Approach to a Patient with Cognitive Complaints-Dementia, Delirium, and Depression in the Older Adult

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YOU KNOW YOU ARE GROWING OLD WHEN
HAPPY HOUR IS A NAP!
SayingImages.com

Objectives:

Identify neurological and psychiatric disorders that can cause cognitive complaints

Describe indications and components of neuropsychological testing

Recognize the characteristic features of the most common types of dementia.

Compare and contrast mild cognitive impairment, dementia, depression, and delirium

NORMAL AGING/MILD COGNITIVE IMPAIRMENT/DEMENTIA

Normal aging- It's okay to forget where you put your keys

Mild Cognitive impairment- Objective cognitive impairments but this does not interfere with Activities of Daily Living (ADL's)

Dementia-Per the National Institute on Aging "Dementia is the loss of cognitive functioning- thinking, remembering, and reasoning- to such an extent that it interferes with a person's daily life and activities."

Differential Diagnosis

- Normal aging
- Polypharmacy/medication side effect
- Mild cognitive impairment
- Dementia
- Depression
- Metabolic disorders
- Toxins

So where do I start?

- History/history/history
- Exam
- Labs
- Imaging
- Cognitive testing
- Psychiatric testing

History

History really is the most important component of evaluation

Even if concerned patient may have dementia allow them to talk

Always ask first if its okay to get collateral from family/friends/caregivers in the room or on the phone

What questions to ask?

How long have you been having these sxs	What are the sxs (memory, language, executive function)	Behavior or personality changes	Neuropsych changes- hallucinations, delusions

Specific history questions

- Functional status
- PMH/comorbidities
- Medications- DO NOT FORGET OTC/SUPPLEMENTS-be very specific as often they will say Tylenol but its Tylenol PM or supplement off QVC
- Family history (especially of cognitive issues or psych)
- ROS-DEPRESSION, ETOH, drugs
- Support-family, caregivers, friends, social activities

How do you function at home?

- IADLs
  - Medications, shopping, meals, household chores, driving, phone/tablet/computer, finances
- ADLs
  - Bathing, dressing, feeding, continence, toileting, transferring
- Compare this to their previous function and if/when anything has changed
- Sometimes you will see someone say oh no I don’t cook and clean but it may be because the spouse has always done it- ask if it has changed

LABS

- Routine Geri labs
  - CBC
  - CMP
  - TSH
  - B12
  - Vitamin D
- Concern for specific causes: RPR (syphilis), HIV, heavy metal


Aging Gracefully
is an art...
Aging Disgracefully
is a total Blast!

Neuropsych Evaluation

- Cognitive screens
- Behavioral observations
- Emotional Screens
- Intellectual functioning

Emotional Screen-Depression

- Risk factors-female, comorbidities, functional/cognitive impairment, uncontrolled pain, widowed/divorced, social isolation
- Nursing facility residence is a huge risk factor
- Depression is a risk factor for suicide in older adults as well
- Often hard to rule out dementia if patient is also depressed “Pseudodementia”

Emotional Screening Tests

- Best single questions is, “Do you ever feel sad or depressed?”
  - Sensitivity 85% & Specificity of 65%
- PHQ-2-should be asked every visit in patients >65
  - Over the last 2 weeks how often have you been bothered by any of the following problems?
  - Little interest or pleasure in doing things
  - Feeling down, depressed, or hopeless
- 5 Item Geriatric Depression Scale (GDS5)- yes/no
  - Sensitivity of 97% & Specificity of 85%
  - 0-1 Not depressed, >=2 Depressed
- Generalized Anxiety Disorder 7-item Scale (GAD-7)
  - 0-4 minimal, 5-9 mild, 10-14 moderate, 15-21 severe
- Cornell Scale for depression in Dementia-allows for observer info

Cognitive Screening Tests

- Mini Cog- really quick and easy to do in the office
- MMSE- 30 point test, used in clinic office settings, limited to those who are in the dementia ‘zone’ as far as best utility
  - Assesses all major domains, in a brief manner
    - Orientation questions (orientation)
    - 3 word recall (memory)
    - Serial 7s (attention)
    - Naming objects, reading and writing sentence (language)
    - Drawing pentagons (visuospatial and somewhat executive)
    - Score <24 abnormal
  - MOCA

DIAGNOSIS

DEMENTIA: Mini-cog

1. Ask patient to remember three words now and later (banana, sunrise, chair). Ask patient to repeat words to ensure learning.
2. Ask patient to draw clock. After numbers are on the face, ask patient to draw hands to read 10 minutes after 11:00.
3. Ask patient to recall three words.

