Evening Medical Update: Geriatric Medicine November 2022

Assessing frailty in MAU – Dr Sarah Turpin, Consultant in Medicine for the Elderly, Borders General Hospital, Melrose

What drug classes should acute physicians look out for when de-prescribing in frail elderly?

There is an excellent paper which specifically addresses deprescribing in the frail elderly and provides an outline of key drug classes and an approach to deprescribing called the STOPFRAIL criteria. I have included a reference and link below. Deprescribing is best approached using a combination of individual clinician experience but for non specialists or those who have access to a pharmacy technician who can screen drug charts, a formal framework is helpful and the STOPFRAIL criteria can provide this. It has been developed by leading experts in the field of polypharmacy and if you google it you can see some examples of NHS trusts who have already implemented some guidelines based on it (such as this one https://www.sunderlandccg.nhs.uk/wp-content/uploads/2018/11/Stoppfrail-v1.pdf)

REference and article link:

https://academic.oup.com/ageing/article/46/4/600/2948308#.WdAS-u779FA.twitter

Reference: Lavan AH, Gallagher P, Parsons C& O'Mahony D: STOPPFrail (Screening Tool of Older Persons Prescriptions in Frail adults with limited life expectancy): consensus validation. Age and Ageing 2017; 46: 600–607.

If a frail pt has suspected malignancy such as presenting with blood in stool, should we investigate further?

These scenarios do not lend themselves well to blanket statements, it is not possible to say that you "should" or "should not" investigate a group of patients based on frailty status alone. The decision to investigate a frail older person for underlying serious and life limiting pathologies such as cancer is highly dependent on a number of individual factors, these include things such as predicted lifespan, patient perception of quality of life, the level of distress caused by the symptoms and the potential treatements available for the possible problem- some of which may not be curative but cannot be accessed without investiation or diagnosis (for example palliative stenting of a rectal tumour that would otherwise cause obstruction etc). Another very important factor that informs these decisions is the personal approach to risk and the individual level of comfort with uncertainty/unknowns in both the patient and the clinician dealing with them. These situations provide an opportunity to fully embrace the concept of shared decision making which is outlined in the Realistic Medicine publication from NHS Scotland, I would recommend reading this to familiarise yourself further with these concepts.

From the definition of frailty, would you consider patients on immunosuppression as frail? Could frailty be considered a reversible condition then?

Frailty is considered to be both a reversible and preventable condition. There is something called "prehabilitation" which is a well defined treatment pathway undertaken in some centres prior to major surgery which involves a multisiciplinary approach to optimising a patients nutritional, functional and cardiopulmonary performance status to reduce the impact of major surgery on their level of frailty and improve their recovery. Comprehensive geriatric assessement is an evidence based condition that slows the progression of frailty and rehabilitation in a number of settings can improved functional status and reduce level of frailty.

I would not consider all patients on immunosupression as frail. if you are using the definition of frailty that i outlined in my talk regarding an increased vulnerability to poor resolution of homeostasis following a stressor event, then theory you could consider immunosupressed patients as frail, however from a practical level it relates more to variability in functional status and ability to care for yourself without help rather than souly being biologically more likely to succomb to an infection, it's more about how that infection will then impact on your overall ability to function and whether becoming unwell will lead to a general downward cascade in your general health, functional and cognitive abilities. However, immunosupressed patients do often have a number of complex comborbidities which will increase their risk of being frail as per the paper by Clegg referenced at the beginning of my talk. Interesting question. Thanks.

When would you consider CT head in a frail pt presenting with new confusion/delirium and would you always consider CT head if hx of falls?

I would consider a CT head if delirium was associated with prolonged reduction in consciousness, associated with focal neurological signs or if there was no other clear cause/trigger after an extensive search although i would generally expect it to be negative. Yes in a history of falls I would have a low threshold for a CT head to check for evidence of subdural, although in the absensce of lareralising neurological signs this tends to be unlikely. The majority of CT heads performed in delirious frail patients do not show acute or causative pathology but it can be a useful negative diagnotic test in some cases.

Where do think specialist palliative care fits in with frailty?

I think there is lots of room for this, although at the moment services still tend to focus on single organ illness and cancer. Nursing homes are esentially hospices for frailty, and would I am sure benefit from input from palliative care speicialists. Level of interaction between palliative care and geriatric medicine varies depending on the system/hospital you work in and also the individual clinicians level of comfort with managing dying

patients and the time available for things like anticipatory care planning. Personally I have always found my colleagues in palliative medicine helpful and approachable when i have any difficulties, so if you are interested in colaborative working or getting advice, then pick up the phone. Most frail patients would trigger on the SPICT criteria which can help identify patients who will benefit from advanced care planning with a mind to palliation and holistic assessment of their needs.

Do you have experience in supporting POA inpatient units with assessing and managing frailty? I think we'd really benefit from doing this but don't have the same general/medical focus that MAUs / geriatric medicine has. (Your talk was amazing- thank you very much!)

Personally, not much, although my department is actually in the midst of developing a joint meeting with our POA colleagues to collaborate more closely, share difficult cases and generally build relationships and optimise the care we deliver within the hospital since the crossover is extensive and we frequently care for patients with very significant behavioural and psychological issues relating to dementia. I think this area is ripe for development and would love to see more input in places like the long stay dementia units and POA wards.