General Geriatric Assesment

Done by :
Dr. Wafaa swalmeh
Family medicin specialist

What is Geriatric Medicine ?

- The branch of medicine concert with the diagnosis, treatment and prevention of the disease in older people and problems specific for aging.
- Geriatric age group is > 65 years old.
- And we should differentiate between geriatric and gerontology which is the study of the aging process it self.

Comprehensive Geriatric Assessment

CGA

What is CGA ?

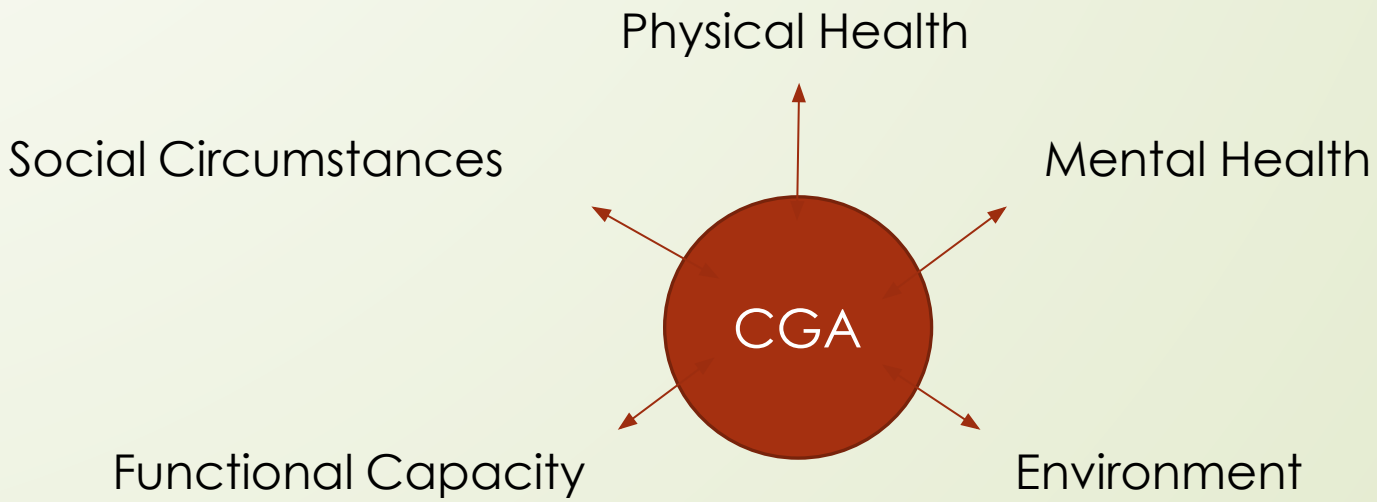
- CGA could be defined as a multi aspect process in which we can evaluate the complains, reach a diagnose and submit a best management for our patient.

- Question : what the deference between the regular assessment and the CGA ?

ACTUAL PROBLEM

Answer

- In geriatric we look to the chief complain and the other hidden aspects with the main complain as the main problem in hence we assets and investigate it all together, as 9 of 10 of the geriatric clinic patient chief complains hidden with other causes and illnesses and they just come with the tip of the " iceberg ".



CGA

- 1. Activities of daily living (FUNCTIONL capacity): Set of activities necessary for normal self-care and independency, such as: toileting, bathing, eating, dressing, and transferring

- 2. Mini-cog test: Step 1: Tell patient 3 unconnected words e.g. ball, tree, book – ask him to repeat them back – Step 2: Ask to draw a clock with all numbers, and hand set to 10 past 11 (11:10) within 3 min (2 points if normal – 0 if abnormal or refused). Step 3: Recall 3 words stated in step 1 (1 point for each)

CON..

- 3. Timed up and go test: patient sitting in a standard arm chair, identify a line 3 m, ask him to stand up, walk to the line at his normal pace, turn, walk back to chair and sit down. ≥12 sec = high risk for fall H/o falls last year – home adjustment
- 4. Mini-Nutritional Assessment score: last 3 months did he have: ↓ food intake, wt loss, immobility, stress, neuropsychological problem + BMI or calf circumference

- Polypharmacy: ≥ 5 medications different physicians + herbal & OTC May cause severe interaction, side effects, and non-adherence
- 6. Urinary: underreported –may lead to social isolation and abuse Fecal: chronic constipation, painful anal condition, or neurological
- 7. Assess visual acuity & hearing, inquire about using aids
- 8. Elder abuse: Physical, sexual, emotional, financial, or neglect. Sign: Bruises/cuts/fractures inconsistent with explanation – unsuitable clothing – bad hygiene – malnutrition - control - forced isolation - argument with elder – changed personality - missing appointments – inadequate care (medication, investigation, aids)

Cont..

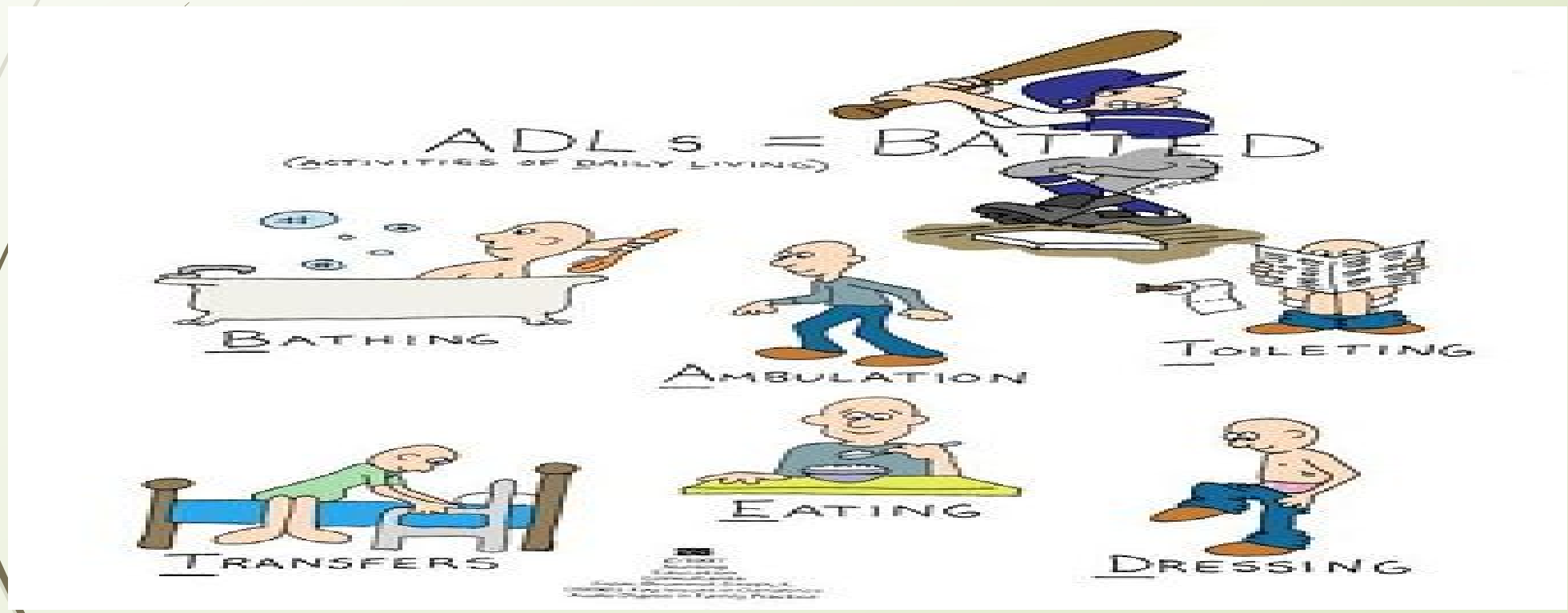
- 9. Geriatric depression: Underdiagnosed - screen last 2 wks for loss of interest and depressed mode – Can cause reversible dementia – should assess suicidal risk
- 10. Health maintenance: screening/immunization

