vent'anni per gli anziani
1988·2008

Gruppo di ricerca geriatrica

Venerdì 23 maggio 2008

Rapporto dall'AGS-2008, Washington

Renzo ROZZINI

Bruciare i campi rom…….
Il 2 agosto 1944 è una data che l'intera etnia zingara non potrà mai dimenticare. In questo giorno 3.000 Rom vennero sbattuti e uccisi nelle camere a gas del campo di concentramento di Auschwitz.
Era l'ultimo atto dell'atroce operazione di sterminio della "razza zingara" da parte dei nazisti. Perché, fatto che molti ignorano, accanto all'Olocausto degli ebrei, si consumò anche quello, forse di minori dimensioni, degli zingari. Nel corso della seconda guerra mondiale ne furono uccisi, per lo più nei lager, circa 500.000. Questa, come tutti sappiamo, fu la tragica conseguenza degli ideali malati del cancelliere Adolf Hitler.

Gli slittamenti linguistici, i lapsus, sono sempre molto più indicativi di quello che sembrano. Da un paio di mesi a questa parte su tutti i quotidiani non esistono più i rumeni (con la “u”, come correttamente dovrebbe essere) ma i romeni (con la “o”). All’improvviso dotti laureati in lettere, i nostri amati giornalisti - sempre così proni di fronte al potere costituito o agli umori della piazza - hanno dimenticato il vocabolario preferendo, “creativamente”, una vocale ad un’altra. Di modo che, neppure troppo sottotraccia, si dia la percezione che i rumeni siano, anche linguisticamente, tutti rom-eni. Rom. Zingari. Mostri, insomma.

WEDNESDAY, APRIL 30, 2008

Time	Session
8:00 AM – 1:00 PM	**COSAR Leadership and Advocacy Training**
8:30 AM – 5:00 PM	**AAHCP Session** (additional fee)
10:00 AM – 12:00 PM	**AGS Member Advocacy Briefing Session**
10:00 AM – 12:00 PM	**Meet and Greet for International Attendees**
	PRE-CONFERENCE SESSIONS
10:00 AM – 5:30 PM	Fellowship Directors Pre-conference Course (additional fee)
1:00 PM – 5:30 PM	Intervention and Prevention of Elder Mistreatment: Policy and Practical Implications for Practitioners (additional fee)
1:00 PM – 5:30 PM	Palliative Care Boot Camp: A Skill Based Workshop for Multidisciplinary Clinicians (additional fee)
1:00 PM – 5:30 PM	How to Survive in a Geriatrics Private Practice (additional fee)
5:45 PM – 7:00 PM	**RECEPTIONS**
	ADGAP Fellowship Program Directors Reception
	COSAR Reception
5:45 PM – 7:00 PM	**SPECIAL INTEREST GROUP**
	Palliative Care
6:30 PM – 9:00 PM	**INDUSTRY-SUPPORTED SYMPOSIA**
	Probiotics: Impact on Health and Quality of Life in Older People
	Phases: Practical Issues in Assessment and Treatment of Sleep Disorders in Older Adults

	THURSDAY, MAY 1, 2008	
7:00 AM – 9:00 AM	**SECTION MEETINGS**	
	Fellows-in-Training Breakfast	Thurgood Marshall Northeast
	Nurses Breakfast	Thurgood Marshall Southwest
7:30 AM – 9:00 AM	**SYMPOSIA**	
	Death by Neglect: What Healthcare Providers Need to Know	Washington 4
	What Every Geriatrician and Geriatric Health Provider Needs to Know About Medicare Advantage Special Needs Plans	Maryland A/B/C
	Regional Differences in Management of Medicare LTC Quality Indicators and Implications for Geriatric Practice	Virginia A/B/C
7:30 AM – 9:00 AM	**PAPER SESSION**	
	Ethics & Quality of Life	Delaware A
7:30 AM – 9:00 AM	**MEET-THE-EXPERT SESSION**	
	CPT Coding: Basic Principles and Practice	Hoover
7:30 AM – 9:00 AM	**WORKSHOPS**	
	Model Geriatric Programs: Geriatric Education Materials and Methods Swap	Delaware B

THURSDAY, MAY 1, 2008, *continued*

Time	Session	Room
7:30 AM – 9:00 AM *continued*	GRECC Workshop – Using Health Information Technology to Improve Medication Management of Geriatric Patients: Lessons Learned from Selected Implementations of Computerized Decision Support	Wilson C
7:30 AM – 9:00 AM	**SPECIAL INTEREST GROUPS**	
	Acute Hospital Care	Taylor
	Geriatric Rheumatology and Musculoskeletal Aging	Harding
	Long Term Care	Jackson
	Veterans Health Administration	Washington 5/6
9:00 AM – 9:30 AM	**AGS Members Meeting**	Salons 1/2
9:30 AM – 10:30 AM	**Henderson State-of-the-Art Lecture**	Salons 1/2
10:00 AM – 4:00 PM	**Exhibit Hall Open**	Exhibit Halls A/B/C
10:30 AM –11:30 AM	**Plenary Paper Session**	Salons 1/2
11:30 AM – 1:00 PM	**Poster Session A**	Exhibit Halls A/B/C
12:30 PM – 4:30 PM	**State-of-the-Art Clinical Updates**	Salons 1/2
12:30 PM – 2:00 PM	**SYMPOSIA**	
	Osteoporosis: Advances and Controversies	Maryland A/B/C
	NIA/NIH Symposium on Cognitive Aging	Virginia
	Preventive Medicine and Life Style Modification in Older Adults	Washington 5/6
	The Impact of Religion on the Health of Older Adults: Doorway Thoughts	Washington 4
12:30 PM – 2:00 PM	**PAPER SESSION**	
	Neurology and Biology of Aging	Delaware A
12:30 PM – 2:00 PM	**MEET-THE-EXPERT**	
	Prostate Cancer in the Older Man	Wilson C
12:30 PM – 2:00 PM	**WORKSHOPS**	
	Multidisciplinary Clinical Skills Workshop	Wasington 1-3
	Collaboration to Incorporate a Prehospice Palliative Program in the Nursing Home: Focus on Community, Family, Caregivers, and Empowerment	Delaware B
12:30 PM – 2:00 PM	**SPECIAL INTEREST GROUPS**	
	Cancer and Aging	Hoover
	Healthcare for Low-Income Seniors	Harding
	PACE	Taylor
	Rehabilitation	Tyler
2:00 PM – 3:30 PM	**Poster Session B**	Exhibit Halls A/B/C
3:00 PM – 4:30 PM	**SYMPOSIA**	
	Strategies for Improving Care in Patients with Advanced Dementia and Feeding Problems: An Interdisciplinary Discussion	Maryland
	Evidence-Based Techniques for Enhancing Health Behaviors of Older Adults: Multidisciplinary Perspectives	Virginia
	Emerging Models of Acute Hospital Care of Older Patients	Washington 4
	Developing Your Career in Academic Geriatrics: From Fellowship to Independence	Washington 5/6
3:00 PM – 4:30 PM	**PAPER SESSION**	
	Health Services & Policy Research	Delaware A

THURSDAY, MAY 1, 2008, *continued*		
Time	Session	Room
3:00 PM – 4:30 PM	**WORKSHOPS**	
	Research Programs and Issues Series: Metabolic Syndrome and Aging	Delaware B
	How Much Do you Know about Advocating for Public Policy Change through Grassroots Efforts-Geopardy or Double Geopardy	Wilson C
	HIV in the Older Population: A Growing Problem	Hoover
	The Longevity Revolution	Taylor
3:00 PM – 4:30 PM	**SPECIAL INTEREST GROUPS**	
	DOs in Geriatrics	Tyler
	Needs of Older Gay and Lesbian, Bisexual and Transgendered Persons	Harding
4:45 PM – 6:15 PM	**PLENARY SYMPOSIUM**	
	Release of the IOM Study on the Future Healthcare Workforce for Older Americans	Salons 1/2
6:30 PM – 7:30 PM	**AGS Presidential Reception**	Salon 3
8:00 PM – 10:00 PM	***An Evening With Friends***	Blue Ballroom, Omni Shoreham Hotel
FRIDAY, MAY 2, 2008		
7:30 AM – 9:00 AM	**SYMPOSIUM**	
	Stem Cell Based Therapies for Older Patients: Realizable Goal or Hopeless Fantasy?	Maryland
7:30 AM – 9:00 AM	**MEET-THE-EXPERT SESSIONS**	
	Get to Know YOUR AGS	Harding
	Improving Health Literacy in Older Adults to Safeguard Patient Safety	Delaware B
7:30 AM – 9:00 AM	**WORKSHOPS**	
	Pearls on Publishing and Reviewing Papers	Delaware A
	Academic Advancement as a Clinician-Educator: Teaching Skills Workshop—Giving Effective Feedback	Wilson A/B
	Emerging Technologies Help Seniors Enjoy Higher Healthcare Standards	Washington 4
7:30 AM – 9:00 AM	**SPECIAL INTEREST GROUPS**	
	Family Physicians in Geriatrics	Taylor
	Geriatric Consultative Services	Tyler
	Hospital Elder Life Program (HELP)	Jackson
7:30 AM – 9:30 AM	**INDUSTRY-SUPPORTED SYMPOSIUM**	
	Across a Spectrum of Risk: Approaching VTE in the Older Adult	Thurgood Marshall Northeast
7:30 AM – 9:30 AM	**WORKSHOP**	
	Constructing Quality Indicators for the Care of Older Patients Visiting Emergency Departments	Hoover
7:30 AM – 9:30 AM	**SECTION MEETING**	
	Medical Subspecialties Breakfast	Truman
8:00 AM – 9:00 AM	**SYMPOSIUM**	
	Federal Legislative Trends in Healthcare Impacting Older Adults	Virginia
9:30 AM – 10:00 AM	**AGS Awards Ceremony**	Salons 1/2

FRIDAY, MAY 2, 2008, *continued*

Time	Session	Room
10:00 AM – 11:00 AM	**Public Policy Lecture**	Salons 1/2
10:00 AM – 6:00 PM	**Exhibit Hall Open**	Exhibit Halls A/B/C
11:00 AM–11:45 AM	**Outstanding Scientific Achievement for Clinical Investigation Award Presentation and Lecture**	Salons 1/2
11:00 AM – 1:00 PM	**ADGAP Business Meeting**	Delaware B
11:45 AM–1:15 PM	**Poster Session C**	Exhibit Halls A/B/C
12:45 PM – 2:15 PM	**SYMPOSIA**	
	Controversies in Geriatric Cardiology in Octogenarians and Beyond	Maryland
	Fighting Against Age Discrimination in Clinical Trials	Virginia
	AGS Washington Update	Washington 5/6
	The Hospice Benefit and the Designation of Advance Directives—The What and When for Non-DNR Status and Its Potential Conflicting Message to Patients, Caregivers and Health Care Professionals	Washington 4
12:45 PM – 2:15 PM	**PAPER SESSION**	
	Geriatric Education	Delaware A
12:45 PM – 2:15 PM	**WORKSHOPS**	
	Research Programs and Issues Series: Pilot Studies	Delaware B
	Teaching Physical Diagnosis in Older Adults	Washington 1–3
12:45 PM – 2:15 PM	**SPECIAL INTEREST GROUPS**	
	E-Learning	Taylor
	Medical Humanities	Tyler
	Private Practice Providers in Geriatrics	Hoover
2:30 PM – 4:00 PM	**SYMPOSIA**	
	Getting to Know the NIA: A Symposium for Go-Getters in Aging Research	Virginia
	Ethics and Quality Improvement Activities in Health Care	Washington 4
	New Frontiers in Geriatrics: The Janhnigen and Williams Awardees Report on Research Leading to Improved Care by Surgical and Medical Subspecialists	Washington 5/6
2:30 PM – 4:00 PM	**WORKSHOPS**	
	Teaching Physical Diagnosis in Older Adults	Washington 1-3
	Cross-Cultural Communication for End-of-Life Care	Delaware B
4:00 PM–5:30 PM	**Presidential Poster Session D & Awards Reception**	Exhibit Halls A/B/C
5:30 PM – 6:30 PM	**SPECIAL INTEREST GROUP**	
	AGS/SGIM Polypharmacy	Hoover
6:30 PM – 8:00 PM	**SPECIAL INTEREST GROUPS**	
	Clinical Research in Dementia	Taylor
	Disaster Planning and Preparedness	Hoover
	Ethnogeriatrics	Tyler
	Mentoring	Jackson
	SGIM	Wilson A/B
6:30 PM–9:00 PM	**INDUSTRY-SUPPORTED SYMPOSIUM**	
	Moving Ahead in Chronic Constipation: Addressing Symptoms and Caring for Patients	Thurgood Marshall Northeast
7:00 – 8:30 PM	**Residents Poster Session**	Washington 1–2

SATURDAY, MAY 3, 2008

Time	Session	Room
7:00 AM–2:30 PM	**Annual Meeting of the Section for Surgical and Related Medical Specialties**	Washington 4
7:30 AM–9:00 AM	**SYMPOSIUM**	
	Clinical Challenges in Evaluating Men with Lower Urinary Tract Symptoms and Prostate Disease	Maryland
7:30 AM–9:00 AM	**MEET-THE-EXPERTS**	
	Using the PDA Version of Geriatrics at Your Fingertips (GAYF) in Teaching and Patient Care	Taylor
	The Benefits and Pitfalls of Screening in Very Frail Older Persons	Truman
7:30 AM–9:00 AM	**WORKSHOPS**	
	Model Geriatric Programs: Geriatric Education Materials & Methods Swap	Delaware B
	Coding and Reimbursement: Stump the Professors	Wilson C
	Research Programs and Issues Series: Integrating Quantitative and Qualitative Methods—The Benefits and Challenges of Using Mixed Methods Studies in Aging Research	Delaware A
7:30 AM–9:00 AM	**SPECIAL INTEREST GROUPS**	
	Elder Abuse and Neglect	Tyler
	Information Technology Issues	Coolidge
	International Activities	Harding
	Osteoporosis and Metabolic Bone Diseases	Cleveland 1
7:30 AM–9:30 AM	**INDUSTRY-SUPPORTED SYMPOSIUM**	
	Adult Vaccinations in 2008	Thurgood Marshall Northeast
9:30 AM–11:00 AM	**SYMPOSIA**	
	Geriatric Fracture Management	Maryland
	Sleep Apnea and Aging: Implications for Cognitive Decline and Dementia	Virginia
	Payment Reform and Patient Safety: How Does the Quality Agenda Improve Safety for the Older Adults?	Delaware B
9:30 AM–11:00 AM	**PAPER SESSION**	
	Epidemiology	Delaware A
9:30 AM–11:00 AM	**MEET-THE-EXPERT**	
	Heart Failure in Older Adults: A Cardiogeriatric Syndrome	Harding
9:30 AM–11:00 AM	**SECTION MEETING**	
	Teachers Networking Session	Wilson C
10:00 AM–2:00 PM	**AGS/AFAR/John A. Hartford Foundation Student Poster Session & Luncheon**	Exhibit Hall C

