

Family Doctor

A Journal of the New York State Academy of Family Physicians



Winter 2023

Volume eleven, Number three

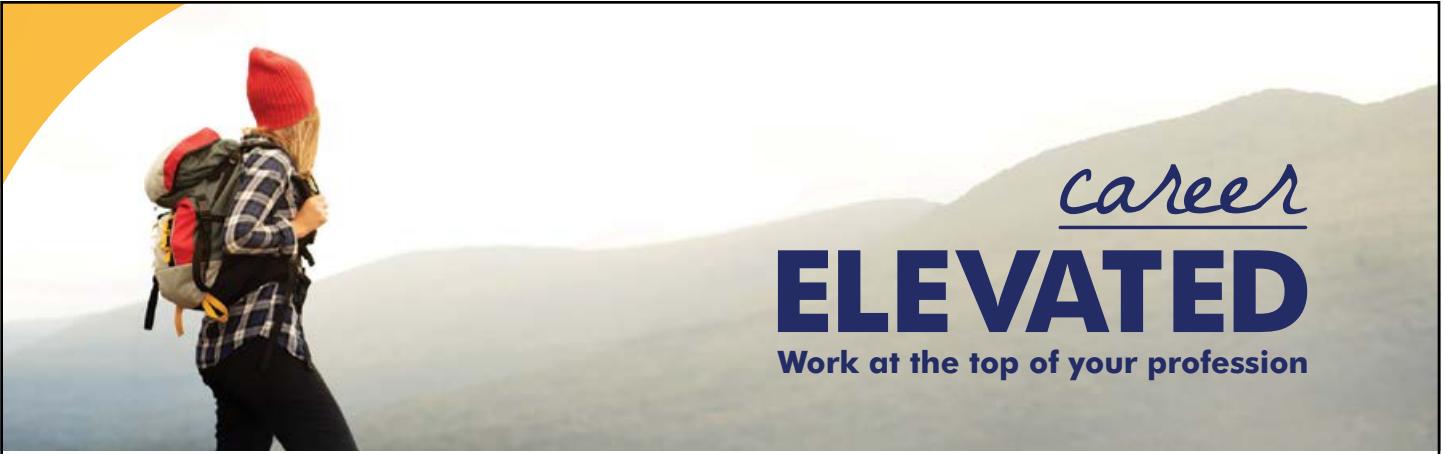


Focus:

Aging & Elder Care

FEATURE ARTICLES:

- Avoiding the Harmful Effects of Ageism
- Behavioral and Psychological Symptoms of Dementia
- Sleep Issues in the Elderly
- Evaluation of Alcohol Use Disorder in Older Adult Population
- Caring for the Elderly in Urgent Care
- Aging, Sexuality and Relationships



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DAILY VALUE

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DAILY VALUE

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DAILY VALUE

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DAILY VALUE

VITAMIN B12



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NIACIN



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DAILY VALUE

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10%
DAILY VALUE

ZINC



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DAILY VALUE

IODINE



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60%
DAILY VALUE

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10%
DRI

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*Source: USDA FoodData Central. FDA's Daily Value (DV) for potassium of 4700 mg is based on a 2005 DRI recommendation. In 2019, NASEM updated the DRI to 3400 mg. Based on the 2019 DRI, a serving of milk provides 10% of the DRI. FDA rule-making is needed to update this value for the purpose of food labeling.

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Family Doctor, A Journal of the New York State Academy of Family Physicians, is published quarterly. It is free to members of the New York State Academy and is distributed by mail and email. Non-member subscriptions are available for \$40 per year; single issues for \$20 each.

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From the Executive Vice President

By Vito Grasso, MPA, CAE

Governor Hochul's election to a full term and the Democrats' retention of majorities in both the Assembly and Senate appear to portend continuation of the political environment which has existed in NY for several years. As we prepare for the new year, we are revisiting several priority issues which we addressed in 2022 and which remain unresolved.

We continue to lobby the Governor regarding her action on two bills passed by the Senate and Assembly. We have encouraged the Governor to sign legislation (S.6534-B, Rivera/ A.7230-A, Gottfried) to create a Primary Care Reform Commission (PCRC). The legislation authorizes the PCRC to review, examine and make findings on the level of primary care spending by all payers in the State. The PCRC would also be required to publish reports on its findings and make recommendations to increase spending on primary care, strengthen primary care infrastructure and increase patient access to primary care without increasing the total cost of health care. The major goal is to develop a plan to increase spending on primary care in total dollars and as a percentage of total spending on health care.

We were joined in our support of the PCRC bill by other organizations representing primary care clinicians and patient advocates and have encouraged the Governor to appoint at least one family physician to the Commission. We have also addressed what we believe is a defect in the bill. It does not include funds for support of the Commission. Instead, it requires several state agencies to provide staff to perform the work of the Commission. We feel this dilutes the purpose and effectiveness of the Commission. We have recommended that funds from the State's \$13.5 billion Medicaid waiver initiative be used to support an independent staff for the PCRC.

The work of the PCRC coincides with and reinforces much of the work we do to achieve reform of the current health care system through increased investment in primary care and through reduction of administrative burdens, which drain the resources of primary care physicians.

The second bill we have lobbied the Governor about is the "wrongful death" bill (S.74A, Hoylman/A.6770, Weinstein). We have encouraged the Governor to veto this bill because it unjustly expands the scope of damages and lawsuits by including compensation of grief and anguish. If enacted, this legislation could increase medical liability premiums by 40%. New York's medical liability costs are already extraordinarily high and contribute to an overall climate which makes it unattractive to practice medicine in New York. Advocates of the bill claim that many other states allow for recovery of compensation for grief and anguish. Most of those states, however, also have policies in place to contain excessive medical liability costs including caps on damages.

There will be new issues as well in the 2023 session. We have already asked the Governor to expand the healthcare worker bonus program to include all clinicians who saw patients during the pandemic and were

exposed to risk and danger. The current program only applies to health care workers employed in practices and other settings which have 20% or more of their patient census in Medicaid.

We continue to work for legislation to accommodate reporting of adult vaccinations to the NY Immunization Information Service. Current law requires adult patients to consent before their vaccinations can be reported to the registry. Vaccinations of children must be reported and we feel the same benefits which accrue to pediatric and adolescent patients should be extended to adult patients as well.

We continue to lobby for relief from administrative requirements, which distract physicians from clinical responsibilities and rarely provide any protection or benefit for patients. Restrictions on the use of prior authorization, step therapy and formularies are all on our agenda.

Our ability to effectively represent family physicians and to influence policy is enhanced by an outstanding team of professionals who monitor developments in the legislature and with the Governor's Office. Our Advocacy Commission under the leadership of Jiana Menendez, MD, and with invaluable support from our lobbyist, Marcy Savage, review bills introduced in either house of the legislature which affect health care. Their recommendations for action on bills are reviewed by our leadership team including the board president Andrew Symons, MD, president-elect Heather Paladine, MD, and myself. We typically comment on bills which affect family physicians or patients. We often meet with legislators and/or the Governor's staff to discuss bills and issues related to those bills. We also lead and/or participate in coalitions of organizations formed to address specific legislation.

There will be some new faces occupying seats in the Senate and Assembly. Long-time Assembly Health Committee chair Dick Gottfried has retired, and Assembly Insurance Committee chair Kevin Cahill was defeated in his campaign for re-election. Some other seats have also turned over and we will be introducing ourselves to new legislators and new committee chairs.

As we prepare for the 2023 session, we welcome, as always, comments and suggestions from members about issues and concerns you feel we should address with elected officials. We also welcome and encourage you to become actively involved by participating on our Congress of Delegates, volunteering to serve on a commission, supporting our grassroots lobbying and participating in our annual lobby day when we schedule appointments with legislators, the Governor's staff and staff of various executive agencies. We are here to serve you and we look forward to the opportunity to do so.

Sarcopenia in the Elderly: Screening and Prevention Strategies for the Family Medicine Physician's Toolbox

By Zachary Scibetta, OMSIV and Erika Sadeghi, MD, CAQSM

The geriatric population in the United States is estimated to increase to 83.7 million in 2050, which is almost double the estimated population in 2012.⁷ Longer life expectancies and the aging baby boomer population contribute to this unprecedented level. As we age, aerobic capacity, muscle mass, and strength decline resulting in a decreased ability to perform daily activities and to enjoy a certain quality of life. Loss of muscle mass increases as physical activity declines with age, resulting in a condition known as sarcopenia. Unfortunately, sarcopenia is a very common disease in the older population defined by decreased muscle strength and mass. The name comes from the Greek roots, “sark” (flesh) and “penia” (poverty), which highlight the core of the disease. There are many proposed ways of diagnosing sarcopenia, usually revolving around the measurement of muscle mass of an individual. However, to any clinician, the physical signs are quite apparent. Difficulty standing, walking, and maintaining balance can all be indicators.

The European Working Group on Sarcopenia in Older People (EWGSOP) is a group that holds meetings every decade to discuss the disease, and ways to recognize it. The group consists of multiple European and international medical societies, which come together to clarify and classify sarcopenia. The severity of sarcopenia is graded by three main characteristics: decreased muscle strength, decreased

muscle quantity/quality, and decreased physical performance. With the first two characteristics, a clinician can be sure that the disease is present. If the third is met, then sarcopenia is severe in nature.⁴

The disease occurs for many reasons. As age increases, the amount of growth factors like human growth hormone decrease. This results in less anabolism of muscle. Patients with insulin resistance have a decreased effect of insulin on muscle, which generally should help with protein synthesis. Even more substantial is neurodegeneration, which occurs as people age, resulting in fewer muscle fibers being recruited. Additionally, inflammatory markers increase with age (TNF, CRP, IL-1), which induce catabolism of muscle. With all these factors combined, is no wonder that sarcopenia is so prevalent.²

One of the greatest tools for screening for sarcopenia is the SARC-F, which consists of five questions regarding the patient's ability to walk with assistance, their strength, their ability to climb stairs, their ability to rise from a chair, and any falls they may have had (Table 1). A score equal to or greater than four suggests further evaluation for sarcopenia. It is suggested that the SARC-F could be as useful of a tool as FRAX score is to predict a fracture due to bone density loss.⁶ While this questionnaire is promising, it must take into consideration the patient's interpretation of the questions. For example, if the patient has consistently had difficulty climbing stairs for the past decade, they might not see the change in their ability over time.

Table 1: SARC-F screen for sarcopenia⁶

Component	Question	Scoring
Strength	How much difficulty do you have in lifting and carrying 10 pounds?	None = 0 Some = 1 A lot or unable = 2
Assistance in walking	How much difficulty do you have walking across a room?	None = 0 Some = 1 A lot, use aids, or unable = 2
Rise from a chair	How much difficulty do you have transferring from a chair or bed?	None = 0 Some = 1 A lot or unable without help = 2
Climb stairs	How much difficulty do you have climbing a flight of 10 stairs?	None = 0 Some = 1 A lot or unable = 2
Falls	How many times have you fallen in the past year?	None = 0 1-3 falls = 1 4 or more falls = 2



Handgrip is an excellent and easy way to test a patient for sarcopenia, as decreases in muscle mass will present as a decrease in handgrip. Tools exist for ease of use in the office, and generally, it is expected for a female to have a handgrip above 16kg and a male to have a handgrip above 27kg. Handgrips below these margins can be suggestive of sarcopenia, due to the decrease in muscle mass and strength inherent with the disease. Of course, the clinician needs to make sure there are not any other conditions that could be causing the decrease in handgrip. Arthritis, neurological damage, and even local trauma could cause false positives. Another even easier technique is to have a patient stand from a seated position without the use of their hands, ideally being able to do so five times in under 15 seconds.² While it may be apparent to the clinician that the patient is suffering from sarcopenia, these are excellent ways to help track the progression of the disease. Comparing a patient's change in handgrip, for example, is an easy metric to obtain and track.

Other techniques can be used, from MRI to CT scans to attempt to quantify muscle mass. The issues arise with the requirements for MRI and CT, which are both expensive and require a clinician trained to interpret them. Because of this, it is much easier for both the patient and the physician to focus on the previously discussed techniques to diagnose sarcopenia.² Once suspicion is established, a clinician should set their sights on ways to prevent worsening symptoms and disease.

To maintain adequate muscle mass, the first place to look is a patient's nutritional intake. As high as 71% of elderly patients in rehabilitation settings have poor oral health, whether due to dental pain or dysphagia, or simply a lack of teeth.¹ A physician should identify these issues by inquiring about a patient's dietary habits, and problems they may have. This is important because the average adult requires 25 to 30g of protein per meal per day. Specifically, proteins from animals are found to be the most beneficial, as they contain higher amounts of leucine which has anabolic properties, helping to build more muscle.⁸ Of course, any protein is better than none, and supplemental protein beverages are often used.

Prevention should begin with an analysis of daily exercise. Resistance training exercise has shown the greatest effect in preventing muscle loss and enhancing strength, specifically resistance that is equal to or above 50% of one rep maximum.³ For example, if a patient can lift 20 pounds maximum for one repetition, then they should do repetitions of 10 pounds or more to maintain and increase strength.

Some medications have been proposed to be helpful with sarcopenia. These range from experimental gene therapies to prevent muscle wasting to proteins that may have the ability to regrow muscle mass. The verdict is unclear on these future therapies – but there are solutions physicians currently have in their toolbox. Controlling co-morbid diseases is an excellent way to combat sarcopenia. Controlling diabetes mellitus with metformin, for example, will not only assist with insulin resistance but may also have an effect directly on skeletal muscle degeneration.⁵

In summary, screening tools such as SARC-F can help identify patients at risk for sarcopenia. Once identified, prevention of sarcopenia consists of physical activity, resistance exercise, nutrition supplementation, and control of comorbid diseases. With the development of screening tools and prevention implementation, providers can protect our aging population and patients can maintain a higher quality of life.

Endnotes

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Albany Report

By Reid, McNally & Savage



2022 NYS Election Update

As the NYSAFP Winter Journal goes to print, New York State has just completed its statewide elections with the Governor, Lieutenant Governor, State Comptroller, Attorney General and all 213 state legislators and congressional representatives up for election on November 8th. Elections this year were complicated by a redistricting process challenged in the courts and a Special Master appointed to draw the new district lines of the State Senators and members of Congress. This led to a split in the primary dates with the Gubernatorial and Assembly primaries being held in June and the Senate and Congressional primaries coming up on August 23rd.

Democratic Governor Hochul handily won the democratic primary and then faced off against Republican Congressman Lee Zeldin in November. This turned into a much-closer-than-expected race with Governor Hochul winning by only about 5% (approx. 300,000 votes). In addition, because of the redistricting process, retirements and aspirations to run for other offices, several Senate and Assembly members did not run this year. Of those that did run, most Senate and Assembly incumbents retained their seats, but there were some notable upsets in both the June Assembly primaries and the November general elections. Senate Health Committee Chairman (and single payer bill sponsor) Gustavo Rivera prevailed in a very close primary for his Bronx seat and will return to Albany in January 2023.

Overall, both the Senate and Assembly will retain their Democratic majorities, and the Assembly is expected to retain its $\frac{2}{3}$ “supermajority” meaning they would have enough votes to override a gubernatorial veto if they wished to do so. There are some races still yet to be called in both houses, but it is also possible that the Senate will end up with a supermajority as well once all election results are final. While there will be a number of new faces in Albany, and the loss of strong institutional knowledge due to retirements as summarized below, it will be largely “business as usual” when lawmakers return to the State Capitol for the 2023 session, with one party rule continuing in the Executive and Legislative branches.

Legislative Changes

Most notably, at the end of this year, longstanding Assembly Health Chair Richard Gottfried (and single payer bill sponsor) will retire after serving in office for fifty-two years and multiple decades as Health Chair. In addition, Assemblyman Kevin Cahill, Assembly Insurance Chair, and Assemblyman Tom Abinanti, Assembly Developmental Disabilities Chair lost their primary elections in June, and Assemblyman Steve Englebright, Assembly Environmental Conservation Chair, and Assemblyman Steve Cymbrowitz, Assembly Housing Chair lost their general elections. This sets up a domino effect with many leadership positions and committee chairs shifting. We may not know until January when the new session starts who the new chairs of key committees of interest to NYSAFP will be. Reach out to your Academy for an updated list.

The following Senators and Assembly Members did not run for re-election:

Senate Incumbents Who Did Not Run:

Jim Gaughran (D)	Mike Martucci (R)
Phil Boyle (R)	Daphne Jordan (R)
Todd Kaminsky (D)	Pattie Ritchie (R)
Diane Savino (D)	Fred Akshar (R)
Alessandra Biaggi (D)	

Assembly Incumbents Who Did Not Run:

Michael Montesano (R)	Kevin Byrne (R)
Brian Barnwell (D)	Sandra Galef (D)
Catherine Nolan (D)	Michael Lawler (R)
Michael Cusick (D)	Colin Schmitt (R)
Yuh-Line Niou (D)	Kieran Michael Lalor (R)
Dan Quart (D)	Mark Walczyk (R)
Richard Gottfried (D)	John Salka (R)

Below are the newly elected members with some seats still left to be called in both houses:

New Senators:

SD3 – Dean Murray (R, Long Island)
SD4 – Monica Martinez (D, Long Island)
SD5 – Steven Rhoads (R, Long Island) <i>Defeated John Brooks</i>
SD7 – Jack Martins (R, Long Island) <i>Defeated Anna Kaplan</i>
SD 9 – Patricia Canzoneri-Fitzpatrick (R, Long Island)
SD17 – Iwen Chu (D- Brooklyn)
SD23 – Jessica Scarella-Spanton (D, Staten Island)
SD34 – Nathalia Fernandez (D, Bronx)
SD38 – Bill Weber (R, Westchester) <i>Defeated Elijah Reichlin-Melnick</i>
SD39 – Rob Rolison (R, Poughkeepsie)
SD43 – Jacob Ashby (R, Rensselaer)
SD49 – Mark Walczyk (R, Watertown)
SD52 – Lea Webb (D, Central NY/Southern Tier)
SD59 – Kristin Gonzalez (D, Queens)

Senate Race in Recount- as of 12/3/22:

SD50 – Incumbent John Mannion (D- Syracuse) vs.
Rebecca Shiroff (R) * Senator Mannion is currently the
Senate Developmental Disabilities Committee Chair

New Assembly Members:

AD4 – Ed Flood (R, Port Jefferson) <i>Defeated Steve Englebright (D)</i>
AD15 – Jacob Ryan Blumencranz (R, Long Island)
AD 21 – Brian Curran (R, Rockville Center) <i>Defeated Judy Griffin (D)</i>
AD30 – Steven Raga (D, Queens)
AD37 – Juan Ardila (D, Queens)
AD45 – Michael Novakhov (R, Brooklyn) <i>Defeated Steve Cymbrowitz (D)</i>
AD46 – Alec Brook-Krasny (R, Brooklyn) <i>Defeated Mathlyde Frontus (D)</i>
AD49 – Lester Chang (R, Brooklyn) <i>Defeated Peter Abbate (D)</i>
AD63 - Sam Pirozzolo (R, Staten Island)
AD65 – Grace Lee (D, Manhattan)
AD73 – Alex Bores (D, Manhattan)
AD75 – Tony Simone (D, Manhattan) <i>Replaced Richard Gottfried</i>
AD80 – John Zaccaro (D, Bronx)
AD92 – Mary Jane Shimsky (D, Westchester)
AD94 – Matt Slater (R, Putnam County)
AD95 – Dana Levenberg (D, Putnam County)
AD97 – John McGowan (R, Rockland County)
AD101 – Brian Maher (R, Montgomery)
AD103 – Sarahana Shrestha (D, Kingston)
AD105 – Anil Beephan (R, Hudson Valley)
AD107 – Scott Bendett (R, Rensselaer)
AD122 – Brian Miller (R, Southern Tier)
<u>Assembly Race in Recount as of 12/3/22</u>
AD23 – Incumbent Stacey Pheffer Amato (D, Rockaway) vs. Tom Sullivan (R)
Hochul Administration Changes
<u>New York Budget Director Robert Mujica and New York State Health Commissioner Mary Bassett Announce January Departures</u>
Shortly after the elections, NY Budget Director Robert Mujica announced he will be stepping down in January. He will relocate to Puerto Rico, where he's been nominated as the next executive director of the island's fiscal control board. Administration insiders said they expect he may be succeeded in the position by Sandra L. Beattie, the first deputy budget director. Mujica will still work on the 2024 state budget before leaving and will transition out of his current role at the end of the year.

Most recently on December 2nd, Dr. Bassett, State Health Commissioner announced that she would also be retiring at the end of the year in the following statement:

"I have submitted my resignation as New York State Health Commissioner effective January 1, 2023, when I will return to the Harvard Chan School of Public Health. This was a very difficult decision. I have tremendous admiration for the work our staff has done during a very difficult year responding to COVID, mpox, polio and the day-to-day challenges of protecting New Yorkers' health. I am leaving now so the next commissioner can have the chance to lead this great department for a full 4-year term under the leadership of Gov. Hochul. I am grateful that the Governor gave me the opportunity to serve as commissioner, and I know that the department and public health will be in good hands thanks to her leadership and the incredible talent and dedication of the staff. Though I am moving back to Massachusetts, I will always be a New Yorker, and I look forward to cheering on the department's accomplishments in the coming years."

2023 Budget Forecast

Hochul Administration to State Agencies:

Keep Budgets Flat Next Fiscal Year

Governor Hochul will present her budget proposal to lawmakers by February 2023. In late November, Budget Director Robert Mujica wrote to the commissioners of the state's 59 executive agencies, telling them not to seek operating budget hikes that are higher than this year's allocation. He cited growing deficits and an uncertain economy.

"Commissioners must be mindful of Governor Hochul's commitment to deliver critical services for New Yorkers while protecting our state's fiscal health, as you develop agency budget requests, which should not exceed enacted FY 2023 funding levels, excluding one-time investments."

The state's budget financial plan anticipates a deficit of \$148 million next fiscal year that is estimated to balloon to \$3.5 billion in the 2025-26 fiscal year and \$6 billion in the 2027-28 fiscal year. Mujica said the state is boosting its reserve funds to prepare for any downturn, but limited spending will be needed. The state budget approved last April hit a record \$220 billion, with a 7 percent increase in school aid.

