

## VAN DIE REDAKSIE : EDITORIAL

## DIE VERSORGING VAN SENIELE BEJAARDES

Ons het al by verskillende vorige geleenthede geskryf oor uiteenlopende aspekte van die probleem van die versorging van bejaardes. Hier wil ons nou graag meer in besonderhede iets sê oor die spesifieke probleem van die huisvesting en versorging van seniele persone.

Vir almal wat belangstel in die samestelling van die gemeenskap en die probleme wat daaruit voortvloei, is dit duidelik dat daar, net soos in alle lande met 'n verbetering van lewenspeil en mediese dienste, ook in Suid-Afrika 'n stygende aantal bejaardes is. Terwyl daar, byvoorbeeld, in 1911 slegs een uit elke 375 van die Blanke bevolking ouer as 80 jaar was, was daar in 1960 ongeveer een uit elke 95 van die bevolking wat 80 jaar of ouer was. Volgens die tempo in toename van die groep oor 80 sou dit 'n verdubbeling van die huidige werklike aantal persone oor die 80 jaar oud meebring binne omtrent 16 jaar.

By die interpretasie van hierdie gegewens is daar twee oorwegings waaroor ons helderheid moet hê: In die eerste plaas moet ons daarop let dat mense nie noodwendig baie langer leef as vroeër nie. Nieteenstaande die vooruitgang in die medisyne oor 3,000 jaar, bly die Bybelse voorspelling van 'n lewensduur van 70 jaar en, as ons baie sterk is 80 jaar, nog baie akkuraat. Die moderne medisyne het wel die lewensverwachting van 'n pasgebore baba dramaties verleng gedurende die afgelope paar dekades, maar gedurende die afgelope 100 jaar is nie veel gedoen om die lewe te verleng van 'n persoon wat reeds die ouderdom van 65 jaar bereik het nie. Al verskil is dat daar vandag baie meer mense is wat die ouderdom van 65 jaar bereik as voorheen. In 1900 het 'n Blanke man van 60, byvoorbeeld, 'n verdere verwagte lewensduur van 14 jaar gehad; vandag is die verwagte (gemiddelde) lewensduur maar net ongeveer 2 jaar verleng.

Die tweede oorweging waaroor ons helderheid moet kry, is dat die effense verhoging van die gemiddelde lewensverwachting, waarna ons hierbo verwys het, en die feit dat meer mense nou ouer word, nie beteken dat die verstandelike of liggaamlike verouderingsproses enigsins gestrem is of sal word nie. Trouens, die feit is net eenvoudig dat daar meer persone van gevorderde leeftyd is wat sorgbehoewend is weens liggaamlike en verstandelike veroudering. In die verband waarin ons skryf, beteken dit dat daar baie meer seniele persone is en sal wees as wat daar ooit tevore was.

Volgens berekening deur kenners beteken die bogenoemde feite dat die *hoeveelheid werk* (en *fasiliteite*) wat vandag nodig is om sorgbehoewende oues van dae te versorg, waarskynlik verdriedubbel het sedert 1951. Die praktiese feite is egter dat die fasiliteite vir die versorging van seniele persone in ons land nie net *nie* verdriedubbel

het sedert 1951 nie, maar dat hulle verminder het. Daar is geen nuwe grootskaalse voorsiening gemaak vir seniele persone nie. En aangesien die hooftklem in die afgelope dekade op behandelbare geestesongesteldheid geval het, is die bestaande hospitale vir geestesiekies traag om seniele persone toe te laat omdat hulle dan sogenaamd 'bedde blokeer' wat anders vir behandelbare pasiënte gebruik sou kon word. Trouens, elkeen wat in die kliniese psigiatrisie praktyk staan, weet dat dit min of meer 'n onbegonne taak is om êrens toelating vir 'n gevorderde seniele pasiënt te verkry.