MOCA (see video) Sensitivity 100% Specificity 77%
MMSE for comparison: Sensitivity 79% Specificity 88

Sensitivity: 76% Specificity 89%

Scoring
1 point each word recalled after clock
2 points for clock, all or nothing:
- All numbers in correct location
- 2 hands, one pointing to 11 and one to 2 (length doesn't matter)

Passing score ≥ 4 out of 5 (normal clock and 2/3 words to pass)

Borson S et al. J Am Geriatr Soc. 2003 Oct;51(10):1451-4.
Freitas S, et al. Alzheimer Dis Assoc Disord. 2013 Jan-Mar;27(1):37-43.
Horton AM, Alana S. Int J Neurosci. 1990 Aug;53(2-4):209-12.

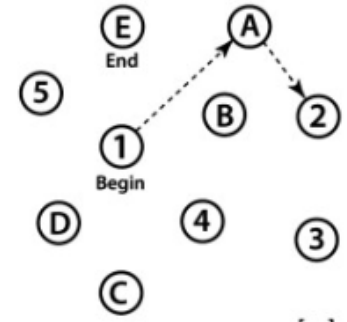
MONTREAL COGNITIVE ASSESSMENT (MOCA)

Version 7.1 Original Version

Education : Sex :

Date of birth : DATE :

VISUOSPATIAL / EXECUTIVE



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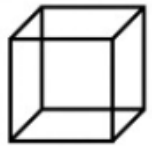


[ ] [ ]

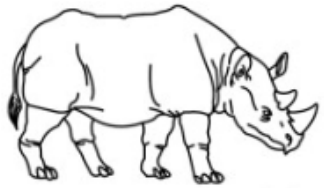
Draw CLOCK (Ten past eleven)
(3 points)

[ ] Contour [ ] Numbers [ ] Hands

POINTS __/5

NAMING

[ ]



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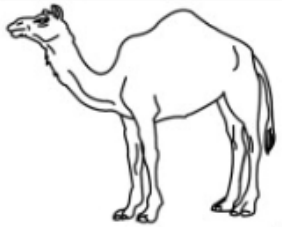

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__/3

MEMORY

Read list of words, subject must repeat them. Do 2 trials, even if 1st trial is successful. Do a recall after 5 minutes.

	FACE	VELVET	CHURCH	DAISY	RED
1st trial					
2nd trial					

No points

ATTENTION

Read list of digits (1 digit/ sec.).

Subject has to repeat them in the forward order [ ] 2 1 8 5 4

Subject has to repeat them in the backward order [ ] 7 4 2

__/2

Read list of letters. The subject must tap with his hand at each letter A. No points if ≥ 2 errors

[ ] F B A C M N A A J K L B A F A K D E A A A J A M O F A A B

__/1

Serial 7 subtraction starting at 100 [ ] 93 [ ] 86 [ ] 79 [ ] 72 [ ] 65

4 or 5 correct subtractions: **3 pts**, 2 or 3 correct: **2 pts**, 1 correct: **1 pt**, 0 correct: **0 pt**

__/3

LANGUAGE

Repeat : I only know that John is the one to help today. [ ]

The cat always hid under the couch when dogs were in the room. [ ]

__/2

Fluency / Name maximum number of words in one minute that begin with the letter F [ ] _____ (N ≥ 11 words)

__/1

ABSTRACTION

Similarity between e.g. banana - orange = fruit [ ] train – bicycle [ ] watch - ruler

__/2

DELAYED RECALL

	Has to recall words WITH NO CUE	FACE [ ]	VELVET [ ]	CHURCH [ ]	DAISY [ ]	RED [ ]	Points for UNCUED recall only
Optional	Category cue						
	Multiple choice cue						

__/5

ORIENTATION

[ ] Date [ ] Month [ ] Year [ ] Day [ ] Place [ ] City

__/6

www.mocatest.org

Normal ≥ 26 / 30

TOTAL __/30

Add 1 point if ≤ 12 yr edu

Administered by: _____

Imaging

- Often not necessary
- Highest yield in young, rapid onset, seizures, abnormal neuro exam
- MRI is preferred but consider CT non-con
- PET-usually in research