SATURDAY, MAY 3, 2008, *continued*

Time	Session	Room
11:15 AM–12:45 PM	**SYMPOSIA**	
	Reducing Avoidable Acute Care Hospitalizations across the Continuum of Health Care	Maryland
	Thinking, Moving, and Feeling: Common Underlying Mechanisms? Report of the NIA U13 Conference	Virginia
	Geriatric International Educational Initiatives: A Global Approach	Salon 1
11:15 AM–12:45 PM	**PAPER SESSION**	
	Clinical Geriatrics	Delaware A
11:15 AM–12:45 PM	**MEET-THE-EXPERT**	
	Using the PDA Version of Geriatrics at Your Fingertips (GAYF) in Teaching and Patient Care	Harding
11:15 AM–12:45 PM	**WORKSHOPS**	
	Enhancing Your Publication Profile	Delaware B
	Translating Dementia Discovery to Dementia Delivery	Wilson C
12:45 PM–2:45 PM	**INDUSTRY-SUPPORTED SYMPOSIUM**	
	Amyloid-based Intervention Strategies for Alzheimer's Disease: Targeting Disease Modification	Thurgood Marsh Northeast
12:45 PM–2:45 PM	**SECTION & SIG MEETINGS**	
	Social Workers Luncheon	Taylor
	Pharmacists Luncheon	Tyler
	Residents Luncheon & SIG	Coolidge
	Junior Faculty Research Career Development SIG & Workshop: A Round-Table Discussion Between Senior Leaders and Young Talent in Geriatrics	Delaware A
3:00 PM–4:30 PM	**SYMPOSIA**	
	Pharmacotherapy Update: 2008	Maryland
	Delirium: Pearls for Practice	Virginia
	Medicare Tomorrow: Less Money, Better Quality?	Salon 1
3:00 PM–4:30 PM	**PAPER SESSION**	
	Research on Geriatric Syndromes	Delaware A
3:00 PM–4:30 PM	**WORKSHOP**	
	House Calls for Academic Programs and Practice	Delaware B
3:00 PM–4:30 PM	**SPECIAL INTEREST GROUP**	
	Health Professional Students	Hoover
4:45 PM–6:15 PM	**PLENARY SYMPOSIUM**	
	That Was the Year that Was: Join Residents and Faculty in Taking the Geriatrics Knowledge Challenge	Salons 1/2
6:30 PM–9:00 PM	**INDUSTRY-SUPPORTED SYMPOSIUM**	
	Managing Antiplatelet Therapy in the Older Patient: Preventive Care in Patients at Risk for Atherothrombosis	Delaware

A case of "Takotsubo cardiomyopathy" in a geriatric patient-A case report.

H. L. Chughtai, A. Andrade, M. Reisner. *Jersey City Medical Center, Brooklyn, NY.*

Supported By: There is no financial disclosures.

Introduction:

Takotsubo cardiomyopathy is a reversible cardiomyopathy also known as "Broken heart syndrome". Pathogenesis of Takotsubo cardiomyopathy involves stress induced transient myocardial dysfunction involving apical region of left ventricle. It does not include coronary ischemia. The name Takotsubo is given due to resemblance of shape of left ventricle to a Japanese octopus trap called "Takotsubo". We describe a geriatric patient who developed Takotsubo cardiomyopathy in the hospital while being treated for urosepsis.

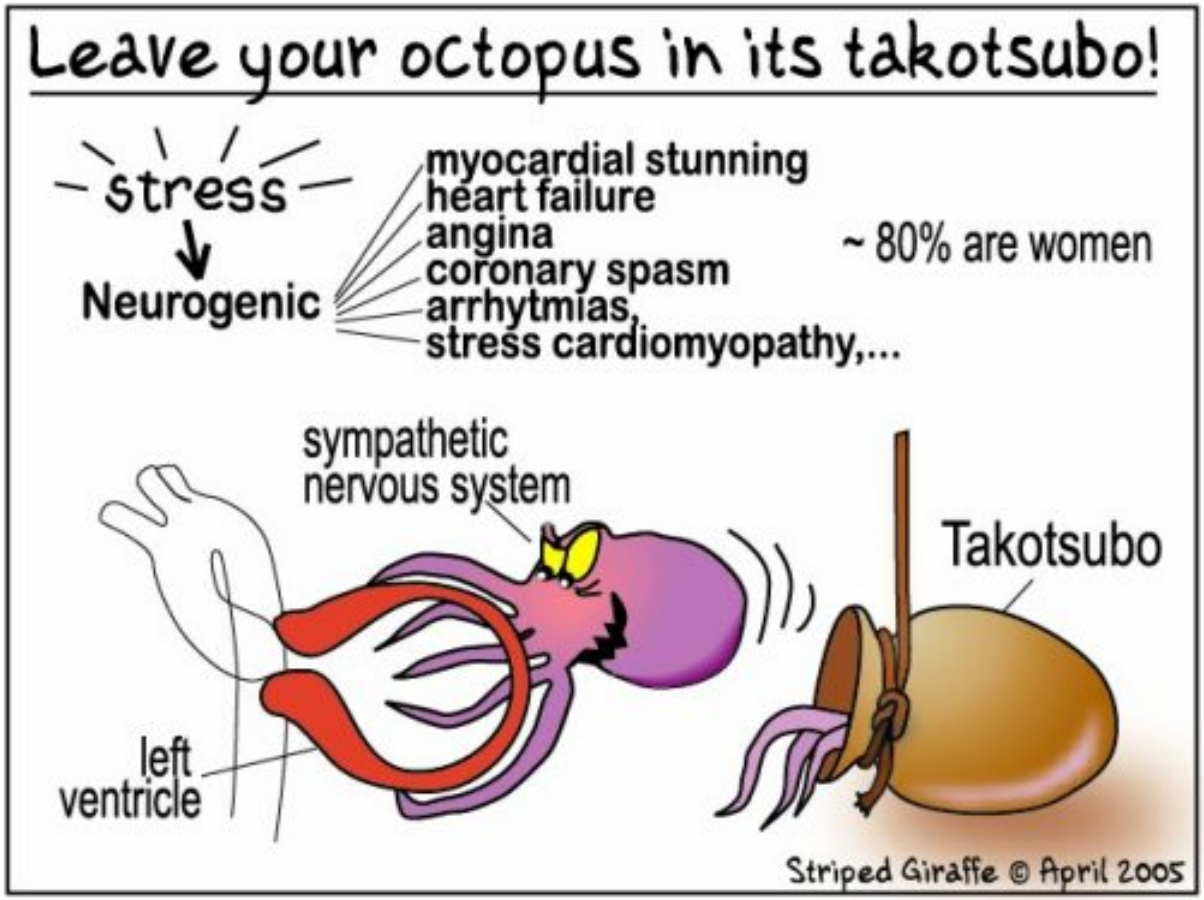
Case:

An 89 years old Caucasian male whose past medical history included hypertension, diabetes mellitus and benign prostatic hypertrophy was admitted to the hospital for fever, chills and mild cough. Patient was recently treated for an episode of urinary tract infection with levaquin. On admission patient had a chronic indwelling catheter. Patient was febrile (T=102.5), tachycardic (HR 132) and BP of 121/42.

On physical exam patient was drowsy but responsive to verbal stimuli. Abdominal exam showed mild suprapubic tenderness and a stage three sacral decubitus. Initial labs showed leukocytosis with left shift. Urinalysis showed cloudy appearance, with large leukocyte esterase and moderate bacteria. Electrocardiogram revealed low voltage, concave-upward ST- segment elevation in leads II, III and PR segment depression in leads II and V3. During hospitalization patient troponin levels started rising up to a peak of 2.22 ng/ml. An initial diagnosis of acute coronary syndrome vs. pericarditis was made. Later an echocardiogram revealed apical cardiomyopathy with ballooning of apex along with normally functioning base of the heart. All these findings are synonymous with Takotsubo cardiomyopathy.

Discussion:

This is a case of Takotsubo cardiomyopathy in a geriatric patient. There are numerous case reports of Takotsubo cardiomyopathy but literature search shows that, Takotsubo cardiomyopathy has been rarely described in the geriatric population. Treatment of Takotsubo cardiomyopathy is conservative and most cases resolve spontaneously with supportive measures in 1-2 months.


Leave your octopus in its takotsubo!
stress
Neurogenic
myocardial stunning
heart failure
angina
coronary spasm
arrhytmias,
stress cardiomyopathy,...
~ 80% are women
sympathetic
nervous system
Takotsubo
left
ventricle
Striped Giraffe © April 2005

A16

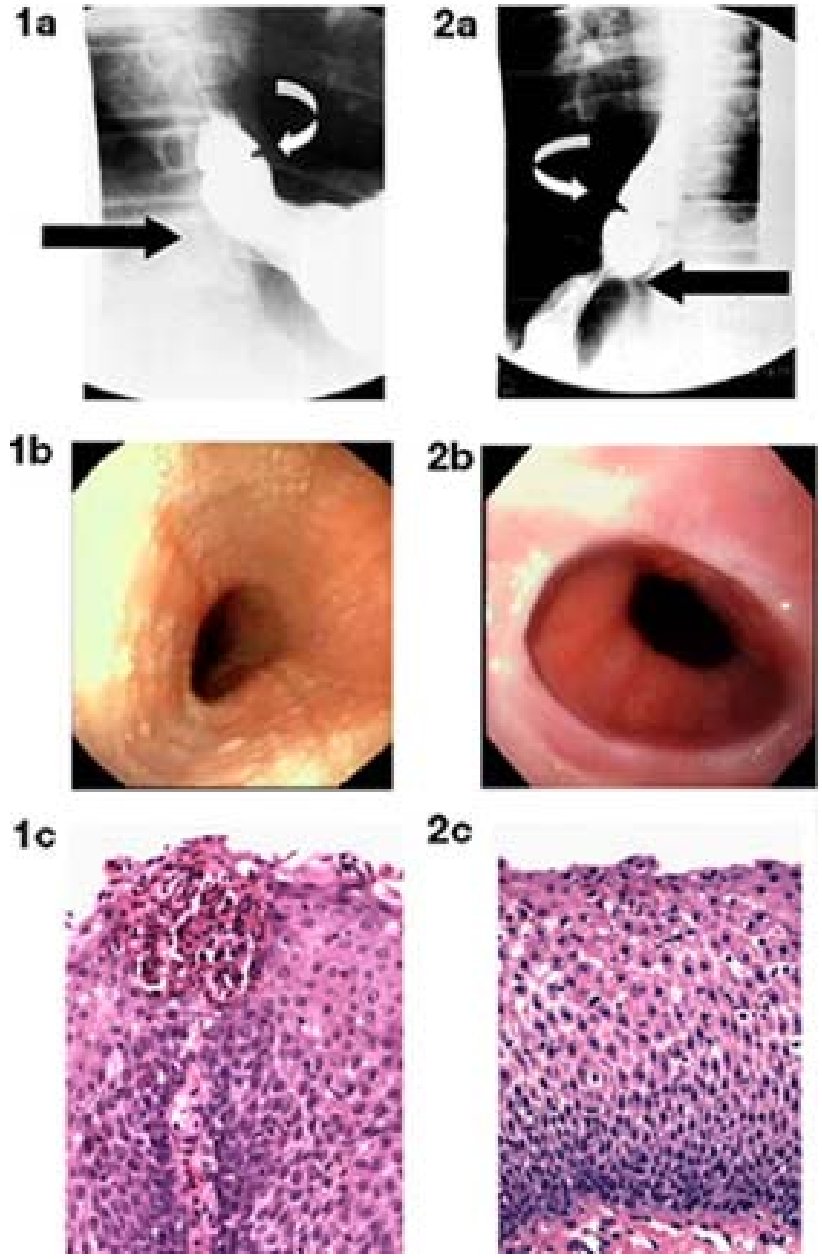
Dysphagia in an Older Adult with Multiple Chronic Conditions.

S. Shan-Bala,[1] E. L. Cobbs.[2,1] *1. Medicine, George Washington University, Washington, DC; 2. Geriatrics and Extended Care, Wash DC VAMC, Washington, DC.*

Case: A 76 year old female with a history of dementia, hypertension, stroke, diabetes, and heart disease, was admitted to the hospital for recurrent nausea and vomiting. She was recently hospitalized elsewhere for similar symptoms and was diagnosed and treated for urinary tract infection. The nausea and vomiting subsided after therapy and were not investigated further. After discharge from the hospital, the nausea and vomiting recurred, worse after large solid meals. She had no abdominal pain, diarrhea, constipation, melena or hematochezia. There was no history of surgery or gastroesophageal reflux disease. Physical exam was unremarkable except for generalized weakness and deconditioning. Stools were hemoccult negative. Complete blood count and liver function tests were normal. Mild electrolyte imbalances were resolved. Urinalysis was normal. Chest xray was normal. Abdominal ultrasound was normal.

A speech and swallowing evaluation led to a videographic study that revealed esophageal dysphagia with normal swallowing function. Endoscopy revealed a Schatzki ring at the gastroesophageal junction. Esophageal dilatation was performed with serially inflated microvasive balloon dilators. The nausea and vomiting resolved, and patient resumed a regular diet.

Discussion: This older adult with dementia had a number of underlying conditions that could have caused dysphagia. Longstanding diabetes mellitus is associated with gastroparesis. Functional swallowing problems are often seen after stroke. Dyphagia with nausea and vomiting may be signs of underlying sepsis caused by urinary tract infection or pneumonia. Esophageal carcinoma can cause mechanical obstruction. Schatzki ring, also known as esophageal ring, is usually seen in patients with a long history of gastroesophageal reflux disease. It is a benign and highly treatable cause of dysphagia. Patients with dementia may experience delays in diagnosis if symptoms appear to resolve in the hospital and outcomes such as tolerance of feeding may not be closely monitored.


1a
2a
1b
2b
1c
2c

A18

Shocks after Deactivation of ICD at the End of Life.

M. Villanueva,[1] N. Lepcha,[2,1] E. L. Cobbs.[2,1] *1. Medicine, George Washington University, Washington, DC; 2. Geriatrics and Extended Care, Wash DC VAMC, Wash, DC.*

Background: Implantable cardiac defibrillators (ICD) are now in widespread use. In the event of life-threatening ventricular tachyarrhythmias, ICDs deliver shocks that can be painful. For patients whose goals of care are focused on comfort and death is expected, healthcare providers are addressing the need to deactivate the ICD.

