The National Medicine for Old Age Psychiatrists conference

The sixth *National Medicine for Old Age Psychiatrists* conference took place, on the 8–9th November 2010, at the Institute of Physics. This report is based on some of the key presentations of the conference.

Dawn Powell Acting Editor
email dawn.powell@oceanmedia.co.uk

The *National Medicine for Old Age Psychiatrists* conference is an annual event that is now in its sixth year. Its aim is to provide old age psychiatrists with a comprehensive review of the common medical conditions that affect older patients. Topics reviewed at the conference included stroke rehabilitation, hypertension, and palliative care in patients with dementia.

Stroke rehabilitation

Stroke is the third largest cause of death in England and is the leading cause of disability.[1] Primary prevention, secondary prevention, and acute stroke management are all vital components of stroke care. But, rehabilitation of stroke patients is equally vital.

Rehabilitation, in terms of stroke, refers to strategies used to limit the effects of the damage to the brain that a stroke causes. Which strategies are used differs depending on the patient and the physician treating them, but five key principles — the "five Rs" — should always be adhered to: realisation, re-enablement, resettlement, role fulfilment, and readjustment.

Realisation refers to achieving the patient's recovery potential, re-enablement is about ensuring that the patient is as independent as possible (ie, able to do as many activities of daily living as possible), resettlement is the need to get the patient back in the community as safely and effectively as possible, role fulfilment is about ensuring the patient's autonomy, and readjustment is about helping the patient's come to terms with their disabilities and impairments.

All patients, regardless of their age or the severity of their stroke, should be managed in a stroke unit. Stroke units are an extremely important part of successful rehabilitation. They provide the assessment, monitoring, and the attention to detail required. For example, in a stroke unit, complications of stroke (such as pressure sores) can be identified and managed that might be otherwise missed. A Cochrane review found that stroke units benefitted all patients and that those with more severe stroke benefitted the most.[1]

But for a stroke unit to provide good care, several important elements need to be in place: multidisciplinary co-ordination, specialist staff expertise, links with carers and patients, information provision, and continuing education. Unfortunately, not all stroke units have these elements.

Rehabilitative therapy (eg, physiotherapy) is also very important for stroke patients. But England does very poorly in terms of providing the intensity and amount of therapy required.[2] Thus, a big challenge in healthcare at the moment is increasing the input of therapy in stroke rehabilitation. Another issue is the need to identify which therapy will benefit which patients. Therefore, randomised trials (with validated outcome measures) comparing different therapies are needed.

Report based on a talk by Dr Ajay Bhalla, Consultant Stroke Physician, Guy's and St Thomas' Hospital, London

Gastroenterology: common conditions in older people

Weight loss is common in older patients. Some see weight loss as a sign of malignant disease but the cause can be more benign: eg, not eating properly as a result of living alone or poor dentition.

Box 1: Rest of the talks of the conference

- Abnormal Blood Parameters

Dr Mark Cottee, Consultant in Geriatric Medicine, St George's Hospital and Medical School

- Advances in brain nuclear dopamine imaging: clinical use in diagnosing

Dr Paul Kemp, Consultant and Honorary Senior Lecturer, Nuclear Medicine, Southampton University Hospital Trust

- Parkinson's disease

Dr Doug Macmahon, Consultant Physician, Director of the Parkinson's Academy

- Neurology

Dr Paul Hart, Consultant Neurologist, Atkinson Morley Neuroscience Unit, St George's Hospital

- Kidney disease

Dr Debabish Banerjee, Consultant Nephrologist, Jackson Memorial Hospital, Miami

The seventh National Old Age Psychiatrists meeting will be held on 7–8th November 2011, at the Institute of Physics. For more information on the next National Medicine for Old Age Psychiatrists conference, see: www.oldagepsychiatry.co.uk

A possible cause of weight loss is oropharyngeal dysphagia. Aside from weight loss, symptoms include delayed or absent swallow initiation, aspiration, nasopharyngeal regurgitation, and post swallow residue.

