Geriatrics 101

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Let's review…

- Medicare
- Hospice
- Pain mgmt.
- Bowel business
- Delirium
- Sleep
- Bad Drugs
- Dementia

A CASE…

Mr. H is an 85 man who lives alone at home. He tripped, fell and had immediate pain in his leg. He presents to the ER where x-rays reveal a *fracture of his hip.*

What is the next appropriate step?

a. Admit for surgery and a 3 night stay

b. Admit under Observation since he will be out in 1-2- days

c. Have the family start looking for a caregiver

d. Tell the family that he will be at the SNF for 100 days

What is the next appropriate step?

a. **Admit for surgery and a 3 night stay**

b. Admit under Observation since he will be out in 1-2- days

c. Have the family start looking for a caregiver

d. Tell the family that he will be at the SNF for 100 days

Another case…

Mr. V is an 85 man who lives alone at home. He tripped, fell and had immediate pain in his arm. He presents to the ER where x-rays reveal a *fracture of his humerus.*

What is the next appropriate step?

a. Admit for pain control and a 3 night stay

b. Send to a SNF for rehab

c. Send home with home health visiting nurse

d. Have family arrange for in-home caregiver

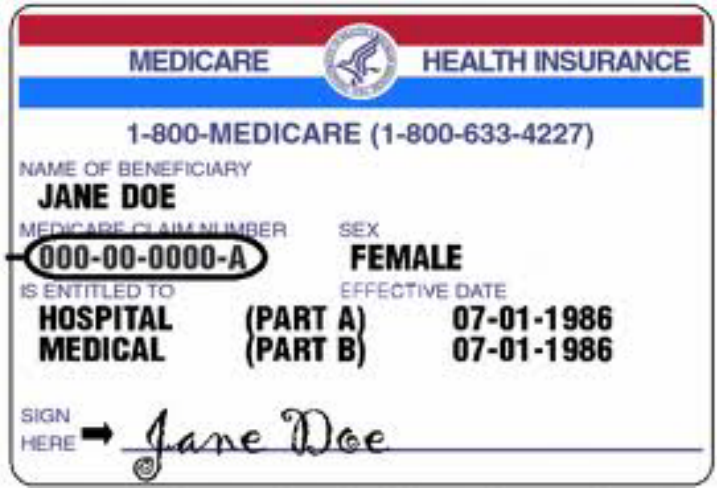
What will Medicare pay for?

- Admit for medically unnecessary pain control for 3 midnights

- **Send to a nursing home for rehab and care**
  - **private pay!**
- **Send home with home health visiting nurse**
  - **Medicare A will pay for this**
- **Have family arrange for in-home caregiver**
  - **Private pay**

What does Medicare cover? Yes, you HAVE to know this!!

- Medicare A
  - Hospital; inpatient
  - Home Care
  - Hospice
  - SNF (qualified)
- Medicare B
  - Physician office visits
  - Outpatient labs
  - New! Hospital observations stays ☹
- Medicare D
  - Prescriptions



Board question:

Medicare Part A covers all of the following **EXCEPT:**

- Inpatient hospital care
- Chronic inpatient care at a skilled nursing facility
- Hospice care
- Home health care after hospital discharge

Board question:

Medicare Part A covers all of the following **EXCEPT:**

- Inpatient hospital care
- **Chronic inpatient care at a skilled nursing facility→ cash, check or charge**
- Hospice care
- Home health care after hospital discharge

Let's keep going

Mr. B is an 85 man who lives alone at home. He tripped, fell and had immediate pain in his leg. He has a history of metastatic prostate cancer. He presents to the ER where x-rays reveal a *fracture of his hip and multiple boney lesions.*

What is the next appropriate step?

a. Admit for surgery and a 3 night stay

b. Talk to the family about hospice

c. Have the family start looking for a SNF

d. Tell the family that he will be at the SNF for 100 days under hospice

Hospice

- A defined Medicare A benefit
- Upon enrolling, you "give up" the usual Medicare
- Hospice is like an HMO for end of life care: with $153/day paid to the hospice, the pt gets…
  - Hospice team
  - DME; hospital bed, oxygen, etc
  - All meds related to the terminal condition
- Hospice care can be delivered at home, at a nursing home, or rarely, as an inpatient
- Generally, a pt will not be seeing a lot of physicians, going to the ER, getting diagnostic tests, blood transfusions, chemo, or radiation

