The interface between psychogeriatrics and geriatric medicine is complex, particularly with overlapping presentations between physical and mental illness. Illnesses tend to have an atypical presentation with rapid progression, the history of the patient may be incomplete and rigorous examination may not be feasible. These factors impact on social welfare, causing greater morbidity and mortality.

A good understanding of the interplay between physical illnesses, medications and psychiatric manifestations is an essential skill for the old age psychiatrist to possess.

In this module, we have:

- suggested processes to interpret symptoms appropriately to arrive at a diagnosis
- offered a selective use of investigations to guide confirmation of diagnosis
- recommended management of common physical illnesses with criteria for the involvement of geriatric physicians.

Dizziness, syncope and falls

- Antipsychotics, anxiolytics, antiepileptics and antidepressants can cause dizziness.
- Medications, history of stroke or transient ischaemic attacks, cardiac illnesses and hypotension are the risk factors.
- Hip fracture from fall causes high rates of morbidity and mortality.
- Important management measures include:
  - multifactorial risk assessment
  - patient education
  - assessment and support of social situation
  - managing sensory deficits
  - walking aids
  - exercise with the involvement of a physiotherapist
  - dietary advice
  - monitoring hydration
  - reviewing medications.

Bowel and bladder

- Urge incontinence in patients with dementia, stroke and Parkinson’s disease requires behaviour therapy.
- Dietary advice, exercise, bowel re-training and reviewing medications are the first line measures in the management of constipation. Where osmotic and stimulant laxatives fail, enemas of suppositories should be tried.
- Management of faecal incontinence involves patient education, routine scheduling, dietary modifications and use of continence aids.

Laboratory investigations

- A rapid increase in calcium can lead to neuropsychiatric manifestations and acute hypocalcaemia is a medical emergency.
- Hyperkalaemia greater than 6.5 mmol/L is associated with ventricular fibrillation.
• Psychiatrists will come across hypernatraemia in dehydrated patients often with an acute illness.
• Medications and alcohol are the most common causes of acute liver disease.

Chronic illnesses (part 1)
• 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.
• CAD is a medical emergency and requires admission to ICU. Oxygen, aspirin (unless there is a contraindication) and nitrates would be essential in managing the patient during transfer to ICU.
• 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.
• Patients with cognitive impairment are prone to developing hypoglycaemia as they might forget food or accidentally take higher doses of antidiabetic treatment.
• Aspirin and dipyridamole are the main stays of treating ischaemic stroke with warfarin used for secondary prevention in patients with atrial fibrillation.
• Long-acting β2 agonists or anticholinergics are the first line inhalers as per NICE recommendations in managing COPD.

Chronic illnesses (part 2)
• Bone densitometry is used to establish a diagnosis of osteoporosis and predict the risk of future fracture.
• Rarely do elderly patients present with typical symptoms of hypothyroidism and they require no more than 75 to 125 µg to treat.
• Microcytic anaemia requires further investigation with OGDscopy and if necessary, sigmoidoscopy.

Further reading
British Hypertension Society. [website]
Nice guidelines. [website]