FUNCTIONAL STATUS

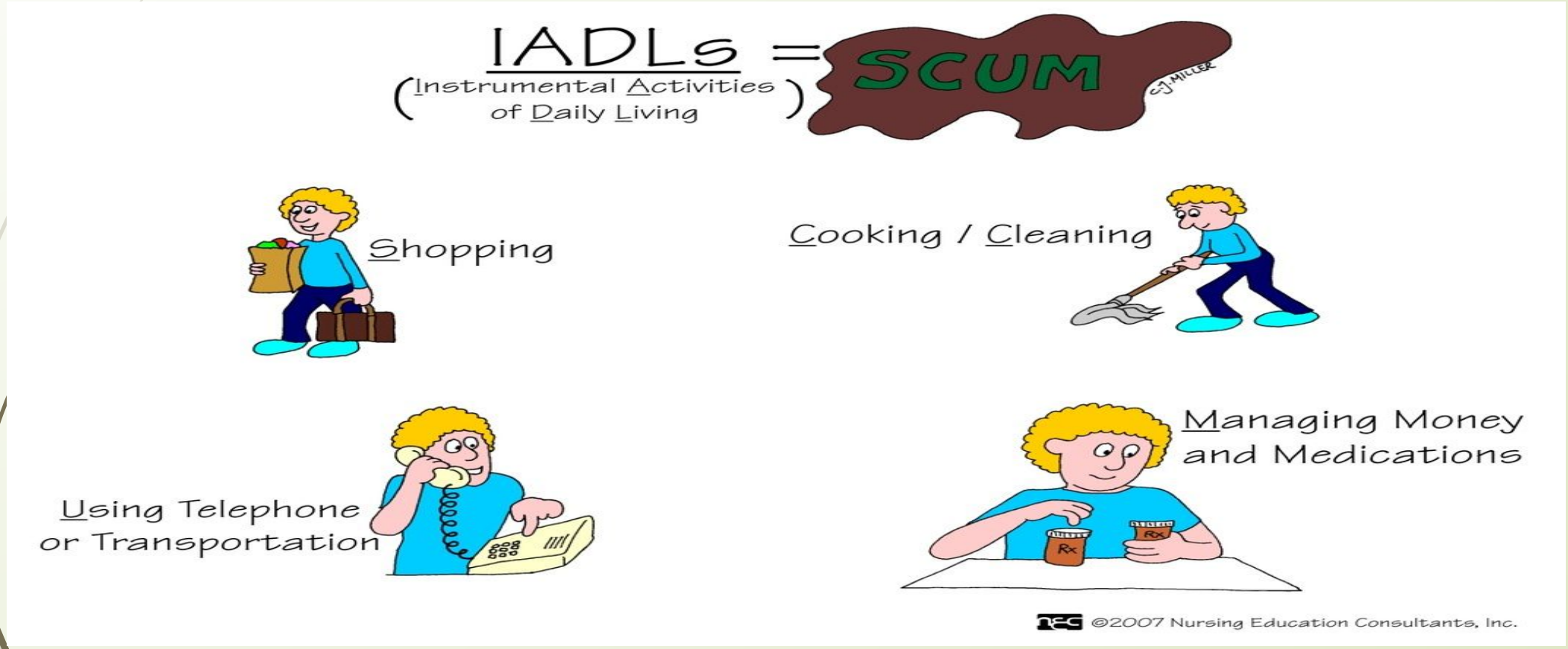
- Pre completed basic and instrumental activities of daily living scales may identify declines in functional status.
- For highly functional patients, a simple open-ended question asking how a typical day is spent provides a good review of daily function.

DAILY LIFE activities

Activities of Daily Living: Everyday personal care tasks that allow someone to live independently with comfort and dignity. (ADL examples: Toileting, dressing, bathing, eating)



- **Instrumental Activities of Daily Living**: Regular maintenance tasks that ensure a person living independently can provide for themselves. (IADL examples: Shopping, cooking, managing medications, housework)



Functional Status

ADLs

- Bathing
- Dressing
- Toileting
- Transfer
- Continence
- Feeding

IADLs

- Telephone
- Traveling
- Shopping
- Preparing meals
- Housework
- Repairs
- Laundry
- Medication
- Money

Activities of Daily Living Checklist

Mark the level of independence for each activity of daily living to determine if additional assistance would be beneficial.

ADL/IADL	Independent	Sometimes Need Help	Always Need Help	Cannot Do
Bathing	☐	☐	☐	☐
Dressing	☐	☐	☐	☐
Toileting	☐	☐	☐	☐
Grooming	☐	☐	☐	☐
Managing Medications	☐	☐	☐	☐
Eating	☐	☐	☐	☐
Walking	☐	☐	☐	☐
Transferring	☐	☐	☐	☐
Climbing Stairs	☐	☐	☐	☐
Shopping	☐	☐	☐	☐
Using the Phone	☐	☐	☐	☐
Housework	☐	☐	☐	☐
Laundry	☐	☐	☐	☐
Driving	☐	☐	☐	☐
Managing Finances	☐	☐	☐	☐

ADL / IADL Checklist

Using a person's functioning level as it relates to Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL) can help with determining the level of care assistance that person needs. Use this easy list to get a baseline of needs based on the actual activities it takes to maintain independence.

- **Activities of Daily Living (ADLs)** are activities in which people engage on a day-to-day basis. These are everyday *personal care* activities that are fundamental to caring for oneself and maintaining independence.
- **Instrumental Activities of Daily Living (IADLs)** are activities related to *independent living* and are valuable for evaluating persons with early-stage disease, both to assess the level of disease and to determine the person's ability to care for himself or herself.

Use the Activities of Daily Living and Instrumental Activities of Daily Living lists below and check the level of function for the person as it relates to each activity.

Activities of Daily Living (ADL)

ADL Function	Independent	Needs Help	Dependent	Cannot Do
Bathing				
Dressing				
Grooming				
Mouth care				
Toileting				
Transferring bed/chair				
Walking				
Climbing stairs				
Eating				

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Katz Index of Independence in Activities of Daily Living

Katz Index of Independence in Activities of Daily Living

ACTIVITIES POINTS (1 OR 0)	INDEPENDENCE: (1 POINT) **NO** supervision, direction or personal assistance	DEPENDENCE: (0 POINTS) **WITH** supervision, direction, personal assistance or total care
BATHING POINTS:_____	**(1 POINT)** Bathes self completely or needs help in bathing only a single part of the body such as the back, genital area or disabled extremity.	**(0 POINTS)** Needs help with bathing more than one part of the body, getting in or out of the tub or shower. Requires total bathing.
DRESSING POINTS:_____	**(1 POINT)** Gets clothes from closets and drawers and puts on clothes and outer garments complete with fasteners. May have help tying shoes.	**(0 POINTS)** Needs help with dressing self or needs to be completely dressed.
TOILETING POINTS:_____	**(1 POINT)** Goes to toilet, gets on and off, arranges clothes, cleans genital area without help.	**(0 POINTS)** Needs help transferring to the toilet, cleaning self or uses bedpan or commode.
TRANSFERRING POINTS:_____	**(1 POINT)** Moves in and out of bed or chair unassisted. Mechanical transferring aides are acceptable.	**(0 POINTS)** Needs help in moving from bed to chair or requires a complete transfer.
CONTINENCE POINTS:_____	**(1 POINT)** Exercises complete self control over urination and defecation.	**(0 POINTS)** Is partially or totally incontinent of bowel or bladder.
FEEDING POINTS:_____	**(1 POINT)** Gets food from plate into mouth without help. Preparation of food may be done by another person.	**(0 POINTS)** Needs partial or total help with feeding or requires parenteral feeding.

