GASTROINTESTINAL DISORDERS OF THE ELDERLY pdf

1: Aging and Digestion: Getting Older Impacts Your Digestive System

With the increase in the number of elderly people in our society, interest in the process of aging and in the field of geriatric medicine has expanded. Brandt wrote this textbook to provide a comprehensive summary of the current knowledge of the aging gut and gastrointestinal disorders in elderly people.

Increasing fiber in the diet Monitoring which foods trigger IBS and avoiding these foods Minimizing stress or learning different ways to cope with stress Sometimes taking medicines as prescribed by your healthcare provider What are structural gastrointestinal disorders? Sometimes, the structural abnormality needs to be removed surgically. Common examples of structural GI disorders include hemorrhoids, diverticular disease, colon polyps, colon cancer, and inflammatory bowel disease. Anal disorders Hemorrhoids Hemorrhoids are swollen blood vessels that line the anal opening. They are caused by chronic excess pressure from straining during a bowel movement, persistent diarrhea, or pregnancy. There are two types of hemorrhoids: Internal hemorrhoids Internal hemorrhoids are blood vessels on the inside of the anal opening. When they fall down into the anus as a result of straining, they become irritated and start to bleed. Ultimately, internal hemorrhoids can fall down enough to prolapse sink or stick out of the anus. Improving bowel habits such as avoiding constipation, not straining during bowel movements, and moving your bowels when you have the urge. Your doctor using elastic bands to eliminate the vessels. Your doctor removing them surgically. Surgery is needed only for a small number of patients with very large, painful, and persistent hemorrhoids. External hemorrhoids External hemorrhoids are veins that lie just under the skin on the outside of the anus. Sometimes, after straining, the external hemorrhoidal veins burst and a blood clot forms under the skin. This very painful condition is called a pile. Anal fissures Anal fissures are splits or cracks in the lining of the anal opening. The most common cause of an anal fissure is the passage of very hard or watery stools. The crack in the anal lining exposes the underlying muscles that control the passage of stool through the anus and out of the body. An anal fissure is one of the most painful problems because the exposed muscles become irritated from exposure to stool or air, and leads to intense burning pain, bleeding, or spasm after bowel movements. Initial treatment for anal fissures includes pain medicine, dietary fiber to reduce the occurrence of large, bulky stools, and sitz baths sitting in a few inches of warm water. Perianal abscesses Perianal abscesses can occur when the tiny anal glands that open on the inside of the anus become blocked, and the bacteria always present in these glands cause an infection. When pus develops, an abscess forms. Anal fistula An anal fistula often follows drainage of an abscess and is an abnormal tube-like passageway from the anal canal to a hole in the skin near the opening of the anus. Body wastes traveling through the anal canal are diverted through this tiny channel and out through the skin, causing itching and irritation. Fistulas also cause drainage, pain, and bleeding. They rarely heal by themselves and usually need surgery to drain the abscess and "close off" the fistula. Other perianal infections Sometimes the skin glands near the anus become infected and need to be drained. Just behind the anus, abscesses can form that contain a small tuft of hair at the back of the pelvis called a pilonidal cyst. Sexually transmitted diseases that can affect the anus include anal warts, herpes, AIDS, chlamydia, and gonorrhea. Diverticular disease Diverticulosis is the presence of small outpouchings diverticula in the muscular wall of the large intestine that form in weakened areas of the bowel. They usually occur in the sigmoid colon, the high-pressure area of the lower large intestine. It is often caused by too little roughage fiber in the diet. Diverticulosis rarely causes symptoms. They include infection or inflammation diverticulitis , bleeding, and obstruction. Treatment of diverticulitis includes antibiotics, increased fluids, and a special diet. Surgery is needed in about half the patients who have complications to remove the involved segment of the colon. Colon polyps and cancer Each year , Americans are diagnosed with colorectal cancer, the second most common form of cancer in the United States. Fortunately, with advances in early detection and treatment, colorectal cancer is one of the most curable forms of the disease. By using a variety of screening tests, it is possible to prevent, detect, and treat the disease long before symptoms appear. The importance of screening Almost all colorectal cancers begin as polyps, benign non-cancerous growths in the tissues lining the colon and rectum. Cancer develops when these polyps grow and abnormal cells develop and start to invade

