Comprehensive Geriatric Assessment

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Objectives

• To review the components of a comprehensive geriatric assessment and to describe the elements of each component
• To review tools to screen elderly patients for geriatric syndromes
• To provide a general overview of best prescribing practices in elderly patients
• To discuss a basic functional assessment that can be utilized efficiently

Components of a comprehensive geriatric assessment

• Systems assessment
• Review of chronic medical problems
• Medication / Polymedicine review
• Psychosocial assessment
• Functional Assessment
• Physical Exam
• Overall assessment and plan
Tools to screen elderly patients for geriatric syndromes

- MNA
- Whisper Test
- Minicog, SLUMs, MoCA
- GDS
- ADLs, IADLs
- Get up and Go
- Katz Index, Other Tools

Best prescribing practices in elderly patients

- START and STOPP
- Beers

Basic functional assessment that can be utilized efficiently

- Brown bag medication review
- Cognitive / Psych eval
- Functional eval short cuts
- Bladder issues
What is Comprehensive Geriatric Assessment?
• British geriatricians first developed CGA in 1930s
• Structured approach to assess older adults
• Multidimensional, multidisciplinary assessment
• Used to evaluate an older person’s functional ability, physical health and chronic medical problems, medications, mental health, cognition, social situation / environment, health maintenance, immunizations, and advance care planning

When to do this?
• Initiated when primary care physician detects a problem or geriatric syndrome such as falls, incontinence, dementia, frailty, functional decline or suspects a social or psychological issue

What can this assessment do?
• Useful in identifying new medical problems, developing treatment plans, simplifying and optimizing medication regimens, and planning for future long term care needs and appropriate placement
• Provides integrated plan for treatment, rehabilitation, support, and long term planning
• Define goals of care
Comprehensive

- Includes nonmedical domains including functional assessment and social situation
- Emphasizes quality of life and planning
- Often incorporates a multidisciplinary team including physician, nurse, clinical pharmacist, social worker, dietician, physical and occupational therapists

CGA Domains

- Physical Health: chronic medical problems; medication review; nutrition assessment
- Mental Health: cognitive evaluation and mood evaluation
- Functional Assessment: IADLs, ADLs, mobility
- Social Assessment: social network, support, caregivers

Can incorporate into Primary Care

- time management concerns in assessing older adults
- more problem directed rather than comprehensive
- rolling assessment over several visits – focus on at least one domain to screen at each office visit; can use patient assessment instruments
Evidence of benefit in inpatients

• Hospital patients who received CGA more likely to be alive and at home at 6 months rather than institutionalized
• For inpatients, CGS results in increased independence and reduced mortality (for inpatients at 6 months); reduction in functional decline

Medical / Systems Assessment

• Constitutional: eating, appetite changes, weight changes, sleep issues
• Pain Assessment
• Teeth: tooth loss, dentures, problems chewing, swallowing; see a dentist
• Nutrition: have you lost or gained 10 pounds in the last 6 months
• Vision Assessment / Optometry / Ophthalmology referral
• Hearing
• CVS: chest pain, palpitations, orthopnea, swelling
• Respiratory: dyspnea, cough
• GU: dysuria, difficulty emptying bladder, weak stream; incontinence
• GI: Constipation, Diarrhea, Abdominal pain, blood in stool, nausea, vomiting
• Neuro: falls, weakness, numbness, tingling
• MS: arthralgia, myalgia, stiffness
• Ext: swelling, pain

Chronic Medical Problems

• At least one chronic health condition in most older adults
• Hypertension, arthritis, heart disease, cancer, diabetes, asthma, COPD, stroke
Prescribing for the older adult

- Consider nonpharmacologic approaches – try to avoid unnecessary drugs
- Consider the risk versus the benefit before prescribing any drug
- Set specific goals and timelines for assessing drug therapy outcomes
- Discontinue unnecessary or ineffective therapy
- Use safe alternatives instead of high risk drugs
- When initiating new agents, start with lower doses, titrate slowly, increase as indicated
- Include pharmacists on the interdisciplinary team

Polymedicine is huge

- Consider any new symptom as a possible drug side-effect; any new symptoms in an elderly patient should be considered a drug effect unless proven otherwise; treating a new symptom that may be drug related with another medication can lead to polymedicine where patient is taking excessive and unnecessary medications

