When Enough is Enough; De-prescribing and Ceasing Preventive Testing/Screening

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Disclosures

I have no disclosures
Learning Objectives

- Identify target medications to de-prescribe
- Describe indicated preventive testing in the older adult
- Determine when to stop preventive testing in the older adult

Patient Case
Polypharmacy

- 70 year old female with PMHx of HTN, HLD, Prothrombin Gene Mutation, Chronic Low Back Pain and Asthma
- Medications include:
  - Albuterol q6h PRN for wheezing
  - Atorvastatin 40mg qpm
  - Baclofen 10mg TID PRN for back spasms
  - Cetirizine 10mg daily
  - Advair 1 puff bid
  - Lunesta 1mg qpm PRN for insomnia
  - Meloxicam 7.5mg daily PRN for pain
  - Montelukast 10mg qpm
  - Morphine 15mg q6h
  - Olmesartan 20mg daily
  - Warfarin 3mg daily (INR difficult to control)
  - Gabapentin 300mg bid

Polypharmacy

- 30% of patients aged 65 year or older are prescribed 5 or more drugs
- 1 in 5 drugs commonly used in older people may be inappropriate, increasing to 1/3 among those in aged care facilities
- Number of drugs that patient is taking is the single most important predictor of harm

Age Related Pharmacokinetic Changes

- Increased volume of distribution for lipophilic medications due to increased body fat to skeletal muscle ratio
- Decreased plasma protein (e.g., albumin) levels, leading to higher free concentrations of drugs that are highly protein bound
- Decreased hepatic and renal function
  - Decreased clearance along with prolonged half-life

Adverse Drug Events

- Falls, falls, falls
- Hospitalizations
- Cardiovascular events
- Decrease in cognitive and psychomotor function
- Drug-drug interactions
- Prescribing cascades
  - Potassium for Furosemide that was started for LE edema d/t CCB
De-Prescribing

What is De-prescribing?

“The systematic process of identifying and discontinuing drugs in instances in which existing or potential harms outweigh existing or potential benefits within the context of an individual patient’s care goals, current level of functioning, life expectancy, values and preferences.”


How to De-prescribe

1. ASK the patient: Recognize psychological connections with medications
2. Goals of care/life expectancy: Is there anything unnecessary on their medication list?
3. Treatment goal
4. Time until benefit: number needed to treat (NNT) will rise as the prognosis decreases

Jama Intern Med. 2015 May;175(5):827-34
When to De-prescribe

1. Evaluate your patients at least annually or if goals of care change:
   - A perfect opportunity for comprehensive medication review

2. Comprehensive medication review at initial visit
   - Match medications to appropriate indications
   - If no indication, does the patient really need it?

3. Adverse effect from medication?
   - Stop potentially inappropriate medications (PIMs) causing unwanted effects
   - Do not fall into the prescribing cascade

JAMA Intern Med. 2015 May;175(5):827-34

Figure. Algorithm for Deciding Order and Mode in Which Drug Use Could Be Discontinued

1. No benefit
   - Significant toxicity OR no indication OR obvious contraindication OR cascade prescribing?
   - Yes
   - No

2. Harm outweighs benefit
   - Adverse effects outweigh symptomatic effect or potential future benefits?
   - Yes
   - No

3. Symptom or disease drops
   - Symptoms stable or nonexistent?
   - Yes
   - No

4. Preventive drugs
   - Potential benefit unlikely to be realized because of limited life expectancy?
   - Yes
   - No

Withdrawal symptoms or disease recurrence likely if drug therapy discontinued?
   - Yes
   - Taper dose and monitor for adverse withdrawal effects
   - No
   - Symptoms stable or nonexistent?

