

The patient presenting with 'Acopia'

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Abstract

Patients may be referred to Acute Medical Units (AMUs) with a diagnosis of 'acopia'. This term is offensive and lazy, implying fault on the part of the patient and allowing the assessing doctor to erroneously label the patient as a 'social admission' when, in fact, such patients are likely to be frail with co-morbidities and have an acute (potentially reversible) illness. Frail older patients should be assessed using the principles of Comprehensive Geriatric Assessment, informed by an understanding of the concept of frailty and of geriatric syndromes such as falls and delirium.

Keywords

Frailty; Comprehensive Geriatric Assessment; acopia; geriatric syndromes.

Key Points

- 'Acopia' is not a diagnosis and the term should not be used in medical practice.
- Patients erroneously labelled with 'acopia' or a 'social admission' often have several co-morbidities and usually have evidence of acute illness which should be actively sought.
- Frailty is a state of increased vulnerability to stressors such that even minor insults can cause problems with homeostasis or functional ability.
- Frail older people are less likely to present with clear cut medical problems and more likely to present with geriatric syndromes (e.g. falls, reduced mobility, acute confusion) that require a thorough assessment.
- Frail older people should be assessed by a team trained in Comprehensive Geriatric Assessment.

Case history

An 86 year old woman was referred directly to the Acute Medical Unit by her General Practitioner (GP). She was triaged in the Emergency Department with a presenting complaint of 'acopia'. The referral letter read as follows:

'Dear doctor

This 86 year old woman was previously managing quite well at home with help from her family. I was called to see her about 10 days go at home as she had collapsed and injured her hip. I sent her to A&E where they didn't find evidence of a fracture but discharged her home with analgesia. Over the past few days she has got more unsteady and now requires the support of her son to walk very short distances. Her son has moved in with her pending a care package but she has fallen 3 times this week and isn't coping. When I saw her today she seemed a little 'off it'.

'Past medical history: hypertension, hypercholesterolaemia, osteoarthritis, cognitive impairment.

Medications: bendroflumethiazide 2.5mg od, ramipril 5mg od, simvastatin 40mg nocte, aspirin 75mg od, co-codamol 30/500mg 2 tabs qds prn. Examination: HR 90, BP 128/70, RR 16, SaO₂ 94% on air, temp 36.2°C. Chest - a few creps at the left base. Abdomen soft non tender. Offensive smelling urine. I wonder whether she has developed a UTI. Please can you assess?'

How should a frail older patient be assessed on arrival in hospital?

When a patient is referred to the Acute Medical Unit with an 'inability to cope at home' or a 'social admission' it is in fact rare that this is the case. Such patients commonly have several co-morbidities and usually have an acute (potentially reversible) illness.¹

An effective way to approach these patients is to use **Comprehensive Geriatric Assessment (CGA)**. This is a multidisciplinary process that covers medical diagnoses, medication review, mental health assessment, functional ability, and a review of social circumstances. A co-ordinated plan of care can then be developed according to the identified problems in order to maximise overall health.²

CGA has a strong evidence base. Randomised controlled trials show that CGA and its interventions lead to improved function and quality of life, and also reduce hospital stay, re-admission rates and institutionalisation, but only if a doctor trained in Geriatric Medicine is included in the multi-disciplinary team.³ A Cochrane review showed that patients who received CGA were more likely to be alive and in their own homes compared to general medical care at 6 months and 12 months after follow up.⁴

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The five basic domains of CGA are shown in Table 1.⁵

Effective CGA will involve several different healthcare professionals including specialist nurses, physiotherapists and occupational therapists, but doctors have a vital role in co-ordinating this process.

Case history revisited

A full history was taken from the patient and her son. She had fallen at home shortly after getting up from her chair. She told her son she felt faint just before she fell but she had not lost consciousness. An X-ray of her hip performed in the Emergency Department on the day of the fall did not show any fracture and she was discharged home with a prescription for co-codamol 30/500mg - two tablets four times a day. Over the next few days, she became more confused at times, mixing up her son with her late husband and talking to people who were not there. In the days leading up to admission she had become increasingly sleepy. She had gone off her food and had only drunk small amounts of fluids. She had fallen three times and become increasingly unsteady on her feet.

