1:55 – 2:40pm

Updates in Geriatrics

SPEAKER

Lee A. Lindquist, MD, MPH, MBA

Presenter Disclosure Information

The following relationships exist related to this presentation:

- Lee A. Lindquist, MD, MPH, MBA has no financial relationships to disclose.

Off-Label/Investigational Discussion

- In accordance with pmiCME policy, faculty have been asked to disclose discussion of unlabeled or unapproved use(s) of drugs or devices during the course of their presentations.

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Learning Objectives

- Describe important advances in the care of older adults published in the past year.
- Describe the strengths and limitations of recent research findings.
- Make at least one change in their clinical care of older adults.

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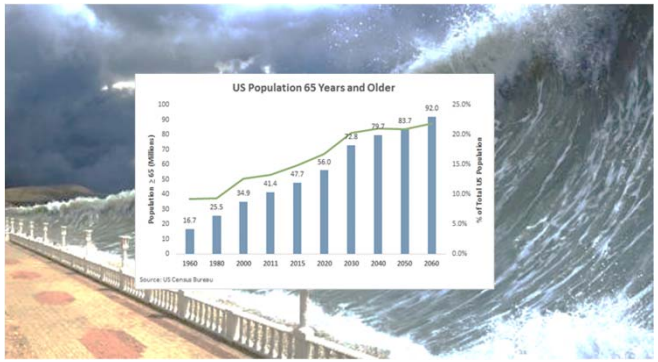
"Gray Wave" and Growing Healthcare Needs.



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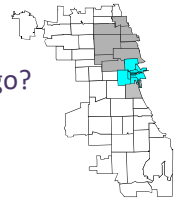
What is a Geriatrician?

- Physician Experts in medical care of older adults (>65 years) – MD/DO with extra years of training.
- There are ~7,500 certified geriatricians in USA but the nation needs an estimated 17,000 geriatricians to care for about 12 million older adults.
- How many in the City of Chicago?



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BEST HOSPITALS U.S.News RANKINGS

NORTHWESTERN GERIATRICS
RANKED #9 Nationally
RANKED #1 in Illinois
IN US NEWS AND WORLD REPORT!!!

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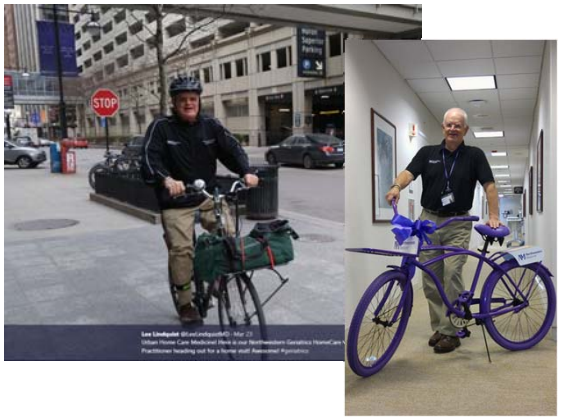

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Syllabi/Slides for this program are a supplement to the live CME session and are not intended for other purposes.

Should I be telling my older patients to EXERCISE? to help their brain?

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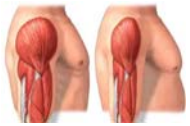
Normal Aging Changes in Muscle

- Begin in 20 y/o's men, 40 y/o's women
- Muscle fibers shrink.
- Fat deposited in muscle.
- Muscle replaced more slowly and with a tough fibrous tissue.



- If not used, muscles become rigid with age, leading to strength loss.
- Where can you notice it ?