Case History: A 73 year old man lived in a nursing home because of dilated cardiomyopathy and heart failure, end-stage kidney disease on hemodialysis, anoxic encephalopathy from cardiopulmonary arrest, diabetes mellitus, chronic obstructive pulmonary disease, depression and arthritis. An ICD had been placed. His health declined due to recurrent exacerbations of his lung and heart disease despite optimal medical management. Recurrent episodes of hypotension occurred requiring hospitalization. The ICD was activated a number of times for ventricular fibrillation. Hemodialysis became impossible due to bouts of hypotension. With options for further treatment were exhausted, goals of care were shifted to promotion of comfort. The decision was made to forgo attempts at cardiopulmonary resuscitation. A cardiologist deactivated the ICD. Intensive palliative care was in place. The following morning (which was a Saturday), the patient exhibited at least four episodes of screaming associated with jerky movements. Staff members grew concerned that these episodes could be attributed to ICD shocks. With instruction from the cardiologist, a magnet was placed on the left abdomen at the site of the ICD directly beneath the scar. The patient's pain medication was also adjusted. The patient had no further episodes of screaming or jerking, died comfortably 36 hours later. A postmortem interrogation of the ICD confirmed that the ICD had indeed been deactivated. There were no events of VF recorded and no ICD therapy delivered from the time of deactivation to the time of death.

Conclusion: This case illustrates a clinical challenge in caring for a dying patient with an ICD. At the time providers lacked the ability to determine definitively the cause. A combination of magnet application and increased pain medication resulted in comfort for the patient. After the interrogation, the most likely cause of the patient's symptoms was myoclonus precipitated by uremia, opiates and acidosis, however it was reassuring to be able to use the magnet to assure that the ICD was indeed deactivated.

A 21

Fatal pulmonary embolism in a post-hip fracture patient who had completed the standard course of prophylaxis for deep venous thrombosis.

P. Yee,[1] C. May,[2] T. Edmonson.[3] *1. Department of Gerontology, University of Maryland, Baltimore, MD; 2. Gerontology, University of Maryland, Baltimore, MD; 3. Section of Geriatrics, Franklin Square Hospital Center, Baltimore, MD.*

A 76 year old woman with a history of diabetes mellitus, hyperlipidemia, depression and degenerative arthritis underwent surgical repair of the right greater trochanter after sustaining a comminuted fracture in a fall. She received low molecular weight heparin from the day of surgery and for 3 weeks thereafter for deep venous thrombosis prophylaxis (enoxaparin 30 mg subcutaneously q12h for 5 days in the hospital, followed by 40 mg subcutaneously daily for 14 days in the nursing home) in accordance with current treatment guidelines. On the sixth post-operative day, a venous Doppler study was performed on the right lower extremity for persistent pain and swelling, which did not reveal the presence of a deep venous thrombosis. The patient could not participate well in physical therapy during the first 15 post-operative days because of pain in the right leg. Thereafter, she was able to ambulate with the walker up to 30 feet,with the restriction by surgery to not bear weight on the right leg. Although ambulating, her mobility status continued to be impaired due to the non-weight bearing status. Subsequently upon review of her 'ambulation' and mobility status,heparin (5000 units subcutaneously q8h) was started 3 weeks after the enoxaparin had been discontinued. On the 52nd day in the nursing home, the patient was found in cardiopulmonary arrest. She was successfully resuscitated initially, and computerized tomography revealed the presence of massive bilateral pulmonary emboli. The patient ultimately expired in the intensive care unit. Although the patient completed the standard duration of treatment with enoxaparin for prophylaxis against deep venous thrombosis following hip surgery, she was not able to perform heel-toe walking on the affected side during her rehabilitation upon completion of a course of enoxaparin. We suggest that physicians in sub-acute rehabilitation units should consider ongoing evaluation of the risk factors for the development of deep vein thromboses, such as weight bearing status in one or both legs, and consider extending the duration of deep venous thrombosis prophylaxis in patients who are not fully ambulatory.

A27

Coca-Cola: A New Therapy for Reflux.

E. Gupta, S. Hartronft, M. Prange. *Geriatrics and Gerantology (GEC/OOE), The University of Texas Health Centre at San Antonio and South Texas Veterans Health Care System, San Antonio, TX.*

Background: Reflux is a commonly occurs after esophagectomy especially when the anastomosis is in the thorax.Since the vagus nerve is cut during this surgery; the reflux is alkaline in nature. Most of the literature suggests only surgical procedures for symptoms of reflux post esophagectomy. We present a case of successful treatment without surgery.

Case report:A 84 year old man with history of HTN, hyperlipidemia, BPH and esophageal carcinoma was admitted to our Extended Care Therapy Center (ECTC) post esophagectomy for continued medical care and rehab assistance. While in the ECTC, he developed intractable nausea accompanied by the reflux of clear liquid. The nausea was treated with dolasetron, metoclopramide, ondansetron and promethazine without success. The patient reported that it was more of a reflux feeling than nausea. Ranitidine was prescribed without improvement. We also discontinued doxazosin, benzonatate, lactulose and morphine which are known to cause nausea. Since post-esophagectomy reflux is alkaline, diet coca-cola was tried for its acidic properties to curtail the alkaline reflux and nausea symptoms. This was met with total success and the patient did not require any further anti-nausea medication.

Discussion: Reflux after esophagectomy is a significant problem, with both clinical and pathological consequences. The usual antiacid reflux medications do not work because the reflux is alkaline in nature. A detailed search of the medical literature revealed few treatment options and most of them require further surgical procedures. The average pH of diet coca-cola is 3.4. It neutralized our patient's alkaline reflux thus improving his quality of life without resorting to surgery. Measures to facilitate gastric emptying, such as gastric tubes, pyloric drainage procedures and using gastric motility agents, may produce a reduction in symptoms but these procedures and medications alone don't control reflux and themselves could add additional risks or side effects. We offer Coca-Cola as cheap, simple and efficacious way of treatment.

A34

An Unusual Presentation of Urinary Tract Infection.

P. Daley,[1,2] S. Gaitonde,[2] P. Scott.[2] *1. Western Maryland Hospital Center, Hagerstown, MD; 2. Good Samaritan Hospital, Baltimore, MD.*

Urinary tract infection is a common problem in older adults and is associated with significant morbidity and mortality. Older adults may present with a variety of symptoms but hardly ever with empyema. Empyema usually results from extension of infection from lung parenchyma into the pleural space. Abdomino-pelvic pathology is rarely discussed as an etiology for empyema. A review of the literature of greater than 20 years revealed only a few cases of such a clinical presentation.

A 75 year old black woman presented to a local hospital with an 8 week history of asthenia,anorexia and a 40lb.weight loss. She reported progressive dyspnea, right sided pleuritic chest pain and recent non-productive cough. There was no history of abdominal or flank pain, hematuria or dysuria. Review of systems and past medical history were unremarkable.

She was afebrile, with tachycardia and tacypnea. Blood pressure was 117/92 mm Hg supine. Room air oxygen saturation was 89%. Physical examination was consistent with a right pleural effusion.

Admission laboratory data revealed anemia, leukocytosis of 60,000 mm3 with bands of 60% and pyuria associated evidence of impaired renal function. Chest X-ray showed a massive right pleural effusion. CT Scan revealed a large staghorn calculus. A thoracentesis confirmed empyema.

A chest tube was inserted. Pleural fluid grew Proteus mirabilis. Urine culture grew Morganella morgagnii at 10,000 - 50,000 colonies per ml. After one week of antibiotics, she underwent a right nephrectomy. The staghorn calculus had eroded through the renal parenchyma just below the hemi-diaphragm. No nephropulmonary fistula was demonstrated intraoperatively. Histopathology confirmed acute and chronic pyelonephritis and an associated perinephric abscess. The patient recovered and

was discharged with normal renal funtion.

Conclusion: Empyema can occassionally result from an unsuspected renal infection. This should be borne in mind especially when Gram negative bacteria are isolated from the pleural space. The site of the perirenal fascial attachment to the diaphragm is usually the point of perforation allowing transdiaphragmatic spread of abdomial infection. Older adults are particularly susceptible to such complex urinary tract infections and may present with no symtoms attributable to the genitourinary tract.

A37

An Atypical Presentation of Lymphoma: the Failure of Ocam's Razor.

R. Cader, R. Shaaban, M. Brennan, W. Ho. *baystate medical center, Springfield, MA.*

BACKGROUND: Lymphoma is a common cancer in older patients. We report an atypical presentation which included spontaneous tumor lysis syndrome and renal failure. Furthermore, the diagnosis was delayed because caregivers focused attention on concomitant nephrolithiasis.

CASE:A 76 yo community dwelling elder developed left flank and leg pain and was treated by his PCP for spinal osteoarthritis. The pain progressively worsened over 3 weeks and a CT revealed renal calculi with mild hydronephrosis and multiple bilateral lesions which raised the possibility of a malignancy. The patient had a lithotrypsy and the ureter was stented. An outpatient evaluation was planned for the lesions on the CT scan. His symptoms improved, but after 3 days pain recurred and the stent was removed. A follow up CT showed persistent bilateral calculi, with extravasated fluid, likely blood, in the area of the renal pelvis. The pain persisted, he became incontinent and developed significant leg weakness and was unable to walk more than a few feet. He returned to the hospital in acute renal failure with a Cr of 3.2, and a uric acid of 16.4. A repeat CT showed interval migration of the left ureteral calculus to the UV junction. Bilateral ureters were stented; the next day he had flaccid paralysis of his legs. An MRI of his spine documented abnormal epidural soft tissue throughout the thoracic and lumbar spinal canal resulting in cord compression. A perirenal biopsy revealed diffuse large B cell lymphoma. He began chemotherapy but developed neutropenia and delirium. His family decided to withdraw aggressive treatment and he passed away peacefully shortly thereafter.

Discussion: This sad case makes at least three important teaching points. First, many diseases present atypically in elders; this lymphoma was characterized by spontaneous tumor lysis and leg weakness but lacked classic signs such as weight loss and lymphadenopathy. Second, the clinical imperative to resolve the hydronephrosis distracted caregivers from making the important lymphoma diagnosis earlier. Finally, there is also a dearth of data around the relative risks and benefits of aggressive treatment in elders; it is not always clear when one ought to shift the goals of care. Collaborative research between geriatricians and oncologists may help to resolve these challenges.

A60

Age, gender, and location dependent patterns of antidepressant prescription.

R. Rozzini,[1] I. Sleiman,[1] F. Lonati,[2] A. Indelicato,[2] M. Gozzoli,[1] M. Trabucchi.[1] *1. Internal Medicine & Geriatrics, Poliambulanza Hospital, Brescia, Italy; 2. ASL, Brescia, Italy.*

Background: Elders are particularly prone to depression. Most of the study show a prevalence of depressive symptoms from 20 to 50% according to the site of the investigation. Increasing rate of diagnosis of depression and antidepressants use are reported, but scant data are available on the proper prescriptions and the possible influences of extraclinical factors.

Objectives: to evaluates the rate of antidepressant prescription in elderly persons.

Design: retrospective study

Setting: community

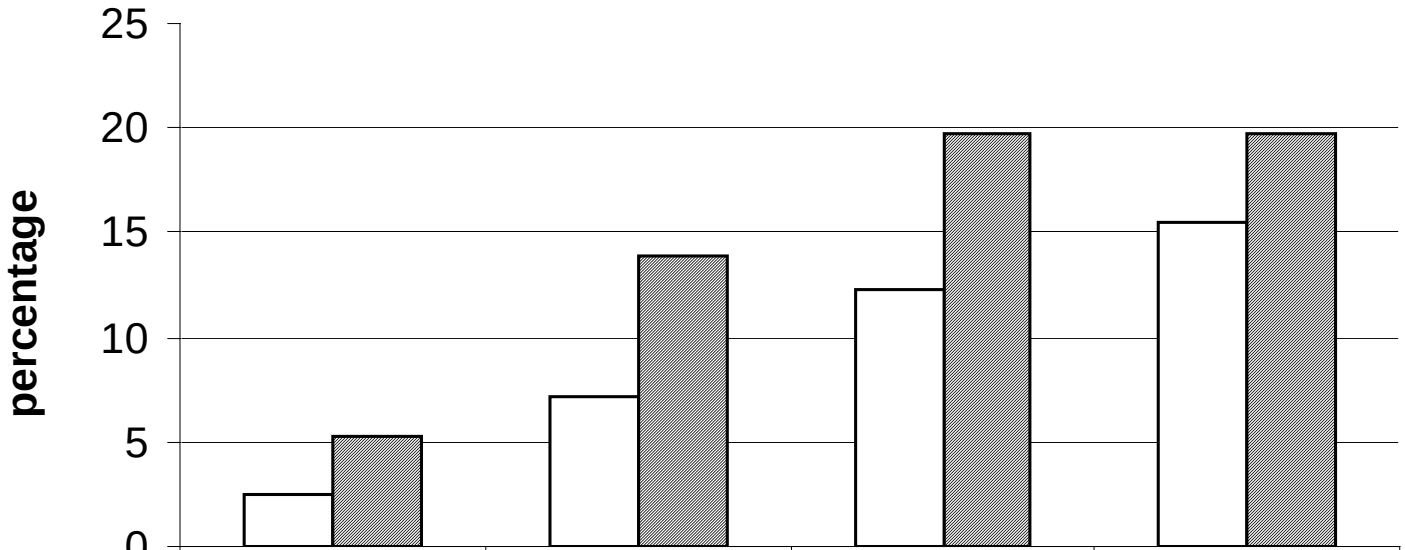
Participants and measurements: data about antidepressants prescriptions were retrieved from Brescia Local Health Authority database concerning 1.000.000 citizen between 1st Jan to 30th June 2006. The database provides the information for 61.036 reimbursed prescriptions (antidepressants are freely prescribed by the Italian NHS), including the patient code. For the aim of the study, population has been divided in four age groups: a) <65, b) 65-74, c) 74-84, and d) >84. Prevalence of antidepressant users was calculated in each age group. It was also analysed the antidepressants consumption in men and women, and according to their living site: in urban (i.e. living in the town of Brescia) and suburban areas (i.e. living in rural areas or in towns smaller than 10.000 inhabitants).

Results: the prevalence of prescriptions rose with age in both sexes, with highest rates in old and very old individuals: the rate treatment was 3.8% in the group under 65 years old, 10.8% between 65 to 74 years, 17.0% between 75 to 84 years, and 18.8% when subjects over 84 years were considered.