TOTAL POINTS = _____ 6 = High (*patient independent*) 0 = Low (*patient very dependent*)

Slightly adapted from Katz, S., Down, T.D., Cash, H.R., & Grotz, R.C. (1970) Progress in the development of the index of ADL. *The Gerontologist, 10*(1), 20-30.

try this: general assessment series
Best Practices in Nursing Care to Older Adults
A series provided by The Hartford Institute for Geriatric Nursing, New York University College of Nursing
EMAIL hartford.ign@nyu.edu HARTFORD INSTITUTE WEBSITE www.hartfordign.org
CLINICAL NURSING WEBSITE www.ConsultGeriRN.org

2) MINICOG TEST

- is a 3-minute instrument that can increase detection of cognitive impairment in older adults. It can be used effectively after brief training in both healthcare and community settings.

- It consists of two components, a 3-item recall test for memory and a simply scored clock drawing test. As a screening test, however, it does not substitute for a complete diagnostic workup.

SCORING

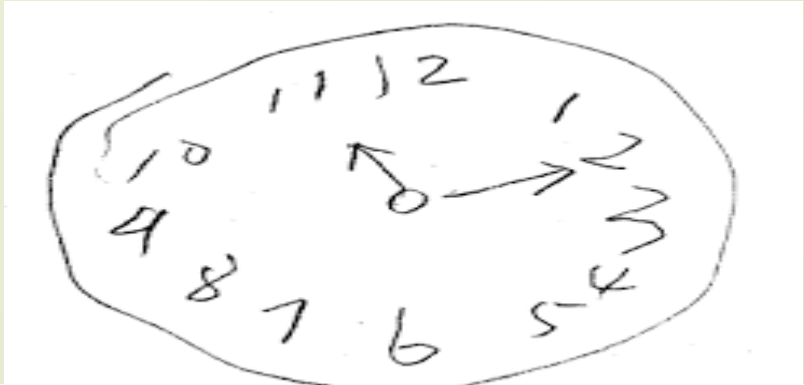
- 3-Item Recall Score:

1 point for each word recalled without cues, for a 3-item recall score of 1, 2, or 3.

- Clock Drawing Score:

2 points for a normal clock or 0 (zero) points for an abnormal clock drawing.

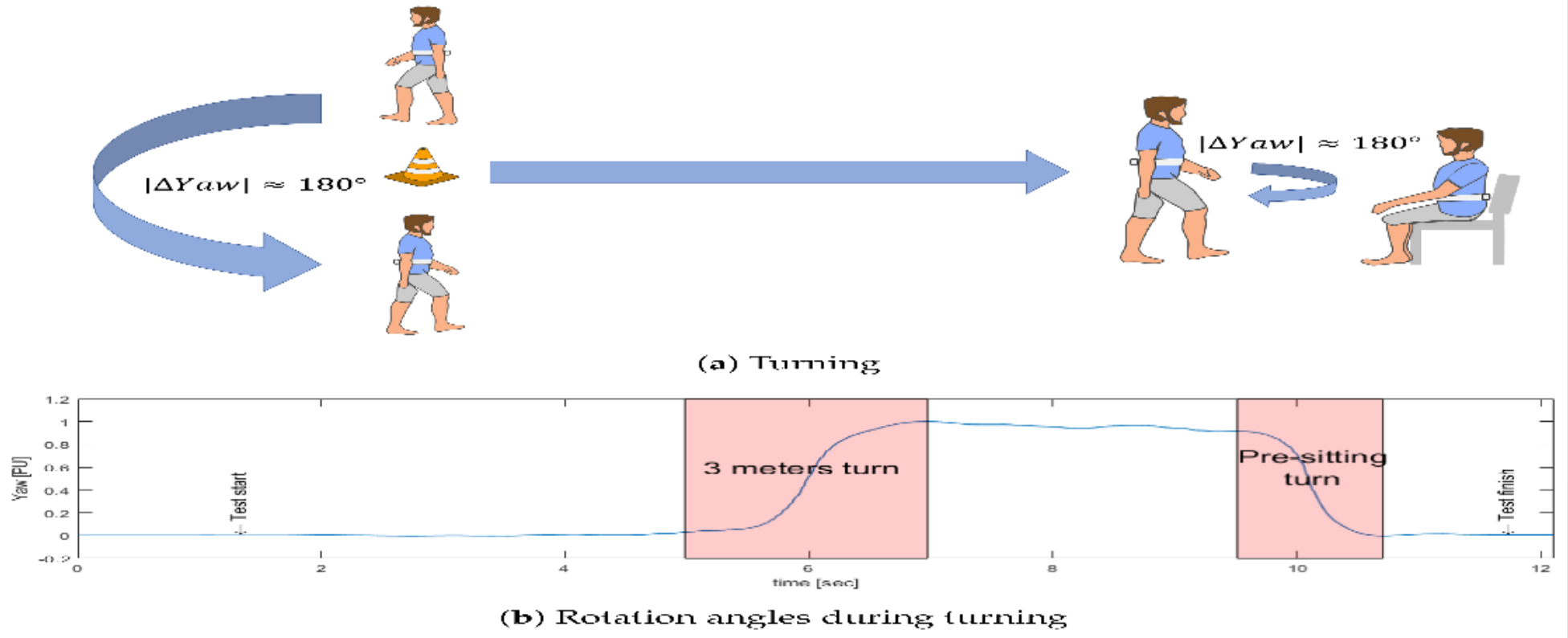
A normal clock must include all numbers (1-12), each only once, in the correct order and direction (clockwise). There must also be two hands present, one pointing to the 11 and one pointing to 2. Hand length is not scored in the Mini-Cog© algorithm.



Interpreting the Mini-Cog© Score:

- Add the 3-item recall and clock drawing scores together. A total score of 3, 4, or 5 indicates lower likelihood of dementia but does not rule out some degree of cognitive impairment.
- The Mini-Cog© is not a diagnostic test for Alzheimer's disease or any other dementia or cause of cognitive impairment.
- Diagnosis of brain disorders that cause cognitive impairment requires a medical examination and additional examinations.

3) TIME up and Go test



- A patient who takes longer than 12 seconds on the Timed Up and Go Test or a physician assessment that gait is mildly abnormal or worse should be evaluated further.
- Patients at high risk of falling need a multifactorial assessment including orthostatic vital signs, visual acuity testing and cataract screening, gait and balance testing, medication review, and investigation of environmental hazards in the home.

