

A SELECTION OF TEN CURRENT READINGS ON TOPICS RELATED TO GERIATRIC CARE UPDATE

Some are available as free full text and some requiring payment
Selection of readings made by A/Prof Goh Lee Gan

READING 1 – APPROACH TO THE FORGETFUL PATIENT

Yoon PS, Ooi CH, How CH. Approach to the forgetful patient. *Singapore Med J*. 2018 Mar;59(3):121-125.

Doi: 10.11622/smedj.2018026. PubMed PMID: 29568856 [Free Full Text]

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ABSTRACT

Singapore has an ageing population with a projected 53,000 people aged ≥ 60 years living with dementia by 2020. Primary care doctors have the opportunity to initiate early work-up for reversible causes of cognitive dysfunction, allowing identification of comorbidities and discussion of medical therapy options.

Early diagnosis confers the sick role on the patient, which allays frustration and explains events and behaviour that may have strained relationships with family and friends. The patient can be encouraged to plan for future health and personal care options with a Lasting Power of Attorney and/or Advance Care Planning. Objective cognitive tests (e.g. abbreviated mental test and Mini-Mental State Examination) and brain imaging are adjuncts that help in formulating the diagnosis.

Referral to a hospital memory clinic activates a multidisciplinary team approach to dementia, including clinical consultation, dementia counselling, physiotherapy sessions on gait/fall prevention, occupational therapy sessions on cognitive stimulation and caregiver training.

READING 2 – MENTAL CAPACITY ASSESSMENT – SCOPE TO IMPROVE PERFORMANCE

Chan CY, Yong SW, Mhaisalkar AS, Sin GL, Poon SH, Tan SM. Audit of Mental Capacity Assessment by Primary Care Physicians Versus Consultation-liaison Psychiatrists. *East Asian Arch Psychiatry*. 2018 Sep;28(3):95-100.

PubMed PMID: 30146497 [Free Full Text].

Chan CY(1), Yong SW(1), Mhaisalkar AS(1), Sin GL(2), Poon SH(2), Tan SM(2).

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ABSTRACT

OBJECTIVE: To review the mental capacity assessment of in-patients referred to consultation-liaison psychiatrists and to compare the assessment first made by primary care physicians.

METHODS: Medical records of in-patients who were referred to consultation-liaison psychiatrists for mental capacity assessment between May and October 2015 were retrospectively reviewed. Assessment was first made by a primary care physician; complex cases were referred to a consultation-liaison psychiatrist. Audit of each case note was conducted independently by at least two of the authors.

RESULTS: Medical records of 37 female and 26 male in-patients aged 24 to 91 (mean, 68.2) years were audited. Only 33.3% of these patients had no psychiatric diagnosis. Overall, assessments by primary care physicians were suboptimal. Assessments by consultation-liaison psychiatrists were more detailed, with documentation of mental capacity (93.7%) and psychiatric diagnosis (88.9%). Nonetheless, patient wishes and beliefs were poorly documented (19.0%), as were whether the patient had a lasting power of attorney or a court-appointed deputy (6.3%) and whether the patient had made advance care planning (0%).

CONCLUSION: Overall, mental capacity assessment was inadequately performed by primary care physicians and consultation-liaison psychiatrists. More work needs to be done to engage, educate, and empower all stakeholders involved.

READING 3 – MANAGING CHALLENGING BEHAVIOURS IN DEMENTIA

Ooi CH, Yoon PS, How CH, Poon NY. Managing challenging behaviours in dementia. Singapore Med J. 2018 Oct;59(10):514-518.

Doi: 10.11622/smedj.2018125. PubMed PMID: 30386856 [Free Full Text]

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ABSTRACT

Dementia is a condition marked by the progressive and irreversible clinical syndrome of cognitive decline that is eventually severe enough to interfere with daily living. Management of dementia is often complex and requires a multidisciplinary approach. This article discusses the behavioural and psychological symptoms of dementia (BPSD), such as agitation, insomnia, restlessness, hallucinations, anxiety and depressed mood, for which patients and their caregivers commonly seek medical advice from their primary care clinician. These symptoms can cause significant distress to patients, their families and caregivers, and may even lead to the patient being prematurely institutionalised. Management consists of assessment of BPSD and supporting the needs of the family, especially those of the caregiver, and can be both non-pharmacological and pharmacological.