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Most Noticeable in HANDS

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Journal of the American Geriatrics Society

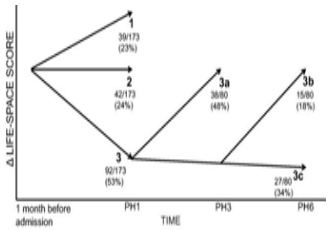
Brief Report

Trajectories of Community Mobility Recovery After Hospitalization in Older Adults

Christine Loyd PhD, T. Mark Beasley PhD, Rebecca S. Miltner PhD, RN, Diane Clark PhD, PT, Barbara King PhD, RN, Cynthia J. Brown MD, MSPH, AGSF

First published: 02 May 2018 | https://doi.org/10.1111/jgs.15397

A majority of older hospitalized adults experienced a clinically significant decrease in community mobility in the first month after hospitalization. Although most pts recovered within 6 mo. of hospitalization, they experienced profound loss of mobility.



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How Much Exercise?

EDITOR'S CHOICE

The Relationship Between Physical Activity and Frailty Among U.S. Older Adults Based on Hourly Accelerometry Data

Megan Huisingh-Scheetz, MD, MPH ✉, Kristen Wroblewski, MS, Masha Kocherginsky, PhD, Elbert Huang, MD, MPH, William Dale, MD, PhD, Linda Waite, PhD, L Philip Schumm, MA

The Journals of Gerontology: Series A, Volume 73, Issue 5, 17 April 2018, Pages 622–629, https://doi-org.ezproxy.galter.northwestern.edu/10.1093/gerona/glx208
Published: 02 November 2017 **Article history**

- Findings indicate that frail elders, men, those who are older, overweight or have multiple comorbidities are most likely to have low activity.
- We suggest defining individual-specific activity goals.

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High Intensity Walking Training?

Feasibility and Impact of High-Intensity Walking Training in Frail Older Adults

MK Danilovich, DE Conroy, TG Hornby

Journal of aging and physical activity 25 (4), 533-538

- https://doi.org/10.1123/japa.2016-0305
- The intervention consisted of 30 min of HIWT at 70–80% of heart rate reserve or ratings of 15 to 17 (hard to very hard) on the Borg Rating of Perceived Exertion scale.
- Training included walking at fast speeds, multi-directions, stairs, and outdoor surfaces with and without an assistive device.
- Training significantly reduced frailty using the SHARE-FI (p = .008), increased fast gait speed (p = .01), improved 6-min walk test distance (p = .03), and enhanced Berg Balance Scale scores (p = .03).
- There were no adverse events and all participants reached target training intensity in all 12 sessions.

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Tai Chi is AWESOME and research is finding it prevents falls and is better than medications for memory loss patients

Effects of Home-Based Tai Chi and Lower Extremity Training and Self-Practice on Falls and Functional Outcomes in Older Fallers from the Emergency Department—A Randomized Controlled Trial

J Am Geriatr Soc 64:518–525, 2016.

- Home-based Tai Chi reduces the incidence of falls and injurious falls more than conventional lower leg exercises in older fallers, and the effects may last for at least 1 year.

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Exercise and Memory Loss / Dementia

Exercise interventions for cognitive function in adults older than 50: a systematic review with meta-analysis

Joseph Michael Northey,[1,2] Nicolas Cherbuin,[3] Kate Louise Pumpa,[1,2] Disa Jane Smee,[2] Ben Rattray[1,2]

- Physical exercise improved cognitive function in the over 50s, regardless of the cognitive status of participants.
- To improve cognitive function, this meta-analysis provides clinicians with evidence to recommend that patients obtain both aerobic and resistance exercise of at least moderate intensity on as many days of the week as feasible.

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What is the "Right" BP for 80, 90, 100 y/o adults?

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ACP Northwestern University

Annals of Internal Medicine

LATEST ISSUES CHANNELS CME/MOC IN THE CLINIC JOURNAL CLUB WEB EXCLUSIVES AUTHOR INFO

‹ PREV ARTICLE | THIS ISSUE | NEXT ARTICLE ›

CLINICAL GUIDELINES | 21 MARCH 2017

Pharmacologic Treatment of Hypertension in Adults Aged 60 Years or Older to Higher Versus Lower Blood Pressure Targets: A Clinical Practice Guideline From the American College of Physicians and the American Academy of Family Physicians FREE

