



## Quality, frailty, and common sense

Providing quality care for the frail elderly patient taxes the skills of the medical artisan. It requires not only knowledge and vigilance regarding appropriate drug prescribing, but also unrushed active listening, creativity, and common sense—in other words, the full palette of the art of medicine. Frail elderly patients are generally excluded from clinical trials. Hence, their management is dictated as much by our clinical experience as by evidence. Treating their congestive heart failure can be particularly challenging.

Congestive heart failure, as noted in the review by Samala et al in this issue of the *Journal* (page 837), is more prevalent in the elderly. Particularly in the frail elderly, managing severe congestive heart failure poses ethical, socioeconomic, and medical challenges. The presence of even subtle cognitive impairment requires detailed dialogue with family and caregivers about medications and about symptoms that warrant a trip to the emergency room. Patients on a fixed income may not be able to afford their medications and thus may use them sporadically. And the preprepared foods they often eat are laden with sodium.

The symptoms of congestive heart failure may easily go unrecognized or be attributed to other common problems. Sorting out the reasons for exertional fatigue, especially a generalized sense of fatigue, can be particularly vexing. Anemia and sarcopenia can directly cause exertional fatigue or “weakness” but may also exacerbate heart failure and cause similar symptoms. Pharmacologic and dietary causes for volume overload must be sought. Even intermittent use of over-the-counter nonsteroidal anti-inflammatory drugs can be problematic.

Severe congestive heart failure is a lethal disease. Current quality guidelines for its treatment emphasize the use of multiple drugs and devices. Yet vasoactive drugs may not be well tolerated in frail patients, who are particularly vulnerable to orthostatic hypotension and cerebral hypoperfusion. Digoxin, of marginal benefit in younger patients without tachyarrhythmias, has an even more tenuous risk-benefit ratio in the frail elderly. Beta-blockers may cause fatigue and depression, and even low-dose diuretics can exacerbate symptoms of bladder dysfunction. Previously implanted defibrillators may be inconsistent with the patient’s current end-of-life desires.

Ideal management of the genuinely frail elderly patient with severe congestive heart failure is not always a matter of ventricular assist devices, biventricular pacers, or angiotensin-converting enzyme inhibitors. At some point, referral to palliative care resources, guided by informed input from the patient, family members, and caregivers, may be the most appropriate high-quality care that we can (and should) offer.

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