Continue drug therapy
   - Yes
   - Restart drug therapy
   - No
   - Discontinue drug therapy
Deprescribing Protocol

- 1) Ascertain all drugs the patient is currently taking and reason for each
- 2) Consider overall risk of drug-induced harm to determine indicated intensity of deprescribing
- 3) Assess each drug for eligibility to be discontinued
  - No valid indication
  - Prescribing cascade?
  - Harm > Benefit
  - Ineffective if symptoms have resolved


Deprescribing Protocol Continued

- 4) Prioritize drugs for discontinuation

- 5) Implement and monitor drug discontinuation regimen
  - Fully document the reasons for, and outcomes of, deprescribing

Examples of unnecessary continuation

- Long-acting nitrates for a past episode of chest pain labeled as angina but with negative workup
- Gastroprotective PPI following cessation of NSAIDs
- Antidepressants for a previous but resolved episode of reactive depression
- Antihypertensives in patients now normotensive
- Risperidone for distant episodes of agitation complicating dementia

High-risk drugs

- Opioids
- Benzos
- Psychotropic drugs
- NSAIDs
- Anticoagulants
- Digoxin
- Cardiovascular drugs
- Hypoglycemic agents
- Anticholinergic drugs
# Risk vs Benefit: Using NNT and NNH

<table>
<thead>
<tr>
<th>Medication</th>
<th>Indication</th>
<th>NNT</th>
<th>NNH</th>
<th>Evidence on removal?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aspirin</td>
<td>Primary Prevention CVD – time to first event</td>
<td>246</td>
<td>167 (bleeding)</td>
<td>Risk vs Benefit: USPSTF does not have recs for primary prevention in &gt; 70 years old</td>
</tr>
<tr>
<td>Anti-platelets</td>
<td>Secondary prevention in high CVD risk patient (h/o MI, previous CVA, TIA)</td>
<td>15</td>
<td>167 (bleeding)</td>
<td>In patients 50-84 on low dose ASA there was no difference in death from CHD with DAPT vs. ASA alone after 1 year</td>
</tr>
</tbody>
</table>


# Risk vs Benefit: Using NNT and NNH

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</thead>
<tbody>
<tr>
<td>Statins</td>
<td>Secondary Prevention of CVD in patients with h/o CVA/TIA</td>
<td>100 (CVA)</td>
<td>10 (muscle damage)</td>
<td>In patients with &lt; 1 year prognosis: stopping may be safe with no increased risk of death</td>
</tr>
<tr>
<td>Statins</td>
<td>Primary Prevention</td>
<td>104 (non-fatal MI)</td>
<td>10 (muscle damage)</td>
<td>In patients with &lt; 1 year prognosis: stopping may be safe with no increased risk of death</td>
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<th>NNH</th>
<th>Evidence on removal?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral hypoglycemics</td>
<td>Intensive glucose control in DM 2</td>
<td>53 (macro and microvascular events)</td>
<td>67 (microvascular events)</td>
<td>6 (hypoglycemic episode requiring hospitalization)</td>
</tr>
<tr>
<td>Warfarin</td>
<td>Prevention of CVA in Atrial Fibrillation</td>
<td>20 (CVA, ICH or serious vascular event)</td>
<td>25 (CVA)</td>
<td>384 (ICH)</td>
</tr>
</tbody>
</table>


### ADA Diabetes Care (2020)


### Table 12.1—Framework for considering treatment goals for glycemia, blood pressure, and dyslipidemia in older adults with diabetes

<table>
<thead>
<tr>
<th>Characteristic/Health Status</th>
<th>Glycemia Goals</th>
<th>Blood Pressure Goals</th>
<th>Lipid Goals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthy (few or no chronic illnesses, intact cognitive and functional status)</td>
<td>7.5% (60 mmol/mol)</td>
<td>&lt;140/90 mmHg</td>
<td>Statin unless contraindicated or not tolerated</td>
</tr>
<tr>
<td>Intermediate (remaining life expectancy, high treatment burden, hypoglycemia, frailty, complicated comorbidities)</td>
<td>8.0% (66 mmol/mol)</td>
<td>90-130 mg/dL (5.0-8.3 mmol/L)</td>
<td>Statin unless contraindicated or not tolerated</td>
</tr>
<tr>
<td>Very complex/poor health (LTC or end-stage chronic illnesses**, or moderate-to-severe cognitive impairment or 2+ ACE dependence)</td>
<td>Limited remaining life expectancy makes benefit uncertain</td>
<td>100-200 mg/dL (6.0-10.0 mmol/L)</td>
<td>Consider likelihood of benefit with state secondary prevention more so than primary</td>
</tr>
</tbody>
</table>

Benefits of Deprescribing

- Lower risk/incidence of adverse drug events
- May improve overall adherence
- Reduce costs and inconvenience
- Relieve unnecessary suffering and disability in older patients

Screening and Prevention in the Older Adult
Screening and Prevention

- Consider a patient’s remaining life expectancy, comorbidities and cognitive and functional status when deciding which preventive health measures to offer.