Normal aging

Deficits that do not impair function and are stable over time

Slower processing information

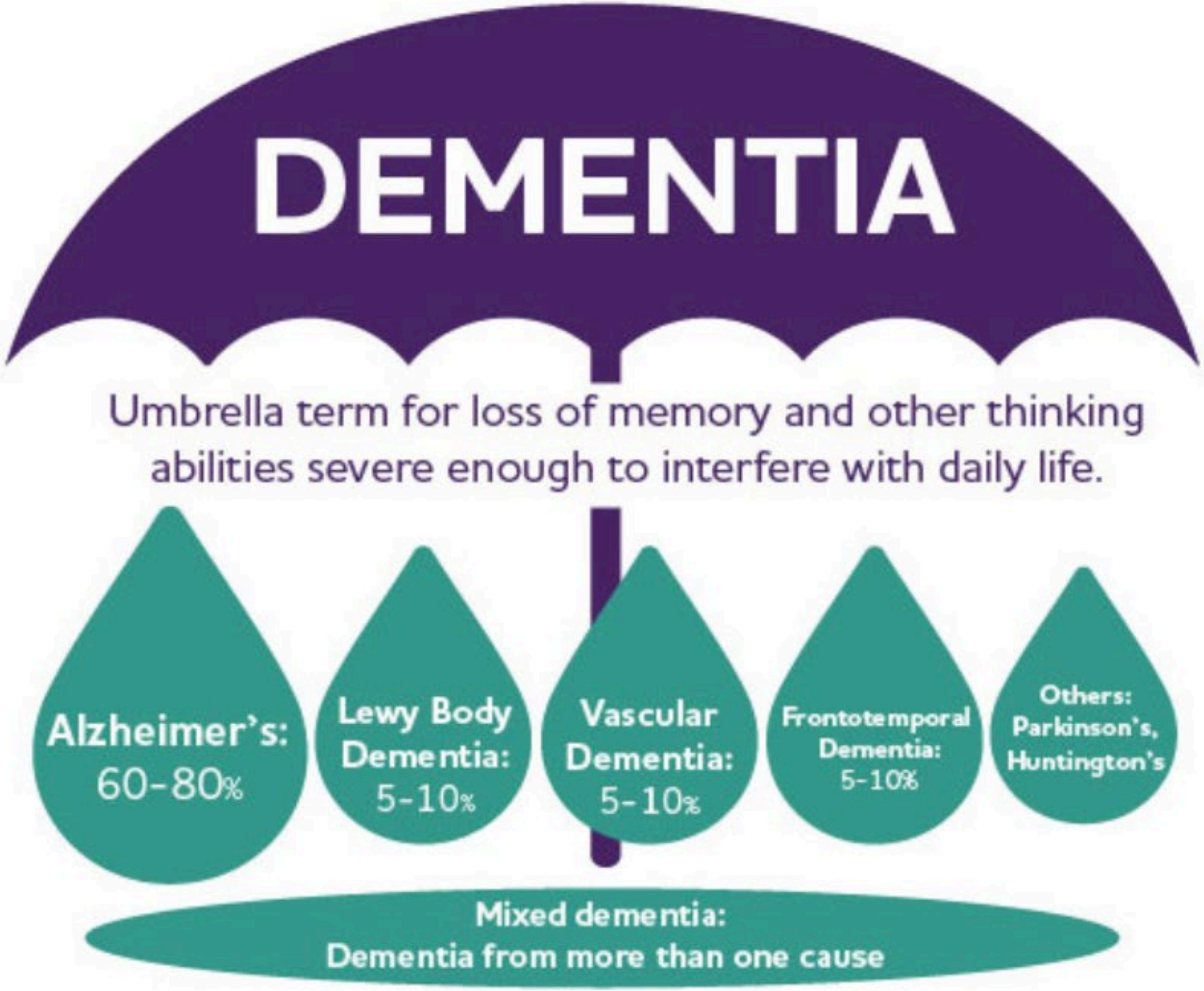
Word finding difficulty is common

Mild Cognitive Impairment (MCI)

Memory complaint with impairment in 1 or more cognitive domains

DOES NOT cause functional impairment or interfere with daily life

Increased risk of Alzheimer's dementia


DEMENTIA
Umbrella term for loss of memory and other thinking abilities severe enough to interfere with daily life.
Alzheimer's: 60-80%
Lewy Body Dementia: 5-10%
Vascular Dementia: 5-10%
Frontotemporal Dementia: 5-10%
Others: Parkinson's, Huntington's
Mixed dementia: Dementia from more than one cause

Alzheimer's Disease

- Most common type of dementia
- Typical-Over the age of 60-65
- Early-onset- <60- usually presents with concern about job performance
- Inherited-rare AD inheritance pattern
- Memory impairment, executive function and judgment/problem solving, behavioral and psychologic symptoms
- Risk factors: family history, female, age, hearing loss, social isolation, female

