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Sepsis and Septic Shock: Outcomes in Elderly and Very Elderly Intensive Care Patients

Sepsis ve Septik Şok: Yaşlı ve Çok Yaşlı Yoğun Bakım Hastalarının Sonuçları

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ABSTRACT Objective: The relationship between age and the development and outcome of sepsis and septic shock is unclear, especially in adults. There are few studies about the incidence, prognosis and mortality rates of sepsis in elderly and very elderly patients. In this study, we aimed to determine the effect of age on the outcome of sepsis and septic shock in elderly and very elderly intensive care unit (ICU) patients.

Materials and Methods: This study was a retrospective observational study conducted in our medical ICU. Two hundred elderly and very elderly patients with sepsis and septic shock were included in this study.

Results: The mortality rate related to sepsis and septic shock was 61.5% (123 patients). The most common site of infection was lung (56.5%, 113 patients), followed by urinary tract (35%, 70 patients). There was no significant difference between the elderly (61.2%, 82 patients) and the very elderly (62.1%, 41 patients) patients in terms of ICU mortality related to sepsis and septic shock ($p>0.05$). Sequential Organ Failure Assessment score on ICU admission [1.195 odds ratio (OR) and 1.052-1.358 95% confidence interval (CI), $p=0.006$], requirement of invasive mechanical ventilation on ICU admission (4.330 OR and 1.529-12.258 95% CI, $p=0.006$), renal impairment at the end of the ICU follow-up (6.457 OR and 1.795-23.233 95% CI, $p=0.004$) and the disability to feed orally in ICU (0.064 OR and 0.018-0.226 95% CI, $p=0.0001$) were found as independent risk factors for ICU mortality.

Conclusion: According to our study, there was no significant difference between the elderly and the very elderly ICU patients with sepsis and septic shock in terms of mortality rates. However, the presence of organ damage during ICU admission and the development of complications during ICU stay significantly affected mortality.

Keywords: Sepsis, septic shock, mortality, elderly, very elderly

ÖZ Amaç: Sepsis-septik şok gelişimi ile yaşın ilişkisi özellikle erişkinlerde açık değildir. Yaşlı ve çok yaşlı hastalarda sepsis ve septik şokun insidans, prognoz ve mortalitesi ile ilgili az sayıda çalışma bulunmaktadır. Bu çalışma ile yaşlı ve çok yaşlı yoğun bakım ünitesi (YBÜ) hastalarında yaşın sepsis ve septik şokun sonuçları üzerine etkisini göstermeyi amaçladık.

Gereç ve Yöntem: Bu çalışma YBÜ'de yapılan retrospektif gözlemsel bir çalışmaya olup 200 yaşlı ve çok yaşlı sepsis-septik şok hastası çalışmaya alınmıştır.

Bulgular: Sepsis-septik şok ilişkili mortalite oranı %61,5 (123 hasta) idi. En sık enfeksiyon odağı akciğer (%56,5, 113 hasta) ve üriner sistemdi (%35, 70 hasta). Yaşlı (%61,2, 82 hasta) ve çok yaşlı hastalar (%62,1, 41 hasta) arasında mortalite açısından anlamlı fark yoktu. YBÜ kabulünde Sıralı Organ Yetmezliği Değerlendirme skoru [1,195 olasılık oranı (OR) ve 1,052-1,358 %95 güven aralığı (GA), $p=0,006$] ve invazif mekanik ventilasyon gereksinimi (4,330 OR ve 1,529-12,258 %95 GA, $p=0,006$), YBÜ takibinin sonunda böbrek yetmezliği gelişmesi (6,457 OR ve 1,795-23,233 %95 GA, $p=0,004$) ve oral yoldan beslenme yetersizliği (0,064 OR ve 0,018-0,226 %95 GA, $p=0,0001$) YBÜ mortalitesi için bağımsız risk faktörleri olarak bulundu.

Sonuç: Bu çalışmada yaşlı ve çok yaşlı hastalar arasında sepsis-septik şoka bağlı mortalite oranları açısından anlamlı bir fark yoktu. Ancak YBÜ'ye kabulü sırasında organ hasarı varlığı ve takipte komplikasyon gelişimi mortaliteyi etkilemekteydi.

