



# The Geriatric 4Ms: towards Age Friendly Health Care

## MENTATION

1



## 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

2



## Case Study

3

## 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.



4

## 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.

5

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

Does the patient have

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

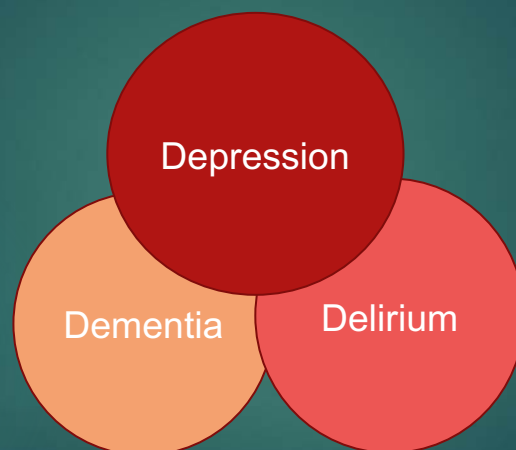
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## Patient has grief

- ▶ 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

7

## Main domains: the 3D's



8

## Other mentation issues

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



9

## Goal of addressing mentation

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

10

## 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

11

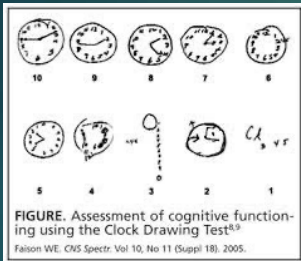


## Screening for the 3D's

CAN BE EDUCATIONAL  
AND PREP THE OLDER  
ADULT FOR BRAIN  
HEALTH

12

# Screen



Mini - cog

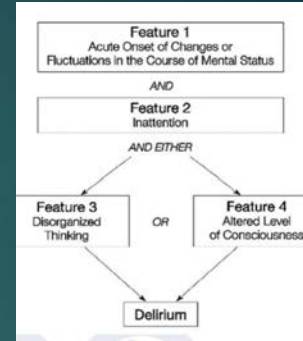
PHQ-2 Questions

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  $\geq 3$  is positive

PHQ - 2



CAM

13

# How to manage screen positive and screen negative older adults

Screen Negative



Screen Positive



Non Rx



Rx

14





How do we prevent the 3D's ?

15

## Prevention: dementia

### Proven

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



### Likely

- ▶ Nutrition
- ▶ Social engagement



16





## Prevention: delirium

### Proven

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

### Likely

- ▶ Mobility

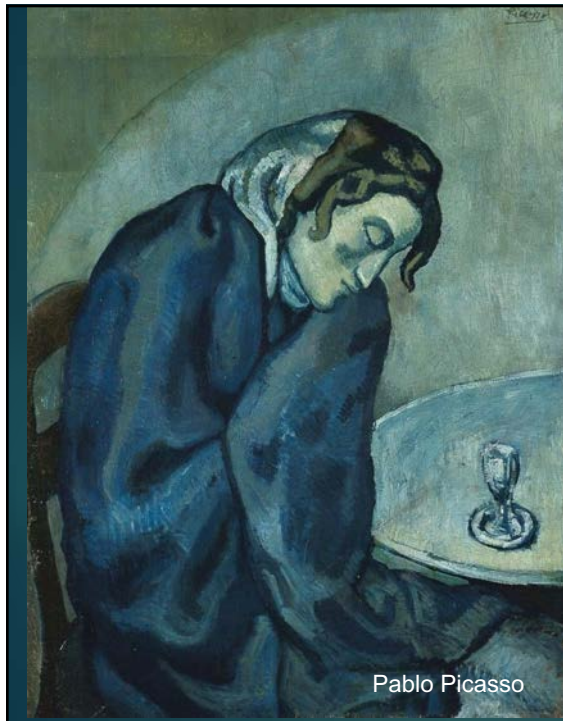
17

## Prevention: Depression



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

18



Pablo Picasso

## Depression

### Objectives

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

19

## Depression risk

sedentary, high BMI, alcohol use and smoker

Low vitamin D levels

Traumatic Brain injury

Caregiver status

20

# Depression

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



Winslow Homer

21

## 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

22

## Late life depression

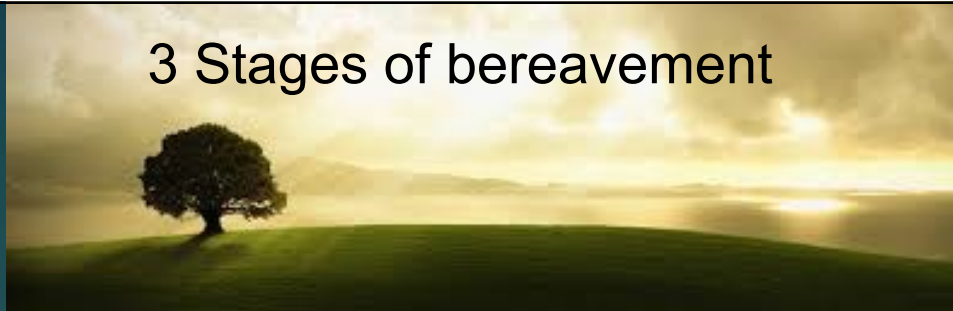


### Atypical manifestations

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

23

## 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

24



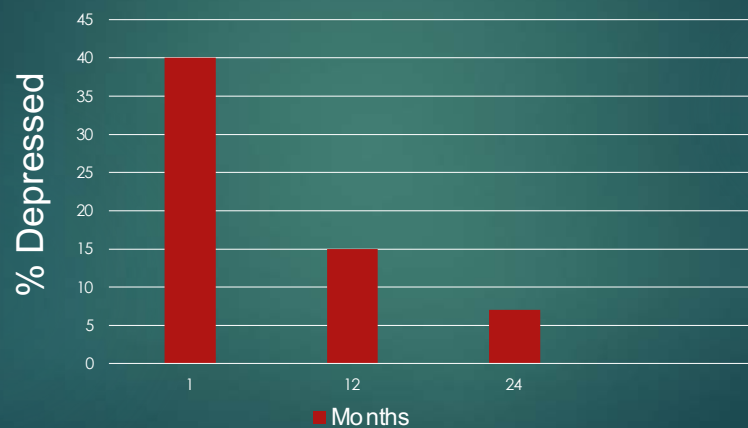
## Bereavement Symptoms

No gender differences:

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

25

## Bereavement and Depression



26

## Risk factors for persistent depression



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

27



## 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 ?

28



## Complicated Grief

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



29

## 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

30

# 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](#)

31

## 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.](#)

32



## 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

33

## 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

34

# 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

35

# 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

36

# 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

37

# 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

38

## Depression treatment

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39

## 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

40



# ANTIDEPRESSANTS

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

41

## 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

42

## 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

43

## 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

44

## 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