On direct questioning, the patient had not opened her bowels for several days. Her son reported that she had complained of urinary urgency and frequency for several years, and had occasional accidents, but that she had been reluctant to seek medical advice for this. Prior to this illness, she had fallen twice in the past year, each time occurring after standing up quickly, with associated dizziness. Her past medical history and regular medications were as recorded in the GP letter.

She lived alone in a house with a stairlift. She was normally only able to walk short distances (10 metres) with a stick due to arthritis. She had carers twice a day who

provided minimal assistance (prompting) with washing and dressing and made sure she took her medications. Her son lived nearby and visited her most days. She usually ate well – toast and tea for breakfast, and a microwave meal for lunch and dinner. Her family managed her finances and did her weekly shopping. Her son described how she had increasing difficulties with short term memory and tasks like cooking which he considered 'part and parcel of getting old'. She had no symptoms consistent with depression or anxiety.

On examination she had a heart rate of 84/min, blood pressure 121/65 lying and 98/60 standing, oxygen saturations 97% on air, respiratory rate 20/min and temperature 35.9° Celsius. Her weight was 61kilogrammes and height 1.6 metres, giving a body mass index of 23.8 kg/m².

The cardiovascular, respiratory and abdominal examinations were normal. A 'get up and go test' was performed. She required assistance to stand and walked slowly and unsteadily with the assistance of one person. She was unable to walk for more than 3 metres before needing to sit down, although she did not appear to be in pain. Her Abbreviated Mental Test score was 6/10. It was noted that she found it hard to follow the conversation but there were no focal neurological signs. Her corrected visual acuity was 6/12 on the right and 6/18 on the left. Fundoscopy revealed bilateral cataracts.

Initial blood tests and a chest X-ray were performed and the results are shown in Table 2.

How should a frail older patient's problems be summarised?

Frail older people rarely present with a single diagnosis. Instead, it is more common to find multiple problems that are better addressed by **formulating a problem list**. A problem list was made for this patient as follows:

Acute problems

1. Acute confusion (delirium).
2. Constipation due to co-codamol causing reduced oral intake.
3. Acute kidney injury.

Table 1. Domains of Comprehensive Geriatric Assessment.

Domain	Details
Medical	• A list of all active and inactive problems, including significant co-morbidities • Consideration of polypharmacy and review of medications • Nutritional status
Mental health	• Cognition • Mood • Patient's fears and concerns
Functional capacity	• Activities of daily living required for basic self care e.g. ability to wash and dress • Instrumental activities of daily leaving e.g. shopping, managing finances • Gait and balance • Activity and exercise tolerance
Social circumstances and environment	• Care services • Facilities and adaptations • Informal support from family and friends • Social network

Table 2. Initial test results.

Test (units)	Result
Haemoglobin (g/dL)	11.4
Total white cell count (×10 ⁹ /L)	7.5
Platelet count (×10 ⁹ /L)	104
Sodium (mmol/L)	131
Potassium (mmol/L)	3.6
Urea (mmol/L)	12.5
Creatinine (μmol/L)	156 (85 one month ago)
C-reactive protein (mg/L)	6
Glucose (mmol/L)	4.5
Liver function tests	Normal
Urinalysis	Leucocytes ++ and nitrites +
Electrocardiogram	Normal
X-ray left hip and pelvis	Osteopenia, no fracture
Chest X-ray	Normal

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4. Opioid toxicity due to acute kidney injury causing drowsiness and falls.
5. ?UTI (but await MSU).

Background problems

1. Underlying cognitive impairment? undiagnosed dementia.
2. Falls (multifactorial – vision, medication, arthritis, bladder problems, cognitive impairment etc.).
3. Urinary incontinence (urge/unstable bladder) exacerbated by thiazide diuretics.
4. Osteopenia on X-rays ?osteoporosis.
5. Frailty.

