to thrive in a given population depends on certain risks. Elderly living in low income settings, exposed to infectious diseases, poverty, victims of elder abuse and neglect, and inadequate nutrition are primarily at risk. Higher rates of geriatric failure to thrive has reported

to occur in economically disadvantaged rural and urban areas. In the United States, there can be a myriad of causes, which are discussed in the following sections.

Because failure to thrive is a syndrome that happens to the elderly, it is easily mistaken for physical and mental decline associated with the aging process. This is particularly evident in countries like the U.S., with growing elderly populations, and the increase of elderly people living in long-term care facilities. However, geriatric failure to thrive is *not* normal. An older person may have chronic illnesses and may have lost a degree of mental acuity but most people can cope with these challenges. A patient who has geriatric failure to thrive is functioning at levels far below what is expected or usual for a patient of similar age and condition. Patients report that they “don’t feel like themselves,” and their relatives notice that the patient “doesn’t seem the same.”

Geriatric failure to thrive is most often caused by multiple and inter-related issues, each of which may be a serious condition by itself. Recognizing geriatric failure to thrive is important because there are effective interventions for many of these issues that may be used if a diagnosis is made.

### **Definition and Causes of Geriatric Failure to Thrive**

The simplest definition of geriatric failure to thrive is *functional decline*. Someone who has geriatric failure to thrive is not functioning, physically, emotionally, and psychologically, at the level that would be expected for them.

There are some important questions and several crucial issues to address related to geriatric failure to thrive. Firstly, functioning and thriving are general terms. In the context of geriatric failure to thrive, functioning describes actions that contribute to maintaining physical and psychological health. To thrive means that a person is doing as well as would be expected in the areas of life, given the person's age and condition.

The difference between the normal decline of abilities and functioning that accompanies aging and the functional losses seen in geriatric failure to thrive needs to be understood. It is *the failure to thrive* that is the key component of the syndrome. If someone's functional ability has declined and there is no ability to compensate for this, a failure to thrive will happen.

Geriatric failure to thrive is not about a person's level of functional ability; it is about how much a person's functional ability affects day-to-day life, the quality of life, and how well a person is coping. This is well-illustrated by the International Classification of Diseases (ICD) description of adult failure to thrive. The ICD is a system of codes that is used to standardize the diagnosis and identification of diseases and medical-surgical conditions. The ICD recognizes a condition that it calls adult failure to thrive, and part of the ICD definition of this condition is: "*The individual's ability to live with multisystem diseases, cope with ensuing problems, and manage his/her care are remarkably diminished.*"

People suffer some level of physical and psychological decline as they get older. What caregivers need to understand is how much a person's functional abilities must decline to constitute geriatric failure to thrive.

It is true that everyone's functional abilities decline as they age but geriatric failure to thrive results from definite causes such as a chronic medical disease or dementia; it is not simply the condition of "getting old." Also, a diagnosis of geriatric failure to thrive is made after a careful, organized evaluation of a patient's ability to perform activities of daily living, ambulatory status, cognitive abilities, mood, and other functional categories. If there are significant deficits, the diagnosis is confirmed.

Someone who has geriatric failure to thrive is not functioning physically, emotionally, and psychologically at the level that would be expected. Geriatric failure to thrive is not a result of the normal aging process. It is important to maintain the perspective that geriatric failure to thrive is caused by medical and psychological conditions that affect someone's physical and mental ability to function.

### **Elderly Patient Profile of Failure to Thrive**

It was mentioned in the introduction that people who suffer from geriatric failure to thrive will often complain of not feeling like themselves, or that family members may notice a disturbing difference in their relative's condition. These impressions, although they are subjective, are insightful and they illustrate important points - the patient's condition has changed and he or she is not doing as well as would be expected. Of course, when someone is ill or, to a lesser degree, when someone is going through the aging process, these types of complaints and observations are common.

The importance of *functional decline* was covered previously and is key to recognizing the syndrome of geriatric failure to thrive, especially the fact that the patient is not functioning as well as would be expected.

Patients with geriatric failure to thrive often seem indifferent and depressed. They may have little interest in activities they previously enjoyed and they do not care to socialize.