Management involves identifying and (if possible) treating the cause. For many patients with a neurological cause (eg, stroke), a cure will not be possible and the aim should be to ameliorate the symptoms. Some patients will require enteral feeding, such as with a percutaneous endoscopic gastronomy (PEG) tube or nasogastric tube. A PEG tube is very beneficial when a patient has a mechanical blockage but it is less useful for neurological conditions. In fact, the debate over whether a PEG tube should be inserted into a patient with a neurological condition (eg, dementia) can be extremely contentious.

Diverticulosis (pouches in the lining of the colon) and diverticulitis (when the pouches become infected and inflamed) are also common conditions in older patients. If a patient presents with symptoms of diverticulitis (abdominal pain), it is important to establish the diagnosis and exclude other potential causes of the symptoms (eg, carcinoma). Management involves the use of antibiotics, such as metronidazole or ciprofloxacin, to treat the infection.

Complications with diverticulitis that can occur include abscesses, perforation, fistula, stricture, obstruction, and bleeding. Management of these complications usually involves percutaneous drainage or surgery.

Biliary stone disease is another common condition in older patients, and it has an atypical presentation in these patients: they may collapse with non-localising, fulminating sepsis or they may present with intermittent fevers, or chest or shoulder pain. They can become very ill very quickly. But aggressive intervention, even in the very elderly, is worthwhile because it can lead to a very good recovery.

Report based on a talk by Dr Richard Sturgess, Director, The Digestive Disease Centre, University Hospital Aintree, Liverpool

Hypertension and heart failure

With hypertension, the bar for new treatments is set high. A new treatment cannot be compared with placebo and must instead compared with the current treatments. Therefore, a new "blockbuster" drug is unlikely.

The ASCOT study[3] changed the way that existing treatments are viewed. Prior to this study, many people followed the ABCD algorithm: A = ACE inhibitor (or ARB), B = β-blocker, C = calcium channel blocker, or D = diuretic. However, after this study was published, β-blockers were

dropped from the algorithm to become a fourth-line treatment. In the future, especially as the National Institute for Health and Clinical Excellence (NICE) is reviewing its hypertension guidelines, diuretics may also be dropped from the algorithm.

The concept of "prehypertension" (high normal blood pressure) is a useful indicator that someone may develop hypertension and possibly may benefit from treatment. The TROPHY[4] study found that significantly fewer patients with high "normal" blood pressure who received antihypertensive treatment progressed to developing clinical hypertension than patients with high normal blood receiving placebo. However, the argument against prehypertension is that it could result in medicating "the normal".

As with hypertension, we have established effective treatments for heart failure. The cornerstone of treatment for patients with impaired left ventricular ejection fraction is the combination of an ACE inhibitor and a β-blocker.

However, the data for patients with preserved left ejection fraction is poor. Therefore, how these patients should be treated is not clear. This is concerning as heart failure with preserved left ejection fraction is the most common cause of recurrent hospital admission for heart failure. Diagnosis is also an issue for these patients. Echocardiography was seen as the gold standard for diagnosing heart failure because it identified when patients had reduced ejection failure. But it is not as useful in patients with preserved ejection fraction.

The new NICE guidance for heart failure[5] recognises the issue with diagnosis and recommends the use of natriuretic peptides in patients with suspected heart failure without prior myocardial infarction. It states that natriuretic peptides will help to identify patients with suspected heart failure with preserved ejection fraction.

Report based on talk by Dr Hugh McIntyre, Consultant Physician, Conquest Hospital, East Sussex

Neuropsychiatric symptoms in dementia

Craig et al[6] showed that neuropsychiatric symptoms, of all types, are highly prevalent in patients with Alzheimer's disease. How these symptoms are managed, particularly with the use of antipsychotics, has become highly controversial. The Banerjee report, endorsed by the Department of Health,[7] stated the prescription of antipsychotics for these symptoms should be reduced by two thirds. Therefore, those treating patients with dementia and neuropsychiatric symptoms need to develop strategies to reduce their use of antipsychotics.

One way would be to prevent or delay the emergence of neuropsychiatric symptoms. There is some evidence to suggest that cholinesterase inhibitors and memantine could be used to delay these symptoms.[8–10] For example, Gauthier et al found that memantine was effective at preventing and treating the behavioural symptoms of moderate to severe dementia, specific persistent benefits were observed on the symptoms of delusions and agitation/aggression.