Stage	Stage Name	Characteristic	Expected Untreated AD Duration (months)	Mental Age (years)	MMSE (score)
1	Normal Aging	No deficits whatsoever	--	Adult	29-30
2	Possible Mild Cognitive Impairment	Subjective functional deficit	--		28-29
3	Mild Cognitive Impairment	Objective functional deficit interferes with a person's most complex tasks	84	12+	24-28
4	Mild Dementia	IADLs become affected, such as bill paying, cooking, cleaning, traveling	24	8-12	19-20
5	Moderate Dementia	Needs help selecting proper attire	18	5-7	15
6a	Moderately Severe Dementia	Needs help putting on clothes	4.8	5	9
6b	Moderately Severe Dementia	Needs help bathing	4.8	4	8
6c	Moderately Severe Dementia	Needs help toileting	4.8	4	5
6d	Moderately Severe Dementia	Urinary incontinence	3.6	3-4	3
6e	Moderately Severe Dementia	Fecal incontinence	9.6	2-3	1
7a	Severe Dementia	Speaks 5-6 words during day	12	1.25	0
7b	Severe Dementia	Speaks only 1 word clearly	18	1	0
7c	Severe Dementia	Can no longer walk	12	1	0
7d	Severe Dementia	Can no longer sit up	12	0.5-0.8	0
7e	Severe Dementia	Can no longer smile	18	0.2-0.4	0
7f	Severe Dementia	Can no longer hold up head	12+	0-0.2	0

Vascular Dementia

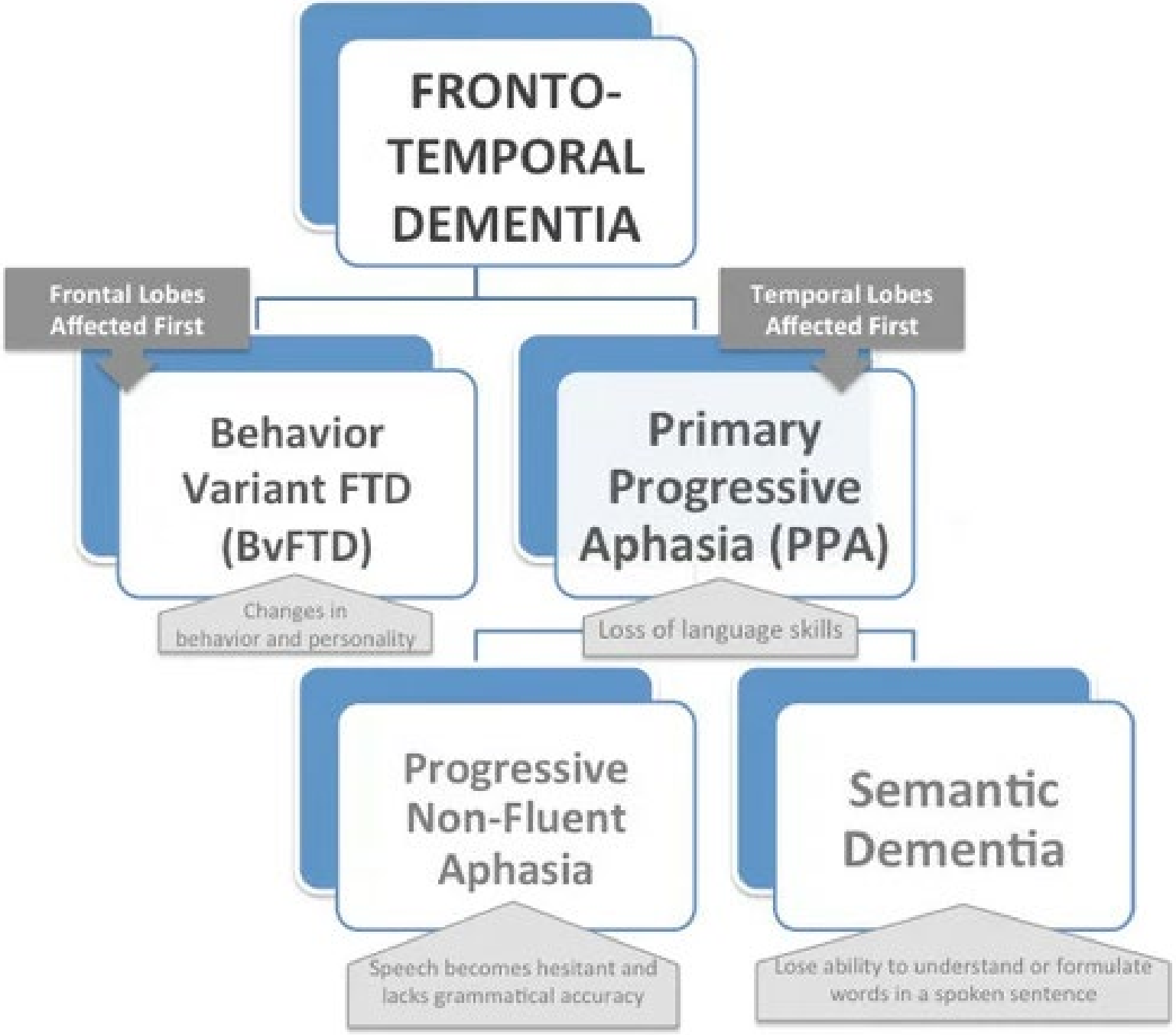
- 2nd most common type
- Often difficult to distinguish between AD-can also have a mixed type dementia
- Risk factors: HTN, DM, HLD, tobacco, age, low physical activity, CAD
- Poststroke dementia- stepwise cognitive decline
- Many have neuropsychiatric changes such as depression, psychosis, delusions, hallucinations