Medications

Big Issue: Anticholinergic Medications
- Falls
- Sedation
- Confusion
- Urinary Retention
- Constipation
- Dry mouth
- Glaucoma, dry eyes
- Memory impairment
Medications with Definite Anticholinergic Effects

- Amantadine
- Amitriptyline
- Amoxapine
- Atropine
- Benztropine
- Brompheniramine
- Carbamazepine
- Chlorpheniramine
- Chlorpromazine
- Clozapine
- Cyclobenzaprine
- Desipramine
- Dicyclomine
- Diphenhydramine
- Doxepin
- Hydroxyzine
- Hyoscyamine
- Imipramine
- Meclizine
- Methocarbamol
- Nortriptyline
- Olanzapine
- Oxycodone
- Perphenazine
- Promethazine
- Quetiapine
- Scopolamine
- Thioridazine
- Tolterodine
- Trifluoperazine

Problem Drugs and Their Alternatives

Antihistamines: First Generation: Side effects

First Generations Antihistamines
- Brompheniramine
- Carboxamine
- Chlorpheniramine
- Clemastine
- Diphenhydramine
- Dimenhydrinate
- Hydroxyzine

Alternatives:
- Allergies or Itching – Use Loratidine or Cetrizine
- Insomnia
  - Sleep hygiene
  - Melatonin
  - Mirtazapine
  - Trazodone
Antidepressants

- Amitriptyline
- Amoxapine
- Clomipramine
- Desipramine
- Doxepin
- Imipramine
- Nortriptyline
- Paroxetine
- Trimipramine

- SSRIs: sertraline, citalopram (max 20 mg), lexapro
- SNRIs: venlafaxine, duloxetine
- Other: mirtazapine, bupropion

Pain

NO NSAIDS!!!!!!!!!!!!

- Kidney damage
- GI bleeding
- Hypertension
- Edema

Avoid anticholinergic muscle relaxants:
- Cyclobenzaprine
- Methocarbamol

First Line: Acetaminophen scheduled

- Neuropathic pain – gabapentin; pregabalin
- Consider duloxetine (watch renal function and don’t use with liver issues)
- Topicals
- Physical therapy
- Alternatives: chiropractic, acupuncture, Tai Chi

STOPP and START criteria – for detecting potentially inappropriate prescribing in old age; 2003

STOPP – screening tool of older persons (potentially inappropriate) prescriptions = potential errors of prescribing commission

START – screening tool to alert to right treatment = potential error of prescribing omission
STOPP – screening tool of older persons (potentially inappropriate) prescriptions = potential errors of prescribing commission

- **Central Nervous System**
  - 1. Tricyclic antidepressants (TCA's) with dementia (risk of exacerbating Parkinsonism)
  - 2. TCA's with constipation
  - 3. TCA's with cardiac conductive abnormalities
  - 4. TCA's with glaucoma
  - 5. Anticholinergic antispasmodic drugs with chronic constipation
  - 6. TCA's with prostatism or prior history of urinary retention
  - 7. Long-term (i.e. > 1 month) neuroleptics as long-term hypnotics
  - 8. Phenothiazines in patients with epilepsy
  - 9. Prolonged use (> 1 week) of first generation antihistamines i.e. diphenydramine, chlorpheniramine, cyclizine
  - 10. Long-term (i.e. > 3 months) use of diltiazem or verapamil with NYHA Class III or IV heart failure
  - 11. Use of dipyridamole as monotherapy for cardiovascular secondary prevention
  - 12. Aspirin at dose > 150mg day
  - 13. Prolonged use (> 1 week) of loop diuretic as first-line monotherapy for hypertension
  - 14. Nebulised ipratropium with glaucoma
  - 15. Warfarin for first, uncomplicated deep venous thrombosis for longer than 6 months duration
  - 16. Warfarin for first uncomplicated pulmonary embolus for longer than 12 months duration
  - 17. Long-term corticosteroids (> 3 months) as monotherapy for rheumatoid arthritis or osteoarthritis
  - 18. Aspirin, clopidogrel, dipyridamole or warfarin with concurrent bleeding disorder
  - 19. Non-steroidal anti-inflammatory drug (NSAID) with history of peptic ulcer disease or gastrointestinal bleeding
  - 20. Theophylline as monotherapy for COPD.