Eating is a low priority and the patient no longer prepares meals. Instead, the patient eats irregularly or snacks on what is at hand. As a result, the patient loses a noticeable amount of weight. The patient's level of physical activity dramatically decreases because of a lack of energy and because the patient's physical abilities have declined.

Finally, a patient who has geriatric failure to thrive has a definite impairment in intellectual ability. This may be evident in minor details, such as the patient has difficulty in performing a simple task or remembering a telephone number; or it may be evident in more serious ways, such as the patient becomes disoriented and does not know the year, the month, or the day of the week, or is incapable of looking up a new telephone number and dialing it.

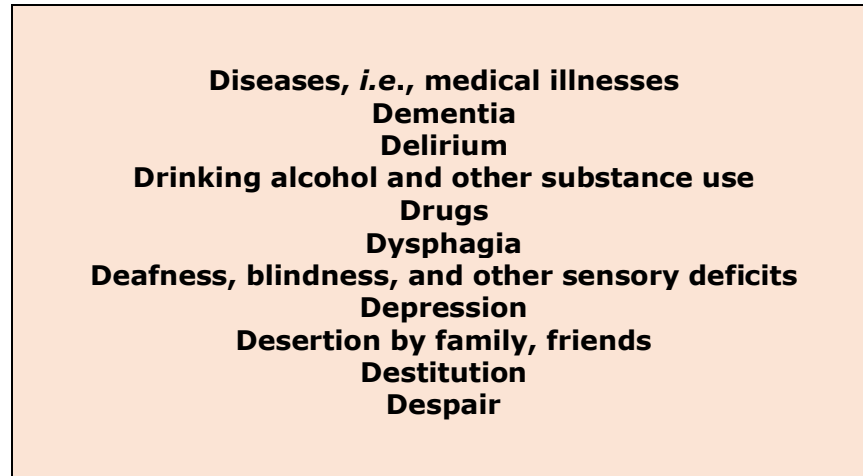
### **Causes of Failure to Thrive**

Geriatric failure to thrive may be due to a single disease or condition but most cases of this syndrome are multi-factorial in origin. There are many medical conditions that can contribute to geriatric failure to thrive and quite often someone who has this syndrome will have several physical and psychological pathologies that are part of the clinical picture.

A helpful way of categorizing and remembering the *basic* causes of geriatric failure to thrive is the phrase, *the 11 Ds*. This list was first

complied many years previously and collectively these are called, for obvious reasons, *The Dwindles*.

### **The 11 Ds of the Dwindles**



The 11 Ds provide a useful starting point for determining the possible reasons why some have geriatric failure to thrive. For each reason, there are multiple possibilities.

Dementia can be caused by Alzheimer's disease, a cerebrovascular accident (commonly called a stroke), Parkinson's disease, and other medical conditions. These conditions negatively impact a person's cognitive ability and functional ability.

Drugs such as sedatives, for example diazepam (brand name of Valium) and antipsychotics, for example haloperidol (brand name Haldol) can cause confusion, drowsiness, and difficulty ambulating. Someone who is confused, drowsy, and may not walk safely, cannot function independently. Also, depression is often present in people who

have geriatric failure to thrive. People who are depressed often have a lack of appetite, they withdraw socially, and they may be apathetic about self-care, all of which can contribute to failure to thrive.

## **Identifying Failure to Thrive**

Identifying geriatric failure to thrive is difficult. There are the 11 Ds of the dwindles as mentioned previously, and for each one there are multiple possibilities and their presence does not necessarily identify someone who has geriatric failure to thrive. However, there are four conditions that are commonly seen in patients who have geriatric failure to thrive and the presence of these strongly suggest its presence: 1) cognitive impairment, 2) depression, 3) impaired physical function, and 4) malnutrition. Because these are such an important part of geriatric failure to thrive they will be covered at length, including the assessment or screening tools used for detecting these syndromes.