Amir Qaseem, MD, PhD, MHA; Timothy J. Wilt, MD, MPH; Robert Rich, MD; Linda L. Humphrey, MD, MPH; Jennifer Frost, MD; Mary Ann Forciea, MD; for the Clinical Guidelines Committee of the American College of Physicians and the Commission on Health of the Public and Science of the American Academy of Family Physicians (*)

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- **Recommendation 1:** *ACP and AAFP recommend that clinicians initiate treatment in adults aged 60 years or older with systolic blood pressure persistently at or above 150 mm Hg to achieve a target systolic blood pressure of less than 150 mm Hg to reduce the risk for mortality, stroke, and cardiac events.*

** systolic BP <140 for patients with prior Stroke and Cardiac Events*

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≤150 SYSTOLIC Blood Pressure TARGET

….but WAIT, what about these:

- Systolic Blood Pressure Intervention Trial (SPRINT),
- Heart Outcome Prevention Evaluation (HOPE) and
- Hypertension in the Very Elderly Trial (HYVET)

Effect of Intensive Blood-Pressure Treatment on Patient-Reported Outcomes

N Engl J Med 2017;377:733-744

Authors: Dan R Berlowitz, Capri G Foy, Lewis E Kazis et. al for the SPRINT Research Group
Funding: National Institutes of Health; SPRINT ClinicalTrials.gov

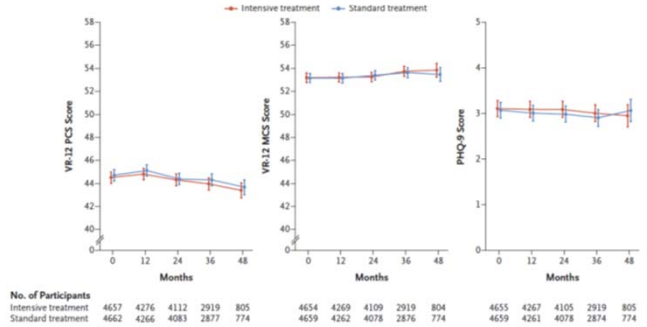
The Systolic Blood Pressure Intervention Trial (SPRINT) showed that older adults with hypertension and a risk for cardiovascular disease had lower rates of cardiovascular events and death with target treatment for SBP <120 compared to SBP < 140.

Maintaining lower BP target than previously recommended may be limited by concerns for patients' health status, side effects, quality of life or satisfaction with care.

Background

- In the SPRINT trial, the intensive treatment group had more of the following symptoms:
  - Symptomatic hypotension
  - Syncope
  - Acute kidney injury
- Potential adverse effects due to decreased cerebral blood flow:
  - Physical and cognitive impairment
  - Confusion
  - Depression

Veterans RAND 12-item Health Survey and
Patient Health Questionnaire 9-item depression scale



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Limitations

- Excluded patients with diabetes and prior history of stroke
- Assessment of patient-reported outcomes were not collected until year later
- SPRINT trial was terminated early due to significant difference, many participants did not have long-term follow up
- Participants were not blinded to their treatment group

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Perspectives on hypertension treatment in older persons

FREE

David J Stott, William B Applegate

Age and Ageing, afy055, https://doi.org/10.1093/ageing/afy055

Published: 21 May 2018 **Article history**

These authors review issues related to SPRINT, HOPE, and HYVET….

… and note that the participants in these trials are not as sick with multi-morbidity, frailty and polypharmacy as are many older persons including in general practice settings.

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SUMMARY

- There is convincing trial evidence for benefit from antihypertensive drugs with reduced risk of stroke, myocardial infarction and mortality.
- Questions remain about who to treat and on optimal blood pressure targets.
- For some older people blood pressure lowering for prevention of vascular disease should be a high priority, with the potential for substantial gains from setting a low treatment target. However for others antihypertensive treatment will be irrelevant or even harmful.

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"You've seen one older adult… you've seen one older adult."

The decision whether or not to treat hypertension in older age, and 'how low to go' remain a matter of expert clinical judgement.

