Clinica Ancelle della Carità

Gruppo di ricerca geriatrica

Fino a che punto riabilitare i grandi vecchi?

Tiziana Torpilliesi

Brescia, venerdì 11 settembre

2009

Il cambiamento dello scenario in generale

Come saremo?

Indicatori di struttura della popolazione

	2006	2025
Indice di vecchiaia	143,1	206,2
Indice di dipendenza	49,5	51,1
Indice di dipendenza giovanile	20,4	16,7
Indice di dipendenza degli anziani	29,2	34,4
Indice di ricambio popolazione attiva	36,6	50,5

Fonte: Elaborazioni IReR su dati ISTAT e Regione Lombardia

La popolazione lombarda continuerà ad invecchiare:

- ✓ ci saranno 206 anziani (invece di 143) ogni 100 giovani
- ✓ ci saranno solo 17 giovani (invece di 20) ogni 100 adulti
- ✓ ci saranno 34 anziani (invece di 29) ogni 100 adulti
- ✓ dall'età attiva usciranno 50 individui (invece di 37) ogni 100 che ne entrano

Il cambiamento dello scenario in generale

Fig. 1. Previsioni demografiche nazionali 1° gennaio 2005-1° gennaio 2050.

Prospetto 2 – Indicatori di struttura della popolazione italiana 1990-2050

Anno	Struttura per età della popolazione				Indici di struttura		
	% 0-14	% 15-64	% 65+	% 85+	Vecchiaia	Dipendenza strutturale	Dipendenza anziani
1990	16,8	68,5	14,7	1,2	88	46	22
2005	14,2	66,4	19,5	2,0	138	51	29
2010	14,0	65,5	20,5	2,8	146	53	31
2020	13,2	63,7	23,2	3,9	176	57	36
2030	12,2	60,8	27,0	4,7	222	64	44
2040	12,4	55,6	32,0	5,8	259	80	58
2050	12,7	53,7	33,6	7,8	264	86	63

Fonte: dati ISTAT_ Previsioni demografiche nazionali 1° genn 2005-1° genn 2050

Il cambiamento dello scenario nell'ambito sanitario

- L'età media degli utenti è aumentata
  - Quota crescente di "oldest old"
- È aumentata la comorbilità
- È diminuita la durata della degenza negli ospedali per acuti (sotto la pressione dei DRG)
- La dimissione è più precoce che non nel passato ed avviene verso i reparti di riabilitazione
- I pazienti giungono in reparto compromesi sotto il profilo funzionale e più "instabili" (eventi clinici avversi) che non nel passato

Il cambiamento dello scenario nella nostra realtà

	2003	2005	2007
Età (anni)	76.2±11.3	76.9±10.7	78.8±10.0
75-89 anni	57.5	57.4	62.6
90 anni	7.4	8.0	10.3
Sesso femminile	71.7	72.8	70.7
MMSE	22.6±6.3	22.5±6.3	21.5±6.6
GDS 15-items	6.1±3.6	5.8±3.3	6.1±3.7
BMI (Kg/cm^2)	24.4±4.9	25.7±5.4	24.2±5.6
Charlson Index	2.7±2.2	2.7±2.0	--
CIRS severity	--	--	1.8±0.3
CIRS comorbidity	--	--	4.2±1.9
Barthel pre-ingresso	81.8±22.0	83.5±21.1	80.8±22.3
Barthel ingresso	55.6±27.7	56.6±26.0	55.1±27.9
Barthel dimissione	74.0±5.7	77.7±25.2	72.6±27.9
≤1 evento avverso	27.6	25.5	31.5
≥2 eventi avversi	11.6	13.2	18.7

I valori sono espressi come Media + DS o %

Da: Bellelli & Trabucchi Riabilitare l'anziano

Un impegno complesso, perché ogni atto di cura (sia in senso stretto, clinico, sia in senso di vicinanza) richiede una sensibilità e una cultura difficili da acquisire in un tempo come il nostro, spesso superficiale, apparentemente incapace di approfondimenti. In questa prospettiva pesa in modo del tutto particolare *la responsabilità* di chi, più di altri, ha il dovere di tracciare la strada, anche se tortuosa e aspra; *sarebbe un'offesa alla storia se, per ignoranza o passività, non fossimo in grado di affrontare con risposte adeguate il più grande cambiamento che la vita umana mai ha compiuto, e in così breve tempo, cioè un aumento della sua durata di quasi un terzo.*

M. Trabucchi

il perchè...

- ...che cos'è la riabilitazione?
- ...quali outcome per gli oldest old?
- ...esiste una riabilitazione dei "grandi vecchi"?

Rehabilitation of Older People

Introduction Rehabilitation is a core element in the practice of medicine for older people involving multidisciplinary team working – crucially physiotherapists, occupational therapists and often (dependent on patient need) speech and language therapists, psychologists or others.

Rehabilitation - what is it? A working definition of rehabilitation is "the reduction of functional deficits without necessarily reversing the underlying biology of the disease" [2]. Its scope is wide and includes acute and chronic perspectives. For example, active treatment to reduce the severity of the underlying disease would be included (e.g. treatment of cardiac failure or pain relief in an arthritic knee), as would adapting the environment to the needs of a disabled person.

- The definition embodies the concepts of:
  - *Impairment* - the specific deficit
  - *Activity limitation* (formerly 'disability') - the resultant limitation in functional capacity
  - *Participation restriction* (formerly 'handicap') – the impact of this limitation on quality of life experienced

(revised 2009) BGS Compendium Document

Rehabilitation of Older People

Comprehensive rehabilitation needs to address a number of different levels which may be contributing to loss of function.

- The damaged system
- Other body systems
- Psychological attitudes
- Immediate material environment e.g. clothes
- The near environment e.g. housing / equipment
- Distant environment e.g. shops, social outlets
- Social support networks.