- Lag time – the amount of time between undergoing an intervention until benefits (e.g., mortality reduction) are seen in RCTs

Screening and Prevention

- Many preventive health measures are underused among older adults
- Immunizations (flu shot, pneumococcal vaccinations), Exercise, Counseling, Depression Screening and Counseling on Geriatric Health Issues (e.g., Safety, falls prevention, incontinence)
- Cancer screening tests are overused among older adults with short remaining life expectancy
Cancer Screening Tests

- Goal is to identify cancers that will lead to morbidity and mortality
- 3 main types of bias
  - Lead Time
  - Length
  - Selection

Harms of screening include:
- Anxiety
- Complications from unneeded diagnostic evaluation
- False reassurance from false-negative test results
- Overdiagnosis leading to overtreatment

Cancer Screening Tests

- Breast Cancer
- Colorectal Cancer
- Cervical Cancer
- Prostate Cancer
- Lung Cancer
Breast Cancer

- Incidence increases with age and peaks between 75 and 79 years
- Mammography screening reduces breast cancer mortality by 19% in women 40-74 years old
- Whether it helps women > 74 years old live longer is not known

The USPSTF states there is insufficient evidence on whether to screen women > 75 years old.

- The American Cancer Society and AGS Choosing Wisely list states not to recommend breast cancer screening to older women without considering their life expectancy
- These recommendations are based on a meta-analysis of RCT’s on mammography screening that showed it takes approx. 10 years before one death from breast cancer is prevented per 1,000 screenings

Possible Harms from Screening

- Anxiety from false-positive tests
  - False-positive rate from 12% to 27% over 10 years
- False reassurance from false-negative test
- Overdiagnosis
- Complications from evaluation and/or treatment of breast cancer
  - 10%-20% of older women with false-positive test undergo breast biopsy
Breast Cancer Screening with Mammography

<table>
<thead>
<tr>
<th>&gt; 10 years life expectancy</th>
<th>5 to &lt; 10 years life expectancy</th>
<th>Moderate Dementia</th>
<th>Near end of life</th>
<th>SOE</th>
<th>Cost-effective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Every 2 years if &lt; 75 years old; consider stopping if &gt; 75 years old</td>
<td>Not recommended</td>
<td>Not recommended</td>
<td>Not recommended</td>
<td>A/C</td>
<td>Somewhat cost-effective for women &lt; 80 years old.</td>
</tr>
</tbody>
</table>
Colorectal Cancer

- Third most common cancer in adults > 70 years old and second leading cause of cancer death in older adults

- Several options for screening (colonoscopy q10 years, annual FOBT or FIT, flexible sigmoidoscopy q5 years with high-sensitivity FOBTs q3 years)

- 4 trials of FOBT screening showed that mortality was reduced (from 11% to 53%) in adults 70-80 years old, but false-positives were common

- PLCO screening trial showed mortality reduction of 35% in adults 65-74 years old with flexible sigmoidoscopy screening

- Colonoscopy is the definitive test for detection of adenomas and CRC and it is the most sensitive (95%)

Possible Harms from Screening

- Perforation after colonoscopy
  - 0.6 per 1,000

- GI bleeding
  - 2.1 per 1,000

- Cardiovascular Events
  - 10 per 1,000
# CRC screening

<table>
<thead>
<tr>
<th>CRC screening</th>
<th>&gt; 10 years life expectancy</th>
<th>5 to &lt; 10 years life expectancy</th>
<th>Moderate Dementia</th>
<th>Near end of Life</th>
<th>SOE</th>
<th>Cost-effective</th>
</tr>
</thead>
<tbody>
<tr>
<td>FOBT or FIT</td>
<td>Yearly up to age 75, stop at age 86</td>
<td>Not recommended</td>
<td>Not recommended</td>
<td>Not recommended</td>
<td>A/C</td>
<td>Yes</td>
</tr>
<tr>
<td>Colonoscopy</td>
<td>Every 10 years to 75, stop at age 86</td>
<td>Not recommended</td>
<td>Not recommended</td>
<td>Not recommended</td>
<td>A/C</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Cervical Cancer

