RAPID BOARD REVIEW—KEY POINTS TO REMEMBER:

Hypertension
- Secondary analysis of major hypertensive studies in older adults finds a nadir for adverse cardiovascular outcomes of 130 to 140 mmHg for systolic blood pressure (sBP) and 80 to 90 mmHg for diastolic blood pressure (dBP).
- New guidelines for hypertension in older adults state that blood pressures below 130 mmHg for sBP and below 65 mmHg for dBP should be avoided, and that a target for sBP of 140 to 145 mmHg can be acceptable for those 80 years and over.

Falls
- Accidental falls are common in older patients, but high-risk patients can be identified in the office by asking them if they have fallen in the previous year or have a balance or gait problem.
- Interventions to reduce the risk of falls should always include the exercise triad: balance, endurance, and resistance training. T’ai chi is explicitly recognized as reducing the risk of future falls.
- Falls may be reduced if the number of medications can be reduced.
- Extraction of the first cataract may lower hip fracture risk in very old adults, particularly those with osteoporosis and severe cataracts.
- Vitamin D 800 to 1,000 units daily may reduce falls and fractures in elders.
- A health-care professional should assess the home to reduce fall risk; a handout that lists potential home hazards is insufficient.

Urinary Incontinence
- Nonpharmacologic therapies for urinary incontinence including behavioral therapies (e.g., patient continence logs, biofeedback, habit training) reduce the number of incontinence episodes in cognitively intact women with mixed (stress/urge) types of incontinence, often obviating the need for medications.
- Neurostimulation of the sacral nerve or the posterior tibial nerve may reduce the incontinence in those with urge or mixed incontinence intolerant to or not responding to medications and nonpharmacologic interventions.
- Consider bladder outlet obstruction causing overflow incontinence early in males with incontinence; a bedside postvoid residual can be helpful in diagnosing this condition.

Delirium
- An acute change in mental status with disturbed consciousness, impaired cognition, and fluctuating course is characteristic of delirium.
- Delirium in a hospitalized patient is a sign of a serious underlying illness and should be evaluated and managed promptly with attention to contributing factors.
- The risk of delirium in hospitalized older adults increases with age, cognitive impairment, vision impairment, poor nutrition or hydration, and severity of illness.
- Hospital delirium may be precipitated or maintained by the use of physical restraints, malnutrition in the hospital, prescription of more than three new medications or any psychoactive medication, use of a bladder catheter, or occurrence of any iatrogenic event.
- Hypoactive delirium may be mistaken for depression.
- The risk of delirium can be reduced 25% to 40% in acute care medical and surgical patients by nonpharmacologic interventions such as maintaining hydration, optimizing cognitive function, encouraging mobility, facilitating satisfactory sleep with nursing interventions, and providing hearing and vision aids as required.
- Treating contributing conditions (shared risk factors, such as generalized weakness, impaired mobility, and use of psychotropic medications) can reduce the incidence of falls, delirium, and urinary incontinence.

Ethics
- The Durable Power of Attorney for Healthcare is a very useful device when a patient lacks capacity, even temporarily.
- The Living Will as the sole advance directive has a very limited utility in most of the decision-making processes.
SUGGESTED READINGS


Sanders KM, Stuart AL, Williamson EJ, et al. Annual high-dose oral vitamin d and falls and fractures in older women: a randomized controlled trial. *JAMA*. 2010;303(18):1815-1822.


