J R Coll Physicians Edinb 2005; 35:153–155

St Andrew's Day Geriatric Medicine Symposium 2004

Y Abousleiman
Specialist Registrar, Department of Medicine for the Elderly, Royal Infirmary of Edinburgh, Edinburgh, Scotland

KEYWORDS Intermediate care, macular degeneration, osteoporosis, pain, Parkinson's disease, risk, statins

LIST OF ABBREVIATIONS Age-related macular degeneration (AMD), Parkinson's disease (PD)

DECLARATION OF INTERESTS No conflict of interests declared.

Correspondence to ***Y Abousleiman, Department of Medicine for the Elderly, Royal Infirmary, 51 Little France Crescent, Edinburgh, EH16 4SA***

tel. ***+44 (0)131 242 6927***

fax. ***+44 (0)131 242 6929***

e-mail ***yabousleiman@yahoo.co.uk***

Geriatric Medicine was the focus of the 44th St Andrew's Day Festival Symposium held at the Royal College of Physicians of Edinburgh on 2 and 3 December. Around 300 delegates from all over the UK and Ireland, and from multi-professional backgrounds, heard a varied programme which addressed both new advances and difficult issues within the specialty.

DAY 1

SESSION 1
PARKINSON'S DISEASE

The diagnosis and management of PD presents many challenges to practising geriatricians. The first session concentrated on three particularly difficult areas, namely the assessment of tremor, choice of medication and management of mental health problems. Dr Graeme Macphee (Consultant Geriatrician, Southern General Hospital, Glasgow) discussed the assessment of tremor in PD, highlighting potential pitfalls in diagnosis. The distinction between PD and essential tremor may be particularly difficult and new imaging techniques such as FP-CIT SPECT scanning may help in resolving uncertainty. Dr David Stewart (Consultant in Elderly Medicine, Mansion House Unit, Glasgow) followed by giving an overview of the current treatment options available in PD. Importantly, we were reminded that an individual approach to choice of treatment is required, and that age alone should not determine this decision. Dr Gillian McLean (Consultant Psychiatrist for the Elderly, Falkirk & District Royal Infirmary) gave a comprehensive overview of mental health problems in PD. Neuropsychiatric complications are both disease and drug induced and it is important to differentiate between them. New generation anti-depressants and anti-psychotics may prove useful in management, and patients with dementia may benefit from cholinesterase inhibitors.

SESSION 2
BALANCE AND VISION

Professor Bal Dhillon (Consultant Ophthalmologist, Princess Alexandra Eye Pavilion, Edinburgh) was asked whether there was new hope for old eyes. Good vision is a major determinant of both quality of life and the ability to function independently in older age. Age-related macular degeneration is the main cause of visual impairment in most developed countries and becomes exponentially more common with increasing age over 70 years. Untreated it can cause falls, depression, social isolation and increasing dependence. It is classified into two types: dry AMD and wet AMD. Wet AMD is rapidly progressive and causes severe visual loss, hence urgent referral for photodynamic therapy is essential. Modifiable risk factors include smoking, obesity and inactivity, hypertension and UV light exposure, indicating a key role for health promotion strategies. Genetic susceptibility to AMD has been identified, and further studies are ongoing in Scotland to characterise this link. Therefore, far from being a diagnosis of despair, there is new promise for the future.

The Marjorie Robertson Lecture was given by Professor Graham Mulley (Professor of Elderly Medicine, St James University Hospital, Leeds) on 'Intermediate or Indeterminate Care: Evidence based community rehabilitation'. Rehabilitation is best achieved by a comprehensive geriatric assessment involving a multidisciplinary team. After defining these terms he reviewed the origins of intermediate care, putting particular emphasis on the National Beds Enquiry and its implications for the future. Professor Mulley analysed the evidence base with a systematic review of all studies and trials involving admission prevention, early discharge and preventing and delaying long term care schemes. Most of the studies are methodologically unsound. More work is needed to evaluate the different schemes.

CME

SESSION 3
DEBATE

This house believes that use of statin treatment in the over 80s is inappropriate

This interactive debate with digivote entertained the delegates for this session. Professor Christopher Gray (Professor of Clinical Geriatrics and Associate Clinical Sub Dean, University of Newcastle upon Tyne) argued for the motion, initially highlighting the large volume of evidence that statins reduce coronary events, all cardiovascular events and total mortality. However, patients over 80 were not well represented in these trials. Although vascular disease is the single most important cause of death in the elderly, statins are less likely to be prescribed, mainly because most elderly patients have multiple co-morbidities and disabilities. Compliance and tolerability are major issues with only 26% of over 65s taking their statins regularly after five years. He argued that other modifiable interventions such as a healthy diet, control of hypertension and use of beta blockers post myocardial infarction have an equally strong evidence base and are more affordable.

