The National Medicine for Old Age Psychiatrists conference

The seventh *National Medicine for Old Age Psychiatrists* conference took place on the 7–8th November 2011 at the Institute of Physics. This report is based on some of the key presentations of the conference.

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The *National Medicine for Old Age Psychiatrists* conference is an annual event that is now in its seventh 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, dementia, hypertension, Parkinson's disease and prostate cancer.

Stroke

The World Health Organization definition of stroke is "rapidly developing clinical signs of focal (or global) disturbance of cerebral function, with symptoms lasting 24 hours or longer or leading to death, with no apparent cause other than vascular.[1]"

The FAST campaign, which captures around 80% of strokes, is another good definition—face, arms, speech and time. However, my favourite definition of stroke is that it is of sudden onset, focal, lasts more than 24 hours and has a presumed vascular course. This definition helps you differentiate stroke from a migraine as it is sudden.

In the past five years stroke care has changed beyond all recognition in the UK. Most of the work is now done on stroke units and this has made a great difference to patients.

Stroke units have not only reduced mortality but also dependency and reduced the need for institutional care. There are now around one million stroke survivors in the UK.

Most cases of stroke present as a common syndrome and we can link symptoms and signs to the causes and treatment. For example, large vessel strokes affect the cortex and the things the cortex does—attention, language and motor control and planning. Whereas vertebrobasilar strokes cause weakness or sensory loss (sometimes this can affect both sides), unsteadiness/falls, as well as cranial nerve problems such as abnormal eye movements and swallowing problems.

The major cause of stroke is an infarction (75%) whereas haemorrhage accounts for 25%. Distinguishing between an infarction and haemorrhage needs a CT scan.

If stroke units have been the enforcer of change, then IV thrombolysis has been the driver for change and remains the only licensed treatment for stroke. We hope to have new drugs in the next five years. There is also a move to a more interventional approach such as angioplasty and stenting.

Stroke is now an emergency. Effective prevention and treatment is now available. Primary prevention of stroke includes smoking, treating hypertension, diabetes and heart failure as well as effective lifestyle advice.

Report based on a talk by Dr Barry Moynihan, Consultant in Stroke Medicine, St George's Healthcare Trust, London

The evolving nature of dementia management—towards a multidisciplinary approach

A recent document from the All-Party Parliamentary Group (APPG) looked at the shift of dementia care into the community setting. Entitled "*The £20 Billion Question—an inquiry into improving lives through cost*

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
- Interpreting CT & MRI Brain Scans in Dementia
  Dr Phillip Rich, Consultant Neuroradiologist, St George's Hospital, London
- Important Drug Interactions in the Elderly
  Professor Malcolm Lader, Emeritus Professor of Clinical Psychopharmacology, Institute of Psychiatry, University of London
- Neurology
  Dr Paul Hart, Consultant Neurologist, Atkinson Morley Neuroscience Unit, St George's Hospital
- Eye Disease in the Elderly
  Mr Dilogen De Alwis, Consultant Ophthalmologist, Croydon University Hospital
- BPH and prostate cancer
  Professor Prokar Dasgupta, Consultant Urological Surgeon, Guy's & St Thomas' Hospital, London

The eighth National Old Age Psychiatrists meeting will be held on 5–6th November 2012, at the Institute of Physics. For more information on the next National Medicine for Old Age Psychiatrists conference, see: www.oldagepsychiatry.co.uk

effective dementia services from the All-Party Parliamentary Group on Dementia,[2]" it found that many areas have been able to not only achieve better outcomes for people with dementia but also to achieve greater value for money in dementia care, by making changes to service provision or adopting new ways of working. Many of the examples focus on earlier intervention to prevent crises or delay the need for more intensive types of support. The document stated: "Witnesses were also clear that integrated models of care are necessary. Professionals from across health and social care need to work closely and co-ordinate services to improve the efficiency and quality of dementia services."

This fits in with the four priority areas in dementia, which are good quality early diagnosis and intervention for all, improved quality of care in general hospitals, living well with dementia in care homes and reduced use of antipsychotic medication.