• Guidelines recommend stopping screening after age 65 for women who have had adequate prior screening regardless of sexual history of new sexual partners

• Three consecutive negative HPV results or 2 consecutive negative HPV results within 10 years before cessation of screening, with the most recent test within 5 years is considered adequate prior screening

• Approx. half of cervical cancers diagnosed in the US occur among women never screened

• Additional 10% occur among women not screened in the past 5 years

Cervical Cancer Screening

• Older women who have undergone total hysterectomy with removal of the cervix and who do not have history of CIN grade 2 or 3 or cervical cancer should not be screened

• 2.6% of women 60-65 years old will be HPV positive despite normal cytology and follow-up testing is recommended

• An older woman who has never been screened or inadequately screened should be screened every 2-5 years, ending at age 70 or 75
Pap Smear

<table>
<thead>
<tr>
<th>Life Expectancy</th>
<th>Moderate Dementia</th>
<th>Near End of Life</th>
<th>SOE</th>
<th>Cost-effective</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt; 10 years</td>
<td>Not recommended</td>
<td>Not recommended</td>
<td>B</td>
<td>Cost-effective to stop</td>
</tr>
<tr>
<td>5 to &lt; 10 years</td>
<td>Not recommended</td>
<td>Not recommended</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 to &lt; 10 years</td>
<td>Not recommended</td>
<td>Not recommended</td>
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Prostate Cancer

- Most common non-skin cancer affecting men > 70 years old
- Second leading cause of cancer-related deaths in this age group
- Rate of intermediate and high-risk prostate cancer increases substantially with age; one study estimated 33% of men > 80 years old compared with 6% of men < 55 years old
- PSA screening usually done annually up to 65 years old
- Most organizations do not recommend routine use of DRE for screening
- ERCSP trial showed a 20% reduction in prostate cancer mortality at 9 years for men 55-69 years old but no reduction in mortality for men > 70 years old
Prostate Cancer Screening

- The ACS recommends that clinicians discuss the potential benefits of PSA screening (modest reduction of morbidity and mortality from prostate cancer) vs.
- Possible harms (false-positive results, unnecessary biopsies, overdiagnosis/overtreatment and possible complications of treatment) among men > 50 years old with at least 10 years remaining life expectancy
- USPSTF recommends against screening > 70 years old

<table>
<thead>
<tr>
<th>PSA</th>
<th>&gt; 10 years life expectancy</th>
<th>5 to &lt; 10 years life expectancy</th>
<th>Moderate Dementia</th>
<th>Near end of Life</th>
<th>SOE</th>
<th>Cost-effective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consider discussing pros/cons if remaining life expectancy &gt; 10 years; stop at age 70</td>
<td>Not recommended</td>
<td>Not recommended</td>
<td>Not recommended</td>
<td>B</td>
<td>Uncertain</td>
<td></td>
</tr>
</tbody>
</table>
Lung Cancer

- Second most common cancer and leading cause of cancer death in the US
- 66% of lung cancers are diagnosed in adults > 65 years old
- Smoking results in 85% of US lung cancer cases and 37% of US adults are current or former smokers
- Annual screening for lung cancer with LDCT is recommended in adults 55-74 years old (ACS) or 55-80 years old (USPSTF) who have a 30 py smoking history and currently smoke or have quit within past 15 years
- Recommend smoking cessation counseling as cessation is the most effective intervention to reduce the risk of lung cancer
- 3 annual LDCTs = 20% morality reduction (NLST)

Possible Harms from Screening

- False-positive tests
  - 39% with 3 annual LDCTs had at least one positive test and 96% of those were false-positive
- Overdiagnosis
  - 9%-25% of tumors detected by screening
- Radiation exposure
LDCT for Lung Ca Screening