"All aspects of business should be reviewed for savings and efficiencies, and funding requests should articulate execution of this review," he wrote. "The effectiveness and efficiency of every program and every dollar spent should be closely evaluated; unnecessary duplication or overlap should be eliminated; energy-and material-saving measures afforded by technology should be pursued; opportunities to provide services and engage residents digitally should be seized; and attracting and retaining top talent must be a priority."

NYSAFP Preparing for 2023 Session

As previously stated, post-election will be largely business-as-usual with Governor Hochul and the Senate and Assembly retaining strong Democratic majorities. However, the key issues for voters in the November elections were focused on crime, public safety and the economy, not abortion and Trump as Democrats hoped, which may have an impact as they work to form their agendas for their next terms. Also, with Governor Hochul beating Conservative Republican Lee Zeldin by a slim 5% margin, it will be curious to see if the moderate Governor moves more to the right to gain more independent support or with the Working Families Party, which took credit for her win given the 11th hour push which brought 5% of the vote which was the margin that she won by. Will she move more to the left feeling compelled to pursue policies that are more progressive?

NYSAFP 2023 priorities

The Academy is finalizing its priorities for 2023 under the leadership of President Andrew Symons, MD, President-elect Heather Paladine, MD and Advocacy Chair Jiana Menendez, MD, and is meeting with the Governor's administration to advocate for the inclusion of NYSAFP's priorities in the SFY 24 Executive Budget.

Priorities include:

- Enhancing recruitment, retention and educational opportunities in family medicine/primary care
- Vaccine promotion and public health infrastructure improvements
- Expanding access and education around reproductive health care including the use of telehealth
- Seeking insurance reforms including advocating for single payer health care, and removing and streamlining burdensome insurance requirements on practices

NYSAFP Lobby Day

NYSAFP will be promoting its 2023 advocacy priorities through a variety of activities throughout the session beginning in January, including legislative meetings, grassroots advocacy, coalition building, garnering media attention and political action. The Academy's annual lobby day, scheduled for Monday February 27, 2023- in person in Albany, is a very important opportunity for members to participate in this process and have a strong impact by letting your own Senators and Assembly members know the issues that greatly matter to family physicians and your patients. We urge you to join! Registration information and other event details will be available through NYSAFP in the near future.

LGBTQ+ and Aging

VIEW ONE

COMPASSIONATE CARE FOR THE ELDERLY

By Christopher J. Awwad, DO; David Sherlock, DO and Anisa Buccellato, DO

INTRODUCTION

Family medicine physicians are typically well-trained in caring for elderly patients. However, medical school and residency curricula are overall lacking in instruction regarding the care of LGBTQ+ patients. Patients who exist at the intersection of these two vulnerable populations often suffer poor health outcomes and receive suboptimal care due to the compounded effects of a multitude of factors including fear of disclosure of identity, inability to identify caregivers accurately, increased incidence of mental health issues, and higher rates of social isolation among LGBTQ+ elders. As the portion of the older adult population identifying as LGBTQ+ continues to increase year over year, family medicine physician knowledge, humility, and cultural competency related to the care of this community will become progressively more important in efforts to provide high-quality care to aging LGBTQ+ patients.

HEALTHCARE DISPARITIES

There are numerous factors that contribute to the healthcare disparities that disproportionately affect LGBTQ+ individuals. There exists a significant amount of distrust between LGBTQ+ patients and the medical community due to well-documented discrimination in care and, at times, outright refusal of care for some.⁶ This distrust is significantly amplified in some elderly LGBTQ+ patients who may have experienced historical misdeeds of the broader healthcare community, including the delayed response to the HIV/AIDS epidemic and the continued presence of homosexuality as a formal psychiatric diagnosis in the DSM (Diagnostic and Statistical Manual) until 1973. Additionally, some LGBTQ+ individuals have been victims of healthcare providers who engaged in “reparative therapy” or “conversion therapy,” a combination of scientifically unfounded methods involving the use of medications, hormone therapy, electroshock therapy, or surgeries to “treat” sexual orientation or gender identity. These practices have been proven harmful, and major medical associations have condemned their use.

Additionally, the lack of an adequate number of physicians with cultural competency and clinical knowledge necessary to sensitively and effectively care for this population contributes negatively to LGBTQ+ patient’s experiences within the healthcare system.⁶ This disparity begins in medical school, where students are frequently undereducated in LGBTQ+ healthcare themes. One survey of medical school deans found the average amount of time spent LGBTQ+ healthcare instruction was just 5 hours.¹

HEALTH DISPARITIES

LGBTQ+ individuals experience higher rates of chronic health conditions, mental health issues, and substance use disorders, likely

VIEW TWO

RECOGNIZING THE ROLE FOR STORY IN DISRUPTED TIMES

By Allison Ogawa, BA; Stephanie Brown Clark, MD, PhD and Lisa Vargish, MD, MS

OVERVIEW

The current research landscape for LGBTQ+ aging largely prioritizes a risk factor and deficit-based model. Traditional, problem-based clinical interviewing often mirrors this approach and risks excluding and devaluing the experiences of LGBTQ+ older adults. Reframing clinical conversations to value story and make room for grief can highlight resilience and improve culturally connected care for this vulnerable group.

Despite growing advancements in age-friendly health systems, our current healthcare system is far from optimal. While most older adults encounter several barriers to accessible healthcare, many LGBTQ+ older adults, especially Queer, Trans, Black, Indigenous People of Color (QTBIPOC), have survived decades of mistreatment within our healthcare system that have created additional barriers. Historical and modern structural inequities have affected the family, community, health, and wealth of LGBTQ+ older adults, along with intersections between race, class, and disability, placing many people in vulnerable positions, which are easily exacerbated by periods of disruption.

The COVID-19 pandemic ushered in significant disruptions and provoked calls for improved support and care of this multifaceted population. After years of invisibility in health research, there is mounting evidence that LGBTQ+ older adults experience higher rates of socioeconomic stress, mental health concerns, and chronic diseases associated with severe COVID-19 than their cisgender, heterosexual counterparts.¹⁻⁶ One recent review of LGBTQ+ older adults’ end of life care needs identified three commonalities: systemic barriers, a lack of lived experience within the literature, and treatment of LGBTQ+ as one homogeneous group.⁷

The current research landscape largely ignores intersectional LGBTQ+ identities, failing to provide competent clinical tools and guidelines for people who experience multiple vectors of structural violence. The *minority-strength model*, developed in 2020, brings a resilience-based focus. However, no older adult participants (age>66) were included in its formation, thus failing to affirmatively incorporate an understanding of aging into the model itself.⁸

In contrast, many scholars of the narrative medicine movement have highlighted the importance of the narrative in healing and therapeutic relationships. Kathryn Montgomery’s foundational work underscores the importance of narrative and legitimacy of storytelling within medicine.⁹ Rita Charon’s “narrative knowledge” expands and contrasts legitimized forms of knowing to include story.¹⁰

related to minority stress and exacerbated by overall poor access to culturally competent medical care, and delay in seeking care due to past negative interactions with healthcare providers or fear of possible negative interactions.⁶ Elderly LGBTQ+ individuals are more likely to suffer from social isolation due to factors like fear of disclosure of sexual or gender identity and historical inability to form family structures like those of their heterosexual or cisgender counterparts. Additionally, discrimination in employment and housing, limited income, limited access to transportation, and limited access to social support such as community and religious groups that may not be accepting of these individuals.⁴

LGBTQ+ individuals are less likely to receive some forms of healthcare maintenance, including routine cancer screening. In many cases, this is due to prior negative interactions with healthcare providers. According to the American Association for Cancer Research, in the 2013-2016 National Health Interview Survey, gay men had over 50% increased odds of reporting a cancer diagnosis and bisexual women had 70 percent increased odds of reporting a cancer diagnosis. This may be in part due to lower rates of cancer screening in the LGBTQ+ community.²

In order to optimally screen and treat patients, physicians must have a clear understanding of a patient's sexual orientation and gender identity as well as their particular risk factors. For example, without knowledge of a patient's natal sex or ongoing hormonal interventions, it is possible to misinterpret lab values that may be gender specific. Additionally, without knowledge of a transgender patient's anatomy, physicians may neglect appropriate screening tests (e.g. cervical cancer screening or breast cancer screening in trans males, prostate cancer screening in trans females). Without appropriate and thorough sexual history taking, physicians may neglect appropriate sexually-transmitted infection screening, as well. Without assurance and advocacy from their physicians, LGBTQ+ patients may avoid screening altogether due to concerns regarding insurance coverage, costs, and the risk of discrimination.

In efforts to avoid perpetuating health disparities, physicians should avoid assumptions regarding a patient's particular behaviors, risks, and concerns. As with all patients, screening tests and interventions should be tailored to the patient's unique needs. Knowledge of specific risks and needs of the elderly LGBTQ+ population can help to drive effective screening and drive care outcomes.

COLLECTION OF SOGI (SEXUAL ORIENTATION AND GENDER IDENTITY) DATA

The collection of sexual orientation and gender identity data in patient registration forms and electronic medical records represents a prime opportunity to improve representation for LGBTQ+ patients in healthcare research and quality improvement initiatives. The infrastructure for collection of this data does not exist in a significant portion of healthcare settings, and even in those where efforts have begun, significant discomfort with the collection of this information limits the success of these efforts. Oftentimes, this hesitancy to inquire about a patient's identity is based on concerns that patients (particularly elderly patients) may be offended by these types of questions. In one study, 80% of clinicians believed patients would refuse to provide their sexual orientation, but only 10% of patients in the same study reported

they would refuse to answer the question.³ These findings underscore the importance of physicians working to acknowledge and address their own preconceived notions in order to avoid negatively impacting patient care by failing to gather important information about their patients. SOGI data, when collected consistently and effectively, can help to guide potential screenings and interventions that will help improve the health disparities previously discussed.⁷

LONG TERM CARE NEEDS OF LGBTQ+ INDIVIDUALS

Fear of aging can be quite common in the LGBTQ+ community. In a survey administered by AARP, 75% of adults aged 45 and older who identified as lesbian, gay, bisexual, or transgender reported being concerned about having sufficient support as they age. Additionally, many of the respondents reported they worried about how they would be treated in long-term care.⁴ Additionally, 34% of all LGBTQ+ survey respondents reported being at least somewhat worried they would have to conceal their sexual identity in order to have access to suitable housing options as they age.⁴ This can include not being able to live with a romantic partner or having limited visitation or private time with a partner, including conjugal visits. Physicians should remain cognizant of policies or procedures in their practice settings that have the potential to negatively impact their LGBTQ+ identifying patients.

END OF LIFE CARE CHALLENGES FOR LGBTQ+ INDIVIDUALS

LGBTQ+ individuals have an increased risk of healthcare disparities at the end of life. In a survey of 865 hospice and palliative care providers, 53.6% of respondents thought that LGB patients were more likely to experience discrimination in their institutions and 23.7% observed discriminatory care. 63.4% reported that transgender patients were more likely to experience discrimination and 21.3% observed discrimination. Additionally, 15% observed the partner or spouse of LGBTQ+ patients have their treatment decisions ignored or minimized, are denied equal access to the patient, and are denied private time.⁵

These figures highlight the importance of physicians developing cultural competency and advocating for patients who may be at risk of unfair treatment based on their sexual orientation or gender identity. As physicians work to support their patients and their loved ones through the dying phase of life, an awareness of the relationships they share with those who support them through the dying process must be validated, valued, and supported in order to effectively provide end of life care.

PROVIDING LGBTQ+ PATIENTS WITH DIGNITY IN HEALTHCARE

The "Maintaining Dignity" survey results demonstrated significant demand for care providers who actively welcome the LGBTQ+ community and demonstrate awareness and knowledge of the specific needs of LGBTQ+ adults as they age. 88% of respondents said that providers with specific training in LGBTQ+ patient needs would make them more comfortable, 86% said that providers who advertise to highlight LGBTQ+-friendly services would make them more comfortable, and 82% said they were made to feel more comfortable by providers displaying LGBTQ-welcoming signs or symbols in facilities and online.⁴

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Story-telling employed by other disciplines rarely crosses into medical education settings or medical knowledge bases (see examples in “Resources” section). In primary care, story is inherent to our conversations, relationships, and healing. Storytelling and story-listening, when applied to the lens of LGBTQ+ aging, offers a more complex narrative – one that includes decades of grief, resilience, survival, and intentional community building.

What could space for story look like in care for LGBTQ+ older adults? In the fall of 2021, author Ogawa embarked on fellowship research in the medical humanities to better understand the narratives of LGBTQ+ older adults living in New Mexico during the time of the pandemic. Thirty LGBTQ+ older adults from different socioeconomic, cultural, ethnic, disability, illness, and religious experiences shared their stories in semi-structured interviews collected between fall of 2021 and spring of 2022. These interviews revealed that many of the challenges of the pandemic including isolation from friends and family, curtailed access to healthcare, and communal and disenfranchised grief were not new to participants. Narratives revealed insights into care-webs, community, end of life, legal concerns and grief not commonly acknowledged in the medical literature or taught in medical schools. Each story was unique and highlighted the heterogeneity and diversity of nuanced experiences within the community collectively referred to as LGBTQ+ older adults.

STORIES

This article will share two narratives. Authors have selected this option instead of including parts of many people’s stories to better illustrate the significance and power in a single story. As with all stories, although the following represent many of the challenges and strengths faced by people who are LGBTQ+ older adults, it in no way encompasses all people’s experiences with special recognition that transgender and gender expansive older adults often face additional layers of discrimination and structural violence. The following stories are shared with permission.

The first story is from a woman in her 80s who identifies as a Black lesbian and lives in a city. She recently lost multiple loved ones, including several younger family members, to COVID.

Well in the beginning, it was just a ripple. But by March of 2020, I want to think is when people are really starting to pay attention. I had a dear friend become very ill with it, and she's lesbian. She lived alone and had no immediate family that could deal with her stuff. She went into the hospital and some people, some of our friends from another state said, "I'm so worried she's in the hospital" and everybody [here] was like "Why? Wait!" So we went; we found her. She was in the hospital and she had gone there because she was feeling so sick...and they kept her right away. She got very ill. She was near death. At one point they intubated her and all of that.

But as a lesbian, here's what was going on. She didn't have a partner so there was nobody immediately there. She had three little dogs. She had just moved. There was nobody to handle her business. And so a bunch of us that knew her started parsing out... who's going to take care of everything? We got someone to foster the little dogs. That was easy, but the rest we had to go through getting a

notarized permission form from her that myself, my daughter, and [a friend who lives in another state] could manage her other stuff. She was going to end up losing her car. She was going to end up being evicted if someone couldn't pay her rent. I mean this is on the ground everyday life stuff.

So [for two months] she was hospitalized. We were dealing with all of this. Some of it was easy. The banking and financial stuff was really hard even when we jumped through all their hoops, then they had some more hoops. So, it just pointed out one more time what happens when any particularly marginalized group of people don't have a support system in place to handle that.... And so emotionally it was really hard, because it really does point out the places in which queer people... if their everything isn't all together, it's not even a crack; is a hole. You're gonna fall in that hole and you are not coming out of it. And so that was one of the big takeaways in terms of that.

As she shares about her experience patchworking care for a friend with severe COVID-19 infection, she illustrates that community is an active process, not just a noun. *We would normally be a community. We would be at each other's or we would go over and say, "Oh my god what can I do? Let me help you with this!" [So at the beginning of the pandemic] any trauma or difficulty that anyone in our community was feeling was always being overshadowed by whether or not the protocols permit a certain level of interaction at the time.* Nevertheless, she and her community innovated and improvised to keep connection.

Leah Lakshmi Piepzna-Samarasinha’s discussion of care-webs, defined as intentional and collective systems of care built by queer, trans people of color in the disability community draws attention to resourceful resilience not acknowledged or supported by many clinical screening tools.¹¹ Understanding the important people or relationships in someone’s life, instead of just asking about family or caretakers, can help facilitate space to acknowledge patient’s care-webs.

The second story is from a man in his 70s who identifies as a white gay man and lives in a rural community. He shared the story of his husband’s death.

I met a man I really fell in love with. We lived together for 11 years, and he died of AIDS. He died at home with me. And that was really, really hard but uh, I got through it. And I was like 40 years old at the time. I tried a little romance here and there because I didn't want to have to live alone; I wanted a companion.

And I ran into my husband, and he was 19 years younger than me, but between Vietnam and AIDS, I didn't really find a lot of gay men my own age that weren't already spoken for... And it worked out. We ended up being together for 26 years, and we've been married for 5. And I never thought I'd have to go through this again, but here we are.

I've been getting through it. I've been through it before. You never get over it, but you do get used to it. It has been a huge change. And probably the loneliness is the hardest part. Well, my husband and I were together like 24 hours a day all the time. And

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A few simple strategies to improve the comfort level of LGBTQ+ patients include the following⁸:

- Display LGBTQ+ related patient education materials.
- Display your non-discrimination policy prominently.
- Provide gender-neutral restrooms.
- Display LGBTQ+ signs and symbols.
- Provide staff with cultural competency training regarding LGBTQ+ inclusive care.
- Include space for chosen name, pronouns, gender identity, and sexual orientation on intake forms.
- Utilize inclusive language such as “relationship status” instead of “marital status” on both intake forms and in conversation.
- Approach patient encounters with humility and an open mind.
- Avoid assumptions and/or curiosity and explain medical relevance in the event of the appearance of discomfort with any line of questioning.
- Ask for clarification of any unfamiliar terminology that arises during patient encounters.
- Inquire about support systems and special people in patients’ lives and acknowledge chosen family and romantic partners as equally valid as blood relatives or spouses.

As the portion of the elderly patient population identifying as LGBTQ+ continues to grow, it will be imperative that family medicine physicians become more comfortable with the unique needs of this subset of the population. As experts in the care of many different communities, family medicine physicians are well-positioned to embrace the clinical and cultural competencies necessary to provide high-quality, patient-centered care to all patients, including those elderly patients identifying as LGBTQ+.

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so, we were really used to each other. And so being alone and not having anyone to share humor with and (crying) you know it's like- everything has to be new now. I don't get to reflect on things with somebody. And that's kind of difficult. It leaves me aware of what I'm missing.

He grieves the loss of music, increasing financial concerns, and estrangement from family. *The past is gone because there is no one to reminisce about it with. The older you get, the more of that [death and loss] you get. That's just the way it goes.... You're old enough. You're not a kid. But the older you get; you have to face it regularly.*

With space for narrative also comes space for grief: disenfranchised and resilient. Disenfranchised griefs, or those that people are forced to conceal, have long been a part of queer and trans love and life. For example, many people navigate estrangement from family and the deaths of socially unrecognized partners or young family members, especially to stigmatized diseases. While many older adults grew up with Kubler-Ross' stages of grief, current grief research offers another perspective. George Bonanno, a groundbreaking researcher on bereavement, offers an alternative. Based on years of research, he has found that people often successfully navigate grief by oscillating between states of deep sadness and moments of relief or joy.¹² Life narratives facilitate space for this sort of reflection, providing an opportunity to witness and understand LGBTQ+ resilience. When asked how he has gotten through grief, the man above responded, *I think... the biggest thing is that I don't take it personally. I really mean that. It is just circumstance.* In response to discussion about grief, the woman above responded, *I've seen COVID ravage younger people in my life. My one friend that almost died was the most severe of the people in my generation. So it's been hard to just think of... it's unsettling. I don't dwell on it a lot, but when I do dwell on it, I really have to sit with it. Or every now and then just call out their names or something. You know what I mean?*

CONCLUSION

Story-listening offers many suggestions for improved clinical care for LGBTQ+ older adults. It is a tool to expand clinician's understanding of the values, desires, resilience, and goals of care.

Studies demonstrate that many LGBTQ+ people delay care or do not disclose to their providers for numerous reasons, including fear of discrimination.¹³ Yet part of understanding a person's goals of care includes understanding and honoring their lived experience. Clinicians can affirm patients by holding welcoming and thoughtful space for stories that have not traditionally been valued in modern medicine. In doing so, we can work to improve outcomes and promote a change of culture.

Despite ever-growing time restrictions in clinical practice, our role as family physicians must include space, both in and out of the clinic, to expand our personal understandings of the plethora of LGBTQ+ aging narratives through longitudinal clinical relationships, story-telling, and story-listening. While there is not time for a narrative approach in every patient encounter, facilitating space and asking questions to illicit story is invaluable for a nuanced approach to care that leaves space for grief and empowers resilience (see suggestions below).

Suggestions for Incorporation into Clinical Practice: The following questions are drawn from interviewing, legacy projects, and narrative medicine practices. While the questions can help start a conversation, appropriate recognition of the relationship and pre-existing power dynamics are necessary when engaging in narrative exploration. The expectation to respond to vulnerable questions within a healthcare setting can be stressful, especially for members of multiple-minority groups. To mitigate this stress, is it essential to verbalize that patients need not share and maintain consistency in one's willingness to hold space without expectation of narrative exchange.

Personal Narrative

- What would you like me to know about you?/ What haven't I asked that you'd like me to know?
- What are a few words to describe your younger years and a few words to describe you now? What about a few words to describe the future you're hoping for?
- What role has [your illness] played in your life? How has it changed the way you live?
- Would you like to share your story or personal narrative with me? (People who are interested can write a page or two about it and bring to the next appointment if desired.)

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Resources to Explore LGBTQ+ Narratives:

The following comprise a few of the numerous ongoing story-telling projects outside of the medical field. While there is growing documentation of story, numerous narratives have yet to be shared.