The assessment or screening tools are administered by nutritionists, primary care physicians, psychologists, gerontologists, and physical therapists who are experienced in working with the elderly and assessing for failure to thrive conditions. It is not necessary that a caregiver memorize the conditions; they are included here to provide examples of the signs and symptoms and functional declines that characterize geriatric failure to thrive. The complete process of evaluating an elderly person for the presence of geriatric failure to thrive will be covered in the following sections.

## **Cognitive Impairment**



The word cognitive means of or relating to consciousness and intellectual ability. Cognitive impairment is a change, a noticeable change for the worse, in someone's ability to think, reason, make judgments, remember, and plan. Everyone loses some degree of mental ability and memory as they age but for the person who has geriatric failure to thrive, the cognitive deficits are greater than what is expected and these deficits negatively affect functioning.

There are many medical conditions that can cause cognitive impairment in the elderly: Alzheimer's disease, cerebrovascular accident (stroke), Parkinson's disease, infections, medication adverse effects and dehydration are some of the more common ones. Screening tests that can be used for detecting cognitive impairment are easily available, and each one has specific uses. The Mini-Mental State Examination and the Mini-Cog test are briefly discussed here.

### **Mini-Mental State Examination**

The Mini-Mental State Examination assesses important aspects of cognitive ability, including the individual's orientation, attention, calculating ability, recall, and language skills. There are 30 questions: a correct answer scores one point and a score of less than 20 usually indicates cognitive impairment. The Mini-Mental State Examination is a screening test only; it can detect cognitive impairment but it cannot determine what is causing it. The other limitation of the Mini-Mental State Examination is that it depends to a large degree on verbal response and reading and writing skills. If there is a language barrier or the person being tested cannot read or write or cannot do either well, the test results would be skewed.

Examples of Mini-Mental State Examination questions are provided below. The questions are very simple and difficulty in answering them correctly will clearly demonstrate cognitive impairment.

### *Mini-Mental State Examination Questions*

#### Orientation:

To determine a person's level of orientation, the examiner will ask: What is the year, the month, the day of the week, and the season?

#### Language Skills:

Show the individual a wristwatch and it to be identified. Repeat the same exercise, using a pencil.

#### Recall:

Ask the individual to repeat the following words: "No ifs, ands, or buts," and ask for the words to be repeated after 3 minutes.

#### Attention and Calculating Ability:

Ask the individual to spell 'WORLD' forward and backward.

Alternatively, ask the individual to start at 100 and count backwards in intervals of 7. Stop after five correct repetitions, *i.e.*, after the number 65.

### *Mini-Cog*

The Mini-Cog test is similar to the Mini-Mental State Examination but it is shorter and takes less time to administer. The Mini-Cog test has three parts: 1) word recognition and short-term memory, 2) the ability to draw a simple picture of a clock, draw in the hours, and then put the hands of the clock at specified time, and 3) recall of the words that

were used in part 1 of the test. Taken together these three parts of the Mini-Cog can detect deficits in memory, language, and motor skills.

The Mini-Cog is a trademarked product and cannot be reproduced without permission but interested readers can see it by accessing this website address: <http://mini-cog.com/>.

### **Depression**

Depression is the most common psychiatric disorder in the elderly and depression, defined simply as a persistent depressed mood accompanied by impaired functioning, can be both a contributing cause of geriatric failure to thrive and a consequence of this syndrome. For example, depression can contribute to geriatric failure to thrive by causing lack of appetite, leading to weight loss and a decrease in strength, increasing the risk for falling, and by causing insomnia.

As a consequence of geriatric failure to thrive, depression leads to a decline in functioning, which further results in a loss of independence, possibly social isolation, and diminished hope for the future. Some of the risk factors for depression in the elderly are listed below.

#### **Risk for factors for Depression in the Elderly**

**Cognitive impairment**  
**Female sex**  
**Functional impairment**  
**Insomnia**  
**Medical conditions that cause pain and/or limit activity**  
**Social isolation**  
**Uncontrolled, chronic pain**



Diagnosing depression in an elderly patient is challenging. Elderly patients who are depressed are more likely to complain of physical symptoms such as being tired or lacking energy than to complain of feeling sad or having mood changes. In addition, signs and symptoms of depression can be mistaken as signs of normal aging.