- **Respiratory System**
  - 1. Anticholinergic drugs with bronchitis (risk of increased post-bronchitis state).
  - 2. NSAID with moderate-severe hypertension (moderate: 160/100mmHg – 179/109mmHg; severe: ≥180/110mmHg)
  - 3. NSAID with heart failure
  - 4. Long-term use of NSAID (>3 months) for relief of mild joint pain in osteoarthritis
  - 5. Alpha-blockers in males with frequent incontinence i.e. one or more episodes of incontinence daily
  - 6. Alpha-blockers with long-term urinary catheter
  - 7. Use of diltiazem or verapamil with NYHA Class III or IV heart failure
  - 8. Calcium channel blockers with chronic constipation
  - 9. Long-term use of calcium channel blockers (risk of exacerbating Parkinsonism)
  - 10. Calcium channel blockers with chronic glaucoma
  - 11. Calcium channel blockers with acute exacerbation of heart failure
  - 12. Calcium channel blockers with chronic renal failure

- **Gastrointestinal System**
  - 1. Diphenoxylate, loperamide or codeine phosphate for treatment of diarrhoea of unknown cause (risk of delayed diagnosis, may exacerbate constipation with overflow diarrhoea, may precipitate toxic megacolon in inflammatory bowel disease, may exacerbate peptic ulcer disease, may worsen acute inflammatory bowel disease)
  - 2. Diphenoxylate, loperamide or codeine phosphate for treatment of severe infective gastroenteritis i.e. bloody diarrhoea (risk of severe dehydration, risk of severe electrolyte disturbance, risk of acute renal failure, risk of delayed diagnosis, risk of toxic megacolon in inflammatory bowel disease, risk of acute exacerbation of peptic ulcer disease, risk of exacerbating Parkinsonism)
  - 3. Prochlorperazine (Stemetil) or metoclopramide with Parkinsonism
  - 4. PPI for peptic ulcer disease at full therapeutic dosage for > 8 weeks

- **Psychotropic System**
  - 1. Long-term (>3 months) use of benzodiazepines with long-acting metabolites e.g. diazepam
  - 2. Benzodiazepines with long-acting metabolites (risk of exacerbating Parkinsonism, risk of exacerbation of tachycardia, risk of severe constipation, risk of severe skin reaction)
  - 3. Benzodiazepines with long-acting metabolites (risk of exacerbating constipation, risk of exacerbating Parkinsonism, risk of exacerbation of tachycardia, risk of severe skin reaction)
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  - 20. Benzodiazepines with long-acting metabolites (risk of exacerbating Parkinsonism, risk of exacerbation of tachycardia, risk of severe skin reaction)
G. Endocrine System

1. Glibenclamide or chlorpropamide with type 2 diabetes mellitus (risk of prolonged hypoglycaemia).
2. Beta-blockers in those with diabetes mellitus and frequent hypoglycaemic episodes i.e. ≥ 1 episode per month (risk of masking hypoglycaemic symptoms).
3. Oestrogens with a history of breast cancer or venous thromboembolism (increased risk of recurrence).

H. Drugs that adversely affect those prone to falls (≥ 1 fall in past three months)

1. Benzodiazepines (sedative, may cause reduced sensorium, impaired balance).
2. Neuroleptic drugs (may cause gait dyspraxia, Parkinsonism).
3. First generation antihistamines (sedative, may impair sensorium).
4. Vasodilator drugs known to cause hypotension in those with persistent postural hypotension i.e. recurrent > 20mmHg drop in systolic blood pressure (risk of syncope, falls).
5. Long-term opiates in those with recurrent falls (risk of drowsiness, postural hypotension, vertigo).

I. Analgesic Drugs

1. Use of long-term powerful opiates e.g. morphine or fentanyl as first line therapy for mild-moderate pain (WHO analgesic ladder not observed).
2. Regular opiates for more than 2 weeks in those with chronic constipation without concurrent use of laxatives (risk of severe constipation).
3. Long-term opiates in those with dementia unless indicated for palliative care or management of moderate/severe chronic pain syndrome (risk of exacerbation of cognitive impairment).

J. Duplicate Drug Classes

Any duplicate drug class prescription e.g. two concurrent opiates, NSAID’s, SSRI’s, loop diuretics, ACE inhibitors. Prolonged use of monotherapy within a single drug class should be observed prior to considering a new class of drug, including duplicate prescribing of related beta agonists (long and short acting) for asthma or COPD.

