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Clinical Update on Nursing Home Medicine: 2015

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This is the ninth yearly update on clinical care in the nursing home. Topics covered this year are disease management in frail elders, heart failure, pneumonia, mild cognitive impairment, meaningful activities in the nursing home, atrial fibrillation, and anticoagulation.

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Disease Management in Frail Elders

Older adults in long-term care (LTC) are typically frail. Most have experienced geriatric conditions such as falls and urinary incontinence, as well as diseases such as hypertension (HTN), chronic obstructive pulmonary disease (COPD), heart failure (HF), diabetes (DM), atrial fibrillation (AF), and osteoporosis (OP). Although clinical guidelines exist for each chronic condition, guidelines typically have not accounted for the multiple concurrent conditions, or the advanced age and shortened life expectancy of frail elders. Adherence to evidence-based clinical guidelines in patients with multiple conditions can lead to polypharmacy as well as contradictory and potentially dangerous prescribing.¹ Prescription use for this population already reflects multimorbidity, with more than 70% of LTC residents receiving 9 or more medications.² In testimony to the challenge of adapting single-condition guidelines to older patients with multimorbidity, a 2015 “app” called “MCC GEMS” was developed to guide clinicians with a patient-centered approach.

However, chronic disease-management guidelines published within the past 2 years are starting to incorporate age and vulnerability, and thus have more applicability to frail patients. The topics in this review, culled from recent literature and professional society recommendations, were chosen because they include guidance that

may influence disease management of frail elders. Topics in this review include updates on current recommendations for managing HTN, hyperlipidemia, and chronic HF. An update from the 2014 Guideline on Non–ST-Segment Elevation Myocardial Infarction (NSTEMI) is included for prognostication as well.

Hypertension

The Eighth Joint National Committee (JNC 8) made 9 evidence-based recommendations for managing high blood pressure (BP), with only one specifically addressing adults 60 years and older.³ JNC 8 recommends that antihypertensive therapy should be initiated at 150/90 mm Hg in this age group to reduce BP to less than that value (grade A recommendation; ie, strong). If treated systolic BP (sBP) is lower than 140 mm Hg without adverse effects, it may be sustained (grade E recommendation; ie, based on expert opinion).³ The new guideline is appropriately more relaxed for older adults than the previous recommendation of lower than 140/90. However, it does not specifically identify the “young-old” who may be in their 60s and early 70s and who may benefit from more aggressive BP targets. The “old-old,” defined loosely as over 75 or 80 years, are more likely to be frail. The risk of adverse cardiovascular events may rise in the latter group when sBP is lower than 130 or diastolic BP is lower than 60 mm Hg.^{4,5}

Hyperlipidemia

The 2013 American College of Cardiology/American Heart Association (ACC/AHA) cholesterol guideline⁶ advocates using a new cardiovascular disease risk calculator. This calculator estimates the

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10-year risk for atherosclerotic cardiovascular disease (ASCVD), based on data from multiple community-based populations and applicable to African American and non-Hispanic white men and women 40 through 79 years of age. Primary prevention with a statin is encouraged for those with a 10-year risk of 7.5% or higher. The tool generated controversy from the moment it was announced, and may overestimate ASCVD risk by 67% in women and 86% in men.⁷ Additionally, the tool excludes the population 80 years and older, those most often encountered in LTC.

However, the guideline does offer new recommendations for adults 75 years and older, emphasizing optimization of tolerability and reduction in polypharmacy.

Additionally, the focus is on statin intensity rather than specific low-density lipoprotein (LDL) targets. This guideline discourages use of multiple drugs to lower cholesterol, specifically deemphasizing the adjunctive use niacin, ezetimibe, and fenofibrate for this purpose alone.

Emphasis on Tolerability

For the old-old (in general, older than 75 years), the guideline recommends reassessing statin choice and intensity according to pain, tenderness, stiffness, cramping, weakness, and fatigue (class IIa recommendation [“reasonable”], level of evidence B [“limited”]). Also recommended is reassessment of statin choice and intensity for patients older than 75 or for those taking multiple medications, drugs that alter metabolism, and conditions requiring complex medications (class IIa, level of evidence C [“very limited”]). For patients with confusion, statin and nonstatin causes should be considered as potential etiologies (class IIb [“consider”], level of evidence C). Of note, recent evidence suggests that the confusion thought to be associated with statin use may be more of a finding in older adults due to their cerebrovascular conditions rather than the drug itself.¹

Initiating high-intensity statin therapy is not recommended by the guideline for those older than 75; however, continuing such treatment is reasonable for patients already undergoing and tolerating the therapy for an appropriate indication. Initiation of moderate-intensity statin therapy in this age group is recommended for those with either clinical atherosclerotic cardiovascular disease or an LDL-cholesterol (LDL-C) level of at least 190 mg/dL.

