



The Geriatric 4Ms: towards Age Friendly Health Care

MENTATION

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Goals

1. Apply mentation assessment and management in the context of the Geriatric 4Ms
2. Prevent mentation problems in older adults
3. Utilize evidence - based tools for assessing mentation
4. Use non - pharmacologic and pharmacologic interventions to address mentation issues

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Case Study

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Case Study

- ▶ 67 year old female
- ▶ HTN, DM, HL, and CAD brought to the ED by her daughter for nausea, confusion, fatigue, and loss of appetite for 3 days.



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Case Study

- ▶ Patient felt sad since her sister passed away 6 weeks ago and was prescribed fluoxetine by her primary care physician 2 weeks earlier.
- ▶ On exam patient was lethargic, only oriented to place and person, and had slow speech.
- ▶ Laboratory studies revealed a serum sodium level of 124 mmol/L.

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What do you think is causing the patient's problems ?

Does the patient have

- ▶ Delirium ?
- ▶ Complicated depression ?
- ▶ Broken Heart syndrome (takotsubo cardiomyopathy) ?

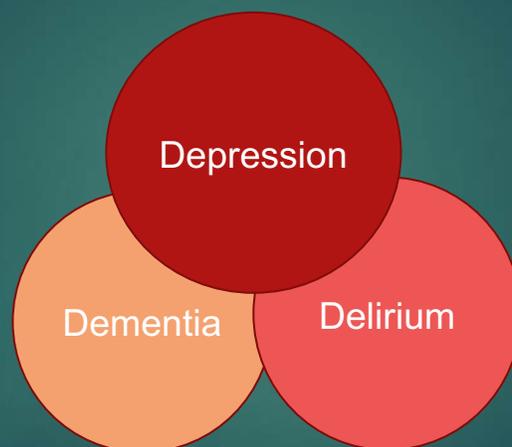
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Patient has grief

- ▶ Hyponatremia induced by SSRI
- ▶ Grief persists in most older adults with loss but *Complicated Grief* occurs when vegetative symptoms persist several months after a sentinel event

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Main domains: the 3D's



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Other mentation issues

- ▶ Safety / stress
- ▶ Anxiety
- ▶ Grief
- ▶ PTSD
- ▶ Loneliness / Social isolation



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Goal of addressing mentation

- ▶ Identify, treat and manage depression, dementia, and delirium
- ▶ Prevent the 3 Ds

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Advantages of asking 4Ms with each clinical encounter

- ▶ Prepares provider for discussion on prevention
- ▶ Prepares patient for prevention or revealing concerns
- ▶ Allows to update What Matters when circumstances change
- ▶ Defines when to transition from curative to palliative care

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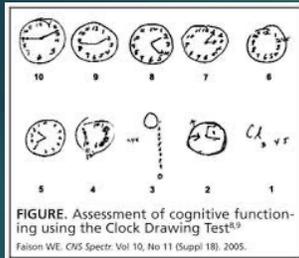


Screening for the 3D's

CAN BE EDUCATIONAL
AND PREP THE OLDER
ADULT FOR BRAIN
HEALTH

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Screen



Mini - cog

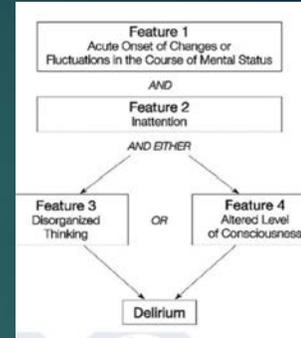
PHQ-2 Questions

Over the last 2 weeks how often have you been bothered by any of the following problems?

| | Not at all | Several days | More than half the days | Nearly every day |
|---|------------|--------------|-------------------------|------------------|
| Little interest or pleasure in doing things | 0 | 1 | 2 | 3 |
| Feeling down, depressed, or hopeless | 0 | 1 | 2 | 3 |

* A cut-off score ≥ 3 is positive

PHQ - 2



CAM

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How to manage screen positive and screen negative older adults

Screen Negative



Screen Positive



Non Rx



Rx

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How do we prevent the 3D's ?