The Geriatric Depression Scale is one of the oldest and most reliable assessment tools for detecting depression in the elderly. There is a short version (15 question) and a long version (30 question); the short version is illustrated below.

#### *Geriatric Depression Scale*

- Are you basically satisfied with your life?  
Have you dropped many of your activities and interests?
- Do you feel that your life is empty?
- Do you often get bored?
- Are you in good spirits most of the time?
- Are you afraid that something bad is going to happen to you?
- Do you feel happy most of the time?
- Do you often feel helpless?
- Do you prefer to stay at home, rather than going out and doing new things?
- Do you feel you have more problems with memory than most?
- Do you think it is wonderful to be alive now?
- Do you feel pretty worthless the way you are now?
- Do you feel full of energy?

- Do you feel that your situation is hopeless?
- Do you think that most people are better off than you?

Each question is worth one point so if someone answered no to question 1, the score would be one point. A score of five points or more suggests that the person is depressed.

### **Impaired Physical Function**

Impaired physical functioning is an obvious contributing cause and consequence of geriatric failure to thrive. Assessment of physical functioning abilities is complex. There are many different types of physical abilities and testing also requires cooperation and some motivation on the part of the patient. In terms of physical ability and functioning, it is helpful to examine how well the patient can perform simple and complex activities of daily living (ADL), and to assess the patient's mobility.

The Katz ADL Scale and the Lawton Instrumental ADL Scale can be used for the former, and the Timed Get Up and Go test can be used for the latter.

#### **Katz ADL Scale**

The Katz ADL Scale assesses basic functional abilities in six areas.

1. Bathing: No need for assistance or needs assistance bathing only one body part.
2. Continence: Complete control of bladder and bowels.
3. Dressing: Able to dress without assistance except for tying shoes.

4. Feeding: Does not need help for feeding except for buttering bread or cutting meat.
5. Toileting: No need for assistance; may need to use a bedpan or urinal at night.
6. Transferring: Except for using cane or walker to get out a chair, no help is needed when transferring.

A 'yes' answer to any of the questions is considered a sign that the patient is independent and each 'yes' answer is worth one point. A score of 4 indicates that the patient has moderate functional impairment; and a score of 2 or less indicates that the patient has severe functional impairment.

### **Lawton Instrumental ADL Scale**

The Lawton Instrumental ADL Scale assesses functional abilities that are more complex and that require higher levels of cognitive functioning and physical abilities, so it is useful for detecting early changes in a patient's functional abilities. There are eight categories, and three are illustrated here. The possible score is 0-8 and only the first answer in each category is given a point. There is some evidence that the Lawton Instrumental ADL Scale is more reliable for assessing women.

#### *Telephone Use Ability*

In this test, the patient is found to perform the following functions.

- Use the telephone without assistance and can look up and dial new numbers.
- Dial a few well known numbers.
- Answer the phone but cannot dial.
- Cannot answer or dial.

### *Food Preparation*

- Independently plans, prepares, and serves adequate meals.
- Prepares adequate meals if supplied with the ingredients.
- Heats and serves prepared meals *or* prepares meals but these are not enough to maintain an adequate diet.
- Needs to have meals prepared and served.

### *Responsibility to Manage Own Medications*

- Takes correct medications at correct doses at correct times.
- Medications are taken correctly if they are prepared in advance.
- Is not capable of dispensing his or her medication.

Mobility is a complex activity. It requires balance, coordination, strength, and good vision. A full assessment of mobility takes time but simple screening tools are available: one of the more popular ones is the Timed Get Up and Go Test. The Timed Get Up and Go Test (sometimes called the Timed Up and Go Test) is a reliable assessment tool for detecting mobility problems and it is simple to use.

### **Timed Get Up and Go Test**

The patient is seated in a chair, wearing normal foot wear. An assistive device can be used if needed. In the next steps of the test the patient is asked to:

- rise from the chair and walk 10 feet.
- turn around, walk back to the chair, and sit down.

The timing begins when the patient is instructed to rise and ends when the patient is sitting again.

A normal time for completion is between 7 and 10 seconds. If someone needs 20 seconds or more this indicates that the patient has a mobility problem.