Falls Assessment

- Special test for assess falling, mobility and balance :
  1. Timed Up and Go Test :
     - The time patient take for stand up from standard armchair with hand resting on arm rest and walk distance of 3 meters, turn around, walk back to the chair and sit down.
     - Values :
       - ≤ 10 seconds = normal
       - ≤ 20 seconds = good mobility, can go out alone but with high risk of fall
       - ≤ 30 seconds = problems, cannot go outside alone, requires gait aid

TIME Up and Go Test

Ask the patient to perform the following series of maneuvers:

1. Sit comfortably in a straight-backed chair.
2. Rise from the chair.
3. Stand still momentarily.
4. Walk a short distance (approximately 3 meters).
5. Turn around.
6. Walk back to the chair.
7. Turn around.
8. Sit down in the chair.

- Observe the patient's movements for any deviation from a confident, normal performance. Use the following scale:
  - 1 = Normal
  - 2 = Very slightly abnormal
  - 3 = Mildly abnormal
  - 4 = Moderately abnormal
  - 5 = Severely abnormal
- A patient with a score of 3 or more on the Get-up and Go is at risk of falling.

- A cut-off score of ≥ 13.5 seconds was shown to predict falls in community-dwelling frail elders, but this score is not verified in other studies[4].

- Scores of ≥ 30 seconds correspond with functional dependence in people with pathology[2]. Standardized cut-off scores to predict risk of falling have not yet been established.

I HATE FALLING

I	Inflammation of joints (or joint deformity)
H	Hypotension (orthostatic blood pressure changes)
A	Auditory and visual abnormalities
T	Tremor (Parkinson's disease or other causes of tremor)
E	Equilibrium (balance) problem
F	Foot problems
A	Arrhythmia, heart block or valvular disease
L	Leg-length discrepancy
L	Lack of conditioning (generalized weakness)
I	Illness
N	Nutrition (poor; weight loss)
G	Gait disturbance

4) ASSESS NUTRION

Malnutrition

- is an independent predictor of mortality in older adults.
- The most accurate evidence of malnutrition in an elderly patient is hypocholesterolemia and hypo-albuminemia.[9,21]
- Assessment of malnutrition involves a dietary history that includes

1)daily caloric intake,

2)the availability of food, t

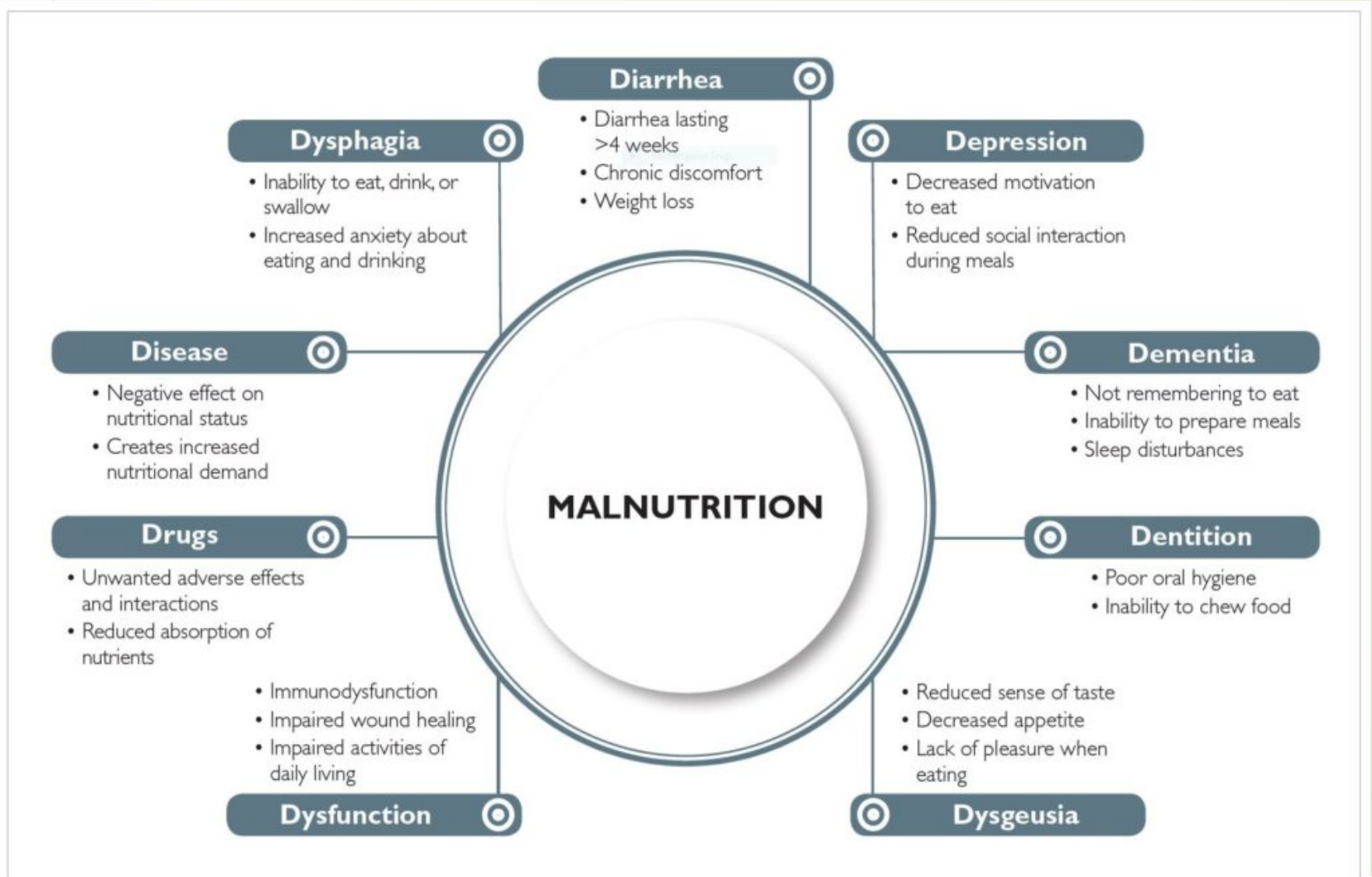
3)he use of nutritional or herbal supplements,

4) and the adequacy of the patient's diet as quantified through the amount of food intake,

5) the number of meals, and the balance of nutrients

- Body weight, weight trend, and muscle wasting that is found on physical examination
- and confirmed by laboratory data (such as serum albumin and total cholesterol levels, and lymphocyte count) should be included.

CAUSES


MALNUTRITION
Diarrhea
• Diarrhea lasting >4 weeks
• Chronic discomfort
• Weight loss
Dysphagia
• Inability to eat, drink, or swallow
• Increased anxiety about eating and drinking
Depression
• Decreased motivation to eat
• Reduced social interaction during meals
Disease
• Negative effect on nutritional status
• Creates increased nutritional demand
Dementia
• Not remembering to eat
• Inability to prepare meals
• Sleep disturbances
Drugs
• Unwanted adverse effects and interactions
• Reduced absorption of nutrients
Dentition
• Poor oral hygiene
• Inability to chew food
• Immunodysfunction
• Impaired wound healing
• Impaired activities of daily living
Dysfunction
• Reduced sense of taste
• Decreased appetite
• Lack of pleasure when eating
Dysgeusia

The Mini Nutritional Assessment

- , a validated tool for measuring nutritional risk in elderly persons that combines anthropometric measures and dietary history, is easy to use in the office setting.
- Patients also should be assessed for oral pathology, ill-fitting dentures, problems with speech or swallowing, medication use that might cause anorexia or dysgeusia, and financial and social problems that may be contributors to malnutrition.