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Prevention: dementia

Proven

- ▶ Blood pressure control
- ▶ Exercise
- ▶ Mind exercises



Likely

- ▶ Nutrition
- ▶ Social engagement



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Prevention: delirium

Proven

- ▶ Avoid anti – cholinergics
- ▶ Wean psychoactive Rx slowly
- ▶ Hydration
- ▶ Orientation
- ▶ Pain free
- ▶ Sleep hygiene

Likely

- ▶ Mobility

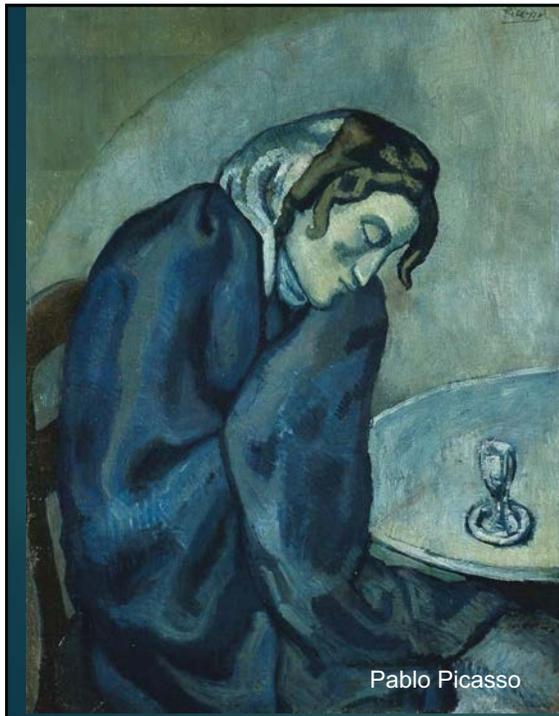
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Prevention: Depression



- ▶ Education
- ▶ Psychotherapy
- ▶ Nutrition
- ▶ Lifestyle
- ▶ Self - help manual with 6 clinic phone calls

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Pablo Picasso

Depression

Objectives

- ▶ Epidemiology
- ▶ Grief versus depression
- ▶ Screening
- ▶ Management

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Depression risk

sedentary, high BMI, alcohol use and smoker

Low vitamin D levels

Traumatic Brain injury

Caregiver status

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Depression

- ▶ 22% of men 65 +
- ▶ 28 % of women 65 +
- ▶ 85 % of these receive no medical help



Winslow Homer

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EPIDEMIOLOGY AMONG OLDER ADULTS

- ▶ **Minor depression**
 - 15% (range 8 - 40%)
 - Associated with
 - ↑ use of health services,
 - excess disability,
 - poor health outcomes,
 - ↑ mortality
- ▶ **Major depressive disorder**
 - 6%–10% of older adults in primary care clinics
 - 12%–20% of nursing home residents
 - 11%–45% of hospitalized older adults

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Late life depression



Atypical manifestations

- ▶ Weight loss
- ▶ Fatigue
- ▶ Somatic symptoms
- ▶ Bereavement

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3 Stages of bereavement



1. Numbness (weeks)
2. Depression (weeks to one year)
3. Recovery

P.J. Clayton **Bereavement**
E.S. Paykel (Ed.), Handbook of Affective Disorders, The
Guilford Press, New York (1982), pp. 403-415

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Bereavement Symptoms

No gender differences:

- ▶ Depressive symptoms
- ▶ Sleep disturbance
- ▶ Crying
- ▶ Anorexia
- ▶ Nervousness
- ▶ Concentration problems / poor memory

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Bereavement and Depression



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Risk factors for persistent depression



- ▶ Younger age
- ▶ Grief beyond 2 months
- ▶ Hx of major depression
- ▶ Depression at 7 months

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How to communicate with bereaved patients

- ▶ Have patient tell their story of loss
- ▶ Ask about positive memories
- ▶ Ask how things are different now
- ▶ Who helps the patient get through the day
- ▶ Any loss of resources or transportation ?

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Complicated Grief

- ▶ 7% of bereaved patients
- ▶ Maladaptive thoughts
- ▶ Dysfunctional behavior
- ▶ Emotionality



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Complicated Grief VS Depression

Complicated Grief

- ▶ Yearning
- ▶ sorrow
- ▶ preoccupying thoughts of the deceased
- ▶ difficult acceptance of death

Depression

- ▶ depressed mood
- ▶ anhedonia
- ▶ worthlessness
- ▶ psychomotor and neuro-vegetative symptoms

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A Clinical Trial of Complicated Grief Treatment

16 sessions

- ▶ Sessions 1 – 3: history, daily grief monitoring, education
- ▶ Sessions 4 – 9: memories and pictures
- ▶ Sessions 10 -16: imaginal conversation with deceased



[JAMA Psychiatry. \(2016\) 73\(7\): 685–694](#)

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Complicated Grief Treatment trial

- ▶ n = 395 (4 sites)
- ▶ Decedent Age = 53 +/- 14
- ▶ ~ 33% violent death (accident, suicide)