Palliative care

- A great concept
- Not a covered Medicare benefit
- All my patients are on “palliative care” whether they know it or not
  - Symptom management
  - Cautious prescribing
  - Avoiding stupid stuff
- Families confuse palliative care with hospice

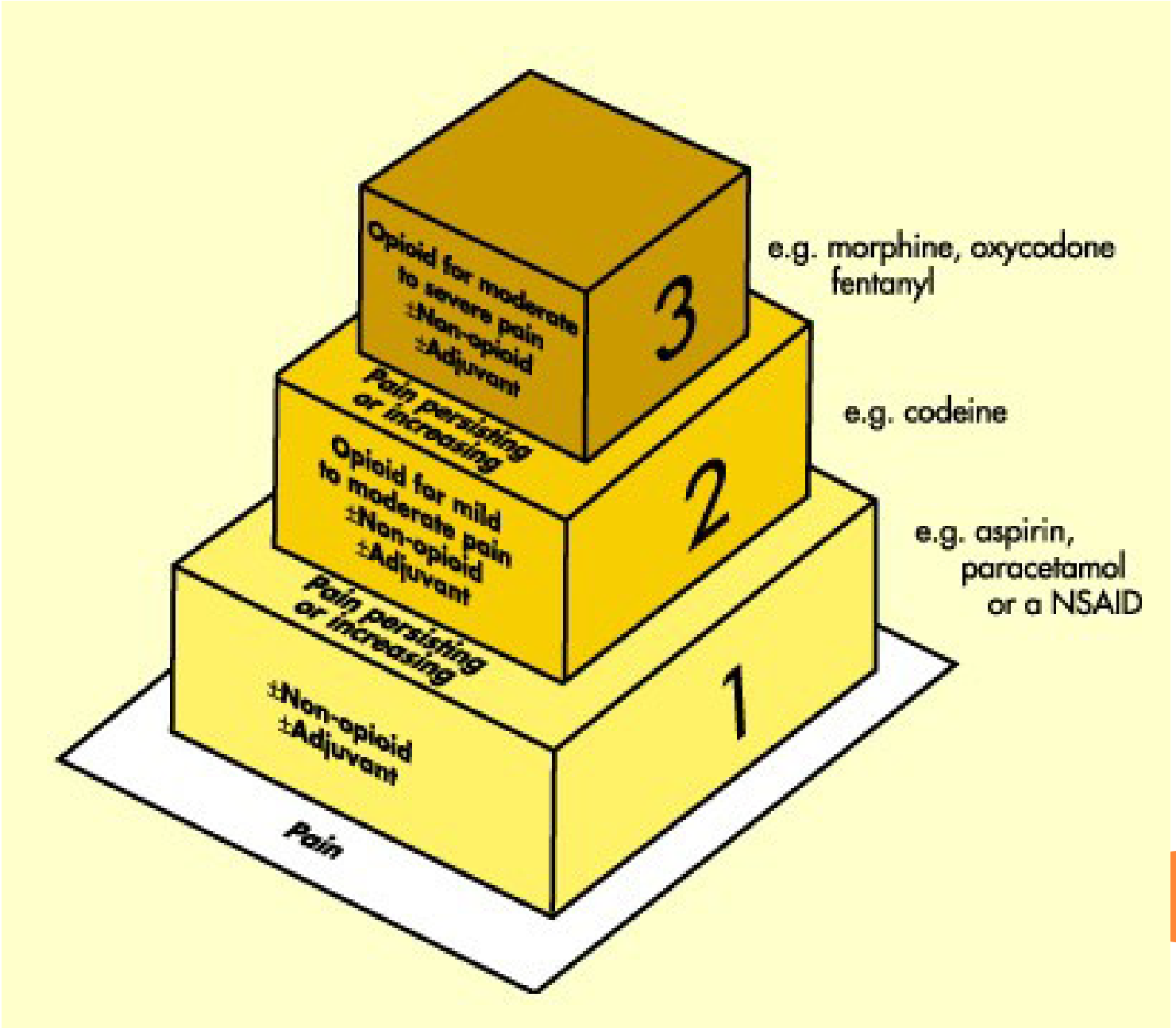
Questions on Medicare ??

