GP symposium 2022
Geriatric cases

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Geriatrician

COUNTIES MANUKAU HEALTH

Greenlane Medical Specialists

Case 1

- 70 year old female presented to GP Sept 21 with
  - 4-week history of headache, perceptual problems, unable to open gates, trouble with spelling, dressing apraxia
  - Long term memory preserved
  - Mildly reduced short term memory
  - MMSE by GP – slow serial 7, unable to spell “WORLD”, recall 2/3 items
  - Bloods normal
  - CT brain normal
  - Referred for further assessment ? Early dementia

PMHx

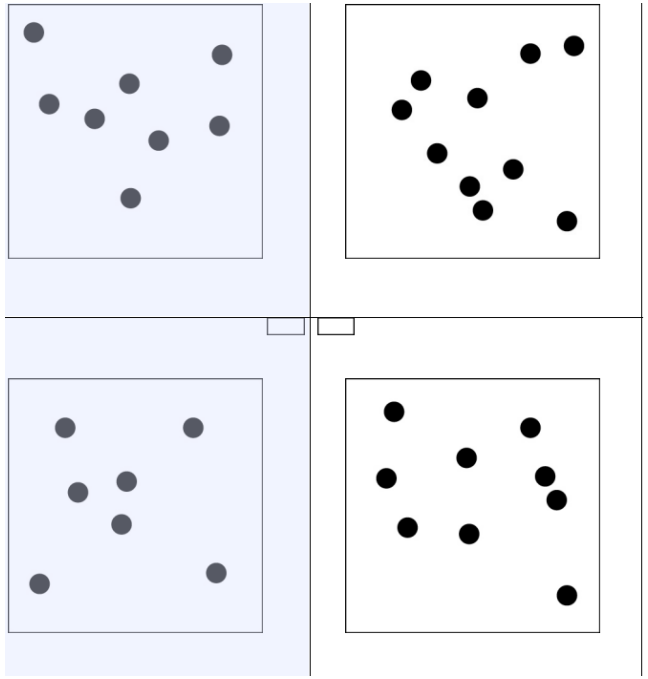
- Hypertension
- Osteoporosis
- Glaucoma

- Medications:
- Bendrofluazide, cilazapril, latanoprost eye drops

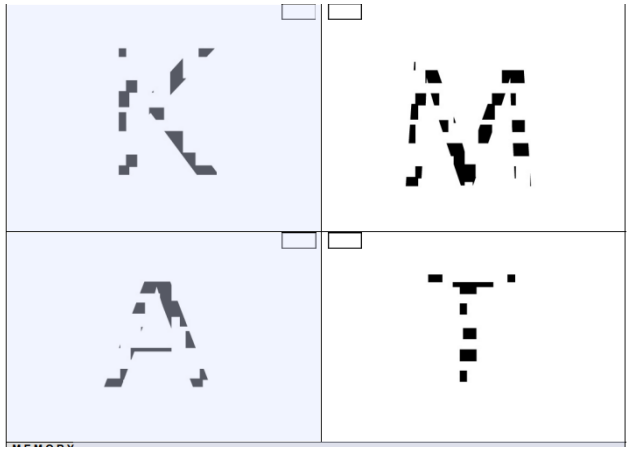
Background

- High functioning physiotherapist, retired early 2021
- Married, lives with husband
- No issues with memory and presented well clinically
- Noticeable rapid decline in function with difficulty with word difficulty (keen gardener and no longer able to name many of the plants/flowers). Unable to recognise ingredients while cooking. Putting cloth on wrong way.