## **Malnutrition**

Malnutrition is very common in older adults and for a variety of reasons the elderly population is vulnerable to this malady. The older adult may have dietary restrictions that limit what can be eaten and this in turn decreases interest and pleasure in eating.

Eating is a social activity and if the older adult is isolated, nutrition can suffer. If there is a decline in cognitive and physical functioning, it may make the planning and preparing of meals simply too difficult. Also, physical problems such as dysphagia and poor dentition can make eating unpleasant or hard to do.

Medical problems and/or certain medications can affect appetite, absorption of nutrients, or swallowing. For an individual who is depressed, the effort involved in cooking and eating may appear to not be worth the effort. A limited income can prevent someone from buying nutritious foods.

Malnutrition affects physical and mental functioning and it is a significant contributor to geriatric failure to thrive. It delays wound healing, negatively affects the immune system, reduces mobility, causes loss of muscle strength, and significantly increases morbidity and mortality. Unfortunately, many cases of geriatric malnutrition are not detected as the signs and symptoms of this condition can be subtle



and they progress slowly or they may be mistaken for the frailty of old age.

Screening for malnutrition should always be done if someone is suspected of suffering from geriatric failure to thrive. There are many screening tools available but because of copyright issues the popular ones cannot be reproduced here. A basic assessment for geriatric malnutrition should include the following measures.

### **Body Mass Index**

Body mass index (BMI) is determined by a mathematical formula involving a patient's body weight and height. Most clinicians are able to access an online calculator to obtain the BMI rather than do the math themselves. The Centers for Disease Control and Prevention (CDC) provides an online calculator for the BMI in adults at: [https://www.cdc.gov/healthyweight/assessing/bmi/adult\\_bmi/metric\\_bmi\\_calculator/bmi\\_calculator.html](https://www.cdc.gov/healthyweight/assessing/bmi/adult_bmi/metric_bmi_calculator/bmi_calculator.html). Clinicians working with children and adolescents can also access a BMI calculator through the CDC. The BMI can be measured using the English height or weight system (most familiar to U.S., clinicians) or the metric system. Once the correct height and weight are entered the BMI will be provided with a descriptor, such as underweight, normal, overweight or obese.

Body mass index is useful because it is a more accurate way of measuring body fat than checking body weight, and because a low BMI (which is expected in people who are malnourished) is associated with a risk for chronic diseases, falls, and increased mortality. Knowing that someone has a low BMI can help plan preventative care.

## **Checking for Recent Weight Loss**

Caregivers should be assessing whether the patient has lost a significant amount of weight in the months prior to the assessment.

## **Food Intake Survey**

The patient's food intake should be determined, such as whether it has declined in the months prior to the assessment. If possible, the patient should be asked what and how much he or she eats and a detailed picture of the dietary habits should be obtained as much as possible.

## **Barriers to Good Nutrition**

The patient should be assessed for the presence of physical, psychological, and socio-economic problems that prevent adequate nourishment.

## **Evaluation for Geriatric Failure to Thrive**

Screening for cognitive impairment, depression, impaired physical function, and malnutrition is the first step in evaluation for geriatric failure to thrive. If these conditions are present, the patient has geriatric failure to thrive and the next step is to do a formal evaluation to find out why.

The evaluation process begins with a patient interview and if needed, speaking with the patient's family. This initial interview is used to get a clear picture of the patient's day-to-day life and to determine what functional disabilities are present. A visit to the patient's home by an occupational therapist or a physical therapist may be helpful for assessing the safety of the environment.

A physical examination would be next, followed by a review of the patient's chronic medical problems (and how these problems are being treated) and then a review the patient's current medication list. The patient should be evaluated for hearing and vision problems and, if needed, referred to the appropriate specialists for testing. Chronic medical problems commonly associated with geriatric failure to thrive are listed in the following table. Medications commonly associated with geriatric failure to thrive are listed next.

When reviewing medications, it is important to find out if the patient understands how to take prescribed medications. It is also important to know if the medications are being taken as directed or are being misused. Inappropriate use of prescription medications is very common. In addition, the patient or the patient's family should be asked about the patient's use of alcohol or illicit drugs.