NYC Trans Oral History Project (transcripts offered online), Old Lesbian Oral Herstory Project (transcripts offered online, housed at Smith College), Telling Queer History (online and in-person events), To Survive on This Shore (art exhibit)

SAGE's Out & Visible study: 2014 survey exploring the experiences and attitudes of LGBTQ+ Older Adults. Includes implications/suggestions. (<https://www.lgbtagingcenter.org/resources/resource.cfm?r=695>)

Resources to Explore Narrative Medicine and Practices:

"Narrative Medicine: A Model for Empathy, Reflection, Profession, and Trust" by Rita Charon M.D., Ph.D in JAMA.¹⁰

"Practical Strategies for practising narrative based medicine" by Allan Peterkin, MD in The Canadian Family Physician.¹⁴

For your patients who are interested in/want to engage with legacy work by themselves or with loved ones, the LegacyProject.org website is a great jumping off place.

Relational Narrative

- Who are the important people in your life? What do those relationships look like?
 - Who is part of your day-to-day? What are those relationships like?
- Grief and End of Life** Be mindful that these questions often elicit especially deep emotion and require attentive listening by the clinician. Only ask if you can be present with whatever comes forth.
- What role has grief played in your life? What is grief/grieving like for you?
 - What comes to mind when you think about end of life? How has this changed?
 - What are you most afraid of as you look forward? What are you most excited for? Why?

Resilience Narrative

- What keeps you going each day? When things are hard, what has helped you get through in the past?
- What are you most proud of?
- What brings you joy?

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Upcoming Events

2023

January 13-15
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Virtual

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Winter Cluster
Renaissance Hotel
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Advocacy Day
Albany

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Avoiding the Harmful Effects of Ageism

By Jennifer Stoll, PhD; Mary Brennan-Taylor; Alexandria Wahler, BS; Robert G. Wahler Jr., PharmD and Ranjit Singh, MD

Overview

We commonly make assumptions about our older patients' capabilities, preferences, and goals. While we do this without ill intent, we are nevertheless committing ageism. Like sexism and racism, ageism is driven by stereotypes and prejudice and leads to discriminatory action. Unlike the other “-isms,” it has received little attention, and there remains limited awareness of its effects. In partnership with her daughter, we will discuss the case of Alice Brennan, an 88-year-old active, independent member of our community who died due to a series of errors and miscommunications in which ageism played a key role.

Lessons from Alice's story, presented from her daughter's perspective, will help family medicine providers to recognize ageism and to take steps to empower their patients. Utilizing the concepts from the Age-Friendly Health System Initiative as a guide, providers can help their patients to overcome the insidious and potentially dangerous effects of ageism.

Acknowledgments: The authors would like to thank Team Alice: An interdisciplinary research team inspired by the life of Alice Brennan and her untimely death due to inappropriate polypharmacy.

Introduction

Alice Brennan was a vibrant 88-year-old woman who tragically died due to medication harm and system failure forty-eight days after entering a hospital for treatment of gout. The root cause of her preventable death was the inappropriate prescribing of cyclobenzaprine, but the story begins 10 days earlier when Alice went to her local ED for neck pain and was prescribed this medication for the first time. The pain resolved, so she never took it. A few days later, at a routine appointment with her neurologist, accompanied by her daughter, Mary, she showed him her medication list, which included cyclobenzaprine. The neurologist correctly recognized this as a skeletal muscle relaxant listed on the Beers Criteria as potentially inappropriate for older adults. He strongly advised Alice to *never* take this medication as he was concerned about serious side effects. A week later, Alice was experiencing acute knee pain and swelling, and her physician arranged for her to be hospitalized for suspected gout. In addition to a blood thinner, a hypertension medication, and an eydrop, the admission medication reconciliation process revealed the recent prescription for cyclobenzaprine 10mg three times a day, and this medication was started unbeknownst to Alice or her family. There was no conversation with either Alice or her daughter Mary prior to initiating the medication. In the subsequent days, she developed delirium (with disturbing hallucinations), urinary retention and incontinence, unsteady gait, falls, and depressed appetite that resulted in dehydration and malnutrition. Her fragile state left her subject to multiple healthcare-acquired infections, including MRSA, vancomycin-resistant Enterococcus, and C. difficile, from which she later passed away in hospice.

Mary shares Alice's story as a cautionary tale for healthcare providers, patients, and families. There are many lessons to learn from the mistakes that harmed Alice and the missed opportunities to save her.¹ A theme that arises multiple times in Alice's story is that of ageism. In this article, we discuss provider and systemic ageism, present Mary's experience of ageism in her mother's care in her own words and demonstrate how incorporating Age-Friendly Health Systems practices could have saved Alice's life.

What is Ageism? How does it Manifest in Healthcare?

Robert Butler coined the term ‘ageism’ over 50 years ago to describe the process of systematic stereotyping or discrimination against people because they are old. His definition included discriminatory practices and institutional policies that perpetuate stereotypes about elderly people.² Ageism, defined by the World Health Organization, refers to the stereotypes (how we think), prejudice (how we feel), and discrimination (how we act) towards others or oneself based on age. While ageism directed towards older adults is prevalent throughout society, it becomes particularly degrading, costly, and dangerous when manifested in healthcare.

Ageism in healthcare can be implicit in how we think and feel and explicit in how we act. Research has shown that providers can be less patient and engaged with older patients resulting in dismissive attitudes toward patient concerns.³ Implicit and explicit bias can lead to the overtreatment and under-treatment of older adults when physicians fail to differentiate the normal aging process from acute symptoms and illnesses.³ Under-treatment is the result of symptoms being attributed to the aging process and therefore, not treated. Over-treatment is the use of unnecessary tests, medications and surgeries based on chronological age. Both reflect a lack of understanding of the heterogeneity of the population and can have deadly consequences and contribute to escalating healthcare costs.³

Patient-centered communication promotes shared decision-making, but older patients are often left out of treatment plans or experience ‘elderspeak’ - the act of speaking loudly and in simplistic terms and patronizing tones.³⁻⁵ There is some evidence that this demeaning communication can lower a patient's self-esteem and potentially lead to disempowerment.³ Further, this paternalistic communication can reinforce negative attitudes with providers and is observable in pejorative terms such as “Q sign” depicting a face with an open mouth with a tongue hanging to one side that has sometimes been used to describe older patients.^{6,7} These ageist negative attitudes have been attributed to the overexposure of medical trainees to homogenous clinical experiences of critically ill hospitalized older patients.^{3,8} Unfortunately, little progress has been made to address ageism in healthcare since Butler defined the crisis a half-century ago. While there may be some generational tendencies of older adults to be deferential to healthcare providers and even to be ageist towards themselves and their peers, this does not make the practice acceptable.

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The Institute of Medicine's Committee on the Future of Health Care Workforce for Older Americans is calling for an increase in the size and cultural competence of the eldercare workforce. High-quality equitable care for older adults will only be actualized when healthcare providers and systems recognize, acknowledge, and address both implicit and explicit ageism.

In the box below, Alice's daughter, Mary, describes how she experienced ageism while helping her mother navigate her complex hospital course.

Alice's Daughter's Experiences with Ageism – in her own Words

Tragically for my mother, the very systems where she entrusted her care were rife with life-threatening examples of ageism, not the least of which was: an utter lack of understanding of medications on the part of the prescribing physicians and pharmacists that were potentially harmful for seniors like her. This seems to be a blatant disregard for the health and safety of a senior patient. When she was admitted to the hospital, nobody went over her medication list with us. There was no discussion about what medications they were prescribing to her or what they were for. The prescribing of the anticholinergic medication Flexeril®, a medication listed on the Beers' Criteria, was undoubtedly the sentinel event that resulted in her ultimate death. In addition to Flexeril®, she was also prescribed 25 additional medications, many listed on the Beers' Criteria, in a desperate attempt to correct a cascade of errors, including numerous antipsychotic medications like Haldol®.

Adding insult to injury, once Mom began exhibiting confusion and hallucinations, it was assumed because of her age that she was suffering from dementia, not medication harm. This would most likely not have happened if she had been a middle-aged patient who began exhibiting cognitive impairment and hallucinations.

When Mom was in a rehabilitation facility for physical therapy (before she started experiencing confusion), she was not even included in her own discharge planning meeting. Instead, my husband, son, and I were present, which seemed to be a total disregard for her input.

Unfortunately, she gradually became weaker and fell several times, but the staff seemed unconcerned, even making it sound like this was normal for someone of her age. I tried to explain that she was usually a very active person, but they did not seem to acknowledge that this was not her. Something was very wrong, but I had a hard time getting this through to them.

Add to this such disrespectful comments by nurses, orderlies, and doctors alike, such as, "Hi there, young lady!", or "Okay Honey, let's just take your pills like a good girl," and you have a toxic healthcare system that can be both demeaning and deadly.

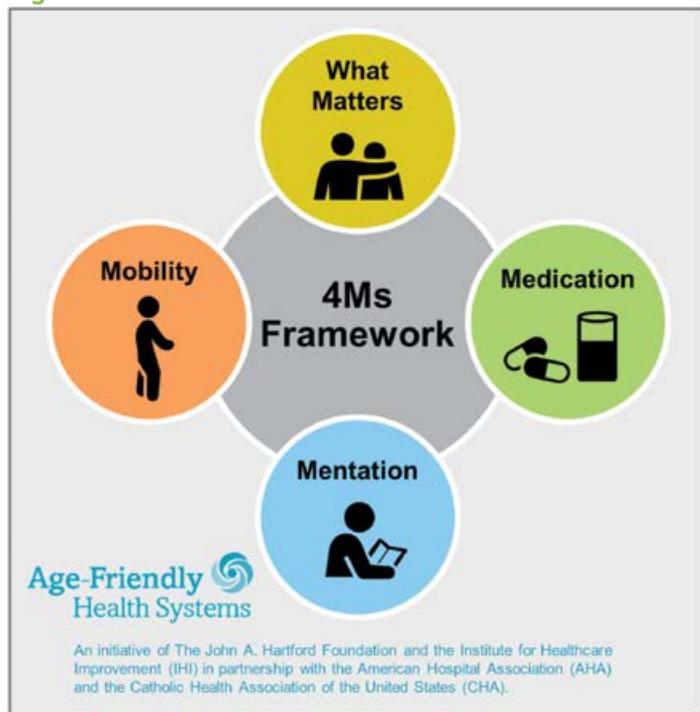
Flexeril® = cyclobenzaprine.

Haldol = haloperidol

Addressing Ageism Using Age-Friendly Systems and Practices Integrating the 4Ms

An Age-Friendly health system is one that actively incorporates the 4Ms of What Matters, Mind, Medication, and Mobility.⁹ This approach can overcome ageism by understanding older adults' priorities, sensitivity to their needs, patient and caregiver empowerment, and meaningful patient engagement. An empowered patient (and caregiver if needed) is integral to incorporating the 4Ms, as defined in Figure 1. Note that the concepts are highly interrelated and interdependent. Below we briefly introduce each of the Ms and illustrate, with reference to Alice's story and Mary's experiences, the role of ageism in each domain and opportunities to overcome it.

Figure 1: 4M's Framework



An initiative of The John A. Hartford Foundation and the Institute for Healthcare Improvement (IHI) in partnership with the American Hospital Association (AHA) and the Catholic Health Association of the United States (CHA).

For related work, this graphic may be used in its entirety without requesting permission.
Graphic files and guidance at ihi.org/AgeFriendly

What Matters

Know and align care with each older adult's specific health outcome goals and care preferences including, but not limited to, end-of-life care, and across settings of care.

Mentation

Prevent, identify, treat, and manage dementia, depression, and delirium across settings of care.

Medication

If medication is necessary, use Age-Friendly medication that does not interfere with What Matters to the older adult, Mobility, or Mentation across settings of care.

Mobility

Ensure that older adults move safely every day in order to maintain function and do What Matters.

What Matters

Typically, what matters should be assessed first as it establishes the priorities of the patient and impacts all the other Ms. When a plan was being made to discharge Alice home from the subacute rehabilitation facility, before she began experiencing mental status changes, she was not included in the discharge planning meeting. The healthcare team assumed that her family would speak for her – depriving her of the agency to make her own choices about what mattered to her. It is unclear whether the team assumed that Alice was unable to make such decisions or that she had delegated these decisions to her family – either assumption was likely based on ageist stereotypes. The use of 'Elderspeak' by Alice's team is evidence that, at least subconsciously, they viewed her as childlike and dependent.

All patients, regardless of age, have the right to determine what matters to them. Decisions should be deferred to others only if the patient is unable to make them, and even in those instances, every effort should be made to involve the patient to the extent possible. And, importantly, every reasonable step should be made to preserve a patient's cognitive and decision-making capabilities – which includes rapidly identifying and addressing any changes in mental status – as discussed next.

Mind

Alice's delirium, starting several days into her hospital stay, was mistaken for dementia, of which she had no prior history. A detailed history from the patient at the time of admission (corroborated by

family if necessary) would have confirmed that Alice lived independently, managed her own home and finances, and had a full social calendar, including serving on the planning committee for her upcoming 70th high-school reunion. Instead of recognizing the acute change in mental status as delirium and carefully looking at reversible causes, she was treated with various medications to manage the symptoms, including antipsychotics that exposed her to additional risk. Ageist assumptions about cognitive function in older adults likely fed into this misdiagnosis of delirium as dementia and its subsequent mismanagement. Though at times co-occurring, Figure 2 illustrates the distinctions between delirium and dementia.^{10, 11} Further, the DSM-5 warns against diagnosing dementia in the setting of delirium.

Ageist assumptions about baseline cognition must be avoided. Thorough assessment and documentation of mental status, coupled with an evaluation of functional status, at admission and every subsequent transition is critical. Equally critical is the practice of reviewing said documentation and further exploring any issues with the patient and/or caregiver as applicable. While this work is potentially labor-intensive, it is essential to providing high quality, safe care to older adults. Alice's teams (across multiple facilities) failed to understand her baseline status and missed the opportunity to identify and treat causes of delirium. In Alice's case, as with most patients, delirium was multifactorial, but medication was the main inciting factor, as discussed below.

Medication

Alice was a victim of excessive polypharmacy and inappropriate medications that impacted her mentation and mobility.

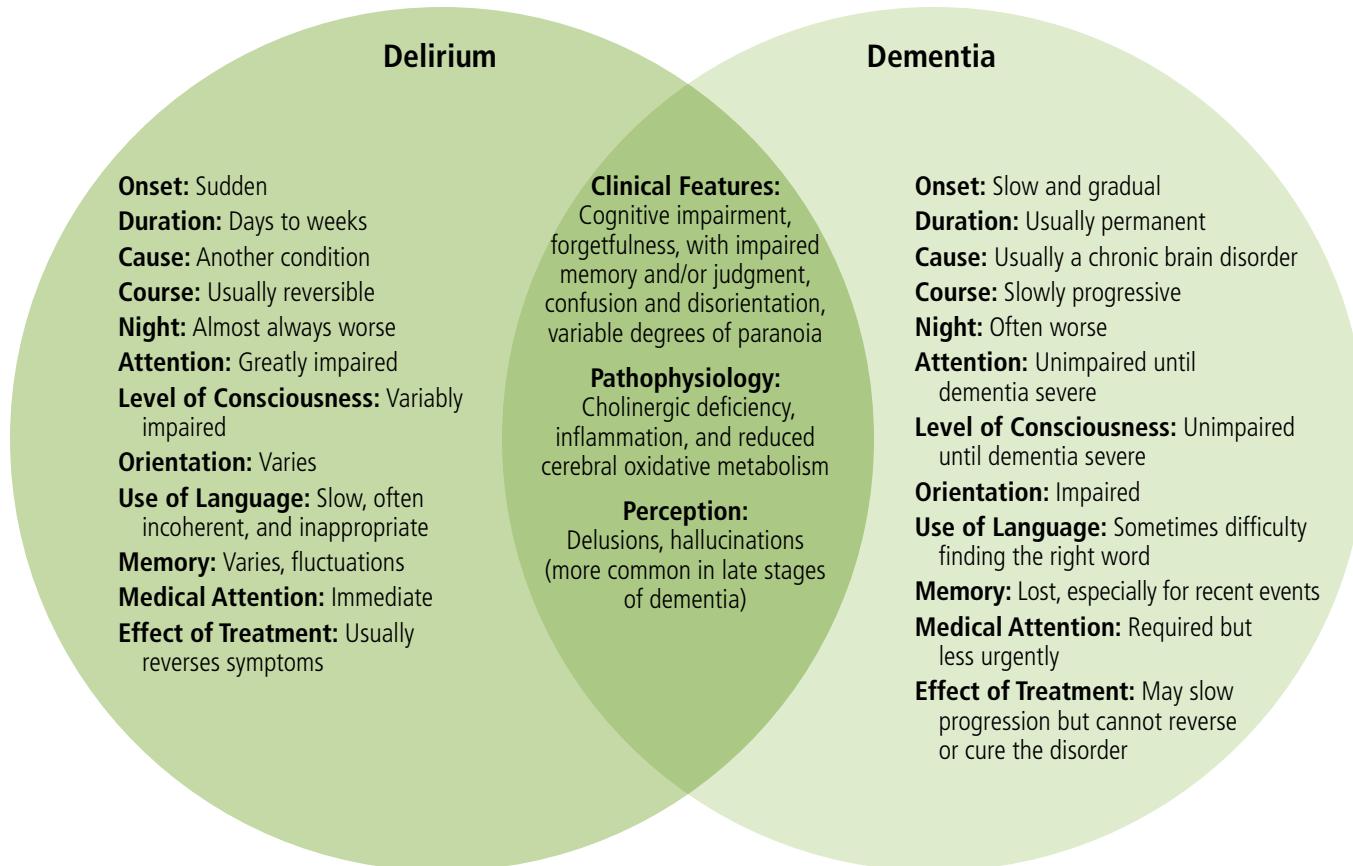
Cyclobenzaprine was the inciting medication that led to a cascade of prescribing to treat altered mental status, including benzodiazepines

and antipsychotics. The Beers Criteria provides a well-known list of medications known to be potentially inappropriate for older adults.¹² Yet, these medications (including skeletal muscle relaxants such as cyclobenzaprine) continue to be prescribed at high rates.^{13, 14} It is interesting to reflect that medication safety for pediatric patients typically receives greater attention – most providers (unless they are very experienced in pediatric dosing) would consult a reliable reference before dosing a medication for a child. Older adults require a similar degree of care, with adjustments in medication choice, as well as dosing – based on consideration of age, weight, renal function, comorbidity, drug interactions, and other factors. Yet, in what could be considered a form of systemic ageism, the same degree of care is often not afforded to older adults as to pediatric patients. Older adults are typically treated the same way as other adults, or are treated as a homogeneous group, failing to account for individual differences in the above factors, as well as in their preferences and goals.

The index event of adding cyclobenzaprine back to her regimen during medication reconciliation was a direct result of the failure to include Alice and Mary in the process. This overlaps with “What Matters,” as the review of the indications for medications would have identified that cyclobenzaprine had been prescribed for a symptom that no longer mattered (the neck pain had resolved). Further, both Alice and Mary were aware of the neurologist’s advice to never take this medicine but did not have the opportunity to intervene. Why was the critical step of reviewing medications with the patient omitted? There may have been multiple factors, but in our assessment, ageism likely contributed. It is common to assume that older adults lack knowledge of their medications (aligning with assumptions about

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Figure 2: Delirium vs. Dementia



impaired cognition) or lack interest or ability to participate in these decisions. In Alice's case, this was a deadly assumption.

Mobility

The importance of mobility is well understood in healthcare settings, including as a means to prevent complications associated with immobility as well as to allow older adults to do "What Matters." Unfortunately, many healthcare personnel have reduced expectations for mobility for older adults. Alice's mobility was severely impacted, and she fell multiple times over the course of her stays in both inpatient and subacute rehabilitation settings due to reversible reasons, including medication side effects and weakness due to infections.

Again, normalizing a deficit - in this case a functional one – fails our elders as it deprives them of the opportunity to have the problem acknowledged and addressed.

Conclusions

As discussed above, the 4 Ms provides a framework to better care for older adults in a way that respects their individuality (What Matters) and addresses key factors such as Medication, Mind, and Mobility. More recently, the concept of 4 Ms has been expanded to include another overarching factor – namely Multi-morbidity (or Multi-complexity). Older adults commonly have multiple chronic conditions and many experience additional complexity in the form of multiple providers, high treatment burden, as well as isolation, poverty, and other social determinants of health. Multi-complexity may even be iatrogenic – as in Alice's case, where an individual with limited comorbidity and a short medication list became a complex patient whose condition spiraled out of control, with multi-morbidity and multi-complexity amplifying the problems with the other 4Ms.

The dangerous effects of ageism need to be acknowledged and faced by family doctors and their teams in all settings. This will require individual changes in attitudes and behaviors, coupled with system changes, to make our care more tailored and safer for older adults. The timing of this could not be more critical as the United States will be confronted with increasing health demands due to an aging population. The New York State Master Plan for Aging goal is to meet these demands so that all "New Yorkers can age with dignity and independence through policies that promote the value of healthy, meaningful aging."¹⁵ Addressing the 4 (or 5) Ms in a manner that empowers patients and their

caregivers appears to have the promise to meet these goals and save the Alices of the world.

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Behavioral and Psychological Symptoms of Dementia

By Cristina Martí-Amarista, MD

Dementia

Dementia is a general clinical term that encompasses a group of neurodegenerative diseases characterized by a decline in cognitive function beyond what is expected from biological aging that interferes with daily life.

The most common types of dementia are Alzheimer's disease, cerebrovascular disease, Lewy body disease, frontotemporal lobar degeneration, and mixed pathologies. Between 2000 and 2019, the reported deaths from dementia increased by more than 145%, making it the fifth-leading cause of death in those aged 65 and older in the United States.¹

According to the World Health Organization, 55 million people have dementia worldwide, and it is expected to rise to 78 million by the year 2030.² In the United States, population-based studies have estimated that about 1 in 9 people (11%) age 65 and older has dementia.³ New York is the third state with the largest number of dementia patients (410,000), after California and Florida, and it is expected to increase by 12.2% by 2025.¹

Irrespective of the type, up to 97% of patients with dementia will have one or more episodes of behavioral and psychological symptoms (BPSD) at some point in the disease.⁴ BPSD, also known as a neuropsychiatric symptom, is characterized by disturbed mood, perception, and/or thought content that carries a significant burden on the patient and caregivers. Understanding BPSD is important to establish the management and prognosis of patients with dementia.