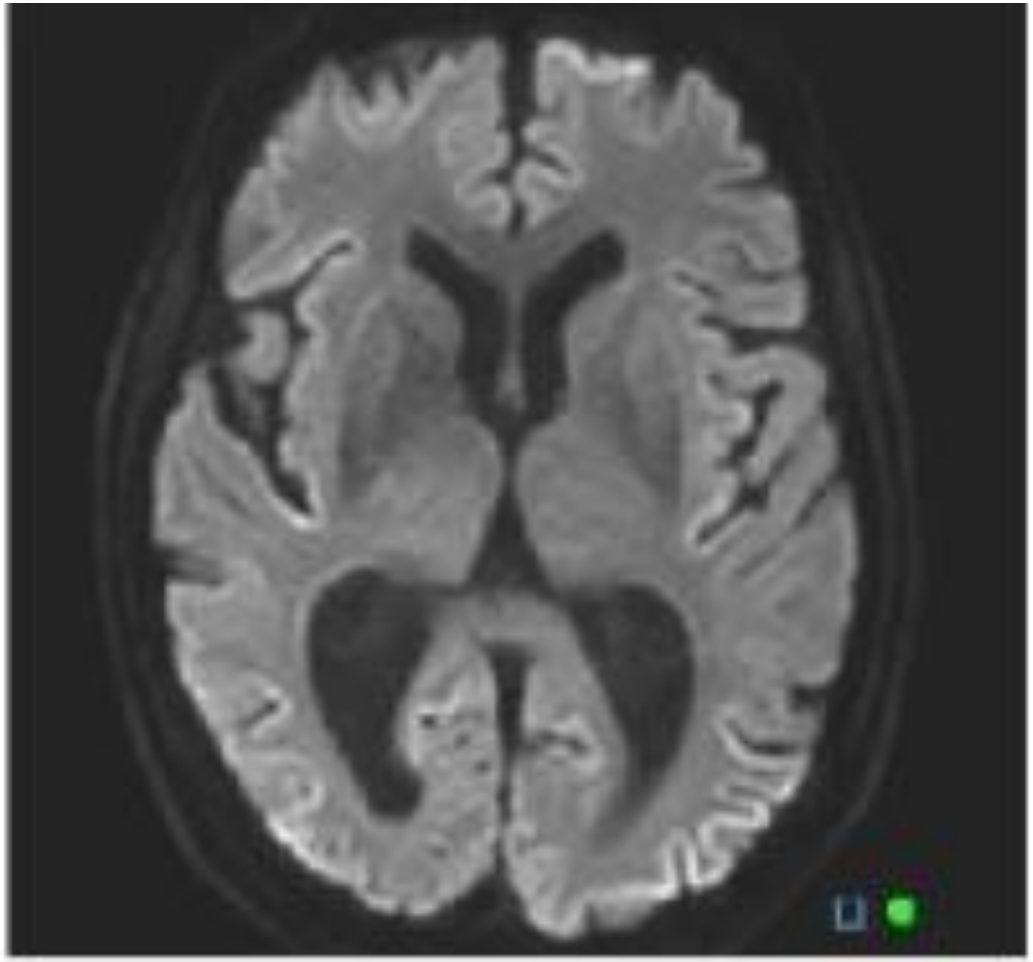
ACE-III 72/100

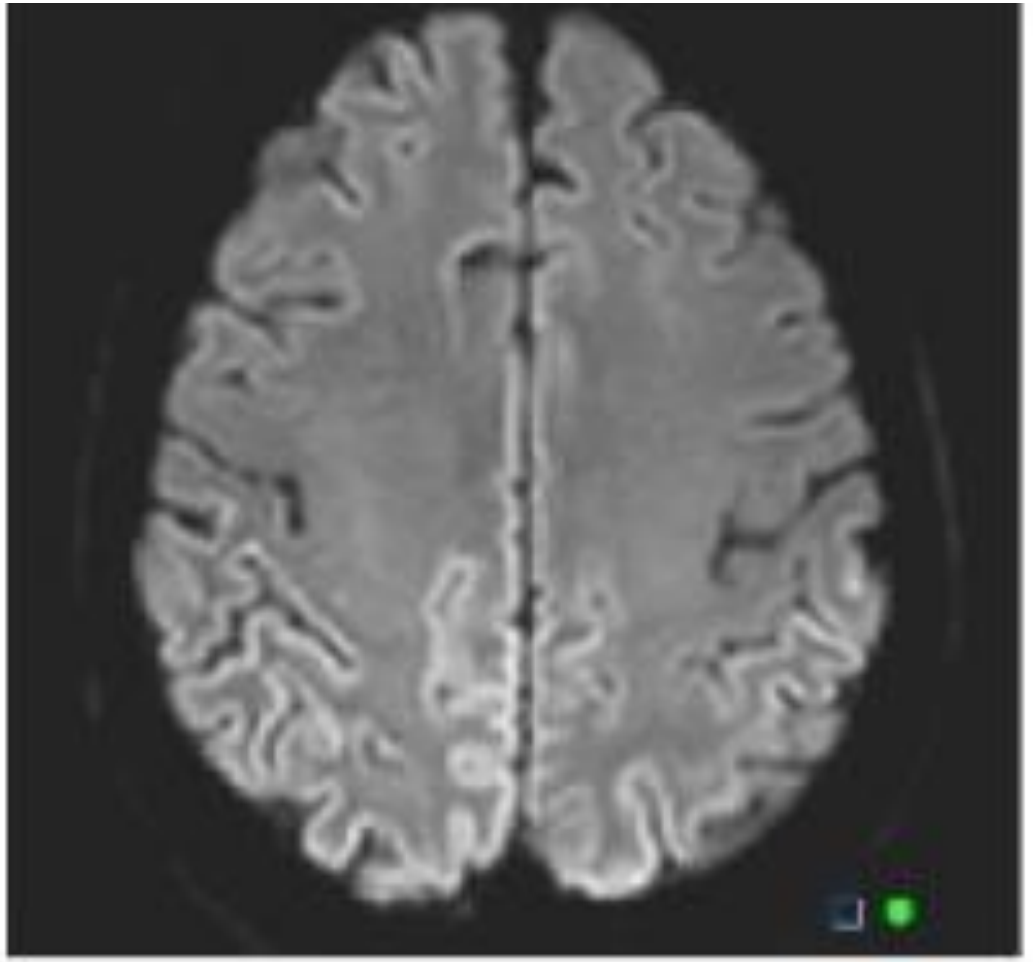


- Attention 15/18 (3 points for serial 7)
- Memory 21/26
- Fluency 7/14
- Language 21/26 (unable to name pictures)
- Visuospatial 8/16 (unable to count dots and recognise letters)



MRI brain





- Elective admission with neurology review, LP, EEG
- Autoimmune/paraneoplastic encephalitis unlikely (but part of differential)
- sCJD (Heidenhain variant)
- CJD registry and medical officer of health notified

