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What matters most: Finding balance after falling

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Ms. M is a 95-year-old woman with mild cognitive impairment, major depressive disorder, osteoporosis, and osteoarthritis in her right knee who was evaluated in the geriatric medicine clinic. She reported sudden, 10/10 excruciating pain—usually dull and chronic—in her right knee. Despite previously completing physical therapy and injections, her chronic pain had persisted. Two years prior, she had been informed by a clinician that she was ineligible for a total knee replacement due to her age. But now due to the pain, she had fallen twice within the last week. To try to prevent herself from falling, she awoke straining for her electric scooter instead of her usual cane **(**Figure 1**)**. She also began wearing adult pull-ups to sleep for fear of falling when going to the bathroom. She reported worsening depression and that she could "no longer live this way," especially when she enjoyed tubing in a lake with her family a year ago.

A referral was placed to orthopedics, and she was diagnosed with end-stage tricompartmental osteoarthritis. Her exam was notable for an antalgic gait with varus thrust on the right lower extremity, right medial joint tenderness, as well as range of motion limited to 110 degrees of flexion due to pain. Treatment options after exhausting all conservative measures were discussed, and she started thinking about surgery as a potential solution.

See related editorial by Powers and Sehgal.

Ms. M returned three weeks later to the geriatric medicine clinic for a preoperative appointment for her right knee replacement surgery. She was deemed to be pre-frail using FRAIL scale.[1] We discussed best-case and worst-case scenarios with her and her family: at worst, National Surgical Quality Improvement Program (NSQIP) surgical risk showed 5.6% risk of serious outcomes, 6.2% risk of any complications, 5.7% risk of readmission, and 60% risk of discharging to a nursing facility—all above average risk, giving us pause to recommend the surgery.[2] At best, she could regain mobility to independently travel and spend time with her family. She was clear about understanding the risks and no longer wanted to live in her current condition and eventually underwent a right total knee arthroplasty **(**Figure 2**).** She recuperated at home under home health care, without requiring subacute rehabilitation or assistive devices. The surgery and recovery were complication-free, and her mood enhanced. Two months postoperatively, no electric scooter or knee could stop her from boogieing on a wedding dance floor **(**Figure 3**).**

TEACHING POINT

This case illustrates the interconnection of the 5Ms, as supporting what **matters most** to this patient, even

FIGURE 1 Dependent on an electric scooter, even on vacations.

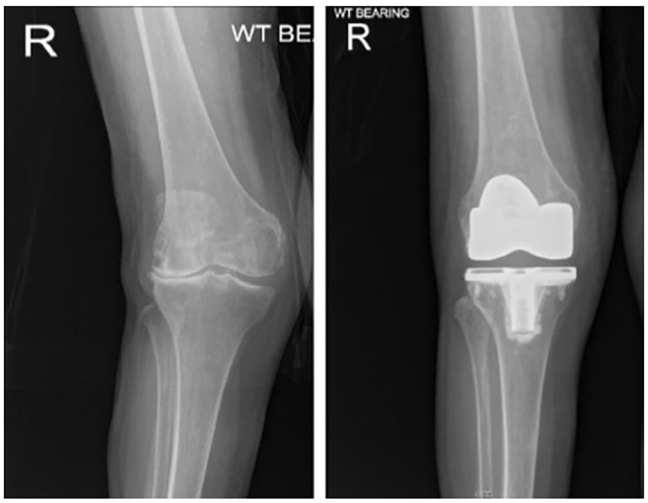

FIGURE 2 Pre- (left) and post- (right) right total knee arthroplasty.

when the numbers—age and risk—point away from intervention, led to optimization of her **mobility** and improvement in her **mind**. Creating the space and time to allow patients to verbalize their preferences and values can guide clinicians through the gray area of facilitating an elective procedure that aligns with their goals.

DISCUSSION

For Ms. M, her worsening **mobility** led to falls, scooter use, and adult diaper use, which contributed to changes in her **mind** by worsening her depression. If continued conservative management were pursued, it would not have aligned with **what mattered most** to her: getting out of bed and to the bathroom without calling for help and being able to travel to family events.

As clinicians, we have the onus of weighing patients' risks versus preferences and presenting this complexity clearly, concisely, and empathetically. Age should not be the sole factor in making decisions to pursue any intervention. In fact, previous studies have shown that octogenarians experience comparable pain relief with total knee replacements as compared to younger patients.[3] However, we were hesitant to recommend this surgery to Ms. M, and initially, we even tried to dissuade her based on her risk level for complications. But for Ms. M, pain relief and the chance to achieve what mattered most to her outweighed those risks. Discussing the best-case-worst-case scenario for Ms. M and discussing what mattered most to her, facilitated shared decision-making and helped her finalize her decision to pursue surgery.[4]

It is important to understand that there were several factors contributing to Ms. M's successful operation and clinical outcome. She was fortunate to have minimal social and structural barriers to health care and to have a strong support system as well as Medicare coverage. For example, her family assisted her with travel to appointments and stayed actively involved in her care. Her daughter often sent electronic portal messages as a formal proxy with updates on her progress which has been shown to facilitate care coordination for patients like Ms. M who have cognitive impairment and limited skills in using technology.[5]

Because Ms. M's surgery was considered elective, she had time to think about her decision, unlike in emergent situations. This allowed us to document clear advance care planning, which is often missed in older adults preoperatively.[6] Prompt communication with the orthopedist was done electronically through a shared electronic medical record, and preoperative testing and appointments were promptly available.

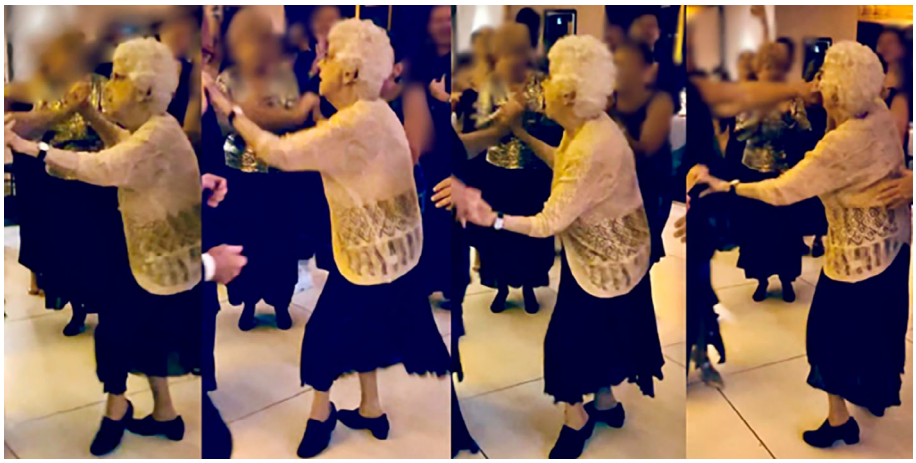

FIGURE 3 Dancing at family wedding.

FIGURE 4 Standing without an electric scooter.

Immediately post-surgery, she was able to work with an interprofessional home health team including a nurse, physical and occupational therapist, which aided her recovery.

The next steps for Ms. M are to work on preventing falls and improving balance with her new right knee. Our hope is that in regaining her mobility, she will continue to improve her overall function and keep dancing at future weddings (Figure 4).

AUTHOR CONTRIBUTIONS

Study concept and design: PL, LJG. Drafting of the manuscript: PL, LJG. Critical revision of the manuscript for important intellectual content: PL, ST, LJG.

CONFLICT OF INTEREST STATEMENT

The authors have no competing interests or conflicts to declare.

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