Behavioral and Psychological Symptoms of Dementia

Classification and Epidemiology

BPSD clinical classification is shown in Figure 1. A systematic review with metanalysis of the prevalence of BPSD in community-dwelling dementia patients found that apathy (23-41%) is the most common symptom, followed by anxiety, depression, and irritability (23-35%), aggression

(21-33%), aberrant motor behaviors (11-21%), wandering (12-19%) and eating and sleep disorders (15-27%).⁶

Research has shown that BPSD first appear within 5 years from the dementia diagnosis, with emotional symptoms, mainly depression, preceding the onset of cognitive symptoms by 0.5 years.⁷ The prevalence of BPSD increases with the severity of the dementia.^{6,8}

A third of the total annual cost of dementia is spent in the direct management of BPSD.⁹ Fall risk increases linearly with the severity of BPSD, as well as a decline in activities of daily living. BPSD is the main determinant of caregiver stress and patient institutionalization.^{10,11}

Etiopathogenesis

The etiology of BPSD is multifactorial, often resulting from the combination of brain circuit dysfunctions, neurotransmitter imbalance, environmental factors, and unmet medical and non-medical needs that ultimately manifest as

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Figure 2. Biological Brain Changes Related to BPSD^{5,12}

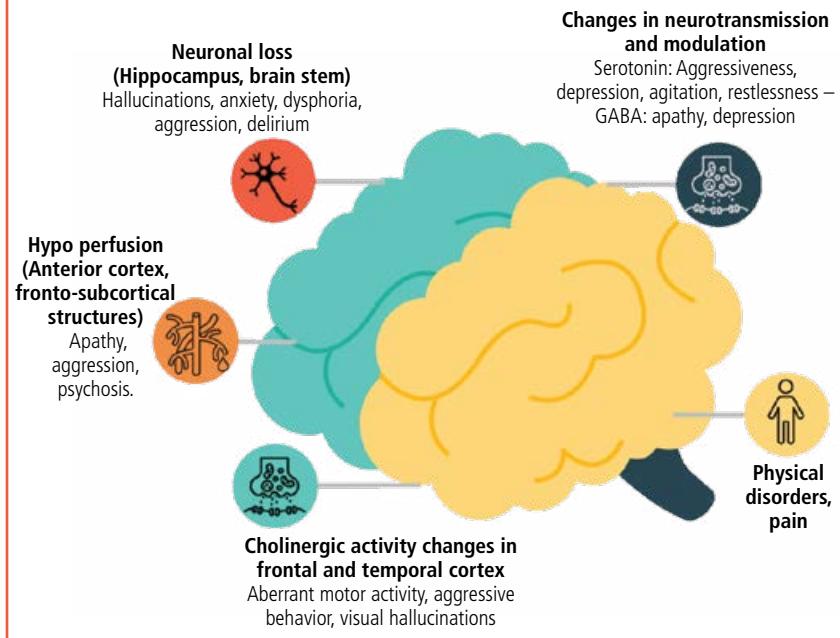


Figure 1. Clinical Classification of Dementia.⁴



abnormal behavior.⁵ Figure 2 summarizes biological brain changes that have been described to cause BPSD.

Figure 3 shows a simplified model for the etiopathogenesis of dementia published by Table et al.⁵ This model considers modifiable, potentially modifiable, and unmodifiable risk factors for the development of BPSD.

Approaching BPSD: History and Physical

Thorough interrogation, medication review, and examination are required when assessing BPSD. The clinician must remember that with or without a superimposed condition (I.e. infection, pain), dementia is associated with dysfunctional brain circuits that disrupt the natural interaction of the patient with the environment, affecting their ability to deal with stress and express their needs. Hence, the behaviors are a manifestation of the disease and not a choice for the patient.

A. Characterizing the Symptom:

Establish the onset, frequency, daily pattern, aggravating and attenuating factors (I.e. family visits, moving, toileting), and relation with meals or medications.

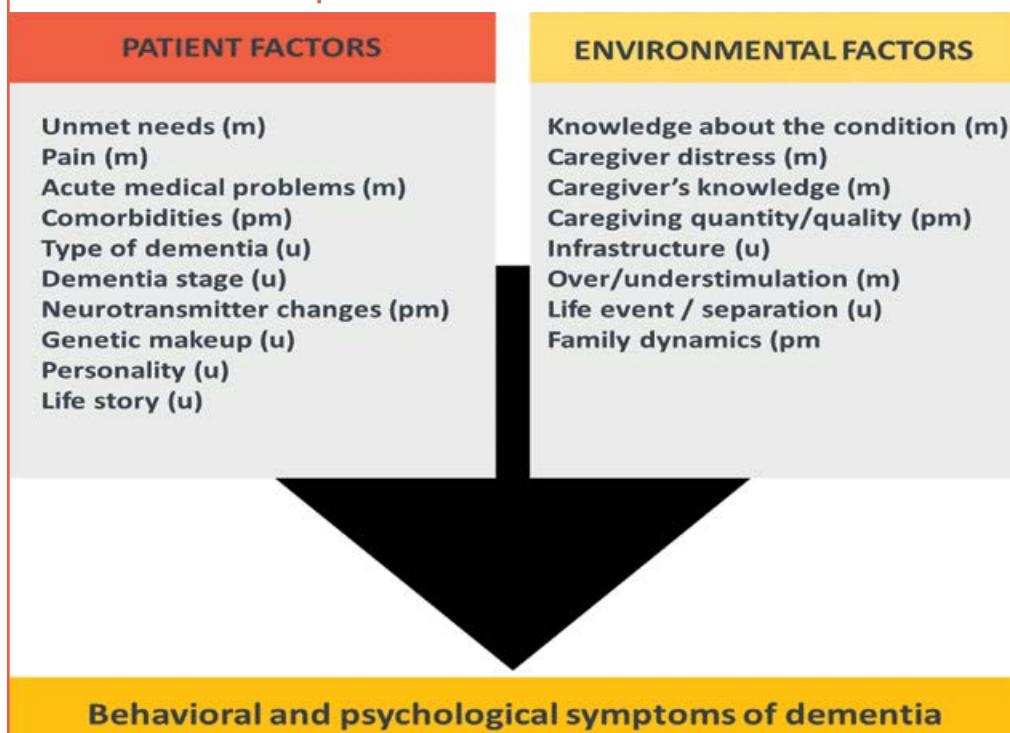
Emotional symptoms: Hostile attitudes, worsening pain, sleepiness, loss of interest, excessive hunger, or crying are frequent complaints in this domain. Depression usually presents as anhedonia, associated with somatic concerns, worry, autonomic activation, and mood lability. In contrast, apathy will present as a lack of activation without dysphoria. Irritability is often found in patients with depression and those with out-of-proportion cheerfulness and feelings of well-being.^{4,13}

Motor/Verbal symptoms: Wandering, slowed movements, decreased physical activity (I.e “lying on the couch all day”), repetitive and purposeless behaviors, inappropriate behaviors (sexual, verbal), rejection of care, and physical aggression are the most common complaints in this domain. Motor symptoms usually worsen during evening hours (sundowning).^{4,5,13}

Perceptual symptoms: Usually persecutory, feelings of danger and abandonment, as well as complaints of theft, are common complaints. Hallucinations can involve any sense but are most commonly visual. If the hallucination is not upsetting, no intervention is warranted.^{4,5,13}

Vegetative symptoms: hypersomnia, insomnia, rapid eye movement, sleep behavior disorder, reversed sleep cycle (daytime napping with night-time awakening), anorexia with weight loss, and hyperphagia are the most common complaints in this domain.^{4,5,13}

Figure 3. Modifiable (m), partially modifiable (pm), and unmodifiable (u) factors contribute to the development of BPSD.⁵



B. Investigate the Possible Causes:

Consider the modifiable and partially modifiable factors shown in figure 3. Harris¹⁹ proposed the 4B's mnemonic to remember the common triggers for BPSD:

- i. Bowels: when was the last bowel movement?
Is there an appropriate bowel regime?
- ii. Bladder: when did they last urinate?
Quantity? Urinary symptoms?
- iii. Beverage: is the patient hungry or thirsty?
Are they being offered preferred beverages or food?
- iv. Bottom: visual survey for obvious precipitants
(i.e. temperature, position, clothing)

Medication reconciliation is mandatory and must include any medication changes in the weeks preceding the onset or worsening of BPSD. Common medications that might cause or worsen BPSD include bladder antispasmodics, antihistamines, opioids, benzodiazepines, muscle relaxants, and antibiotics (fluoroquinolones and sulfa drugs). In patients on antipsychotics with complaints of abnormal motor behaviors, akathisia must be considered.⁴ Pain is underdiagnosed and undertreated in dementia patients, with a prevalence of up to 49% in community dwelling and up to 80% in skilled nursing facility dementia patients, making it a common cause of BPSD.¹⁴

In dementia patients with gradually worsening BPSD and the absence of a history of physical findings concerning alternative causes, further workup is unnecessary. Those with acute onset of symptoms warrant complete blood count, electrolytes, liver and kidney function evaluation, urinalysis, toxicology screening, and/or head CT to rule out causes of delirium.⁴

C. Characterize the Severity, Best Location, and Urgency of the Interventions:

A reliable family member or caregiver is essential when assessing BPSD severity, as dementia patients may have limitations in two or more cognitive domains (amnesia, apraxia, agnosia, aphasia, attention, or comportment) that limit their communication skills. However, the patient's concerns must be listened to.¹³ For all patients with acute or worsening BPSD, the following two questions must be answered to determine the urgency and best location for the interventions:

Is the patient delirious? A simple, quick assessment of delirium must be done on all patients with BPSD, as it usually is caused by infection, intoxication, or withdrawal, requiring thorough evaluation that likely will require hospital admission. The 4AT tool is useful for a quick delirium assessment.⁴

Is the patient a threat to themself or others? Injuries, property damage, and rejection of care (food, fluids, hygiene) warrant consideration for hospitalization.⁴

D. Learn the Patient's Baseline:

When caring for any patient with dementia, with or without BPSD, it is important to establish a baseline on the following items, as they will help measure the impact of the behaviors once the present:^{4,5}

- Past experiences: learn about premorbid personality and stressful life events
- List of medications, including “as needed,” and how the patient responds to them
- Bowel and urinary patterns
- Appetite, overall solids, and liquid intake
- Sleep problems
- Pain

Before administering any behavior assessment tool, it is important to evaluate the patient-caregiver interaction and, if possible, obtain information from more than one caregiver.¹³ The emotional stress of caregivers, younger age, lower education, and the number of service

hours influence assessment ratings and are associated with higher rates of BPSD.¹⁵ Characteristics of the most used BPSD instruments are shown in Table 1.

Treatment

Non-pharmacological interventions are the first line for the management of BPSD.²⁰ The main goal of any intervention is to improve the quality of life for the patient and caregiver. Research has shown that a comprehensive multidisciplinary approach to BPSD can reduce severe behavioral problems in patients with dementia.²¹

A. Patient-directed Non-pharmacological Interventions:

Sensory practices: Have been shown to help correct sensory imbalances, increase alertness, reduce anxiety and agitation, and promote regulation of the circadian rhythm. The interventions include ensuring working eyeglasses and hearing aids, aromatherapy, acupuncture, massage, bright-light therapy, or a combination of all through multisensory stimulation.^{21,22}

Cognitive/emotion-oriented interventions: Include pleasurable activities like word games, puzzles, music, cooking, sensory gardening, and horticultural activities, reminiscence therapy (discussion of past experiences through photographs and familiar items), validation therapy (enhancing verbal and non-verbal communication), and simulated presence therapy through tapes and video of meaningful moments or people in the patient's life.^{21,22}

B. Caregiver-directed Interventions:

Psychoeducational programs in the form of group sessions focused on teaching caregivers how to deal with BPSD increase caregiver confidence and reduce burnout. Training of caregivers is the most effective intervention for BPSD.²¹⁻²⁴

Pharmacological interventions for BPSD have variable efficacy and effectiveness and raise safety concerns. In the USA, there are no FDA-approved medications for BPSD management, and therefore, available medications are used off-label.

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Table 1. Validated BPSD assessment tools¹⁶⁻¹⁸

Tool	Number of items	BPSD measured	Measurement	Rater	Respondent
CMAI	29	Agitation, irritability	Frequency for the last 2 weeks	Clinician	Caregiver
NPI	12	Depression, anxiety, apathy, irritability, elation, hallucinations, delusions, agitation, and sleep problems	Severity, frequency, and distress caused for the last 4 weeks	Clinician	Caregiver
BEHAVE-AD	25	Depression, anxiety, hallucinations, delusions, sleep problems, wandering, irritability	Severity for the last 2 weeks	Clinician	Caregiver

CMAI = Cohen-Mansfield Agitation Inventory

NPI = Neuropsychiatric Inventory

BEHAVE-AD= Behavioral Pathology in Alzheimer's Disease rating scale

Not all BPSD will respond to pharmacological treatment. Apathy, depression, anxiety, hyperactivity, sleep disturbances, and physical and verbal aggression are the symptoms that most likely respond to medications. When choosing how to treat, an electrocardiogram should precede starting any medication. The medication must target the specific symptom, always start low and consider gradual dose reduction as early as possible. There is limited evidence for efficacy of benzodiazepines in the management of BPSD.

Conclusion

Behavioral and psychological symptoms are highly prevalent among dementia patients. The diagnosis and management of BPSD requires a systematic approach to decide the appropriate management, setting, and urgency of the interventions.

Table 2. Pharmacological Treatment of Dementia and BPSD

Medication	Type	Indication	Possible target in BPSD	Side effects
Donepezil	ChEIs	Mild to moderate AD	Hallucinations, agitation, depression, anxiety, apathy	Nausea, vomiting, diarrhea, bradycardia
Rivastigmine				
Galantamine				
Memantine	NMDA antagonist	Moderate to severe AD	Limited evidence alone or in combination with ChEIs	Dizziness, headache, confusion, constipation
Aducanumab	Monoclonal IgG1 antibody, binds to the amyloid beta protein	Mild AD	No evidence to date	Headache, confusion, delirium, altered mental status, disorientation, dizziness, vision abnormality, and nausea
Citalopram*	SSRI	Antidepressant	Delusions, anxiety, and irritability/lability**	Dizziness, nausea, lethargy, headache, anxiety, and agitation
Escitalopram				
Sertraline				
Bupropion	Reuptake inhibitor of dopamine and norepinephrine	Antidepressant	Apathy	Anxiety, dry mouth, nausea, weight loss
Risperidone	Decrease dopaminergic and serotonergic pathway activity in the brain	Antipsychotic	Severe agitation, aggression, and psychosis	Metabolic syndrome, orthostatic hypotension, sudden cardiac death
Quetiapine	Histamine receptor blocker (antihistamine) and α1-adrenergic			
Aripiprazole	Dopamine partial agonist at D2 receptors			

ChEIs = Cholinesterase inhibitor

AD = Alzheimer's dementia

NMDA = N-methyl-D-aspartate

SSRI = selective serotonin reuptake inhibitors

*Best evidence of all SSRI

**Effect is comparable to antipsychotics

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Sleep Issues in the Elderly

By Ghazal Sinha, MD; David Oczos, DO, and Lovedhi Aggarwal, MD

Sleep disorders are common in the elderly and often underdiagnosed.¹ Several diverse factors contribute to many sleep problems in the elderly, including retirement, caffeine, smoking, alcohol intake, changes in circadian rhythms and co-morbid diseases. Sleep problems are not an inherent part of the aging process. There are changes to sleep architecture over the lifespan that are not, in themselves, pathologic, but can be viewed as making older adults more vulnerable to sleep disturbances.²

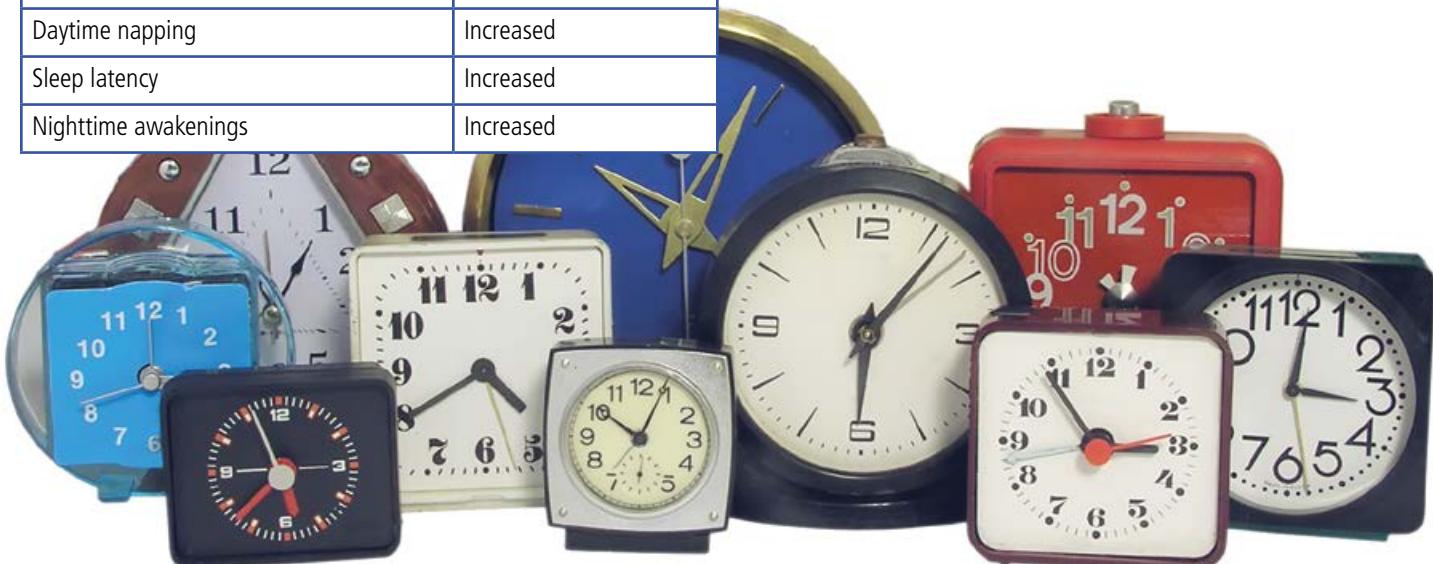
Given the large number of older adults with sleep complaints and sleep disorders, there is a need for family physicians to have an increased awareness of these sleep disturbances to better enable them to assess and treat these patients. Aggressive screening and appropriate treatment of primary sleep problems can improve the quality of life and daytime functioning of older adults, significantly lowering the mortality and morbidity associated with sleep disorders.²² In this paper we review the diagnosis, characteristics, and treatment of common sleep disorders in the elderly.

Sleep Changes in Normal Aging

Older adults in general have increased sleep latency, increased nighttime awakenings and decreased sleep efficiency and sleep time. Some notable changes in sleep structure include decreased slow wave (Stage N3), the deeper stage of sleep, decreased rapid eye movement (REM sleep) and increased N1 and N2 stages of sleep. These changes are summarized in Table 1.²³

Table 1—Age-Related Changes in Sleep

Sleep Characteristic	Age-related Change
Total sleep time	Decreased
Sleep efficiency (time asleep over time in bed)	Decreased
Slow wave sleep (Stage N3)	Decreased
Percent rapid eye movement (REM)	Decreased
Daytime napping	Increased
Sleep latency	Increased
Nighttime awakenings	Increased



Common Sleep Disorders with Case Vignettes

Case 1:

A 73-year-old male comes to the office complaining of increasing daytime fatigue and trouble sleeping at night for several years. He goes to bed at 8:30 PM, it takes him 2 hours to fall asleep and he wakes up several times each night. Each time he wakes, it takes him another hour to sleep. He wakes up at 5 AM every morning.

Insomnia

As many as 50% of older adults complain about difficulty initiating or maintaining sleep.² Prevalence of insomnia is higher in older individuals than in the younger population.³

Insomnia is often classified as the predominant symptom of either difficulty in sleep onset or sleep maintenance. Sleep maintenance symptoms are most prevalent among individuals with insomnia (50% to 70%), followed by difficulty in initiating sleep (35% to 60%) and nonrestorative sleep (20% to 25%).⁴

The Diagnostic and Statistical Manual of mental disorders (DSM V)⁵ defines insomnia as difficulty with initiating and maintaining sleep that is associated with distress or impairment in multiple areas of one's life (i.e. social, occupational, educational, academic, behavioral). In addition to other features, diagnostic criteria also indicate that the sleep problems must occur at least 3 times per week and (to meet criteria for chronic insomnia), must have been present for at least 3 months, and not explained by another sleep disorder.

Several factors cause insomnia, including medications like anticholinergics, antidepressants, antihypertensives, caffeine, steroids, diuretics, nicotine, levodopa, H2blockers, and alcohol. Additional causes include primary sleep disorders like REM behavioral sleep disorder, restless leg syndrome, sleep apnea, periodic limb movements of sleep and medical disorders including neurological disorders (e.g. Parkinson's and Alzheimer's disease), psychiatric disorders (e.g., anxiety, depression, delirium, psychosis), gastrointestinal and cardiovascular disorders.

Management of Insomnia

Treatment of insomnia is imperative to avoid multiple medical and psychological consequences. Treatment can be divided into nonpharmacological and pharmacological options. Aging increases body fat, and reduces total body water and plasma proteins, resulting in increased drug elimination half-life and the potential risk of adverse effects. Older adults should subsequently be treated with non-pharmacological options prior to pharmacological options.⁶

Non-Pharmacological Methods

There are several non-pharmacological methods to treat insomnia and they should be tried first.

Sleep hygiene methods include maintaining a regular sleep-wake time and routine, avoidance of excessive time in bed, having a relaxing bedtime routine, exercise, avoidance of caffeine, alcohol and nicotine at night, not using the bed for reading, watching TV or eating and maintaining a comfortable temperature.