#### **Medical Conditions Seen with Geriatric Failure to Thrive**

<p><b>Cancer</b> <b>Chronic lung disease</b> <b>Chronic kidney disease</b> <b>Congestive heart failure</b> <b>Diabetes</b> <b>Inflammatory bowel disease</b> <b>Stroke</b></p>
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#### **Medications Associated with Geriatric Failure to Thrive**

Medications associated with a geriatric failure to thrive are listed in this section, and include a wide range of drug types. The Certified nursing assistant (CNA) is not expected to be knowledgeable of medication types and how they affect the patient, however it can be helpful to

have a general understanding of drug types and the possible drug effect on a geriatric person.

### *Anticholinergic Drugs*

Amitriptyline, diphenhydramine, and haloperidol are commonly used medications that can cause anticholinergic effects such as confusion, dizziness, and dry mouth.

### *Antiepileptic Drugs*

The antiepileptic drug category includes phenytoin and valproic acid, which can cause anorexia, ataxia and drowsiness.

### *Antipsychotics*

Commonly used antipsychotics, *i.e.*, aripiprazole, olanzapine, and risperidone are associated with drowsiness, dizziness, and orthostatic hypotension.

### *Benzodiazepines*

The benzodiazepines, *i.e.*, alprazolam and diazepam, often cause drowsiness.

### *Diuretics*

Hydrochlorothiazide and furosemide, used to treat congestive heart failure and hypertension, can cause electrolyte disorders.

### *Multiple Medications*

Taking more than four prescription medications – which is not uncommon in the elderly - increases the risk for adverse drug interactions.

### *Opioids*

Opioids cause constipation and drowsiness.

Laboratory testing and other diagnostic studies will be done as needed. The examining physician may also order consultations with an audiologist, a nutritionist, occupational and physical therapy, a pharmacist, a mental health professional, a speech therapist, and with specialists who treat the chronic medical conditions found in the patient's health history.

## **Treatment for Geriatric Failure to Thrive**

The primary focus of care for a patient who has geriatric failure to thrive is treatment of cognitive impairment, depression, impaired physical function, and malnutrition.

### **Cognitive Impairment**

Cognitive impairment can be mild or severe, acute or chronic, and it may be treatable or it may be permanent. There are so many causes of cognitive impairment that a discussion of treatments is not possible here, but correctable issues should be addressed and potentially maximized.

### **Depression**

The causes, signs and symptoms, and consequences of depression in the elderly are often very different than they are for other age groups. Depression in an elderly patient requires specialized psychiatric intervention. If possible, someone who has experience working with depressed older adults should be consulted.

Exercise as tolerated can always be recommended, regardless of the acuity or length of someone's depression. Exercise has psychological and physical benefits that can help improve a person's mood and reduce anxiety.

While there is no single therapy that works for everyone, in addition to exercise, the use of antidepressants and psychotherapy are common treatment approaches that have been successful for depression in the elderly.

For mild cases, pharmacotherapy or psychotherapy seem to be equally effective. For moderate to severe depression, pharmacotherapy may be the best choice, while for chronic depression a combination of pharmacotherapy and psychotherapy is preferred.

The selective serotonin re-uptake inhibitor (SSRI) antidepressant medications such as citalopram, fluoxetine and paroxetine are the drug of first choice for treating elderly patients who are depressed. These medications are effective for this purpose but the effects often take 4 to 6 weeks to be seen. In addition, anorexia is a common side effects of these drugs, an obvious problem for someone who has geriatric failure to thrive.

If the SSRIs are unsuccessful or not tolerated, atypical antidepressants, tricyclic antidepressants, the monoamine oxidase inhibitors, or a stimulant drug like methylphenidate (commonly known by the brand name of Ritalin) can be tried. However, those medications - especially the tricyclic antidepressants such as amitriptyline and doxepin - may cause side effects that are particularly troublesome for elderly patients. Although the SSRIs are the preferred treatment, the best medication for treating depression is the one that works and is best tolerated.

