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Orthogeriatrics

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Preface – Why Orthogeriatrics?

Frail, elderly patients with fragility fractures make up a large proportion of the workload of most trauma and orthopaedic (T&O) departments. Their needs are very different from younger patients with musculoskeletal injury or conditions requiring surgery, such as total joint replacements. There is now sufficient evidence from around the world to say with confidence that a multidisciplinary approach to their care is not only better for them, but better also for the efficient and cost-effective running of the T&O unit as a whole.

The editors and most of the authors of this book are active members of the Fragility Fracture Network (FFN) of the Bone and Joint Decade – a global organisation that aims to facilitate the ability of health services everywhere to cope with the rising tide of fragility fractures, particularly hip fractures, that is a consequence of ageing populations. The FFN believes that, despite the differences between the health services of different countries, the superiority of multidisciplinary care in this group of patients is universal.

The term 'orthogeriatrics' is used as shorthand, because historically it was collaboration between the specialities of orthopaedic surgery and geriatric medicine that generated the evidence supporting the multidisciplinary approach. However, there are obviously many parts of the world where the speciality of geriatrics is not sufficiently established for this to be feasible. The purpose of this book is therefore to describe and analyse what are the essential components of the orthogeriatric approach that make a beneficial difference to the care of elderly fracture patients, so that activists in all countries can plan how to develop the necessary competencies within the available resources and deliver the care that patients need.

Several characteristic features of geriatric medicine can immediately be identified as being especially beneficial to elderly fracture patients:

1. Understanding of the geriatric syndrome of **frailty**. This is a physiological syndrome – quite distinct from **fragility** which is a mechanical issue affecting bone (it is unfortunate that the same word is used to denote both entities in some languages).
2. A holistic view of older patients' health, with an appreciation of the interactions between body systems and between physical, mental and social dimensions.
3. A pragmatic view of treatment goals, identifying what is achievable given the patient's overall state and what is worth the cost to the patient of treatment.

4. Familiarity with, and influence in, the network of resources available for elderly patients – particularly useful in planning timely discharge from the fracture unit.
5. Resources for, and experience in, coordinated multidisciplinary rehabilitation teams for older patients.

However, physicians with geriatric competencies are not enough to meet the needs of older fracture patients. Without the input of orthopaedic surgeons, their efforts would be the equivalent of one hand clapping. The geriatrician needs the surgeon to restore the patient's locomotor abilities and remove the cause of their pain – just as much as the surgeon needs the physician to keep the patient alive and safe throughout the perioperative and postoperative phases of the acute fracture episode. Furthermore, surgeons need to tailor their treatment to the needs of the frail elderly, for instance by recognising the importance of one single operation that allows full weight-bearing whenever possible (this may seem obvious now, but was not so before the involvement of geriatricians brought the necessary reality check).

Of course, the orthopaedic surgeon and the geriatrician are not the only members of the multidisciplinary team that the patient needs. Anaesthetists are also crucial team members; fracture units that have been fortunate enough to find one who sees the elderly fracture patient as a fascinating challenge - rather than a somewhat scary chore - have seen massive improvements in efficiency and quality. Nurses, particularly specialist nurses with experience of elderly patients and fractures, are an immensely valuable resource, capable of multiplying the contribution of geriatric co-management many fold. In countries with specialists in rehabilitation medicine, the later phases of functional recovery need to be integrated with the earlier pre- and postoperative phases. Psychological support for the patient and their carers has a valuable role to play.

As with all fragility fractures, an essential part of the management of the acute fracture episode is a systematic attempt to prevent another fracture, by addressing osteoporosis and falls risk. The system for reliably achieving this may be led by an osteoporosis specialist, but we consider this function as an integral part of the holistic orthogeriatric approach. Again, the role of nurses is usually central in delivering secondary prevention on the required scale.

We and our contributors have covered all these aspects to the best of our ability. We hope that this book will be helpful in spreading this modern system of management, to the benefit of patients worldwide.

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