READING 4 – REDUCING BPSD IN DEMENTIA

Jaïdi Y, Guilloteau A, Nonnonhou V, Bertholon LA, Badr S, Morrone I, Novella JL, Mahmoudi R. Threshold for a Reduction in Anticholinergic Burden to Decrease Behavioral and Psychological Symptoms of Dementia. J Am Med Dir Assoc. 2019Feb;20(2):159-164.e3.

Doi: 10.1016/j.jamda.2018.10.015. PubMed PMID: 30503588 [Payment required].

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ABSTRACT

BACKGROUND: A high anticholinergic burden (AB) is associated with the occurrence of behavioral and psychological symptoms (BPSDs), which are frequent in dementia.

OBJECTIVES: Our aim was to determine the threshold for a reduction in AB that would lead to a clinically significant improvement in BPSDs (in terms of frequency, severity, and disruptiveness).

DESIGN: A single-center prospective study.

SETTINGS: Dedicated geriatric care unit specializing in the management of patients with dementia.

PARTICIPANTS: The study involved older patients with dementia, hospitalized for management of BPSDs.

METHODS: One hundred forty-seven patients were included (mean age = 84.1 ±5.2 years). The AB was assessed using 3 scales, namely, the Anticholinergic Drug Scale (ADS), the Anticholinergic Cognitive Burden scale (ACB), and the Anticholinergic Risk Scale (ARS). A clinically significant improvement in BPSDs was defined as a reduction of 4 points in the frequency × severity (F×S) score of the Neuropsychiatric Inventory-Nursing Home (NPI-NH) questionnaire. The threshold for a reduction in AB that corresponded to a clinically significant improvement in BPSDs was determined by multiple linear regression.

RESULTS: One hundred forty-seven patients were included (mean age = 84.1 ±5.2 years). Using the ADS, a reduction of 2 points in AB in patients with moderate-intensity BPSDs was associated with a clinically significant improvement in the F×S score of the NPI-NH [6.34, 95% confidence interval (CI) 4.54-8.14], and a reduction of 3 points was associated with a clinically significant improvement in the occupational disruptiveness score (4.26, 95% CI 3.11-5.41).

CONCLUSIONS/IMPLICATIONS: In older patients with dementia presenting BPSDs, the risk-benefit ratio of anticholinergic drugs is debatable and, where possible, drugs with a lower AB would be preferable. Because BPSDs are a frequent cause of hospitalization, a standardized approach to analysis and reduction of AB is warranted in this population. Depending on the scale used to assess anticholinergic burden (AB), a small reduction in AB is associated with a decrease in frequency, severity, and disruptiveness of moderate-intensity BPSDs. Drugs with a high AB should be avoided where possible in older patients with dementia, and drugs with a lower AB would be preferable. Heterogeneity between the assessment scales for AB precludes generalization of the impact of a reduction in AB on BPSDs.

READING 5 – INSOMNIA IN THE OLDER ADULT

Brewster GS, Riegel B, Gehrman PR. Insomnia in the Older Adult. *Sleep Med Clin.* 2018 Mar;13(1):13-19

Doi: 10.1016/j.jsmc.2017.09.002. **PubMed PMID:** 29412980 [Free Full Text]

Brewster GS(1), Riegel B(2), Gehrman PR(3).

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ABSTRACT

Although insomnia is not a normal part of the aging process, its prevalence increases with age. Factors such as medications and medical and psychiatric disorders can increase the risk for insomnia. To diagnose insomnia, it is important for older adults to complete comprehensive sleep and health histories. Cognitive-behavioral therapy for insomnia, which includes stimulus control, sleep restriction, sleep hygiene, and cognitive therapy, is the recommended first-line treatment of insomnia and is more effective than medications for the long-term management of insomnia. Medications, such as benzodiazepines and antidepressants, should be avoided for the treatment of insomnia in older adults.

READING 6 – OSTEOSARCOPENIA

Paintin J, Cooper C, Dennison E. Osteosarcopenia. *Br J Hosp Med (Lond)*. 2018 May 2;79(5):253-258.