Lewy Body Dementia

- Umbrella term for dementia with lewy body and parkison disease with lewy body dementia
- Dementia starts before the parkinsonism in DLB
- Dementia and at least 2 “core clinical features”
  - Fluctuating cognition with pronounced variations in attention and alertness
  - Recurrent visual hallucinations that are typically well formed and detailed
  - REM sleep behavior disorder, which may precede cognitive decline
  - One or more spontaneous cardinal features of parkinsonism (bradykinesia, rest tremor, rigidity)
- SEVERE REACTIONS TO ANTIPSYCHOTICS

Frontotemporal Dementia

- Usually younger patients, mostly men
- Clinical presentation
  - Disinhibition- patient who gave all his money to a scammer on the phone
  - Apathy and loss of empathy
  - Hyperorality (binge eating, sweets, alcohol, tobacco)
  - Compulsive behaviors (checking, cleaning, hoarding


FRONTO-TEMPORAL DEMENTIA
Frontal Lobes Affected First
Temporal Lobes Affected First
Behavior Variant FTD (BvFTD)
Changes in behavior and personality
Primary Progressive Aphasia (PPA)
Loss of language skills
Progressive Non-Fluent Aphasia
Speech becomes hesitant and lacks grammatical accuracy
Semantic Dementia
Lose ability to understand or formulate words in a spoken sentence

Caregiver Concerns

- Driving- can refer to OT driving school where they will test
- Money management-recommend early oversight
- Medicines- pill box or some pharmacies can do pill poppers already prepared
- Housing- financial issues with SNF/LTC/ALF/ILF VERY EXPENSIVE!
- Caregiver Burden-many resources available- North Carolina Alzheimer's association has lots of resources including caregiver support groups

Advanced Care Planning

- START EARLY
- Power of attorney for healthcare
- Power of attorney for finance
- Living will/advanced directive
- CODE STATUS- makes it much easier in the hospital if these discussions have been had by PCP

Capacity

Component	Patient's role	Physician's approach	Sample questions	Impaired in
Communication	Express a treatment choice	Ask patient which treatment option they prefer	Have you decided whether to get X or Y treatment?	Psychiatric disorders; extreme (pathologic) indecision
Understanding	Recall information, link causal relationships, process general probabilities	Ask the patient to paraphrase their view of the situation	Can you tell me how you view the current situation? How likely do you think that X will happen to you?	Problems with memory, attention span, intelligence
Appreciation	Identify illness, treatment options, and probable outcomes as it relates to them	Ask patient to describe disease, treatment, outcomes, and probabilities as they apply to them	What do you think is wrong with your health? What treatments do you think would help? What do you think is your alternative?	Denial; delusional disorder
Rationalization	Weigh risks and benefits to come to a conclusion in keeping with patient's goals	Ask the patient to compare risks vs. benefits of the proposed treatment and alternatives	What made you choose option X? Why do you think option X is better than option Y?	Depression, psychotic thought disorder, depression, anxiety, phobia, delirium, dementia

