History and Physical Examination of the Older Adult

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The history and physical examination is the foundation of the medical treatment plan. The interplay between the physiology of aging and pathologic conditions more common in the aged complicates and delays diagnosis and appropriate intervention, often with disastrous consequences. This chapter assumes that practitioners will perform the thorough history and physical examination that is expected of an excellent general internist. It highlights the special considerations required for the older adult.

History

General considerations

The history may take more time because of sensory or cognitive impairment or simply because an older patient has had time to accrue numerous details. Several sessions may be required.

The patient should be recognized as the primary source of information. If doubts arise about accuracy, other sources should be contacted with due respect paid to the sensitivities and confidentiality of the patient. When interviewing the patient and caregiver together, ask questions first to the patient, then to the caregiver.

If the patient's responses to initial questions are clearly inappropriate, turn to the mental status exam immediately.

The patient should be dressed and seated. The physician should also be seated and facing the patient at eye level, speaking clearly with good lip movement. If the patient is severely hearing impaired and an amplifier is not available, write questions in large print.

Use honorifics (i.e., Mr., Mrs., Miss, or Ms.) unless the patient specifically requests you to do otherwise.

Areas requiring special emphasis

- **Function**—(see Functional Status Assessment) Pay attention to deficits in basic and instrumental activities of daily living (ADL). Prepare to assess those systems in the physical examination, looking for reversible conditions that could upgrade function, e.g., treatment of arthritis to improve dressing capability.

- **Medications**—(see Pharmacotherapy). Polypharmacy and excessive dosages are common causes of iatrogenic illness. A "paper bag" test is often useful to explore this possibility, i.e., ask the patient or caregiver to gather all medications into a paper bag and bring it to the office visit. Be sure to include over-the-counter (OTC) preparations.

- **Review of systems**—Cardiovascular illness is the major cause of death in older adults and these systems should be investigated thoroughly. Of particular importance also are: weight change and gastrointestinal (GI) symptoms, headache (temporal arthritis), dizziness and falls, sleep pattern, sensory impairment, constipation and other changes in bowel habits (colon cancer), urinary pattern and incontinence, sexual dysfunction, depression, cognitive impairment, transient paralysis, paresthesias or visual changes (transient ischemic attack), musculoskeletal stiffness or pain (osteoarthritis or polymyalgia rheumatica).

- **Social history**—(see Psychosocial Issues in Geriatric Medical Care). Assessment of lifestyle,
affect, ognition, function, values, health beliefs, cultural factors and caregiver issues is also important. Consultation with a social worker in obtaining this information and adapting the care plan is often critical but the initial identification of need for such consultation is part of the primary care evaluation. A home visit is often very valuable (see Interacting with Long Term Care Systems, pp. 53-56).

- **Nutritional history**—(see Nutritional Assessment and Treatment Strategies). Performing the basic nutritional assessment will identify patients at risk of malnutrition and in need of referral for dietetic consultation.

**Physical Examination**

*General considerations*

Limit the time the patient is in the supine position as this may cause back pain for persons with osteoarthritis or kyphoscoliosis and shortness of breath for those with cardiopulmonary disease--having several pillows on hand for these patients will be greatly appreciated.

Multiple sessions may be required for a complete physical exam due to patient fatigue. While they are important, the rectal and pelvic exams may be deferred to a later session, if not urgently required.

*Areas requiring special emphasis*

- **General Observation and Vital Signs**
  
  Check:
  
  a. Signs of ADL deficits, poor hygiene, disheveled appearance.
  b. Rectal temperature if patient is seriously ill because of blunted immune response (see Infectious Diseases).
  c. Orthostatic changes in blood pressure (BP) and pulse.
  d. Osler's maneuver if systolic BP is greater than 160 to screen for "pseudohypertension"-positive if radial artery is palpable with cuff inflated above systolic BP level.
  e. Weight (at each visit to identify losses early and to establish a pattern).
  f. Signs of malnutrition or trauma (elder abuse and neglect or falls).

- **Skin**—Neoplasm (especially in sun exposed areas), nipple retraction, peau d'orange.

- **HEENT**—Visual acuity, lens exam for cataracts, fundoscopy (glaucoma, hypertension, diabetic retinopathy), visual fields, extraocular movements (stroke).
  
  a. Gross auditory acuity, otoscopy to determine possible reversible causes of hearing loss and disequilibrium (cerumen impaction, serous otitis media, ruptured tympanic membrane).
  b. Inspect the mouth after removal of dentures to assess conditions that may affect nutrition (neoplasm, stomatitis, oral health, adequacy of dentures).
  c. Palpate temporal artery for tenderness, thickening or nodularity in the patient complaining of headaches.