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What about Statins in Older Adults?

Northwestern Medicine

JAMA Internal Medicine | Original Investigation

Effect of Statin Treatment vs Usual Care on Primary Cardiovascular Prevention Among Older Adults
The ALLHAT-LLT Randomized Clinical Trial

Benjamin H. Han, MD, MPH; David Sutin, MD; Jeff D. Williamson, MD; Barry R. Davis, MD, PhD; Linda B. Piller, MD, MPH; Hannah Pervin, PhD; Sara L. Pressel, MS; Caroline S. Blaum, MD; for the ALLHAT Collaborative Research Group

Funding: NIH, multiple pharmaceutical companies, CMS

JAMA Intern Med. 2017;177(7):955-965.

55 years and older
Data collection: 1994-2002
Hypertension, randomized to additional antihypertensive
N=42,418

ALLHAT-LLT added pravastatin versus usual care

Inclusion:
No known CHD
LDL 120-189 mg/dL
TG <350 mg/dL

Exclusion:
Already on lipid lowering therapy or intolerant of statins
Significant renal/hepatic disease
Known secondary cause of HLD
N=10,355: 5170 pravastatin VS 5185 usual care

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Results

	Pravastatin	UC	Totals
65-74	1092	1049	2141
≥ 75	375	351	726
Totals	1467	1400	**N= 2867**

Deaths	Pravastatin	UC	HR; 95% CI; p-value
65-74	141	130	1.08; 0.85-1.37; p=0.55
≥ 75	92	65	1.34; 0.98-1.84; p=0.07
CHD events			
65-74	76	89	0.85; 0.62-1.15; p=0.29
≥ 75	31	39	0.70; 0.43-1.13; p=0.14

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Are statins beneficial as primary cardiovascular prevention in older adults?

- Han et al say "no"
- "non-significant trend toward increased all-cause mortality with pravastatin" among those 75 years and older

- Potential adverse effects of statins:
  - MSK effects including myopathy and myalgias
  - Weight loss
  - Diarrhea, N/V
  - Cognitive impairment?

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Are there any other guidelines for older adults you should know about?

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Journal of the American Geriatrics Society

Clinical Investigation | Free Access

Percutaneous Feeding Tubes in Individuals with Advanced Dementia: Are Physicians "Choosing Wisely"?

Marzena Gieniusz MD, Liron Sinvani MD, Andrzej Kozikowski PhD, Vidhi Patel MS, MBA, Christian Nouryan MA, Myia S. Williams MA, Nina Kohn MBA, MA, ... See all authors

First published: 04 October 2017 | https://doi.org/10.1111/jgs.15125

DESIGN: Multicenter, mixed-mode, anonymous questionnaire.
PARTICIPANTS: Internal medicine physicians (N = 168).
RESULTS: Ninety-nine percent of physicians reported having cared for someone with advanced dementia; 95% had been involved in the PEG decision-making process; 38% were unsure whether the ABIM/AGSChoosing Wisely recommendations advise for or against PEG tubes in advanced dementia.

CONCLUSION: Despite the scientific evidence supporting the ABIM/AGSChoosing Wisely recommendations against the use of PEG tubes in individuals with advanced dementia, numerous incentives for placement complicate the decision for PEG placement. In today's healthcare environment, it is incumbent upon healthcare practitioners to be aware of the available evidence and to provide leadership to guide this complex decision-making process to promote true person-centered care.

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Choosing Wisely
An initiative of the ABIM Foundation

American Geriatrics Society
AGS

Ten Things Clinicians and Patients Should Question

Released February 21, 2013 (1-5) and February 27, 2014 (6-10); Revised April 23, 2015 (2,3,6,7,8 and 10)

DOWNLOAD PDF

1

Don't recommend percutaneous feeding tubes in patients with advanced dementia; instead offer oral assisted feeding.