Anahtar Kelimeler: Sepsis, septik şok, mortalite, yaşlılık, çok yaşlı

Introduction

Aging is a natural consequence of human life, and the elderly population increases globally within years. Recent developments in the field of medicine such as improvement in diagnostic tools and treatments seem to be the main reason for this increase. The World Health Organization defines elderly people as over 65 years of age. In addition, people aged between 65 and 80 years are defined as elderly and those above 80 are defined as very elderly according to this description. According to data from the United Nations Population Fund, 9 percent of the world's population consisted of people aged 65 and over in 2018. The proportion of people aged 60 and over is expected to reach 16.5 percent in 2030 and 22 percent in 2050 (1).

Older age is associated with increased prevalence of chronic diseases, functional impairments, and elevated intensive care unit (ICU) admission rates. The increase in the elderly population is expected to create a major problem in health care systems. In general, the number of ICU admissions and follow-ups is rising throughout the world. For adults, there is also a strong and positive correlation between ICU admission rates and age, and more than half of the hospitalization days of ICU stay consist of elderly patients (2).

Sepsis is a very common and lethal disease in the United States, and more than 750,000 people are diagnosed with sepsis every year. This contributes to nearly 20% of all in-hospital deaths (2,3). Early detection and treatment are crucial for better recovery and outcome in septic patients. On the other hand, diagnosis of sepsis is more difficult in elderly patients compared to younger ones, because the main symptoms of infection such as fever, tachycardia and hypoxia are replaced by non-specific ones like fatigue, delirium, anorexia, incontinence and falls (4). Therapeutic interventions may easily be delayed under these circumstances, and this leads to worse recovery and outcomes in this patient population. Therefore, in this study, we aimed to investigate the development, progression, and outcome of sepsis and septic shock in elderly and very elderly ICU patients.

Materials and Methods

Study Design and Patient Population

This study was a retrospective observational study conducted in our tertiary medical ICU. Patients aged 65 and

over who were admitted to the ICU due to sepsis/septic shock or diagnosed with sepsis and septic shock during ICU stay were included in this study. Patients aged under 65 years, those who did not meet the diagnostic criteria of sepsis and septic shock and those who stayed in the ICU for less than 48 hours were excluded from the study.

The study was in accordance with the declaration of Helsinki. Since the study was retrospective, written consent was not obtained from the patients. The study was approved by the Gazi University Clinical Research Ethics Committee (decision no: 53, date: 08.07.2013).

Definitions

Sepsis and septic shock were defined according to the international guidelines. In 2016, the definitions of sepsis and septic shock were revised by the Third International Consensus Definitions for Sepsis and Septic Shock (5). Sepsis was defined as life-threatening organ dysfunction due to irregular host response to infection. The task force recommended that an increase in the Sequential (Sepsis-related) Organ Failure Assessment (SOFA) score of at least 2 points should be used when infection was encountered as a criterion of sepsis. Baseline SOFA score may be considered zero in patients without prior organ dysfunction. Patients with septic shock was identified by the need for vasopressor to maintain a mean arterial pressure of ≥ 65 mmHg and having a serum lactate level >2 mmol/L (>18 mg/dL) despite adequate fluid resuscitation. Early goal-directed therapy (EGDT) refers to a treatment bundle including early intensive fluid administration using physiologic targets to guide resuscitation within first six hours in sepsis and septic shock, which is routinely followed for septic patients in our ICU (6). EGDT has widely been accepted in clinical practice; however, there is conflicting evidence regarding the effectiveness of individual resuscitation elements and targets (7,8).

Data Collection

All clinical data were collected from the ICU medical files of the patients and hospital electronic records. We recorded demographic data, main diagnosis, underlying comorbidities, microbiological data and source of infections, Acute Physiology and Chronic Health Evaluation-II (APACHE-II) and SOFA scores, Risk, Injury, Failure, Loss of kidney function, End-stage renal disease (RIFLE) scores, need and type of mechanical ventilation support and vasopressors and need for renal replacement therapy (RRT). Data related to

complications during the ICU follow-up [Acute respiratory distress syndrome (ARDS), impairment in renal and hepatic functions, etc.] and types of nutritional support were also recorded.

