RCPE Edinburgh International Course in Medicine of the Older Adult
19 & 20 May 2021

The injured older adult in the Emergency Department - Dr Jonathan Carter

Q. **What can we do for a delirious patient who is maxed out on lorazepam and also has a pmh of Parkinson's disease?**

A. Gosh I would find this situation very difficult. I guess the key thing here would be to find out what is driving their delirium. In trauma it can be pain, having the neck collar on, needing to pass urine, being in a loud, bright and uncertain environment, not having hearing aids in or glasses on - the list goes on. This applies to all older people and not just those with Parkinson's.

Beyond that, I would be seeking advice from a Geriatrician about how to manage delirium in PD beyond benzodiazepines. If it was a matter of procedural sedation (e.g. reducing a dislocated prosthetic hip) and we're thinking of using ketamine or propofol, I would speak to Anaesthetics and probably a Geriatrician about the safest approach. I suspect ketamine would not be ideal if you have PD.

Finally, it is essential that you continue their PD meds and this should be started in the ED. We're lucky to have an ED pharmacist in working hours who can help. I've put a link below to a Parkinson's calculator which looks really helpful and which was recommended to me. One of the things it can do is convert your patient's PD meds to alternative routes, e.g. from oral to transdermal.

http://www.parkinsonscalculator.com/

Q. **Would central cord compression be conservative management/ what is the prognosis?**

A. I think the most important thing about central cord syndrome, from an ED point of view, is to recognise it. That's often very tricky to do. I should add to my MUD-E mnemonic, in that patients can complain of allodynia or burning in their hands, or in a cape like distribution over their upper limbs. So I should change the mnemonic to MUD-E CAPE!

(Change of font again) Once you suspect it, then you can move on to imaging and making sure the patient's neck is at its most comfortable and least liable to movement.
With regards to treatment and prognosis, I would be speaking to the Neurosurgeons about this. I suspect the Neurosurgeons would want MRI imaging and then decision about management. I suspect it would be conservative with an Aspen or Miami-J collar, unless the injury was unstable. Prognosis seems to be better in younger people (<50 years). Sorry I can't be more specific about central cord syndrome but I would speak to your friendly neighbourhood neurosurgeon for more information.

Below is a link to an EM site with a useful overview of central cord syndrome:

coreem.net/core/central-cord-syndrome/

Acute stroke management - Professor Richard Lindley

Q**. Any role for wearables in the assessment of PAF while inpatient in the stroke unit?**

A. Inpatient care should involve continuous ECG monitoring for those with an initial resting ECG showing sinus rhythm – as these are the patients in whom you want to identify paroxysmal AF. For those with initial ECG showing AF, there is less of a case for 24 hour monitoring. The case for wearables and implantables is best considered for those with an unknown source of likely embolic stroke in the post-discharge period and there is no consensus at the moment for the best approach that will depend on local resources.

Q. Are there any new antithrombotic or anti platelets being developed that may be more effective?

A. Current antiplatelet evidence in the acute and secondary prevention phase of stroke tells us that there is limited gain from additional antiplatelet therapy due to the increased risk of bleeding. We already know that double antiplatelet therapy for minor acute ischaemic stroke and TIA is best time limited to 3 weeks, and there is most evidence from aspirin and clopidogrel. Aspirin and Ticagrelor has also been assessed in the acute phase of ischaemic stroke and TIA but the increased risk of bleeding remains. For long-term secondary prevention for those in sinus rhythm single antiplatelet therapy is best. Remember that dual antiplatelet therapy carries an annual risk of serious bleeding of about 1%, therefore this combination should only be used for high risk periods.

Q. What is it about stroke units that reduces morbidity and mortality post stroke?

A. It is likely that the main benefit from stroke units is the ability to do numerous simple interventions well. On their own, such interventions may only have very modest benefits, but when done consistently for most people with stroke, this cumulated benefit becomes powerful. Remember, the staff on such units (doctors, physiotherapists, nurses, occupational therapists, speech therapists and social workers) become stroke experts and we all want to be treated by such expert staff.

Host response biology: personalising oncology care in the older person - Professor Gordon Cook

Q. Should we repeat myeloma screening in patients who complain of back pain & generally unwell - even if previous myeloma screening done within 6 months was negative?

A. Probably not. If they have a negative screen when they have back pain, then not likely to change

Q. Would you recommend we refer on any patients diagnosed with Myeloma - ie. do you think referring clinicians are good at deciding who would be fit for treatment or should that be left to the specialists?

A. Yes! Refer all newly diagnosed to haematologists. There is much we can offer in addition to systemic anticancer therapy

Skin - Dr Michael Farrugia

Q. How can we very certain in a patient who is found to have a secondary in the brain (admitted with ich) and radiologist asked to look for any menanoma (some brain imaging appearance characteristics to melanoma) how best to examine and where to look carefully?

Re: Brain melanoma metastases can originate anywhere on the skin surface, as well as very rarely from a mucosal, ocular, or meningeal source.

Re: skin examination it is a simple head to toe looking for any abnormal moles or nodules. These may be amelanotic. The person may have many moles and the changes may be relatively subtle and require a dermatoscope. A person could also have had a mole removed in the past elsewhere that could have been the primary but was not looked at histologically (occurs occasionally in cosmetic settings).

I think the patient you mention would merit a dermatology review to search for a primary which can be biopsied.