NNT = 3.6

SSRI did not improve outcome



[JAMA Psychiatry. 2016 Jul 1; 73\(7\): 685–694.](#)

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Geriatric syndrome: Late Life Depression

- ▶ Older adults may be preoccupied with somatic symptoms and less frequently report depressed mood
 - Among those who do not acknowledge sustained sadness, anhedonia for at least 2 weeks is necessary for a diagnosis of major depressive disorder

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Geriatric syndrome: Late Life Depression

- ▶ Diagnosis of depression in physically ill older adults is confounded by the overlap among symptoms of major depressive disorder and somatic illness
 - “Mood disorder due to a general medical condition” should be used for patients with depression that appears to result directly from a specific medical condition

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SCREENING

9-Item Patient Health Questionnaire (PHQ-9)

- 9 items cover diagnostic criteria for major depressive disorder
- Those who acknowledge thinking they would be “better off dead” or “hurting themselves” should be asked about presence of a firearm in the home
- Initial 2 questions (PHQ-2) can be used for screening
- Serial administrations can be used to reliably assess response to treatment

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SCREENING

| PHQ-9 score | Depression severity | Clinician response |
|-------------|---------------------------|--|
| 1–4 | None | None |
| 5–9 | Mild to moderate | If not currently treated, rescreen in 2 weeks. If currently treated, optimize antidepressant and rescreen in 2 weeks |
| 10–14 | Major depressive disorder | Start antidepressant therapy |
| ≥15 | Major depressive disorder | Start antidepressant therapy; obtain psychiatric consultation if suicidality or psychosis suspected |

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SCREENING

Geriatric Depression Scale (GDS)

- 15-items, Yes/No format
- Free of somatic and sleep queries
- Lacks suicidal ideation query
- Not useful for assessing treatment response

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Depression treatment

- ▶ 50% of patients with major depressive disorder respond to initial antidepressant treatment
 - Additional 1/3 recover when switched to another agent or combined with a second antidepressant or psychotherapy
 - 40-60% of those who recover experience recurrence
- ▶ Current approach to mood disorders in late life:
 - Aggressive acute phase of treatment to bring about remission
 - Continuation treatment for an additional 6 months after symptom remission to prevent relapse
 - Maintenance treatment to prevent recurrence

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Depression treatment

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First weeks of treatment.....

- ▶ 4 weeks is a milestone to predict who at 12 weeks will be nonresponders or partial responders
 - At 4 weeks, 1/3 will be nonresponders, 1/3 will have responded fully, and 1/3 partially
- ▶ A visit or phone call
 - ▶ first 10 days to insure adequate dosage and adherence
 - ▶ week 4 to identify non responders

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ANTIDEPRESSANTS

- ▶ Selective Serotonergic Reuptake Inhibitors (SSRIs)
- ▶ Selective Serotonergic and Noradrenergic Reuptake Inhibitors (SSRI/SNRIs)
- ▶ Tricyclic Antidepressants (TCAs)

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SSRIs

| Drug | Initial Dosage | Final Dosage | Comments/Precautions |
|--------------|----------------|----------------|--|
| Citalopram | 10 mg qam | 20 mg qam | Risk of Qtc prolongation in doses >20 mg, nausea, tremor, hyponatremia, serotonin syndrome |
| Escitalopram | 10mg qam | 10-20 mg qam | Nausea, tremor, serotonin syndrome; reduce dosage in renal insufficiency |
| Sertraline | 25mg qam | 100-200 mg qam | Nausea, tremor, insomnia, serotonin syndrome |

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SSRI and SNRI side effects

- ▶ hyponatremia with serum sodium of less than 130 mmol/L
 - ▶ 0.06% to 2.6% for SSRIs (e.g., fluoxetine)
 - ▶ 0.08% to 4.0% for the SNRI venlafaxine

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SSRI and SNRI side effects

- ▶ Falls and Fractures
 - ▶ Canadian study 6600 post menopausal women
HR 1.88 for fragility fractures

Osteoporos Int 2014;25(5):1473–81

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SEROTONIN SYNDROME

- ▶ Cognitive and behavioral changes: agitation, hyperactivity, worsening confusion, restlessness
- ▶ Diaphoresis
- ▶ Diarrhea and GI upset
- ▶ Fever usually $>100.5^{\circ}\text{F}$
- ▶ Hyperreflexia with or without myoclonus
- ▶ Incoordination, ataxia, or new onset falls
- ▶ Ocular clonus
- ▶ Rhabdomyolysis
- ▶ Shivering
- ▶ Seizures
- ▶ Tremor