Two thirds of people with dementia never receive a diagnosis; the UK is in the bottom third of countries in Europe for diagnosis and treatment of people with dementia; only a third of GPs feel they have adequate training in diagnosis of dementia.

In regard to improved quality of care in general hospitals, 40% of people in hospital have dementia. The excess cost is estimated to be £6 million per annum in the average general hospital and comorbidity with general medical conditions is high meaning people with dementia stay longer in hospital.

Two thirds of people in care homes have dementia. Dependency is increasing and behavioural disturbances are highly prevalent and are often treated with antipsychotic drugs.

There are an estimated 180,000 people with dementia on antipsychotic drugs. In only about one third of these cases are the drugs having a beneficial effect and there are 1800 excess deaths per year as a result of their prescription.

To aid this, the Alzheimer's Society has worked with the Department of Health to develop a best practice guide for health and social care professionals.[3] The guide provides information, advice and resources for treatment and person-centred care for people with dementia experiencing behavioural and psychological symptoms.

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

Managing hypertension and heart failure

The joint NICE and British Hypertension Society updated guidelines on hypertension were published last year.[4] Confirming the diagnosis of hypertension is an important part of that document especially as the guidance mandates the need for lifelong hypertension treatment.

It states that if the clinic blood pressure is 140/90mmHg or higher, offer ambulatory blood pressure monitoring (ABPM) to confirm the diagnosis of hypertension. At least two measurements per hour are taken during the person's usual waking hours and the average value of at least 14 measurements are used to confirm a diagnosis of hypertension. The guidance also adds that when using home blood pressure monitoring (HBPM) to confirm a diagnosis of hypertension, ensure that for each blood pressure recording, two consecutive measurements are taken, at least one minute apart and with the person seated. The blood pressure is recorded twice daily, ideally in the morning and evening and blood pressure recording continues for at least four days, ideally for seven days. Discard the measurements taken on the first day and use the average value of all the remaining measurements to confirm a diagnosis of hypertension.

The guidance defines stage one hypertension as a clinic blood pressure of 140/90mmHg or higher and subsequent ABPM daytime or HBPM average blood pressure of 135/85mmHg or higher; stage 2 is 160/100mmHg (ABPM daytime or HBPM average 150/95mmHg or higher); severe hypertension is 180/110mmHg or higher. For people over 80 years with treated hypertension the target is 150/90mmHg.

In regard to treatment, the guidance states that people aged under 55 years should be offered an angiotensin converting enzyme (ACE) inhibitor or an angiotensin receptor blocker (ARB). If an ACE inhibitor is prescribed and is not tolerated (for example, because of cough), offer a low-cost ARB. People aged over 55 years and black people of African or Caribbean family origin of any age should be offered a calcium-channel blocker (CCB). If a CCB is not suitable, for example because of oedema or intolerance, or if there is evidence of heart failure or a high risk of heart failure, offer a thiazide-like diuretic.

The NICE heart failure guidance[5] was updated in 2010 and looked at the optimisation of diagnostic strategy making it simpler and faster. Optimising diagnosis can be done by measuring serum natriuretic peptides, use of echocardiography and referring patients to the specialist multidisciplinary heart failure team.

The treatment strategy has been optimised by organised first-line and second-line care. Both ACE inhibitors and beta-blockers licensed for heart failure are first line treatment. An ARB is offered if the patient is intolerant of ACE inhibitors. Organisation of care is done by ensuring an integrated approach to care delivered by a multidisciplinary team.

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

Parkinson's disease

Is Parkinson's disease a movement disorder with neuropsychiatric complications or just a neuropsychiatric disorder? Recently focus has been on non-motor symptoms such as sleep, cognition, pain and hypotension.

There is a four stage paradigm of Parkinson's disease care which includes diagnosis, maintenance, complex and palliative. Non motor symptoms dominate the clinical picture of advanced Parkinson's disease and correlate with advancing age and disease severity.

The PDS survey[6] found that non motor symptoms have a major impact on quality of life such as balance, sleep, memory failure, confusion and drooling. These type of symptoms have more impact on quality of life than motor symptoms, and they are likely to lead to nursing home placement and are therefore costly. Non motor symptoms though are often under-recognised and inadequately treated.