Doi: 10.12968/hmed.2018.79.5.253. PubMed PMID: 29727228 [Free Full text]

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ABSTRACT

Osteosarcopenia is a newly described syndrome that describes the co-existence of osteoporosis and sarcopenia, two chronic musculoskeletal conditions associated with ageing.

Osteoporosis, a condition of low bone mass and micro-architectural deterioration of bone, and sarcopenia, the loss of muscle mass, strength and function, often co-exist in a frail subset of the elderly population, leading to significantly worsened outcomes than seen in either condition alone. These include a greater risk of falls, fractures and institutionalization, and significant socioeconomic costs.

With our ageing population, osteosarcopenia is a public health concern that will become increasingly relevant in the future. Its aetiology is multifactorial, with mechanical, biochemical, genetic and lifestyle factors all contributing to involution of the 'bone-muscle unit'. Improved understanding of the interactions between muscle and bone could facilitate the development of new therapeutic agents which target muscle and bone as one.

Together with existing pharmacological, nutritional and exercise-based therapies, this should enable a more holistic approach to osteosarcopenia in the future.

READING 7 – TREATMENT OF AUTONOMIC DYSFUNCTION IN PARKINSON DISEASE AND OTHER SYNUCLEINOPATHIES

Palma JA, Kaufmann H. Treatment of autonomic dysfunction in Parkinson disease and other synucleinopathies. *Mov Disord*. 2018 Mar; 33(3):372-390.

Doi: 10.1002/mds.27344. PubMed PMID: 29508455

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ABSTRACT

Dysfunction of the autonomic nervous system afflicts most patients with Parkinson disease and other synucleinopathies such as dementia with Lewy bodies, multiple system atrophy, and pure autonomic failure, reducing quality of life and increasing mortality. For example, gastrointestinal dysfunction can lead to impaired drug pharmacodynamics causing a worsening in motor symptoms, and neurogenic orthostatic hypotension can cause syncope, falls, and fractures.

When recognized, autonomic problems can be treated, sometimes successfully. Discontinuation of potentially causative/aggravating drugs, patient education, and nonpharmacological approaches are useful and should be tried first.

Pathophysiology-based pharmacological treatments that have shown efficacy in controlled trials of patients with synucleinopathies have been approved in many countries and are key to an effective management.

Here, we review the treatment of autonomic dysfunction in patients with Parkinson disease and other synucleinopathies, summarize the nonpharmacological and current pharmacological therapeutic strategies including recently approved drugs, and provide practical advice and management algorithms for clinicians, with focus on neurogenic orthostatic hypotension, supine hypertension, dysphagia, sialorrhea, gastroparesis, constipation, neurogenic over active bladder, under active bladder, and sexual dysfunction.

READING 8 – FACTORS THAT LEAD TO HOSPITALISATION IN PATIENTS WITH PARKINSON DISEASE

Koay L, Rose J, Abdelhafiz AH. Factors that lead to hospitalisation inpatients with Parkinson disease-A systematic review. *Int J Clin Pract.* 2018Jan;72(1).

Doi: 10.1111/ijcp.13039. PubMed PMID:29119656 [Payment required].

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ABSTRACT

OBJECTIVES: Parkinson disease (PD) frequently leads to acute hospitalisation resulting in increased cost to health care systems and reduced quality of life for patients. The objective of this review was to identify causes that lead to acute hospitalisation of patients with PD.

METHODS: A systematic review of English language literature from 1997 to present.

FINDINGS: The incidences of acute general medical or surgical problems that trigger acute hospitalisation in patients with PD are similar to those in the general population. However, falls, acute decompensation of PD symptoms and infections are far more common in PD patients and are responsible for more than 50% of the causes of hospitalisation in this patients' group.

IMPLICATIONS: Preventive strategies to avoid decompensation of PD symptoms and early detection and treatment of infections are needed to reduce hospitalisation in patients with PD.

READING 9 – HEALTH-RELATED QUALITY OF LIFE LOSS ASSOCIATED WITH FIRST-TIME STROKE

Yeoh YS, Koh GC, Tan CS, Tu TM, Singh R, Chang HM, De Silva DA, Ng YS, Ang YH, Yap P, Chew E, Merchant RA, Yeo TT, Chou N, Venketasubramanian N, Lee KE, Young SH, Hoening H, Matchar DB, Luo N. Health-related quality of life loss associated with first-time stroke. *PLoS One.* 2019 Jan 28;14(1):e0211493.

