RCPE Medicine of the Older Person

11 March 2022

Optimising brain health: 'Aducanumab' or 'Adu-can't-umab'? - Professor Rob Howard

Q: Can we get aducanumab easily?

A: Not in the UK as far as I know. Straightforward in the US.

Q: Now with copyright for MMSE (which is used in most trials), which tool would you advise for clinical use?

A: I still use the MMSE or the MoCA.

Q: Should we be starting cholinesterase inhibitors and similar cognitive enhancers much earlier - at the stage of Cognitive Impairment?

A: Less evidence they have effect in mild AD but worth starting as part of giving the diagnosis and getting patients used to taking them while they are still early in the disease.

Q: We see people with amyloid cerebral angiopathy on our stroke wards - is there a role for aducanumab in other cerebral amyoidopathies?

A: Not been looked at but I would worry about ARIA in such individuals where the immune response might be stronger than AD.

Q: Do the adunumab trials suggest an alternative pathophysiology for AD?

A: They don't support that amyloid drives AD.

Q: Has the drug been licensed in Europe?

A: No

Q: Have we reduced dementia or delayed dementia with cardiovascular interventions

A: We've reduced the age-specific incidence of dementia. To me that is reducing dementia.

Parkinson's disease (PD) and acute illness - Dr Edward Richfield

Q: I find that referral to SLT when concerns re dysphagia frequently results in a 'nil by mouth' status for days on end - where does the balance lie then? safety from aspiration vs disempowering patients with regards to food/drink/tablets?

A: I think this requires discussion with SLT, how bad is the risk and do we think there is a reversible precipitant? If yes, then NGT likely the right thing, with a clear time frame for review, accepting that the swallow unlikely to recover completely and ay be in a EDAR scenario eventually. There are degrees of EDAR risk, so some recovery may still be important and prevent catastrophic swallow which also removes pleasure from eating. Of course a balance and needs to be aligned with patient wishes.

Q: Given the risks of anticholinergics for patients with PD (and others) how do you manage overactive bladder problems in these patients?

A: I tend to use a modern anticholinergic first that doesn't cross BBB, but still counsel about risk to cognition and to be alert for this. So....Trospium, Tolteradine or solifenacin. I believe trospium has best evidence for not crossing BBB so I go there forst, unless worried about other systemic anticholinergic effects as solifenacin is most specific for the bladder.

Osteoporosis - Dr Veronica Lyell

Q: In what clinical situations do you feel prophlaxis is inappropriate? Advanced old age? Multiple comorbidities? Immobility?

A: reductions in fracture risk start from abut 6 months, so if life expectancy confidently below that, I wouldn't start. But although 50% of men admitted to hospital won't survive a year, they are hard to distinguish from those who will. And background population mortality doesn't reach 50% a year until 104 years of age. So I err on side of treatment if tolerable. However, if renal function precludes bisphosphonates and comorbidities/immobility make monitoring and delivery of denosumab disproportionate, I then use vit D prophylaxis only.

Q: In younger/fitter people, how frequently BMD should be monitored by DXA?

A: In general every 3-5 years, but might be sooner if clinical risk factors change, or a fracture occurs on treatment after a year.

Q: If there is a several weeks / months delay before IV Zol can be given in the community, should we start oral therapy in the meantime?

A: Yes, that is very appropriate, assuming no CI. And consider supporting moves to improve access to iv zol services.

Q: Would you consider myeloma screen in patients with fragility fractures despite not having hypercalcemia, anemia or renal impairment?

A: In younger patients, esp men, without alternative contributors, probably yes, though the yield is obviously lower the fewer pointers there are.

Q: How strong is the case for using teriparetide to treat spinal osteoporisis in men who have not yet had a vertebral fracture?

A: I understand the evidence base for fracture reduction is low due to short studies, but likely equivalent to women. However, NICE guidance limits it to: men who are 65 years or older and have a T-score of –4.0 SD or below, or a Tscore of –3.5 SD or below plus more than two fractures, or who are aged 55– 64 years and have a T-score of –4 SD or below plus more than two fractures. i.e. can only use in extreme low BMD if have not fractured. no distinction is made between vertebral and appendicular fractures in accessing treatment however.

Q: Should there be overlap between denusomab and BP when denusomab treatment is ending?

A: I believe the ZOLARMAB trial is looking at this. Currently recommendations would be for BP at approx 6 months post last D'mab dose (ie as it is wearing off)

End stage renal disease - Professor Edwina Brown

Q: What about complications with PD in frail elderly, eg infections peritonitis etc at home?

A: Peritonitis rates with assisted PD in my own unit experience are no different to the whole patient group. The literature is varied with some studies showing higher infection rates and others lower compared to younger patients

Q: How many hours does it take? Is it overnight?

A: Model of supportive assisted CAPD requires 2 manual exchanges done during the day time; each exchange takes 30-40 minutes. Assisted PD can also be provided as automated PD (APD) with a cycling machine - the patient is then on the machine for an average of 9 hours; some are dependent on assistant visits for connection and disconnection, others may have family to help with connection and/or disconnection and the assistant just sets up the machine

Unintentional weight loss - Professor Margot Gosney

Q: How robust is serum albumen as a measure in assessment of patients with unintentional weight loss?

A: Albumin is generally pretty unreliable unless it is very low. Prealbumin is much more reliable but not measured routinely. Albumin may raise in acute illness so don't be fooled by a normal albumin if someone looks malnourished.

Q: What is your approach to investigation of unintentional weight loss?

A: Diagnose it first. Carefully quantify it and then look for cause. Remember that weight loss despite a good appetite triggers the need to exclude, DM, thyrotoxicosis and malabsorption. Other weight loss without a good appetite triggers a search for physical or psychological causes. Look carefully at number of calories consumed and then start to try to reverse.

Q: When I was a junior doc, I could just ask for a cooked breakfast for a patient. Now I have to go through a dietician, presumably for cost reasons, and someone has to go get it separately by which time it is cold. In a time of more and more financial pressures, how do we prioritize food?

A: We all need to push hard to work as a team including kitchen staff and porters. There is no easy answer just keep asking difficult questions and eventually people do take notice. I take menus and food to important meetings. Nothing like a senior member of staff serving hospital food to a government minister!

Q: What would you recommend; 5-6 small portions over the day or 3 meals with snacks?

A: 5-6 small portions. No one ever eats a full meal. They need to be varied and be seen as important as a medicine round.

Q: Is there a healthier but palatable diet for elderly patients? I'm very concerned about focusing on cakes, crisps and sugar laden food.

A: Yes there are many savoury dishes that can be fortified. Soup is a great example but so are baked potatoes ladened with protein toppings. Don't forget small pasta dishes that can be fortified but also contain vegetables and meat. No one wants to only serve sugar ladened foods but when someone is only eating 600Kcal post-surgery, I am happy to get calories in any way.