Non-pharmacological management of neuropsychiatric symptoms is another way of reducing antipsychotic use. This would include counselling, psychosocial therapy, and behavioural therapy. However, properly trained staff are probably the key to ensuring these therapies are successful.

For some patients, atypical antipsychotics may be necessary. They do have the best data for managing neuropsychiatric problems. But Ballard and Howard,[11] because of safety concerns about the long-term use of these drugs, recommend that they are only used in the short-term. If antipsychotics are used for patients with dementia, the treating physician should document their use and the steps they have taken to avoid using them.

Report based on a talk by Professor Peter Passmore, Professor of Ageing and Geriatric Medicine, Queen's University, Belfast. The talk was supported by Lundbeck UK

Palliative care and dementia

According to the World Health Organization,[12] palliative care neither hastens nor postpones death. Its aim is to improve the quality of life of patients (and their carers) facing the problems associated with a life-threatening illness — and that includes people with dementia.

Dementia is a terminal illness, which Rait et al[13] showed when they found that median survival was lower in a dementia population compared with screened populations.

Healthcare professionals do not always recognise patients with end-stage dementia as being terminal. This can result in patients not receiving optimum palliative care.[14] The problem is that determining when a patient has reached the terminal stage is extremely difficult. Mitchell,[15] however, did identify 12 factors that increase the risk of death within six months. These ranged from unstable medical condition to not being awake for most of the day.

When a patient with dementia reaches the terminal stage, their current medication should be reviewed as it may no longer be necessary. Statins, unless there are coronary or cerebrovascular events, may not be of use in patients with a short life-expectancy. Similarly for patients with type-2 diabetes, a better option may be to stop treatment and monitor the patient than continue to use antidiabetic medication. Furthermore if a patient develops a condition, they do not necessarily need treatment. An asymptomatic urinary tract infection should be left alone. However it should be treated if it is symptomatic.

Report based on a talk by Dr Trevor Rimmer, Macmillan Consultant in Palliative Care, East Cheshire

Benign prostatic hyperplasia

Benign prostatic hyperplasia (BPH) is a condition of age. The exact pathological cause of BPH is unknown but it does relate to testosterone.

The enlarged prostate associated with BPH causes an obstruction to the bladder and, predictably, this can lead to certain symptoms: hesitancy, poor flow, dribbling, and incomplete bladder emptying. The bladder reacts to the obstruction and this causes more symptoms: frequency, urgency, and incontinence. The first set of symptoms are known as the "voiding" symptoms and the second set of symptoms are know as the "storage" symptoms. As people only spend a small proportion of their time voiding (ie, urinating), the storage symptoms will probably be the most bothersome to the patient.

Several tests can be used to diagnose BPH. A dipstick urine test will identify a urinary tract infection as well other conditions such as diabetes. An ultrasound will indicate if there are bladder stones or if there is post void residual volume. The prostate-specific antigen (PSA) test is seen as controversial but can play a useful part in diagnosing BPH. Although seen as a sign of prostate cancer, an abnormal PSA should instead be seen as an indication that something may be wrong with the prostate (ie, not necessarily cancer).

The management of BPH involves α-receptor blockers and 5-α-reductase inhibitors. α-receptor blockers will reduce symptoms relatively quickly. 5-α-reductase inhibitors are also an effective treatment but they may take longer to work. If medical treatment fails, surgery via transurethral resection of the prostate (TURP) is an option. This will not effect all of the symptoms of BPH but it will help to alleviate some of them.

Report based on a talk by Mr Billy Dunsmuir, Consultant Urologist, St Peter's Hospital, Chertsey, Surrey

Box 2: Exhibitors

Lundbeck UK
http://uk.lundbeck.com/uk/
Pfizer
www.pfizer.co.uk
Gerimed
www.gerimed.co.uk
GE Healthcare
www.gehealthcare.com/uken/
Conference organised by
Thirst for Knowledge Events
www.tfke.co.uk

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