surrounding tissue. Removal of polyps can prevent the development of colorectal cancer. Almost all precancerous polyps can be removed painlessly using a flexible lighted tube called a colonoscope. If not caught in the early stages, colorectal cancer can spread throughout the body. More advanced cancer requires more complicated surgical techniques. Most early forms of colorectal cancer do not cause symptoms, which makes screening especially important. When symptoms do occur, the cancer might already be quite advanced. Symptoms include blood on or mixed in with the stool, a change in normal bowel habits, narrowing of the stool, abdominal pain, weight loss, or constant tiredness. Most cases of colorectal cancer are detected in one of four ways: By screening people at average risk for colorectal cancer beginning at age 50 By screening people at higher risk for colorectal cancer for example, those with a family history or a personal history of colon polyps or cancer By investigating the bowel in patients with symptoms A chance finding at a routine check-up Early detection is the best chance for a cure. Colitis There are several types of colitis, conditions that cause an inflammation of the bowel. Treatment depends on the diagnosis, which is made by colonoscopy and biopsy. Can gastrointestinal disease be prevented? Many diseases of the colon and rectum can be prevented or minimized by maintaining a healthy lifestyle, practicing good bowel habits, and submitting to cancer screening. Colonoscopy is recommended for average risk patients at age If you have a family history of colorectal cancer or polyps, colonoscopy may be recommended at a younger age. Typically, colonoscopy is recommended 10 years younger than the affected family member. For example, if your brother was diagnosed with colorectal cancer or polyps at age 45, you should begin screening at age If you have symptoms of colorectal cancer you should consult your doctor right away. A change in normal bowel habits Blood on or in the stool that is either bright or dark Unusual abdominal or gas pains Very narrow stool A feeling that the bowel has not emptied completely after passing stool Unexplained weight loss.

GASTROINTESTINAL DISORDERS OF THE ELDERLY pdf

2: Common Diseases Of The Elderly

Gastroesophageal reflux disease (GERD) is the most common upper GI disorder in older adults, although people of all ages can get it. GERD occurs when stomach acid backs up into the esophagus.