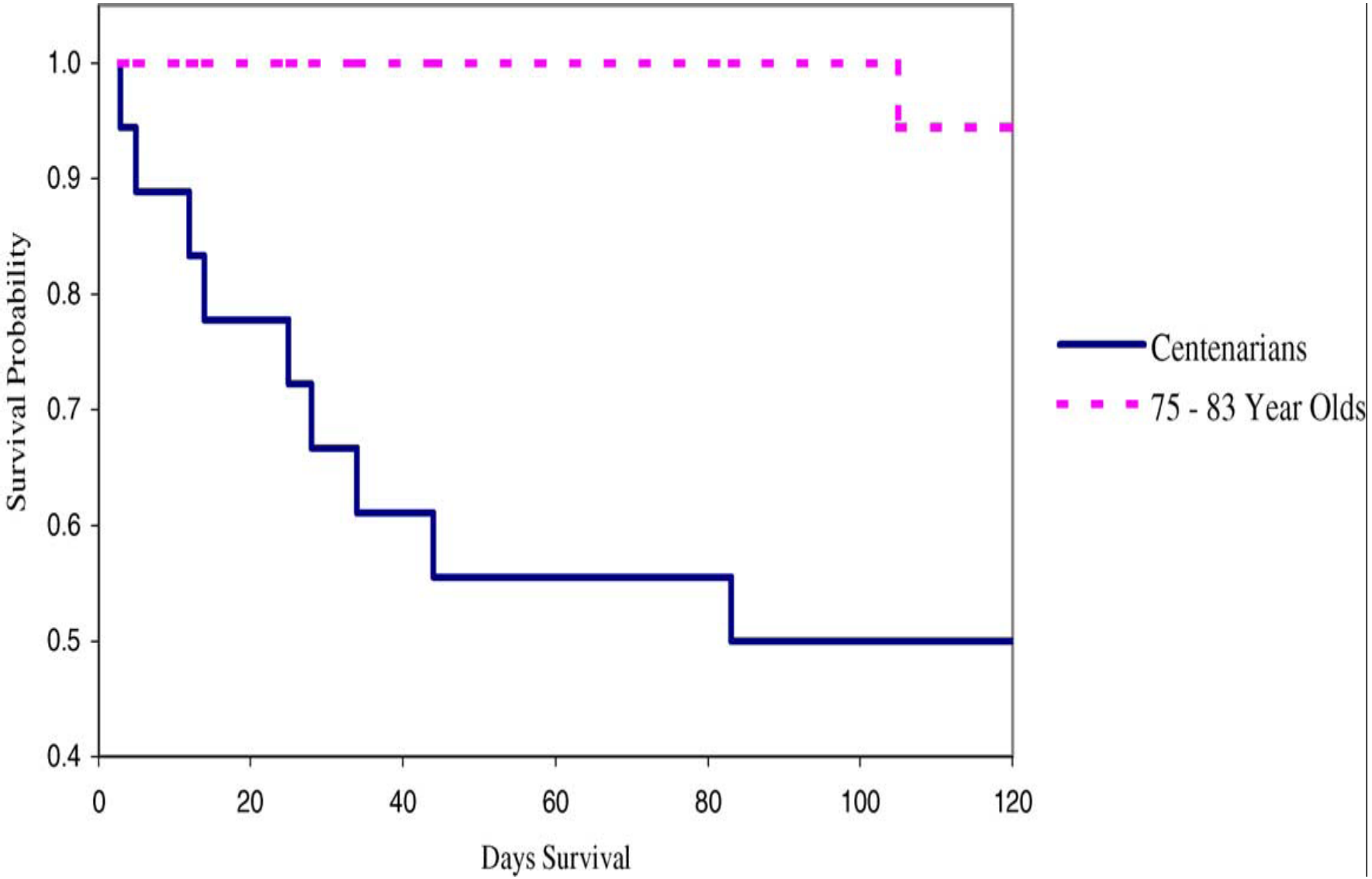
(revised 2009) BGS Compendium Document

Hip fractures in centenarians

C.W. Olivera,C.Burkeb

Summary The centenarian population is increasing yet there is little about their morbidity and mortality rates following hip fracture. The aim was to review centenarians treated for proximal femoral fractures in Edinburgh describing treatment outcomes in relation to mortality, walking ability and residential status comparing centenarians with a the more typical hip fracture population. In this retrospective review, 18 centenarians sustaining hip fractures in Edinburgh between 1998 and 2002 were compared to 18 randomly selected "normal" hip fracture patients aged 75—83 years. Centenarian in-hospital, 1 and 4 month mortality was 11.1, 33.3 and 50%, respectively, versus 0, 0 and 5.6% in the normal group. Centenarian 4 month mortality was significantly greater than that of the normal group (Fisher's Exact Test, P ¼ 0:00723). A total of 22.2% of centenarians regained pre-fracture walking ability compared to 58.8% of the normal patients. A total 28.6% of centenarians could continue living independently post-fracture compared to 69.2% of the normal group.

Injury, Int. J. Care Injured (2004)



Injury, Int. J. Care Injured (2004)

Rehabilitation of oldest old people

- Che senso ha considerare tra gli outcome la mortalità in una popolazione la cui spettanza di vita è per definizione ridotta o in una popolazione che in alcuni casi (come nel caso dei centenari) potrebbe essere definita "sopravvissuta"?
- Allora forse acquista ancor più significato la funzione in termini di prognosi"quoad valetudinem". Permettere uno stato che sia il meno dipendente possibile... *per il resto della vita.* Dove probabilmente nell'essere meno dipendente assumono grande rilevanza i "piccoli guadagni"
- Ma è possibile ottenere un miglioramento funzionale in una popolazione già di per sé fragile?

Old versus oldest old

Pulmonary rehabilitation improves functional capacity in patients 80 years of age or older

OBJECTIVES: to determine whether patients 80 years of age or older gain similar benefits from pulmonary rehabilitation as do younger patients.

DESIGN: Outcomes were compared in 230 consecutive inpatients with moderate to severe lung disease who participated in a comprehensive pulmonary rehabilitation program during a one-year period. Outcomes included 6 min walk test distance (6MWT), the number of stairs completed in 2 min (2MST), Borg dyspnea scores after exertion and objective functional scores.

MA Baltzan et al. *Can Respir J* 2004.

Pulmonary rehabilitation improves functional capacity in patients 80 years of age or older

Baseline characteristics of patients

	Age		
	<80 years	80+ years	P
Number	187	43	
Male (%)	46 (39 to 53)	37 (22 to 52)	0.24
FEV_1 (L)	0.72 (0.67 to 0.78)	0.77 (0.67 to 0.87)	0.36
FVC (L)	1.36 (1.27 to 1.49)	1.48 (1.29 to 1.68)	0.74
BMI (kg/m^2)	25.9 (24.8 to 27.0)	23.4 (21.6 to 25.3)	0.025
$PaCO_2$ (mmHg)	48 (46 to 50)	46 (43 to 49)	0.21
COPD (%)	89 (84 to 94)	93 (84 to 100)	0.86
LTOT (%)	34 (27 to 40)	37 (22 to 52)	0.73
Recent mechanical ventilation (n)	16 (11 to 21)	2.3 (0 to 7)	0.018
Number of chronic diseases	2.7 (2.5 to 2.9)	2.4 (2.0 to 2.8)	0.19
Cardiac disease (%)	40 (12 to 23)	35 (2 to 22)	0.53
Depression (%)	21 (15 to 27)	9 (0 to 18)	0.070

Means or percentages of each age group are presented. 95% CI are in parentheses. P values are for comparisons between age group with an F test for frequencies and Student's t *test for continuous variables. BMI Body mass index; COPD Chronic obstructive pulmonary disease; FEV_1 Forced expiratory volume in 1 s; FVC Forced vital capacity; LTOT Long-term O_2 therapy; $PaCO_2$ Partial pressure of carbon dioxide in arterial blood*

MA Baltzan et al. *Can Respir J* 2004.