<table>
<thead>
<tr>
<th>&gt; 10 years life expectancy</th>
<th>5 to &lt; 10 years remaining life expectancy</th>
<th>Moderate Dementia</th>
<th>Near end of Life</th>
<th>SOE</th>
<th>Cost-effective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consider annually in those at risk, stop at age 75-80</td>
<td>Consider in those at risk, stop at age 75-80</td>
<td>Not recommended</td>
<td>Not recommended</td>
<td>A</td>
<td>Uncertain</td>
</tr>
</tbody>
</table>

Geriatrics Review Syllabus: A Core Curriculum in Geriatric Medicine, 10th ed.
Other Cancers

- The USPSTF states there is insufficient evidence to recommend whole-body skin examination by PCP or to counsel older adults about sun protection.
- Also insufficient evidence to assess benefits and harms of screening for cancer of the mouth, bladder, or thyroid.
- Screening for ovarian cancer with CA-125, transvaginal US or pelvic exam do not reduce ovarian cancer mortality in a large RCT of women 55-75 years old at average risk.

Other Screening Tests and Preventive Measures
Disease Screening Tests

1. The condition being screened for must be serious and prevalent in the population being tested
2. The disease should have a significant asymptomatic phase that can be detected by the screening test
3. The screening test must be safe, sensitive and specific to limit false-positive and false-negative tests
4. Effective treatment must be available for use early in the natural course of the disease that results in lower morbidity and mortality than treatment given after symptoms develop

Thyroid Disease

- Early detection and treatment of asymptomatic adults with abnormal TSH with or without abnormal T\textsubscript{4} levels may be of benefit
- May prevent longer-term morbidity and mortality from fractures, cancer or CVD
  - TSH levels rise with age, fluctuate and are sensitive to acute illness and certain Rx
- A TSH level $> 10$ mIU/L (on two separate occasions 6-12 months apart) is generally considered threshold for initiation of treatment
Hypertension

• Very prevalent, affecting 67% of adults > 60 years old and is a major contributing risk factor to heart failure, MI, CVA and CKD
• USPSTF recommends screening adults for high blood pressure. However, because 15%-30% of the population have higher readings in clinic, the USPSTF recommends to confirm the Dx with readings outside clinic before starting treatment
• JNC 8 recommends goal BP < 150/90 for adults > 60 years old
• SPRINT and SPRINT MIND trials (Goal BP of 120/80)
  • In 75 and older, resulted in significantly lower rates of fatal and nonfatal CV events and death from any cause


Hypertension

• Patients with prevalent and frequent falls, advanced cognitive impairment, and multiple comorbidities may be at risk of adverse outcomes with intensive BP lowering, especially when they require multiple BP-lowering medications.
• Older persons in this category typically reside in nursing homes and assisted living facilities, are unable to live independently in the community, and have not been represented in RCTs

Type 2 Diabetes Mellitus

- Incidence increases with age until about 65 years and then levels off.
- Older adults are at high risk of development of type 2 diabetes due to increasing insulin resistance and impaired pancreatic cell function with aging.
- The ADA recommends that all adults > 45 years old be screened every 1-3 years with a fasting plasma glucose, A1c, or GTT.
- The USPSTF recommends screening 40-70 years old who are overweight or obese.
- < 10 years of life expectancy are unlikely to benefit from intense BG control.

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**ADA Diabetes Care (2020)**


| Table 12.1—Framework for considering treatment goals for glycemia, blood pressure, and dyslipidemia in older adults with diabetes |
|---|---|---|---|---|---|---|
| Patient characteristics/health status | Reasonable A1C goal | Fasting or preprandial glucose | Blood pressure | Lipids |
| Healthy (few coexisting chronic illnesses, intact cognitive and functional status) | Less than 7.5% (58 mmol/mol) | 90-130 mg/dL (5.0-7.2 mmol/L) | Less than 120/80 mmHg | Statin unless contraindicated or not tolerated |
| Complex/intermediate (multiple coexisting chronic illnesses*, or 2+ instrumental ADL impairments, or mild to moderate cognitive impairment) | Less than 8.0% (66 mmol/mol) | 90-150 mg/dL (5.0-8.3 mmol/L) | 100-180 mg/dL (5.6-10.0 mmol/L) | Statin unless contraindicated or not tolerated |
| Very complex/poor health (LTC or end-stage chronic illness**, or moderate to severe cognitive impairment or 2+ ADL dependencies) | Less than 8.5% (69 mmol/mol) | 100-180 mg/dL (5.5-10.0 mmol/L) | 130-200 mg/dL (8.1-11.1 mmol/L) | Consider benefit of benefit with statin (secondary prevention more so than primary) |