Age-related health conditions include macular degeneration, osteoarthritis, hypertension, and neuromuscular and anatomical changes in the gastrointestinal GI tract. As we grow older, onset of digestive symptoms such as dyspepsia related to gastroesophageal reflux disease GERD , diarrhea, constipation, bloating, and flatulence become multifactorial. Oral health, lifestyle and diet, medication use, motility or anatomical alterations, and hormonal shifts are among the contributing factors. Oral Health Poor oral health can contribute to various GI symptoms. For example, dental decay and changes in dentition can disrupt nutritional status and cause constipation. Tooth loss is associated with age-related decline in bone mass and calcium content in the skeleton. Soft, easy-to-process foods are preferable for the edentulous, but they often lack fiber, which can impact colonic transit, as many fibers have a laxative effect. Adequate mastication, which increases the surface area of food in the mouth to allow enzymes to efficiently break it down, enhances digestion, and this process begins with the salivary enzyme amylase. Moreover, a decline in basal salivary gland secretion appears to occur with normal aging and therefore may impact digestion. More specifically, a sedentary lifestyle, excess alcohol intake, and overeating can worsen GI symptoms or create a new health issue that disrupts GI function or requires medications that cause GI side effects. A sedentary lifestyle coupled with a slower metabolism often leads to weight gain in middle age. Overweight and obesity increases diabetes risk, and diabetes can cause a decrease in GI motility, resulting in gastroparesis. Moreover, additional weight puts pressure on aging joints, which can further inhibit exercise. One hundred forty six billion dollars are spent annually on treating obesity-related chronic diseases including GERD. Frequent large meals, eating before bedtime, alcohol use, along with insufficient exercise, contribute to GERD risk. Symptoms include indigestion, burping, bloating, and heartburn. Geriatric patients are the heaviest users of NSAIDs because of the pain and discomfort linked with osteoarthritic changes. Narcotics or neuroleptic medications can lead to a decline in colonic transit contributing to constipation. Proton pump inhibitors may promote small intestinal bacterial overgrowth SIBO by minimizing gastric acid, a key antibacterial barrier in the small bowel. SIBO is a condition in which abnormal amounts of bacteria overgrow in the small bowel, resulting in gas, bloating, and changes in bowel habits. Anatomical and Neuromotor GI Changes Physical or anatomical changes in older people due to muscular atrophy also are common. The GI tract comprises a series of muscular organs. While coordinated movements of these muscles contribute to normal peristalsis, aging can weaken the muscles, and circumstantial events, such as pelvic floor damage due to difficult childbirth, potentially can culminate in the onset of GI symptoms, including constipation and bloating. Neuromotor changes in how nerves impact motility, due to neurodegeneration, can occur in the GI tract during aging, which can contribute to dysphagia, GERD, and constipation. Alcohol intake is a risk factor for diverticulosis and perhaps is the reason this condition is more prevalent in Westernized countries, although heavy intake of highly processed, low-fiber foods also has been implicated. Diabetes can further contribute to constipation due to delayed transit times secondary to autonomic neuropathy. Age-related changes in the physical structure and function of the pelvic floor likely contribute to constipation and fecal incontinence. Rao, MD, renowned motility expert and gastroenterologist at Georgia Regents University in Augusta, Georgia, says, "Pelvic floor disorders encompass many problems that include dyssynergic defecation, rectal prolapse, excessive perineal descent, fecal incontinence, and others. Recognizing the problem, defining the underlying mechanisms, and providing appropriate treatments are cornerstones for successful management. This requires a multidisciplinary approach involving gastroenterologists, registered dietitians, biofeedback therapists, and motility labs. However, GI symptoms associated with celiac disease are subtler in older individuals. Eradication of the bacterial overgrowth corrected the lactose malabsorption, revealing the role of microbes in this condition. Fecal incontinence is common in middle age and also may occur due to chronic constipation, diarrhea, or chronic diseases such as multiple sclerosis or diabetes. Whether this is a direct effect of hormone withdrawal on

motility or an immune-related mechanism needs to be determined. Some theorize that lower estrogen levels decrease bowel motility through changes in neurotransmitters. Reducing meal size and intake of high-fat foods, and modifying caffeine and alcohol consumption can reduce GERD symptoms. The new and emerging low-FODMAP diet, an eating pattern reduced in commonly malabsorbed short-chain carbohydrates, can decrease gas and bloating related to functional gut disorders. In addition, minimizing excess weight gain and the stress it places on aging joints potentially can lead to reduced use of NSAIDs. Dietitians can suggest alternative ways to reduce stress to clients and patients such as walking, meditation, or a warm bath rather than relying on alcohol as a means to alleviate tension. Reducing alcohol consumption may lower the risk of diverticulitis and GERD. RDs can encourage clients to maintain adequate fluid and fiber intake to hasten colonic transit, and choose fiber with the most evidence basis to relieve constipation, such as psyllium fiber, rather than rapidly fermentable fibers, such as chicory root or inulin, if gas and bloating are troubling symptoms. Fiber and functional gastrointestinal disorders. Ageing and the gut. Non-steroidal anti-inflammatory drug toxicity in the upper gastrointestinal tract. Assessing NSAID prescription use as a predisposing factor for gastroesophageal reflux disease in a Medicaid population. Lindgren S, Janzon L. Prevalence of swallowing complaints and clinical findings among year-old men and women in an urban population. Alcohol consumption is a risk factor for colonic diverticulosis. Severe spruelike enteropathy associated with omesartan. Ageing of the enteric nervous system. Innervation of the gastrointestinal tract: Bhutto A, Morley JE. The clinical significance of gastrointestinal changes with aging. Hoffman JC, Zeitz M. Small bowel disease in the elderly: Best Prac Res Clin Gastroenterol. Increasing prevalence and high incidence of celiac disease in elderly people: Lactose malabsorption in the elderly: Fecal incontinence in US adults: Heitkemper MM, Chang L. Do fluctuations in ovarian hormones affect gastrointestinal symptoms in women with irritable bowel syndrome? Int J Clin Pract. Great Valley Publishing Company, Inc.