Pulmonary rehabilitation improves functional capacity in patients 80 years of age or older

Six-minute walk distance after pulmonary rehabilitation

	Age		P
	<80 years	80+ years	(YP vs OP)
6 min walk (m)			
Admission	144 (131 to 157)	133 (108 to 158)	0.48
Discharge	231 (231 to 244)	185 (159 to 211)	0.004
P (admission versus discharge)	<0.0001	<0.0001	
Dyspnea at end of 6 min walk (Borg scale)			
Admission	4.2 (3.9 to 4.5)	3.4 (2.8 to 4.1)	0.038
Discharge	3.5 (3.3 to 3.8)	3.1 (2.7 to 3.4)	0.033
P (admission versus discharge)	<0.0001	0.13	

Means with 95% CI in parentheses. P values are for comparisons between age groups with an unpaired Student's t test, and within age groups with a paired Student's t test. OP Older patients; YP Younger patients

MA Baltzan et al. *Can Respir J* 2004.

Pulmonary rehabilitation improves functional capacity in patients 80 years of age or older

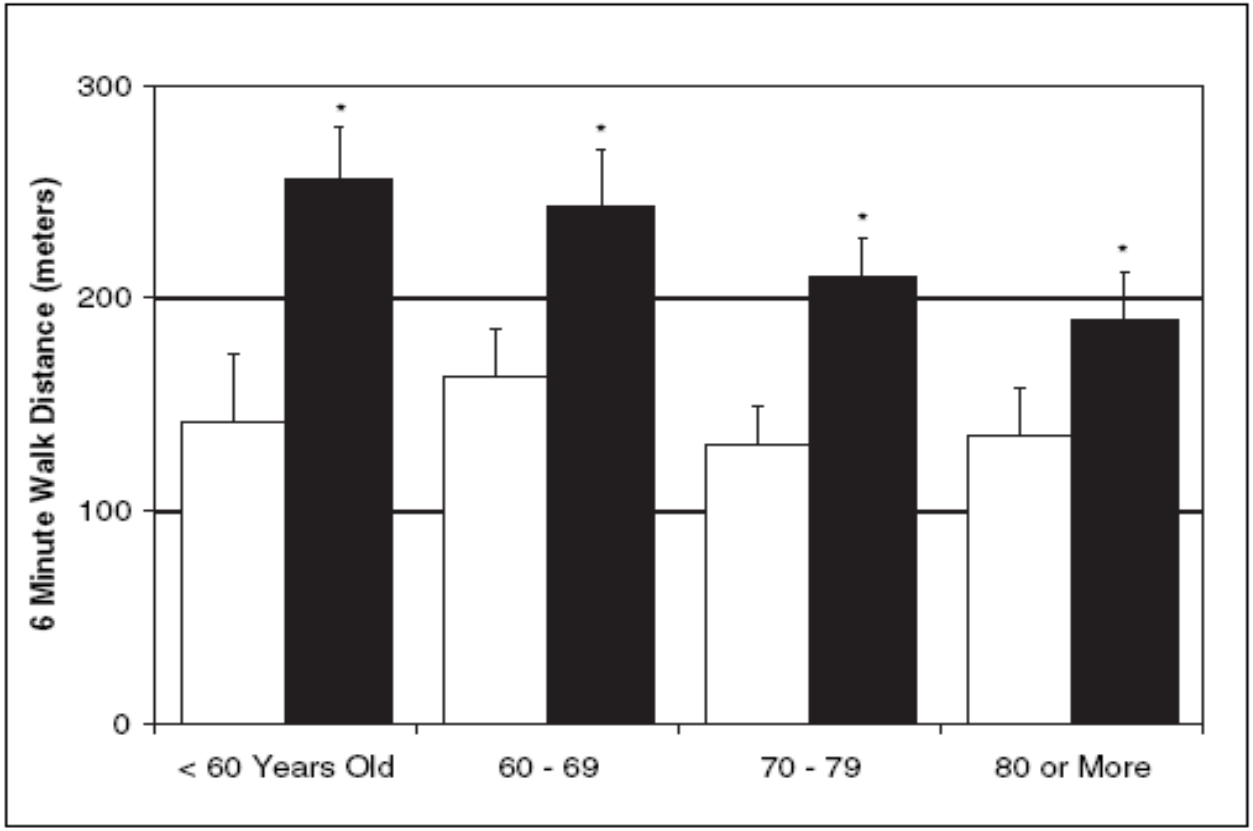


Figure 1) *Changes in 6 min walk distance according to age group. Mean admission distance (open bars) and discharge distance (black bars) shown with 95% confidence upper limits. All four groups improved significantly (P<0.0001) from admission to discharge. χ^2 tests for age-related trend were P=0.16 at admission and P<0.001 at discharge*

MA Baltzan et al. *Can Respir J* 2004.

Pulmonary rehabilitation improves functional capacity in patients 80 years of age or older

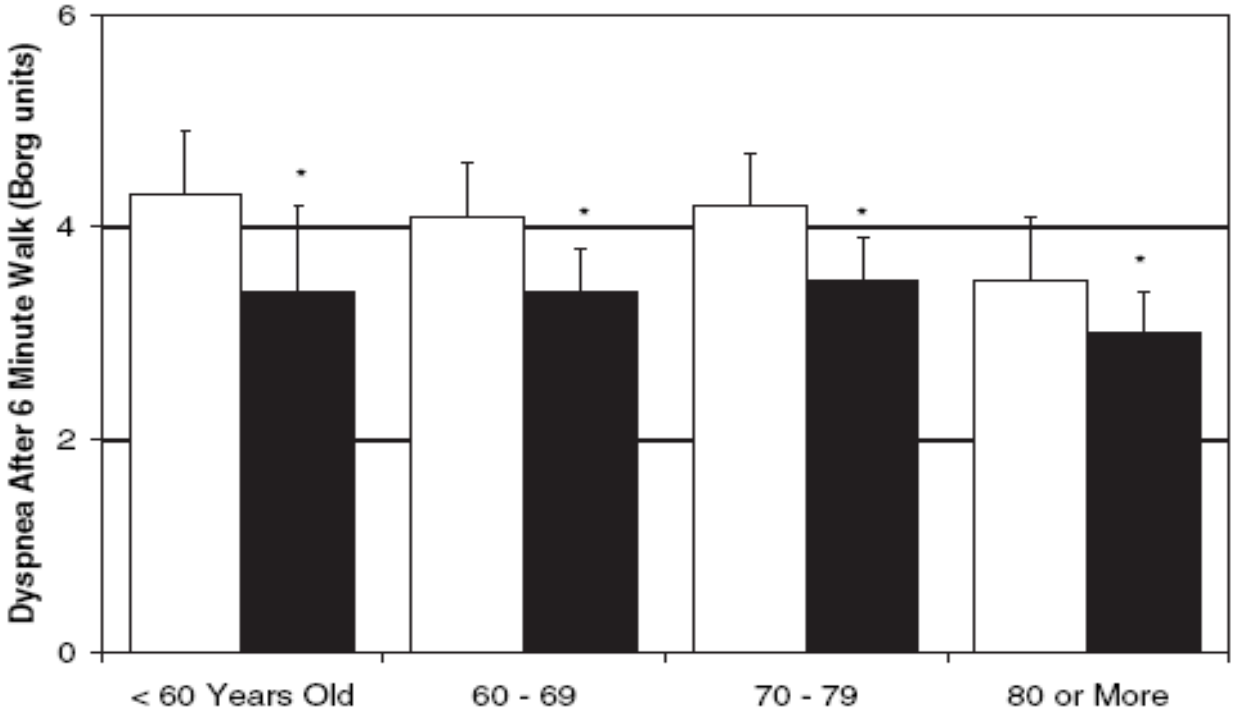


Figure 2) *Changes in Borg dyspnea scores after 6 min walk according to age group. Mean admission (open bars) and discharge (black bars) dyspnea scores presented with 95% confidence upper limits. All four groups improved significantly (P<0.0001) from admission to discharge. Dyspnea was significantly lower in patients 80 years of age or older at admission and discharge. χ^2 tests for age-related trend were P=0.22 at admission and P=0.35 at discharge*

MA Baltzan et al. *Can Respir J* 2004.