- Mr. V is an 85 man who lives alone at home. He tripped, fell and had immediate pain in his arm. He presents to the ER where x-rays reveal a fracture of his humerus. He goes home with help. He has a lot of pain in his arm. NKA. No previous experience with pain meds. What pain meds would you Rx?

  - A. Tylenol 650 mg Q6h prn
  - B.Naproxen 500 mg BID
  - C. Norco 5/325 prn
  - D.Fentanyl 25 mcg patch

A ROCK AND A HARD PLACE…

- Older patient are more susceptible to pain meds' side effects
- BUT… they still need pain meds
  - Postop
  - Falls with injury
  - Chronic illnesses ex. DJD
- Remember your pain ladder


3
Opioid for moderate to severe pain
±Non-opioid
±Adjuvant
e.g. morphine, oxycodone
fentanyl
Pain persisting or increasing
2
Opioid for mild to moderate pain
±Non-opioid
±Adjuvant
e.g. codeine
Pain persisting or increasing
1
±Non-opioid
±Adjuvant
e.g. aspirin, paracetamol or a NSAID
Pain

Pointers from the trenches:

- Codeine (T#3) is soooo constipating
  - Take this out of your geri toolbox ☹
- Hydrocodone (Vicodin) is useful in small, regular doses; every 6 hours or so
- Fentanyl patch 12 mcg is a consideration, but not in opioid-naive pts
  - *Useful for long term pain needs*
  - *For example, vertebral compression fx*
- Tramadol is better tolerated but remember to renally dose

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  - A. Tylenol 650 mg Q6h prn—not effective
  - B.Naproxen 500 mg BID—not with his kidneys
  - C. **Norco 5/325 prn but encourage ATC**
  - D.Fentanyl 25 mcg patch—not for opioid naive

Bowel business

- Mr. V is an 85 man who lives alone at home. He tripped, fell and had immediate pain in his arm. He presents to the ER where x-rays reveal a fracture of his humerus. He goes home with hydrocodone one half tab every 4 hours for pain. Is there anything else he should have?
- Colace®
- Senna S ® prn constipation
- Senna S ® 2 every HS
- Compazine ® prn nausea

Bowel business

- Colace® is WIMPY (ineffective)!
  - Evidence based! Really!
- Better: Senna-S two at bedtime; increase to 8 a day, as needed!
- Prunes are magic! But not sufficient in opioid use
- Also: Miralax daily or BID (not PRN!!)
- Avoid MOM, suppositories, enema
  - a sign of **failure** to geriatricians!

LET'S GET DELIRIOUS…

Mr. H is an 85 man who is brought in from the NH with a UTI. He is pulling out his IV's and oxygen tubing. Trying to get out of bed and refusing oral meds.

What is the next appropriate step?

a. stat CT head

b. IV lorazepam

c. physical restraints

d. IV haloperidol

Let's get delirious…

Mr. H is an 85 man who is brought in from the NH with a UTI. He is pulling out his IV's and oxygen tubing. Trying to get out of bed and refusing oral meds.

What is the next appropriate step?

a. stat CT head—generally not indicated but CYA

b. IV lorazepam—makes everything worse

c. physical restraints—makes everything worse

d. **IV haloperidol—evidence based**

BAD DRUGS : THE BEERS LIST

- Dr Mark Beers
- Researched medications in the elderly in the 1980s
- Published the first Beer's List in 1991
- He died in February 2013 from complications of diabetes
- Widely uses by policymakers, etc

The Beers List: meds to avoid

- Anticholinergics
- Nitrofurantoin
  - In pts with CrCl <60 (=all)
- Clonidine
- Digoxin >0.125mg/d
- Spirinolactone >25 mg/d
- Antipsychotics
  - BBW on ↑ mortality
- Benzodiazepines!
- Megace