GASTROINTESTINAL DISORDERS OF THE ELDERLY pdf

3: Gastrointestinal Disorders in Elderly Patients | Roberto Grassi - www.enganchecubano.com

The gastroenterologist will frequently encounter elderly patients with complaints of dysphagia, anorexia, dyspepsia, and disorders of colonic function. Understanding age-related changes in gastrointestinal physiology and effects of common comorbid illnesses enhances the ability to evaluate and treat these common, troublesome symptoms.

Roberto Grassi This article appeared in a journal published by Elsevier. The attached copy is furnished to the author for internal non-commercial research and education use, including for instruction at the authors institution and sharing with colleagues. Other uses, including reproduction and distribution, or selling or licensing copies, or posting to personal, institutional or third party websites are prohibited. In most cases authors are permitted to post their version of the article e. With the marked increase in any alteration can have severe consequences, population aged 65 years and over, the study such as malnutrition, dehydration, aspiration and care of GI disorders should be a high priority pneumonia, or airway obstruction. Swallowing dis- for both clinicians and researchers. Both the usual orders have a variety of causes: Most problems encoun- normal swallowing in an ambulatory, alert patient tered occur at the proximal and distal ends of the to an apparent inability to swallow at all in a se- GI tract. Elderly are caused by central nervous system disorders patients have a diminished sensorium, allowing pa- of pyramidal and extrapyramidal pathways and pe- thology to advance to a very dangerous state before ripheral nervous system motor impairment. Mes- orders, brain stem lesions, lesion of the cranial enteric ischemia and small bowel obstruction nerves or their neuromuscular junctions, or lesions SBO must be included in the initial differential diag- of the oral, pharyngeal, or esophageal striated nosis of abdominal pain, because an early diagno- muscles. Radiol Clin N Am 46 â€" doi: Bolus in the hypopharynx, in the home residents have some form of swallowing im- pharyngo-esophageal segment and cervi- pairment. These individuals are particularly prone cal esophagus: The laryngeal vestibule to episodes of choking during swallowing, a sign remains closed from the inward fold move- that the swallowing mechanism is abnormal. Some of these patients develop compensatory Stage VI. Reopening of the pharynx and lar- mechanisms of the swallowing process, either vol- ynx: Imaging features patient but that can lead to respiratory altera- allow an accurate study of the tongue, palate, tions, as laryngospasm, asthma, and airway pharynx, and larynx, providing useful information inflammation. The bolus phy, are used in the dynamic evaluation of is maintained within the mouth by the close swallowing disorders. The videofluorographic ex- apposition of the soft palate to the poste- amination allows patients who have normal swal- rior aspect of the tongue. Initial stage of swallowing: Eleva- have swallowing alterations that require a specific tion of the soft palate that is apposed rehabilitation program. The an- or exclude the presence of food aspiration or pen- terior and downward movement of the etration into the airways; this information influ- tongue contributes to create a receiving ences the type of nutrition oral or nonoral the space of the bolus in the oropharynx patient should receive. Simultaneous examination with initial filling of the glossoepiglottic using videofluoroscopy concurrent with solid- valleculae. The bolus in the oropharynx: The qualitative, and quantitative information by epiglottis tilts downward and posteriorly combining movement analysis with pressure to prevent laryngeal injection. The larynx is mote-controlled radiographic apparatus connected closed and elevates during swallowing. In uncooperative patients eg, elderly patients Stage IV. The bolus in the hypopharynx: The who have neurologic disease , the examination hyoid bone and the larynx reach the maxi- could be performed using lateral acquisitions mum position. Closure of the larynx results with the patient seated rather than standing. Swallowing alterations often are a result of of the motility of the larynx and vocal chords several impairments, so they can appear as a com- with a first series of acquisitions during pho- plex syndrome with multiple findings rather than as nation the patient pronounces the vocal a single, isolated dysfunction. The purposes of the dynamic radiologic study of tion of the oropharynx with acquisition dur- the pharynx are ing the swallowing of a high-density barium bolus 1. To define the normal anatomy of oropha- ryngeal region Small boluses 15â€"20 mL of high-density 2. To detect the mechanism responsible for lowing. For patients suffering from dysphagia to the alteration liquids, the study also includes acquisitions dur- 4. Examination of the motility of the soft palate. A At rest the soft palate is in normal position white line. Tongue