Mini Nutritional Assessment

MNA®

Nestlé Nutrition Institute

Last name: First name:

Sex: Age: Weight, kg: Height, cm: Date:

Complete the screen by filling in the boxes with the appropriate numbers. Total the numbers for the final screening score.

Screening

A Has food intake declined over the past 3 months due to loss of appetite, digestive problems, chewing or swallowing difficulties?
0 = severe decrease in food intake
1 = moderate decrease in food intake
2 = no decrease in food intake ☐

B Weight loss during the last 3 months
0 = weight loss greater than 3 kg (6.6 lbs)
1 = does not know
2 = weight loss between 1 and 3 kg (2.2 and 6.6 lbs)
3 = no weight loss ☐

C Mobility
0 = bed or chair bound
1 = able to get out of bed / chair but does not go out
2 = goes out ☐

D Has suffered psychological stress or acute disease in the past 3 months?
0 = yes 2 = no ☐

E Neuropsychological problems
0 = severe dementia or depression
1 = mild dementia
2 = no psychological problems ☐

F1 Body Mass Index (BMI) (weight in kg) / (height in m^2) ☐
0 = BMI less than 19
1 = BMI 19 to less than 21
2 = BMI 21 to less than 23
3 = BMI 23 or greater ☐

IF BMI IS NOT AVAILABLE, REPLACE QUESTION F1 WITH QUESTION F2.
DO NOT ANSWER QUESTION F2 IF QUESTION F1 IS ALREADY COMPLETED.

F2 Calf circumference (CC) in cm
0 = CC less than 31
3 = CC 31 or greater ☐

Screening score ☐☐
(max. 14 points)

12-14 points: ☐ Normal nutritional status
8-11 points: ☐ At risk of malnutrition
0-7 points: ☐ Malnourished

Save
Print
Reset

Ref. Vellas B, Villars H, Abellan G, et al. *Overview of the MNA® - Its History and Challenges*. J Nutr Health Aging 2006;10:456-465.
Rubenstein LZ, Harker JO, Salva A, Guigoz Y, Vellas B. *Screening for Undernutrition in Geriatric Practice: Developing the Short-Form Mini Nutritional Assessment (MNA-SF)*. J. Geront 2001;56A: M366-377.
Guigoz Y. *The Mini-Nutritional Assessment (MNA®) Review of the Literature - What does it tell us?* J Nutr Health Aging 2006; 10:466-487.
Kaiser MJ, Bauer JM, Ramsch C, et al. *Validation of the Mini Nutritional Assessment Short-Form (MNA®-SF): A practical tool for identification of nutritional status.* J Nutr Health Aging 2009; 13:782-788.

"تقييم التغذية المصغر"

Mini Nutritional Assessment-Short Form
MNA®

Nestlé Nutrition Institute

إسم العائلة:	الإسم الأول:
الجنس: العمر: الوزن(كغ): الطول(سم):	التاريخ:

[illegible]

المسح الأولي

A [illegible]

B [illegible]

C [illegible]

D [illegible]

E [illegible]

F1 [illegible]

[illegible]

F2 [illegible]
0 = أقل من 31 سم
3 = 31 سم أو أكثر

مجموع النقاط المحرزة في المسح الأولي (الحد الأقصى 14 نقطة)

12-14 نقطة: الحالة الغذائية طبيعية
8-11 نقطة: معرض لخطر سوء تغذية
0-7 نقطة: حالة سوء تغذية

Ref. Vellas B, Villars H, Abellan G, et al. Overview of the MNA® - Its History and Challenges. J Nutr Health Aging 2006;10:456-465.
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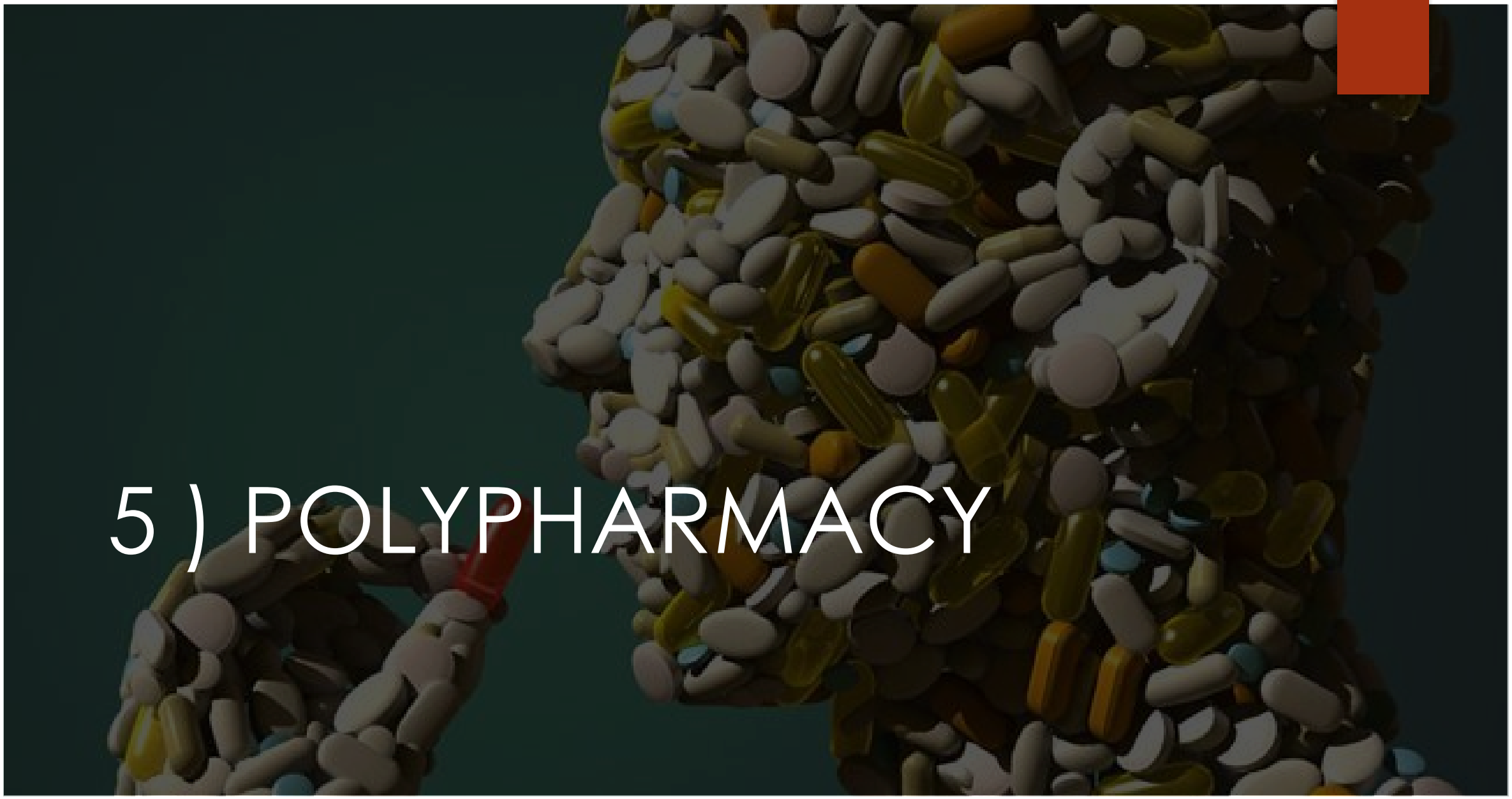
www.mna-elderly.com :لمزيد من المعلومات