Antidepressants are an effective treatment for depression in the elderly but getting a patient to accept them may not be simple. Many older patients do not want to take medications for their depression, being afraid of addiction and/or side effects, or they may be unwilling to admit they are depressed.

Psychotherapy can be helpful for elderly depressed patients. Most of the therapies used for these patients have used a short-term approach, and the therapy duration has typically been 2 to 4 months.

Aerobic exercises such as walking or swimming and resistance exercise with weights are proven treatments for depression in the elderly. Persuading someone who is depressed to exercise can be difficult, because many people who are depressed lack energy and have no interest in being physically active. If a patient is experienced at aerobic and resistance exercise then he/she can do these alone, but the program they follow should be reviewed by a physician and a physical therapist.

Anyone who has not previously exercised should do so under direct supervision until it is clear that he or she understands the exercise program and can tolerate what is required.

### **Impaired Physical Functioning**

Impaired physical functioning is similar to cognitive impairment. There are many possible causes and a multitude of treatments, and some physical impairments may not be treatable. However, any correctable impairments should be addressed and the patient's physical abilities should be utilized as best they can. The current consensus is that the most effective treatments for improving the physical condition of patients who have geriatric failure to thrive are dietary supplements, exercise (previously discussed), and reducing the number of prescription medications the patient uses.

Dietary supplementation would be prescribed by the treating physician in collaboration with a nutritionist. Reducing the number of prescription medications and using the minimal effective doses can reduce adverse drug effects that may be contributing to failure to thrive. A regular review of medications and how the patient is using medications should be done, as well. If possible, any medication that may affect balance, mobility, or strength would need to be discontinued or used sparingly, and the patient's physician should be notified for appropriate medication adjustments to be made.

### **Malnutrition**

Malnutrition in the elderly who have geriatric failure to thrive typically has several causes. Diseases like cancer, chronic obstructive pulmonary disease (COPD), and chronic kidney disease often make



people anorexic. Poor dentition and dysphagia can mean that chewing and swallowing are uncomfortable and possibly dangerous.

Chemotherapy drugs cause loss of appetite but so do many commonly prescribed medications such as antibiotics, digoxin, and over-the-counter analgesics like ibuprofen. Psychological and socioeconomic problems, such as depression and social isolation, are frequently the basis for malnutrition in the elderly.

Treating malnutrition in someone who has geriatric failure to thrive begins with care that is specific to cause, but there are also some basic treatments that are helpful. Calorie, protein, and vitamin D supplementation are recommended for anyone who is malnourished and suffers from geriatric failure to thrive. Liquid supplement drinks are easily available, relatively inexpensive and are a good source of calories and protein. A balanced diet could provide these but there is evidence that elderly adults have higher daily protein requirements than other people so protein supplementation is likely to be needed.

Extra vitamin D for a diagnosis of vitamin D deficiency is common in the general population and the elderly are more likely than other people to be deficient as they have less vitamin D in their diets, they have less sun exposure, and their bodies have a reduced ability to synthesize vitamin D. Vitamin D supplementation in the elderly can be helpful by preventing loss of muscle mass, increasing bone strength, and reducing the risk of falling.

The appetite stimulants dronabinol and megestrol have labeled uses for treating anorexia in patients who have acquired immunodeficiency syndrome (AIDS) and for treating nausea and vomiting caused by

chemotherapy. These medications have been used for patients who have geriatric failure to thrive and malnutrition but they are not a standard therapy for this problem.

### **Summary**

Geriatric failure to thrive is a complex condition in the elderly. It is caused by physical and psychological impairments that slowly decrease an individual's functional abilities over time and result in a failure to thrive. Geriatric failure to thrive is not the same as the normal declines in mental and physical capacities that occur with aging. Someone who has geriatric failure to thrive is functioning at levels far below what is expected given the person's capabilities- that is a key identifying feature of geriatric failure to thrive.

Geriatric failure to thrive may be caused by a single medical condition but in most cases there are multiple issues, some treatable and some not. Identifying this syndrome is challenging but the hallmarks of geriatric failure to thrive are cognitive impairment, depression, impaired physical functioning, and malnutrition. Treatment is individualized and a multi-disciplinary team approach provides the best chance for success.