CJD

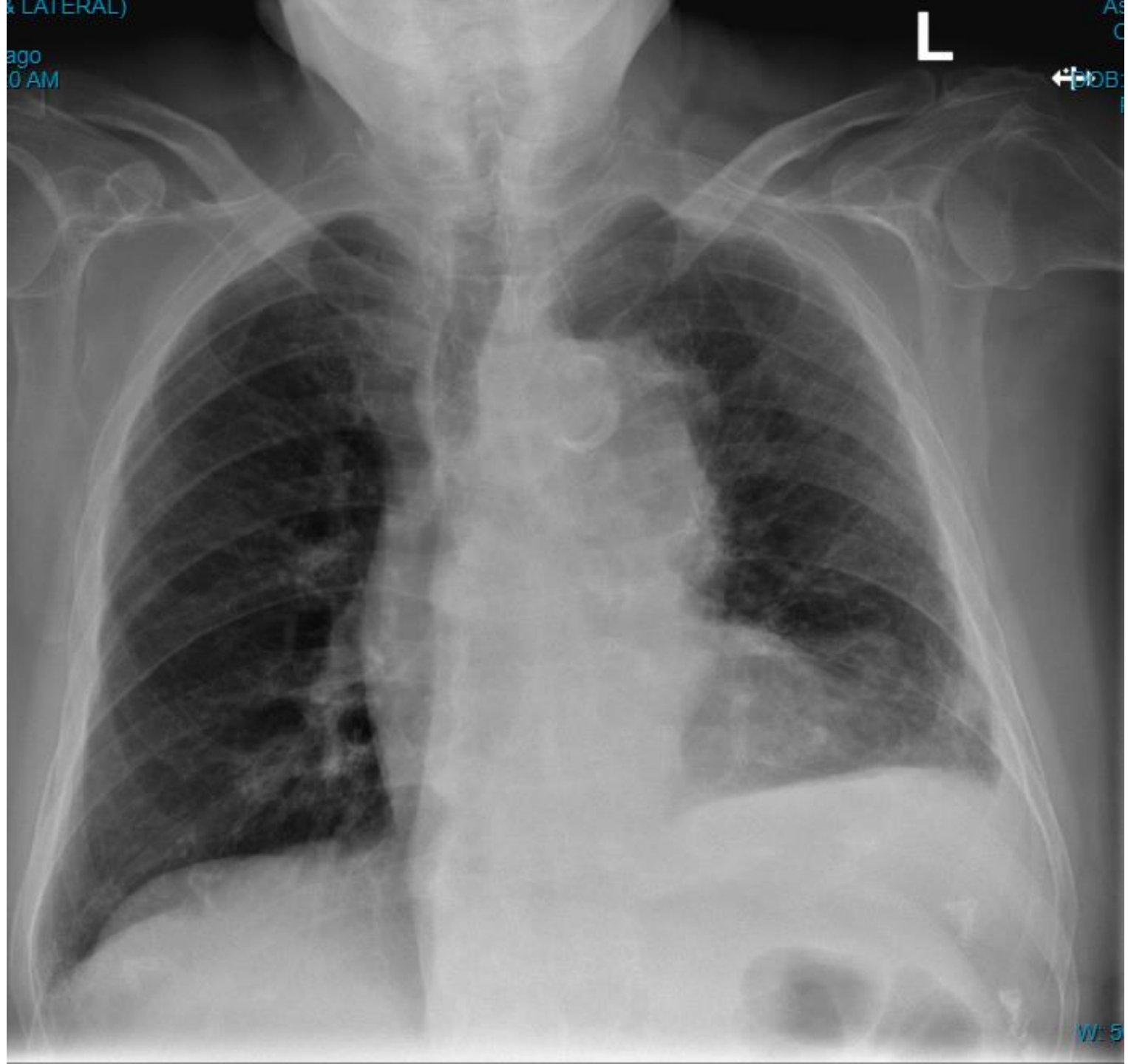
- Rare neurocognitive disorder due to prion disease
- Most cases are sporadic
- 1-2 per million
- No specific treatment and fatal within 12 month’s of symptom development

Key learnings

- Rapid progression over weeks is always a red flag
- CT brain may still miss pathology – good screen but MRI remain critical/essential for atypical cases
- Breakdown of cognitive testing and deficit is important (72 ≠ 72)

Case 2

- 99 year old Taiwanese man
- Initially referred for general unwell with high ferritin of 2000
- Clinical examination unremarkable
- Bloods – mild lymphopenia. Ferritin 2401 (normal 6 months prior), normal LFT, Ca, TFT, CK, myeloma screen. Cr 169 (stable). CRP 46
- BNP normal
- CXR suggest mild CHF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PMHx

