

CPD Online take-home notes

Basics of geriatric medicine

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Dizziness

- Dizziness is associated with depression and has a negative effect on the quality of life.
- Antipsychotics, anxiolytics, antiepileptics and antidepressants can cause dizziness.
- Life threatening causes of dizziness include hypovolemia, anaemia, cardiac dysrhythmia, myocardial infarctions, transient vertebrobasilar ischemia or stroke, infections and adverse effect from drugs.
- Patient education and support with assessment of the social situation, managing sensory deficits, walking aids, exercise with involvement of the physiotherapist and reviewing medications are extremely useful.

Syncope

- Medications, history of stroke or transient ischaemic attacks, cardiac illnesses and hypertension are the risk factors.
- ECG would be a sufficient investigation apart from routine blood investigations.
- Reviewing the medications, nutrition and hydration, treating the underlying illness and patient education regarding triggers are vital.

Falls

- Hip fracture from fall causes high rates of morbidity and mortality.
- Multifactorial risk assessment and management programmes are the most effective in the prevention of falls.

Urinary incontinence

- The most common form of urinary incontinence is urge incontinence.
- Urge incontinence in patients with dementia, stroke and Parkinson's disease requires behaviour therapy.
- Severe stress incontinence and overflow incontinence from obstructive disorders require urgent surgical referral.

Constipation

- Irritable bowel syndrome, sedentary lifestyle, diabetes mellitus, hypothyroidism, hypercalcaemia, neurological disorders such as Parkinson's disease, multiple sclerosis and stroke, sedentary lifestyle and drugs contribute to constipation.
- Dietary advice, exercise, bowel re-training and reviewing medications are the first line measures.
- Where osmotic and stimulant laxatives fail, enemas or suppositories should be tried.

Faecal incontinence

- Management of faecal incontinence involves patient education, routine scheduling, dietary modifications and use of continence aids.
- Incontinence clinics and nurse specialists play a very important role.

Calcium

- A rapid increase in calcium can lead to neuropsychiatric manifestations.
- A calcium level of >3.2 mmol/L requires emergency treatment to restore euvolemia.
- Acute hypocalcaemia is a medical emergency that requires intravenous calcium gluconate, whereas a symptomatic hypocalcaemia can be treated with calcium and vitamin D.

Potassium

- A hyperkalaemia associated with raised urea and creatinine is indicative of renal failure or Addison's disease, and hyperkalaemia in an impaired kidney can be precipitated by ACEIs, spironolactone or amiloride.
- There is a risk of developing ventricular fibrillation if >6.5 mmol/ L and requires emergency medical admission.
- The common causes for hypokalaemia are diuretics, GI loss from laxatives or diarrhoea, malnourishment, insulin and acute illnesses.

Sodium and urea

- Psychiatrists will come across hypernatraemia in dehydrated patients often with an acute illness.
- In acute renal failure there is a sustained increase in urea and creatinine.

Liver function

- Medications and alcohol are the most common causes of acute liver disease.
- Infection, GI bleeding or electrolyte imbalance can cause further deterioration and would require emergency treatment from gastroenterologists.

Hypertension

- According to the step-up therapy recommended by NICE the first line drug in the treatment of hypertension is either calcium-channel blocker or thiazide diuretic.
- ACE inhibitors are preferential in hypertension with diabetes, congestive heart failure, left ventricular hypertrophy and renal insufficiency.

Coronary artery disease

- Hyperthyroidism, anaemia or hypertension can precipitate an unstable angina or MI in a person with CAD.
- CAD is a medical emergency and requires admission to ICU.
- Oxygen, aspirin (unless there is a contraindication), nitrates would be essential in managing the patient during transfer to ICU.

Cardiac failure

- All patients with left ventricular systolic dysfunction should be offered ACE inhibitors and beta-blockers should be commenced following this as they reduce mortality and increase survival rate.
- All patients with CHF should be screened for depression.

Diabetes mellitus

- Physical examination should include measurement of weight, blood pressure, peripheral pulses, examination of skin, sensory system, visual acuity, examination for common infective foci and fundoscopy.
- Patients with cognitive impairment are prone to developing hypoglycaemia as they might forget food or accidentally take higher doses of antidiabetic treatment.

Cerebrovascular disease

- CT scan is however important in ruling out haemorrhagic stroke.
- Aspirin and dipyridamole are the mainstays of treatment with warfarin used for secondary prevention in patients with atrial fibrillation.

COPD

- Patient education and advice to stop smoking are important.
- Long-acting β_2 agonists or anticholinergics are the first line inhalers as per NICE recommendations. Inhaled corticosteroids are added to patients with a $FEV_1 <$

50% and who have exacerbations requiring treatment with antibiotics or steroids at least twice a year.

Osteoporosis

- Bone densitometry is used to establish diagnosis of osteoporosis and predict the risk of future fracture.
- For T scores less than -2.5 pharmacological therapy is indicated.

Thyroid dysfunction

- It is common for elderly patients to present with few of the typical symptoms.
- Rarely do elderly patients require more than 75 to 125 µg to treat hypothyroidism.
- Propylthiouracil and methimazole are the treatments for overt hyperthyroidism.

Anaemia

- Microcytic anaemia requires further investigation with OGDscopy and if necessary sigmoidoscopy.
- The sheet anchor is investigating and treating the underlying cause for microcytic, normocytic and macrocytic anaemias.
- Blood transfusion should be considered in patients with Hb less than 6 or patients in hypovolaemic failure.

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