For patients older than 75 without atherosclerotic cardiovascular disease, LDL-C less than 190 mg/dL, or with DM, no specific guidance is provided. In these groups, statin therapy may be initiated, continued, or intensified (class IIb, level of evidence C).

Reasonable Sodium Restriction

Although sodium restriction has been standard practice in HF for decades, restricting sodium in the elderly was given only a IIa (“reasonable”) classification, based on level C (very limited) evidence.⁸

Strong evidence exists that middle aged and young-old adults with HF (with preserved or reduced ejection fraction) should reduce their sodium intake by approximately 1 g per day or aim for a mean 24-hour urinary sodium excretion of approximately 2.3 g per day. However, little evidence exists to support a specific long-term target intake, and no evidence exists for “old-old” patients. Given the lack of evidence for feasibility or benefit for very low sodium intake, the “2-g sodium diet” may not be a blanket recommendation for all patients with HF. Rather, sodium restriction can be individualized to the response of the individual, optimizing medication use and liberalizing diet to prevent sarcopenia and nutritional deficits.

Heart Failure

Aldosterone antagonists have been recommended for moderate-to-severe HF (New York Heart Association [NYHA]⁹ III-IV) for some time.

ACC/AHA guidelines issued in 2013 also recommend them for mild HF (NYHA II).⁸

The Eplerenone in Patients with Systolic Heart Failure and Mild Symptoms (EMPHASIS) trial¹⁰ randomized 2737 patients, median age 69, with NYHA II HF and an ejection fraction of no more than 35% to receive the aldosterone antagonist eplerenone (up to 50 mg daily) or placebo, in addition to recommended therapy. The trial was stopped early after a median follow-up of 21 months when the treatment group was found to have a significantly lower risk of cardiovascular death or hospitalization for HF or for any cause.

Of note and concern to older adults, or those of any age with even mildly impaired renal function: hyperkalemia occurred in 11.8% of the eplerenone group versus 7.2% in the placebo group ($P < .001$). The high frequency of hyperkalemia in the placebo group may have been due to concomitant use of angiotensin-converting enzyme inhibitors. Caution with the use of either of the existing aldosterone antagonists in older adults is needed due to higher prevalence of renal impairment than younger adults.

Caution With Digoxin

Use of digoxin has been recommended in patients with HF with reduced ejection fraction (HFrEF) to reduce hospitalization,⁸ but more recent publications have raised questions regarding its safety and purported efficacy. One prospective study followed 2891 patients, mean age 69 years, with newly diagnosed HFrEF over 2.5 years, with 529 patients prescribed digoxin. The digoxin group had a higher rate of death (14.2 vs 11.2 per 100 patient-years) and HF-related hospitalization (28.2 vs 24.4 per 100 person-years).¹¹ The study was unable to determine if the digoxin level influenced the results, because approximately 30% of participants had no digoxin level drawn, and an additional 27% had only one level drawn during the time period of the study. For those with measured blood levels, the mean digoxin level for men was 0.83 ng/mL and 1.12 ng/mL for women. Risks and benefits of this particular medication should be weighed carefully.

Tension Between Guidelines

The higher threshold for HTN treatment and the lower threshold for statin therapy create tension between guidelines, and between guidelines and epidemiological data.

For example, the ACC/AHA ASCVD risk calculator predicts a 10-year risk of less than 7.5% in a 67-year-old woman without DM and with a favorable lipid profile, if sBP is 147 mm Hg. However, if the patient’s BP is 148 or 149 mm Hg and all the other variables were the same, the JNC 8 would **not** recommend initiating antihypertensives to reduce the risk of cardiovascular complications, but the ACC/AHA guidelines (Figure 1) **would** recommend preventive statin therapy for that purpose due to the effect of the BP value on the risk calculator.

Tension also exists between HTN guidelines and epidemiological data on HF. Multiple studies demonstrate a reduction in HF incidence with HTN treatment. A 70-year-old man whose systolic BP is 140 mm Hg has an approximate 15% lifetime risk of HF. If his sBP were 160 mm Hg, his lifetime HF risk is more than 50%.¹² If his sBP were 149, his lifetime risk of HF is between 15% and 50%, but the JNC 8 criteria do not recommend antihypertensive therapy to reduce the risk of cardiovascular complications.

Another example of tension between a guideline and epidemiological data is the incidence of white matter disease (WMD) burden and BP targets over time. The burden of WMD may be associated with the presence and degree of cognitive impairment. A longitudinal study of adults 80 years and older with a mean Folstein of 25.8 had the lowest burden of WMD when systolic targets were between 140 and 160 mm Hg.¹³ So an 80-year-old man may appear to tolerate an antihypertensive keeping his sBP at 130, but may develop more WMD

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