TREATMENT DEPRESSION/ANXIETY

Drug properties and doses of antidepressants in older adults and medically ill

Drug	Starting dose	Suggested dose range	Precautions*	Potential advantages
Selective serotonin reuptake inhibitors (SSRIs)¶				
Escitalopram	5 mg every morning or every evening	5 to 20 mg daily	Mild discontinuation symptoms may occur absent tapering.	Applies to escitalopram and citalopram: Generally well tolerated. Non-sedating, low risk of sleep disturbance, comparatively few significant drug interactions. Good choice for initial treatment of depression in most older adults.
Citalopram	10 mg every morning or every evening	10 to 20 mg[Δ] daily	Dose-related risk of QT prolongation[¶Δ]. Mild discontinuation symptoms may occur absent tapering.	
Sertraline	12.5 to 25 mg every morning	25 to 200 mg daily	More frequent gastrointestinal symptoms including diarrhea. Variable oral bioavailability. Oral solution contains alcohol. Discontinuation symptoms may occur absent tapering.	Non-sedating, low risk of insomnia, lacks significant cardiovascular effects. Good choice for initial treatment of depression in most older adults.
Fluoxetine	5 to 10 mg every morning	5 to 60 mg daily	Activating. Significant drug interactions. Prolonged half-life and active metabolites require weeks to reach steady state, prolonging time needed to evaluate effect of dose adjustment and complicating wash-out and withdrawal.	Activating effect may be useful for treatment of depressed patients with low energy or hypersomnia. Tapering upon discontinuation is not needed due to long half-life.
Paroxetine	10 mg every evening	10 to 40 mg every evening	Weakly anticholinergic. May cause constipation, dry mouth, or drowsiness. Associated with more severe discontinuation symptoms in absence of tapering.	Useful for patients with insomnia. Moderate half-life with no active metabolites.
Fluvoxamine	25 mg every evening	25 to 200 mg every evening	Significant drug interactions. Short half-life associated with discontinuation symptoms in absence of tapering.	May be useful for patients with insomnia.

Serotonin-norepinephrine reuptake inhibitors (SNRIs)[◇]				
Venlafaxine (extended release)	37.5 mg once daily	75 to 225 mg once daily	Applies to venlafaxine and desvenlafaxine: Activating. May cause dose-dependent increases in blood pressure (primarily diastolic) and heart rate. Monitor blood pressure regularly. Gastrointestinal symptoms (eg, nausea) may be more prominent with immediate-release venlafaxine. Associated with discontinuation symptoms absent tapering. Taper desvenlafaxine by increasing interval between doses.	Applies to venlafaxine and desvenlafaxine: Activating effect may be useful for treatment of melancholic depressed patients with low energy or hypersomnia. Useful for patients with comorbid painful conditions such as diabetic neuropathy.
Venlafaxine (immediate release)	18.75 to 37.5 mg every morning or twice daily	75 to 150 mg twice daily		
Desvenlafaxine	50 mg every morning CrCl <30 mL/min: 50 mg every other day	50 mg every morning CrCl <30 mL/min: 50 mg every other day		
Duloxetine	10 to 20 mg daily	20 to 60 mg once daily	Significant drug interactions.	Mildly sedating. Low risk of insomnia. Useful for patients with comorbid painful conditions such as diabetic neuropathy or chronic pain.
Atypical antidepressants[◇]				
Mirtazapine	7.5 mg every evening	15 to 60 mg every evening	Prolonged half-life and active metabolites. Risk of accumulation with renal and/or hepatic insufficiency. Dose reductions necessary. Drowsiness, weight gain. Rare reports of agranulocytosis.	Sedating. Low risk of sexual dysfunction. Appetite stimulant and antinausea effects can be noted within days. Useful for patients with insomnia or who may benefit from weight gain.
Bupropion sustained release	75 mg in morning initially then twice daily	150 mg in morning and midafternoon (twice daily)	Avoid in seizure disorders and depressed patients with agitation. Dose-dependent increase in diastolic blood pressure. May worsen insomnia.	Stimulant effect may be useful for treatment of depressed patients with low energy and apathy. Low risk of cognitive toxicity. Dopaminergic action may be advantageous for depressed patients with Parkinson disease.
Vilazodone	10 mg once daily with food for seven days or more	20 to 40 mg once daily with food	Take with food to assure bioavailability. Diarrhea, nausea, vomiting, dizziness, insomnia. Significant drug interactions via CYP 3A4 require dose adjustment.	Low incidence of weight gain or sexual dysfunction. Role in therapy for treatment of depressed older adults or adults with comorbid illness is not yet defined.
Trazodone	12.5 to 25 mg taken 30 to 60 minutes before bedtime for hypnotic effects	25 to 100 mg taken 30 to 60 minutes before bedtime for hypnotic effects; antidepressant effects require higher doses	Sedation, orthostatic hypotension, nausea. Residual daytime sedation and cognitive impairment. Reports of hyponatremia.	Used in low doses as adjunct to SSRI for treatment of insomnia.
Tricyclic antidepressants (TCAs)[§]				
Nortriptyline	10 mg every evening	10 to 100 mg every evening or in two divided doses	Applies to nortriptyline and desipramine: May be poorly tolerated by medically ill and older adults due to anticholinergic effects that include dry mouth, constipation, urinary retention, or altered vision (eg, avoid in prostatic disease or narrow angle glaucoma). May be fatal in overdose. Potentially cardiotoxic, can cause arrhythmia or orthostatic hypotension. Significant drug interactions.	Applies to nortriptyline: Established therapeutic serum concentration 50 to 150 ng/mL. Mildly sedating. Taken at bed time for depressed patients with insomnia. May be useful for melancholic, anxious, depressed patients who have not responded to first- and second-line antidepressants.
Desipramine	10 mg every morning	25 to 150 mg every morning or in two divided doses		Applies to desipramine: Established therapeutic serum concentration 125 to 300 ng/mL. Mild stimulant effects may be useful for depressed patients with low energy and hypersomnia who have not responded to first- and second-line antidepressants.