Treatment

- Treatment of failure to thrive should focus on identifiable diseases and be limited to interventions that have few risks for these frail patients.
- Failure to thrive commonly occurs near the end of a person's life, so the potential benefits of treatment should be considered before evaluations and treatments are undertaken.
- Initially, treatment involves efforts to modify possible causes.
- A team approach that includes a dietitian, a speech therapist, a social worker, a mental health professional, and a physical therapist may be helpful.[3]



5) POLYPHARMACY

Polypharmacy

- Defined as greater than four prescription medications or greater than three new medications in a 24-hour period.
- Four or more prescription medications increases the risk for falls in the elderly.
- Five or more prescription medications increases the risk of adverse drug reactions.
- 30% of older adult hospital admissions can be linked to drug-related effects, and polypharmacy is the fifth leading cause of death for hospitalized elders.

Polypharmacy

- In clinical way, the criteria utilized for identifying polypharmacy involve :

  - Taking medications that have no obvious indication.
  - Using therapeutic equivalents to treat the same illness .
  - Concurrent usage of interacting medications.
  - Using an inappropriate dosage .
  - Utilizing other medications to treat adverse drug reactions.

POLYPHARMACY

- Increased use of prescription and over-the-counter medications puts older adults at risk of adverse drug reactions, impaired cognition, falls, and functional decline.

- A thorough medication review can identify medications that are underprescribed and necessary, those that are not being used correctly, and those that are inappropriate and should be discontinued.

Solutions for Decreasing Polypharmacy

- Tools to Help Decrease Polypharmacy :
  1. Beers Criteria
  2. STOPP Criteria
  3. START Criteria

6) HEARING AND VISION

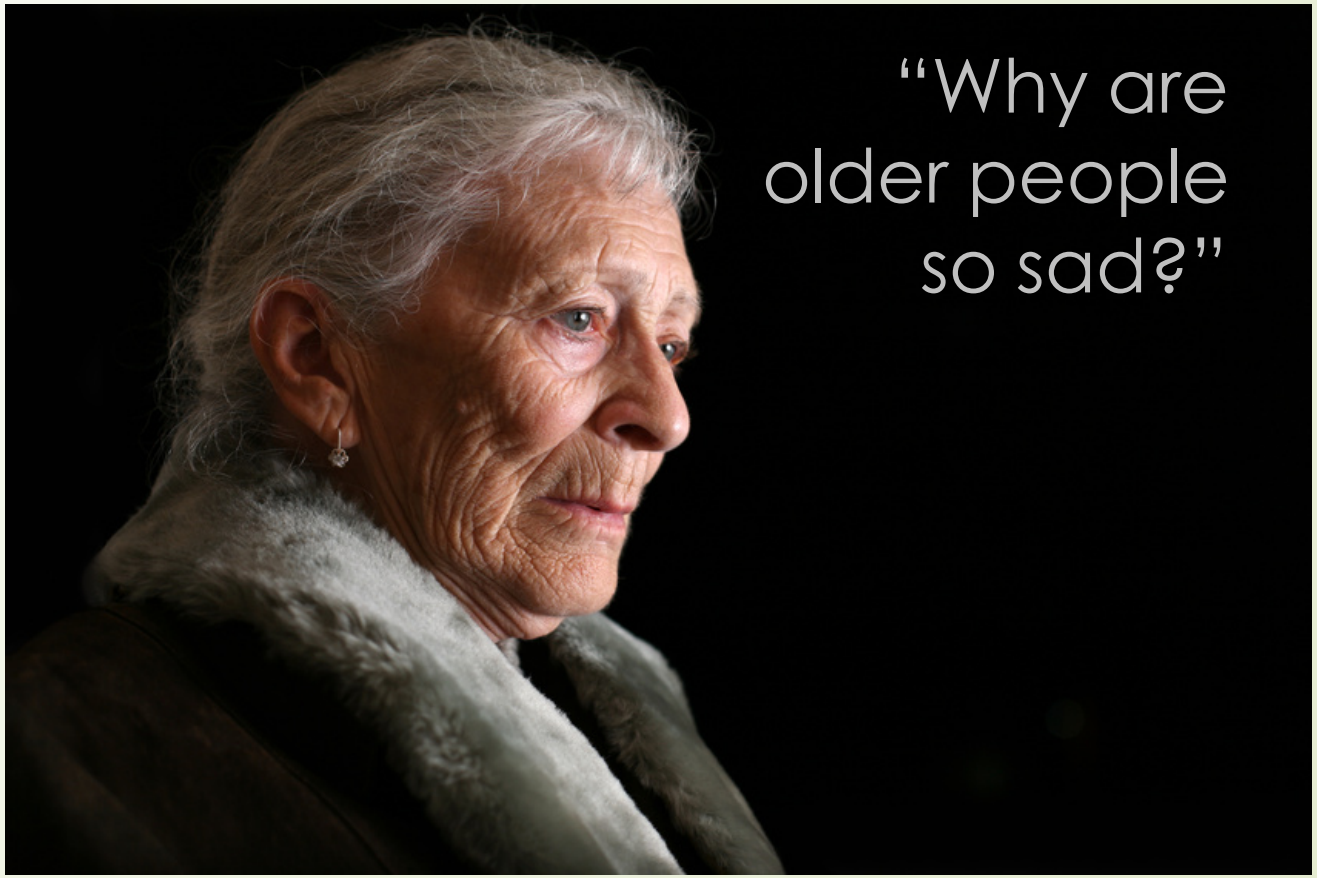
- Hearing loss is often unrecognized by patients, and affects more than 80% of adults older than 80 years.
- Only 10% to 20% of older adults with hearing loss have used hearing aids.
- Moderate to severe hearing loss is associated with a three- to fourfold higher incidence of dementia.
- The USPSTF and the AAFP concluded that there was insufficient evidence to recommend screening for hearing loss in asymptomatic adults older than 50 years.
- Physicians should assess for objective hearing impairment when the patient or a family member raises a concern, or if there are cognitive or mood symptoms that could be influenced by hearing loss, and refer for hearing aids when appropriate.
- Although audiometry is the screening standard, a whispered voice test at 2 ft or a single question (e.g., "Do you feel you have hearing loss?") is an effective alternative.

Vision loss

- is common among older adults in the United States, affecting 12% of those 65 to 74 years of age and 15% of those 75 years and older.
- Common causes of visual impairment include macular degeneration, cataracts, glaucoma, refractive errors, and diabetic retinopathy.
- Decreased visual acuity increases the risk of falls, fractures, social
- isolation, and depression.
- In 2016, the USPSTF and AAFP concluded that the current evidence was insufficient to assess the balance of benefits and harms of screening for impaired visual acuity in older adults.
- Despite lack of evidence of benefit, vision testing offers little harm and can be accomplished by office staff using a Snellen chart.

7) DEPRESSION

Depression



Depression in the Hospitalized Patient- Why Screen?