Furthermore women received antidepressant treatment more frequently than men. The overall proportion of females under treatment was 7.7%, twice as higher than the rate detected in men (3.5%). Results documented a 6.8% prescription rate in individuals living in the urban area, while it is 5.3% in rural areas. The highest differences in antidepressant rate of prescription were recorded in individuals over 84 years, 22.5% in urban areas and 17.5% in rural ones.

Conclusions: our study has detected an overall increase of antidepressant prescription rates related to age, a major likelihood to be treated with antidepressant in women regardless of age, and a higher rate of antidepressant treatment in urban areas than in rural ones.

Rates of antidepressant prescriptions according to gender and age in elderly patients living at home



	<65	65-74	74-84	>84
□ males	2,5	7,2	12,3	15,5
▨ females	5,2	13,9	19,7	19,8

Rozzini et al. Int J Geriatr Psychiatry, 2008

A75

High-fidelity Medical Simulation for Geriatrics Emergency Medicine Training.

L. Ragsdale,[1] D. Gutman,[1] A. Tuya.[2] *1. Emergency Medicine, Brown University, Providence, RI; 2. Medicine, Division of Geriatrics, Brown University, Providence, RI.*

Supported By: Partially funded by the Geriatrics Education for Specialty Education Program funded by AGS throught The John A. Hartford Foundation

One of every five individuals will be aged 65 or over by 2030. Geriatrics patients are the most frequent and resource-intensive Emergency Department (ED) patients of any age group. These challenging and unique patients require a comprehensive approach to their emergency care.

High fidelity medical simulations can facilitate learning among trainees and use of this tool in emergency medicine has grown widely over the last ten years. To improve geriatrics training in Emergency Medicine our Emergency Medicine and Geriatrics faculty created eight high-fidelity medical simulation (SIM) scenarios.

The Geriatrics Emergency Medicine (GEM) simulation curriculum featured the following patient presentations and conditions: 1) Abdominal pain with syncope [appendicitis], 2) Gait unsteadiness and fall [possible elder abuse and alcohol use], 3) Altered mental status [delirium and drug-drug interactions], 4) Non-specific "flu-like illness" [acute coronary syndrome], 5) Mental status change with hypothermia [sepsis], 6) Low back pain becoming unresponsive patient [ruptured aortic aneurysm with discussions of end of life care], 7) Dizziness [vertebrobasilar insufficiency] and 8) Shortness of breath [atrial fibrillation with rapid ventricular response with flash pulmonary edema].

These cases were designed to emphasize the core GEM principles: complexity of elderly patients, atypical presentations of common illnesses, confounding comorbidities, need for age-dependent interpretation of diagnostic tests, consideration of baseline functional status and physiologic reserve, polypharmacy, essential role of social support systems, and psychosocial impact of medical conditions.

Several GEM simulation sessions have been completed. A video of the simulations will be presented as well as feedback from the participants. Additional sessions are planned to assess pre- and post-test knowledge base and skills of residents and medical students who will care for this unique patient population. Future studies will evaluate the benefits of simulation versus the standardized geriatrics patient.

A77

Prognostic Importance of Pulmonary Hypertension in Elderly Patients with Heart Failure.

N. Muñoz, M. Mendez, S. Nieto, P. Renieblas, C. Sanchez, A. Perez, L. Audibert, F. Ortiz-Alonso. *Hospital Gregorio Maranon, Madrid, Spain.*

Supported By: Hospital Gregorio Maranon

Introduction. Many elderly patients with heart failure (HF) who undergo echocardiography are found to have preserved ejection fraction and severe pulmonary hypertension (PHT). However, the prognostic importance of PHT is not well established in elderly patients with HF not selected for HF etiology and ejection fraction.

Objective. To assess the risk associated with PHT, estimated by echocardiography, in elderly patients with symptomatic HF with preserved or reduced ejection fraction.

Patients and Methods. The first 110 elderly patients included in a HF disease management program underwent echocardiography and 85 (77%) had pulmonary systolic pressure (PASP) estimated. They were divided into Severe-PHT (N=36) with PASP ≥60 mmHg, and Moderate-PHT (N=49) with PASP <60 mmHg. Primary outcome measure was event-free survival, defined as time to hospital readmission for HF or death. Kaplan-Meier curves and log-rank test, and Cox regression model were used to determine if Severe-PHT is an independent predictor.

Results. Patients in the Severe-PHT group tended to be older (80±7 vs. 77±5, $p<.05$), functionally more impaired with more severe NYHA Class ($p<.05$), more dependent in basic and instrumental activities of daily living (both $p<.05$), have more anemia ($p<.05$), and more renal failure ($p<.05$). There number of deaths were 12 (33%) in Severe-PHT and 11 (22%) in Moderate-PHT; and the number of readmitted patients were 20 (59%) in Severe-PHT and 16 (31%) in Moderate-PHT. Time to first event (HF readmission or death) was shorter in Severe-PHT (log-rank test: $p<.05$). In Cox regression analysis, Severe-PHT was an independent predictor of time to event (Hazard ratio; 95% CI: 4.09; 1.61 to 10.40). Other independent predictors of readmission or death were increasing age, lower ejection fraction and higher NYHA functional class. COPD was not associated with the event.

Conclusions. In elderly HF patients, pulmonary arterial hypertension is associated with increased risk of death or readmission for decompensated HF independent of ejection fraction and the presence of COPD. Given the poor prognosis of elderly HF patients with severe PHT, studies are needed to established PHT-targeted therapies.

A84

Functional status and mortality of elderly patients in a critical care setting.

I. Sleiman,[1,2] R. Rozzini,[1,2] A. Giordano,[1,2] A. Ricci,[1,2] C. Mattanza,[1,2] M. Trabucchi.[2] *1. Internal Medicine & Geriatrics, Poliambulanza Hospital, Brescia, Italy; 2. Geriatric Research Group, Brescia, Italy.*

Background: older individuals are a heterogeneous population. Clinicians have used measurements of existing conditions and functional status to attempt to capture this heterogeneity for prognostic and therapeutic purposes. Previous research reported higher mortality rates and worse outcomes for elderly patients admitted to an intensive care unit and highlighted that age itself is not an important predictor of poor outcomes. However the literature pays low attention to physical function changes.

Objectives: to investigate the association between change of function during hospitalization, in hospital and 90 day mortality

Design: retrospective study.

Setting: in-hospital medical patients admitted to a Sub-Intensive Care Unit for elderly patients, which is a level of care between ordinary wards and intensive care

Participants: Patients consecutively admitted to our Sub-Intensive Care Unit during a twelve months period were evaluated. Patients with neurological illness that directly affect disability (i.e. stroke), patients who died in hospital, and those lost at follow-up were excluded. Three hundreds sixty were selected and subdivided in 2 groups according to ability or inability to regain function during hospitalization

Measurements: demographic, mental status (MMSE, GDS), main diagnosis, comorbidity (Charlson Index), APACHE-APS), number of drugs. Disability was assessed by Barthel Index on admission and at discharge.

Results: mean age was 78.3±8.8, male gender 49.6 %, MMSE was 20.4±9.4, Barthel Index on admission was 28.0±34.9, and at discharge 46.8±40.0. APS was 14.8±6.1; Charlson Index 6.5±1.9. Main admitting diagnosis were heart diseases (30.7%), respiratory diseases (47.3%), and GE disease (7.4%). Ninety day mortality was 31.1%. Patients that show a lack of functional improvement during hospitalization have a significant higher mortality than controls. After controlling for variables associated to mortality in univariate analysis (male sex, APS, MMSE and acute respiratory failure diagnosis) being unable to regain function during hospitalization had an independent association with 90 day mortality (OR= 1.9, 95% CI= 1.1-3.4).

Conclusions: In elderly patients lack of functional improvement after an acute event is an independent predictor of mortality and should be considered as a unfavorable prognostic condition.

P31

Causes of death in elderly men after the diagnosis of prostate cancer.

M. N. Ketchandji,[1] Y. Kuo,[1] V. B. Shaninian,[2] J. S. Goodwin.[1] *1. Internal Medicine, University of Texas Medical Branch, Galveston, TX; 2. Internal Medicine, University Of Michigan, Ann Arbor, MI.*

Objective: To examine the underlying causes of death in elderly men after a diagnosis of prostate cancer

Design: Population-based retrospective cohort study

Participants: Men aged 65-84 diagnosed with prostate cancer (n= 99,388) from 1992-2002 included in SEER-Medicare. We developed an aged matched non cancer cohort of 47,435 men from SEER-Medicare data to serve as non-cancer controls.

Measurements: Comorbidity and race were derived from Medicare files. Comorbidity was assessed using Medicare claims. Cause of death, tumor characteristics and age were obtained from SEER- Medicare. Cox proportion hazard model was used to estimate the hazard ratio of mortality as a function of age, race, clinical stage and comorbidity.

Results: Kaplan-Meier survival curves showed little impact of a diagnosis of stage I, II or III prostate cancer on overall survival of men aged 65-69 or 80-84 years. Diagnosis of stage IV prostate cancer clearly had a substantial impact on survival for men aged 65-69 or 80-84 years. In multivariable hazard analyses, without accounting for histological grade at diagnosis, stage II prostate cancer had a similar impact on survival as did one additional year of age; HR=1.12 (95% confidence intervals; 1.10, 1.15) for stage II cancer vs 1.10 (1.10, 1.10) for each additional age. The impact of stage III prostate cancer (HR=1.44; 1.37, 1.52) was comparable to the impact of a comorbid condition such as peripheral vascular disease (HR=1.47; 1.40, 1.54) or diabetes (HR=1.47; 1.43, 1.51). For men aged 65 to 84 diagnosed with stage I or II prostate cancer, cardiovascular disease was the most frequent cause of death 6.65%, followed by other cancers at 3.75%, and prostate cancer was third at 3.60%.

Conclusion: Given the good survival of men with early stages of prostate cancer, attention has to be paid to other comorbid conditions. Management of preexisting medical comorbidities continues to be critically important post prostate cancer diagnosis, as these have a significant impact on survival. Preventive health care measures and screenings for conditions such as diabetes, hypertension, cardiovascular disease and other cancers remain important in these patients despite their diagnosis of prostate cancer.

A19

Cramping With Crohn's: New Diagnosis Of Crohn's In A 88 Year Old Man.

S. Hussain, S. Wartak, A. Rosales, A. Deray. *Internal Medicine, Baystate Medical Center/Tufts University School of Medicine, Springfield, MA.*

Introduction-

Crohn's disease(CD) usually presents at a younger age, but a second peak is described in the later decades. Atypical symptoms in the elderly and limited treatment make it a management dilemma.

Case-

88 year old man complaining of intermittent right sided abdominal pain shortly after his right inguinal hernia surgery. His general practioner ruled out hernia recurrence, is treated for postoperative pain. He has a background history of: hypertension, parathryroidectomy, past alcohol abuse, and osteoporosis for which he takes relevant medications.

After two weeks, patient is admitted for a five day history of worsening right sided abdominal pain with nausea and vomiting. The patient is dehydrated with leucocytosis, and CT abdomen shows thickened terminal ileum and colon. Colonoscopy demonstrates diverticulosis and biopsy confirms CD. Patient is treated with steroids and mesalamine and discharged on tapering steroids.

Patient returns two weeks later with a CD flare-up and is treated again with intravenous steroids. After discharge, he is symptom free, but non-compliant with his medications. He cannot tolerate his pills and is fully aware of possible adverse outcome. He is deemed capable of making informed decisions and prefers taking less number of medications.

Discussion-

CD is known to have a peak in later life. Use of immunosuppressants presents a challenge for treating the disease in this age group since there is limited data looking at the overall outcome in this population. Furthermore, co-morbid conditions potentially complicate the treatment for exacerbations. We present a unique management dilemma in the context of geriatric care. Our patient has CD diagnosed late in life has already experienced a flare up shortly after diagnosis. He has good social support and is capable of making decisions. He is also aware of the importance of his medications. However, he chooses not to be compliant due to self-reported intolerance to the treatment reports feeling better without them. He is a frail but independent man who would rather have a life free of medications. After discussing the importance of drug compliance, patient opted to keep taking the medications he was comfortable taking. As physicians, we need to be compassionate to the needs and concerns of an ageing population. Our case exhibits the challenges faced when treating the elderly with a remitting-relapsing condition.

A34

An Unusual Presentation of Urinary Tract Infection.

P. Daley,[1,2] S. Gaitonde,[2] P. Scott.[2] *1. Western Maryland Hospital Center, Hagerstown, MD; 2. Good Samaritan Hospital, Baltimore, MD.*

Urinary tract infection is a common problem in older adults and is associated with significant morbidity and mortality. Older adults may present with a variety of symptoms but hardly ever with empyema. Empyema usually results from extension of infection from lung parenchyma into the pleural space. Abdomino-pelvic pathology is rarely discussed as an etiology for empyema. A review of the literature of greater than 20 years revealed only a few cases of such a clinical presentation.

A 75 year old black woman presented to a local hospital with an 8 week history of asthenia,anorexia and a 40lb.weight loss. She reported progressive dyspnea, right sided pleuritic chest pain and recent non-productive cough. There was no history of abdominal or flank pain, hematuria or dysuria. Review of systems and past medical history were unremarkable.

She was afebrile, with tachycardia and tacypnea. Blood pressure was 117/92 mm Hg supine. Room air oxygen saturation was 89%. Physical examination was consistent with a right pleural effusion.

Admission laboratory data revealed anemia, leukocytosis of 60,000 mm3 with bands of 60% and pyuria associated evidence of impaired renal function. Chest X-ray showed a massive right pleural effusion. CT Scan revealed a large staghorn calculus. A thoracentesis confirmed empyema.

A chest tube was inserted. Pleural fluid grew Proteus mirabilis. Urine culture grew Morganella morgagnii at 10,000 - 50,000 colonies per ml. After one week of antibiotics, she underwent a right nephrectomy. The staghorn calculus had eroded through the renal parenchyma just below the hemi-diaphragm. No nephropulmonary fistula was demonstrated intraoperatively. Histopathology confirmed acute and chronic pyelonephritis and an associated perinephric abscess. The patient recovered and

was discharged with normal renal funtion.

Conclusion: Empyema can occassionally result from an unsuspected renal infection. This should be borne in mind especially when Gram negative bacteria are isolated from the pleural space. The site of the perirenal fascial attachment to the diaphragm is usually the point of perforation allowing transdiaphragmatic spread of abdomial infection. Older adults are particularly susceptible to such complex urinary tract infections and may present with no symtoms attributable to the genitourinary tract.