Behavioral treatments, summarized in Table 2 have been consistently shown to prove of great benefit in treating older adults with insomnia. The American College of Physicians (ACP) recommends CBT as the first line treatment in managing insomnia in adults.^{5,7,8}

Table 2 – Behavioral Treatments for Insomnia²⁴

Cognitive Behavior Therapy	Combines stimulus control, sleep restriction, and cognitive interventions, with or without relaxation techniques. It consists of 6 to 10 sessions with a trained therapist that focus on cognitive beliefs and counterproductive behaviors that interfere with sleep.
Sleep Restriction Therapy	This therapy involves restricting time in bed to the number of hours of actual sleep, until sleep efficiency improves. If after 10 days sleep efficiency remains lower than 85%, sleep time in bed should be restricted by 15 to 30 minutes until sleep efficiency improves. Time in bed is gradually advanced by 15 to 30 minutes when the time spent asleep exceeds 85% of total time in bed.
Stimulus Control Therapy	This therapy attempts to re-associate use of the bed and the desired bedtime to sleep only.
Relaxation Techniques	To recognize and relieve tension and anxiety and can include meditation and guided imagery.

Pharmacotherapy

Insomnia that does not respond to behavioral methods should be treated with medications. Several pharmacological options are available, and the risks and benefits of medications should be discussed before beginning pharmacotherapy. A summary of common medications available to treat insomnia are included in Table 3.

Table 3 - Pharmacotherapy for Insomnia

Class	Dosing	Clinical use/Comments
Non- Benzodiazepine Receptor Agonists (BZRA's)		
zolpidem (Ambien)	5-10 mg	Short half-life, sleep onset or sleep maintenance insomnia
zaleplon (Sonata)	5-20 mg	Sleep onset insomnia, short half life
eszopiclone (Lunesta)	1-3 mg	Sleep onset or sleep maintenance insomnia, intermediate half life
Melatonin Receptor Agonist		
ramelteon (Rozerem)	8 mg	No withdrawals after discontinuation, avoid in patients with hepatic impairment
Dual Orexin Receptor Antagonists		
suvorexant (Belsomra)	5-20 mg	Next day somnolence Contraindicated for patients with narcolepsy, Schedule IV
lemborexant (Dayvigo)	5-10 mg	Next day somnolence Contraindicated for patients with narcolepsy
Sedating Antidepressants		
doxepin (Silenor)	3-6 mg	H1 Antagonist, used for sleep maintenance insomnia, side effects somnolence and headaches
mirtazapine (Remeron)	7.5-30 mg	Can cause weight gain, H1 antagonist
trazodone	25-100 mg	Limited evidence of use in insomnia, can cause priapism in men

[Adapted from Geriatricscareonline.org Accessed Nov 30th 2022]

Case 2:

A 69-year-old male with a past medical history of hypertension, obesity, diabetes and hyperlipidemia complains of excessive daytime sleepiness and fatigue. He frequently dozes off during the day. The patient's wife is accompanying him and tells you that he snores "quite a bit". Today his blood pressure is 160/90 and he is on maximal doses of HCTZ, Amlodipine and Lisinopril.

Obstructive Sleep Apnea

Obstructive sleep apnea (OSA) is a common disorder characterized by repetitive collapse or obstruction of the pharyngeal airway during sleep. OSA is common in older patients and presents with excessive daytime sleepiness and impaired neurocognitive dysfunction. OSA is a treatable condition associated with cardiovascular disease, including hypertension, stroke, myocardial ischemia, arrhythmias, fatal and nonfatal cardiovascular events, and all-cause mortality.^{9,10}

continued on page 28

There is growing evidence that sleep disordered breathing is associated with cognitive decline in older adults.¹¹

Screening for Sleep Apnea

Several screening tests are available to screen for sleep apnea in older adults but the most used is the STOP-Bang Questionnaire, which includes items such as snoring, excessive daytime sleepiness, apneas, high blood pressure, BMI >35, age >50, neck >16 inches and male gender.¹²

Treatment of Sleep Apnea

Most OSA patients are treated with continuous PAP (CPAP) therapy. Other mechanical options are available. For example, bi-level PAP (BPAP) devices reduce expiratory pressure compared with CPAP. Oral (i.e. dental or mouth) appliances are also available, but CPAP is more effective in improving many aspects of OSA. Oral appliances are generally recommended only in patients with mild symptomatic OSA or in those unwilling or unable to tolerate CPAP. There is also evidence that CPAP treatment of sleep apnea in patients with mild to moderate Alzheimer's disease is associated with improved cognitive and slower cognitive decline.¹³

Case 3:

A 78-year-old male with history of Parkinson's disease reports of vivid dreams at night. He struck his wife at night while she was asleep, and she no longer feels safe sleeping with him.

REM Sleep Behavior Disorder

REM sleep behavior disorder (RBD) is a parasomnia characterized by excessive motor activities associated with dream enactment behavior during sleep and a pathologic absence of the muscle atonia that normally occurs during REM sleep. The presenting symptoms are usually vigorous sleep behaviors associated with vivid dreams, and patients may first present because of injuries (to themselves or their bed partners). The condition can be acute or chronic, and it is much more common in older men (in some case series, >85% of cases are older men) with family predisposition. RBD typically presents from the 6th decade of life onwards, with cases of medication- or lesion-induced disease more commonly seen in those under 50 years.¹⁴

The chronic form of the disorder can be idiopathic but is increasingly recognized as associated with neurodegenerative disorders such as the synucleinopathies (e.g., Parkinson disease, Lewy body dementia, multisystem atrophy) and other conditions. Video-polysomnography is indicated to establish the diagnosis of RBD.

Treatment includes behavioral measures – ensuring patient and bedpartner safety, such as removing dangerous objects from the bedroom, putting cushions on the floor around the bed, protecting windows, and in some cases, putting the mattress on the floor.

Melatonin is the preferred first line therapy in RBD.¹⁵ It is better tolerated than clonazepam that has long been suggested as the first-line treatment option. Melatonin is beneficial for the management of RBD with reductions in clinical behavioral outcomes and decreases in muscle tonicity in REM sleep.¹⁵

Case 4:

A 74-year-old female with major depression in remission, treated with sertraline, complains of months of daytime fatigue. Her husband shares that she kicks her legs a lot in her sleep.

Periodic Limb Movements at Night

Periodic limb movements during sleep (PLMD) are defined as periodic episodes of repetitive and highly stereotyped limb movements that occur during sleep. According to a cross sectional study in Europe, done via telephone interviews, factors specific to PLMD were being a shift or night worker, snoring, daily coffee intake, use of hypnotics and stress. Factors solely associated with RLS were advanced age, obesity, hypertension, loud snoring, drinking at least three alcoholic beverages per day, smoking more than 20 cigarettes per day and use of SSRI.¹⁶

Dopaminergic medications such as pramipexole, ropinirole, and other drugs like gabapentin, pregabalin that are the mainstay of treatment for restless leg syndrome, may also cause a reduction in periodic limb movements in patients with PLMD.¹⁷

Physicians should also be cautious in avoiding certain antidepressants like mirtazapine, venlafaxine, sertraline, fluoxetine, amitriptyline as they may aggravate periodic limb movements. Bupropion is the preferred medication in treating patients with concomitant depression. Other antidepressants like trazodone, nefazodone, and doxepin do not worsen PLMD.¹⁸

Case 5:

An 80-year-old female with hypertension, diabetes and peripheral vascular disease reports that she suffers intense urge to move her legs at night. Her symptoms improve once she gets up and moves around.

Restless Leg Syndrome

Restless legs syndrome (RLS) involves a strong urge to move one's legs, usually accompanied by an uncomfortable and unpleasant sensation of the legs that worsens with inactivity, improves with movement (or while moving), and occurs exclusively or predominantly in the evening or night. The symptoms occur while the person is awake and can also involve the arms. Women are more likely to be affected than men.¹⁹ Diagnosis is made by obtaining a thorough history and exam. Serum ferritin should be measured in all patients suspected to have RLS. Polysomnography is rarely required but when done usually shows periodic limb movements.

RLS significantly decreases the quality of life in older individuals and treatment should be considered in all patients including behavioral therapies like exercise,²⁰ avoidance of triggers like caffeine, antidepressants, antipsychotics and antihistamines before bedtime, and pneumatic compression stockings.²¹

For patients with persistent RLS (symptoms for more than 2 days a week) therapy with gabapentin, pregabalin and gabapentin enacarbil should be given. Dopamine agonists such as ropinirole and pramipexole are initial choices for patients who are at increased risk of side effects from gabapentinoids.

Benzodiazepines and opioids have also been used for refractory RLS but carry greater risk of adverse effects in older adults.



Final Comments

Changes in sleep architecture are normal throughout the lifespan but the need for sleep does not decrease as people age. Sleep disturbances in older patients are multifactorial and identifying and treating primary sleep disorders can significantly improve the quality of life in older adults. More information on sleep and sleep disorders is available from various national organizations. Useful websites include the American Academy of Sleep Medicine (<http://www.aasm.org>), the National Sleep Foundation (<http://www.sleepfoundation.org>) and RLS.org.

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Getting Ahead of Dementia: An Updated Review of Screening Guidelines

By Abisha Dowla, OMS-III; Ambika Sharma, DO, MS and Elizabeth Loomis, MD

Introduction

Dementia is an umbrella term used to describe a group of symptoms characterized by a steady, progressive decline in memory and cognitive function. In 2019, it was estimated that 5.8 million Americans were living with dementia with the vast majority of those affected being 65 years of age and older.³ With the gradual aging of the US population, those numbers are projected to increase. Despite this expected increase, specific guidelines for screening for dementia are inconclusive. In February of 2020, the USPSTF concluded that more research is necessary to make a recommendation for or against screenings for cognitive impairment. There are multiple screening tools available for cognitive assessment however, given the broad differential that accompanies cognitive impairment and the special considerations needed when assessing different forms of dementia, properly evaluating patients can be challenging for many primary care physicians. This review aims to identify updated screening and evaluation strategies that will allow practitioners to effectively assess their patient population for this debilitating disease process.

Background

Dementia is a crippling disease that affects millions of Americans. While the full pathophysiology of dementia has not been elucidated, excluding its vascular subtype, dementia is generally characterized by an accumulation of proteins in the brain.¹ The most common form of dementia is Alzheimer's dementia (AD), but other forms of dementia include frontotemporal, vascular, and dementia with Lewy bodies.¹ Certain modifiable factors are associated with lifetime risk of dementia. These include hypertension, smoking, heavy alcohol use (>21 drinks per week), and obesity.² Dementia often presents later in life; however, it is not a normal part of aging. It is a pathologic process that is both physically and emotionally devastating for the patient and their family.

Epidemiology

The prevalence of dementia increases as age increases. Representative data from the 2020 National Health and Aging Study (NHATS) demonstrated 18.7% persons ages 85-89 were living with dementia compared to 27.7% in ages 90+.³ In persons aged 70+, dementia was also found to be more prevalent in women vs men (11.5% vs 9.2%) and in Black and Hispanic Americans (16.8% and 16.0% respectively).³ While the overall

prevalence of dementia in persons aged 70+ declined from 10.6% in 2011 to 8.0% in 2019, as the US population ages the total number of dementia patients will rise. 47 million people are estimated to have dementia worldwide and that number is expected to triple by 2050.⁴

Screening Guidelines

Screening for cognitive impairment in older adults presents a unique challenge. Patients with dementia may often present with initial symptoms of the disease in a primary-care setting. However, despite the frequency of this presentation, many primary care providers (PCPs) do not feel confident in diagnosing cognitive impairments. A recent cross-sectional study interviewed 150 PCPs and 50 neurologists across the US who routinely see older adults (age 55+) on their clinical characteristics and confidence when diagnosing neurocognitive disease. Over half of the PCPs interviewed performed cognitive screening or referred patients for cognitive testing in over 50% of their patients. However, only 20% of those PCPs reported high confidence in interpreting results of those cognitive tests.⁵ One quarter of all clinicians surveyed noted lack of familiarity with diagnostic criteria for neurocognitive syndromes as a barrier to clinical practice.⁵ In addition to unfamiliar diagnostic criteria, the inconclusive guidelines that surround screening for neurocognitive issues presents clinicians with another challenge. The most recent guideline from the United States Preventive Services Task Force in February of 2020, concluded that more research is needed to make a recommendation for or against screenings for cognitive impairment.⁶ While this conclusion regarding universal screenings is reasonable, not assessing a patient with possible cognitive decline before starting interventions is suboptimal. Instead of universal screening, individualized screening should be utilized for older patients, especially when they present with "red-flag" symptoms. Symptoms that warrant additional screening include memory issues that impact daily life, functional decline that cannot be explained, decreased hygiene or adherence to medication regimens and new-onset psychiatric symptoms.^{7,8} When adult patients of any age present with these symptoms, dementia should be included in the differential.

Screening Options

Many screening tools for dementia exist and selecting the appropriate one to use can be challenging. One way to approach the choice of what tool to use is to consider generalizability and practical considerations such as cost, and time required to administer. Not all tests are able to screen for all kinds of dementia, nor capture patients with early mild cognitive impairment (MCI). Additionally, while most available instruments have undergone accuracy studies, few have been examined in more than one study.⁹ One way to approach practical considerations that also generally stratifies degree of impairment detected is length of time required to administer the tool. Table 1 reviews some of the more common screening tools that may be used for dementia organized by time required for administration.

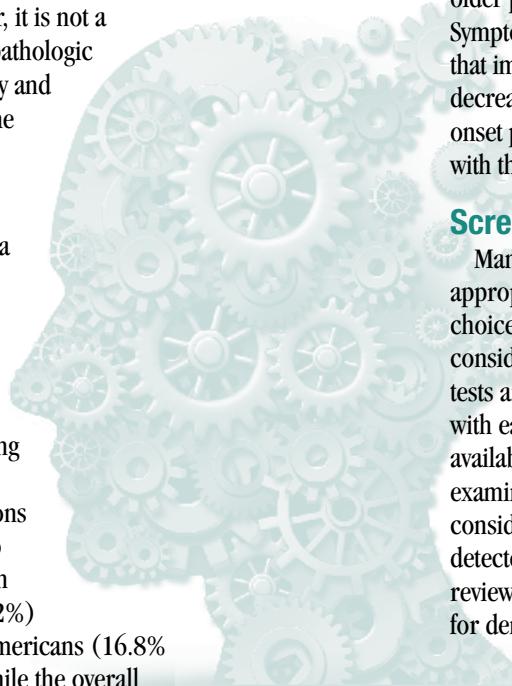


Table 1 – Common Screening Tools for Dementia

Tool name	Time requirement for administration	Special features	Additional considerations	Cost	Availability
Clock drawing ¹⁰	1-2 minutes	Simple, only requires patients to draw a clock face and indicate a specific time	Multiple variations exist so scoring is not consistent	Free	Scoring scheme available from Sunderland et al. ¹⁴
Minicog ¹¹	3 minutes	Includes word recall with clock drawing	Specificity is less than sensitivity, better sensitivity for AD than for MCI	Free	Download available at https://mini-cog.com/download-the-mini-cog-instrument/
Memory impairment screen ¹²	5 minutes	Focused on memory, includes free and cued word recall	Works best for AD, variable sensitivity but better specificity for AD	Free through Alzheimer's Association	Download available at https://www.alz.org/media/Documents/memory-impairment-screening-mis.pdf
Mini Mental Status Exam ¹³	5-10 minutes	Most well studied of all screening tests, ¹² available in 10 other languages	Most sensitive for mild/moderate AD	Approx cost \$1.86 per administration ¹²	Official version copyrighted by Psychological Assessment Resources and available at https://www.parinc.com/products/pkey/238
Saint Louis Mental Status Exam (SLUMS) ¹⁴	7-10 minutes	Different thresholds can be used to detect MCI vs dementia, 23 language translations available	Recommended to review a training video prior to administering	Free	Available at https://www.slu.edu/medicine/internal-medicine/geriatric-medicine/aging-successfully/assessment-tools/mental-status-exam.php
Rowland Universal Dementia Assessment Scale (RUDAS) ¹⁵	7-10 minutes	Developed for patients with low levels of education, limited language fluency and diverse cultural backgrounds, available in 3 languages	Recommended review of 25-page instruction booklet	Free	Available at https://www.dementia.org.au/resources/rowland-universal-dementia-assessment-scale-rudas
Montreal Cognitive Assessment (MoCA) ¹⁶	15 min	More sensitive to MCI than other tools with emphasis on cognitive function, 3 different English versions, 60 languages	Has versions for visual impairment and hemiplegia	Official access granted after a training and certification process costing \$125	Available at https://www.mocatest.org/
Informant Questionnaire on Cognitive Decline in the Elderly (IQCODE) ¹⁷	Self-administered by informant (person close to the patient)	Not influenced by level of education, cultural or language differences, available in 15 languages	25 situations asking informant to rate how much the patient has changed over the past 10 years	Free	Short form available online: https://patient.info/doctor/informant-questionnaire-on-cognitive-decline-in-the-elderly-iqcode

AD=Alzheimer's dementia, MCI= Mild cognitive impairment

Screening Tools for Specific Populations

Individuals with Down syndrome (DS) are at a significantly higher risk of developing AD and earlier than the general population with one study showing dementia in 51% of people with DS over the age of 35.¹⁸ Screening should be considered when there are concerns that someone with DS has lost independence or skill in Activities of Daily

Living (ADLS) or Instrumental Activities of Daily Living (IADLS). The Dementia Scale for Down Syndrome (DSDS) relies on informant answering of 60 questions and can also be used in individuals with other intellectual disabilities though may miss early MCI in higher functioning individuals.¹⁹

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Spinal Cord Injuries (SCI) may present unique challenges in screening for MCI and dementia due to physical limitations. We know that in SCI, there is a high but difficult to accurately capture rate of cognitive dysfunction in part due to co-occurring neurological trauma.²⁰ The Neuropsychiatry Unit Cognitive Assessment Tool screens for MCI following spinal cord injury. It consists of 21 items across 5 domains and takes 30-40 min to administer. It can be adjusted for other co-occurring neurological deficits such as head injury and epilepsy and has hands free alternatives for those who have impaired upper extremity control.²¹

While HIV Associated Dementia (HAD) and HIV Associated Neurocognitive Disorder (HAND) are decreasing in prevalence thanks to the widespread use of antiretroviral therapy, it is still important to monitor for these conditions. The MoCA test described in Table 1 can be used in HIV²² as well as the International HIV Dementia Scale (IHDS) although the IHDS may be more useful in detecting HAND.²³

Differential & Special Considerations

Diagnosing dementia in an outpatient setting can be confounded by other conditions such as MCI, delirium, and Parkinson's disease among others. There are also several distinct types of dementia, which add another layer of complexity in achieving the correct diagnosis.²⁴

Central to the initial evaluation of a patient with potential dementia is determining whether the evolving changes are reversible or irreversible (Table 2). Hypothyroidism, psychiatric illness such as depression, vitamin deficiencies especially B12, alcoholism, and medication side effects should be considered. Rare central nervous infections including neurosyphilis and HIV may present with dementia-like symptoms. If symptoms are suggestive of surgical brain lesions such as subdural hematoma, tumors, and normal pressure hydrocephalus, then imaging may be warranted and helpful in narrowing down the diagnosis.²⁵

One of the most common challenges after excluding reversible causes is distinguishing MCI and dementia. Both share similar characteristics of visible cognitive decline. The main distinction between the two is that in dementia there is loss of more than one cognitive domain, as well as marked interference in daily life as evident in ADLS. The five cognitive domains to assess are learning and memory, language, visuo-spatial, executive, and psychomotor.²⁶ Executive function is also often impaired in dementia. Patients should only be considered to have an irreversible cause after a thorough workup, including lab work, necessary imaging, and detailed social history.²⁷

In the hospital setting it can be difficult to differentiate dementia from delirium. Delirium is characterized by acute onset of mental status changes usually in a range of hours to days. This change in cognition and decline in attention waxes and wanes with occasional alterations in perception such as delusions and hallucinations.²⁸ Patients with underlying cerebral or systemic disease are more susceptible to delirium. In dementia there will be a history of slow progressive cognitive decline with changes in ADLS and symptoms are less likely to be oscillating in nature such as those seen in delirium.²⁸

The umbrella term of dementia can be further broken down into specific pathologies with unique characteristics specific to those diagnoses. Some of the more common types of dementia include Alzheimer's dementia (AD), Parkinson's disease (PD), fronto-temporal dementia (FTD), Lewy body dementia, and vascular dementia.²⁹ These can be differentiated by the first clinical symptoms that present. In AD, that will be memory loss and imaging will show cortical and hippocampal atrophy. A distinguishing component in PD is that it is chiefly classified as a movement disorder with pathognomonic symptoms of tremors, shakiness, rigidity, aphasia, and apathy. Most individuals with PD will develop dementia as their disease progresses, but motor symptoms are often evident first. In FTD, the first symptoms will be apathy, poor judgment or insight, problems in speech/language and hyperorality. Imaging in FTD will show frontal, insular, and/or temporal atrophy with sparing of posterior parietal lobe. For LBD, the first signs will be visual hallucinations and imaging will show posterior parietal atrophy as well as larger hippocampi than that seen in AD. For vascular dementia, the cognitive decline will often occur suddenly with associated apathy, falls and focal weakness. Decline often occurs in a "step-wise" pattern with discrete points of worsening cognitive deterioration over a long time period. In vascular dementia, imaging will show cortical and/or subcortical infarcts and confluent white matter disease.²⁹ In Table 2 we outline a list of lab values to help rule out other etiologies that can be confused for dementia.

Table 2: Initial Workup for a New Presentation of Cognitive Decline^{30,31,32}

Laboratory Tests and Imaging To Order

Thyroid Stimulating Hormone (TSH) with free thyroxine (T4)

Vitamin B12 and folate levels

Thiamine (Vitamin B1)

Computed Tomography (CT) head

Complete blood count

Complete metabolic panel

Calcium, copper, magnesium, lead, lithium, alcohol levels to rule out toxicity

Advance Care Planning

While clinicians should address advance care directives with patients long before they present with cognitive concerns, if this has not been done, it becomes imperative to do so when memory difficulties arise. Patients should designate a primary and secondary medical proxy and be guided on discussions to have with their healthcare proxies to make sure their values and goals are understood. Living wills as well as Medical Orders for Life-Sustaining Treatment (MOLST) with specific care directives can be signed and made part of the electronic medical record. Finally, a diagnosis of dementia does not automatically mean a patient lacks capacity for

decision making. In mild and moderate presentations, individuals with dementia may still be able to evaluate and understand decisions to be made as well as clearly communicate their choices. In these cases, it is important to include the patient in the decision-making process to ensure their preferences are being taken into account.