Careful hand feeding for patients with severe dementia is at least as good as tube feeding for the outcomes of death, aspiration pneumonia, functional status and patient comfort. Food is the preferred nutrient. Tube feeding is associated with agitation, increased use of physical and chemical restraints and worsening pressure ulcers.

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Avoid using prescription appetite stimulants or high-calorie supplements for treatment of anorexia or cachexia in older adults.

***AGS Choosing Wisely Workgroup. American Geriatrics Society Identifies Another Five Things That Providers and Patients Should Question. J Am Geriatr Soc 2014; 62:1-11.

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Don't use Benzodiazepines or other Sedative-Hypnotics in Older adults as choice for insomnia.

No Diphenhydramine (including OTC combination medications)

*** DO NOT STOP COLD TURKEY***

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Insomnia and Sleeping medications

- Anti-insomnia medications prescribed during hospitalizations
  "Do you need something to help you sleep?"
- Many patients become dependent.
- It's Natural: You sleep differently as you get older.

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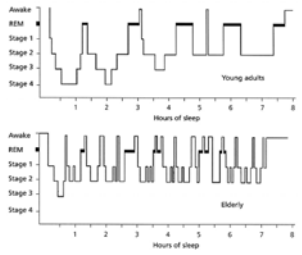
It's Cruel but Natural….

- Decreased sleep efficiency
- Increased sleep latency
- Early AM awakenings
- Shortened REM
- Decreased stage 3,4
- Stage 1 & 2 remain the same or increase



Espiritu JR. Aging-related sleep changes. Clin Geriatr Med. 2008 Feb;24(1):1-14.

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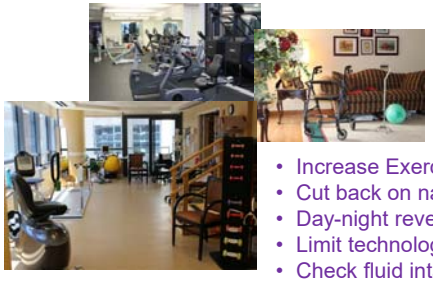
Non-Pharm Treatments of Insomnia



- Increase Exercise
- Cut back on naps
- Day-night reversals
- Limit technology in PM
- Check fluid intake in PM
- Incontinence?

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Don't use antimicrobials to treat bacteriuria in older adults unless specific urinary tract symptoms are present. [NOT MENTAL STATUS CHANGES!!!]

5

Don't use antimicrobials to treat bacteriuria in older adults unless specific urinary tract symptoms are present.

Cohort studies have found no adverse outcomes for older men or women associated with asymptomatic bacteriuria. Antimicrobial treatment studies for asymptomatic bacteriuria in older adults demonstrate no benefits and show increased adverse antimicrobial effects. Consensus criteria has been developed to characterize the specific clinical symptoms that, when associated with bacteriuria, define urinary tract infection. Screening for and treatment of asymptomatic bacteriuria is recommended before urologic procedures for which mucosal bleeding is anticipated.

***AGS Choosing Wisely Workgroup. American Geriatrics Society Identifies Another Five Things That Providers and Patients Should Question. J Am Geriatr Soc 2014; 62:1-11.

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Don't recommend screening for breast, colorectal, prostate or lung cancer without considering life expectancy and the risks of testing, overdiagnosis and overtreatment.

7

Don't recommend screening for breast, colorectal, prostate or lung cancer without considering life expectancy and the risks of testing, overdiagnosis and overtreatment.

Cancer screening is associated with short-term risks, including complications from testing, overdiagnosis and treatment of tumors that would not have led to symptoms. For prostate cancer, 1,055 older men would need to be screened and 37 would need to be treated to avoid one death in 11 years. For breast and colorectal cancer, 1,000 older adults would need to be screened to prevent one death in 10 years. For lung cancer, much of the evidence for benefit from low dose CT screening for smokers is from healthier, younger patients under age 65. Further, although screening 1,000 persons would avoid four lung cancer deaths in six years, 273 persons would have an abnormal result requiring 36 to get an invasive procedure with eight persons suffering complications.