Wat is die gevolg hiervan? Die gevolg is dat nog 'n bykomende groot las op die skouers van die produktiewe bevolking van tussen ongeveer 15 en 65 jaar geplaas word. 'n Studie van die sensussyfers oor die afgelope jaar toon aan dat die persentasie van afhanklikes effens gestyg het, afgesien van 'n gemiddelde afname van die aantal kinders. Dit beteken dus dat die strekking van die afhanklikheidspersentasie grotendeels die gevolg is van die toenemende aantal bejaardes.

Die wêreld verwag (in morele en praktiese terme) van die middel groep van produktiewe persone in die samelewing om te werk en die sake van die wêreld te dryf, om hulself en hul kinders te versorg, om—almeer gedurende die afgelope tye—hul geestesversteurde verwante self te versorg, en nou ook nog om in toenemende mate sorgbehoewende en seniele oues van dae te versorg. Tesame met die toenemende spannings en drukke van die moderne lewe is die las besig om vir die gewillige werkers te swaar te word, en ons kan 'n tyd van grootskaalse ineenstorting voorsien indien nie betyds opgetree word nie.

Ons wil dit hier stel dat gevorderde seniele persone *nie* in private huise behoort versorg te word nie. In die meeste gevalle kán hulle ook nie só versorg word nie. Die tyd het dus gekom dat daar meer doeltreffende fasiliteite geskep moet word vir die versorging van seniele persone. Die meeste psigiaters en geneeshere is teen die skepping van inrigtings wat die beskrywing: 'geen hoop op herstel' sal dra nie. In hierdie geval moet ons egter 'n onvermydelike lewensgebeure in die gesig staar en aanvaar. Aan alle hospitale vir geestesiekies en ook in alle groot algemene hospitale moet daar voorsiening gemaak word vir chroniese, gevorderde seniele pasiënte. Ook moet alle organisasies wat sulke dienste onderneem aangemoedig en gehelp word. Indien ons dit nie *nou* en *met alle mag* doen nie, sal ons ons almeer blootstel aan onverskoonbare kommersiële uitbuiting van die omstandighede van seniele bejaardes en hul families, en sal ons ook die swaarder-wordende las van die produktiewe deel van ons bevolking tot sy breekpunt laat ontwikkel.

## BENZODIAZEPINE COMPOUNDS

The benzodiazepine derivatives constitute a relatively new chemical class of compounds. The drugs at present in use include chlordiazepoxide hydrochloride (Librium), now included in the *British Pharmacopoeia Addendum 1966*,

diazepam (Valium), and nitrazepam (Mogadon). The first two drugs are generally classified as minor tranquillizers; they differ from the major tranquillizers (phenothiazines, reserpine, butyro-phenones) which are used in the treat-

ment of major psychoses; they are being much used in the treatment of anxiety but they are also used to produce skeletal muscle relaxation and in combating alcoholism. Nitrazepam is being used as an hypnotic.

Chlordiazepoxide has an action on the central nervous system but it also has certain peripheral actions on cholinergic, adrenergic and other systems. It produces a definite sedative effect, but has weak hypnotic action. There are many reports that this drug and its congener, diazepam, produce subjective improvement when used as centrally-acting muscle relaxants; they block internuncial neurones. After oral administration both drugs are rapidly absorbed, reach a peak level in the blood in about eight hours and persist in the blood for 48 hours or longer; plasma levels decrease slowly over a period of several days. They are excreted in the urine.

Single or repeated doses do not affect blood pressure or respiration. Common side-effects include drowsiness, ataxia and lethargy. There is sometimes loss of appetite, but there may be stimulation of appetite leading to an increase in weight; this effect has also been observed in patients taking barbiturates. Skin rashes, nausea, headache and vertigo may occur occasionally. Sometimes the patient becomes excited and ataxic, as may occur with the barbiturates; this paradoxical excitement seems to be rare with diazepam. Other toxic effects that have been reported include agranulocytosis and menstrual irregularities.

These drugs should be used with care in elderly patients as they may become confused. They should also be avoided in those driving motor cars or handling machines. Their use in combination with other drugs such as alcohol, barbiturates, MAO inhibitors and imipramine compounds requires great care. Diazepam should be avoided in patients who have glaucoma. The toxicity of these benzodiazepine compounds would appear to be relatively low, as demonstrated by the numerous suicide attempts with doses much larger than those ordinarily given and with subsequent recovery. The continued use

of large doses given to psychiatric patients can lead to physical dependence resembling that produced by the barbiturates.