A102

An Acute Care for Elders Unit in a Public Hospital.

K. Gamson,[1] E. Pierluissi.[2] *1. School of Medicine, UCSF, San Francisco, CA; 2. Geriatrics, UCSF, San Francisco, CA.*

Supported By: Katelyn Gamson is supported by the Medical Student Training in Aging Research (MSTAR) Program of AFAR

Introduction: The Acute Care for Elders (ACE) model of hospital care for older adults can improve function and reduce nursing home admission post-hospitalization. The efficacy of this model of care has not been evaluated in a public hospital serving a low-income, diverse population. An ACE unit opened at San Francisco General Hospital, a public hospital, in February 2007.

Purpose: Describe a cohort of patients in an ACE unit and compare ambulation during hospitalization and discharge destination to patients receiving usual care.

Methods: Retrospective chart review of patients (age ≥65) admitted to general medical-surgical wards directly from the Emergency Department from February 2007 to June 2007. Patients with a length of stay at least two days and no longer than 35 days were included. We studied 48 patients admitted to the ACE unit and a random sample of 29 patients admitted to non-ACE wards as a comparison.

Results: The average age of patients admitted to the ACE unit was 77 years and 75 for those admitted to the non-ACE units. Forty-two percent of ACE patients were male compared to 55% admitted elsewhere. The ethnicity of patients was 40% Asian, 31% White, 16% Latino and 13% African-American, compared to 24%, 28%, 21%, and 28%, for ACE and non-ACE units, respectively. Over 621 ACE shifts, in 48.6% the patient ambulated, in 27.5% the patient was out of bed but not ambulating, in 14% the patient was on bedrest, and in 9.8% the patient's level of activity was not documented. Of 372 non-ACE shifts evaluated, in 19.6% the patient walked, in 21.0% the patient was out of bed but not walking, in 29.8% the patient was on bedrest, and in 29.6% the patient's level of activity was not documented. The average length of stay was 7.0 days and 8.8 days (p=0.23) in the ACE and non-ACE units, respectively. The major discharge destinations for patients in the ACE unit were home (68%), skilled nursing facility (10.6%), board and care facility(12.8%), and other (4.3%), compared to home (53.9%), skilled nursing facility (19.2%), board and care facility(3.8%), and other (15.4%) for patients discharged from non-ACE units (p=ns).

Conclusion: An ACE model of care in a public hospital serving a low-income, diverse population resulted in improved processes of care, as measured by more ambulation, and trends toward increased discharge to home and reduced length of stay.

A114

Gender differences in associations of lifestyle changes and depressive symptoms in mid-life and older adults.

D. Densmore, H. M. Blanck, M. K. Serdula, D. R. Brown. *NCCDPHP/Division of Nutrition, Physical Activity and Obesity, CDC, Atlanta, GA.*

Supported By: No funding.

Purpose: Obesity, sedentary lifestyle, smoking and alcohol use are major public health concerns for an aging U.S. population and are associated with depression. Depressive symptoms are related to increased medical care costs, disability and other negative health outcomes. Men and women differ in risk for depressive symptoms, however, little is known about the differential effects of lifestyle changes as middle-aged adults approach older adulthood.

Methods: We assessed participants (Women: n=3083, Men: n=2306, age=51-61 years) in two waves (1992, 1998) of the Health and Retirement Study. We classified obesity as self-reported body mass index (weight [kg]/ height [m2]) >=30 and high level of vigorous physical activity (PA) as >=3 times/week. Depressive symptoms were defined as the upper quintile score (Women >=3, Men >=2, range: 0-8) of the modified Center for Epidemiologic Studies Depression scale (CES-D). Logistic regression analysis determined adjusted odds ratios (AORs) for depressive symptoms at follow up (1998) with 4 change categories within each lifestyle variable (vigorous PA, obesity, smoking, and alcohol use) since baseline (1992). Referent groups were those who in 1998 reported maintaining high levels of vigorous PA, not being obese, not smoking and not drinking since baseline. Adjustment variables were changes in marital status and baseline factors (CES-D score, race, education, income, and treated chronic illnesses).

Results: Men and women differed in both the type and magnitude of lifestyle changes on depressive symptoms. Among women, decreasing from high vigorous PA (AOR=1.89, 95% confidence interval [CI]=1.17, 3.07), becoming obese (AOR=1.54, 95% CI=1.06, 2.25), remaining obese (AOR=1.46, 95% CI=1.15, 1.87), and quitting smoking (AOR=1.55, 95% CI=1.10, 2.19) were associated with a higher odds of depressive symptoms. Among men, starting smoking (AOR=2.23, 95% CI=1.05, 4.74) and starting drinking (AOR=3.61, 95% CI=1.73, 4.54) were associated with a higher odds of depressive symptoms. For both genders, still smoking (Men AOR=1.55, 95% CI=1.16, 2.06; Women AOR=1.69, 95% CI=1.31, 2.17) was associated with depressive symptoms.

Conclusions: The association of most lifestyle factors and depression differed by gender. These differences should be considered in designing and targeting behavioral interventions for optimizing mental health.

A123

Low respiratory infections, dementia and mortality in elderly patients.

R. Rozzini,[1,2] I. Sleiman,[1,2] P. Barbisoni,[1,2] M. Ferri,[1,2] S. Boffelli,[1,2] N. Travaglini,[1,2] M. Trabucchi.[2] *1. Internal Medicine & Geriatrics, Poliambulanza Hospital, Brescia, Italy; 2. Geriatric Research Group, Brescia, Italy.*

Supported By: None to declare

Background: low respiratory infections (LRI) are common in patients with dementia, and account for two thirds of deaths in this population. Prognosis, including long-term mortality, is important because lack of knowledge could foster underuse of palliative care services for those who would benefit and overuse of aggressive therapies for those who are unlikely to recover.

Objectives: investigate the association between LRI and three-month mortality in elderly patients with and without dementia.

Design: retrospective study.

Setting: in-hospital medical patients admitted to a Sub-Intensive Care Unit for elderly patients.

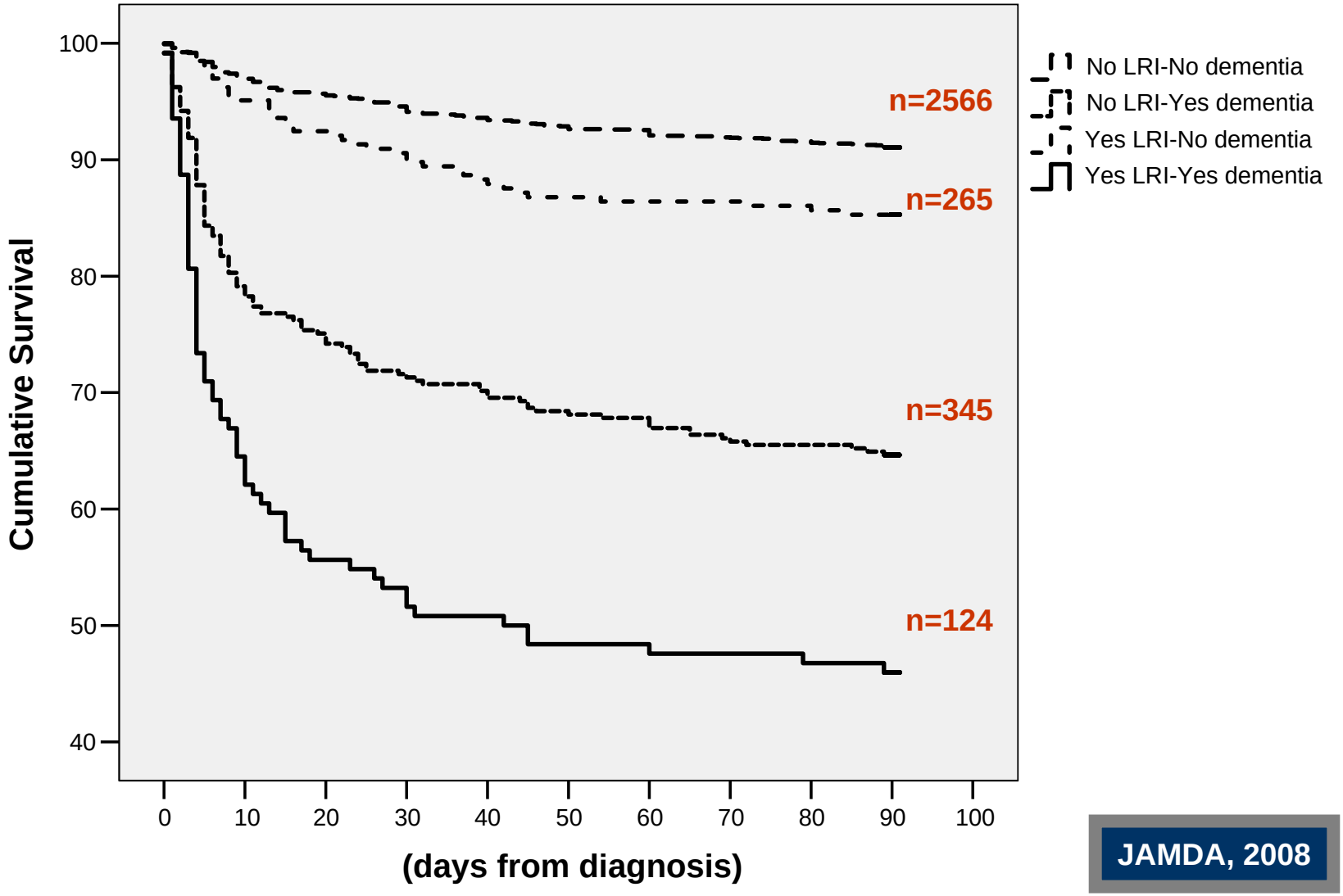
Participants: 3300, admitted to our Sub-Intensive Care Unit, were selected and subdivided in 4 groups: 2566 patients without LRI and dementia, 265 with LRI and without dementia, 345 without LRI and with dementia, and 124 with LRI and dementia.

Measurements: age, gender, Barthel Index detected 2 weeks before admission and on admission, APACHE-II, Charlson Index, were assessed. Cognitive impairment was evaluated with MMSE and severe dementia as MMSE <12. LRI was diagnosed by clinical signs and chest radiography and treatment done according to the American Thoracic Society guidelines.

Results: Severity of somatic, biological, psychic, and functional conditions was higher in patients affected by pneumonia than in those with acute non infectious diseases. Three month mortality was also significantly higher in pneumonia (27.2%) than in other patients (13.1%). In particular in patients without LRI and without dementia mortality was 9.0%, in those with LRI and without dementia: 14.7%, in those without LRI and with dementia: 35.4%, and in those with LRI and dementia: 54.0%.

Conclusions: at a 3-month follow up 46% of subjects diagnosed with severe dementia and LTI are still alive. Currently we are unable to demonstrate if these results are due to a clinical effect or to the "vis medicatrix naturae" (Healing Power of Nature). Should we be allowed to withhold antibiotic treatment in these patients? Whatever the therapeutic options in these patients we must provide a palliative care for pain and other subjectively distressing conditions.

Three months survival of elderly patients according to lower respiratory tract infection (LRI) and dementia



JAMDA, 2008

A136

Hip fracture in elderly male patients: differences in clinical outcome and predictors of mortality.

M. Álvarez-Nebreda, F. Coca, E. Marañón, Y. Gracia, M. Garcia-Alhambra, J. Serra. *Geriatrics, Gregorio Marañón Hospital, Madrid, Spain.*

Objective:to study characteristics,in-hospital outcome and mortality of elderly male patients with hip fracture when comparing with women.To analyze which factors predict in-hospital mortality and after 3 and 6 months.

Methods:prospective longitudinal study including 832 consecutive patients older than 64 years with a hip fracture,from March 2004 to October 2006.We compared 2 groups:male(N=136, 16.4%)and female patients.Descriptive variables analyzed were:social-demographic characteristics,functional status(Katz),ambulation (FAC),complications,length of stay and mortality.Patients were followed by telephone to analyze mortality after 3,6 and 12 months.Kaplan-Meier method was used for survival analysis.Factors associated with mortality were analyzed by multiple logistic regression.

Results:mean age:83.7±7 years.Male patients were:previously more functional and ambulation independent(Katz 1.5 vs 1.3;FAC 4-5:88.1 vs 79.3),had history of tumoral disease(22 vs 10%)and COPD(24 vs 6%).They had more complications like delirium(46 vs 33%),hydroelectrolytic alterations(22 vs 15%)and pressure sores(13.4 vs 7%).There was a trendy in the male group of longer total length of stay (20±10.4 vs 18.2±10.4,p=0.06),more in-hospital mortality(7.4 vs 4%,p=0.09)and more functional and ambulation independence at discharge(Katz 1.5 vs 1.3,p=0.06 and FAC 0.9 vs 0.7,p=0.07).There were differences in mortality between male/female at 3(14 vs 6%,p=0.001)and 6 months(9.9 vs 4.1%,p=0.01)but not at 12 months.The main cause of mortality was respiratory infection followed by heart failure.Predictors of in-hospital mortality in women were:age,functional status,dementia and postsurgical pneumonia,being the last one the only predictor in male patients.Predictors of 3-month-mortality in women were: age(OR 1.09),dementia(OR 5.4)and malignancy(OR 6.8),being history of COPD(OR 3.4)the only predictor in male patients.Predictors of 6-month-mortality in women were age(OR 1.13)and new nursing home placement(OR 4.8),not being any factor related to in male.

Conclusions: elderly male patients with hip fracture have worse clinical outcome and more mortality at 3 and 6 months after discharge than women,although they have better functional status.Age or dementia predict mortality in women.In men,the only variables associated(pneumonia, COPD)are more related to the main cause of short-term mortality(respiratory infections)

A137

Hip fracture in non-ambulant elderly patients: in-hospital outcomes and mortality after one year.