- IHD – PCI 2000, nil symptoms since
- HT
- DM – HbA1c 53

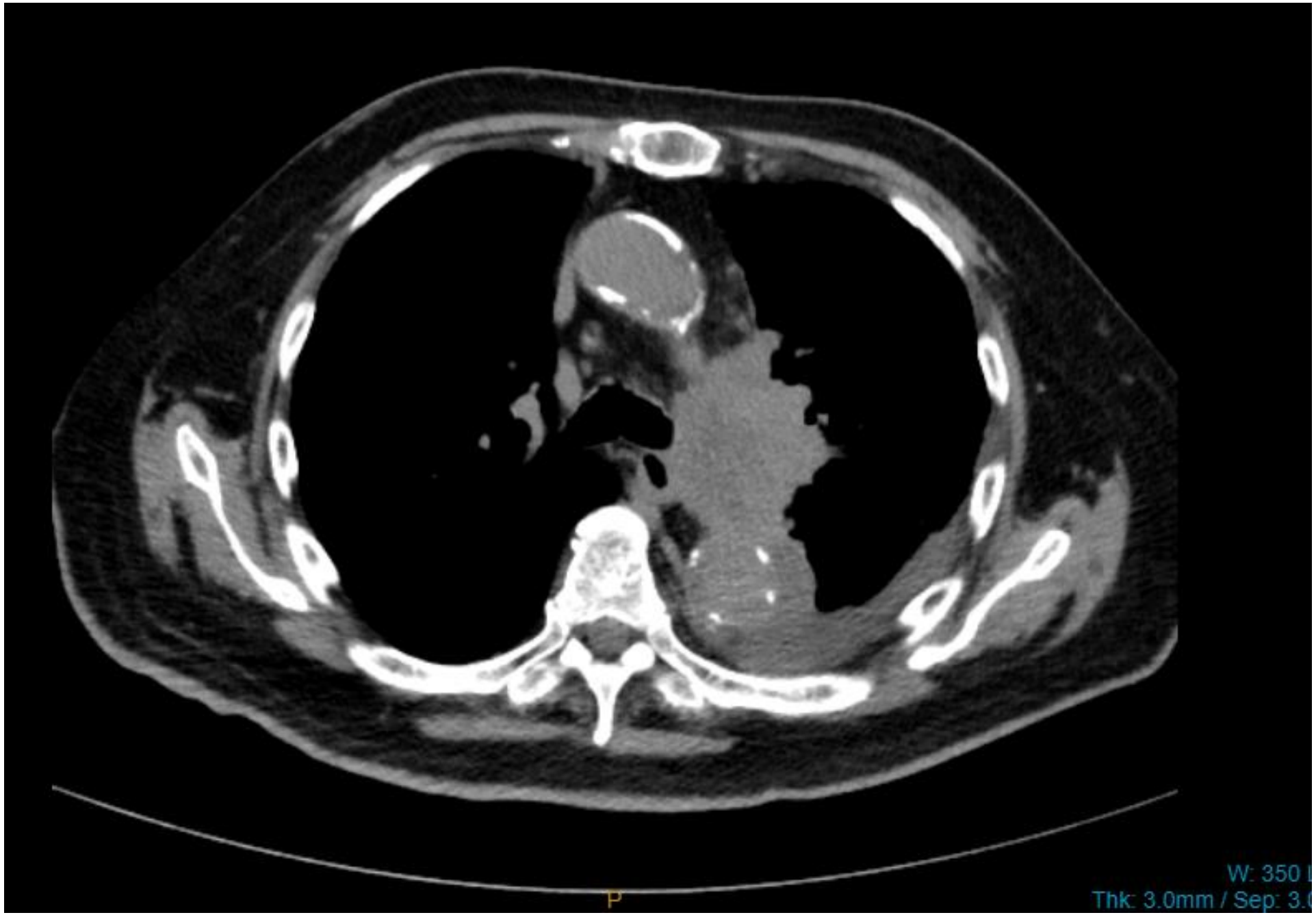
Function

- Completely independent. 2 months prior, lives with wife in large 2 storey house. Mobilised well with a stick. Can climb up stairs with ease. Attended all personal cares. No cognitive concerns.

- Rapid physical decline. Poor appetite with nausea and dysphagia. Often cough after food and drinks. New constipation without symptoms of GI bleed. 5kg weight loss. Now no longer able to climb stairs. Assistance with mobility and needing commode over 1 week period to get to toilet.