- **Neck**
  
  a. Dix-Hallpike positional test maneuver for benign positional vertigo (see Dizziness).
  b. Jugular venous pulse is better observed on the right side since compression of the left innominate vein by an elongated aortic arch may cause false distension on the left.

- **Cardiovascular**
  
  a. PMI may be displaced by kyphoscoliosis, so palpation is less reliable to determine cardiomegaly. Atrial and ventricular arrhythmias are common. Systolic murmurs are frequently present and most are due to benign aortic sclerosis. Symptoms, risk of morbidity and special characteristics that suggest aortic stenosis or endocarditis should guide evaluation. Diastolic murmurs are always important, as are right and left ventricular S3 gallops.
  b. Signs of arterial insufficiency (hair loss, bruits, decreased pulses) and venous disease (stasis skin changes and edema) are common. Arterial ulcers present distally with claudication and
ischemia while venous ulcers present painlessly and are usually located near the medial malleoli. Most peripheral edema is venous insufficiency not congestive heart failure (CHF) although the latter is common and should be ruled out. (The effects of diuretics on perfusion and electrolyte balance usually outweigh cosmetic benefit.)

- **Lungs**–Age-related changes in pulmonary physiology and age-associated pulmonary pathology often result in rales that may not indicate pneumonia or pulmonary edema. For this reason, it is important to document a baseline exam at a time when the patient is not ill. Localized wheezes may indicate an obstructing bronchial lesion (carcinoma).

- **Breast exam**--Tumors may be easier to palpate because of atrophy and less fibrocystic disease. Remember, men may have gynecomastia or malignancy.

- **Abdomen**
  a. Patients who are unable to lie flat (kyphoscoliosis or cardiopulmonary disease) may give the impression of distension. This phenomenon and commonly occurring pulmonary hyperaeration may cause the liver edge to be palpable below the costal margin without hepatomegaly. This must be assessed by percussion.
  b. Peritoneal signs may be blunted or absent in frail elderly patients (see Infectious Diseases).
  c. Palpation will assess urinary retention (bladder can be percussed also) or aortic aneurysm. Ventral, inguinal and femoral hernias should be checked for reducibility. The sigmoid colon will often be palpable and a fecal impaction may present as a left lower quadrant mass.

- **Extremities**–Arthritis (rheumatoid, degenerative and crystalline), deformities, contractures, injuries, podiatric care, poor hygiene all increase the risk of pain, infection and gait disturbances. Although basic gait assessment adds little time to the examination, it yields information that has impact on independent function and guides consultation with rehabilitation professionals (see Falls). Invest in a good pair of nail clippers. Do not hesitate to comment on style and fit of shoes or to refer to a podiatrist.

- **Rectal**–Assess for diseases of the prostate, fecal impaction, integrity of sacral reflexes in persons with impotence, spinal stenosis or posterior column findings, hemoccult.

- **Pelvic examination**--Assess for pelvic prolapse, uterine, adnexal or vaginal neoplasm, infections, estrogen deficit. The lithotomy position may produce discomfort in the osteoarthritic patient. An alternative is the left lateral decubitus position with the right hip flexed more than the left. Pap smears should be done in elderly women, but the recommended frequency is debated. Speculum examination may be painful and difficult due to atrophic changes and vaginal stenosis. A pediatric speculum is often necessary and, occasionally, the examination is so difficult that gynecologic consultation is indicated.

- **Neurological**
  a. Mental status examination should be performed in all patients to establish a baseline in the event of future dysfunction (see Mini-Mental State Examination). This need not occur in the first session.
  b. Deep tendon reflexes and vibratory sense may be decreased normally.
  c. Deficits of language, coordination and other subtle focal findings may indicate cerebrovascular disease that is responsible for cognitive impairment or deficits in instrumental ADL's.
  d. Extrapyramidal signs (muscle rigidity, tremor) may indicate either adverse effects of neuroleptic medication or Parkinson's disease. In most instances, intention tremor and some resting tremors are benign conditions. Unilateral tremors may indicate stroke. A resting tremor with a "pill-rolling" character is worrisome as is any tremor that impairs function.

When physicians have a high index of suspicion with knowledge of the subleties of physical assessment in the older adult, an adequate information base can guide timely intervention.
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