Acute management plan

Once a thorough problem list has been formulated it is easier to make a management plan, as older people can be clinically complex. Pain, opioid analgesia and constipation are all causes of delirium, which is defined as acute confusion with a fluctuating course, reduced ability to sustain attention and disturbance in conscious level that is best explained by an acute illness.⁶ Constipation in older people (as well as opioid-induced nausea) can lead to reduced oral intake, in this case causing an acute kidney injury exacerbated by an ACE inhibitor, and leading to accumulation of opioids causing falls and drowsiness.

While constipation can lead to incomplete bladder emptying causing urinary tract infections, and urinary tract infection is also a cause of acute kidney injury in older people, bacteriuria (i.e. the presence of bacteria in the urine) can be a normal finding in elderly women⁷ and there are common non-infective causes of urinary symptoms in this age group. Urine dipsticks should not be used for diagnosis of urinary tract infections in older adults.⁸

The acute management plan for the patient was as follows:

- Stop co-codamol and prescribe paracetamol.
- Temporarily stop ramipril.
- Stop bendroflumethiazide (low sodium, bladder symptoms, previous postural hypotension).
- Treat constipation.
- Intravenous fluids.
- Send mid-stream specimen of urine.
- Manage delirium.

Delirium often, but not always, has a clear precipitant. A common error is to think only of infection as a possible cause and to ignore all the other components of the management of delirium. The National Institute of Health and Clinical Excellence (NICE) guidelines recommend a multicomponent intervention which should include the following:⁶

- Re-orientation strategies.
- Provision of clear lighting, signage, a clock and calendar.

- Provision of aids e.g. spectacles and hearing aids.
- Review of medication.
- Treatment of pain, constipation and dehydration.
- Encouragement of mobility.
- Adequate nutrition.

Case continued

The patient was transferred to a side room on a Geriatric Medicine ward that practiced the multicomponent interventions described above. Within two days her creatinine was back to normal and her mobility and drowsiness had improved. Her acute confusion, however, improved more slowly – a feature commonly seen.

A repeat AMT performed when her family thought she was back to her baseline cognitive state was 7/10, and a 6-CIT (cognitive impairment test) was performed and she scored 12/28. A diagnosis of dementia was made, in keeping with the history of gradual memory loss and the need for prompting in the history.⁹ A series of blood tests (a ‘cognitive screen’) was performed: calcium, thyroid function, B12 and folate levels. These were normal. The patient was referred to a specialist memory clinic as an outpatient.

The patient was also assessed by a physiotherapist, occupational therapist and ward pharmacist. Once back to normal, she was discharged home with her usual care package on ramipril 5mg od and aspirin 75mg od. She was referred to ophthalmology for consideration of cataract surgery and to a continence nurse specialist as an outpatient.

What is ‘acopia’?

The authors searched MEDLINE, EMBASE and CINAHL for articles using the search term ‘acopia’. Nine articles were identified.

‘Acopia’ is colloquial term used to describe patients who are unable to cope with tasks of daily living although alternative definitions have been proposed (Box 1). A retrospective analysis of patients triaged with ‘acopia’ as their presenting complaint in a UK district general hospital identified 81 patients with a median age of 85 years.¹ The majority of patients had one or more co-morbid conditions (81.5%) and of particular interest, almost all (93.8%) were found to have at least one acute medical problem. Thirty-eight patients (46.9%) presented with geriatric syndromes e.g. falls,

Box 1. Definitions of ‘acopia’.

- An inability to cope with activities of daily living.¹
- An all-encompassing term to describe the frail older patient with multiple medical problems.¹
- An inability to copy.¹¹
- A town in Peru.¹²
- An inability to cope with a stressful situation usually leading to tears and breakdown.¹³
- The quickest way to get a Geriatrician fuming when presenting a patient on the post-take ward round.¹⁴

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reduced mobility and confusion. In total, 18 patients died during their admission, giving a mortality rate in this study of 22.2%.