Examples:

- Loop diuretic for edema
- Loop diuretic as first line therapy for hypertension
- Aspirin greater than 150 mg per day: increased bleeding risk, no increased efficacy
- TCAs
- Long term benzodiazepines
- Prolonged use of first generation antihistamines
- Long term NSAID use

START – screening tool to alert to right treatment = potential error of prescribing omission

- Warfarin for atrial fibrillation
- Aspirin for ASCVD
- Statin for ASCVD where the patient’s functional status remains independent for ADLs and life expectancy is greater than 5 years
- Ace inhibitor for CHF and after MI
- Calcium and vitamin D for osteoporosis
- Metformin
Handy Pocket Cards

AGS BEERS CRITERIA
FOR POTENTIALLY INAPPROPRIATE
MEDICATION USE IN OLDER ADULTS

Do a Brown Bag Review of Medications

Psychosocial Assessment
Social History

- marital status / children / caregivers
- home environment; caregiver burden
- education
- substances; tobacco, alcohol, drugs
- sexual activity

Advance Planning

- Living will, advance directive, POLST
- Education
- Planning for increased level of care

Social Support Network

- Critical in maintaining safety in the community
- Caregiving status
- Social networks: personal contact including family, friends, contacts, formal and informal caregivers; number of people is important but also availability and frequency of contact
- Economic resources (caregivers, assisted living, senior living)
Elder Abuse Screen
1. Has anyone at home ever hurt you
2. Are you afraid of anyone in your family
3. Has anyone ever scolded or threatened you
4. Are you receiving enough care at home
5. Financial exploitation

Financial Issues / Financial Exploitations

Red Flags in Patient History
- social isolation
- bereavement
- dependence on another to provide care
- financially responsible for adult child or spouse
- alcohol or drug abuse
- depression or mental illness
Red Flags from clinical observations

- cognitive problems
- fearful, emotionally labile, or distressed
- suspicious, delusional
- change in appearance, poor hygiene
- accompanied by caregiver who is overly protective; dominates patient
- change in ability to perform activities of daily living including self-care, daily finances, medication management

Questions to ask:

Introductory question: We find that some older adults worry about money; may I ask you a few questions about this?
  - Who manages your money day to day? How is that going?
  - Do you run out of money at the end of the month?
  - Do you regret or worry about financial decision you’ve recently made?
  - Have you given power of attorney to another person?
  - Do you have a will? Has anyone asked you to change it?

Are you having any of the following common concerns?

- I have trouble paying bills because the bills are confusing to me
- I don’t feel confident making big financial decisions alone
- I don’t understand financial decisions that someone else is making for me
- I give loans or gifts more than I can afford
- My children or others are pressuring me to give them money
- People are calling me or mailing me asking for money, lotteries
- Someone is accessing my accounts or money seems to be disappearing
Cognitive Evaluation

- Screening Test
- Assess functional status
- Neuropsychological testing when in doubt
- Check labs – CBC, CMP, TSH, B12 (maybe RPR, HIV)
- Head Imaging

Minicog

- 1. 3 word recall
- 2. Clock Draw Test = normal if all numbers are present in the correct sequence and the hands display the correct time in a readable way
- Patients recalling none of the words are classified as demented
- Patients recalling all three words are classified as non-demented
- Patients with intermediate (one to two) word recall are classified based on the CDT (abnormal = demented; normal = non demented)
SLUMS

MoCA
- http://www.mocatest.org/
Depression Evaluation: Geriatric Depression Scale

Sleep
- Do you experience problems with sleeping?
- Do you use sleeping medications, if so, how often?
- No benadryl, sedative hyphotics
- Try melatonin, mirtazapine, trazodone, sleep hygiene

Functional Assessment: SHAFTTT
- IADLs = instrumental activities of daily living = associated with independent community living
- Shopping
- Housekeeping
- Accounting
- Food preparation
- Taking medication
- Transportation
- Talking on the Phone
IADL questions of Lawton and Brody

- IADL functioning
- IADL dependency

Functional Assessment: DEATH

- ability to perform tasks required for daily living
- activities of daily living: essential elements of self-care
- dressing, eating, ambulating/transferring, toileting, hygiene/bathing