defi- ping at vocal cord level. It is important to ciency resulting from atrophy, weakness, or lack distinguish laryngeal penetration from aspiration of coordination may be compensated by the Fig. On dynamic glossoepiglottic valleculae and pyriform sinuses radiologic study Fig. Excessive retention of food in found to have barium aspiration in the airway the pharynx after swallowing may be caused by without coughing silent aspiration. Resid- greater for patients who aspirate than for those ual bolus spreads throughout pharynx after who do not. The odds ratio of death is 9. An epiglottis that attains an obliquity be demonstrated by dynamic radiologic study. A The unintentional loss of saliva from the mouth drooling white arrows. B The incompetence of the seal between the tongue and the palate results in premature leakage white arrows. Excessive retention of barium in the pharynx arrow after swallowing caused by weakness of the pharyngeal constrictor muscle. Entry of swallowed ma- terial into the larynx during swallowing, stopping at the level of the vocal cord white arrow. Laryngeal injection through the vocal cords into the trachea may occur during swallowing, before During radiologic examination, various thera- swallowing, or after swallowing. Timing of the in- peutic modifications of head position, laryngeal el- jection has important therapeutic implications. This bar makes a posterior indentation in the barium column that persists throughout the swallow. Because of the multiplicity of these disorders Fig. The epiglottis attains an oblique position and and the variety of symptoms which are not related does not tilt down properly but remains in a transverse easily to individual diseases and which present in position during deglutition white arrows. Entry of swallowed material through the larynx A white arrow over vocal cord level B white arrow. Furthermore, it This examination allows the radiologist to detect is common for a dynamic radiologic examination structural abnormalities that may support func- of endopelvic structures to reveal multicompart- tional defects of posterior pelvic floor compart- mental dysfunction in patients whose initial clinical ment Fig. Endovaginal examination is useful observation was oriented to a single-compartment in studying the female sphincter, and it is espe- disorder. It is expected that further and posteriorâ€”is largely artificial, because the information regarding the usefulness of the ultra- pelvic floor structures are closely interrelated; sound transperineal approach34 with dynamic patients who have abnormalities in one compart- acquisition in the contraction and straining phases ment often have disorders in others. In the proximal portion of the anal canal this proce- The patient is seated on a portable lavatory seat dure visualizes the puborectalis muscle as a hyper- on the step of the fluoroscopy table, and a lateral echoic arch-shaped structure opened anteriorly pelvic radiograph is taken at rest and during the Fig. In the middle level of the canal the exter- contraction, straining, and defecatory phases. The distal portion determined by the basal tone of the pelvic floor of the canal is defined by the subcutaneous muscles. A At the proximal level the puborectalis muscle is visible as a U-shaped hyperechoic sling. B At the middle level the internal anal sphincter is visible as a hypoechoic dominant inner ring. Medially to the internal sphincter is the hyperechoic thin ring of the mucosa-submucosa complex. C At the distal level the subcutaneous external sphincter is visible as a hyperechoic round structure that lies below the termination of the internal sphincter. The rectal ampulla, the bladder, and, in In the straining phase, the impact on the pelvic women, the vagina must be opacified: Dur- ultrasonographic gel mL mixed with gadoli- ing evacuation it is possible to observe bladder nium-diethylenetriamine pentaacetic acid 3 mL ; excursion and the loss of the puborectal impres- and the vaginal walls are opacified with the sion with the anorectal angle becoming more same mixture. The protocol MR imaging has been applied to pelvic floor dy- consists of T2-weighted sequences in the axial, namics to evaluate the complex anatomy and coronal, and sagittal planes and, for dynamic topography of pelvic structures and simulta- study, T2-breath-hold sequence slice, 10 mm; neously to assess their variations during physio- TR, 6. The MR the excursion of bladder, rectum, uterus, and va- images so obtained then are assembled in cine- gina, and it analyses the efficacy of puborectalis view in postprocessing. It also visualizes mucosal prolapse, defines its extent into the anal canal, and reveals any involvement of small intestinal loops. MR imaging provides a level of detail other- wise unobtainable. It can be used to assess pelvic floor mobility with precision and the involvement of Fig. A superficial fistula anterior and middle compartments. Note that identi- Rectocele fication of the fistulous tract is enhanced by hydrogen peroxide injection arrows. Rectocele is a protrusion of the anterior rectal wall during evacuation Fig. Rectocele is common in Dynamic MR imaging has better accuracy in women, because the rectovaginal septum is rela- detecting and characterizing