Statistical Analysis

SPSS (SPSS Inc., Chicago, version 21.0) was used for statistical analysis. Continuous data were presented as median and interquartile ranges, and categorical data were presented as frequencies and percentages. The Mann-Whitney U test was used to compare continuous data between groups, and the chi-squared test was used to compare categorical variables. Logistic regression analysis was performed to determine independent risk factors for mortality. P values <0.05 were considered as statistically significant.

Results

Two hundred elderly and very elderly patients were included. The median age of the patients was 76 (70-87), and half of them were male (50%). The most common causes of ICU admission were sepsis and septic shock in 132 patients (66%), respiratory failure in 102 patients (51%) and renal impairment in 31 patients (15.5%). Most common sites of infection were respiratory tract in 113 patients (56.5%), urinary tract in 70 patients (35%) and blood and/or catheter in 21 patients (10.5%). Baseline characteristics of the patients were shown in Table 1. One hundred thirty four (67%) patients were in the elderly group, and 66 (33%) patients were in the very elderly group. Length of ICU stay was longer in the very elderly group ($p=0.02$). The risk of malnutrition, presence of decubitus ulcers, swallowing problems, stool and urinary incontinence were higher in the very elderly group before ICU admission ($p=0.009$, $p=0.008$, $p=0.004$, $p=0.0001$, respectively). When the patients were evaluated by admission RIFLE score, failure ($p=0.008$) component of the score was more frequent in elderly patients and risk ($p=0.008$) component was more frequent in very elderly ones. There was no difference between the elderly and very elderly groups in terms of various factors including reason of ICU admission, APACHE-II score, source of infection, requirement of mechanical ventilation support and complications in ICU follow-up (ARDS, impairment in renal functions, requirement of RRT). Detailed information on the characteristics of elderly and very elderly patients were given in Table 2. In addition, there was no difference

between the mortality rates of the elderly (61.2%, 82 patients) and very elderly patients (62.1%, 41 patients) ($p=1$). APACHE-II, Glasgow coma scale, SOFA scores on ICU

Table 1. Baseline characteristics of study patients	
Age, median (interquartile range)	76 (70-87)
Gender, male, n (%)	100 (50%)
Most frequent reasons for ICU admission, n (%)	
Sepsis/septic shock	132 (66%)
Respiratory failure	102 (51%)
Renal function disorders	31 (15.5%)
APACHE-II score on admission, median (interquartile range)	25 (18-30)
SOFA score on admission, median (interquartile range)	9 (5-12)
GCS on admission, median (interquartile range)	13 (8-15)
Need of IMV on admission, n (%)	111 (55.5%)
Need of NIMV on admission, n (%)	33 (16.5%)
Source of infection on admission, n (%)	
Pulmonary	113 (56.5%)
Urinary tract	70 (35%)
Catheter related blood stream infection	21 (10.5%)
Type of infectious agent on admission, n (%)	
Gram-negative, bacterial	93 (46.5%)
Gram-positive, bacterial	29 (14.5%)
Fungal	38 (19%)
Viral	8 (4%)
Sepsis/septic shock on admission, n (%)	132 (66%)
Sepsis/septic shock episode during ICU follow-up, n (%)	68 (34%)
Source of infection in sepsis/septic shock episode during ICU follow-up, n (%)	
Pulmonary	46 (23%)
Urinary tract	18 (9%)
Catheter related blood stream	10 (5%)
Type of infectious agent in sepsis/septic shock episode during ICU follow-up, n (%)	
Gram-negative, bacterial	46 (23%)
Gram-positive, bacterial	11 (5.5%)
Fungal	21 (10.5%)
Viral	2 (1%)
Mortality, n (%)	123 (61.5%)
SOFA: Sequential (Sepsis-related) Organ Failure Assessment, APACHE-II: Acute Physiology and Chronic Health Evaluation-II, GCS: Glasgow coma scale, ICU: intensive care unit, IMV: invasive mechanical ventilation, NIMV: non-invasive mechanical ventilation	