Pulmonary rehabilitation improves functional capacity in patients 80 years of age or older

Global functional score before and after pulmonary rehabilitation

	Age		P
	<80 years	80+ years	YP vs OP
Global functional score (max 100)			
Admission	89 (87 to 90)	85 (81 to 89)	0.040
Discharge	94 (93 to 95)	91 (88 to 93)	0.002
P (admission versus discharge)	<0.0001	<0.0001	

Means with 95% CIs in parentheses. P values are for comparisons between age groups with a Student's t test, and within age groups with a paired Student's t test. OP Older patients; YP Younger patients

CONCLUSION: A comprehensive inpatient pulmonary rehabilitation program is beneficial in selected patients 80 years of age or older.

MA Baltzan et al. *Can Respir J* 2004.

Rehabilitation following stroke in patients aged 85 and above

To assess the course and results of rehabilitation following stroke in patients aged 85 and above, we conducted a prospective study to compare 45 patients 85 years and above and 220 consecutive patients aged 75 to 84 years who were hospitalized for rehabilitation following stroke. Functional status was measured and compared by the Functional Independence Measure™ (FIM) scale and successful rehabilitation was defined as FIM > 80 at discharge.

Eighteen patients in the 85+ group (40%) underwent successful rehabilitation compared with 115 (52%) in the 75 to 84 group (not significant). No significant differences were found between the groups in any other parameters that measure success and/or efficacy of rehabilitation, but in all these parameters, without exception, lower values were found in the 85+ group. No differences in the length of rehabilitation and complications rates were found between groups.

D. Lieberman, et al. *JRRD*, 2005

Rehabilitation following stroke in patients aged 85 and above

Comparison between 85+ and 75 to 84 age groups for functional status by Functional Independence Measure™ (FIM) score prior to stroke, on admission, to and at discharge from rehabilitation, and percentage of patients discharged to their homes. No difference is statistically significant.

Variable	No. (%)		*p*-Value
	85+ (*n* = 45)	75–84 (*n* = 220)	
Prestroke FIM (mean ± SD)	117 ± 12	118 ± 13	0.39
FIM on Admission (mean ± SD)	64 ± 20	66 ± 20	0.65
Discharge FIM (mean ± SD)*	72 ± 24	77 ± 24	0.23
Change in FIM (admission to discharge) (mean ± SD)*	8 (11)	11 (13)	0.11
FIM > 80 at Discharge (*n* [%])*	18 (40)	115 (52)	0.14
FIM Change (admission to discharge) > 10 (*n* [%])*	18 (40)	117 (53)	0.12
Effectiveness of Rehabilitation*†	0.44 ± 0.52	0.59 ± 0.63	0.12
Absolute Efficacy of Rehabilitation‡	15.5 ± 18.7	20.8 ± 22.4	0.14
Discharged to Their Home (*n* [%])*	36 (80)	193 (88)	0.14
Length of Rehabilitation (days, mean ± SD)	21 ± 11	23 ± 11	0.33

*Data for these variables relate only to patients who survived hospitalization.
†Change in FIM ÷ by number of days of rehabilitation.
‡Change in FIM ÷ (maximum FIM – initial FIM) × 100.
SD = standard deviation

D. Lieberman, et al. *JRRD*, 2005

Rehabilitation following stroke in patients aged 85 and above

We conclude that patients in the 85+ group who are carefully selected for rehabilitation following stroke are similar in most basic clinical, mental, and functional characteristics to younger elderly populations undergoing the same process. The length of rehabilitation and the rate of complications are similar in the two groups.

Although the success rate for rehabilitation is lower in the oldest old, the results still appear to justify the effort invested in rehabilitation in the 85+ group, at least no less than that in the younger elderly group.

D. Lieberman, et al. *JRRD*, 2005

Rehabilitation After Proximal Femur Fracture Surgery in the Oldest Old

Objective: To assess the course and results of rehabilitation after proximal femur fracture (PFF) in patients 85 years of age or older, compared with younger elderly patients, with an emphasis on functional status.

Design: Prospective cohort study.

Setting: A rehabilitation geriatric ward in a tertiary university hospital in southern Israel.

D. Lieberman, et al.*Arch Phys Med Rehabil*, 2002

Table 1: Comparison of the 85+ and the 75-to-84 Groups: Surgical Factors, Comorbid Conditions, Cognitive Scores, and Functional Scores

Variable	85+ Group (n=127)	75–84 Group (n=297)	*P*
Mean age ± SD (y)	88.8±3.1	79.3±2.9	
Female gender	96 (76)	233 (79)	NS
Surgical factors			
Location of fracture			
Subcapital	48 (38)	125 (42)	
Intertrochanter	67 (53)	145 (49)	NS
Subtrochanter	12 (9)	27 (9)	
Nail fixation	77 (61)	172 (58)	NS
Spinal anesthesia	90 (71)	200 (67)	NS
Previous proximal femur fracture	23 (18)	39 (13)	NS
Comorbid conditions			
Ischemic heart disease	39 (31)	111 (37)	NS
Pulmonary disease	23 (18)	47 (16)	NS
Smokers (past or current)	15 (12)	39 (13)	NS
Hypertension	67 (53)	172 (58)	NS
Diabetes mellitus	16 (13)	61 (21)	NS
Parkinson's disease	10 (8)	14 (5)	NS
Joint disease	17 (13)	60 (20)	NS
Past CVA	4 (3)	23 (8)	NS
Mean total no. of diseases ± SD	2.0±1.4	2.4±1.6	.02
Cognitive scores			
Mean MMSE ± SD	20.5±6.1	23.2±5.9	.00005
Mean clock-drawing test ± SD	6.5±2.2	7.8±2.2	.000002
Mean GDS ± SD	9.5±6.4	8.9±5.7	NS
Functional scores			
Mean recall FIM score ± SD	108.4±18.1	116.1±14.1	.0000001
Mean admission FIM score ± SD	62.7±17.9	73.8±16.0	.0000001

NOTE. Values are n (percentage) unless otherwise indicated.
Abbreviation: SD, standard deviation; NS, not significant; CVA, cerebrovascular accident.

D. Lieberman, et al.Arch Phys Med Rehabil, 2002

Rehabilitation After Proximal Femur Fracture Surgery in the Oldest Old

Conclusions: From the functional standpoint, rehabilitation after PFF surgery is much less successful in the 85 age group than in the 75-to-84 age group but did not differ in its duration, rates of most complications, or mortality. Nonetheless, a significant percentage of patients in this age group have successful rehabilitation so they should not be deprived the chance.

