Screening for Geriatric Syndromes

Falls, Urinary/Fecal Incontinence, and Osteoporosis

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KEYWORDS

• Geriatric syndromes • Screening • Urinary incontinence • Fecal incontinence • Falls • Osteoporosis

KEY POINTS

- History of falls and fear of falling are clues that should trigger a multifactorial assessment of fall risk and targeted interventions to reduce falls.
- Urinary and fecal incontinence are common and underreported by patients. Simple screening questions, such as, "Do you leak or lose control of urine or stool?" can help trigger more detailed assessments and interventions.
- Screening for osteoporosis is indicated for women over age 65. Intervals for follow-up screenings are controversial and can be dictated based on initial test results and a patient's desire for treatment.
- The benefits of screening for osteoporosis in men are uncertain, but likely screening should be done at least once for men over age 70 or at high risk.
- The Fracture Risk Assessment tool can be used to determine which patients are at high risk and who should have bone mineral density screening.

INTRODUCTION

Given the high prevalence of geriatric syndromes and their typical multifactorial etiology, screening can be a high-yield part of a geriatric assessment or geriatric preventative care visit. Given the multifactorial nature of these syndromes, addressing a positive screening often involves a multipronged approach.[1] This article reviews screening for 3 such syndromes, which significantly affect quality of life and functional status of older patients: falls, incontinence, and osteoporosis.

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SCREENING FOR FALLS

Risk of falling and history of prior falls are important components of the geriatric assessment. In the geriatric population, falling and the fear of falling can have a tremendous effect on quality of life and independence.[2] Falls are a significant source of morbidity and mortality in the older adult. The Centers for Disease Control and Prevention (CDC) reports that in 2014 almost 30% of older adults reported a fall, and deaths in older adults due to falls numbered approximately 27,000.[3] The estimated Medicare cost for falls in 2015 was more than $31 billion.[4]

The etiology of falls in older adults is complex and often a combination of environmental factors and disease processes. Increasing age is itself a risk factor for falls. A 90 year old is up to 4 times more likely to fall than a 60 year old.[5] History of falls is a strong predictor of future falls.[6] Medical conditions with an increased risk of falling include lower extremity osteoarthritis, depression, heart disease, and nocturia.[5,7,8] Medications often associated with increased fall risk are sedating or affect gait and balance.[2]

Given how frequent falls are, how devastating the consequences can be, and the availability of interventions to reduce falling, it seems that there would be high-quality evidence for the benefits of screening for falls and who should be routinely screened for falls. Unfortunately, there is not any 1 screening test that has sufficient evidence to support its widespread use in identifying patients at risk of falling who would benefit from interventions to reduce future risk.[6] There is consensus based on expert opinion that screening for falls and risk of falls should be done, because evidence supports that interventions, such as exercise or physical therapy, have moderate benefit in fall prevention.[9]

In the recommendation statement of the U.S. Preventive Services Task Force (USPSTF) for fall prevention, in-depth screening for all community-dwelling older adults is not recommended due to lack of currently available evidence.[6] The USPSTF states that there may be a role for a multifactorial risk assessment in patients with history of falls and certain comorbid diseases, but that the small net benefit is only seen when this is combined with management of fall prevention.[6] In regard to gait and mobility tools in screening for fall risk, the USPSTF determined that there are no validated tools to predict falls, but that the Timed Up and Go Test and the Functional Reach Test predict fall risk and are practical in the constraints of a primary care office (**Box 1**).[6]

Box 1
Timed Up and Go Test and Functional Reach Test

Timed Up and Go Test

- Patients can use walking aid if needed.
- Patient starts sitting back in a standard arm chair.
- Mark off a line 3 m away on the floor
- Measure the time it takes the patient to stand up from the chair, walk to the line at a normal pace, turn, walk back to the chair, and sit down.
- Various cutpoints are used in research studies, but the CDC recommends greater than 12 seconds as a positive screen for a patient at high risk for falls.

Functional Reach Test

- Assesses a patient's stability by measuring the maximum distance an individual can reach forward while standing in a fixed position.
- Patient stands close to, but not touching a wall, with arm that is closer to the wall at 90° of shoulder flexion (reaching out) with a closed fist next to a ruler on the wall.