Table 2. Characteristics of elderly (65-79 years) and very elderly (≥80 years) ICU patients with sepsis/septic shock			
	65-79 yrs (n=134)	≥80 yrs (n=66)	p-value
Age, median (interquartile range)	73 (65-76)	84 (81-87)	-
Gender, male, n (%)	75 (56%)	25 (37.9%)	0.024
Length of ICU stay, days, median (interquartile range)	6 (4-13)	8 (5-14)	0.020
APACHE-II score on admission, median (interquartile range)	25 (18-31)	24 (16-28)	0.13
GCS score on admission, Median (interquartile range)	13 (8-15)	12 (9-15)	0.80
SOFA score on admission, median (interquartile range)	9 (6-13)	7 (4-12)	0.012
RIFLE score on admission, n (%)			
Risk	30 (22.4%)	27 (40.9%)	0.008
Injury	15 (11.2%)	7 (10.6%)	1
Failure	39 (29.1%)	8 (12.1%)	0.008
Loss	1 (0.7%)	2 (3%)	0.21
End stage renal disease	25 (18.7%)	9 (13.6%)	0.42
Patients' characteristics before ICU admission, n (%)			
Malnutrition	6 (4.5%)	7 (10.6%)	0.009
Decubitis ulcer	15 (11.2%)	14 (21.2%)	0.008
Swallowing disorders	-	2 (3%)	0.004
Urinary incontinence	19 (14.2%)	25 (37.9%)	<0.001
Frequently falls	-	1 (1.5%)	0.15
Most frequent reasons for ICU admission, n (%)			
Sepsis/septic shock	86 (64.2%)	46 (69.7%)	0.52
Respiratory failure	70 (52.2%)	32 (48.5%)	0.65
Renal failure	21 (15.7%)	10 (15.2%)	1
Need of vasopressors support on admission, n (%)	93 (69.4%)	43 (65.2%)	0.62
Need of central venous catheter on admission, n (%)	83 (61.9%)	42 (63.6%)	0.87
Need of invasive arterial monitorization on admission, n (%)	103 (76.9%)	48 (72.7%)	0.60
Need of IMV on admission, n (%)	74 (55.2%)	37 (56.1%)	1
Need of NIMV on admission, n (%)	22 (16.4%)	11 (16.7%)	1
Source of infection on admission, n (%)			
Pulmonary	74 (55.2%)	39 (59.1%)	0.65
Urinary tract	45 (33.6%)	25 (37.9%)	0.63
Catheter related blood stream infection	13 (9.7%)	8 (12.1%)	0.62
Type of infectious agent on admission, n (%)			
Gram-negative, bacterial	56 (41.8%)	37 (56.1%)	0.007
Gram-positive, bacterial	20 (4.9%)	9 (13.6%)	1
Fungal	21 (15.7%)	17 (25.8%)	0.12
Viral	5 (3.7%)	3 (4.5%)	0.78
Source of infection in sepsis/septic shock episode during ICU follow-up, n (%)			
Pulmonary	32 (23.9%)	14 (21.2%)	0.72
Urinary tract	10 (7.5%)	8 (12.1%)	0.30
Intraabdominal	3 (2.2%)	-	0.20

Catheter related blood stream infection	5 (3.7%)	5 (7.6%)	0.24
Type of infectious agent on admission, n (%)			
Gram-negative, bacterial	30 (22.4%)	16 (24.2%)	0.58
Gram-positive, bacterial	8 (6%)	3 (4.5%)	0.67
Fungal	14 (10.4%)	7 (10.6%)	1
Viral	2 (1.5%)	-	0.31
Nutritional support in ICU, n (%)			
Oral	68 (50.7%)	36 (54.5%)	0.72
Enteral	87 (64.9%)	50 (75.8%)	0.22
Parenteral	90 (67.2%)	45 (68.2%)	0.80
Complications during ICU stay, n (%)			
ARDS	4 (3%)	2 (3%)	0.98
Acute renal failure	27 (20.1%)	17 (25.8%)	0.37
Need for RRT	65 (48.5%)	24 (36.4%)	0.13
RIFLE score at the end of ICU follow-up, n (%)			
Risk	20 (14.9%)	16 (24.2%)	0.12
Injury	13 (9.7%)	7 (10.6%)	0.80
Failure	48 (35.8%)	15 (22.7%)	0.07
Loss	1 (0.7)	5 (7.6%)	0.008
End stage renal disease	28 (20.9%)	9 (13.6%)	0.24
Mortality, n (%)	82 (61.2%)	41 (62.1%)	1
SOFA: Sequential (Sepsis-related) Organ Failure Assessment, APACHE-II: Acute Physiology and Chronic Health Evaluation-II, GCS: Glasgow coma scale, RIFLE: Risk, Injury, Failure, Loss of kidney function, End-stage renal disease, ICU: intensive care unit, IMV: invasive mechanical ventilation, NIMV: non-invasive mechanical ventilation, ARDS: acute respiratory distress syndrome, RRT: renal replacement therapy			