Table 4. Comparison of the 85+ and 75-to-84 Groups for Functional Status at Discharge, Change During Rehabilitation, and Discharge Home

Variable	85+ Group (n=127)	75–84 Group (n=297)	*P*
Discharge FIM (mean ± SD)*	74.8±22.1	90.5±18.8	.0000001
Change in FIM (admission to discharge) (mean ± SD)*	11.4±9.8	16.5±9.4	.000001
FIM score <80 at discharge*	68 (54)	72 (24)	.00000001
FIM score change <10*	53 (42)	62 (21)	.0001
Discharged to home*	105 (83)	270 (91)	.02

NOTE. Values are n (percentage) unless otherwise indicated.
* Data relate only to patients who survived hospitalization.

D. Lieberman, et al.*Arch Phys Med Rehabil*, 2002

Outcomes 6 Months After Rehabilitation of a Proximal Femur Fracture in the Oldest Old

Of the 85 patients admitted in that period, 6 were excluded.

The comparison outcomes obtained at admission were similar to those of Lieberman and Lieberman, with the oldest old showing a poorer response to the treatment.

Global outcomes, however, were more favorable, because within the group ->85 years old, at admission, 75% obtained a functional gain that was clinically significant (we established this as a difference of ->20 points between discharge and admission Barthel Index scores). Moreover, 50% of this group obtained some slight functional dependence at discharge (defined as a Barthel Index score of ->60), which continued for the next 6 months.

D. Lieberman, et al.Arch Phys Med Rehabil, 2003

Table 1: Comparison of the Groups Less Than 85 and ≥85 Years Old: Variables at Admission and Clinical Outcomes at Discharge and 6 Months

Variable	<85y (n=47)	≥85y (n=32)	*P*
Age ± SD (y)	77.47±5.17	88.75±3.60	<.001
Female gender (%)	74.5	93.8	<.05
Location of fracture (%)			<.05
Subcapital	42	54	
Intertrochanter	56	40	
Subtrochanter	2	6	
Charlson Comorbidity Index	1.74±1.62	1.53±.27	NS
SPMSQ cognitive score	2.43±2.25	4.53±2.83	<.001
SPMSQ score ≥5	17%	50%	<.01
Previous Barthel Index score	90.94±13.74	84.19±16.08	.06
Admission Barthel Index score	39.87±19.72	27.16±15.67	<.01
Discharge Barthel Index score	71.23±22.30	58.31±17.50	<.01
Discharge Barthel Index score ≥60	80.9%	50%	<.01
Change in Barthel Index score (admission to discharge) ≥20	80.9%	75%	NS
Institutionalization at discharge	10.6%	18.8%	NS
Days hospitalized for rehabilitation	20.87±9.26	26.56±11.73	<.05
Outcomes at 6mo			
Mortality	9.1%	6.3%	NS
Institutionalization	12.5%	16.7%	NS
Barthel Index score	79.18±30.17	61.47±21.34	<.01
Barthel Index score ≥60	82.5%	50%	<.01
Poor outcomes*	31.8%	56.3%	<.05

NOTE. Values are mean ± SD or as otherwise indicated.
Abbreviations: standard deviation, SD; NS, not significant.
*Poor outcomes: death or institutionalization or Barthel Index score <60 at 6 months.

Outcomes 6 Months After Rehabilitation of a Proximal Femur Fracture in the Oldest Old

- The outcome of the nonadjusted analysis of age (separated into <85y and ->85y) was associated with the occurrence of poor outcomes and an odds ratio (OR) of 2.75 (95% confidence interval [CI], 1.07-7.08) for the group -->85 years old.
- When the analysis included other variables, such as the presence of previous functional disability (Barthel Index score prior to femur fracture <90), the presence of cognitive impairment at admission (SPMSQ score -->5), and high comorbidity (Charlson Index score ->2), age was no longer associated with poor outcomes;instead they were associated with previous functional disability and cognitive impairment at admission.

D. Lieberman, et al.Arch Phys Med Rehabil, 2003

Survival and functional outcome in patients 90 years of age or older after hip fracture

The purpose of the present study was to evaluate functional recovery in nonagenarian patients with hip fractures. The study focused on (i) **functional outcome** and recovery of gait after intensive rehabilitation treatment; (ii) **rate of survival** and (iii) maintenance of walking and **functional ability** in patients **followed for almost 2 years.**

Table 1. Demographic characteristics and disease comorbidity of very elderly patients with hip fractures

Age	92.6 ± 3.5
Female	38 (89.4)
Male	4 (10.5)
Hip fracture	
Intertrochanteric	30
Femoral neck	12
Type of surgery	
Prosthesis	24
Internal fixation	18
Disease comorbidity	*2.62 ± 1.53*
Cardiovascular	28 (66.6)
Hypertension	22 (52.3)
Diabetes mellitus	8 (19.4)
Pulmonary	6 (14.2)
Chronic renal failure	8 (19.4)
Cerebrovascular	6 (15.7)
Haematological	12 (28.5)

D. Intiso, et al.Age Ageing, 2009

Survival and functional outcome in patients 90 years of age or older after hip fracture

Gait ability: *grade 0*, no gait or bedridden *grade 1*, uses a wheelchair *grade 2*, uses a double support or walker grade 3, unaided walking or uses a cane

	Admission	Discharge	Follow-up
Patients	42	40	34
MMSE	23.4 ± 2.2	22.8 ± 3.6	22.3 ± 4.1
Barthel	51.6 ± 7.8	82.7 ± 18.2*	81.4 ± 19.1*
Gait ability			
Grade 3	0	20 (50)	14 (41.1)
Grade 2	20	16 (40)	10 (29.4)
Grade 1	8	0	2 (5.8)
Grade 0	12	4 (10)	10 (29.4)
Deceased	–	2 (4.7)	6 (19.04)
Living at home	40 (95.2)	34 (85)	26 (76.4)
Nursing facilities	2 (4.7)	6 (15)	8 (23.5)

MMSE (Mini-Mental State Examination), $^{*}P < 0.0001$, Barthel mean score at discharge and follow-up compared to admission. Percentage is reported in brackets.