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*Hare: ACE inhibitors, ARBs, 
**Hare: Angiotensin receptor blockers, 
***Hare: Angiotensin receptor blockers.
AAA

- More common in men than women (7% v. 2% over 65 yo who have smoked)
- The USPSTF recommends 1-time screening of men 65-75 year old who have ever smoked (defined as > 100 cigarettes in lifetime)
- Medicare offers coverage of this screening test only as part of “Welcome to Medicare” preventive visit for all men and for women with a family history of AAA

Osteoporosis

- Over half of women > 80 years old have osteoporosis on DEXA scan
- Routine screening with DEXA is recommended by the USPSTF for all women > 65 years old and for women > 60 years old at high risk
- Insufficient evidence for recommendation for DEXA for men (USPSTF)
- NOF recommends screening all men > 70 years old
- Screening interval after initial DEXA depends on results
  - Normal (10 to 15 years)
  - Osteopenia (3 to 5 years)
  - Osteoporosis (2 years)
### FRAX® Fracture Risk Assessment Tool

**Calculation Tool**

Please answer the questions below to calculate the ten year probability of fracture with BMD.

<table>
<thead>
<tr>
<th>Country: US (Caucasian)</th>
<th>Name/ID:</th>
<th>About the risk factors</th>
</tr>
</thead>
</table>

#### Questionnaire:

1. Age (between 40 and 90 years) or Date of Birth:
   - Age: [ ]
   - Date of Birth: [ ]

2. Sex: [ ] Male [ ] Female

3. Weight (kg):
   - [ ]

4. Height (cm):
   - [ ]

5. Previous Fracture: [ ] Yes [ ] No

6. Parent Fractured Hip: [ ] Yes [ ] No

7. Current Smoking: [ ] Yes [ ] No

8. Glucocorticoids: [ ] Yes [ ] No

9. Rheumatoid arthritis: [ ] Yes [ ] No

10. Secondary osteoporosis: [ ] Yes [ ] No

11. Alcohol 3 or more units/day: [ ] Yes [ ] No

12. Femoral neck BMD (g/cm²): [ ]

#### BMI 31.1

- The ten year probability of fracture (%)
- [ ] with BMD
- Major osteoporotic fracture: [ ]
- Hip fracture: [ ]

If you have a TBS value, click here: [Adjust with TBS]

#### Weight Conversion

- Pounds: [ ]
- kg: [ ]

#### Height Conversion

- Inches: [ ]
- cm: [ ]

[07870053](https://www.frax.info) Individuals with fracture risk assessed since 1st June 2011
Hyperlipidemia

- CVD is the leading cause of morbidity and mortality in the US, accounting for 1 of every 3 deaths among adults
- Low or moderate dose statin use has been associated with a reduced risk of all-cause mortality, CV mortality, CVA and MI in adults 40-75 years old
- However, statins showed no benefit on overall mortality in adults > 75 years old
- For adults > 75 years old, guidelines state that there is insufficient evidence to recommend for or against statin use for 1st prevention

Hepatitis B and C

- HBV high risk include patients from endemic areas, HIV-positive, IVDU, household contacts with HBV and MSM
  - Cirrhosis, ESLD and HCC
- HCV most common chronic blood-borne pathogen in US
  - Cirrhosis and ESLD
- USPSTF recommends screening adults at high risk of infection with Hepatitis B surface Ag testing
- USPSTF recommends offering one-time screening for HCV infection to adults born between 1945 and 1965 and those at high risk
Healthy Lifestyle Counseling

- Physical Activity – recommend older adults get > 150 minutes per week of moderate-intensity or 75 minutes of vigorous-intensity aerobic activity
- Alcohol Use Disorder – ask all adults > 65 years old annually about their EtOH use. If yes then screen with AUDIT or SMAST
- Smoking Cessation – at any age decreases rates of COPD, many cancers and CAD
- STI's – USPSTF recommends routine screening up to age 65 and > 65 for those at increased risk
- Latent Tuberculosis Infection - USPSTF recommends screening for LTBI in persons at increased risk
Geriatric Health Issues