A large study looked at the prevalence of non-motor symptoms. Of the 149 people recruited 15 to 18 years ago in the Sydney Multicenter Study of Parkinson's disease, one third survived. The original study compared low-dose levodopa with low-dose bromocriptine. Problems experienced by people who survived 15 years from diagnosis included falls, which occurred in 81% of patients, and 23% sustained fractures. Cognitive decline was present in 84%, and 48% fulfilled the criteria for dementia. Hallucinations and depression were experienced by 50%. A quarter of patients had been admitted to nursing homes by 10 years.[7]

Predictors of nursing home placement are increasing age, dementia and hallucinations.

The frequency of depression is also high in Parkinson's disease patients at 40%, which is twice the rate of severe depression seen in other equivalently disabled patients. Psychosis is also a big problem as is dopamine dysregulation syndrome, REM behavioural sleep disorder and impulse control disorders .

It is important to work with the multidisciplinary team to manage Parkinson's disease and community psychiatric nurses are very key in this. There is room for improvement and all of us can work better together and manage these neuropsychiatric issues.

Report based on a talk by Dr Doug MacMahon, Consultant Physician, Coventry

Box 2: Exhibitors

Lundbeck UK
http://uk.lundbeck.com/uk/
St Magnus
http://www.stmagnus.co.uk
ID Medical
http://www.id-medical.com
The Royal College of Psychiatrists
http://www.rcpsych.ac.uk
Gerimed
www.gerimed.co.uk
GE Healthcare
www.gehealthcare.com/uken/
Conference organised by
Thirst for Knowledge Events
www.tfke.co.uk

Diagnosing and managing common infections in older people

When dealing with infections in older people we need to define the problem, then we need to look at management, prognosis, prevention and general principles of patient care. The most common infections in this population are chest and urine infections as well as *Clostridium Difficile* infection.

Up to 40% of patients in a general hospital will have a urinary tract infection (UTI). This may be an incidental finding or the cause of that person arriving in that bed. Some 50–60% of elderly women will have at least one UTI a year. Urinary tract instrumentation increases incidence and prevalence.

Another common infection is community acquired pneumonia (CAP). The definition is adults admitted to hospital with symptoms and signs of a lower respiratory tract infection, associated with new chest radiographic changes for which there is no other explanation. This is a long-winded way of saying fits, coughs and fever. Suspected CAP is an acute illness with cough and at least one of the following: new focal chest signs, fever lasting over four days, dyspnoea or tachypnoea. Incidence varies with age but 34 per 1000 are aged over 75 years, 22-44% of patients with CAP are admitted to hospital with up to 10% admitted to intensive care. Mortality in adults in hospital with CAP is 5.4 to 14%.

Hospital Acquired Pneumonia is pneumonia developing 48 hours after hospital admission. It affects 0.5–1% of hospital admissions and increases length of stay by 7.5 days.

C. difficile is a spore forming, anaerobic toxin-producing Gram positive bacterium. Around 10–15% of older people who are debilitated or have extensive healthcare contact have *C. difficile* in their stools. The rate is now declining and community onset cases were approximately 50% in 2010. We have a large number of patients who are prone to *C. difficile* and immunodeficient because of their age. It is made even more difficult if a patient has challenging behaviour.

Early therapy matters because of the development of delirium, increased risk of the giants of geriatric medicine such as incontinence, falls, impaired hearing and vision and intellectual decline. It leads to increased length of stay and it makes other conditions difficult to manage as well as increasing mortality.

Infection is a major cause of death. Remember the underlying psychiatric issues, prevent complications and remember the geriatric giants.

Report based on a talk by Professor Margot Gosney, Director Clinical Health Sciences, Reading

References

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3. www.alzheimers.org.uk/site/scripts/documents_info.php?documentID=548 (accessed 10/1/12)
4. http://publications.nice.org.uk/hypertension-cg127 (accessed 10/1/12)
5. www.nice.org.uk/CG108 (accessed 10/1/12)
6. www.parkinsons.org.uk/about-us/results-of-the-members-survey.aspx
7. Hely MA et al. *Mov Disord* 2005; **20**(2): 190–99