D. Intiso, et al.Age Ageing, 2009

Survival and functional outcome in patients 90 years of age or older after hip fracture

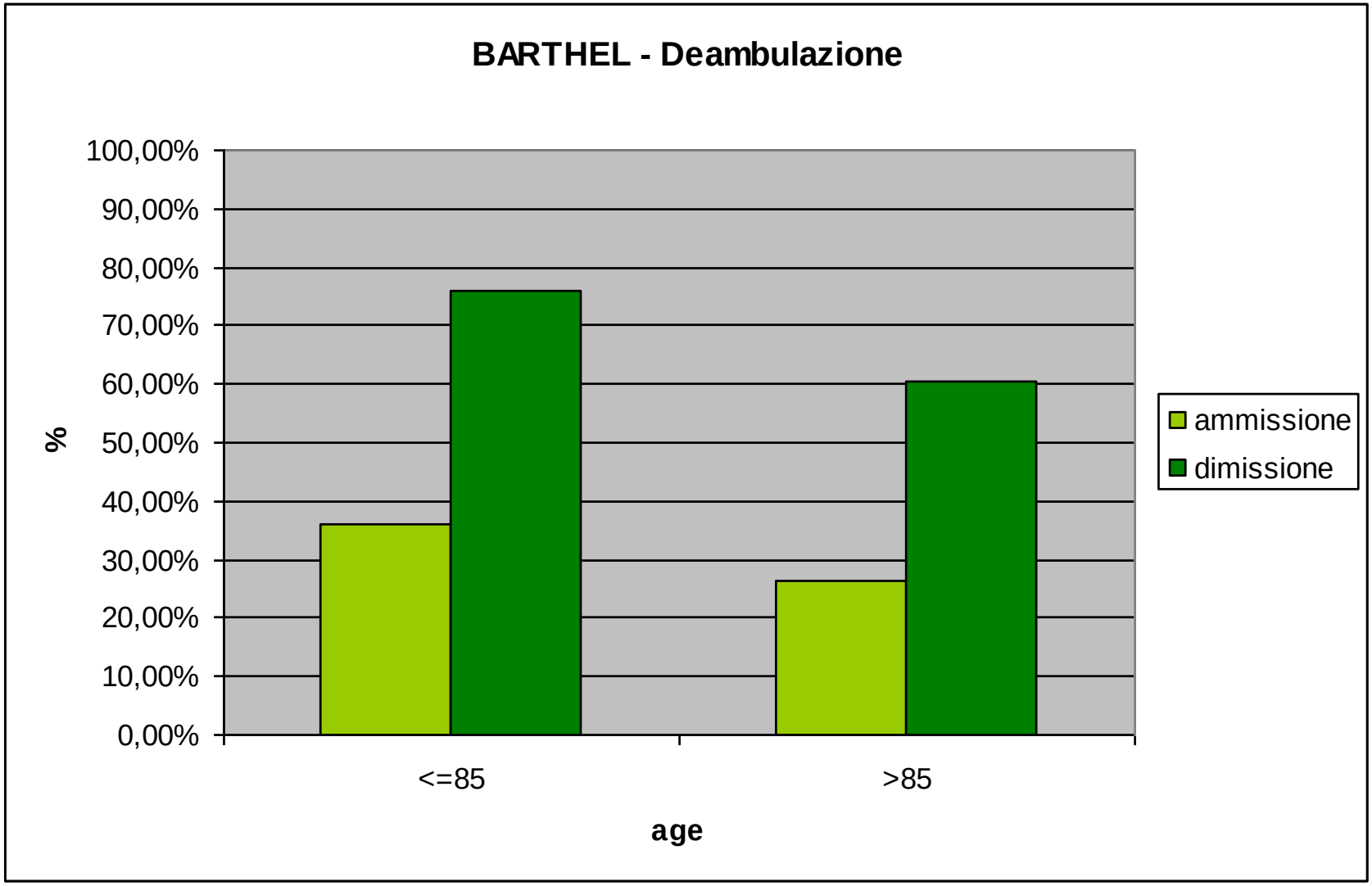
The results of the present study demonstrate that nonagenarians with hip fracture and few concomitant diseases can achieve and maintain good recovery after intensive rehabilitation treatment.