M. Álvarez-Nebreda, F. Coca, E. Marañón, Y. Gracia, M. García-Alhambra, J. Serra. *Geriatrics, Gregorio Marañón Hospital, Madrid, Spain.*

Objective: to study the characteristics, in-hospital outcome and mortality after one year of previously non-ambulant elderly patients with a hip fracture

Methods: prospective longitudinal study including all consecutive patients older than 64 years of age with a hip fracture, from December 2004 to October 2007. We compared 2 groups: previously non-ambulant elderly patients or patients who walk with help from 2 people (Functional Ambulation Classification, FAC=0, N=50) and the other patients (FAC=1-5, N=1450). Descriptive variables analyzed were: social and demographic characteristics, functional status (Katz), ambulation (FAC), medical and surgical complications, length of stay and mortality. All the patients admitted from March 2005 to October 2006 were followed by telephone interview to analyze mortality after 1 year

Results: we studied 1500 patients, mean age: 83.5±7 years, 82% female, 21% living in nursing facilities, 32% with total ADL independence, 81% with independent ambulation and 31% demented. The patients in non-ambulant group are: previously more dependents (Katz 0.4 ± 0.7 vs 1.4 ± 0.9, p<0.001), they have more comorbidity (4.4±1.8 vs 3.4±1.9, p=0.001), history of stroke (26 vs 14%, p=0.02), tumoral disease (29 vs 13%, p=0.005) and dementia (75.5 vs 30%, p<0.001), are on more treatments (6±2.9 vs 4.7±2.8, p=0.004) and have more placement in nursing home (70 vs 19%, p<0.001). They have more complications like pneumonia (12.2 vs 4.4%, p=0.02), urinary tract infections (20.4 vs 8.6%, p=0.009) and pressure sores (18.4 vs 6.6%, p=0.006) and more in-hospital mortality (12 vs 4%, p=0.02), have shorter length of stay (9.3 ± 4.4 vs 10.9 ± 7.3, p=0.02) and are less admitted to in-hospital rehabilitation (14% vs 67%, p<0.001). From the 28 non-ambulant patients who were followed for 1 year, the mortality at 3, 6 and 12 months was: 6 (21.4%), 1 (cumulated mortality, Cm: 25%) and 2 (Cm: 32%)

Conclusions: previously non-ambulant elderly patient with a hip fracture are a subgroup of more fragile patients because they have more comorbidity, dementia, dependency on basic-ADL and nursing home placement. They have more infectious complications, develop pressure sores more frequently and have more in-hospital mortality (1 of each 8 patients). One of each 3 survivors on discharge has died after 1 year

B6

Charles Bonnet Syndrome and Mild Cognitive Impairment: A treatment dilemma.

N. Arkfeld, J. Peacock, H. H. Atkinson. *Gerontology and Geriatric Medicine, Wake Forest University Medical Center J Paul Sticht Center of Aging, Winston Salem, NC.*

Supported By: Wake Forest University Medical School

<Case Report/>: A 100-year-old man presented to our geriatric consultation clinic for evaluation of vision loss and hallucinations. His past medical history was significant for glaucoma, cataract surgeries and macular degeneration. Although he had a lengthy history of moderate visual loss, his vision had subacutely and irreversibly deteriorated, to near blindness. As his vision declined, he began to suffer from visual hallucinations, including automobiles and children, but his insight was intact and the visions did not disturb him. Physical examination showed severe visual impairment, a slightly broad-based gait, and no cogwheeling or tremor. Although the Mini Mental State Examination was limited by visual loss, the patient scored 16/22 points. A diagnosis of CBS, complicated by probable MCI was made, and supportive care for his visual loss was recommended without pharmacological therapy. However, after 6 weeks, his hallucinations changed to visions of canyons, which his severe fear of heights made quite frightening. The patient's family provided 24-hour caregiving due to his visual impairment (inability to find clothes, use utensils appropriately, etc) and worsening fear in reaction to his hallucinations. The MCI was then treated with donepezil; however, this did not provide relief of his symptoms. Quetiapine was initiated, with no relief of symptoms after a two-week trial. The patient was admitted to our Acute Care for the Elderly unit because of his acute agitation (seeing people pushing his wheelchair off of a cliff). Delirium was considered, but no cause was identified. After a review of available case reports on CBS, medication management was attempted with risperidone followed by olanzapine, without improvement in his nightly hallucinations. Finally, gabapentin 200 mg po qhs was started, and for the first time in over 3 weeks, he had no hallucinations. Due to physical deconditioning, he moved to subacute rehabilitation. His hallucinations, though not completely eradicated, were significantly lessened.

<Discussion/>: CBS is a poorly understood disorder, and the co-occurrence of cognitive impairment makes the diagnosis and treatment difficult. Gabapentin may decrease neuronal excitation, which has been postulated as a cause of CBS. Our experience adds to the limited body of literature on CBS and may support the use of gabapentin for complex cases.

B9

Alcohol abuse in an older man: one physician's eye-opener.

C. M. Khandelwal. *Division of Geriatric Medicine and Center for Aging and Health, UNC Chapel Hill, Chapel Hill, NC.*

Supported By: Geriatric Fellowship Program, University of North Carolina

Case: An 85-year-old male with a history of prostate cancer with incontinence and hypertension, was accompanied by his wife to his physician's office for concern of memory changes and worsening urinary incontinence. The patient's wife noticed this change in her husband since he retired from his job as a pharmaceutical sales representative just three months prior. The patient's wife reported that he began misplacing common items, including where he parked his own car one day. He denied depression or mood changes, as confirmed by his wife. The patient's wife expressed that her husband's personality and sense of humor were otherwise well preserved.

The patient's medication list includes: an aspirin, enalapril, and simvastatin daily. The patient was a well-dressed, well-nourished appearing man with a normal physical exam. His neurological examination was normal with the exception to deficits to vibratory sensation extending up to his knees bilaterally, as well as loss of temperature sensation in his toes bilaterally. On a MMSE, the patient's score was 25/30 (errors in orientation and recall). The patient's depression screen was negative. The patient's Trail B test results placed him above average for his age. CMP, CBC, and TSH were unrevealing. B12 level was 302. The initial screening questions for 'quantity and frequency' of alcohol consumption, followed by the CAGE assessment, to our surprise, placed the patient in the "at-risk" drinking category. Since retirement, the patient increased his number of cocktails at lunch and dinner leading to a consumption of over six ounces of alcohol per day. It was agreed for the patient to taper his alcoholic beverages to one drink per day, which will likely represent the best means of improving his cognition and incontinence.

DISCUSSION: The goal of proactive alcohol screening in the geriatric population is to identify the presence and severity of alcohol problems that may otherwise be misinterpreted as normal consequences of aging, medication side effects, or worsening illness. The challenge in doing this is that existing screening instruments used for alcohol use disorders may be inadequate for this population, and thus, may result in underdetection among this age group. Therefore, supplemental information provided by the 'quantity and frequency screening instrument' of alcohol consumption should be used- which is a more sensitive screening instument than the CAGE questionnaire.

B16

A 92 year-old male with Herpes Zoster Encephalitis (HZE) and Prolonged Delirium: did he make it?

N. Lamaie,[1,2] P. Kurian,[1] R. Finley,[1,2] D. Espino,[1,2] L. Oakes.[1,2] *1. Family and Community Medicine-Geriatric Division, uthscsa, San Antonio, TX; 2. Geriatric Division, Nix Hospital, San Antonio, TX.*

Supported By: GACA (Geriatric Academic Career Award)

OBJECTIVE: To raise clinical suspicion of HZE in patients with delirium and history of zoster.

CASE: A 92 year- old male with a history of mild dementia and hard liquor use (8 oz/day) over 50 years, presented with facial herpes zoster. The emergency room physician prescribed prednisone, acyclovir, and antibiotics. On returning home the patient grew weak, incontinent and progressively confused. He was hospitalized for herpes zoster ophthalmicus with delirium. A non-contrast head CT showed senile atrophy and moderate ischemic changes. A chest x-ray and brain MRI were unremarkable. CSF examination revealed xanthochromia, WBC 271, RBC 43, with 100% lymphocytes. Blood cultures were negative, and PCR was positive for HSV 6 days after admission. He was treated with a 21 day course of IV acyclovir for HZE. Several days after admission patient's mental status improved but the delirium remained and he subsequently developed dysphagia. Barium swallow demonstrated severe dysphagia and a PEG tube was subsequently placed. The patient was then released to a skilled nursing facility where his mental status significantly improved.

DISCUSSION: HZE accounts for 10% to 20% of viral encephalitis. The virus has a predilection for the temporal lobes. Presentation can vary from aseptic meningitis and fever to a severe rapidly progressive form involving altered consciousness. HZE can occur either through hematogenous spread or neuronal transmission of the ophthalmic branches or the olfactory tract.

CSF viral cultures are positive in <5 % of patients with antibodies appearing up to 3 weeks after onset of symptoms. A polymerase test of CSF yields the definitive diagnosis. A negative MRI does not rule out encephalitis.

CONCLUSION: Delirium etiology can be challenging in elderly patients like this: our challenges included disruption in physiologic homeostasis due to the Herpes opthtalmicus, prednisone induced altered mental status, alcohol withdrawal, pain due to the HZ and consideration of the HZE as a major factor. HZE as a cause of delirium in older patients can easily be overlooked. A high index of suspicion can lead to early diagnosis and treatment potentially improving patient outcome.

B44

Level of Function and Independence in Older Adults Hospitalized from the Emergency Department with Suspected Infection.

E. D. Losman, B. L. Smith, W. J. Meurer, P. N. Malani, J. G. Younger.
Emergency Medicine, University of Michigan, Ann Arbort, MI.

Supported By: University of Michigan Claude D. Pepper Older Americans Independence Center

Hartford Foundation

The Emergency Department (ED) is the conduit for hospitalization for most older adults; infection is a leading cause for admission in this group. Previous reports note functional decline and loss of independence in older adults post hospital discharge. We assessed the relationship between pre-admission independence and activities of daily living (ADL) with length of hospital stay (LOS) and 90-day mortality in patients admitted from the ED with suspected infection. A prospective consecutive sample of patients age > 70 admitted from the ED with 2 or more SIRS criteria were enrolled between 7/01/07 and 12/01/07. Pre-illness function including ADLs and Independent ADLs were assessed via structured interview and were each quantified (0 = unable, 1 = able with assist, 2 = able). Follow-up was by telephone at 90 days. Functional metrics were fitted to length of stay and 90-day level of independence and survival. 30 females (median age 85; IQR 79-87) and 20 males (75; 74-83) were enrolled. Median hospital length of stay was 4 days. Follow-up is complete on 24 patients. 24% died during the study window. Cumulative ADL scores on admission were lower among women (20; 16-21) than men (21; 20-21), $p < 0.01$, and correlated with age. Neither ADL nor IADL at admission predicted 90-day survival. Decline in ADL occurred regardless of gender, but tended to be less severe in women (mean -5.7) than in men (mean -7.8). A similar decline in IADL was noted among women (-8.6) and men (-12). 31 of 50 patients lived independently at home prior to admission. Of these, 12 returned to their previous arrangement, 6 acquired a degree of home-health aid, 4 went to a subacute facility, and 3 went to a long-term facility. No patient enjoyed an improvement in independence following hospitalization. These data highlight the short-term mortality and prevalence of post-hospitalization functional decline among older adults evaluated for serious infection in the ED. We did not find evidence to support screening of functional status to risk stratify admitted patients. There was no observed relationship between pre-admission ADL scores and length of stay or decline in post-hospitalization level of function.

C45

Do geriatric interventions in the Emergency Department reduce the need of Hospital admission of frail older adults?

T. PAREJA. *GERIATRIC UNIT, UNIVERSITY HOSPITAL OF GUADALAJARA, GUADALAJARA, GUADALAJARA, Spain.*

Supported By: There was no economical support for this research

AUTHORS: Pareja T, Alvarez B, Madrigal M, Mauleon C, Hornillos M.

DEPARTMENT OF GERIATRIC MEDICINE. UNIVERSITY HOSPITAL OF GUADALAJARA, SPAIN.

OBJECTIVE: To evaluate the impact of comprehensive geriatric assessment of high risk older patients in a medical Short Stay Unit located in the Emergency Department of a General Hospital in terms of clinical outcomes.

DESIGN: Prospective study of 1200 patients evaluated in the Short Medical Unit for Geriatrics of the Emergency Department between January 2006 and March 2007, to determine if specialized geriatric evaluation may avoid hospital admission and iatrogenesis.

INTERVENTION: Assessment of physical and cognitive status, identification of geriatric syndromes, medical and social problems and to establish a specific care plan in the most appropriated level of assistance for each frail older patient. They are admitted to this unit by the Emergency Department medical staff to be evaluated by a Geriatrician and receive treatment for acute-mild severity pathologies or unstable chronic diseases that can be improved in three days of medical therapy and decide the need of hospital admission or ambulatory care.

RESULTS: Patients were an average of 37 hours (12-72h). Their mean age was 86, women 57%. 59% had moderate physical impairment and 30% where severely inmovilized. Mild–moderate cognitive impairment was detected in 60% of the patients. 38% came from a nursing home. The main clinical diagnoses were heart failure, respiratory infection in COPD, acute neurological events (confusion and stroke with total recovery), UTI-renal failure, arrhyithmias and isquemic cardiopathy. 72% of the patients could be discharged home after being stabilized, to be followed up in the geriatrician clinics (29%), by home care medical team (9%) or by nursing home-primary care doctor (14%). 28% of the patients had to be admitted the Geriatric Department because of the absence of improval or severity of acute disease. 18% of the discharged patients needed hospital attention in the following month.

CONCLUSIONS: Geriatric patients in the ER have different patterns of service use and health care needs. The actual disease oriented models of emergency attention may not be adequate for frail older patients. Short medical units carried out by geriatritians seem to have the potential to increase patient satisfaction, reduce the length of hospital stay and improve the efficiency of the emergency departments.

C47

Factors associated with longer emergency department lengths of stay.

J. Hwang,[1,2] C. B. Schechter,[3] C. Kim,[1] S. Reiff,[1] L. W. Gerson.[4] *1. Emergency Medicine, Mount Sinai School of Medicine, New York, NY; 2. Geriatrics, Mount Sinai School of Medicine, New York, NY; 3. Family and Social Medicine, Albert Einstein College of Medicine, New York, NY; 4. Epidemiology, Northeastern Ohio Universities College of Medicine, Rootstown, OH.*

Older emergency department (ED) patients tend to have atypical presentations and more complex medical histories and conditions. It is likely that they have longer and more complicated evaluations while in the ED. The effect the growing numbers of older persons will have on the delivery of emergency patient care is unknown.

OBJECTIVES: To 1) determine if older adults have greater ED lengths of stay and 2) determine if there are predictors associated with prolonged ED lengths of stay.

METHODS: This retrospective observational study was done in a 76,000 annual visit urban, tertiary care ED. All visits from 8 randomly selected days in 2005 were reviewed. Patient-related data including age, gender, race/ethnicity, Charlson comorbidity score, use of radiographic imaging, use of specialty consultation in the ED, and times of care were recorded. The outcome of interest was ED length of stay (time of ED bed placement to ED discharge). Cox-proportional hazard modeling was used for analyses.