Dr Chris Isles (Consultant Physician, Dumfries & Galloway Royal Infirmary, Dumfries) argued against the motion and contended that fit over 80s with vascular disease would benefit from statins. He reiterated the overwhelming evidence for the use of statins in vascular disease, although there is no evidence for their use in primary prevention in this age group. The digivote narrowly carried the motion, with 50·9% of delegates in favour.

CME

DAY 2

Chronic pain is often poorly understood, difficult to manage and impacts negatively on patient quality of life. These issues were addressed in the morning sessions.

SESSION 1
THE PAIN PROBLEM

Dr William Macrae (Consultant Anaesthetist and Pain Specialist, Ninewells Hospital, Dundee) gave a comprehensive overview of the physiology of pain from Descartes to the present day. In particular he encouraged the audience to be less judgmental in assessing pain, and more aware of recent advances in physiology and treatment modalities.

Dr Duncan Forsyth (Consultant Geriatrician, Addenbrooke's Hospital, Cambridge) addressed the difficulties associated with assessment of pain in dementia. Pain is common in older people but frequently under-reported, especially in the cognitively impaired. Decline in verbal communication skills with worsening dementia makes assessment very difficult, particularly as most pain assessment tools rely upon such skills. Untreated pain is associated with increased disability, depression, behavioural problems and worsening cognition.

Dr Barbara Dymock (Associate Specialist in Palliative Medicine, Roxburgh House, Royal Victoria Hospital, Dundee) discussed pain control in cancer, stressing the need for individual assessment. It is important to be able to recognise the symptoms and signs of opioid toxicity, which are more common in the elderly, but age alone should not be a barrier to the use of any therapeutic agent.

SESSION 2
CHRONIC PAIN IN THE ELDERLY

The lecture on 'Acupuncture and Pain' was presented by Dr Juliet Spiller (Consultant in Palliative Medicine, St John's Hospital and Marie Curie Hospice, Edinburgh). Acupuncture has been around for thousands of years, and has become a standard treatment in western clinics. There are clear benefits in some individuals, but potential problems with funding and lack of time for clinicians.

The Sydney Watson Smith Lecture was given by Professor Bruce Ferrell (Associate Professor, David Geffen School of Medicine at UCLA, Los Angeles). Professor Ferrell gave a wide-ranging review of the management of non-malignant pain. He encouraged use of both pharmacological and non-pharmacological approaches, and reminded us that new advances were constantly on the horizon.

SESSION 3
RISK MANAGEMENT

Dr Simon Maxwell (Consultant Physician, University of Edinburgh) addressed the commonly asked question 'but will it do me any good, Doctor?' Patients are increasingly involved in their own care, and improved education, changing attitudes and a political drive towards patient-centred care have resulted in more shared decision making. Patients often have preferences regarding their treatment, but need to be given sufficient information about the potential risks and benefits in order to make such decisions. Doctors need to be prepared for this changing aspect of medical practice and be equipped with scientifically reliable data and good communication skills. Visual treatment decision aid charts can be helpful in presenting risk/benefit data, and the use of warfarin in atrial fibrillation was presented as an illustration.

Dr David Oliver (Senior Lecturer, Elderly Care Medicine, University of Reading) reminded us that falls are common in hospitals and care homes and carry a significant amount of morbidity and mortality. However, many interventions are lacking in evidence, and there is a need for well-designed and appropriately powered clinical trials.

J R Coll Physicians Edinb 2005; **35:**153–155

Intervention should never be at the expense of promoting rehabilitation or patient autonomy.

SESSION 4
OSTEOPOROSIS

Dr Roger Francis (Reader in Medicine (Geriatrics), University of Newcastle upon Tyne and Honorary Consultant Physician, Freeman Hospital, Newcastle upon Tyne) discussed recent studies relating to calcium and vitamin D supplementation in older people. With advancing age there is reduced exposure to sunlight as well as a reduction in dietary vitamin D intake. This results in low levels of 25-hydroxyl vitamin D, with a consequent reduction in calcium absorption and bone strength. This in turn leads to an increase in body sway resulting in falls and fractures. There is good evidence that supplementation reduces the incidence of falls and non-vertebral fractures in elderly care home residents. However, the studies show conflicting results with regard to reduction of non-vertebral fractures in older patients. Results of these trials should not be extrapolated to patients who are concomitantly treated with bisphosphonates.

Dr Donald Farquhar (Consultant Physician, St John's Hospital, Livingston) presented a series of case studies which were put to the expert panel of Professor Stuart Ralston (Director of the Institute of Medical Sciences and Professor of Bone Metabolism, University of Aberdeen) and Dr Roger Francis (Reader in Medicine, University of Newcastle upon Tyne, Newcastle). Interaction from the audience was encouraged and the ensuing debate confirmed that there is often clinical uncertainty over the best management of frail older people.

ACKNOWLEDGMENTS

I would like to thank Dr Susan Pound for her help with this manuscript.

CME