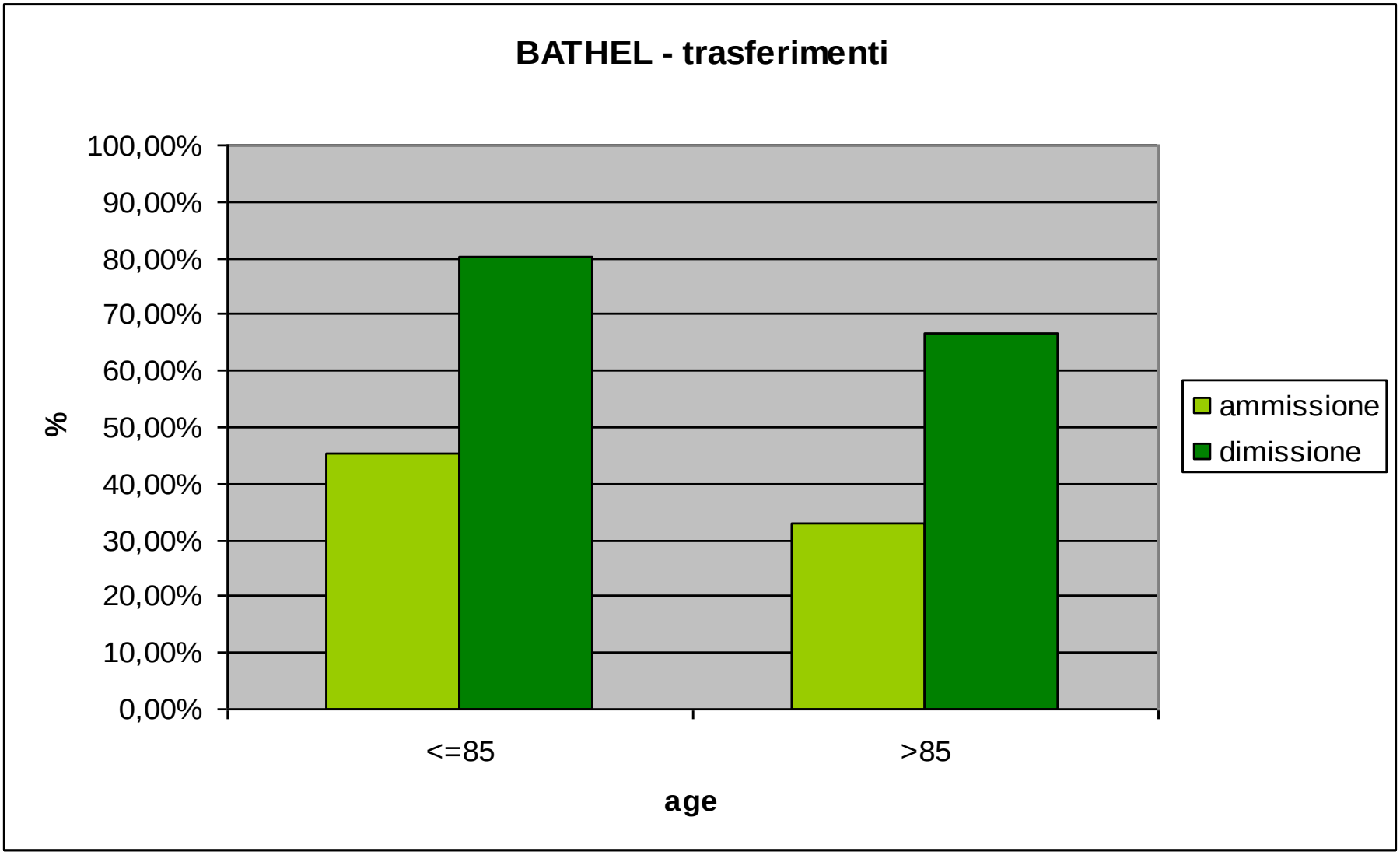
D. Intiso, et al.Age Ageing, 2009

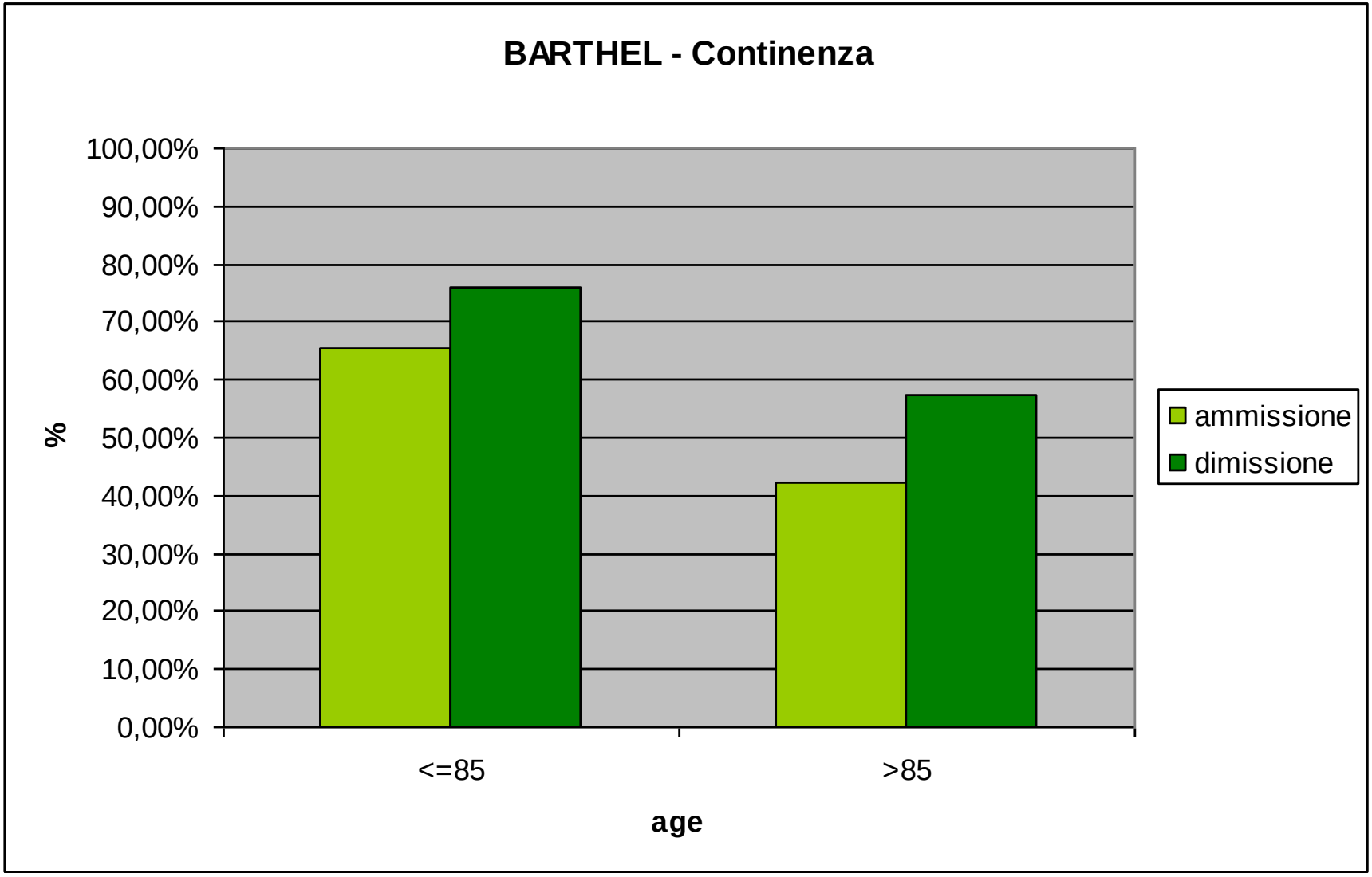
Riabilitare i grandi vecchi: la nostra realtà

Caratteristiche dei pazienti ammessi presso la nostra Riabilitazione tra 2006-2007 divisi per età

	65 E 85 ANNI (n=1649)	> 85 ANNI (n=510)	P
Age, years	77.6±5.3	89.5±3.37	.000
Female, n (%)	1175 (70.8)	410(79.6)	.000
Body Mass Index (BMI), Kg/cm^2	25.2 ± 6.8	23.2 ± 4.6	.000
PCR	2.9±4.6	2.5±3.7	.059
Albumin on admission	3.2±0.5	3.1±0.4	.000
Colesterolo	176.6±44.0	166.2±48.6	.000
Mini Mental State Examination (0-30)	22.5±6.2	18.9±6.4	.000
Geriatric Depression Scale (0-15)	5.8±3.5	6.4±3.6	.004
N° of drugs on admission	5.4±2.5	5.0±2.5	.038
N° of drugs on discharge	4.3±2.1	3.7±2.1	.000
Total length of stay, days	27.5±11.6	28.8±11.8	.029
Barthel Index (1 month before) (0-100)	83.9±20.4	75.5±20.9	.000
Barthel Index on admission (0-100)	58.5±27.0	46.0±27.5	.000
Barthel Index on discharge (0-100)	76.9±25.6	63.9±28.7	.000
Delta Barthel (BI disc-BI adm) assoluto	18.7±18.7	17.9±18.4	.424
Delta Barthel (BI disc-BI adm) rel	85.2±111.9	74.1±71.2	.059
Tinetti on admission (0-28)	13.0±8.0	9.5±7.3	.000
Tinetti on discharge (0-28)	19.9±6.7	17.0±7.0	.000
Delta Tinetti (TI disc-TI adm) assoluto	6.8±5.3	7.1±5.4	.234


BARTHEL - Deambulazione
100,00%
90,00%
80,00%
70,00%
60,00%
50,00%
40,00%
30,00%
20,00%
10,00%
0,00%
%
<=85
>85
age
ammissione
dimissione


BATHEL - trasferimenti
100,00%
90,00%
80,00%
70,00%
60,00%
50,00%
40,00%
30,00%
20,00%
10,00%
0,00%
%
<=85
>85
age
ammissione
dimissione


BARTHEL - Continenza
100,00%
90,00%
80,00%
70,00%
60,00%
50,00%
40,00%
30,00%
20,00%
10,00%
0,00%
%
<=85
>85
age
ammissione
dimissione

Outcome alla dimissione dalla nostra Riabilitazione tra 2006-2007 divisi per età

	65 E 85 ANNI (n=1649)	> 85 ANNI (n=510)	P
Casa, n (%)	1352 (80)	375(70.9)	.000
Mortalità, n (%)	26 (1.5)	24 (4.5)	.000
Altro*	312 (18.5)	130 (24.6)	.000