Katz Index of Independence in Activities of Daily Living

ADL functioning
Assess ADL dependency
Functional Assessment

• observe patient performing simple task such as buttoning / unbuttoning, picking up a pen and writing a sentence, putting on shoes, climbing up and down from exam table
• deficits indicate need for more in-depth evaluation such as home PT/OT evaluation, need for additional assistance

Gait Assessment

• Get up and Go = rise from chair with arms crossed, walk 10 feet, turn around, walk back to chair, sit down; normal time required to complete test = 7-10 seconds; further evaluation required if test not performed in 20 seconds; can use assistive device
• PBASS
  --posture
  --balance
  --armswing
  --stance
  --stride

Falls: General Questions to Ask

• Have you had a fall in the last 6 months? Have you fallen once or more in the past twelve months?
• Have you fallen since your last visit?
• Are you afraid of falling?
• Do you feel off balance?
• Do you use an assistive device to walk?
• Do you have vision problems?
• Do you have problems with weakness?
• Do you have arthritis?
• Frequency of falls?
• Do you experience dizziness?
• Are you using a walking aid
• Do you exercise?
More on History Taking -- Falls

- Circumstances of fall -- activity at time of fall, location, time, footwear, lighting
- Associated symptoms -- lightheadedness, vertigo, syncope, weakness, confusion, palpitations, joint pain, joint stability, foot pain
- Injuries
- Past medical history -- stroke, parkinsonism, cardiac disease, diabetes, seizures, depression anxiety, anemia, sensory problem, vision loss, osteoarthritis, osteoporosis, thyroid, renal disease, cognitive impairment, urinary incontinence, diabetes, neuropathy, NPH, low vitamin D, vertigo
- Mobility difficulties
- Environment: potentially contributing environmental factors (lighting, floor coverings, door thresholds, railings, furniture)

Physical Exam for Falls

- Orthostatic blood pressure; orthostatic hypotension = drop in systolic blood pressure greater or equal to 20 mm Hg or greater or equal to 20% with or without symptoms either immediately or within 3 min of rising from lying to standing
- Vision -- visual acuity, visual fields, cataracts
- Musculoskeletal -- arthritis, gait problems; get up and go test
- Neurological exam; gait, righting, romberg
- Heart exam -- arrhythmia
- Cognitive evaluation
- Foot exam -- pulses, monofilament, vibration, reflexes

Falls

- Assess ADLs
- Assess Depression / GDS
- Assess Cognition / SLUMS
- Assess medications
Work Up Falls

- FRAX / Dexa
- Labs -- CBC, CMP, TSH, B12, D
- Cardiac eval, EKG, echo, holter
- Head imaging / spinal imaging
- Drug concentrations

Help for Falls

- PT/OT -- home exercise program; exercise classes incorporating more than one type of exercise (e.g., gait training, balance, strengthening) are effective in reducing the rate of falls; Tai Chi
- Eye care referral; avoid multifocal lenses
- Manage hypotension; educate patient to sit for 2-3 minutes before transferring from lying to standing; educate patient to clench hands or pump ankles prior to standing or when feeling lightheaded; pressure stockings; liberalize salt intake; 1 cup of caffeinated coffee for postprandial hypotension

Help for Falls

- Supplemental vitamin D; vitamin D to achieve a vitamin D level greater than 30
- Podiatry / orthotics
- Home safety eval / modifications / assistive device
- Treat depression / memory problems
- Refer to neurology, cardiology if needed
- Stop bad medications (anticholinergic, etc.)
- Additional supervision and support from caregivers
Driving

- Fender benders
- Accidents / near misses
- Tickets / traffic citations
- Getting lost
- Changes in driving practices
- Ask patient and ask family
- Others criticized driving / refused to drive with patient

Urinary Incontinence: History

- Onset, duration, frequency, volume, timing, precipitants (e.g., caffeine, diuretics, alcohol, cough, physical activity, medications); pad use
- Red Flag symptoms that require prompt evaluation – sudden onset, pelvic pain, hematuria
- Lower urinary tract symptom review: frequency, nocturia, slow stream, hesitancy, interrupted voiding, terminal dribbling; dysuria
- Fluid intake
- Medications
- Previous Treatments