pelvic organ pro- tively weak, as is the pelvic floor support, second- lapse but has lower sensitivity than cine colpo- ary to aging, obesity, pregnancy, and vaginal cystodefecography in detecting parietal and delivery. A protrusion of the rectum also may be mucosal alterations. MR defecography external or internal, and it may be limited to mu- is the best way to assess rectal ampulla and pelvic cosa or may involve the full thickness of the rectal floor descent, and it is able to determine if the wall. Currently, surgical repair of recto- canal and remains there during straining. If the cele usually is performed using the double-stapled entire thickness of the rectal wall is extruded transanal rectal resection technique. Image from a three-dimensional data set. Chronic intersphinteric abscess 1 presenting as an area of intermediate reflectivity A in the frontal view and B its deep extension in the lateral view. The depth of a rectocele is measured from its an- terior aspect horizontal dotted line to the vertical from the anterior wall of the anal canal vertical dotted line. Enterocele, elitrocele, edrocele, anterior Lateral perineal hernias rectal wall hernia sigmoidocele, Perineal hernia is a very rare clinical finding. It oc- and omentocele curs when the hernial sac passes through the Enterocele is a descent of the small bowel, perito- perineal wall. This pathology is related to a defect neal fat, or sigmoid colon into the rectogenital in the anatomic structures forming the pelvic space above the superior portion of the vaginal diaphragm. The pelvic diaphragm is made up of dome. If these structures enter the vaginal fornix the levator ani muscle, the coccygeus muscle, posteriorly, there is an elitrocele posterior vaginal the sphincter externus muscle, and the ani and hernia ; if they enter the rectum anteriorly, there is perineal fascia. Dynamic MR imag- ACUTE ABDOMEN ing has the advantage of visualizing intestinal descent without the need to opacify bowel loops, Elderly patients who have acute abdomen are and it better assesses pelvic floor excursion and much less likely to have the classic presentation the real dimensions of the hernial orifice Fig. Some differences in presenta- Furthermore, it easily detects omentocele, which tion of the acute abdomen are caused by age- is peritoneal fat herniation, and sigmoidocele, associated physiologic changes. An aged immune which is a descent of sigmoid colon. Sagittal T2-weighted images of the pelvis with rectal and vaginal contrast. A At rest the position of the pelvic viscera is normal. B In the contraction phase, the efficacy of puborectalis muscle contraction and the excursion of bladder, rectum, uterus, and vagina can be evaluated. C Position of the pelvic viscera during straining. D As the patient defecates, there is further descent of the bladder, vaginal angulation, and an anterior rectocele. Their pain often is well-known and common conditions, the diagno- much less severe than would be expected for sis and the choice of the correct treatment still a particular disease, because decreased neural pose challenges for those working in emergency sensitivity causes reduced sensation of pain and clinical settings. Clinicians must take into account leads to a delay in the presentation of an acute atypical presentations and the many clinical differ- abdomen. Often, elderly patients who have seri- entials. Once they have established the diagnosis, ous pathology are misdiagnosed initially as having they need to decide whether, how, and when to benign conditions such as gastroenteritis or intervene.