Doi: 10.1371/journal.pone.0211493. PubMed PMID: 30689666 [Full Free Text]

Yeoh YS(1), Koh GC(1), Tan CS(1), Tu TM(2), Singh R(2), Chang HM(3), De SilvaDA(3), Ng YS(4), Ang YH(5), Yap P(5), Chew E(6), Merchant RA(7), Yeo TT(8), ChouN(8), Venketasubramanian N(9), Lee KE(10), Young SH(11), Hoening H(12)(13), Matchar DB(14)(15), Luo N(1).

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ABSTRACT

OBJECTIVES: This study aimed to quantify health-related quality of life (HRQoL) loss associated with first episode of stroke by comparing patient-reported HRQoL before and after stroke onset. The impact of stroke in local population was also evaluated by comparing the pre- and post-stroke HRQoL with that of the general population.

METHODS: The HRQoL of stroke survivors was assessed with the EQ-5D-3L index score at recruitment, for recalled pre-stroke HRQoL, and at 3 and 12 month post-stroke. Change in HRQoL from pre-stroke to 3 and 12 month was self-reported by 285 and 238 patients, respectively. Mean EQ index score at each time point (baseline: 464 patients; 3 month post-stroke: 306 patients; 12 month post-stroke: 258 patients) was compared with published population norms for EQ-5D-3L.

RESULTS: There was a significant decrease in HRQoL at 3 (0.25) and 12 month (0.09) post-stroke when compared to the retrospectively recalled patients' mean pre-stroke HRQoL level (0.87). The reduction at 3 month was associated with the reduction in all EQ-5D-3L health dimensions; reductions remaining at 12 month were limited to dimensions of mobility, self-care, usual activities, and anxiety/depression. Stroke patients had a lower mean EQ index than the general population by 0.07 points pre-stroke (0.87 vs. 0.94), 0.33 points at 3 month (0.61 vs. 0.94) and 0.18 points at 12 month (0.76 vs. 0.94) post-stroke.

CONCLUSIONS: Stroke has a substantial impact on HRQoL in Singapore, especially in the first three months post-stroke. Compared to the general population, stroke survivors have lower HRQoL even before stroke onset. This pre-stroke deficit in HRQoL should be taken into account when quantifying health burden of stroke or setting goals for stroke rehabilitation.

READING 10 – ESPEN GUIDELINE CLINICAL NUTRITION IN NEUROLOGY

Burgos R, Bretón I, Cereda E, Desport JC, Dziewas R, Genton L, Gomes F, Jésus P, Leischker A, Muscaritoli M, Poulia KA, Preiser JC, Van der Marck M, Wirth R, Singer P, Bischoff SC. ESPEN guideline clinical nutrition in neurology. Clin Nutr. 2018 Feb;37(1):354-396.

Doi: 10.1016/j.clnu.2017.09.003. PubMed PMID: 29274834 [Payment required].

Burgos R(1), Bretón I(2), Cereda E(3), Desport JC(4), Dziewas R(5), Genton L(6), Gomes F(7), Jésus P(4), Leischker A(8), Muscaritoli M(9), Poulia KA(10), Preiser JC(11), Van der Marck M(12), Wirth R(13), Singer P(14), Bischoff SC(15).

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ABSTRACT

Neurological diseases are frequently associated with swallowing disorders and malnutrition. Moreover, patients with neurological diseases are at increased risk of micronutrient deficiency and dehydration.

On the other hand, nutritional factors may be involved in the pathogenesis of neurological diseases. Multiple causes for the development of malnutrition in patients with neurological diseases are known including oropharyngeal dysphagia, impaired consciousness, perception deficits, cognitive dysfunction, and increased needs. The present evidence- and consensus-based guideline addresses clinical

questions on best medical nutrition therapy in patients with neurological diseases. Among them, management of oropharyngeal dysphagia plays a pivotal role. The guideline has been written by a multidisciplinary team and offers 88 recommendations for use in clinical practice for amyotrophic lateral sclerosis, Parkinson's disease, stroke and multiple sclerosis.