Chlordiazepoxide and diazepam are very popular with physicians and patients. They have proved effective in the management of mild anxiety states, tension states associated with organic conditions, and also in combination with other drugs used in the treatment of depressive states and psychoses. Their anti-anxiety action has been of value in acute reactive anxiety, in chronic psychoneurotic anxiety, and even in excessive anxiety in psychotic patients and for the somatic manifestations of anxiety such as angina, spastic colon and neurodermatitis. Childhood athetosis, hemiballism, and neuromuscular spasms secondary to arthritic or orthopaedic conditions are ameliorated. They have also been much used in the treatment of alcoholic patients, especially to alleviate the symptoms of alcohol withdrawal and the excited episodes occurring during alcoholic intoxication, and also to relieve anxiety and tension in post-withdrawal treatment. It has been stated that diazepam may be more useful than chlordiazepoxide in mildly disturbed psychotic patients, but further information is necessary.

Nitrazepam induces sleep in about thirty minutes, the effect lasting for four to ten hours. The patient can readily be awakened but is able to fall asleep again. As with the benzodiazepines mentioned above, care is required in elderly patients, especially those with organic cerebral changes or cardiorespiratory insufficiency. Exceptionally, as with the other benzodiazepines and with barbiturates, there may be a paradoxical reaction with restlessness and confusion. Patients should avoid taking alcohol while under the influence of this type of drug; also, driving ability and behavioural reactions in traffic can be influenced by such drugs, depending on the dose and on individual susceptibility.

1. Goodman, L. S. and Gilman, A. (1965): *The Pharmacological Basis of Therapeutics*. London: Collier-Macmillan.

2. Cohen, S. (1965): *Modern Treatment*, vol. 2, p. 505. New York: Harper & Row.

## MANNITOL FOR PROLONGED COMA FOLLOWING INSULIN HYPOGLYCAEMIA

Hypoglycaemic coma induced by insulin in diabetics usually responds with dramatic rapidity to the intravenous injection of glucose. Too frequently, however, the diagnosis and necessary therapy is over-long delayed and a further injection of insulin may even be administered. In such cases, in spite of a return to normal or high blood-sugar levels, the patient may remain deeply comatose for several days, eventually dying or recovering consciousness only with severe neurological or psychiatric damage. Although life may be prolonged for a time by artificial methods, there has been little possibility of satisfactory therapy, although occasional success has been claimed with corticosteroids.<sup>1,2</sup>

Hoffbrand and Sevitt<sup>3</sup> have recently reported the cases of two apparently doomed patients who recovered following the use of 20% mannitol given intravenously. They remark that cerebral oedema has been found at necropsy in many instances in which death has occurred from prolonged coma following hypoglycaemia. Consequently they thought that a hypertonic agent with fairly long action

might be helpful. Their first patient was a man of 73 who had been unconscious for twelve hours despite hyperglycaemic blood levels. Intravenous hydrocortisone had no effect, but he became fully conscious thirty minutes after 200 ml. of 20% mannitol and recovered completely. Their second patient was a 33-year-old man who was similarly treated after four hours of coma and recovered within forty-five minutes.

Since this report appeared mannitol has been tried in two similar patients in a local hospital, with total lack of response. Indeed it is difficult to see why the osmotic effect of mannitol should be so much more effective than that of glucose, since blood-sugar levels are usually maintained at around 300 G per 100 ml. in such cases. Admittedly, however, we do not know the concentration of glucose in the brain cells, so presumably mannitol should continue to be given a further trial in such a hopeless condition.

1. Bloom, A. and Wolff, F. (1955): *Brit. Med. J.*, **1**, 1460.

2. Kay, W. H. (1961): *J. Ment. Sci.*, **107**, 194.

3. Hoffbrand, B. I. and Sevitt, L. H. (1966): *Lancet*, **1**, 402.