

# Outcomes of Mechanically Ventilated Critically Ill Geriatric Patients in Intensive Care Unit

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Dear Editor,

Thank you very much for this informative article regarding the post Intensive Care Unit (ICU) outcomes of patients admitted over the age of 60 years [1]. I am writing in response to offer my opinion as a senior medical student practicing in the UK. I have recently completed my geriatrics rotation and concur with the authors viewpoints that Chronic Obstructive Pulmonary Disease (COPD) is the most common cause of mechanical ventilation. Respiratory distress is a prevalent reason for admittance to the ICU and patients in this age category are largely sufferers of COPD and interstitial lung disease.

Such patients with severe COPD requiring such intensive treatment in my opinion who also are of this age category usually have poor outcomes, thus questioning whether an ICU admission will offer any benefit in the first instance. On the contrary, acute sepsis and Cerebrovascular Accident (CVA) episodes requiring shorter intense treatment which can have complications requiring an ICU admission are favourable candidates as research has shown a lower mortality at 30 days.

In the UK the success rate of a cardiac resuscitation event post Myocardial Infarction (MI) is 10% at 30 days [2]. This encompasses all patients with this presentation. Elderly patients (>60 years) have less chance of success due to the nature of polypharmacy and comorbidities. Frailty is another modernising term being used in UK Hospitals to describe clinical state of elderly patients. On admittance onto a ward, a frailty score is calculated to understand the patient's baseline for activities of daily living and thus generate

a greater understanding of their acute admission and rehabilitation [3]. This can offer predictive validity on the 30 days mortality of such patients.

The article concluded that with appropriate intensive care settings and protocol based therapy, outcomes with older patients can be comparable to younger patients on mechanical ventilation. I would also like to add that a comprehensive understanding of patient complexities can help justify this conclusion such as the clinical parameters and concept of frailty as we have in the UK to perhaps explain this concept further. Moreover, the specific issue rendering the patient reliant on mechanical ventilation is an important predictor of mortality with longer term conditions like COPD having questionable outcomes compared to sepsis.

Overall, I very much enjoyed reading this article and it affirmed my desire to read more articles published in your journal. I hope my insights prove informative and that you consider this as a request for publication. I look forward to sharing my insights during my future clinical years here in the UK to help advance clinical research globally.

## REFERENCES

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