Summary

While universal screening for dementia is not recommended, family physicians need to be able to confidently evaluate patients presenting with concerns for cognitive impairment and be prepared to diagnose dementia. An understanding of how and when to use available screening tools and the initial process of excluding other diagnoses will assist the family physician in achieving these goals.

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Preventing Dementia Through Lifestyle Modification

By Jen Baker-Porazinski, MD

How we communicate, connect with and care about others is what makes us unique. These intrinsic human qualities are shaped by our experiences and are influenced by our families and the communities where we live and work. Our memories serve as a treasury for every moment of our lives. From the mundane to the extraordinary, our triumphs and failures are filed away for future reference. Dementia not only robs us of our memory but it makes the most rudimentary tasks difficult, from doing household chores to finding our way in familiar surroundings. People suffering from dementia struggle to communicate their needs at first. As the disease progresses, though, their core personality changes and they withdraw from friends and family. When they lose cherished memories of the ones they love, they have lost themselves. There is no cure for this heartbreak, making prevention so crucial.

Prevention of dementia is also important because of the financial and emotional burden for caregivers as well as the immense cost to our health care system. Education in prevention is challenging in a busy practice because of time constraints and, for some, a lack of education in evidence-based primary prevention. For many, though, prevention somehow seems “less scientific” than deciphering clues of an elusive diagnosis or managing prescriptions with complex pharmacology. Prevention isn’t as flashy as saving lives through modern medical interventions and miraculous pharmaceuticals. Unlike a cardiac stent or thrombolytic drugs, we will never actually know if we’ve prevented future calamities in our patients. Perhaps even more discouraging, our patients won’t know either.

Despite these reasons, there are many more in favor of preventing cognitive decline as this will not only benefit the patient in front of you, but will help our entire health care system. Evidence-based lifestyle interventions not only help protect our brains from degenerative disease, but also prevent chronic disease in general – no small feat since the CDC’s National Center for Chronic Disease Prevention and Health Promotion reports that chronic diseases are responsible for 70% of all American deaths. Decreasing the emotional impact on loved ones, as well as the financial toll on our system, will have a greater impact than the individual patient you may have spared. Lessening the burden of chronic illnesses will allow our health care dollars to be diverted from managing them to researching their cure.

The Scope of the Problem

In an article published this October in *JAMA Neurology*, investigators analyzed 2016 data from in-depth neuropsychological tests and interviews with nearly 3,500 people over age 65. Their

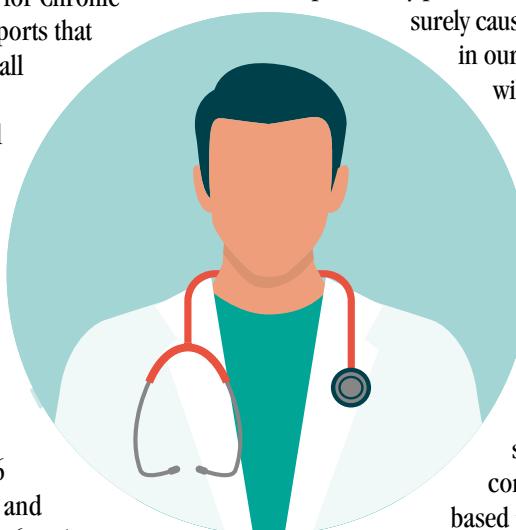
research showed that approximately 1/3 of their interviewees had dementia or mild cognitive impairment (those thought to be transitioning from normal aging to dementia).¹ In a typical American family this could mean at least one grandparent affected.

While the incidence of Alzheimer’s appears to be declining (due to improvements in modifiable risk factors, such as education), the total number diagnosed is expected to continue to grow because of our aging population. An estimated 6.5 million Americans over 65 are currently living with Alzheimer’s dementia, a number expected to climb to 12.7 million by 2050. In New York State alone, dementia is projected to increase 12.2% between 2020 and 2025. Add to this another 11 million Americans (over 1/2 a million of them New Yorkers) serving as their caregivers (providing 16 billion hours, or \$271 billion, of unpaid assistance) and it’s easy to see that the true number of Americans impacted by this progressive disease is staggering.²

Why it Matters

In addition to the obvious psychological pain experienced by loved ones, cognitive decline impacts an affected person’s ability to perform the everyday activities of living independently. As this worsens, they require progressively more help and supervision, often culminating in full-time long-term care. Aside from disability though, Alzheimer’s dementia is in the top 10 causes of death in our country.² The emotional and financial cost to families, the public health impact of millions of Americans living in a state of severe disability, and the economic burden for care and services threatens our health care capacity.

Despite diagnosing dementia in up to 85% of cases, 40% of primary care doctors report they aren’t comfortable making this determination, preferring to refer to specialists.² I count myself among them. Particularly early in the disease, I tend to avoid giving this diagnosis to protect my patients from the heartbreak this incurable decline will surely cause. Unfortunately, there aren’t enough specialists in our country to meet the growing demand, which will nearly double by 2050.²



Yet despite our discomfort in diagnosis (after the disease has already declared itself), and the fact that up to 40% of dementia cases are attributable to modifiable risk factors,² prevention is frequently neglected in busy primary care offices. Given our aging population (with age being the biggest risk factor for developing dementia) and physician shortages, it is imperative that we gain competence advising our patients on science-based primary prevention. In fact, because we lack

effective treatment, prevention remains our best strategy for reducing both the psychological and financial burden of dementia as well as the potential threat to an already over-burdened health care system.

Risk Factors for Dementia

Knowing the risk factors for dementia can help guide the primary care doctor in prevention. Because there is no cure, addressing modifiable risk factors is key. See Table 1.

Table 1

Risk Factors for Cognitive Decline and Dementia

Air pollution	Hyperlipidemia*	Physical inactivity*
Alcohol misuse	Hypertension*	Smoking*
Depression	Less education	Social isolation
Diabetes mellitus*	Obesity*	Traumatic brain injury
Hearing loss		

* Addressed by Life's Simple 7.⁴

Information from references 3 and 4.

American Family Physician, Issue January 2022 Preventing Cognitive Decline; ANTHONY J. VIERA, MD, MPH, Duke University, Durham, North Carolina (*Am Fam Physician*. 2022;105(1):13-14)

International experts recommend focusing efforts on improving brain health to just six areas. These include improving neurovascular health, sleep, physical activity, and nutrition as well as promoting social connection and cognitive stimulation. These recommendations are compatible with the American Heart Association's "Essential 8" interventions to minimize the aging brain's vulnerability ("sleep" was added to "Life's Simple 7" in 2022). Shockingly, few American adults aged 40-59 met these goals in 2020, before sleep was included: 11% met five of the seven, 2.2% met six, and virtually none met all seven.³ The AHA's Essential 8 are not recommendations relegated to the specialty of cardiology, but comprise normal counseling that occurs in a primary care office.



Improve Neurovascular Risk

What's good for the heart is good for the brain, rendering dementia prevention counseling effective across a broad range of health conditions. Stroke is a strong risk factor for dementia; therefore improving vascular factors known to lower stroke risk (and prevent cardiovascular disease) also protect the brain. These include not smoking as well as controlling blood pressure, cholesterol and blood sugar, all of which are also included in AHA's Essential 8.



Improve Sleep

In February 2021, *The Harvard Gazette* shared a survey showing the risk of dementia among older adults who slept less than five hours to be double that of those who reported sleeping seven to eight hours.⁴ Up to 50% of the elderly report sleeping difficulties,⁵ putting much of our older population at risk for dementia. Furthermore, there's a bidirectional relationship between sleep deprivation and dementia: lack of sleep increases the risk of dementia but people with dementia also have disrupted sleep – as do their caregivers.

Why is sleep important enough to be included as a major area of focus for dementia experts and the AHA? The glymphatic nervous system, which clears the brain of metabolic waste such as beta amyloid, is most active during sleep.⁶ When we sleep our brain cells shrink, allowing more space between them so that waste can be removed. Sleep deprivation decreases the effectiveness of clearing out potentially toxic byproducts, allowing proteins such as beta amyloid to accumulate. Beta amyloid clusters form the plaques associated with Alzheimer's dementia. Like sleep quality, the glymphatic system deteriorates with age, suggesting a causal relationship between sleep disturbances and dementia.⁷

The Global Council on Brain Health note that sleep is also essential for general mental and physical health and well-being. Inadequate sleep not only increases the risk for dementia and heart disease, but also increases depression, obesity, diabetes, fall-related injuries, and cancer. Although sleep changes with age, people can still change their behavior to improve their sleep. Excessive daytime sleepiness is not a normal part of aging.

Be More Active

 Physical activity increase BDNF in the brain, a neurotrophic factor associated with cognitive improvement as well as the alleviation of depression and anxiety.⁸ The neuroprotective effect of exercise is particularly evident in memory and learning, possibly through hippocampal neurogenesis. Even minimal exercise routines have beneficial effects on the brain's mood, function, and neuroplasticity, counteracting impairment found in dementia.⁹

Because of its long known cardiovascular benefit (physical activity is also an Essential 8), exercise may be one of the most important activities to promote to protect the brain. The Department of Health and Human Services recommends 150 minutes a week of moderate activity, which can be calculated using heart rate. However, for elderly people not wearing tracking devices, there's an easier way to determine this level. When performing moderate activities, a person can talk but not sing. When performing vigorous activities, a person can't talk or sing. Presuming it is safe for your patient, more physically fit seniors may choose to do 75 minutes of vigorous activity as an equivalent – every minute of vigorous activity counts as 2 minutes of moderate activity. Finally, balance training and muscle strengthening are important in the prevention of falls and for general health. Balance activities can be woven into everyday activities (standing on one foot while brushing teeth, for example). Strength training should occur 2-3 times a week.

Eat Better and Manage Weight

 Both dementia experts and the heart experts agree that managing diet and weight are essential in protecting the brain and heart, which is why these are also included in the Essential 8. What we eat today directly influences our health as we age. The MIND diet, an eating pattern combining a Mediterranean-type diet with the American Heart Association's DASH diet, can help prevent cognitive decline.

According to one prospective study, the estimated effect was a 53% risk reduction for rigorous adherents and a 35% reduction for those with modest adherence, independent of other lifestyle behaviors and cardiovascular conditions. This difference is the equivalent of having a brain 7.5 years younger.¹⁰

Both the Mediterranean and DASH diets are high in vegetables, berries, nuts, beans, whole grains, fish, poultry, olive oil and wine. Berries may be particularly beneficial in protecting the brain. In analyzing the cognitive abilities of over 16,000 registered nurses in the Nurse's Health Study older than 70, researchers found that those consuming larger amounts of strawberries and blueberries (high in antioxidant-rich and anti-inflammatory flavonoids) delayed cognitive aging by up to 2.5 years.¹² In addition, both diets limit meat and dairy products (because of saturated fats) as well as sweets and fast or fried foods. The Harvard Women's Health study showed that women with the highest intake of saturated fat increased their odds of cognitive deterioration.¹¹ The DASH diet also restricts sodium intake to between 1500-2300 mg.



Connect with Others

From the time of hunter-gatherers, humans evolved as social animals because it was dangerous to survival to be separated from the tribe. Researchers have long known about the effects of social isolation on health. A 2018 Cigna survey of 20,000 Americans compared the health risks of loneliness to that of smoking 15 cigarettes a day. Loneliness not only accelerates decline in brain function, but also increases the risk of cancer by 40%, as well as CVD, and all-cause mortality.¹³

The pandemic made this academic understanding real as doctors witnessed patients dying from well-intended isolation. This was most apparent in nursing homes, where family visits were forbidden and residents were mostly shut away in their rooms for their protection. In an effort to shield them from the virus, though, we sometimes accelerated their demise. Even in areas where community infection was low, older adults with dementia had a greater risk of dying early in the pandemic than those without the disease. In addition to COVID itself, researchers believe that the higher death rate was related to lockdowns and social isolation.¹⁴ Family doctors who worked in nursing homes at that time likely shared my experience:

At the nursing home, I pushed my way through the new security measures and sought out my patients, no longer congregating socially along the hallways. The few scattered elderly not confined to their rooms desperately called out to me and to other staff passing by. Many of them, confused before the pandemic, couldn't understand this radical change in their routine. They didn't like their freedom of movement blocked by the heavy closed doors to their units. They missed social mealtimes in the dining hall. They weren't accustomed to masked caregivers. They were agitated. Weary nurses and their assistants tried to reassure and redirect them. One glance into the caregivers' eyes, peeking above their masks, revealed that the staff was in need of reassurance just as much as the residents. Worry was as contagious as the virus causing it.

Simply put, we need each other.



Use your Brain

Cognitive stimulation, in particular learning new things, has been shown to improve brain function. While doing Sudoku certainly isn't bad for the brain, this likely makes us better at doing Sudoku more than it improves our odds of not getting dementia. Our brains need novel challenges to form new synaptic connections. In the recent past, medical schools taught that the adult brain was hard-wired after a period of critical development in childhood. fMRI science, however, tells a different story.

The brain changes throughout life in response to environment, behavior, thinking and emotions. Neuroplasticity refers to structural and functional changes in the brain caused by training and experience. Connections between neurons engaging together are strengthened, forming new neural connections. These changes offer a protective benefit, not only making the brain amazingly resilient, but also preventing cognitive decline. Encourage your patients to learn a second language, pick up an instrument, and travel to new places. It's never too late to try new things.



Side Effects: Happiness

While guiding our patients toward healthier lifestyle choices in these six areas isn't a full-proof guarantee to prevent dementia, these efforts will also prevent other chronic illnesses.

Although we may never know for sure the result of our education in prevention, the benefits of lifestyle changes are revealed in other aspects of life. Living a healthy life makes us feel better physically and mentally. Scientists who do empirical research on happiness included nearly all of these lifestyle recommendations as ways to increase happiness. Not surprisingly, their top recommendations are the very same things that not only help prevent chronic illness but also protect the brain.¹⁵

- Connect: focus on social bonds (more so when focus on happiness of others)
- Seek Meaning: live up to your values, be generous, volunteer
- Be Active: regular physical exercise, keep learning, set goals, seek new challenges
- Mind Your Health: get regular sleep, check your physical and mental health
- Cultivate a Positive Outlook: self-acceptance, laugh, gratitude journal

Our bodies possess miraculous healing capability, but only when we don't continually damage them. Just as your skin heals when it's banged against a hard object, so can the rest of the body – including the brain. But, if we continue to bump into the same place repeatedly, we're never given the opportunity to heal. We can change the layout of furniture to prevent recurrent injury. In the same way, by removing offending insults (cigarettes, saturated fats, salt, high glycemic foods), and improving our ability to maneuver around obstacles (sleeping better, increasing physical activity, improving balance), as well as enlisting the help of others (social

connection) and seeking out creative solutions (cognitive stimulation) we can assist our body's natural capacity to heal.

Encourage your patients to make big changes – this is how they will feel better in their body. With this positive feedback on their well-being, healthier lifestyle choices become rewarding and, therefore, sustainable.

Endnotes

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Primary Care Approach to Evaluation of Alcohol Use Disorder in Older Adult Population

By Sarah A. Abdelsayed, MD; Hui Tung Tony Lin, MD; Kimberly J. Wilkins, MD and Richard D. Blondell, MD

Background

The growing rates of substance use disorders (SUD) continue to have devastating impacts on families and communities. It is estimated that 4% of people age 65 and older in the US meet criteria for an SUD.¹ The most common substance used is alcohol followed by non-alcohol sedatives (e.g. benzodiazepines) and over the counter medications. Approximately one in ten geriatric adults engages in binge drinking patterns of behavior.² The future concern in a rapidly aging US population with a large “baby boomer” generation is the upward trend in prevalence of current drinking; this rises 0.7% per year in men ages 60+ and notably 1.6% per year in women.³

It is estimated that 20.4 million people in the United States were diagnosed with an SUD² while only 10% received treatment.⁴ This gap is revealed in the \$13.2 billion SUD-attributable hospital healthcare utilization costs with \$7.6 billion specifically related to alcohol use.⁵ Risk factors increasing vulnerability of alcohol use in older adults include chronic medical conditions, use of medications interacting with alcohol, isolation and loneliness, retirement, bereavement, and additional life changes. COVID has further emphasized these vulnerabilities, particularly in older women.⁶

The National Institute on Alcohol Abuse and Alcoholism (NIAAA) has set the recommended drinking limit for adults 65 years and older as no more than 7 standard drinks per week (1 drink or less per day)

and no more than 3 standard drinks on any given day. Binge drinking, the most common pattern of alcohol use disorder seen in elderly adults, occurs when older adults have more than 3 drinks on any occasion. Defining one standard drink is an important step to accurately quantify a patient's alcohol use and thereafter screen for alcohol use disorder (Figure 1).⁷ One standard drink contains about 14 grams of pure ethanol which can be found in 12 ounces of 5% beer, 5 ounces of 12% wine, and 1.5 ounces of 40% distilled spirits.

The United States Preventive Services Task Force (USPSTF) assigns a Grade B recommendation for screening for alcohol use in adults over 18 years old in primary care settings and providing brief intervention for patients with risky or hazardous drinking.⁸

Practical Approach

Screening Options

One method for screening is to ask patients about the quantity and frequency of their alcohol use. Examples of these questions are:

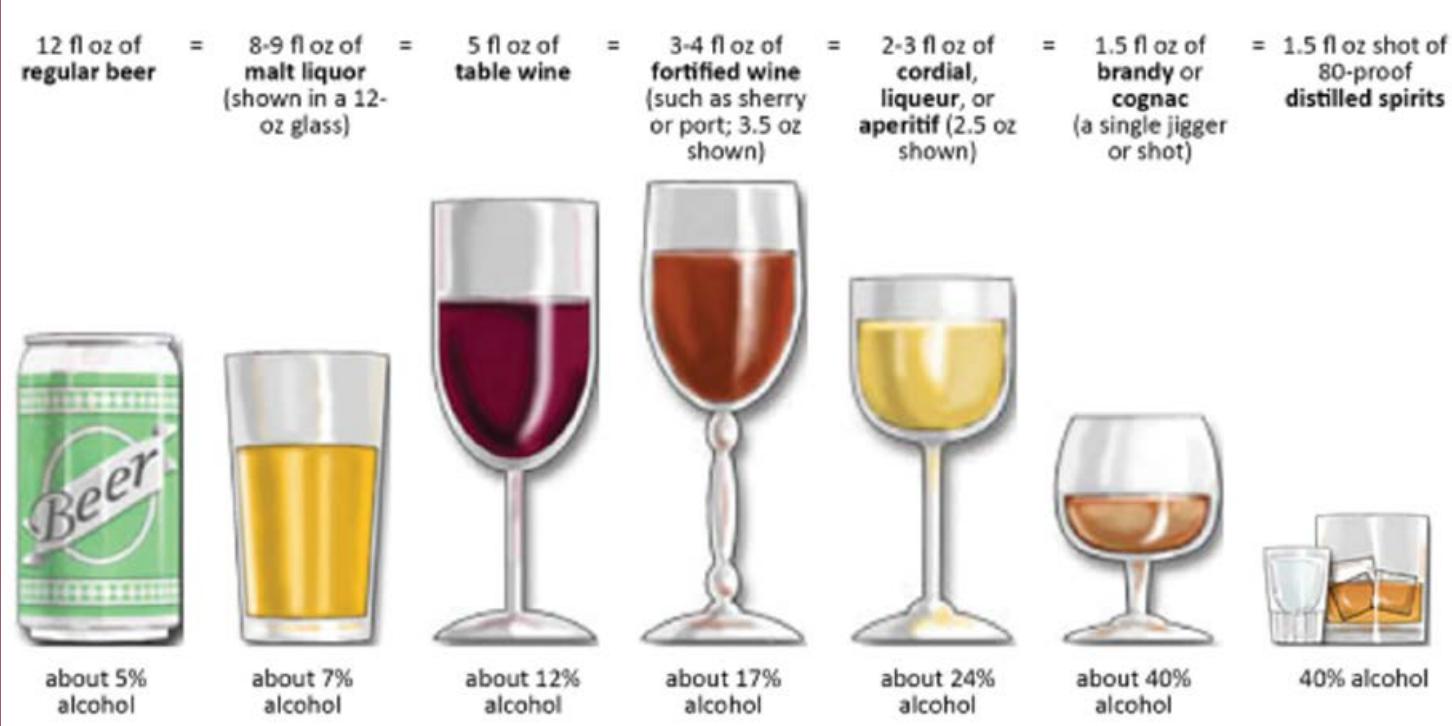
“How many days of the week, on average, do you consume alcohol?”

“On the days that you do have alcohol, how many drinks do you have?”

“What do you consider to be one drink?”

“Do you ever have more than three drinks on any occasion?”

Figure 1 - Standard Alcohol Drink⁷



After obtaining this information, the physician compares the patient's alcohol use to the NIAAA recommended drinking limit and assigns a risk level to guide the approach to management. An additional method for screening is use of questionnaires such as Alcohol Use Disorders Identification Test (AUDIT)⁹ and Two-Item Conjoint Screen (TICS).¹⁰ The AUDIT score ranges from 0 – 40 with a score of 8 – 14 indicating harmful alcohol use and 15+ moderate to severe alcohol use disorder; the cutoff score of 8 in the general population is lowered to 5 in older adults.¹¹ The Short Michigan Alcoholism Screening Test-Geriatric version (SMAST-G) is a screening tool specific for detecting problematic alcohol use in the elderly.¹²

Take Action Based on Risk Level

Identification of a patient's risk level helps guide the next steps in your clinical approach. The four risk levels are abstinence or low risk, at-risk use, problematic use, and alcohol use with dependence. This can be an easier classification system to use in primary care whereas a more detailed assessment using DSM-V criteria is used in addiction medicine.