GASTROINTESTINAL DISORDERS OF THE ELDERLY pdf

4: Changes, functional disorders, and diseases in the gastrointestinal tract of elderly.

Gastrointestinal disorders are common in elderly patients, and the clinical presentation, complications, and management may differ from those in younger patient. Most impairment occurs in the proximal and distal tract of the gastrointestinal system.

Main content Aging and Digestion As you grow older, are you more likely to suffer from indigestion, constipation and other ailments of the digestive system? Unfortunately, the answer is yes, says Sacramento gastroenterologist Roger Mendis, M. Everything changes as our body ages, and some of those changes do impact your GI tract. Sluggish Metabolism A slower metabolism can trigger constipation. The work of the colon involves the coordinated contraction of smooth muscle in the gut. Activity level, diet, water intake and metabolism all play a role in digestive health. As we age, our metabolism may slow, as does our activity level, resulting in harder, drier stools that are more difficult to pass. Drinking more water, modest activity walking and incorporating fiber into the diet may be beneficial in maintaining healthy bowel habits. See more on constipation. Susceptibility to Diverticulosis Almost half of older adults will have this condition, in which small pouches develop in the lining of the colon. Most adults remain symptom free, but these diverticula pouches can also cause constipation and discomfort. If the pouches become inflamed diverticulitis , they can cause pain, fever and abdominal tenderness. Bleeding may occur in a minority of individuals. Seemingly Unrelated Conditions Health problems like diabetes or thyroid conditions can impact your metabolism and your digestive system, causing constipation or diarrhea. Calcium channel blockers, often prescribed for heart conditions, can cause constipation. Pain relievers, particularly narcotic pain relievers, are well known to cause constipation. And aspirin or other non-steroidal anti-inflammatory NSAID pain relievers, sold over-the-counter, can upset the stomach and cause GI bleeding. Being Overweight As your metabolism slows, it takes more effort to keep the pounds off. Increased weight can lead to increased acid reflux and heart burn, as abdominal fat pushes the stomach into the chest. Inactivity Painful arthritis can cause us to become more sedentary as we age, and that too can slow digestion. Your digestive system works best when you are active and mobile. If aging means you spend more time sitting and less time moving, your GI tract may become sluggish. Mendis says it hard to pinpoint exactly why, older adults commonly find they can no longer tolerate the spicy foods, alcohol or coffee in the quantities they used to love. Help for Digestive Problems Associated with Aging So what can you do about the inevitable movement of time, keeping your digestion moving along as smoothly as possible? Mendis offers his patients a number of recommendations, valuable at any age and also beneficial for warding off other serious diseases like heart disease or cancer: Eat a low-fat, high-fiber diet, rich in fruits and vegetables. Substitute brown for white â€” for rice, bread and pasta. See the Mediterranean Diet Guide for easy suggestions and meal ideas. Drink adequate water, and add more water if you drink coffee and alcohol, which can be dehydrating. Walking, bike riding, gardening or swimming are great. Triathlons are not needed, but some regular exercise is always a necessity. See eight ways to overcome your fitness obstacles. If your doctor prescribes a new medication, ask the doctor or your pharmacist what impact it may have on your digestive system. Evaluate your medication list with your doctor on a regular basis. Know the warning signs of serious digestive problems: Progressive abdominal pain, sudden weight loss, and unexplained bleeding always deserve an evaluation by a doctor.

GASTROINTESTINAL DISORDERS OF THE ELDERLY pdf

5: Digestive Wellness: The Link Between Aging and Digestive Disorders - Today's Dietitian Magazine

CHANGES in the anatomy and physiology of the epithelium of the digestive organs because of aging are slight. 1 The functional capacity of both the secretory and absorptive cells of the gut is so.

