OLDER PERSONS AGE 65+
SCREENING and INTEGRATED CARE CHECKLIST
For NEW ZEALAND GENERAL PRACTICE 2015

GENERAL PRACTICE **OTHER SERVICE**
+/- PRIMARY CARE REFERRAL

General Practice Topics below are an Overview only:
Excludes detailed history, examination, investigation, treatment

1 FUNCTIONAL SCREENING – May or may not be appropriate

'Assessment Tools' and 'Forms' and 'Allied Health Input'

Memory -- > Cognitive Screening (1) -- > Geriatric Team Input (2)

Activities Daily Living -- > Modified Barthel ADL Index (3) -- > Occupational Therapist
Home Help (4)

Falls -- > Falls Risk and Vitamin D (5) -- > Occupational Therapist
Physiotherapist

Incontinence -- > Continence Screening (6) -- > Continence Nurse
International Prostate Symptom Score (IPSS) (7)

Driving -- > Drivers Licence Form DL9 (8) -- > Occupational Therapist (9)
Mobility Parking Permit (10)

2 LIFESTYLE SCREENING – May or may not be appropriate

Nutrition & Exercise (11) -- > Dietary Advice -- > Dietician
Green Prescription Exercise e.g. Gym

Sleep (12) -- > Sleep Service

Relationship & Sexual Health -- > Counselling and/or Therapy

3 FAMILY INPUT – May or may not be appropriate

Family Support -- > Family Meeting -- > Social Worker
Elder Abuse Screen Respite Care
Supported Living Payment (13)

Financial and Legal -- > Advance Care Planning (14)
Enduring Power of Attorney -- > Legal Services
Will

4 IMMUNISATIONS (15) – May or may not be appropriate

Shingles Age 50+ (16)

Influenza Annual Immunisation Age 65+

Pneumococcal Vaccine Age 65

Tetanus/diphtheria Age 65

5 SENSORY SCREENING (17) – **May or may not be appropriate**

Vision
- Acuity
- Cataract
- Glaucoma (18)
- Macular Degeneration (19)

-- > Optometrist
Ophthalmologist

Hearing

-- > Audiologist
Otolaryngologist

Oral Health

-- > Dentist

Pain (20)

-- > Orthopaedics
Rheumatologist
Pain Service

Skin (21) -- > Actinic Keratosis, SCC, BCC, Melanoma (22) -- > Mole Map
Dermatologist/Surgeon

6 MEDICAL SCREENING – **May or may not be appropriate**

CVD Risk Assessment – includes Diabetes Screen (23) -- > Medical Physician

Peripheral Vascular Disease (24) -- > Vascular Clinic

Chronic Obstructive Pulmonary Disease (COPD) (25) -- > Respiratory Physician

Chronic Kidney Disease (26) -- > Renal Physician

Osteoporosis (27) -- > DEXA bone scan

Polypharmacy (28) -- > Pharmacist

7 CANCER SCREENING

– **May or may not be appropriate**
– **Excludes 'Skin Cancer' covered under Topic 'Skin'**

-- > Oncology
Palliative Care

Cervical Screening (29) -- > Cervical Smear

Breast Screening (30) -- > Mammography

Bowel Cancer (31) -- > Colorectal Surgeon

Prostate Cancer (32) -- > -- > Urologist

8 MENTAL HEALTH & ADDICTIONS SCREENING

– May or may not be appropriate

Mental Health including Loneliness and Social Isolation (33) -- > Psychogeriatric Team

Smoking (34) -- > Smoking Cessation Service

Alcohol and Drugs (35) -- > Alcohol and Drug Support

Gambling (36) -- > Gambling Support Service

9 ENTITLEMENTS and OTHER SUPPORT – May or may not be appropriate

Disability Allowance Form (37)

High User Health Card (38)

Medical Alarm (39)

Medical Alert Bracelet (40)

Ministry of Social Development www.msd.govt.nz

- Offers a number of different services for seniors.
- This is a comprehensive resource to describe these services and provide you with appropriate contact information.

Veterans' Affairs www.veteransaffairs.mil.nz

- There are a number of ways that Veterans' Affairs is able to support veterans financially through: Pensions, Entitlements and Reimbursements.

Age Concern www.ageconcern.org.nz

- Age Concern provides many services and support for elderly people in the community including:
  - Loneliness and Social Isolation
  - Elder Abuse & Neglect
  - Wellbeing
  - Housing and Care
  - Money Matters
  - Policy and Research

Energywise www.energywise.govt.nz

- "Warm Up New Zealand: Healthy Homes" provides free ceiling and underfloor insulation for people with health needs related to cold, damp housing.
- People with a Community Services Card living in a house that has occupants aged <18 or >65 years are eligible to apply, however, funding is limited and not all areas of New Zealand are covered.

