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Geriatric Dermatology—A Framework for Caring for Older Patients With Skin Disease

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The number of people in the United States older than 65 years is growing. By 2030, 20% of all Americans will be older than 65 years, making the geriatric population the same size as the pediatric population. The number of people older than 85 years is the fastest growing segment of the US population, expected to double from 4.7 million in 2003 to 9.6 million in 2030, and will reach 20 million by 2060. The incidence of dermatologic conditions is rising in parallel, with more than 27 million visits to dermatologists and more than 5 million new skin cancers each year, most in older adults.¹

“Geriatric dermatology is, of course, essentially the same as just plain dermatology,”^{2(p756)} Harry L. Arnold Jr, MD, wrote in 1981. We disagree. However, this sentiment is important to address, because the practice of dermatology would benefit from including unique provisions for older patients. It is now widely recognized that screening for breast, colon, and prostate cancer, as well as treatment and follow-up of low-grade malignancies, should differ in those with limited life expectancy. Although the principles underlying treatment of common skin conditions are similar, these insights that have permeated internal medicine may not yet have informed dermatology.³

In this Viewpoint, we present unique considerations for the care of older persons with skin disease, and we describe central principles of geriatric science that allow for more appropriate care for this rapidly expanding segment of the population (Table).

Life Expectancy Is Not the Same as Chronological Age

Although older age is broadly associated with higher risk of death, older persons of similar age can differ significantly in their overall health. For example, the average life expectancy for an 80-year-old man is 6.7 years; but 80-year-olds in the sickest quartile will live only 3

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years, while those in the healthiest quartile will live another 11 years.⁴ Thus, age is a crude measure of life expectancy, and should not be used as a sole predictor when making screening or treatment decisions. Instead, a patient's overall health status is a better predictor of life expectancy. Online prognostic calculators summarized here can be helpful in estimating a patient's life expectancy (<https://eprognosis.ucsf.edu/>).

Lag Time to Benefit

Many interventions in dermatology bring powerful and fast benefits to our patients. For example, treatment of a very itchy dermatitis or removal of a painful nodule can help a patient almost immediately. Other interventions help in the future. For example, the purpose of a total body skin examination is to detect a melanoma in its earliest stages, before it becomes invasive. Similarly, the reason we treat an individual asymptomatic actinic keratosis (AK) is to prevent the development of squamous cell carcinoma in the future. For such interventions performed by dermatologists, consideration needs to be given to the future benefit; thus, the question of "When will it help?" is as important as "How much will it help?"

The lag time to benefit, defined as the time between an intervention and the time when improved health outcomes are seen, has been estimated for medications and screening procedures.⁵ For example, the lag time to benefit for colorectal cancer screening is about 10 years, meaning that this intervention makes sense for patients who are likely to live at least a decade. Understanding the lag time to benefit of treatment of dermatologic conditions in relation to a patient's life expectancy is essential in making appropriate decisions.

Multimorbidity, Polypharmacy, and Medication Adverse Effects

As we age, we accumulate health problems. Multimorbidity (the presence of 2 or more chronic health conditions) is associated with mental health problems, lower quality of life, fragmented and poorly coordinated care, and higher health care use.⁶ Furthermore, multimorbidity contributes to another problem: polypharmacy. Each additional medication increases the risk of adverse effects, and many medications viewed as safe in younger persons are not always safe in older persons. A key example relevant to dermatology is the use of antihistamines for pruritus. Because of anticholinergic adverse effects, including confusion, constipation, and reduced clearance in advanced age, antihistamines are listed on the Beers Criteria of potentially inappropriate medications in older adults. Nonetheless, sedating antihistamines are still used by dermatologists in older patients. Furthermore, the use of sedating antihistamines remains part of dermatologic guidelines for treatment of sleep disturbance in atopic dermatitis without explicit exceptions for older adults.⁷

Function, Cognition, and Social Support

Functional decline is common in older adults, who are more likely to experience difficulties with mobility, activities of daily living, and cognition. Approximately 15% to 20% of adults older than 65 years have mild cognitive impairment, and 9% have dementia. In addition, approximately 14% of persons older than 65 years' experience difficulty or dependence with

activities of daily living (eg, walking, dressing, bathing, or eating). These challenges often necessitate additional social support and caregivers. The degree of support varies tremendously among older adults and may determine whether a patient is able to change a bandage at home or even come back for a follow-up visit to the dermatologist.

Implications for Our Specialty

Applying the principles of geriatrics to routine clinical care leads to situations in which physicians must balance benefits and harms for an individual patient. This balance does not lend itself to a one-size-fits-all recommendation, and the relative weight of benefits and harms will often be swayed by the patient's preferences. For example, a cosmetically visible AK may not require treatment in a 90-year old patient who is not bothered by it, but treatment may be necessary for a similar patient who is bothered by the appearance of this lesion, or for a patient with dementia who picks at it.

The purpose of the consultation visit is to determine the best treatment for the patient, considering all relevant factors. We need to explicitly incorporate principles of geriatrics in the practice of dermatology in the same way that principles of pediatrics have been incorporated into dermatology for decades. This shift requires that we inform our current practice when caring for older adults, to consider their unique characteristics: life expectancy, multimorbidity, polypharmacy, function, cognition, mobility, social support, and patient preferences. These characteristics are literally and metaphorically “more than skin deep.” By paying attention to them we can improve the quality of dermatologic care for millions of our patients.

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Principles of Geriatrics Applied to Dermatology

Table.

Geriatrics Principle	Relevance to Dermatology	Example
Life expectancy is more than age	Treatment of low-risk basal cell carcinoma (BCC)	A healthy 80-year-old may have a life expectancy of over 10 years, making treatment of low-risk BCC appropriate to prevent future growth. Meanwhile, a frail 80-year-old with many comorbidities may not live long enough to benefit from treatment of a low-risk BCC.
Lag time to benefit	Screening total body skin examination	A patient in the last year of life may not benefit from routine screening total body skin examination.
Polypharmacy and medication adverse effects	Sedating antihistamines	A patient with itch who is prescribed a sedating antihistamine may experience dizziness and fall due to this medication.
Cognition	Ability to tolerate minor procedures	A patient with dementia may not understand why they are having a biopsy procedure performed, and what seems like a simple procedure can induce anxiety and fear. In a patient prone to behavioral symptoms, this risks precipitating agitation, significantly complicating the caregiver's management during and after the procedure. Also a patient with dementia may not keep a bandage on, and may have hard time keeping the wound clean.
Function and mobility	Wound healing, office visits, bandage changes	Pressure ulcers may develop due to immobility, and wound healing may be complicated by difficulties bathing and moving.
Caregivers, social support	Office visits, bandage changes	A clinic visit may be logistically challenging for the family of a patient who needs support during and after visits. Caregiver availability may determine if follow-up visits and bandage changes are possible.
Patient preferences matter	Treatment of actinic keratoses (AK)	Regarding a painless but cosmetically visible AK, treatment may not be necessary for a patient who is not bothered by it, but may be necessary for a patient who is bothered by its appearance.