

Individualize Geriatric Patient Assessments

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PHILADELPHIA — People in their 80s are much more varied in their physical condition than people in their 20s, Dr. Moira Fordyce said at a conference sponsored by the American Society on Aging.

As a result, a physician must carefully assess each elderly patient to determine their status and the body systems that need particular attention.

Of course, aging itself is not an illness, and aging alone does not cause illness. But aging does bring a loss of resilience to most people, and makes the possibility of illness more likely. In addition, normal aging changes coupled with the potential for having multiple problems, taking multiple medications, and having delayed diagnoses means that many disorders have an atypical presentation in the elderly, said Dr. Fordyce, a geriatrician in Belmont, Calif.

Atypical presentations are common in the elderly for disorders that include cardiovascular diseases, infections, constipation, confusion and other central nervous system disorders, diabetes and other metabolic disorders, endocrine disorders such as thyroid disease, and injuries, such as head injuries.

Symptoms and signs of disease are sometimes unreliable, such as pain, temperature, and white blood cell counts. Other types of symptoms require careful investigation, including bowel symptoms such as new-onset constipation or other changes in bowel habits, shortness of breath at rest, bleeding, and a low hemoglobin level.

Other disorders that require assessment include agitation, ankle swelling, confusion, depression, pain, stiffness, and difficulty swallowing.

The interval between physical examinations also needs tailoring to specific patient needs. In robust, older adults, a physical examination every year is not needed, although many patients like an annual connection with their doctor. Time spent with a patient is more important than screening tests, said Dr. Fordyce, who is also a clinical professor of medicine at Stanford (Calif.) University.

Screening tests must be used judiciously, with realistic expectations about the likelihood of disorder in an asymptomatic patient and the potential value of the test's results. Screening tests are limited by the risk for false-positive results, a risk that becomes substantial if enough tests are done. If 20 screening tests are performed on a

patient, there is a 64% risk that at least one will be a false positive that identifies an abnormality that really doesn't exist.

Laboratory tests also are more difficult to interpret in elderly patients, in part because the variability of normal values increases with age. But lab tests can add valuable information when they're ordered to rule out or confirm a diagnosis that is suspected based on the history and physical. They also are useful for tracking changes in elderly patients, and to monitor responses to therapy.

Multifactorial clinical syndromes are a special problem for the elderly. Falls, for example, can have several intrinsic or extrinsic causes. Elderly patients who have had more than one fall in the prior year should be carefully evaluated to find the reason.

Other multifactorial syndromes include urinary incontinence, which is not a normal consequence of aging. Incontinence is a symptom, not a disease, and while it is often neglected, all types can be helped, and some sorts even cured. Incontinence can have local causes, such as a tumor, stone, or weak pelvic floor muscles; a general cause such as dementia or stroke; causes of transient incontinence include drugs, retention, infection, and polyuria.

Confusion is more common as a presenting feature of illness than fever or pain in the elderly. It can result from medical causes, medications, mobility issues, delirium, dementia, and depression. "Find and treat the treatable [confusion] as soon as possible, and manage the irreversible," Dr. Fordyce advised.

Cognitive impairment and dementia are, of course, common syndromes affecting the elderly. About 80% of everyone older than 70 has some age-related change in their memory. But cognitive impairment and dementias involve memory loss that is worse than expected for age. About 40% of people with cognitive impairment progress to dementia within 3 years.

Dr. Fordyce recommended testing elderly patients with the 30-question, Mini-Mental Status Examination. Asking the patient to draw the face of a clock and fill in the numbers is also a sensitive test, she said. Other effective screening tools are asking the patient to name in 2 minutes as many flowers or other items in a list as they can. A patient who says they're worried about their memory usually does not have Alzheimer's disease. If a caregiver says that the patient has memory problems, Alzheimer's is much more likely, she said. ■

CLINICAL GUIDELINES FOR FAMILY PHYSICIANS

Anemia in the Long-Term Care Setting

BY NEIL S. SKOLNIK, M.D., AND PAMELA ANN FENSTEMACHER, M.D.

Anemia is seen in up to 60% of residents in the long-term care setting, and research findings show that in older patients, it is a marker for increased morbidity, mortality, hospitalization, and health care costs, as well as frailty, mobility impairment, and an increased incidence of Alzheimer's disease. This guideline was developed by the American Medical Directors Association (Clinical Practice Guideline: Anemia in the Long-Term Care Setting, 2007.)