TREATMENT DEMENTIA

Only approved if moderate dementia but often used

Acetylcholinesterase inhibitors

Donepezil 5mg qhs, increase by 5mg q4weeks up to 10mg- bad GI upset/bradycardia

Galantamine 4mg bid- can increase by 4-8mg q4 weeks up to 12mg BID

Rivastigmine 1.5mg BID, increase by 1.5mg up to 6mg BID- available in patch

NMDA agonist

Memantine 5mg daily, increase by 5mg qweek to 10mg BID

DELIRIUM

- Increased mortality, hospital complications, falls, infections, ADL dependence and long-term function impairment, institutionalization, dc to nursing home, long-term cognitive impairment, depression, PTSD, and impaired QOL
- 75% of providers will miss if not using a validated tool
- Predisposing factors: functional impairment, age>75, dementia, depression, ETOH, sensory impairment.

Delirium Triggers
(Dr. DRE PINCHED ME)

- **D**iseases
- **D**rug **R**emoval
- **E**nvironmental

- **P**ain
- **I**nfection/**I**schemic/**I**ntoxication
- **N**utrition
- **C**onstipation/urinary retention
- **H**ypoxia/**H**ypercapnea, **H**ypo/**H**ypertension
- **E**lectrolytes
- **D**ehydration
- **M**etabolic
- **E**KG changes (MI)

Other Delirium Precipitators

- Many Metabolic – dehydration, electrolyte abnormalities, acidosis, resp alkalosis, hypoxemia, hyper/hypoglycemia, AKI, hepatic encephalopathy, hyper/hypothyroid
- Infection (UTI, PNA, cellulitis, bacteremia, encephalitis/meningitis, sinusitis if s/p NGT)
- Intracranial process (stroke, TIA, tumor, seizure, vasculitis)
- Sleep deprivation
- ANYTHING and EVERYTHING!

DELIRIUM: bCAM

Sensitivity: 82% Specificity 96%

1. Acute onset or fluctuating

Ask RN or family "*Is patient more confused than normal? Is his mental status fluctuating?*"
Yes to either = POSITIVE

+

2. Inattention

Can you name the months backwards from December to July?
More than one error = POSITIVE

+

3. Altered Level of Consciousness OR 4. Disorganized Thinking

RASS ≠ 0 = POSITIVE (below)

Term	RASS Score	Description
Combative	+4	Overtly combative, violent, immediate danger to staff
Very agitated	+3	Pulls or removes tube(s) or catheter(s); aggressive
Agitated	+2	Frequent non-purposeful movement, fights ventilator
Restless	+1	Anxious but movements not aggressive
Alert and calm	0	
Drowsy	-1	Not fully alert, but has sustained awakening (eye-opening/eye contact) to voice (≥10 seconds)
Light sedation	-2	Briefly awakens with eye contact to voice (<10 seconds
Moderate sedation	-3	Movement or eye opening to voice (but no eye contact)
Deep sedation	-4	No response to voice, but movement or eye opening to physical stimulation

Any errors = POSITIVE

1) Will a stone float on water?
2) Are there fish in the sea?
3) Does one pound weigh more than two pounds?
4) Can you use a hammer to pound a nail?

Command: "Hold up this many fingers" (Hold up two fingers). "Now do the same thing with the other hand (Do not demonstrate).

bCAM POSITIVE = 1 + 2 + (3 or 4)

DELIRIUM

Sessler CN et al Am J Respir Crit Care Med. 2002 NoV 15;166(10):1338-44

Ely EW, et al. JAMA. 2001; 286: 2703-2710
Han JH , et al. Ann Emerg Med 2013;62:457-65.