More than half of the geriatric population either does not drink alcohol or uses below the recommended limit. However approximately 40% of the geriatric patients you see engage in alcohol use ranging from at-risk binge drinking patterns to daily use with dependence.¹³ Table 1 illustrates a recommended clinical approach for family physicians when addressing alcohol use in older adults. Some patients are appropriate for ambulatory withdrawal management while those at high risk for a severe withdrawal course should be referred to an inpatient stabilization unit. Patients at high risk for severe withdrawal include severe alcohol withdrawal syndrome-related symptoms, concurrent acute illness, chronic cardiovascular and renal disease, at high risk for developing delirium tremens, and serious psychiatric comorbidity.¹⁴

Brief Intervention

Motivational Interviewing/FRAMES Model

After screening, a patient may be offered a brief intervention. This is intended to help a patient understand the need to change their alcohol use and increase their desire to make a change. The FRAMES acronym may be used as a guide.¹⁷ The acronym stands for: Feedback with concern, Reinforce responsibility, Advise action, Menu of options, Express empathy, and Support self-efficacy. Examples of phrases that may be used are:

- F: "I'm concerned that you were not able to cut down to one drink a day and that your liver shows some damage."
- R: "Only you can change your drinking pattern."
- A: "Let's have you try again to control your drinking and try to stop completely for 2 weeks. Then, come back and we'll re-check your liver tests."
- M: "Please take this pamphlet for more information and some options on how to control your drinking."
- E: "I know this is not an easy conversation to have."
- S: "I think you can be successful."

This brief intervention may then be supplemented with an in-office video or a paper handout for the patient to take home.

The physician may also offer the patient brief advice. An example of this is "I'm concerned that your drinking could impact your health. I recommend cutting back to no more than one drink on any given day. Meanwhile, I will order some lab tests to see if your drinking is having any negative effects on your internal organs. Let's have you come back in 4-6 weeks to see how you're doing. If you are having trouble cutting back, we can talk about options that may help."

Brief interventions are flexible and adaptable for many different treatment settings, including primary care.

Medications

Once the primary care physician has identified unhealthy alcohol use and provided brief intervention, the next step is the decision for treatment and referral. FDA-approved medications for treatment of alcohol use disorder are naltrexone (oral or intramuscular injection), acamprosate, and disulfiram.⁷ Off-label uses of medications are not included in this discussion.

Disulfiram

First approved in 1951 for treatment of AUD, disulfiram inhibits aldehyde dehydrogenase, which results in acetaldehyde accumulation when alcohol is consumed. This process results in highly unpleasant reactions (nausea, flushing, vomiting, etc.) termed the disulfiram-alcohol reaction. Disulfiram should not be given within 12 hours of last alcohol use and should be avoided in patients taking metronidazole. It is not recommended for patients with a history of severe myocardial diseases or psychoses.¹⁸

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Table 1 - Clinical Approach to Addressing Alcohol Use^{15,16}

Risk Level	Prevalence	Alcohol Use	Clinical Approach
Abstinence/ Low Risk	60%	Below the recommended limit	Reinforce current positive behavior
At-risk Alcohol Use	25%	Binge use patterns, exceed daily limits	Brief advice, further medical assessment, arrange follow-up
Problematic Alcohol Use	10%	Alcohol use with adverse consequences	Brief intervention, assess for referral to treatment, further medical assessment, arrange follow-up
Alcohol Use Disorder with Dependence	5%	Adverse consequences and physical dependence	Referral to treatment

Acamprosate

Acamprosate, FDA-approved in 2004, interacts with the brain's glutamatergic system although the exact mechanism is still not well understood. European trials¹⁹ have found acamprosate to be more effective than placebo but evidence is mixed in the US.²⁰ Acamprosate has been shown to be most helpful in supporting abstinence in those who have stopped drinking, particularly for people with negative affect and anxiousness associated with cravings.²¹ Medication treatment for alcohol use disorder with acamprosate is also clinically relevant in cases of intolerance or contraindication to naltrexone such as concurrent opioid use and cirrhosis. While the medication is contraindicated in patients with severe renal impairment, it can be used in most with dose adjustment for weight and renal function.²²

Naltrexone (oral, injection)

Naltrexone is a non-selective opioid antagonist that blunts the reward and euphoria associated with alcohol use. Both oral and long-acting injectable formulations are available for medication treatment of alcohol use disorder and have similar efficacy.²³ Naltrexone is found to decrease recurrence of alcohol use or return to heavy use.²⁴ An ideal candidate for naltrexone therapy is a patient with a desire to drink less or quit drinking altogether, does not have severe liver disease, and without concurrent opioid use.²¹ Options for patients with alcohol and opioid use include consideration of acamprosate as medication treatment and/or weaning off opioid and administration of naltrexone after an opioid-free interval of 7-10 days.²⁵

Billing

SBIRT Services Can be Reimbursed

The process of Screening, Brief Intervention, and Referral to Treatment (SBIRT)²⁶ described above is reimbursable for office and telehealth visits through commercial insurances and Medicare. Based on the intervention length, the fee schedule ranges from \$29.42 to \$65.51.²⁷ Specific documentation criteria have been outlined by Medicare Learning Network.²⁸

Commercial (CPT 99408: \$33.41, CPT 99409: \$65.51)

In order to qualify for commercial insurance SBIRT billing, SBIRT training approved by local state agencies may be required. For instance, providers are eligible for SBIRT service reimbursement by Highmark when they have completed training conducted by the Office of Alcoholism and Substance Abuse Services in New York State.²⁹ The specific commercial codes are CPT 99408: \$33.41 for interventions from 15-30 minutes and CPT 99409: \$65.51 for interventions greater than 30 minutes.

Medicare (G0396: \$29.42, G0397: \$37.69)

Similarly, Medicare reimbursements are structured based on length of intervention. SBIRT is billed under preventative services and additional training or certification of SBIRT is not necessary. Codes for Medicare SBIRT services include G0396: \$29.42 for 15 to 30 minutes and G0397: \$37.69 for greater than 30 minutes.³⁰

Summary

Talking to older adults about their experiences with life changes and screening for alcohol use is an important part of the health maintenance visit with their family doctor. The family physician's role in addressing alcohol use disorder in the geriatric population and taking the next appropriate steps involves the critical steps of screening, brief intervention and referral to treatment outlined here.

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Caring for the Elderly in Urgent Care

By Joel Fandel, MD and Sandy Wang, MD, MPH

Overview

Elderly patients are a unique population who visit urgent care centers more often with illnesses that are often serious and nonclassical presentations compared to their younger counterparts.² They are often at higher risk for hospitalization with an even higher rate for ICU admission, thus with a growing elderly population in the US, it is important that family medicine physicians are equipped with skills to care for this group of patients. Some of the most common complaints that the elderly present with include abdominal pain,^{10,11} concerns for pneumonia³ and abnormal vital signs.² While some of the decision to send a patient home or to a higher level of care comes from experience, it is prudent to follow established evidence based guidelines and scales to help guide clinical decision making, as outlined by professional societies.

Introduction

With increasing emergency department wait times and unavailability of primary care provider same day appointments, the urgent care setting has become an attractive and popular option for patients to obtain acute assessments and care. Urgent care centers are often staffed by family medicine physicians who possess the skill set in balancing outpatient longitudinal care with more emergent assessments. Most complaints are straightforward such as the common cold, urinary tract infection, or abdominal pain, and assessments in otherwise uncomplicated, healthy patients can be made quickly. However, elderly patients are a unique population who visit urgent care centers more often with illnesses that are severe and with nonclassical presentations compared to their younger counterparts.² For example, geriatric patients are more likely to present with atypical vital signs, vague abdominal pain and subtle pulmonary findings that mask serious underlying conditions.⁴ When urgent care centers become busy with repetitive chief complaints, it is easy to misdiagnose or miss these subtle clues that would affect mortality and morbidity in elderly patients.

In this paper, we will review guidelines from the American Academy of Family Physicians and American Geriatric Society to help guide family medicine physicians' clinical decision making for caring for the elderly in acute care settings. Specifically, we will focus on interpreting vital signs, the pneumonia severity index score (also known as the PORT score- Pneumonia Patient Outcomes Research Team score), and management of abdominal pain.

CC: Abnormal Vitals

The geriatric population's set of vital signs are unique compared to other populations, due to reduced ability to adapt to physiological stressors. Blood pressure increases with age with systolic numbers being affected more than diastolic. Hypertension affects over 74% of women and 61% men 65-74, and 83% of women and 69% of men ≥ 75 .³ Thus, for blood pressure readings, it is more important to look at a patient's symptoms as well as charts to see trends from previous outpatient visits than rely on single measures, especially when there is

frailty present. For example, if a patient's blood pressure is found to be elevated in an urgent care visit, it is important to compare that value to the "patient's normal" rather than the generally accepted normal range.¹ Despite these findings, orthostatic hypotension is also common, affecting 30% of older outpatients and 50% of nursing home residents,³ so checking orthostatic blood pressure readings is important for dizziness and fall work up.

Regarding pulse readings, geriatric patients tend to have decreased maximal heart rate and increased resting heart rate; there is also decreased heart rate variability. This is important to consider as physiologically, the pulse has a decreased response to sympathetic stimulation and may mask underlying pain or other noxious stimuli that would have otherwise presented as tachycardia in a younger patient.²

Elderly patients also have lower core temperature, and thus a subtle rise from baseline may be significant. These patients often do not have fever even with underlying sickness, so any fever in an elderly patient is often a sign of something significant, and potentially life threatening. It is important to pay very close attention and perform a very thorough assessment for underlying infection such as a UTI or pneumonia.

Finally, observing respiratory rate on primary assessment of the elderly is crucial. Elderly patients have decreased chest wall compliance and require increased work of breathing, which is physically demanding. In patients who are frail, they may not have the physiologic reserve to maintain high respiratory rates. These patients also have decreased response to hypoxia and hypercapnia. The CURB-65 score, which is discussed below, highlights that a respiratory rate >30 is a high predictive value for serious adverse morbidity.

CC: Pneumonia

Pneumonia is one of the most common diseases that presents to the urgent care setting. In the geriatric population, mortality rates from pneumonia increase steadily with age, from a rate of 24 per 100,000 admissions for patients aged 60 to 64, to 1,032 per 100,000 admissions for those aged 85 and older.⁶ Therefore, when these patients present to urgent care with concern for pneumonia, appropriate triage is critical, especially in the elderly population where disease course and prognosis can be extremely variable in severity.

Patients can be stratified into risk categories to help guide treatment decision making. The pneumonia severity index (PSI) is a stratification score that helps clinicians decide which patients can be managed as outpatients and which ones warrant inpatient workup. Refer to Table 1, which comes from Dr. Michael Fine and colleagues' in the NEJM. A score is determined by first taking the "age for men" or "age - 10 for women", and from there, various other risk factors added on such as residing in a nursing home or having chronic disease like neoplasia, congestive heart failure, cerebrovascular disease, or renal disease. One key factor, which adds 20 points to a patient's score, is altered mental status, which is a symptom often present in the elderly population and one that is often not immediately attributed to respiratory illness.

Patient's PSI scores can be added up and distributed into categories: Class I includes patients with an absence of all risk factors, class II is for PSI scores ≤ 70 , class III is scores 71-90, class IV is 91-130, and class V is > 130 . Patients that fall into categories I - III can generally be treated with outpatient antimicrobials, whereas patients with scores in classes IV or V are more appropriate for an inpatient hospital setting.^{2,4} For borderline scores, brief 24 hour hospital observation with intravenous antimicrobials and quick wean to oral can be considered, or further risk stratification with CURB-65 can be used, though PSI is preferred over CURB-65.¹⁰ More frequently used in the inpatient setting, CURB-65 dedicates a point for each of the following: confusion, urea > 7 mmol/l, respiratory rate ≥ 30 /min, systolic BP < 90 mm Hg or diastolic BP ≤ 60 mm Hg, and age ≥ 65 years. A total score of 0 or 1 is typically suitable for home treatment, a score of 2 may warrant closely supervised treatment such as a brief hospital observation stay, and a score of 3 or more is a predictor of high mortality and should typically be managed in the hospital.⁷

Table 1: Pneumonia Severity Index (PSI) as described by Fine et al.⁴

Characteristic	Points Assigned
Demographic Factor	
Age	
Men	Age (yr)
Women	Age (yr) -10
Nursing home resident	+10
Coexisting illnesses [†]	
Neoplastic disease	+30
Liver disease	+20
Congestive heart failure	+10
Cerebrovascular disease	+10
Renal disease	+10
Physical-examination findings	
Altered mental status [‡]	+20
Respiratory rate ≥ 30 /min	+20
Systolic blood pressure < 90 mm Hg	+20
Temperature $< 35^{\circ}\text{C}$ or $\geq 40^{\circ}\text{C}$	+15
Pulse ≥ 125 /min	+10
Laboratory and radiographic findings	
Arterial pH < 7.35	+30
Blood urea nitrogen ≥ 30 mg./dl (11 mmol/liter)	+20
Sodium < 130 mmol/liter	+20
Glucose ≥ 250 mg/dl (14 mmol/liter)	+10
Hematocrit $< 30\%$	+10
Partial pressure of arterial oxygen < 60 mm Hg [§]	+10
Pleural effusion	+10

CC: Abdominal Pain

In the elderly population, a number of factors make the assessment of abdominal pain difficult compared to the typical presentation in younger populations. These include atypical symptoms which are masked by polypharmacy, significant comorbidities, unexpectedly normal lab findings, and communication problems.^{2,11}

Initial blood work can be done at some urgent care centers to guide next steps, but even with reassuring labs such as lack of leukocytosis, further workup is often still needed. White blood cell counts were found to be normal in 30% of elderly patients with acute surgical conditions.¹¹ Similarly, vital signs may be normal, including no fever even in serious infectious etiologies like acute appendicitis.² Therefore, the index of suspicion and threshold for transfer to an ED to obtain a CT scan should be lower compared to a younger patient population^{2,5,10} CT Imaging for acute abdominal pain in patients age ≥ 65 increased diagnostic certainty from 36% to 77% and affected the decision to hospitalize in 26% of cases.

For example, in our experience, a 70 year-old female presented to urgent care with generalized abdominal bloating and periumbilical pain. She reported some constipation but was mostly concerned that she felt "off". Physical exam was notable for pain in her left lower quadrant with otherwise reassuring vitals. Despite these findings, the clinician felt this case warranted more work up. She was sent to the emergency department for CT imaging and was found to have diverticulitis with abscess, requiring hospitalization.

In urgent care centers without lab draw capabilities, any geriatric patient who presents with abdominal pain can still be worked up. A thorough history can often be more important than the physical exam itself. From the above discussion, subtle vital sign changes from a patient's baseline, changes in bowel habits, or even the patient reporting that they do not feel at baseline can be clues that there is serious underlying illness. Small bowel obstruction, diverticulitis, mesenteric ischemic, colitis, or even malignancy prevalence tends to increase in advanced age groups. A young, healthy person presenting with constipation may be stable enough to be discharged home with a bowel regimen, but a concerned geriatric patient with constipation warrants more thorough early investigation oftentimes.

Conclusion

In conclusion, as more patients rely on urgent care centers for prompt assessment, it is important to study special populations so that clinicians can provide better care for diverse needs. This is especially important in geriatric patients who often present with vague and atypical symptoms compared to pediatric and younger adult patients. We discussed vital signs, pneumonia severity index, and abdominal pain as a few examples of differences in patient presentation, but there are also many more differences discussed in the American Geriatric Society website and the AAFP. We urge all family medicine clinicians seeing patients in acute care to seek further reading on these topics so that geriatric patients can continue to receive appropriate, evidence-based care for their needs.

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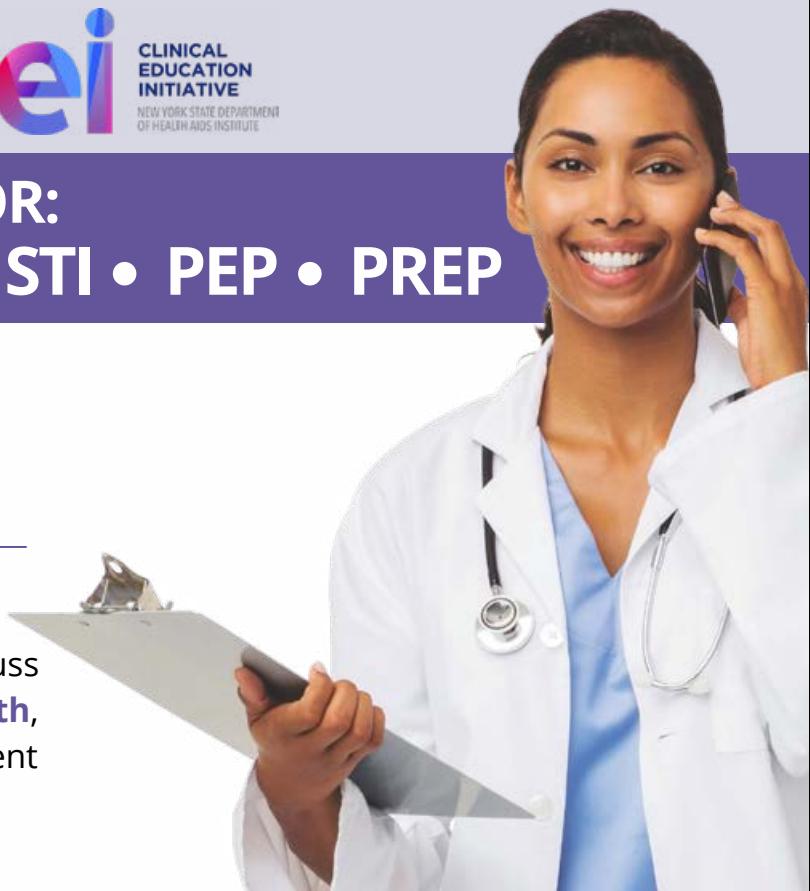
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Aging, Sexuality and Relationships

By Tyler Buchiero, LCSW and Pebble Kranz, MD, FECSM, IF

It's a typical day in the office. One of your dearest long-term patients, an 85 year-old woman who is recently widowed, says shyly at the end of her routine visit, "I have one more thing I'd like to discuss. I'm in a new relationship that is giving me great joy. He's a wonderful companion. Our relationship is going in a new direction recently, and we are getting more 'intimate'... I've noticed some vaginal dryness and itching and the last time we had sex it was pretty painful."

Family physicians naturally find themselves on the front lines of a wide variety of health struggles including our patients' concerns about sex. As population trends skew towards people aged 65 and over, the role of primary care in promoting sexual health conversations and facilitating patients' optimal sexual experiences rises. Indeed, aging trends suggest that people aged 65 and over are expected to number 77 million in 2035.¹ An often overlooked, yet chief component of health in later life is the desire and need to be close to others as we age, which may include the desire to continue an active, satisfying sex life.

Lindau et al found that almost half of partnered older adults engage in sexual activity and more than two thirds engaged in a variety of forms of physical tenderness. They found that overall greatest barrier to being sexually active at an older age is lack of a partner, which particularly affects women, but that 73% of 57-64 year-olds engage in some form of sexual intimacy, 53% among 65-74 year-olds, and 26% among 75-85 year-olds.² A 2022 Belgian study found that 31% of 70-99 year-olds participated in some form of sexual play and that

47% of those non-sexually active experienced some form of physical tenderness (cuddling and kissing).³ Given these statistics, and other data that indicate that only about a third of primary care providers engage their patients in conversations about sexual function and satisfaction, we may be missing a major opportunity to engage our patients on a topic fundamental to their current life experience.

Unfortunately, healthcare communication about sexual

issues is not occurring with a frequency one would hope. Wimberly et al found that while almost three in five primary care providers asked about sexual activity at a routine visit, many fewer (12-34%) asked about important aspects of sexual health such as asking about partners or about sexual orientation. They ultimately concluded that sexual histories as part of routine and preventive healthcare are less common, and many physicians miss essential components of a comprehensive sexual history.¹² Sexual histories tend to focus on STDs and reproduction and even fewer primary care providers are discussing sexual function and satisfaction with their patients of any age. The rates of sexual history taking were even less for geriatricians. In a study of 120 geriatricians regarding the frequency of sexual history taking, 76 (63.3%) of the total group were of the opinion that sexual history taking should not be routine, 32 (26.6%) thought it should be routine, and 11 (9.1%) would take a history where they felt it was appropriate.¹³

Meanwhile, sexuality remains paramount for many older adults seeking primary care services and in multiple studies, it is clear that patients want their health care providers to be the ones to raise the topic. Existing as a sexual being can be a major aspect of continued life satisfaction. A handful of studies have indicated that an active and trouble-free sex life may be associated with reduced risk of disease outcomes among older adults.⁴ A US study of 1046 men and 1158 women (aged 57-85 years) indicated that the frequency and quality of sex protected against cardiovascular events in later life and has also been shown to be associated with reduced risk of fatal coronary events, and prostate and breast cancer.⁴ Moreover, sexual activity is a form of physical activity and is associated with positive mental and physical health.⁵ Many relational benefits exist as well, as sexual activity can act as a bulwark against the social isolation that older adults are more likely to experience, thus reducing mental health comorbidities as well.⁶ In this way, focus on the sexual health of older adults in primary care may augment preventative and responsive care already being provided. Ultimately, simply having these discussions with older patients may be an effective way to improving health outcomes in these patients.

What then is the role for family medicine in sexual health interventions for older adults, and what are the barriers?

Our role, to begin with, may seem clear; that providers need only initiate these discussions with their patients about their sexual health and wellbeing, including asking questions about sexual function and satisfaction. These conversations must go beyond generalized screeners on most pre-appointment patient forms. Indeed, the presence of questions about sexual function and satisfaction on most screeners is rare, and even then, rather vague. Even when there are specific screener questions about sexual function and satisfaction, it may be rarer still that there is follow up during the appointment. This leaves practitioners and patients in a difficult situation. By appearing to

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open the door with screener questions focusing on sexuality and then failing to follow through with greater discussion in session, we may inadvertently send the message that discussion of sexuality is neither an appropriate use of time nor of great importance.