- Can increase length of stay because it slows recovery and mobilization
- Inpatient is a good time to make a diagnosis and get referrals in place
- Treatments are effective

Who is at Risk?

- Female Gender
- Divorced or separated status
- Low socioeconomic status
- Poor social support
- Comorbid illness
- Cognitive impairment
- Adverse/Stressful life events
- Family history
- Prior depressive episodes
- Previous suicide attempts
- Financial stress

Associated Medical Problems

- Dementia
- Diabetes Mellitus
- Rheumatoid Arthritis
- History of Cerebro-Vascular Accident
- Myocardial Infarction
- Cancer
- Parkinson's Disease

Symptoms:

1. Sadness
2. Felling worthlessness
3. Crying spells
4. Lack of concentration
5. Change in the apatite

Atypical Presentation

- Older depressed patient often has different complaints and presentations than younger patients
- Less commonly experience "mood symptoms"
- Older patients often have more somatic symptoms and may end up hospitalized

Depression in Older Adults: What else to look for?

- Irritability, anxiety or decreased functional status
- Recognize that the role of co-existing medical problems, cognitive deficits, multiple medications complicates the picture
- Many assume depression is a normal part of aging

TABLE 2

PHQ-2 Screening Instrument for Depression

Over the past two weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

Scoring: A score of 3 or more is considered a positive result. The PHQ-9 (Table 3) or a clinical interview should be completed for patients who screen positive.

PHQ = Patient Health Questionnaire.

Adapted from Patient Health Questionnaire (PHQ) screeners. http://www.phqscreeners.com. Accessed February 8, 2018.

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: _____ **DATE:** _____

Over the *last 2 weeks*, how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3
	add columns:		+	+

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card.) **TOTAL:**

10. If you checked off *any* problems, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- **Not difficult at all** _____
- **Somewhat difficult** _____
- **Very difficult** _____
- **Extremely difficult** _____

ZT274388

Severity levels	PHQ-9 score	Frequency (%) (*N*=174)
Normal	0–4	77 (44.3)
Mild	5–9	73 (42.0)
Moderate	10–14	14 (8.0)
Moderate to severe	15–19	6 (3.4)
Severe	20–27	4 (2.3)

Medications that can Cause Depression

- Antihypertensives
  - Beta Blockers
  - Clonidine
- Anti Parkinson's Medications
  - Carbidopa/Levodopa
- Others
  - Benzodiazepines
  - Antihistamines
  - Barbituates

Treatment: Medications

- Selective Serotonin Reuptake Inhibitors (SSRIs) are somewhat interchangeable regarding effectiveness.
- Choose an SSRI based on side effect profile, drug interactions and compliance.
- Citalopram and Sertraline are often recommended among experts for efficacy and tolerability in the elderly.
- Paxil: Anticholinergic properties

Treatment: Therapy

- Cognitive Behavioral Therapy and Interpersonal Therapy
- In the outpatient setting, medications and brief psychotherapy have been shown to be more effective than usual care.

Treatment:

- Just as depression has no single cause, no single treatment works for all patients.
- Typical treatment for depression compose of combination of therapy, medication and lifestyle changes.

8) IMMUNIZATIONS

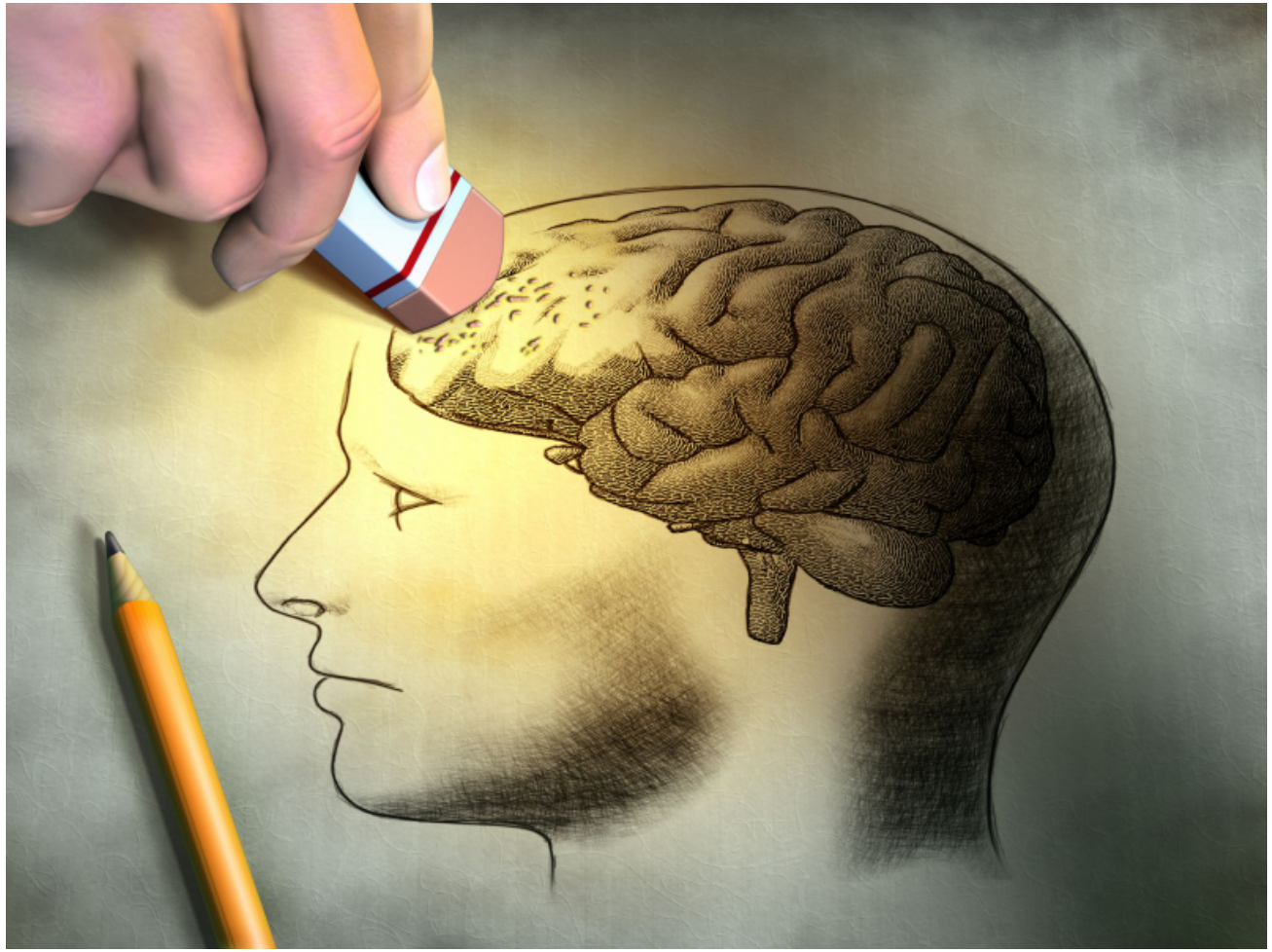
- Geriatric assessment is an opportunity to identify older adults who have not received recommended vaccinations.
- Patients older than 60 years account for 60% of tetanus cases and more than 90% of influenza deaths, and the morbidity of pneumonia and zoster greatly increases after 65 years of age.
- The Advisory Committee on Immunization Practices (ACIP) recommends :

I. annual influenza vaccination.

II. It also recommends that clinicians not miss the opportunity to vaccinate persons older than 65 years with the tetanus toxoid, reduced diphtheria toxoid, and acellular pertussis (Tdap) vaccine and the tetanus and diphtheria toxoids (Td) booster vaccine every 10 years thereafter.