***AGS Choosing Wisely Workgroup. American Geriatrics Society Identifies Another Five Things That Providers and Patients Should Question. J Am Geriatr Soc 2014; 62:1-11.

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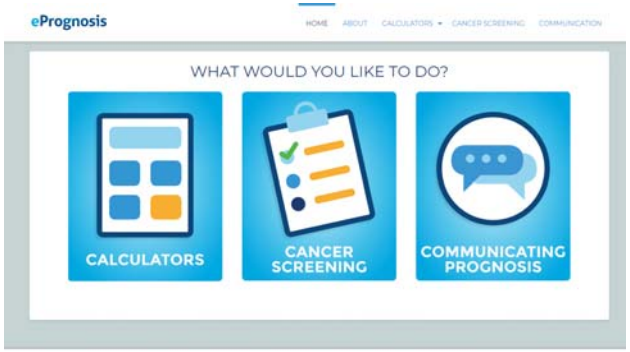
https://eprognosis.ucsf.edu/



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JAMA Internal Medicine | Original Investigation
August 1, 2017

Older Adults' Views and Communication Preferences About Cancer Screening Cessation

Nancy L. Schoenborn, MD; Kimberley Lee, MD; Craig E. Pollack, MD, MHS; Karen Armacost, RN, MSA; Sydney M. Dy, MD; John F. P. Bridges, PhD; Qian-Li Xue, PhD; Antonio C. Wolff, MD; Cynthia Boyd, MD, MPH

Abstract | Full Text

JAMA Intern Med. 2017; 177(8):1121-1128. doi: 10.1001/jamainternmed.2017.1778

This qualitative interview study examines community-dwelling older adults' perspectives on the decision to stop cancer screening when life expectancy is limited.

Objective To examine older adults' views on the decision to stop cancer screening when life expectancy is limited and to identify older adults' preferences for how clinicians should communicate recommendations to cease cancer screening.

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Table 2. Older Adults' Reasons for Stopping Cancer Screening

Reason	Example
Older age	"I just figured I'm not gonna worry about it anymore at this age. I've lived a good life ....what more can I do?"
Poor health or quality of life	"Because I felt like the quality of life I have now [is not good]. If anything happens I'd be ready to go, so why go through a lot of procedures if I don't have to."
Would not want downstream treatment	"If I would get cancer I would not want anything done as far as a procedure to cure it and that's when I made my decision [to stop screening]."
Risks or burdens of the screening test	"I just think that's too much prodding and poking of older people and unnecessary prodding and poking ... When I had my last mammogram they had me come back... for a second evaluation ...There was a lot of unnecessary anxiety and I have issues with anxiety anyway and it raised that level... and there was nothing wrong."
Physician's recommendation	"If a doctor of his caliber suggests let's not be hasty, we probably won't have to do this [prostate-specific antigen test], then I was very willing to say don't worry about it now."

Table 3. Older Adults' Objections to a Choosing Wisely Statement About Not Recommending Cancer Screening in Those With Limited Life Expectancy[a]

Objections	Example
Uncertainty of prediction	"I don't think they should do that...I don't think you can predict if a person's gonna live 10 more years."
Life expectancy can change	"I wouldn't like that because whatever's wrong with me they could come up with a cure within the time and my life expectancy could go up."
Skepticism of lag-time to benefit	"I think they probably should get [screened] because if [cancer] can be prevented if caught early. I think that ...obviously it's gonna extend your life, it should extend your life."
Statement does not account for patient preference	"It's up to the person. If they want to go through with it they can, they should leave it up to the person."
Negative wording	"That's like hitting you over the head with a hammer, I think it's too harsh."
Belief that cancer screening may still help others	"If it's not gonna help me live I still would do it because I might be helping somebody else."

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What you should and shouldn't say….

Specific wording of life expectancy was important;
Many felt the language of "you may not live long enough to benefit from this test" was unnecessarily harsh compared with the more positive messaging of "this test would not help you live longer."

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