More Incontinence Questions

- During the last 3 months, have you leaked urine? Have you leaked urine in the past 3 months? What were you doing when leaking occurred?
- Stress Incontinence Questions
  - When you are performing physical activity or when you cough, sneeze, lift, exercise? Stress
  - Urge Incontinence Questions
    - Was there a sense of urgency when leaking occurred?
    - Can’t get to the toilet fast enough
    - Lock in key
    - Running water
    - Up in bed
    - Both – Mixed
    - Other
    - Functional = cannot get to the bathroom; mentally or physically
    - Overflow = bladder chronically full
Incontinence:
Assess precipitating and aggravating factors

- Delirium
- Infection: check UA; urgency, frequency, UTI – treat once; if bacteria and incontinence – if no improvement, do NOT treat because this is asymptomatic bacteriuria
- Atrophic vaginitis: pelvic – vaginal estrogen; uro/gyn
- Pharmaceuticals
- Psychological: depression, delirium – treat both
- Excessive urination, edema; Endocrine – diabetes
- Restricted mobility
- Stool impaction: constipation – treat this and urinary incontinence improves

Drugs

- Medication review; otc; caffeine – bladder irritant and mild diuretic; new medications; sedative, ace inhibitors (cough), antispychotics (parkinsonism, OAB), diuretics, alpha blockers, anticholinergices and narcotics – incomplete bladder emptying and overflow

Labs

- UA, culture, chem 7, PVR
Physical Health Assessment

- Medical history, review of systems, past and chronic, ongoing medical problems, family and social history

Physical Assessment

- Focus on geriatric syndromes
- Nutrition, weight changes, sleep issues, dental problems, swallowing issues, pain assessment, vision, hearing, incontinence, constipation, falls, arthritis

Physical Exam

- Observe for loss of subcutaneous fat, muscle loss, fluid accumulation
- Oral exam: condition of lips, tongue, teeth, dentures
- Measure height and weight; weight loss: loss of lean mass / sarcopenia and associated with functional decline
Physical Exam

Upper extremity evaluation
• Proximal = touch the back of your head with both hands
• Distal = pick up the pen
• Examine for pain, weakness, limited ROM
• Consider PT referral

Lower extremity evaluation
• timed get up and go test = rise from chair, walk 10 feet, return, sit down; abnormal > 15 seconds

Nutrition
• MNA – screening tool for nutrition to identify elderly who are malnourished or at risk of malnutrition
  • http://www.mna-elderly.com/
• DETERMINE
  • http://www.healthcare.uiowa.edu/igec/tools/categoryMenu.asp?categoryID=9
• physiologic changes of aging can impact nutrition
• sensory impairment (taste and smell) can reduce appetite
• Olfactory changes lead to altered taste; also decreased ability to discriminate salty, sweet, sour, bitter
• poor dental hygiene and oral health can cause problems with chewing and poor quality food
• vision and hearing loss and loss of mobility can effect ability to shop and prepare food
• isolation and depression can also result in altered eating habits and risk of malnutrition
Causes of weight loss; weight loss of 5% of usual body weight in 6-12 months

- Medications
- Poor oral health / dental hygiene
- Anosmia (loss of smell)
- Restrictive medical diet (low salt, low fat, low carbohydrate)
- Dysphagia diet (thickeners)
- Social isolation
- Inadequate resources for transportation / shopping / cooking (financial or caregiver)
- Depression
- Dementia
- Inflammatory disease
- Hyperthyroidism
- Infection
- Malignancy
- End stage disease such as heart failure or COPD

Medications associated with weight loss

- Ace inhibitors, lithium, antihistamines (altered state or saliva)
- SSRI and SNRI (anorexia)
- Benzodiazepines, antipsychotics (excessive sedation)
- NSAIDs, amiodarone, digoxin, iron, opiates (GI complaints)
- Medication side effects cause problems: change in taste and smell, xerostomia, GI upset, slow gastric motility, early satiety, changes in thirst, anorexia

Hearing and Vision

- Hearing: do you experience hearing difficulties
- Vision: do you experience difficulties with your vision
- Whisper test = stand approximately 3 feet behind patient and whisper a series of letters and numbers after exhaling to assure a quiet whisper = failure to repeat most of the letters and numbers indicates hearing impairment; audiology referral
Health Maintenance / Disease prevention / Screening

• weigh potential harms of screening with benefits
• consider patient and family preferences, functional status, co-morbid conditions, and life expectancy

Other Tools

• http://www.healthcare.uiowa.edu/igec/tools/
• University of Iowa Assessment Tools

References

References