admission, invasive mechanical ventilation on admission, complications during ICU follow-up (ARDS, acute renal failure, requirement of RRT) and failure component of RIFLE score at the end of ICU follow-up were significantly higher in non-survivors. Characteristics in survivors and non-survivors are addressed in Table 3. In multivariate analysis, SOFA score on ICU admission, the requirement of invasive mechanical ventilation on ICU admission, having a failure component of RIFLE score at the end of ICU follow-up and disability to feed orally were found as independent risk factors for ICU mortality (Table 4).

Discussion

The incidence of sepsis/septic shock and the rate of hospitalization due to this problem increases with age. Englert and Ross (9) reported that there was an increase in hospitalization rates due to sepsis between the years 1997 and 2011 and that this increase was 3 times higher in the ages between 65 and 84 and 2 times higher in ages ≥ 85 . Angus and van der Poll (10) demonstrated that the

incidence of sepsis was 0.2/1,000 in the pediatric age group and 26.2/1,000 in individuals ≥ 85 years of age, which was almost 100 times higher compared to that found in children. Martin et al. (11) showed that the incidence of sepsis was 13 times higher in patients ≥ 65 years old compared to that found in individuals younger than 65 years old. On the other hand, Özbilgin et al. (12) stated that the most common reason for admission to ICU was respiratory conditions such as postoperative respiratory failure, chronic obstructive pulmonary disease and pneumonia. In our study, the most common reason for admission to the ICU was sepsis/septic shock [132 patients, (66%)]. In addition, the most common reason for admission to ICU was the same and there was no significant difference between the two groups when elderly and very elderly patients were compared (64.2% vs. 69.7%, $p=0.52$). One of the reasons affecting this condition may be that trauma or postoperative patients were not followed up in our ICU. The causes of increased sepsis rates with age include structural and functional changes in the immune system with progressive age, increased physiological and biological changes with age, decreased functional reserve,

Table 3. General characteristics of the patients according to survival

	Survivors (n=77)	Non-survivors (n=123)	p-value
Age, median (interquartile range)	76 (69-81)	76 (70-82)	0.67
Gender, male, n (%)	42 (54.5%)	58 (47.2%)	0.38
APACHE-II score on admission, median (interquartile range)	19 (16-25)	27 (23-34)	0.0001
GCS score on admission, median (interquartile range)	15 (13-15)	10 (7-13)	0.0001
SOFA score on admission, median (interquartile range)	6 (4-9)	11 (7-14)	0.0001
Most frequent reasons for ICU admission, n (%)			
Sepsis/septic shock	50 (64.9%)	82 (66.7%)	0.87
Respiratory failure	37 (48.1%)	65 (52.8%)	0.56
Renal failure	11 (14.3%)	20 (16.3%)	0.84
RIFLE score on admission, n (%)			
Risk	18 (23.4%)	39 (31.7%)	0.26
Injury	6 (7.8%)	16 (13%)	0.35
Failure	14 (18.2%)	33 (26.8%)	0.17
Loss	1 (1.3%)	2 (1.6%)	0.85
End stage renal disease	16 (20.8%)	18 (14.6%)	0.33
IMV on admission, n (%)	14 (18.2%)	97 (78.9%)	0.0001
NIMV on admission, n (%)	18 (23.4%)	15 (12.2%)	0.20
Source of infection on admission, n (%)			
Pulmonary	37 (48.1%)	76 (61.8%)	0.64
Urinary tract	32 (41.6%)	38 (30.9%)	0.55
Catheter related blood stream infection	6 (7.8%)	15 (12.2%)	0.68
Type of infectious agent on admission, n (%)			
Gram-negative, bacterial	34 (44.2%)	59 (48%)	0.74
Gram-positive, bacterial	10 (13%)	19 (15.4%)	0.82
Fungal	13 (16.9%)	25 (20.3%)	0.64
Nutritional support in ICU, n (%)			
Oral	73 (94.8%)	31 (25.2%)	0.0001
Enteral	53 (68.8%)	84 (68.3%)	0.84
Parenteral	29 (37.7%)	106 (86.2%)	0.0001
Complications during ICU stay, n (%)			
ARDS	-	6 (4.9%)	0.049
Acute renal failure	4 (5.2%)	40 (32.5%)	0.0001
Need for RRT	22 (28.6%)	67 (54.5%)	0.0001
SOFA: Sequential (Sepsis-related) Organ Failure Assessment, APACHE-II: Acute Physiology and Chronic Health Evaluation-II, GCS: Glasgow coma scale, RIFLE: Risk, Injury, Failure, Loss of kidney function, End-stage renal disease, ICU: intensive care unit, IMV: invasive mechanical ventilation, NIMV: non-invasive mechanical ventilation, ARDS: acute respiratory distress syndrome, RRT: renal replacement therapy			