An earlier Australian study noted the tendency of doctors in Emergency Departments to use the term to describe patients with 'social problems', when in fact these patients often had multiple medical problems.¹⁰ The average number of medical diagnoses per patient was eight. Of interest, 52% of the patients with 'acopia' had previously been living independently in their own homes without receiving assistance from social services, yet a significant proportion of the patients in the study were dependent on discharge. Only 1% of patients with 'acopia' were admitted from a nursing home, although 25% of the patients identified in this study were discharged to a nursing home and there was a 3% mortality rate.

What is Frailty?

Understanding frailty as a clinical syndrome is fundamental in acute care for older people but the term is often poorly understood. Frailty in Geriatric Medicine is considered to be 'a state of increased vulnerability to [physiological] stressors'.¹⁵ This is a consequence of cumulative decline across multiple organ systems due to the combination of ageing and disease, leading to reduced physiological reserve. Patients who are frail may present with a significant illness such as delirium, even when the initial trigger is apparently minor.

In the case described, relatively minor initial insults – pain and constipation – led to significant illness, a common occurrence in patients who are frail. Too often these patients may be written off as 'not coping at home' when in fact they are suffering from a recognised medical syndrome and one or more identifiable acute medical problems.

Older women? who present like the case described are often presumed to have a urinary tract infection, often in the absence of urinary symptoms or any convincing evidence for this diagnosis. Urinary tract infections can be difficult to diagnose in older people and are commonly over-diagnosed. One retrospective case note review found that 43% of patients discharged from hospital with a diagnosis of UTI did not have any evidence for this, despite using generous criteria for diagnosis.¹⁶ Urinary tract infections should only be diagnosed in older people if there are acute urinary symptoms, or if there is bacteriuria plus systemic inflammation without an alternative, more likely, source of infection present.¹⁷

Many authors have criticised the use of the term 'acopia'.^{10 12 18 19} The riposte of others has been that we should embrace the term and instead consider it as an indicator for urgent geriatric assessment.^{1 20} This may be considered analogous to those who have reclaimed offensive words previously used in a derogatory fashion against certain minority groups. The authors agree with the first camp that the term is lazy and offensive. It implies fault on the part of the patient for 'not being able to cope' when in fact it is the assessing doctor that should be able to cope better. Patients labelled with 'acopia' are frail and vulnerable and often unable to voice their opinions on this label. As such we suggest that the term 'acopia' is banned from clinical practice.

The term 'acopia' reduces what can be a complex clinical scenario to one that does not require further examination – a 'social problem' or 'probable UTI'. However, when a full assessment of such patients is carried out by a person trained in the assessment of frail older people, it is usual to discover multiple disease processes, each obscured by the patient's inability to describe the course of their illness. In many cases, incomplete assessment occurs due to a lack of the knowledge and skills required to assess frail older people. But it is also true that negative attitudes towards frail older people exist, leading to the use of words such as 'bed blockers' and GOMERs ('Get Out of My Emergency Room').¹⁹

The Royal College of Physicians of London 'Hospitals on the Edge' report in 2012 stated that, 'Despite patients over 65 [years old] making up the larger share of the hospital population, the system continues to treat older patients as a surprise, at best, or unwelcome, at worst. Much more can be done to prevent unnecessary hospital admission and readmission, shorten length of stay and ensure the smooth and effective transfer of care for patients ready to leave hospital. Areas with integrated services for older people have lower rates of bed use; these hospitals also tend to have lower admission rates and deliver good patient experience'.²¹

There is now such convincing evidence for the need for and the effectiveness of Comprehensive Geriatric Assessment for frail older people that the authors recommend this service should be provided routinely in all Emergency Department and Acute Medical Units.

Conflict of Interest

This study was funded entirely by the authors and they have no conflict of interest with any third party.

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