RESULTS: 1208 visits were reviewed. Mean age was 48 (sd 20) years, 23% were >=65 years in age (older), 62% were female, 60% were Black or Hispanic, the median Charlson comorbidity score was 1 (iqr 0, 2), 46% had imaging, and 16% received specialty consultation. Median time from bed placement to ED discharge for older patients was 282 (iqr 169, 426) minutes vs. 175 (74, 351) minutes for younger patients. Patients who were older had longer ED lengths of stay (HR=0.77, p=0.0003) and were more likely to remain in the ED for greater than 4 hours (RR=2.17, p<0.0001). Older age, however, was not significant (HR=1.01, p=0.88) in adjusted multivariable models. Instead, longer length of stay was associated with greater comorbidity (HR=0.79, p=0.0004), use of radiographic imaging (HR=0.40, p<0.0001), and specialty consultation (HR=0.70, p<0.0001).

CONCLUSIONS: Older adults have longer lengths of emergency department stay. Their longer stays are due to greater complexity and more extensive evaluation. The increasing number of elders seeking emergency care will affect the delivery of emergency department care.

C50

Mortality predictors among elderly patients admitted to a geriatrics ward.

T. J. Silva, C. Szlejf, J. M. Farfel, J. E. Curiati, W. Jacob Filho. *Geriatrics Service, Hospital das Clinicas of the University of Sao Paulo Medical School, Sao Paulo, SP, Brazil.*

Supported By: Geriatrics Service – Hospital das Clinicas of the University of Sao Paulo Medical School

(a) Introduction: The continuous growth of the Brazilian elderly population observed during the last decades, and consequent increase in the prevalence of older individuals among hospitalized patients, demands a better knowledge of the factors which determine their clinical outcome during hospitalization in order to propose ever more adequate inpatient therapeutic approaches. Objective: To determine the mortality predictors among elderly patients admitted to a geriatrics ward. (b) Methods: This was a prospective study carried out with 778 elderly patients aged from 60 to 104 years old admitted to HC-FMUSP's Geriatrics Infirmary from February 2004 to October 2007. Statistical analysis of the association between in-hospital death and the following factors was performed: sex, age, length of stay, number of drugs in use at admission, number of diagnosis at admission, heart failure history, neoplastic disease diagnosis, immobility syndrome diagnosis, occurrence of delirium or infectious complications during hospital stay, and entry laboratorial tests (serum albumin and creatinine). (c) Results: The general mortality rate verified in this study was of 16.58%. The multivariate analysis indicated that the independent factors related to mortality during hospitalization were: occurrence of delirium (Odds ratio (OR)=3.07, confidence interval (CI)=1.92-4.91, p<0.001); neoplastic disease diagnosis (OR=4.49, CI=2.74-7.355, p<0.001); immobility (OR=1.78, CI=1.08-2.925, p=0.024); low serum albumin levels at admission (OR=0.28 per added albumin point, CI=0.19-0.41, p<0.001); and elevated serum creatinine levels at admission (OR=1.29 per added creatinine point, CI=1.13-1.485, p<0.001). (d) Conclusion: Delirium, cancer, immobility, lower serum albumin levels, and elevated serum creatinine levels, were all related to higher mortality rates among hospitalized older patients and should be assessed because of their importance as indicators of clinical outcome.

D17

Drug-induced Parkinsonism with Amiodarone.

N. E Erdem, *Division of Geriatric Medicine and Center for Aging and Health, University of North Carolina, Chapel Hill, NC.*

Case: An 85 year old woman with paroxysmal atrial fibrillation (PAF) presented with a 7 month history of memory loss, fatigue and failure to thrive (FTT). She was living independently when family noted difficulty remembering names, dates and balancing checkbook. She developed difficulty speaking, auditory and visual hallucinations, and nightmares. She had fatigue, malaise, and developed FTT with 15 pound weight loss and further functional decline.

She was on longstanding amiodarone to treat PAF, and 15 other medications including levodopa/carbidopa and entacapone for tremor in hands and "feeling shaky", cyproheptadine for weight loss, and alprazolam for "nerves" and insomnia.

Neurological exam revealed unsteady gait with tremor in hands, but no shuffling, masked facies or cogwheeling. She was tearful, emotionally labile, and sleepy during the exam. Her mini-mental status examination (MMSE) score was 10/30. She was disoriented, had no delayed recall, and was unable to complete serial 7's, or even count from 10 to 1.

The primary diagnosis was medication-induced delirium, but the instigating factor was misdiagnosis of drug-induced parkinsonism (DIP) as Parkinson's disease. This led to prescribing of dopamine agonists and a COMT inhibitor which caused hallucinations, anorexia and contributed to memory loss. The anticholinergic effects of cyproheptadine contributed memory loss and fatigue. Levodopa/carbidopa, entacapone, cyproheptadine, and alprazolam were discontinued, and amiodarone dose was reduced. Mirtazipine was started for depression accompanied by insomnia and FTT. Homehealth was consulted for OT and PT.

Two weeks later tremor, hallucinations and insomnia were resolved, fatigue was improved and MMSE score increased to 18/30. Three months later her MMSE was 26/30. She was able to regain independence at home.

Discussion: Although amiodarone has known adverse drug reactions (ADRs), it is still one of the most frequently prescribed antiarrhythmics in the US. Amiodarone can be neurotoxic when taken at high doses long-term, manifesting as tremor, ataxia and peripheral neuropathy. It is unclear how amiodarone can cause extrapyramidal (EP) toxicity but there is suggestion that the EP system is particularly vulnerable to amiodarone. These EP effects do appear reversible with dose reduction or drug discontinuation.

Conclusion: When prescribing amiodarone, one must consider DIP among the list of other ADRs caused by this drug.

D33

Role of ERCP in the Very Elderly.

S. Raghunathan, N. Haboubi. *Elderly medicine, Nevill Hall Hospital, Abergavenny, Wales, United Kingdom.*

Background:

Endoscopic Retrograde Cholangio Pancreatography (ERCP) is effective in the investigation and treatment of biliary disease; however in the very elderly a perception of high procedural risk and lack of efficacy may limit its use.

Method:

Retrospective analysis of ERCPs performed on patients 90 years of age and older between Jan 2000- Apr 2007 at Endoscopy suite, Nevill hall hospital. Each patient's co morbidities, functional status, clinical diagnosis, USS/MRCP findings, sedations used for ERCP, ERCP findings, early and late complications, success rate and indications for repeat ERCP (if performed) were noted.

Results:

64 ERCPS were performed on 34 patients who were 90 years of age and older. The primary indications were Obstructive jaundice ?cause (47%)(n=16), Cholecystitis (24%)(n=8), Biliary colic (12%)(n=4) and non specific causes(12%)(n=4). The main endoscopic findings were Choledocholithiasis with or without Gall stones (65%)(n=22), Malignancy(24%)(n=8) and Gallstones alone(12%)(n=4). Most patients(n=30) required a repeat ERCP mostly for stent change or removal . The overall success rate for the procedures were 81%(n=64). High failure rates were noted in patients with biliary strictures secondary to malignancy(50%).No major procedure related complications or adverse effects from sedation were noted. Minor bleeding and transient desaturation were reported in 4 patients.Three patients with underlying malignancy died of non-procedural causes 6-23 days after ERCP.

Conclusion:

ERCP is effective for both diagnosis and treatment of biliary obstruction in Nonagenerians. Choledocholithiasis and Cholangiocarcinoma (89%) were the common diagnoses during ERCP. Procedure related complications were transient and mortality is usually related to severity of underlying illness and malignancy.

SPECIAL INTEREST GROUPS

7:30 – 9:00 AM

ACUTE HOSPITAL CARE

ROOM: Taylor

CHAIR: Robert M. Palmer, MD, MPH

The mission of the Acute Hospital Care Special Interest Group is to improve the outcomes of hospitalization of elderly patients through improvements in clinical care, dissemination of research findings and promotion of health professional education. Innovative approaches to acute hospital care are discussed at AGS meetings. The SIG meeting is open to all AGS participants.

OSTEOPOROSIS: ADVANCES AND CONTROVERSIES

ROOM: Maryland A/B/C

CME: 1.5 credits ■ Nursing contact hours: 1.8

CME/CEU Session Code: 0111

ASCP Program # 203-999-08-045-L01-P

1.5 Contact Hours

MODERATOR: Gustavo Duque, MD, PhD

Developed by the Osteoporosis and Metabolic Bone Diseases Special Interest Group.

This symposium will explore the major advances and controversies concerning the treatment of osteoporosis with emphasis on new developments in the older population. Learning objectives: (1) review the most recent advances in the treatment of osteoporosis from an evidence-base approach; (2) identify the appropriateness of the diagnostic methods for osteoporosis in older adults (ambulatory and institutionalized); (3) identify the major controversies in the treatment of osteoporosis focusing on the potential side effects recently reported in the literature; and (4) provide a framework for osteoporosis treatment decisions in frail and institutionalized older adults.

Advances in the Treatment of Osteoporosis
Douglas P. Kiel, MD, MPH

Controversies in Osteoporosis: Are They Supported?
Gustavo Duque, MD, PhD

Osteoporosis in Frail Populations: When to Treat? How to Treat?
Cathleen S. Colón-Emeric, MD

MULTIDISCIPLINARY CLINICAL SKILLS WORKSHOP

ROOM: Washington 1-3
CME: 1.5 credits ■ Nursing contact hours: 1.8
CME/CEU Session Code: 0117
MODERATOR: Maura J. Brennan, MD
Developed by the Nurses and Fellows-in-Training Sections, the Residents Special Interest Group and the Education Committee.

This workshop will be an interactive, hands-on program featuring ten skills stations to develop clinical skills relevant to the care of older adults. Learning objectives: (1) enhance confidence in breaking bad news, demonstrate ability to inject the knee and shoulder and list 3 warning signs for elder abuse; (2) list 4 drugs to avoid in geriatric patients, commit to asking elders about driving problems, be able to use at least 3 different cognitive screening tools; (3) describe 3 interventions to decrease risk for hospitalized elders, learn to perform a basic gait and balance exam and apply the skills learned during community-based screening for gait and balance problems in the Washington DC area, perform a thorough exam for low back pain, and know how to write an exercise prescription; and (4) recognize the importance of a team approach in geriatrics and value the expertise of those in other disciplines.

Station 1: Joint Injections
David C. Thomas, MD, MS; Don Scott, MD, MHS; C. Bree Johnston, MD, MPH

Station 2: Breaking Bad News
Maura J. Brennan, MD & Susan E. Mahoney, MSW

Station 3: Medications to Avoid in Elders
Daniel L. Swagerty, MD, MPH, AGSF & Nicole Brandt, PharmD, CGP, BCPP, FASCP

Station 4: Warning Signs of Elder Abuse
Carmel B. Dyer, MD & Sabrina Pickens, MSN, APRB-BC

Station 5: Hazards of Hospitalization
Helen Fernandez, MD, MPH & Eileen H. Callahan, MD

3:00 – 4:30 PM

EMERGING MODELS OF ACUTE HOSPITAL CARE OF OLDER PATIENTS

Room: Washington 4
CME: 1.5 credits ■ Nursing contact hours: 1.8
CME/CEU Session Code: 0121
Moderator: Robert M. Palmer, MD, MPH

Developed by the Clinical Practice and Models of Care Committee and the Acute Hospital Care Special Interest Group.

This symposium will discuss emerging models of care that hold great promise to impact the quality and outcomes of hospitalization of elders. Learning objectives: (1) describe a strategy to use health information technology to bring principles of the ACE model of hospital care to seniors throughout a large health care system; (2) describe the Hospital Elder Life Program, and overview the challenges in the dissemination process and adaptations made by programs to meet some of these challenges; (3) summarize the rationale for and experience with implementing the Geri-FIT model of care, including a preliminary analysis of the program's outcomes; and (4) place the role of the ACE tracker, HELP and Geri-FIT models in the context of other interdisciplinary models of acute care and quality improvement.

ACE Tracker- Bringing the Acute Care for Elders (ACE) Model to a Health Care System
Michael L. Malone, MD

The Hospital Elder Life Program (HELP): Lessons Learned from the Dissemination Process
Sharon K. Inouye, MD, MPH

Meeting Patients Where They Are: The Geriatric Floating Interdisciplinary Team Model for Care Transitions in the Hospital
Samuel C. Durso, MD, MBA

Discussant
Mary D. Naylor, RN, PhD & Bruce Leff, MD

HOSPITAL ELDER LIFE PROGRAM (HELP)

ROOM: Jackson

CHAIR: Sharon K. Inouye, MD, MPH

The Hospital Elder Life Program (HELP) is an innovative model of hospital care designed to prevent delirium and functional decline and to improve overall quality of hospital care for older persons. The mission and goal of this SIG is to allow all current and potentially interested HELP sites to come together to discuss successes and challenges in the implementation process. A new HELP website (funded by the National Library of Medicine) was implemented to try to meet the needs of HELP sites nationally and internationally. At this SIG, we will discuss the progress on our HELP collaborative paper, as well as the latest updates on the website. We hope to gain feedback on both projects. All current HELP sites, and anyone interested in learning more about HELP are encouraged to participate. You need not have an active HELP site to participate, just an interest in improving hospital care for older persons.

What is the Hospital Elder Life Program?

The Hospital Elder Life Program (HELP) is a patient-care program, developed by Dr. Inouye and doctors and nurses at the Yale School of Medicine, that is designed to prevent delirium among hospitalized older patients. HELP does this by keeping hospitalized older people oriented to their surroundings, meeting their needs for nutrition, fluids, and sleep and keeping them mobile within the limitations of their physical condition.

Is Your Hospital in Need of HELP?

The hospital should be a place where older people can go to recover from their illnesses.
Yet, more than two million older Americans this year will develop delirium and functional decline during their inpatient care. These complications will result in increased morbidity and mortality, prolonged hospital stays, increased provider liability, a greater likelihood of needing long-term care and billions of dollars in excess health care costs. This scenario is not inevitable.

HELP is on the way
This section of the website provides general information about the background, goals, and implementation of the Hospital Elder Life Program. It also provides information about our dissemination activities to assist other institutions in implementing HELP.

Goals of the Hospital Elder Life Program

HELP was created by Sharon K. Inouye, M.D., M.P.H., at Yale University School of Medicine.

The program is an innovative approach to improving the hospital care for older patients. The primary goals of the program are:
-Maintaining cognitive and physical functioning of high risk older adults throughout hospitalization
-Maximizing independence at discharge
-Assisting with the transition from hospital to home
-Preventing unplanned hospital readmissions

These goals have been accomplished using a multicomponent intervention strategy. In addition to targeted interdisciplinary geriatric assessment, the Program uses an innovative volunteer model to provide personal, supportive attention to vulnerable older patients. HELP materials include a structured curriculum for instructing volunteers to deliver daily orientation, early mobilization, feeding assistance, therapeutic activities, a non-pharmacological sleep protocol, and hearing/vision adaptations.