Table 4. Factors affecting mortality on multivariate analysis

	p-value	OR, %95 CI (min-max)
SOFA score on ICU admission	0.006	1.195 (1.052-1.358)
Requirement of IMV on ICU admission	0.006	4.330 (1.529-12.258)
Ability to feed orally during ICU stay	0.0001	0.064 (0.018-0.226)
Failure component of RIFLE score at the end of the ICU follow-up	0.004	6.457 (1.795-23.233)
SOFA: Sequential (Sepsis-related) Organ Failure Assessment, ICU: intensive care unit, IMV: invasive mechanical ventilation, RIFLE: Risk, Injury, Failure, Loss of kidney function, End-stage renal disease, OR: odds ratio, CI: confidence interval, min: minimum, max: maximum		

increasing number of chronic diseases with age, more frequent hospital admissions and interventional procedures because of these chronic diseases, malnutrition and higher rates of stay in nursing homes and rehabilitation centers.

According to some studies, increasing age not only results in increases in the incidence of sepsis, but it also increases the rates of mortality due to sepsis. The studies conducted by Englart and Ross (9) and Knaus et al. (13) demonstrated increased mortality of sepsis with age. Similarly, Özbilgin et al. (12) showed that the mortality of ICU increases with advancing age. Martin et al. (11) showed that sepsis mortality was 2.26 times higher in patients ≥65 years compared to those <65 years. On the other hand, Şahintürk et al. (14) showed that mortality in surgical intensive care patients was not related to age but associated with infection. Palomba et al. (15), Lerolle et al. (16), Garnacho-Montero et al. (17) and Uzun et al. (18) showed that sepsis mortality was not related to age. Palomba et al. (15) attributed these age-associated increases in mortality to the fact that older patients received less aggressive modes of treatment. Lerolle et al. (16) showed that the chance of survival in older individuals increased 2.9 times higher compared to the chances in the 1990s with the introduction and administration of more advanced monitoring methods and more effective treatment modalities such as RRT in the 2000s. However, mortality rates were not found to be different in older patients compared to the very elderly in several studies, including those conducted by Somme et al. (19) (75-84 age vs ≥85 age) and McLean et al. (20) (65-74 age vs ≥75 age) on the overall mortality rates in ICUs. In our study, we examined the rates of mortality due to sepsis in elderly and very elderly patients; however, we could not find any differences between the mortality rates obtained in these two groups of patients (61.2% vs. 62.1%, p=1). The

reason for this finding may be either due to the fact that we applied the same approach to each patient regardless of their age or due to the fact that the age difference between the two age groups in our study was not high enough (the median ages were 73 years and 84 years in the old age and very old age groups, respectively).