Examination

- Unrewarding apart from generally reduced strength and occasional basal creps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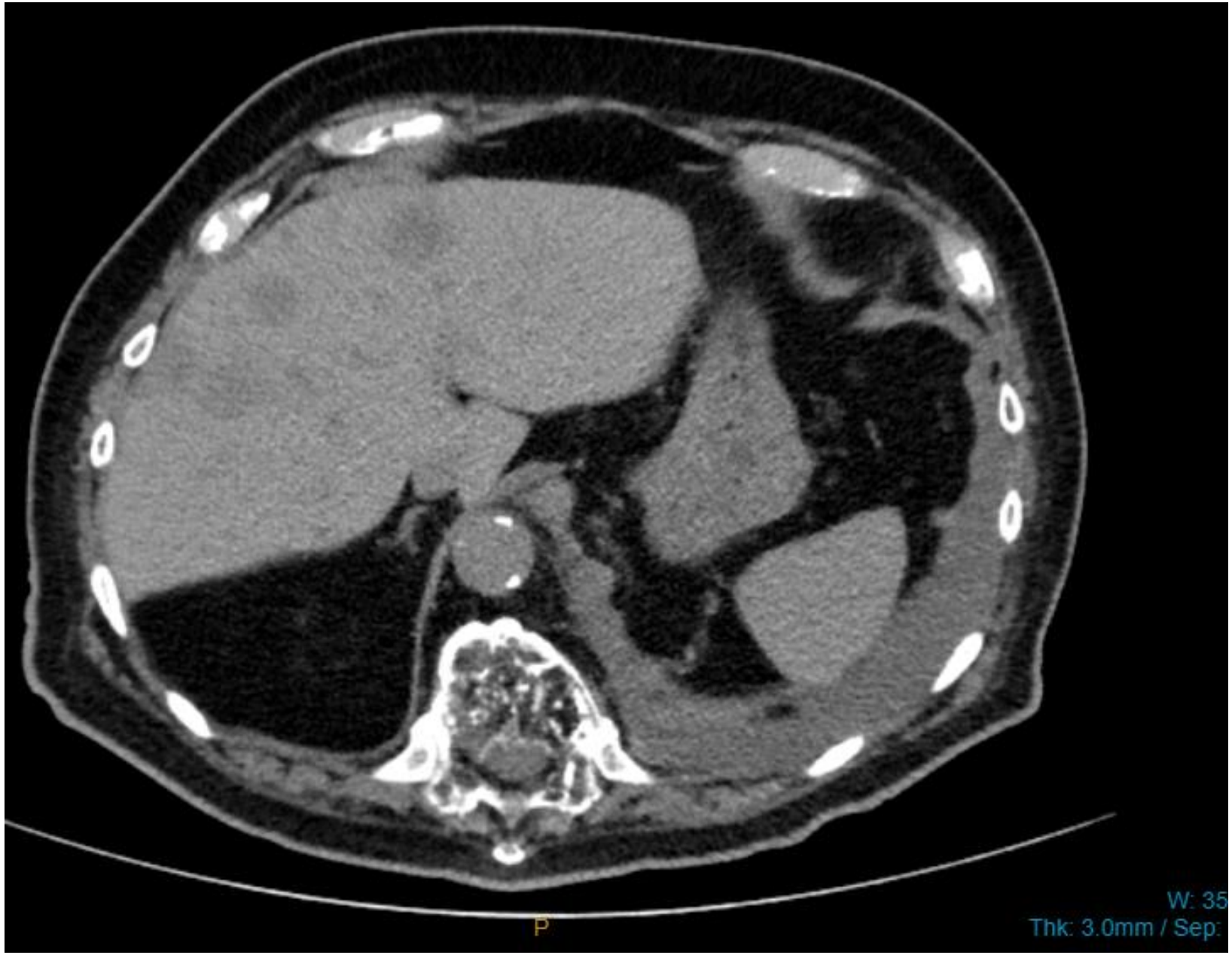
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- (presumed) lung cancer with liver and adrenal mets
- Referred to hospice, patient/family wanted to be at home and passed away 2 weeks later

Learning points

- Rapid clinical/physical decline are red flags (regardless of age)
- High level of suspicion even with “normal” plain Xray or bloods if clinical picture does not fit