*"Altro": trasferimento in RSA o altro reparto, ADI

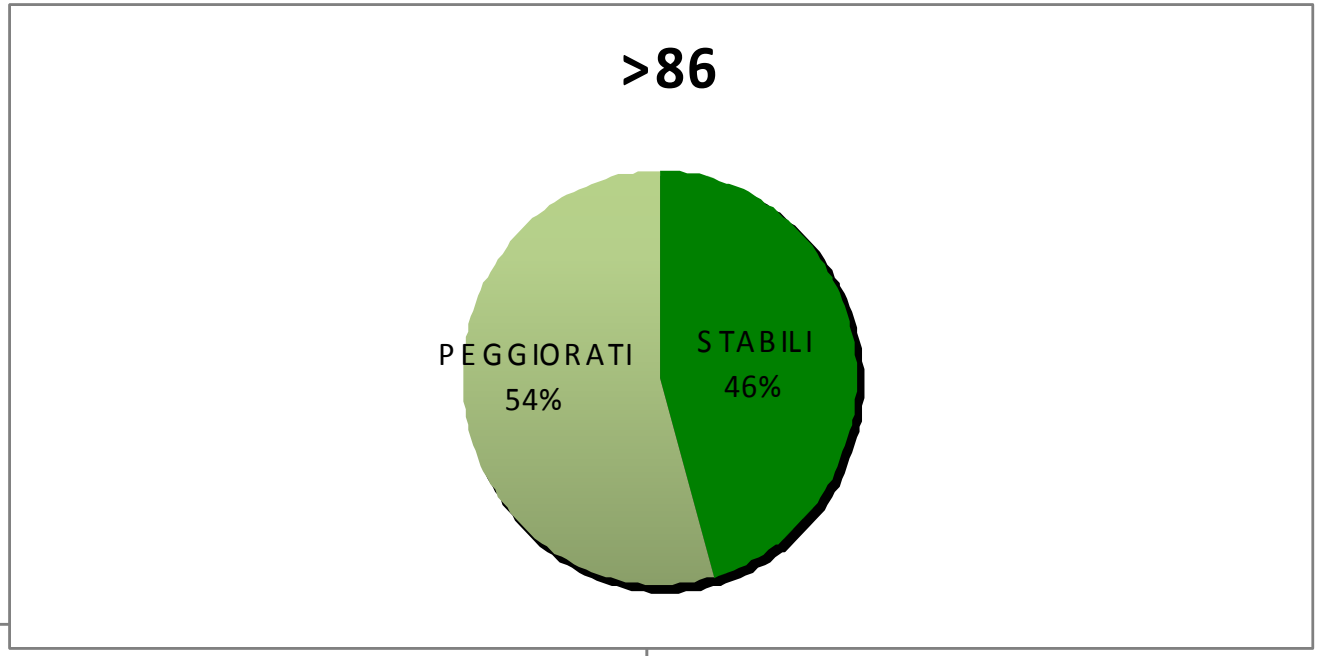
Outcome ad un anno dei pazienti dimessi dalla nostra Riabilitazione tra 2006-2007 divisi per età

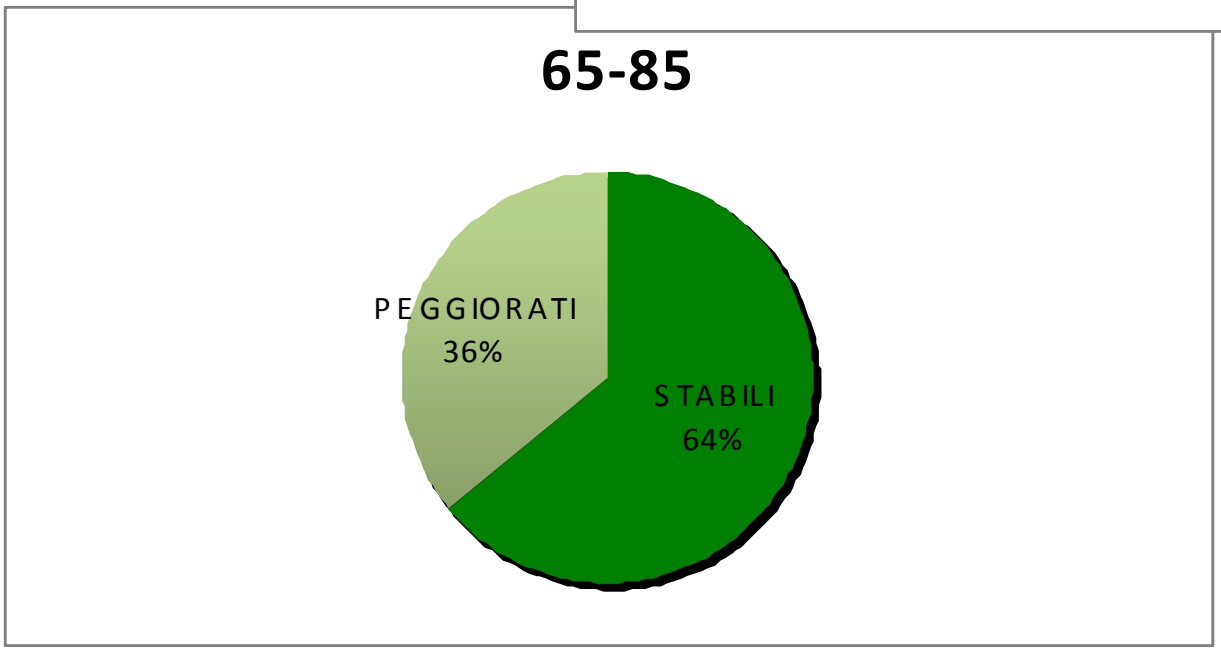
	65 E 85 ANNI (n=582)	> 85 ANNI (n=154)	P
Instituzionalizzazione, n (%)	35 (7.3)	19(17.1)	.002
Mortalità, n (%)	87 (14.9)	38 (24.7)	.004

Outcome ad un anno dei pazienti dimessi dalla nostra Riabilitazione tra 2006-2007 divisi per età

Delta Barthel-deambulazione

(dimissione- follow-up)





Il pessimismo rinunciatario non può avere spazio, quindi, in chi vive il nostro tempo; è pur vero, però, che dobbiamo accettare l'eterna dialettica tra l'utopia,cioè l'idea che attraverso il progresso si possa migliorare l'essere umano, o almeno la sua vita, e il disincanto che induce ad agire qui e ora per costruire piccoli spazi di libertà.

Noi che ci occupiamo della persona che invecchia viviamo fino in fondo il disincanto; non andiamo alla ricerca dell'"uomo nuovo" – pseudovincitore sulle difficoltà della vita grazie al "successo" – , ma cerchiamo di ridurre la fatica di vivere dell'uomo vecchio.

Ma forse anche la ricerca continua per ridurre la fatica di vivere della persona richiede un po' di utopia, perché «nessuna carovana ha mai raggiunto l'utopia, però è l'utopia che spinge la carovana nel deserto». Ancora più realisticamente, è l'utopia che permette di inseguire ogni giorno e di raggiungere i piccoli guadagni (small gains) che migliorano la vita dell'anziano.

Partendo da quello che ciascuno è, dal riconoscimento appassionato della realtà di ogni persona che invecchia.

M. Trabucchi