Evaluation and Diagnosis

When evaluating the frail elderly with nonspecific symptoms, you should order a complete blood count if there isn't one from the last 6 months, or if there is suspected bleeding or any significant change in cognition or physical function. The World Health Organization defines anemia as a hemoglobin concentration of less than 12 g/dL in women and less than 13 g/dL in men.

If anemia is present, then the usefulness, type, and extent of any diagnostic evaluation need to be determined. The decision to evaluate and treat anemia may need to be shared with the patient and/or the caregiver, and should be pursued only if it is in the patient's best interest.

The choice and order of the noninvasive laboratory tests will depend on the suspected cause of the anemia and the patient's underlying disease. Suggested tests could include CBC and reticulocyte count; peripheral smear examination; ferritin, serum iron, and total iron-binding capacity; serum folate and serum B₁₂; hepatic and renal function; sedimentation rate; serum protein electrophoresis; stool for occult blood; and thyroid stimulating hormone.

Treatment

There are specific treatment options for different types of anemia, which include iron- or nutrient-deficiency anemias and anemia associated with chronic kidney disease (CKD).

Iron-deficiency anemia should be suspected if the patient has a low serum ferritin, high total iron-binding capacity, low serum iron, and low transferrin saturation. Dosing iron once daily is effective and can minimize the unpleasant gastrointestinal side effects. Iron should be taken on an empty stomach; vitamin C can be added to increase iron absorption if a reticulocyte response in 7-10 days is not adequate.

If tests show that folate levels are low, it is important not to overlook vitamin B₁₂ deficiency when you supplement with folate because that could lead to progression of any neurologic problems caused by the vitamin B₁₂ deficiency. New intranasal gel and sublingual forms of vitamin B₁₂ are more costly, but they can be helpful if the patient has dysphagia or cognitive impairment and if absorption through the gastrointestinal tract is not deficient.

In pernicious anemia and other malabsorption disorders, vitamin B₁₂ must be administered by deep subcutaneous or intramuscular injection. Anemia is present in 44% or more patients with creatinine clearance of less than 29 mL/min and is primarily caused by an under-

production of erythropoietin in the kidney.

The anemia associated with CKD can be severe and could have other causes, but it is typically not responsive to iron, vitamin B₁₂ or folate supplementation. Instead, synthetic erythropoietin-stimulating agent (ESA) therapy improves quality of life, exercise performance, and cognitive function in these patients. The therapy should be reserved for long-term care patients who are likely to obtain important clinical benefit, but the guideline does not recommend a level of hemoglobin at which treatment should be initiated.

Given the risk of cardiovascular complications when hemoglobin levels rise above 12 g/dL with ESA treatment, the patient's hemoglobin concentration should be maintained at 10-12 g/dL and measured twice a week for the first 2-6 weeks of treatment. The ESA dose should be adjusted if the hemoglobin increases by more than 1 g/dL in any 2-week period.

Patients being considered for ESA therapy should be screened for concurrent iron deficiency and treated before ESA therapy begins. Blood transfusions should be used only as a last-resort treatment for chronic anemia when the hemoglobin drops below 7 g/dL if the patient is asymptomatic, or below 8 g/dL if the patient is symptomatic. During acute blood loss that produces hypotension with associated tachycardia and tachypnea, an immediate blood transfusion is often indicated.

When monitoring anemia, pay attention to the patient's symptoms and signs, and follow up on underlying etiologies and laboratory values. Interventions must be monitored for efficacy and magnitude of response, and any underlying diseases—such as gastritis—that are causing anemia must be treated if possible. It is important to watch for any adverse effects of anemia treatment, such as allergic reactions and constipation.

The Bottom Line

Anemia is common in the frail elderly population. AMDA's guideline is for use in long-term care facilities, but it can be applied in all settings. The management of anemia should aim to optimize the patient's function and quality of life and minimize complications and negative consequences of the anemia.



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Guidelines are most useful when they are available at the point of care. A concise yet complete handheld computer version of this guideline is available for download, compliments of FAMILY PRACTICE NEWS, at www.redireference.com.