The question of why sexuality topics are avoided is a multifaceted one. A questionnaire survey of 133 GPs reported that most participants identified more than one barrier to sexual health conversation, with the most commonly cited barriers including concerns about their own knowledge and expertise in this area, fears of opening a ‘floodgate’ and personal embarrassment.⁷ Similarly, a questionnaire survey of 234 nurses identified similar barriers, including lack of time, lack of training, and concerns about not being able to cope with the issues raised by the patient.⁸ These studies were focused on sexual health discussions in a range of patient populations and there may be further barriers when considering sexual health conversations with older adults. There are significant misperceptions about the importance of later life sexuality including the culturally driven idea that sexuality and old age are often seen as incompatible. Societal images of sexuality revolve around youth, ability, and health, often to the exclusion and marginalization of groups not fitting that narrow profile. In summary, it seems that the primary barriers are both internal (erasure and the taboo of sexuality in later life) and external (lack of training for family medicine practitioners with emphasis on the specific sexual needs of older adults). Those who work in family medicine have a unique opportunity to improve quality of life for their older adult patients through recognition and challenge of these internal biases and pursuing education as to the sexual health needs in later life.

Sexuality does change with age. It is simply not going to look the same as it did for our patients in their 20’s and 30’s. Older adults often must adapt sexual activity to accommodate changes in physical health. For instance, circulatory and neurologic conditions may contribute to changes to arousal, with concerns such as erectile dysfunction and decreased vaginal lubrication. Hormonal changes with age may have an impact on all phases of sexual function including desire, arousal, and orgasm. Untreated genitourinary syndrome of menopause, previously termed “vulvovaginal atrophy,” as well as vulvar dermatoses, may lead to either sexual pain or persistent and unwanted feelings of genital arousal (called persistent genital arousal disorder/genitopelvic dysesthesia). A wide variety of chronic health conditions, more prevalent in older adults, may also impact the hormonal, neurologic, vascular, or musculoskeletal physiology necessary for desire, arousal and orgasm. Additionally, the treatments for cancer and other chronic health conditions may cause anatomic, neurologic, and hormonal changes altering sexual function. The embarrassment and inconveniences associated with fecal and urinary incontinence can affect sexual behaviors and satisfaction. There may need to be adaptations to bowel or bladder incontinence, as well as adaptations to joint mobility and stiffness limiting positioning or even cognitive changes or dementia.⁹

While all this may seem insurmountable, solutions exist for many of these changes in sexual functioning – from proactive assessment and treatment of genitourinary syndrome of menopause to the use of PDE5i medications to adjustments of medical regimens to facilitate sexual function. It’s equally important to understand that changes and

differences in anatomy and physiology need not have ANY effect on sexual pleasure. Sexual pleasure is healthy in ALL bodies and is a dynamic and adaptable human process.

Family physicians can help their older adult patients simply by opening the discussion on sexuality. This includes assessment of sexual function and satisfaction including normal aging changes, disability, chronic health issues, medications, and environmental factors, and how these changes may be impacting a patient’s ability to have the sex that they want and deserve.

Furthermore, the sexual activities that older adults are more likely to engage in will again look different. For example, older adults are less likely to engage in penis-vagina intercourse with a greater emphasis instead on oral sex and other forms of sexual play. The function of all these sexual behaviors remains the same; to express intimacy, feel connected, please their partner, and feel pleasure themselves.¹⁰ There also needs to be consideration of sexual risks for older adults, as there is a statistically elevated presence of STIs in a population less accustomed to including barrier methods in their sexual behaviors.

If older adults are already a de-eroticized population, than the intersectional stigma of LGBT+ older adults is all the more so. APA reports that more than 39 million people in the U.S. are age 65 years or older including 2.4 million people who identify as lesbian, gay, bisexual or transgender (LGBT). As the baby boomer generation ages, the older adult population will increase from 12.8 percent to an estimated 19 percent in 2030.¹¹ Adding to the disproportionate impact of mental health concerns and societal stressors they are already at risk of experiencing, LGBT+ older adults may find greater difficulty in accessing competent and affirming services in primary care, in sexual health as well as other aspects of their healthcare needs.

Fortunately, the practice of avoiding sexual conversations with our older adult patients is alterable. At least insofar as providers are able to manage their own internal discomfort. The intervention, simply, is to ask all of our patients – at multiple times and in multiple ways. The goal here is twofold; to build internal comfort with the inquiry and to create a culture of openness with our patients. When we engage with them about their sexual health with genuine curiosity and a commitment to their pleasure, it communicates that we feel it is worth the time. The conversation should be started by the provider, which requires getting permission to have a sexual health conversation that is non-pressuring and shame free. In fact, demonstrating such curiosity to a patient’s sexual life can be a healing and destigmatizing intervention in itself. The assumption must be that all of your patients are having some kind of sex and that many would value the opportunity to share some concerns.

In the event that the patient responds with a sexual health concern, or merely wishes to share that all is going well, the way that we engage subsequently sets the tone for the overall helpfulness of the intervention. Remember, providers need not have all of the answers or a remedy in that very moment. The most important thing is establishing oneself as a resource to patients; somewhere they can turn for conversations that might otherwise be awkward. Notably, we want to hold to some principles of clear communication while discussing sexual health with patients. Using specific language as

providers and inviting our patients to do so as well helps to set the tone for collaboration and relaxed conversation. The priority is to get to the bottom of their concern, in which case providers may need to use facilitating language. “Would it be alright with you if we talked a bit more about your sexual experience? Your overall health, including sexual health, is important to me. You can be as candid with me as you would like and use what language feels best to you, and we will figure it out along the way.” “Many of my older adult patients have questions and concerns about sexual function and satisfaction, do you have any questions or concerns?”). Practice in maintaining an ethos of openness and specificity helps to dispel both the provider’s own discomfort and the patient’s.

Knowledge of where to turn for patients whose sexual concerns remain unresolved is also important. Sexual medicine specialists can be found in provider listings for several national and international organizations (International Society for the Study of Women’s Sexual Health (ISSWSH), Sexual Medicine Society of North America (SMSNA), and the International Society of Sexual Medicine (ISSM)) and certified sex therapists can be found in provider listings for the American Association of Sexuality Educators Counselors and Therapists (AASECT) and the Society for Sex Therapy and Research (SSTAR). Menopause specialists can be found at National American Menopause Society (NAMS). ISSWSH, ISSM, SMSNA, and NAMS also offer excellent educational opportunities for family medicine providers who want to learn more about these important, and undertaught, areas of medical care.

It can be difficult in primary care to overcome the constraints of time, practice, as well as how many of us have been socialized. However, conveying to patients our genuine interest and openness to their sexual health concerns must begin to take a more prominent place in the care we provide. Not just for the clear health and relational benefits, but also in the hopes that we can shift the larger conversations and care around sexual health to be inclusive, competent, and in pursuit of the sexual pleasure all people deserve.

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A Widow's Melancholia

By Thomas C. Rosenthal, MD

It was 1834, my first year of practice, when William Johnson asked if I, Jabez Allen MD, might stay for a brandy nightcap. He ushered me into the library where his sister Millicent and William's fiancée Rebecca were waiting. The hour was late, so William got right to the point, "Dr. Allen, we would like your opinion, and perhaps your assistance. Millicent and I are deeply concerned about our mother."

William was a newly minted attorney in his mid-twenties. His sister, Millicent, a couple of years younger, was named after their mother Millicent, the latter being the subject of my story.

William explained that mother Millicent had become a recluse since the death of her husband, their father, nearly a year prior. She seldom left her second floor rooms and concern for her health had caused William and Rebecca to postpone their wedding.

William and his sister Millicent had been born near Delhi, NY. Their father, Captain Samuel Johnson, had received a land grant in Delaware County for his distinguished service in the Revolutionary war battle at Ticonderoga. The land was rich with virgin hardwood that he cut and transported down the Delaware River to Philadelphia, becoming quite wealthy in the process. Seeking greater opportunities for William, the Johnsons moved into a stately East Aurora home two years ago. Shortly after the move, Captain Johnson took ill, dying in 1833.

William continued the story, "Mother did allow Dr. Hasack to visit once, but since Dr. Hasack's unexpected death, Mother has refused any other medical attention. In the last several months, she admits

only one lady friend who brings mother a bottle of Dover's powder each week. Every day mother takes several doses of Dover's dissolved in brandy. Jabez, we wonder if you might consider taking mother on as a patient."

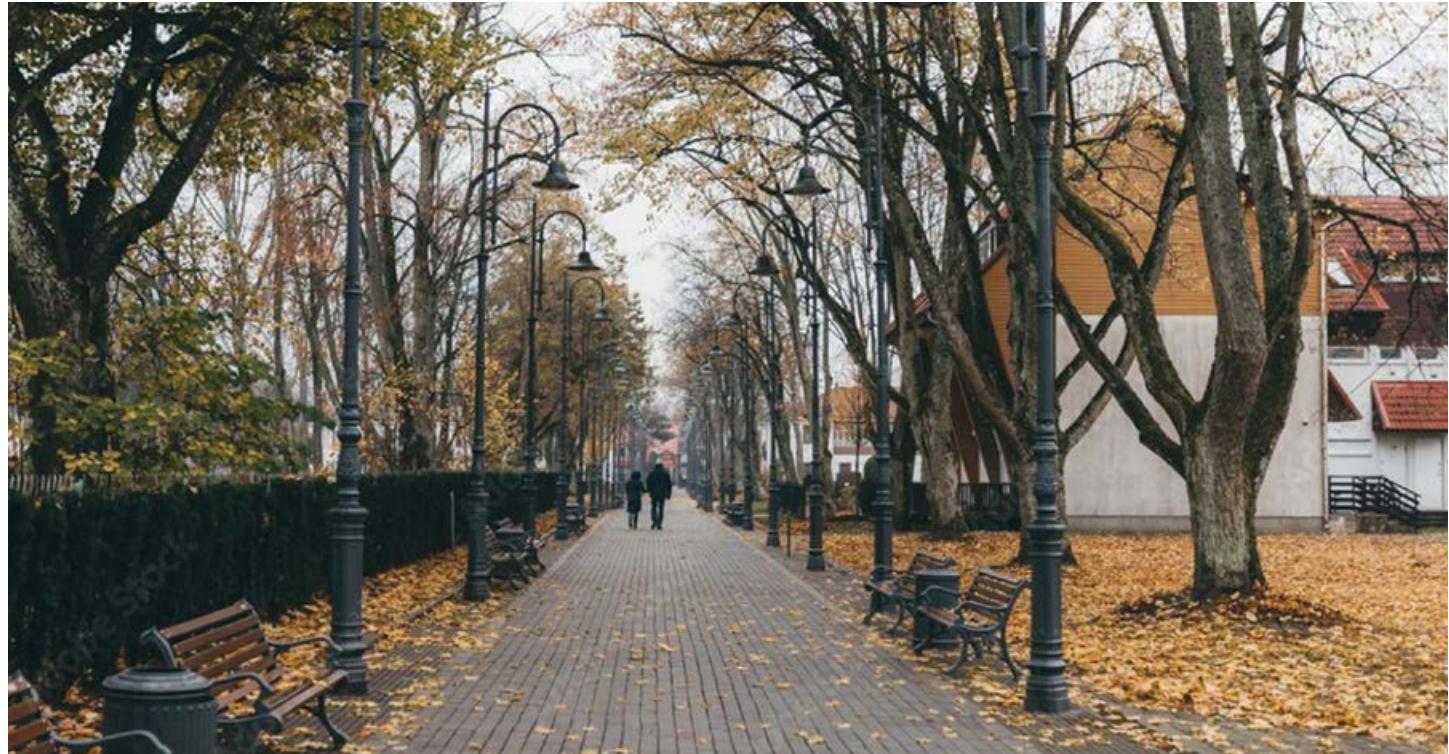
Straightaway I found myself switching to the professional persona that cohabitates with the social me,

"Dover's powder is a very popular combination of ipecacuanha and opium. In moderate doses, it stimulates the bowels and supports the nervous system. Forgive my implication, but does your mother have a history of melancholia?"

Now daughter Millicent spoke, "William resolutely protects mother, but I have always thought our mother possessed a weak nature. I may be struck by the hand of God for saying this, but mother was seventeen years younger than our father and I have always thought he addressed her as one would a child. That he loved her I am certain, but he was often brusque and his tone more of a disciplinarian than an adoring husband. Even as a child I would recoil at her tolerance of his patronizing ways."

With unflinching resolution, Millicent continued, "I loved my father but will never tolerate such treatment from a man. Mother coped by silent withdrawal. I believe she suffers an unremitting guilt that she could not be the wife he seemed to desire, though in fact I think she was. Unfortunately, that guilt now seems to consume her and I worry she may now be insane."

Let No Patient Walk Alone



Friendship complicates medical advice. Though most patients become friends, it is different when the sequence of acquaintance is reversed. When friends ask for medical advice, I wonder if they seek simple friendly support, or if they want the objective evaluation of a physician. I again deferred to 'Dr. Allen,' but sounded like a college lecturer.

"Philadelphia's Benjamin Rush wrote a book in 1812 claiming that depression and insanity are associated with exhaustion of the mind. I favor the view taken by Professor Griesinger, director of the German school of medical psychology. Griesinger writes that melancholia is a disease of the brain characterized by delusions fixated on a specific topic. The patient suffers a debilitating sadness, not uncommonly associated with hypochondriasis and vague feelings of oppression, anxiety, dejection and gloom. The disposition is one of pain and indifference. Does that describe your mother's situation?"

William responded, "Our mother is only 59 years old and widowed now for nearly a year. Father dominated all of us, including our mother. Though welcoming and attentive to us children, I recall mother spending long hours alone in her bedroom complaining of 'a little headache, nothing serious.' Millicent and I spent a great deal of time reading books and being quiet to avoid upsetting mother or father. Mother rose to every occasion that demanded she appear gay and cheerful, but always seemed exhausted afterwards."

Millicent picked up the story. "Mother endured seven pregnancies, five of which resulted in miscarriage. William and I are her only children. Her exhaustion has been chronic and Father's death added further burden. She has long-standing constipation for which she takes regular doses of senna. She blames a painful right hip on events surrounding her last pregnancy and she leaves her rooms only for Sunday church. Will you agree to take mother on as a patient?"

I was both flattered and unsettled, "I would be honored. But these matters can be challenging. May I suggest that you tell her you have asked me to examine her hip, in the hope that I might suggest something to relieve her pain? If you allow me that opening, I will take it from there."

Two days later Millicent sent a message that her mother had agreed to my visit. I made my first call that afternoon.

Mrs. Johnson remained dressed as I conducted my exam of her right hip. She localized her discomfort to the anterior right hip. The range of motion was limited and the pain worsened with rotation. Her hand exam revealed the nodes described by Heberden. I informed Mrs. Johnson that her symptoms were most likely due to a chronic arthritis for which letting blood provides temporary relief. With her consent, I applied a tourniquet to the right thigh, located a vein in the back of her knee, and withdrew twelve ounces of blood. As expected, Mrs. Johnson reported improvement just as I noticed a rise in her pulse. I encouraged her to take a few steps and, placing my arm around her waist, we walked the circumference of the room. A few tears appeared which Mrs. Johnson dismissed as tears of relief. I hugged her a little closer.

Eberle's textbook recommends purgatives at this point, but I felt Mrs. Johnson too frail for aggressive measures. Her Dover powder was nowhere in sight, a sign I took to mean that she had no desire to be challenged about its use. I prescribed tincture of colchicum seed, twenty drops to be taken every four hours until nausea or stooling occurred. She indulged my promise to return the next day.

The next day a half-empty bottle of Dover's powder sat on the table next to Mrs. Johnson's chair. Foolishly, I sprang to suggest she stop using Dover's. She met my folly with a stinging rebuke, "Are you incapable or incompetent? You are the second doctor to examine me and you appear to be no better at remedies than the other. My pain returned during the night, worse than ever. Dover's provides my only relief."

On the verge of derailing the relationship I hoped to establish, I made a quick retreat by refocusing on her right hip. "Mrs. Johnson, can you estimate what time your hip pain returned?" I asked, noting that in her scolding anger she stood to confront me. The day before she had risen only for our little walk around the room.

"It was in the early hours of the morning if you must know," she replied.

"Please advise me if you were awake prior to the pain returning or if you think the pain woke you up from a sound sleep?" I asked.

"I find your question impertinent but will humor you only because my daughter has begged me to do so. Your medicine upset my stomach and, after using the night pot, the pain recurred upon returning to bed."

"I assume the pain was quite intense yesterday. How would you judge its intensity today?" I continued.

It seemed that Mrs. Johnson suddenly realized she was standing, forcing a more nuanced assessment of her pain, "I will confess to moving better, but young man, it comes at the cost of excruciating pain."

"Then, Mrs. Johnson, if you will indulge me further, I would like to offer a repeat letting of blood, a change in medication and another twenty-four hours of observation."

"If you must. But only to appease my children. I fail to appreciate what Millicent sees in you other than persistence. I insist that this time you release the blood from my arm."

She was acting dismissive, but did not discharge me. And, there was a hint of incongruence between her words and her expression. Mrs. Johnson was grasping for control. Bloodletting near the site of pain is recommended, but I subtracted six ounces of blood from her arm. During the procedure I chattered, "I treated yesterday's blood with a few drops of citric acid. Then, allowing it to stand undisturbed, I noted the white band between the red blood and yellow plasma. It's called a buffy coat. A wide buffy coat indicates aggressive antiphlogistic treatments are required." I hesitated, hoping to draw out Mrs. Johnson's curiosity.

"Come, come young man. What did your buffy coat reveal?" Mrs. Johnson inquired. My trap was sprung.

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"I am relieved to report that your buffy coat was narrow. And now, seeing that you received no relief from the colchicum, I am confident we can focus our treatments and that you will one day resume the activities you find enjoyable. Your wisdom has seen you through the first treatment phase, that of strict rest. If you are willing, I shall apply myself to the next phase of your recovery."

I did not push for an agreement. Mrs. Johnson had invested her energies in a reclusive state that could not be reversed by a few simple words. I contented myself with the permission her silence implied.

Heberden associated his nodes with a chronic rheumatism generally visiting the weight bearing joints and hands of older persons. I prescribed a compound of gum guaiacum and cinnamon to be taken three times a day and a preparation of camphor dissolved in ether to be massaged onto her hip three times a day. I told Mrs. Johnson that Dr. Eberle, the author of my favorite textbook, was a respected Philadelphia professor who held guaiacum in high opinion. I also recommended that she allow her daughter to apply hot compresses to her hip before application of the camphor, hoping that would increase interaction between mother and daughter.

I found Millicent in her mother's room at the next few visits. I bled Mother Millicent only once more having convinced myself that repeated venesection had limited use in the absence of inflammation. One day I found Mother Millicent alone and in a pensive mood. Sitting on her footstool, I leaned forward, took her hand, and waited for her to speak. Her words are stamped in my memory. "Since Mr. Johnson's death it appears that everything around me is precisely as it used to be. But that's impossible. His death changed everything. All that is around me wears aspects of the old, as if denying his death."

As her words put down roots, I moved to hold both her hands. She resumed, "Will this gloom ever lift? It's either a nightmare or a devil's torment. I seem unable to cross over to widowhood. How does one settle into a life that one does not want? Enjoyment of any kind seems a sin. All associations with friends expose me to that sin. Even attending church, I feel overcome with fear that I might experience pleasure. I am both grateful and angry that you have reduced my pain. But I am frightened because I do not know who I am to be."

Mrs. Johnson's description of survivorship was not taught in medical college. As I reflected on the startling wisdom of the meek, her words unwrapped the lingering wounds I harbored about my mother's death. A few more moments passed before I became aware of how firmly I held Mrs. Johnson's hands. We had both shed a few tears, for ourselves, and for each other.

Hippocrates believed melancholia was caused by excessive black bile, combining the Greek word melas, (black), and khole (bile). Eberle classifies it as an emotional insanity characterized by depression and occasionally mania, often following a sudden reversal of fortune. Courage and initiative are exhausted and replaced by a feeling of illness that dominates the patient's attention. Recovery requires refocusing the patient's attention from herself to others.

Mrs. Johnson had not abandoned logic and I was struck by the contrast in ways we confronted our demons. After my mother's death, I slipped into near manic behavior that included giving up all rights to the family farm and throwing myself onto the frontier and into the village where I now practiced. Mrs. Johnson's path led into depression. We had many things to teach each other.

That night I obsessed over my books, reading Eberle and Griesinger again. They agreed with Rush's contention that bleeding relieves the cerebral congestion. One warned that bleeding may lead to mania if done too frequently. Griesinger advocated for applying leeches behind the ears and plasters of tartar emetic to the neck. Opium, in doses higher than Dover's, produces the most immediate results, but alcohol is uniformly condemned.

According to Griesinger, activity of the body works on the mind. Idle lounging becomes a habit and leads to considerable enfeeblement. Treatment may include religious instruction, but total reliance on it is to be discouraged. The wealthy may indulge in prolonged travel, but for most, relief lies in early rising, a nutritious diet, and finding simple activities that can be repeated under agreeable conditions.

Fortified by my textbooks, I bargained for substituting Dover's powder with laudanum. I compounded the laudanum in my store and gradually reduced the opium content while decreasing the frequency. More importantly, we agreed that each morning, Mother Millicent and her daughter would take a walk. Each walk was to last thirty minutes, with time being more important than distance.

I was genuinely curious about melancholia, so I joined a number of those walks and kept notes for an empirical analysis of her recovery. More importantly, I joined their conversation. Language suffers from inadequate words for fondness and devotion, but in those three months, a platonic love for Mother Millicent grew within me. That winter a family acquaintance, the abolitionist George Washington Jonson, scheduled a lecture in our village. Mother Millicent invited me to a welcoming reception she hosted. She called it her 'coming out' and she pulled it off with enviable vigor and expertise.

Caring is a window to the human soul, theirs and ours.

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