The Beers List: MORE meds to avoid

- Aspirin >325/d
- NSAIDs
  - Unless also on PPI
- Glyburide and SSI
- Muscle Relaxants
  - Good rule of thumb for all pts
  - They don't work "relax" muscles
  - Just sedate…ZZZZZ

I CAN'T SLEEP…

- Mrs. H tells you that she has been on sleeping pills "since before you were born". She takes Tylenol PM® one at bedtime. Her ROS is remarkable for dry mouth, constipation , and dizziness.
- What could you consider?
  - A. Restoril 15 mg at HS
  - B. Trazodone 25 mg at HS PRN
  - C. Trazodone 25 mg QHS
  - Continue her Tyl PM since she is tolerating it
  - Seroquel 25 mg at HS

Benadryl® (diphenhydramine): active ingredient in Tylenol PM®

- Anticholinergic medication
  - Dry eyes
  - Dry mouth
  - Constipation
  - Urinary retention
  - Mental confusion
- It's an allergy med!
  - Not indicated for sleep…that's just a side effect!

Sleepers

- What could you consider?
  - A. Restoril 15 mg at HS
  - B. Trazodone 25 mg at HS PRN
  - C. **Trazodone 25 mg QHS**
  - Continue her Tylenol PM since she is tolerating her side effects—should be a felony! ☹
  - Seroquel 25 mg at HS

Estimating renal function

An 80-year old man with no known renal disease or hypertension has a serum creatinine of 1.2. His height is 68 inches and weight 154 lbs. (70kg). The best estimate of his creatinine clearance is:

- 125 ml/min
- 100 ml/min
- 75 ml/min
- 50 ml/min
- 25 ml/min

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- 75 ml/min
- **50 ml/min**
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Let's try a dementia case

- Real Case: Friday afternoon, 4 pm
- Mrs. Jones calls to report that her husband, who lives at home with her and a part-time caregiver, is getting more agitated. He is getting mean and hostile in the late afternoon and often has visual hallucinations at night (dogs, children).
- He is not sleeping much at night and she is getting stressed out with his care at home
- She pleads "Please give him something to calm him down. We can't afford a nursing home!".

Which drugs are best when aggressive Alzheimer's patients need medication?

Recommendations/ Pearls

- Evaluate for delirium
- Infection
- New medications
- "Unmet needs"
  - Pain
  - Impaction or urinary retention
- Overly stimulating environment
- Music or aromatherapy

What do tell Mrs. Jones?

a. “Do you have any Tylenol PM at home?”
b. “He really just needs to go to a nursing home”
c. “Let me call in a prescription for some Xanax®”
d. “Have we ever tried Seroquel® in him?”
e. “I would do this: _____”

Background

- More than half of people with Alzheimer's develop neuropsychiatric symptoms
  - Agitation
  - Aggression
  - Delusions
  - Hallucinations
- These symptoms decrease quality of life for the patient, the family, and the caregivers
- These symptoms can lead to NH placement

Antipsychotic medications

- Antipsychotic medications have traditionally been used for these behaviors
  - Haloperidol (Haldol ®)
  - Risperidone (Risperdal®)
  - Quetiapine (Seroquel ®)

- But! not approved by the FDA!

- And! they carry a Black Box Warning
  - "elderly patients with dementia-related psychosis treated with atypical antipsychotic drugs are at an increased risk of death compared to placebo"

Bottom Line from the Research…

- Typical antipsychotics are effective for behavioral issues of dementia, but the BBW mandates careful consideration, weighing risks and benefits
  - SOR=A, based on multiple RCTs
- SSRI medications may be a safer, effective alternative
  - SOR=B, limited studies
- Non-pharmacologic therapy should be first line for all patients
  - [SOR=A, common sense]

What do tell Mrs. Jones?

a. ~~"Do you have any Tylenol PM at home?"~~
b. ~~"He really just needs to go to a nursing home"~~
c. ~~"Let me call in a prescription for some Xanax®"~~
d. "Have we ever tried Seroquel® in him?"
    a. If danger to self or others
e. "I would do this: *get a caregiver, sleep hygiene, exercise, Tylenol ATC for any pains, etc*"
f. Of course, our favorite: "Go to the ER!"

Thank you for your care of older patients!