By Jason Wu, President February 23, Is your elderly relative experiencing above average gastrointestinal distress? As a family caregiver, it can be hard to care properly for your loved one when they have digestive issues. Caregiver in Davis CA: Senior Digestive Disorders Watch for Symptoms of Digestive Distress Many things slow down in the body because of age, and the digestive system is one of them. Common symptoms of gastrointestinal distress include heartburn, indigestion, abdominal tenderness, belching, flatulence, diarrhea, and constipation. With extremely serious digestive issues, seniors may experience abdominal pain, rectal bleeding, nausea, fever and chronic diarrhea. If your elderly loved one is experiencing any of these serious symptoms, you or their senior care assistant needs to get them to a doctor soon. You need to get your aging loved one to a doctor for treatment. Remember, early diagnosis is the best way for seniors to treat conditions affecting the digestive system. Improving Digestive Health in the Elderly While the digestive system can be affected by age, there are many healthy habits that elderly adults can adopt that boost digestion. You can assist your elderly loved one by supporting all efforts to improve overall health and specifically digestive issues. It only takes a few simple lifestyle changes to make significant changes to health and wellness. The easiest things to do that impact the digestive system is to drink plenty of liquids and enjoy a healthy diet with adequate fiber. Seniors can sip water with each meal and drink throughout the day for maximum impact. Food like broth, tea, and juicy fruits and vegetables also count as fluids. Senior care assistants and other family members should include proper food and drink as often as they can. Another thing that aides in digestion is activity Whether they engage in actual exercise or merely stay active by walking, gardening or cleaning, seniors and their digestion will benefit. Activity levels help keep muscles along the digestive tract moving, easing the process. You want your elderly loved one to enjoy the best that life has to offer. Recognizing the symptoms of digestive disorders in the elderly is the first step toward treatment and a better way of life.

6: Digestive Disorders & Gastrointestinal Diseases | Cleveland Clinic

Gastrointestinal disorders include such conditions as constipation, irritable bowel syndrome, hemorrhoids, anal fissures, perianal abscesses, anal fistulas, perianal infections, diverticular diseases, colitis, colon polyps and cancer.

7: What are some GI problems associated with aging? | Digestive Health - Sharecare

Recognizing the symptoms of digestive disorders in the elderly is the first step toward treatment and a better way of life. If you or an aging loved one is considering a Caregiver in Davis, CA, or the surrounding areas please contact the caring staff at ApexCareÂ®.

8: Symptoms of Digestive Disorders in the Elderly - Home Care in Sacramento by Apex Care

because the prognosis is poor, and the treatment Author's personal copy Gastrointestinal Disorders in Elderly Patients the superior mesenteric artery is obstructed at the origin by an embolus, most of the small in- testine and the right colon are subject to ischemia Nonocclusive mesenteric ischemia, most fre- quent in the elderly.

GASTROINTESTINAL DISORDERS OF THE ELDERLY pdf

The museum profession Patrick J. Boylan Entopy and Partial Differential Equations Reincarnation Is A Fact And Justice for Some Don Driver-With Spirit Government internal audit manual Lets have an evangelist! Miles Davis for Beginners Blockbuster! museum responses to Alexander John F. Cherry I Like Outer Space (Things I Like) B-2 Stealth Bomber Introduction Kevin Hughes Traces of paradise Oral microbiology at a glance Simmers annual autumn catalogue of bulbs, plants, seeds, etc. Jobs that save our environment. Over here stories Elections in independent Africa Piano Classics Easy Adult Piano III-V Nitrides Semiconductors and Ceramics Vignettes of campus transformation Donald M. Norris, James L. Morrison The definitive guide to mongodb 3rd edition Hawaii, the best of paradise The rise fall of Jim Crow Becoming Swedish-American The New Zealand immigration guide The L.A. Dodgers, the world champions of baseball Blood bank project report The first officer 2 Hole-in-one adverbs Mixed-bloods and tribal dissolution Enhancing your public relations Paleotethysides in West Yunnan and Sichuan, China Handbook of veterinary anesthesia 5th edition Adobe photoshop cs6 full book The Greek World 479-323 BC (Routledge History of the Ancient World) Lomolino biogeography 4th edition filetype Intel386 SX microprocessor programmers reference manual. Ayurvedic perspectives on selected pathologies Why cant my be aloud