Several studies have indicated that the respiratory system and genitourinary system are the two most common loci associated with sepsis in old individuals. Gram-negative infections are considered to be the most frequent causative agents. Martin et al. (11) reported that sepsis originating from the infections of the respiratory system [relative risk (RR): 1.29] and genitourinary system (RR: 1.38) was more common in older ages. In addition, it was reported that Gram-negative microorganisms were the most common causative agents of sepsis (RR: 1.31) in old ages compared to younger people. Nasa et al. (21) reported that sepsis originated from the respiratory system and the urinary system at rates of 45.5% and 21.2%, respectively. Similar to literature, in our study the respiratory system (56.5%) and the urinary system (35%) were found as the most common two loci of sepsis, and Gram-negative bacteria (46.5%) were the most common causative agents in sepsis. The most common source of sepsis was respiratory system when the elderly and very elderly patients were compared and there was no significant difference between the two groups (55.2% vs. 59.1%, $p=0.65$). Although Gram-negative bacteria were the most common agent in both groups, this rate was significantly higher in the very elderly group (56.1% vs. 41.8%, $p=0.007$). Similarly, when the patients were compared according to survival status, the most common focus of sepsis was respiratory system and Gram-negative bacteria the most common causative agents in both groups. There was no significant difference between the two groups in terms of sepsis focus and infectious agent (61.8% vs. 48.1, $p=0.64$ and 48% vs. 44.2, $p=0.74$).

In old patients with sepsis/septic shock, besides increased age, the following were identified as the mortality-associated risk factors in the univariate or multivariate analyses: the need for mechanical ventilation, presence of renal dysfunction, presence of comorbidities, intensive care-acquired infections, requirement for inotropic support, APACHE-II or SOFA scores and the number of dysfunctional organs (22,23). Palomba et al. (15) found APACHE-II score, lactate level, the number of organ failures, the need for mechanical ventilation, the need for vasopressor

administration and the presence of cirrhosis as independent risk factors for mortality in sepsis patients. Knaus et al. (13) reported that, besides age, comorbidities and developing organ damage during the ICU stay determined the sepsis mortality. Park et al. (24) stated that the presence of cancer, APACHE-II and SOFA scores on the first day of ICU stay and metabolic dysfunctions determined the mortality rates in sepsis. Özbilgin et al. (12) also showed that APACHE-II score was associated with mortality. Furthermore, Nasa et al. (21) reported that, besides increased age, the following factors determined mortality rates in sepsis: the need for mechanical ventilation, presence of renal impairment and the need for inotropic support. Consistent with the literature, we demonstrated that the following factors were associated with increased mortality rates in elderly septic patients: presence and severity of organ failure (SOFA score) on admission, the need for mechanical ventilation and the development of renal failure in the ICU (RIFLE score at the end of the ICU follow-up). This result (not only SOFA score, but also need for mechanical ventilation and development of renal insufficiency during ICU follow-up) showed that the number and severity of organ failure were more important than age in terms of ICU mortality. We also showed that the ability to eat during the intensive unit stay was a factor reducing the mortality rates.

There were some limitations in our study. Firstly, this was a single center and retrospective study, which potentially limited the generalizability of our findings. Secondly, we only evaluated geriatric patients by dividing them into two age groups, so we did not compare the outcomes of geriatric patients with younger adults. Thirdly, we used 65 as the cut-off age, but we did not evaluate the functional status of the patients. The chronological age is not always representative of the functional condition of the patients. Lastly, our study did not include the long-term outcomes of the patients discharged from the ICU.

Conclusion

In our study population (elderly and very elderly sepsis/septic shock patients), age was not a major determinant risk factor for ICU mortality, but having organ failures on ICU admission and developing complications during ICU stay (such as renal failure) showed significant effects on ICU mortality. Our results also showed that the very elderly patients with sepsis/septic shock responded to early

aggressive sepsis treatment like the elderly ones. To better understand the relationship between mortality and age in sepsis, randomized controlled trials should be conducted in broader age groups, with a greater number of participants, in various ICU types and by including the functional status of the patients.

Ethics

Ethics Committee Approval: The study was approved by the Gazi University Clinical Research Ethics Committee (decision no: 53, date: 08.07.2013).

Informed Consent: Since the study was retrospective,

written consent was not obtained from the patients.

Peer-review: Externally peer-reviewed.

Authorship Contributions

Concept: K.I., G.A., Design: K.I., G.A., M.T., Data Collection and Process: B.C., M.T., Analysis or Interpretation: G.A., M.T., Literature Search: B.C., K.I., Writing: B.C., G.A.

Conflict of Interest: No conflict of interest was declared by the authors.

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