

Submitted: 05 Sep 2026

Revised: 14 Sep 2026

Accepted: 20 Sep 2026

Published: 30 Sep 2026

Access This Article Online


 Website:
theanaesthesiologist.com

Geriatric anaesthesia in Keralam: Preparing for a different perioperative future !!

Rajesh.M.C.

ORCID : (0009-0002-8646-1256),

Editor in Chief, Senior Consultant & Academic coordinator,

B M H Calicut, Keralam, Pin - 673004.

rithraj2@yahoo.co.in

How to cite this article: Rajesh.M.C. Geriatric anaesthesia in Keralam: Preparing for a different perioperative future !! TAISAK 2026; 2 (2): 05-06

Keralam's longer life expectancy is a public health achievement. As a reflection of this, our routine operation lists are shifting towards complex geriatric procedures. The state's life expectancy at birth was estimated at 75.1 years during 2019–2023, while the proportion of people aged 60 years and above is projected to rise from 13% in 2011 to approximately 23% by 2036 [1]. These figures make geriatric anaesthesia a present clinical priority, not a distant subspecialty concern.

Older surgical patients cannot be defined by chronological age alone. A vigorous 80 year old and a frail 65 year old may respond very differently to the same perioperative conditions. Although ageing reduces the physiological reserve across organ systems, the degree of decline differs significantly between individuals [2]. The practical question is therefore not simply, "How old is this patient?" but, "What reserves can this patient draw upon during surgery and recovery?"

Pharmacology adds another layer of complexity. Changes in body composition, organ function and drug sensitivity can alter both pharmacodynamic & pharmacokinetic effect of anaesthetic agents. Many older patients need smaller doses to achieve a given effect, while an apparently modest dose may produce prolonged sedation, hypotension or respiratory depression. Careful titration, assessment of

the clinical response and appropriate monitoring are more useful than applying a uniform age-based dose reduction [3]. Polypharmacy further increases the importance of medication reconciliation, particularly when anticoagulants, antihypertensives, sedatives and medicines affecting glucose balance are involved.

Frailty should be included alongside comorbidity in preoperative assessment, as it captures vulnerability that clinical diagnoses or ASA grades may miss. A systematic review confirms that frailty, measured by the Clinical Frailty Scale, is associated with significantly higher postoperative mortality [4, 5]. Preoperative screening enables early risk stratification and shared decision-making. Brief assessments of mobility, nutrition, and cognition can help identify patients who require prehabilitation and enhanced recovery support. Even 2-3 weeks of prehabilitation can improve functional capacity.

The brain is equally vital. Postoperative delirium is a serious complication in elderly requiring active prevention and management. Guidelines from the European Society of Anaesthesiology and Intensive Care Medicine advocate for a multidisciplinary approach covering the entire perioperative period [6]. For older patients, recovery should be measured

by functional independence, not just surgical success. Consequently, routine cognitive screening and non-pharmacological prevention such as minimizing anticholinergic drugs, early mobilization, and monitoring depth of anesthesia during surgery.

Geriatric anesthesia includes a psychosocial dimension. Patients often worry about dependency, finances, and post discharge support, while caregivers face their own pressures. Research indicates these emotional challenges persist from the surgical decision through recovery [7]. Assessing a patient's living situation, support system, and personal goals is therefore a vital component of perioperative care, rather than an optional courtesy.

For our practice in Keralam, the response need not begin with an elaborate new service. It can begin with a change in attitude : identify frailty and cognitive vulnerability; review medicines and reversible problems; discuss the expected effect of surgery on function and independence; tailor anaesthetic drugs and monitoring; prevent and detect delirium; encourage appropriate prehabilitation and adopt to enhanced recovery after surgery pathways. This is the present challenges for perioperative caregivers including anaesthesiologists, surgeons, geriatricians, physicians, nurses, physiotherapists [2, 5, 6].

As the population ages, the measure of perioperative success must expand beyond survival and an uneventful stay in the recovery room. We should ask whether patients return to their usual level of mobility, cognition and participation in family life. Keralam has gained years of life. Geriatric anaesthesia must help ensure that necessary surgery protects the quality and independence of those years.

Conflict of interest: NIL

Financial support: NIL

REFERENCES

1. United Nations Population Fund (UNFPA) India, International Institute for Population Sciences (IIPS). India Ageing Report 2023: Caring for Our Elders—Institutional Responses. New Delhi: UNFPA India; 2023.
2. Tjeertes EKM, Schmidt GB, Mattace-Raso FUS. Perioperative care of the geriatric patient. *Eur J Anaesthesiol*. 2026;43(2):93–102.
3. Coetzee E, Absalom AR. Pharmacokinetic and pharmacodynamic changes in the older adults: impact on anesthetics. *Clin Geriatr Med*. 2025;41(1):19–35.
4. Zhang HT, Tan N, Gao Y, et al. Prediction of postoperative mortality in older surgical patients by clinical frailty scale: a systematic review and meta-analysis. *Geriatr Nurs*. 2024;59:581–589.
5. Sieber F, McIsaac DI, Deiner S, et al. 2025 American Society of Anesthesiologists practice advisory for perioperative care of older adults scheduled for inpatient surgery. *Anesthesiology*. 2025;142(1):22–51.
6. Aldecoa C, Bettelli G, Bilotta F, et al. Update of the European Society of Anaesthesiology and Intensive Care Medicine evidence-based and consensus-based guideline on postoperative delirium in adult patients. *Eur J Anaesthesiol*. 2024;41(2):81–108.
7. Kata A, Dillon EC, Keny C, et al. “There’s so much that they’re enduring”: experiences of older adults undergoing major elective surgery. *Ann Surg*. 2025; 282(2):242–248.