- Comprehensive Geriatric Assessment
  - Medications, cognitive status, functional status, nutritional status, hearing, vision, affect, social support, gait and balance
  - Can lead to immediate benefit whereas cancer screening tests may not show benefit for upwards of 10 years
  - General well-being, life satisfaction, iADLs and fewer clinic visits
  - High priority in frail older adults with limited remaining life expectancy

Falls

- Leading cause of injury in adults > 65 years old
  - AGS recommends clinicians ask annually about falls, balance or gait problems
  - 30%-40% of noninstitutionalized older adults fall each year and the annual incidence approaches 50% in those > 80 years old
  - Increasing age, a history of falls, mobility problems and poor performance on “Timed Up and Go” test are important risk factors
  - Prevention with PT/OT, Vitamin D, home safety eval, medication review, management of foot problems/footwear
Incontinence

- Affects 15%-30% of older community-dwelling women
- Can have major social and emotional consequences which may lead to only 30%-45% of women with incontinence seeking care
- Older women should be screened, particularly those who have had children, who have comorbid conditions associated with increased risk (DM, obesity, neurologic disease) and who are > 65 years old
- Do you ever leak urine when you don’t want to?
- Do you ever leak urine when you cough, laugh or exercise?

Cognitive Status

- USPSTF states that evidence is insufficient to recommend screening older adults for dementia
- Medicare AWV must include detection of cognitive impairment by direct observation with consideration of concerns from family and patient
- Screen with Mini-Cog if concerned. If positive then proceed to MMSE or MoCA
- 3 actions to maintain cognitive health
  - 1) Be physically active
  - 2) Reduce and manage CVD risk factors
  - 3) Regularly discuss and review health conditions and medications
Depression

- 1%-2% prevalence of MDD, 2% prevalence of dysthymia and 13%-27% prevalence of subsyndromal depression among community-dwelling older adults
- PHQ-2 and Geriatric Depression Scale are effective screening tools
  - [https://consultgeri.org/try-this/general-assessment/issue-4.pdf](https://consultgeri.org/try-this/general-assessment/issue-4.pdf)
- A positive response should be followed by a fuller assessment of severity and duration of symptoms
- Older white men have higher suicide rates – should ask specifically about symptoms if screen is positive

Vision

- Approx 9% of adults > 60 years old have impaired visual acuity
- Most common causes are presbyopia, cataracts, glaucoma, DM retinopathy and age-related macular degeneration
- USPSTF found insufficient evidence to recommend for or against visual acuity screening by PCP
- However, Medicare Initial Preventive Physical Exam requires a visual exam
Hearing

- Prevalence of hearing impairment is 20%-40% in adults > 50 years old and more than 80% in those > 80 years old
- Presbycusis, genetic factors, exposure to loud noises or ototoxic agents, history of ear infections and presence of systemic diseases
- USPSTF states there is insufficient evidence to assess the balance of benefits and harms of screening for hearing impairment
- Medicare’s initial AWV requires screening for hearing impairment

Mistreatment of Older Adults (Elder Abuse)

- Older adults who present with contusions, burns, bite marks, genital or rectal trauma, pressure injury or BMI < 17.5 kg/m² with no clinical explanation
  - Should be asked about possible mistreatment or referred to social work for assessment
- USPSTF states there is insufficient evidence to recommend routine screening for mistreatment of older adults
Take Home Message

- Weigh benefits vs harms when reviewing medications and potential cancer/disease screenings
  - Strongly encourage discontinuation of potentially harmful Rx
  - Explain benefit or non-benefit of screenings (mortality, lag time etc.)
- Align treatment plans with what matters most to patients and their families
  - Some patients may not desire stringent BP or BG goals, especially with decreased life expectancy
- Revisit these goals at each visit and never hesitate to assess patient and family understanding of what we are trying to do for them
  - Always think when refilling medications and ordering “routine” labs

References

References


- Jama Intern Med. 2015 May;175(5):827-34


Questions??