Case 3

- 92 year old lady
- Acute ED presentation with 2 week history of intermittent slurred speech and diplopia
- No other localising neurological symptoms or clinical findings
- Mild leg cellulitis
- Family report episodes seems to occur after evening medications and often last 1-2 hours before slowly resolving
- CT head – normal
- Bloods shows new AKI (Cr increased from 60 ->120) – CrCL ~23ml/min

PMHx

- Recent d/c from rehab 1 month prior for multiple pelvic fractures
- Stage 3 CKD
- TAVI for AS 2012
- HT/dyslipidaemia
- COPD
- TSJR and THJR for OA
- Depression

Medications

- Aspirin EC 100mg daily
- Losartan 50/12.5mg daily
- Metoprolol CR 47.5mg daily
- Frusemide 20mg mane
- Atorvastatin 40mg nocte
- Omeprazole 20mg daily
- Citalopram 20mg daily
- Paracetamol 1g QID
- Pregablin 75mg BD
- Oxycontin 10mg BD
- Tramadol 100mg BD prn
- Celecoxib 100mg BD

Medication review

- At discharge, pain well controlled. Only using regular paracetamol and 1-2 dose of 2.5mg oxycodone liquid. Was previously on celecoxib and tramadol prior to fall (stopped during admission)
- Rapid escalation of pain relief with starting 2 weeks prior to admission
  - Oxycontin 10mg BD
  - Pregablin 75mg BD
  - Celecoxib 100mg BD
  - Tramadol 100mg BD prn

- Medication induced neurological symptoms and AKI

- Returned to baseline with rapid wean without significant pain or limitation to her physical function
  - Pregablin 25mg nocte
  - Oxycodone liquid prn
  - Cessation of celecoxib/tramadol

Pregablin

- Fully funded since May 2018
- Pharmacological action not fully understood and despite resemblance to gabapentin, action not related
- More rapidly absorbed and higher bioavailability
- Potentially more addiction risk
- UK data suggesting potential increased mortality (usually also with other analgesia in combination)

- NZMJ Vol 131 No 1478

Dose

- NZF recommend starting adult dose 75mg BD with adjustment for elderly or frail
- Also adjustment for impaired renal function
- No clear guide for dose conversion from gabapentin

- Pregablin 25mg = ~100mg TDS of gabapentin

- Go low and go slow

Case 4

- 77 year old Chinese lady referred for general unwell
- Nightsweats, palpitation, chest pain
- Multiple EC presentation without cause found

PMHx

- Intermittent CP – ETT, CTCA, echo normal 2018
- Recent acute glaucoma – require urgent surgical intervention
- Dry mucosa ? Sicca syndrome
- Labile hypertension – normal 24 hour AMBP
- Benign thyorid nodule – annual USS monitoring
- Dystonic head tremor – neurology
- Osteoprosis
- Dyslipidaemia

Meds

- Atorvastatin 20mg daily
- Amlodipine 2.5mg daily
- Fosamax plus weekly

History

- Initial presentation to EC with acute headache and dry/blurry eyes
  - Reassured and basic investigation/clinical exam NAD
  - Subsequent diagnosed with acute glaucoma requiring urgent surgery
  - Since surgery, general sense of worry with intermittent left sided numbness, tremor, tiredness, excessive sweating. Believes eating honey helps with these symptoms.

  - Lives with husband but limited family in NZ. House bound with little socialisation since COVID lockdown.

- Reports prone to been anxious. Diagnosed with severe depression in her 40s. Reacted badly to antidepressant but resolved with family support.

- anxiety/depression with disordered breathing/HVS triggered by glaucoma and COVID lockdown

- Referred to Asian family service for counselling and better breathing physiotherapist

Cross sectional cohort study NZ

- Data from first 10 weeks of COVID in NZ
- Depression and anxiety exceeded population norm
- Smoking, alcohol, underlying health condition highest risk
- Lower loneliness, exercise and pet ownership associated with lower risk of depression/anxiety

- Open BMJ

Kiwis seek comfort of pets during Covid, splash out on premium petfood

Bonnie Flaws Tina Morrison · 05:00, Nov 24 2020