Qualitative feedback regarding the additional benefits of the HELP Program:

- **This innovative program prevents decline in older patients and decreases human suffering for patients and their families.**
- **Provides a venue for hospitals to become recognized as centers of excellence in the provision of geriatric care.**
- **Personal attention and support are caring services that are valued by patients and their families. Patient satisfaction and outcomes improve.**
- **Hospital nursing staff appreciate HELP because it improves patient care without adding to their responsibilities.**
- **HELP creates opportunities for many departments to become educational sites for geriatric care.**
- **Provides good, cost-effective care. It's a win-win-win-win for patients, HELP staff, hospital staff and hospital administration.**
- **HELP creates opportunities for a broader type and number of volunteers, thereby strengthening the hospital's linkage to the community.**
- **Provides a constructive, concrete experience to prepare families, communities and our health care system for our aging society.**

The intervention resulted in:

- **A significant reduction in the development of delirium (9.9% of intervention patients vs. 15% of usual care patients, odds ratio = 0.60, P=0.02). NEJM 1999;340:669-76**
- **A significant reduction in total n. of days with delirium (105 vs. 161 in usual care, P=0.02).**
- **A significant reduction in total n. of delirium episodes (62 vs. 90 in usual care, P=0.03).**
- **A significant reduction in functional decline (14% in intervention patients vs. 33% in usual care patients). JAGS 2000;48:1697-170**
- **A reduction in use and costs of hospital services. The program was demonstrated to be cost effective for the 73% of intervention patients who were at intermediate risk of developing delirium. The costs of implementing the program were offset by the cost savings from the program. Med Care 2001;39:740-752**
- **A dose-response relationship between adherence with the interventions and delirium reduction. Higher levels of adherence resulted in reduced rates of delirium in a directly graded fashion. Arch Int Med2003;163:958-964**
- **A reduction in use of long-term nursing home services. Intervention was associated with a 15.7% decrease in long-term nursing home costs, and average savings of $9446 per long-term nursing home patient. JAGS. 2005;52:405-409**

Replicating the Hospital Elder Life Program in a Community Hospital and Demonstrating Effectiveness Using Quality Improvement Methodology

Fred H. Rubin, MD, Jennifer T. Williams, BS,† Dianne A. Lescisin, MHPE,† William J. Mook, MS,‡ Shuja Hassan, MD,* and Sharon K. Inouye, MD, MPH§‖*

OBJECTIVES: To evaluate a replication of the Hospital Elder Life Program (HELP), a quality-improvement model, in a community hospital without a research infrastructure, using administrative data.

DESIGN: A pretest/posttest quality-improvement study.

SETTING: A 500-bed community teaching hospital in western Pennsylvania.

PARTICIPANTS: Four thousand seven hundred sixty-three hospitalized patients aged 70 and older admitted to one nursing unit over 3.5 years.

INTERVENTION: Application of the HELP multicomponent intervention targeting patients at risk for delirium.

MEASUREMENTS: A proxy measure for delirium was developed using administrative data to calculate delirium rate and differences in variable costs of care and length of stay for patients before and after the intervention. Similar calculations were used in delirious patients for variable costs and length of stay before and after the intervention. Satisfaction surveys were administered to nursing staff and patient families before and after the intervention.

RESULTS: The intervention reduced the absolute rate of delirium according to proxy report 14.4% from baseline, which represented a relative reduction in risk of 35.3% ($P = .002$). Total costs on this 40-bed nursing unit were reduced $626,261 over 6 months. Satisfaction of nursing staff and families was high in the intervention group. In addition, the intervention showed sustained benefits over time and remains funded by the hospital.

CONCLUSION: HELP can be successfully replicated in a community hospital, yielding clinical and financial benefits.
J Am Geriatr Soc 54:969–974, 2006.

Key words: delirium; acute confusional state; Hospital Elder Life Program (HELP); intervention; hospital care; quality improvement

Delirium has been recognized as the most-common complication of hospitalization for older persons.[1] Aspects of routine hospital care, such as bedrest and sleep interruptions, contribute to poor outcomes.[2,3] Delirium has received considerable attention, because it entails high morbidity and mortality and is so prevalent in this population. Incident delirium also serves as a marker for quality of care and patient safety in hospitalized older people.[4]

Delirium in older people is usually multifactorial in origin, including baseline patient characteristics present at admission and acute precipitating stressors that develop in the hospital. Examples of the former include dementia, severe illness, and sensory impairment, and examples of the latter include the use of physical restraints, malnutrition, addition of new medications, and the use of a bladder catheter.[5,6] The Yale Delirium Prevention Program, which provides standardized protocols targeted toward six delirium risk factors (cognitive impairment, sleep deprivation,

The roles of senior management in improving hospital experiences for frail older adults.

Bradley EH, Webster TR, Schlesinger M, Baker D, Inouye SK.

J Healthc Manag. 2006; 51: 323-36

With the aging of the population, healthcare executives are paying increased attention to fostering safe and high-quality care for older adults who become hospitalized. The Hospital Elder Life Program (HELP) is an evidence-based program that has been shown to be cost-effective in reducing episodes of delirium, functional decline, and long-term nursing home placement for older hospitalized adults. Senior administrators are known to play a role in quality improvement, but little is known about their roles in adopting clinical improvement programs such as HELP. Therefore, we conducted a mixed-methods study of 63 hospitals at different stages of adopting HELP to identify key roles and motivations of senior management to adopt HELP and the perceived impact of HELP on patient and staff outcomes. Our findings can be used by hospital management teams as they identify ways to influence and benefit from efforts to improve clinical quality, safety, and the experiences of older adults treated in their hospitals.

HELP Perspective:

-fall

-function

-LOS

A108

Using Hospitalists Instead of Geriatricians in a Hospital Elder Life Program Intervention.

K. Brummel-Smith,[1] F. Tinson,[2] L. Granville,[1] K. Holcomb.[2] *1. Geriatrics, Florida State University College of Medicine, Tallahassee, FL; 2. Tallahassee Memorial Hospital, Tallahassee, FL.*

Supported By: D.W. Reynolds Foundation

Purpose & Background: The Hospital Elder Life Program (HELP) utilizes a geriatric care team and trained volunteers to provide a multifactorial intervention to prevent delirium. Traditionally the HELP approach uses a geriatrician to provide medical oversight. However, hospital-based geriatricians are uncommon in most hospitals. This is the first study of HELP using hospitalists to provide the medical oversight.

Methods: A study geriatrician provided training to two hospitalist groups (Family Medicine Residency faculty and private hospitalist group) operating in a 770-bed community hospital. The geriatrician is not involved in direct patient assessment or care. Patients are screened using standard HELP criteria: 70 years or older, able to communicate, and at least one risk factor for cognitive decline. Patients meeting inclusion criteria are enrolled in the HELP program after giving informed consent. Baseline cognitive and functional assessments are performed. Patients receive daily interventions by trained volunteers, including mental and physical stimulation; companionship and assistance at meals; assistance with walking and exercises; relaxation exercises; and non-pharmacologic sleep enhancements.

Results: In the first 3 months forty-three (n=43) patients were enrolled. Forty-two of these have been discharged and one patient remains hospitalized. The mean length of stay (LOS) is 4.7 days, the median is 3 days (1 - 23). Our hospital's average LOS for patients 60 years and over at the time of review was 5 days. All patients maintained or improved their MMSE score from admission to discharge. Additionally, 97% percent had the same or improved their ADL score and only 1 patient (3%) showed a decline of 3+ points. No patient has developed delirium. The discharge destination for HELP patients included; home without paid services n=16 (38.1%), home with paid services n=6 (14.3%), rehabilitation in long term care facility n=11 (26.2%), chronic care/long term care facility/residential care facility n=2 (4.8%), assisted living n=2 (4.8%), transferred to another unit due to medical condition n= 5 (11.9%).

Conclusion: The HELP intervention is an effective method for preventing delirium in hospitalized elders and hospitalists can deliver the medical care component of the intervention with additional training in delirium management.

STEM CELL BASED THERAPIES FOR OLDER PATIENTS: REALIZABLE GOAL OR HOPELESS FANTASY?

Room: Maryland

CME: 1.5 credits ■ Nursing contact hours: 1.8

CME/CEU Session Code: 0201

Moderator: George A. Kuchel, MD

Developed by the Research Committee.

This program will describe recent developments in stem cell research and the debate regarding the potential application of such discoveries to the care of older adults. Learning objectives: (1) gain an understanding of seminal developments in stem cell biology which have taken place since the vast majority of AGS members have completed their professional training; (2) gain an understanding of recent developments in tissue engineering strategies and their potential relevance to common geriatric conditions; (3) explore some of the biological and physiological realities associated with aging, disability and disease which may pose constraints on the use of these technologies in older patients; and (4) explore some of the clinical, ethical and political realities associated with aging, disability and disease which may pose constraints on the use of these technologies in older patients.

A Novice's Primer on Recent Breakthroughs in Stem Cell Biology and Tissue Engineering

David W. Rowe, MD

Biological and Physiological Constraints in Bringing Stem Cell Based Therapies to Older Patients

George A. Kuchel, MD

Clinical, Ethical and Political Constraints in Bringing Stem Cell Based Therapies to Older Patients

James Lai, MD

CONTROVERSIES IN GERIATRIC CARDIOLOGY IN OCTOGENARIANS AND BEYOND

ROOM: Maryland
CME: 1.5 credits ■ Nursing contact hours: 1.8
CME/CEU Session Code: 0211
MODERATOR: Michael W. Rich, MD, AGSF
Developed by the Clinical Practice and Models of Care Committee.

This session will use a protagonist/antagonist format to debate two controversial issues in the management of cardiovascular disease in older adults. Learning objectives: (1) understand the rationale and current evidence in support of aggressive treatment of octogenarians with stage I isolated systolic hypertension (SBP 140-159 mm Hg, DBP < 90 mm Hg); (2) recognize limitations in the current evidence base for the treatment of stage I isolated systolic hypertension in octogenarians, and the potential disadvantages of aggressive treatment of this condition; (3) understand the rationale and current evidence in support of an invasive management strategy for the treatment of octogenarians presenting with non-ST-elevation acute coronary syndromes; and (4) understand the rationale and current evidence in support of a conservative management strategy for the treatment of octogenarians presenting with non-ST-elevation acute coronary syndromes.

Aggressive Treatment of Stage I Isolated Systolic Hypertension in Octogenarians is Indicated: Protagonist Perspective
Susan J. Zieman, MD, PhD

Aggressive Treatment of Stage I Isolated Systolic Hypertension in Octogenarians is Indicated: Antagonist Perspective
John E. Morley, MB, BCh

An Early Invasive Strategy is Indicated in the Treatment of Octogenarians with Non-ST-Elevation Acute Coronary Syndromes: Protagonist Perspective
Daniel E. Forman, MD

An Early Invasive Strategy is Indicated in the Treatment of Octogenarians with Non-ST-Elevation Acute Coronary Syndromes: Antagonist Perspective
Steven P. Schulman, MD

HEART FAILURE IN OLDER ADULTS: A CARDIOGERIATRIC SYNDROME

ROOM: Harding

CME: 1.5 credits ■ Nursing contact hours: 1.8

CME/CEU Session Code: 0313

SPEAKER: Michael W. Rich, MD, AGSF

This interactive session will utilize a case-based approach to discuss current concepts and challenges in the management of heart failure in older adults. Learning objective: (1) discuss current issues related to the management of heart failure in older adults.

PLENARY SYMPOSIUM

4:45 – 6:15 PM

THAT WAS THE YEAR THAT WAS JOIN RESIDENTS AND FACULTY IN TAKING THE GERIATRICS KNOWLEDGE CHALLENGE

ROOM: Salons 1/2
CME: 1.5 credits ■ Nursing contact hours: 1.8
CME/CEU Session Code: 0327
ASCP Program # 203-999-08-054-L01-P
1.5 Contact Hours
MODERATOR: Maura J. Brennan, MD
Faculty: Maura J. Brennan, MD; Sandra Bellantonio, MD; Don Scott, MD, MHS; Gail M. Sullivan, MD, MPH; Serena Chao, MD, MSc; Helen Fernandez, MD, MPH

Developed by the Education Committee and the Residents Special Interest Group.

Four teams of house officers will compete in a "jeopardy" quiz show which will provide a thorough review of current articles in the geriatric literature to identify those areas where new strong evidence has been uncovered that should affect your practice. Categories to be covered include: medications, palliative medicine, dementia/delirium/depression, function and falls, prevention/screening and general/miscellaneous. Learning objectives: (1) identify at least 4 recent advances to improve function, avoid falls and appropriately select drugs for older patients; (2) list at least four important developments in screening and prevention and end of life care/palliative medicine that are relevant for the care of elders; and (3) list at least four recent advances in dementia, delirium, depression and general geriatrics important for the care of older adults.

I costi dell’assistenza

Nei giorni scorsi abbiamo partecipato a Washington all’annuale congresso dell’American Geriatric Society, ormai tradizionale momento per fare il punto sulle novità più recenti nei vari ambiti della nostra disciplina.

In altra sede mi soffermerò sui dati più rilevanti; qui invece vorrei trasmettere ai lettori lo stato di disagio per un’atmosfera generale che si respira sia nel nostro ambiente sia nella società americana in generale e che ho colto in modo particolarmente acuto in questi giorni. Domina infatti sopra ogni altra la preoccupazione per i costi dell’assistenza fornita alle persone anziane, per cui ogni provvedimento che viene delineato ha come premessa la riduzione della spesa, prima ancora di considerarne l’efficacia per l’ammalato.
Noi da sempre ci siamo posti i problemi derivanti dalle compatibilità economiche dell’assistenza geriatrica (ma anche di quella più in generale rivolta a tutte le persone che a causa della loro condizione costano molto alla collettività); però non possiamo sottoscrivere questo modo di pensare che sembra dimenticare gli obiettivi veri della medicina per costruirne altri, legati all’uso del denaro. Altrimenti chi difende la parte più debole del sistema, cioè gli anziani vulnerabili? Ognuno deve fare il suo mestiere, con serietà, serenità e responsabilità; i geriatri sono e restano i difensori più vicini dell’anziano ammalato, in grado di delineare interventi che dovranno prima di tutto migliorare lo stato di salute e ridurre la sofferenza. Spetterà ad altri discuterne con noi l’eventuale costo elevato, per andare assieme alla ricerca di risposte ritenute più sostenibili…….

(mt)