III. For pneumonia vaccination, the ACIP recommends the 13-valent pneumococcal conjugate vaccine (Prevnar 13) at 65 years of age and the 23-valent pneumococcal polysaccharide vaccine (Pneumovax 23) one year later.

IV. The ACIP recommends two doses of recombinant herpes zoster vaccine (Shingrix) administered two to six months apart for immunocompetent adults 50 years or older



9) DEMENTIA

Definition:

- Dementia is a general term for decline in the mental ability sever enough to interfere with daily life activity.
- The first symptom are recognized by other family members rather than the patient himself.

Causes of Dementia:

- There are more than 70 causes of dementia such as :

1. Alzheimer Dementia (AD)
2. Vascular Dementia (VaD)
3. Mixed AD & VaD
4. Dementia Lewy Body (DLB)
5. Frontotemporal Dementia (FTD)

DELIRIUM

Definition :

- An acute mental disturbance characterized by confused thinking and distributed attention usually accompanied by disorders in speech and hallucinations.

Types of Delirium :

1. Hyperactive delirium : probably it is the most easily reorganized type it may include (restlessness, agitation, hallucination & refusal to cooperate)
2. Hypoactive delirium : Inactivity or reduce in motor activity.
3. Mixed delirium : this type will include both hyperactive & hypoactive symptom's.

10) Insomnia

- Difficulty in initiating or maintaining sleep
- NOT excessive daytime sleepiness
  - Usually due to a primary sleep disorder (sleep apnea, narcolepsy, periodic limb movement disorder)
- Most commonly due to
  - Psychiatric illness
  - Pyschophysiologic problems
  - Drug or Alcohol Dependence
  - Restless Leg Syndrome

Treatment for Insomnia

Alter the environment to make it less disturbing at night . .

- minimize night time lighting, sounds and procedures (labs and vitals) and make the bed comfortable (the fewer restraints the better).
- Make sure the patient is active (not napping) during the day with physical therapy, family, and volunteers to help keep the patient company.
- Evaluate the medications and make sure the patient's pain is well controlled.
- Warm milk/tea, relaxing music/white sound, and massages can be helpful.
- Safer medications for the geriatric population include low dose Trazodone or Mirtazapine.

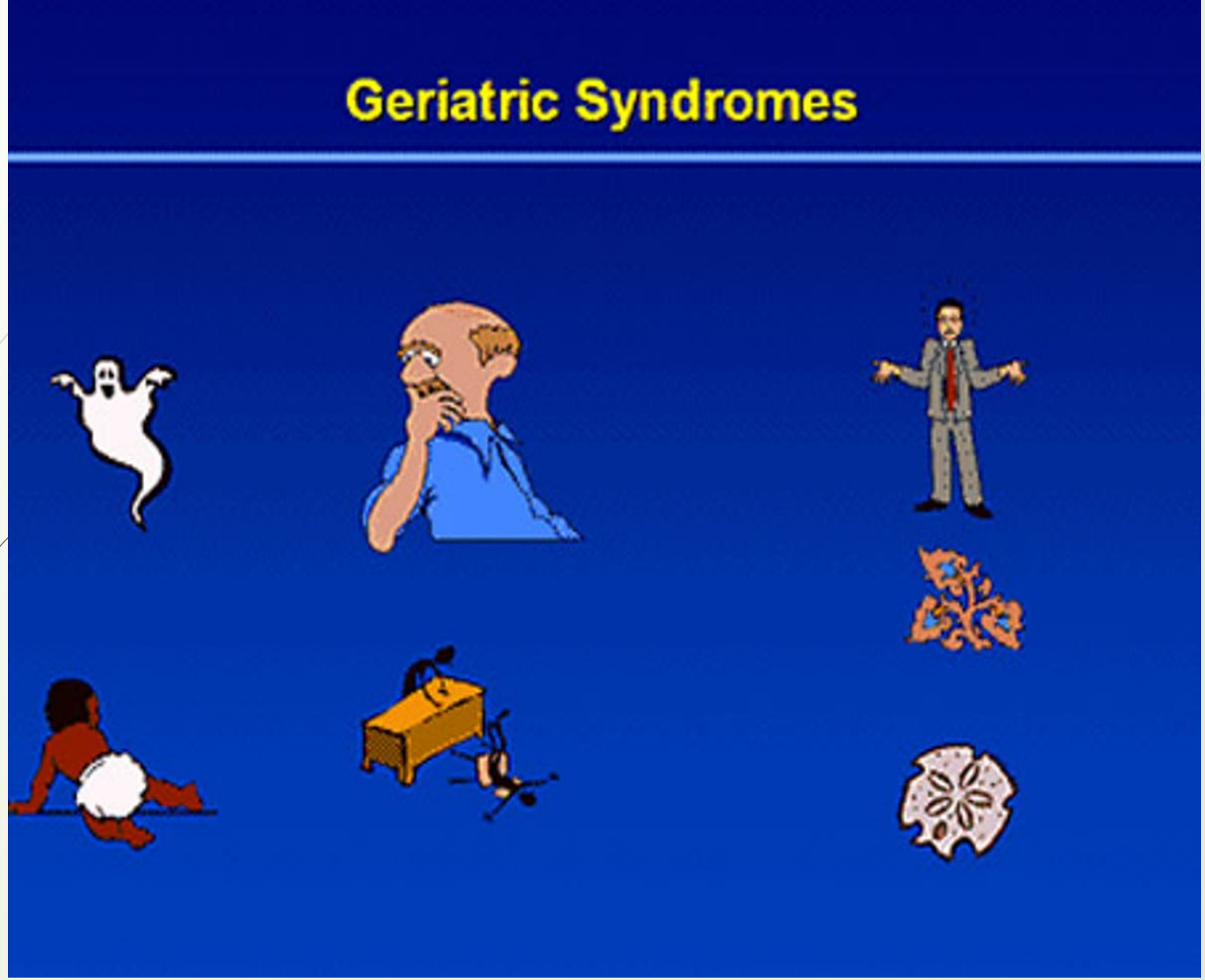
11) URINARY INCONTINENCE

- Urinary incontinence is a common condition impacting 70% of long-term nursing home residents, and 24% of community-dwelling older adults experience incontinence that is rated as moderate to very severe.
- Although the incidence increases with age, urinary incontinence is abnormal at any age and significantly affects quality of life.
- Incontinence is often unidentified because of embarrassment.

A two question screening tool is effective in identifying urinary incontinence: (1) In the past year, have you ever lost your urine and gotten wet? and (2) If so, have you lost your urine on at least six separate days?

Positive responses to both questions should lead to a more in-depth assessment of transient and established factors that are contributing to the incontinence.

Geriatric Syndromes



- **Geriatric syndromes** include a number of conditions typical of, if not specific to, aging, such as dementia, depression, delirium, incontinence, vertigo, falls, spontaneous bone fractures, failure to thrive, and neglect and abuse.
- **Geriatric syndromes** are associated with reduced life expectancy.

Respect old age ; it is your future


The past is
in your head.
The future is in
your hands.