TREATMENT

HOMMEES: Nonpharmacologic recommendations for delirium prevention and treatment:

- Hydration & nutrition- ensure staff feeds patient if unable, r/o bowel/bladder retention
- Orientation
- Mobilize 3x/daily out of bed as able, PT/OT consults
- Manage pain.
- Minimize medications (see next page)
- Eliminate devices (foleys, restraints, and unnecessary tele and lines)

  Only use foley catheters for these indications:

  - 1) Inability to void (acute urinary retention)
  - 2) Need for accurate UOP monitoring when patient unable to comply
  - 3) Urinary Incontinence AND stage 3-4 sacral or perineal wound
  - 4) Perioperative Use
  - 5) Comfort care at end of life
- Engage Family
- Sensory restoration - use eyeglasses and hearing aids
- Sleep - minimize nighttime vitals; lights on and windows open during the day, earplugs/sleepmask and no TV at night

Polypharmacy

- DEPRESCIBING IS FUN!
- A new symptom in an older adult is often the side effect of a medication
- Medstopper is a great site to use- will help with which to discontinue first and what are the withdrawal symptoms
- Beers Criteria- potentially inappropriate medications

MEDICATION

- Melatonin (2-4 hours before bedtime)
- Trazodone 25mg q8 hours
- Benzos- alcohol withdrawal
- Precedex- need to be in the ICU (risk of bradycardia)
- Depakote- can be used IV or sprinkles- 125mg TID or BID to start. Can titrate up.

	EPS/TD	Sedation	Anticholinergic	Orthostatic hypotension	*QTc prolongation
Haloperidol (Haldol)	+++	++	-/+	-	+
Aripiprazole Abilify	+	+	-	-	-/+
Olanzapine (Zyprexa)	+	++	++	+	+
Quetiapine (Seroquel)	-/+	++	++	++	+
Risperidone (Risperdal)	+++	+	+	+	+
Ziprasidone (Geodon)	-/+	+	-	+	++

Adapted from:
Jibson MD., Marder S, ed. UpToDate. Waltham, MA: UpToDate Inc. https://www.uptodate.com (Accessed on Mar 22, 2019.)
*QTc prolongation may vary by source

A checklist for rounding

Cognition (mini-cog +/- MOCA first visit, bCAM daily)

ADLs [walking/transferring, toileting (voiding/last BM), feeding (eating/drinking), do you need to consult PT/OT/speech?]

Devices (minimize foley, tele, lines, IV meds)

Drugs
- Minimize number, anticholinergic, CNS, nephrotoxic
- Pain med requirements over 24 hours
- PRN meds
- Schedule pain meds (cautiously) if dementia or delirium and in pain

Ad**V**ance directives

Estimate Discharge Date and Needs

Relay updates to primary team and family

Top 10 Signs You Need a Geriatrician:

10. You think the Beer's list has something to do with happy hour.
9. You talk about a patient to others as if he/she is not in the room.
8. The letters NH/SNF/LTC/LTAC/ALF just sound like alphabet soup.
7. Your review of systems fails to assess geriatric-specific issues.
6. You let patients stay in bed. 23 hours/day.
5. You miss a diagnosis because it presents atypically.
4. You fail to determine the patient's baseline functional and cognitive status.
3. You let patients elect full code without fully educating them about the reality of CPR success rates in the old frail adult.
2. You trust a history from a patient without screening for delirium and dementia with a validated tool.
1. You assume evidence-based recommendations and guidelines apply unanimously to frail, older adults.

www.americangeriatrics.org: American Geriatrics Society's website, many free clinical guidelines, requires registration (free)
www.healthinaging.org: Educational site of AGS, great for info for patients/caregivers
www.pogoe.org: Educational materials, requires registration (free)
http://eprognosis.ucsf.edu: Evidenced-based prognostic calculators for older adults
www.mskcc.org/nomograms: Prognosis calculators for cancer patients
http://www.med.unc.edu/aging/ace/ed_articles.htm: Online library of high yield articles in geriatrics
www.icudelirium.org : Vanderbilt website landmark studies, diagnostic instruments, videos. Also a great resource for patients and families.
www.geripal.org: Geriatrics & Palliative Care pearls from UCSF clinician educators
www.agilemd.com: download the Agile MD app, and add the high-yield Geriatrics Quick Reference

KEY POINTS

- Normal aging can be differentiated from cognitive impairment by impact on ADL's
- History is the most important component of the cognitive evaluation
- Lab and imaging evaluation for cognitive impairment is rarely helpful
- Screen for depression on every visit as it can mimic cognitive complaints
- Several screening tests however many take time so a mini cog is the most efficient in the office
- Dementia is an umbrella term and the different types often overlap-> treatment generally the same
- Advanced Care Planning should be discussed early
- Don't miss delirium in the hospital setting-treat with non-pharm measures first
- Don't treat a side effect of a medication with another medication
- ALWAYS ask what matters most to a patient

QUESTIONS?


I believe my house is haunted. Every time I look in my mirror a crazy old lady stands in front of me so I can't see my reflection!