OVERVIEW

- The purpose of the article, is to provide a checklist of common conditions and forms, General Practitioners may encounter when caring for older patients.

- To keep the article succinct, references are brief and may contain:
  - A URL (website address) which will direct the reader to a more detailed explanation of the topic
  - Listed bullet points maybe useful in clinical practice and/or cause significant patient morbidity e.g. Nutrition & Exercise, Urinary Incontinence

- ORANGE HIGHLIGHTED - is a form (hard copy or online) that maybe completed by the General Practitioner for an external agency

REFERENCES and EXPLANATORY NOTES

(1) Cognitive Screening

Reference: www.healthpointpathways.co.nz
Management of Cognitive Impairment Clinical Pathway

- Northern Region Clinical Pathway for the Management of Cognitive Impairment is adapted from Canterbury HealthPathways Cognitive Impairment www.canterburyinitiative.org.nz and the Waitemata DHB Pathway.

(2) Geriatric Team Input

Reference: www.bpac.org.nz June 2015
Prevention is better than cure: five tips for keeping older people healthy and out of hospital during winter

- Many geriatric units offer both inpatient and outpatient care, with a multi-disciplinary team including doctors, nurses, occupational therapists, physiotherapists, pharmacists, speech language therapists, dietitians and social workers.

(3) Modified Barthel Activities of Daily Living Index

Reference: Oxford Handbook of General Practice 3rd edition
Form accessible from home page of website www.nzgpwebdirectory.co.nz
Disclosure – website created by author

- Measure of physical disability used widely to assess behaviour relating to activities of daily living for stroke patients or patients with other disabling conditions. It measures what patients do in practice.
- Assessment is made by anyone who knows the patient well.
  - A total score less than 15 usually represents moderate disability
  - A total score less than 10 usually represents severe disability

(4) Home Help

Reference: www.bpac.org.nz June 2015
Prevention is better than cure: five tips for keeping older people healthy and out of hospital during winter

- The aim of care is to support older people in maintaining their independence and quality of life.
- Assistance is available for personal care (e.g. showering, dressing, medicine management), household support (e.g. preparing meals, housework) and equipment to make the home safer, as well as support for carers.
- To access some of these services, the person must be a New Zealand citizen or resident who is eligible for publicly funded health or disability services and must undergo an assessment performed by the DHBs Needs Assessment Service (NASC) agency.
- Referral to the NASC agency can be initiated by anyone involved in a patients care, including the person themselves, family members/friends or a clinician.

(5) Falls

Reference: www.bpac.org.nz April 2015
Stand up to falls - April Falls month and the Health Quality & Safety Commission's reducing harm from falls campaign
Contributed by the Health Quality & Safety Commission

- Falls are the most common and costliest cause of injury in older people, with around 30 – 60% of people aged 65 and over falling each year and 10 – 20% of those falls resulting in injury such as hip fracture, hospitalisation or death.
- The Commission – through its falls programme as well as April Falls and the campaign focus on falls – supports and encourages a number of proven preventive measures that can be integrated into routine health care.
  These include:
    - Exercise programmes, such as the Otago Exercise Programme, and group exercise classes, such as tai chi, which can reduce falls by 30–40% in older people living in the community
    - Vitamin D prescribed for those at risk of vitamin D deficiency
    - Home safety assessments and modifications where necessary
    - Individually targeted multi-factorial interventions

Reference: www.bpac.org.nz August 2015
Stay Independent Falls Prevention Toolkit

- The Stay Independent Falls Prevention Toolkit is an aid for Primary Care Teams for the assessment of an individual's risk of falling, including practical strategies to reduce this risk.
- The toolkit is based on the STEADI falls campaign developed by the United States Centers for Disease Control and Prevention (CDC), and has been adapted for use in New Zealand by bpac^{nz} in association with the Health Quality & Safety Commission.

- Screening for falls risk involves asking three simple questions which quickly cover several important points:
    - Have you slipped, tripped or fallen in the last year?
    - Can you get out of a chair without using your hands?
    - Are there some activities you've stopped doing because you are afraid you might lose your balance? Do you worry about falling?
- A positive answer to any one of these three questions above leads to multi-factorial risk assessment and intervention.

(6) Continence Screening

Reference: www.bpac.org.nz October 2013
Urinary incontinence in adults

- Approximately 10% of people experience urinary incontinence at some point in adulthood, and incidence increases with age. Incontinence is approximately six times more common in females than in males.

Reference: www.nhs.uk

- The causes of Urinary incontinence maybe categorized broadly into 4 categories:
    - (i) Stress
        - Stress incontinence occurs when the pressure inside your bladder as it fills with urine becomes greater than the strength of your urethra to stay closed (the urethra is the tube through which urine passes out of your body).
        - Any sudden extra pressure on your bladder, such as laughing or sneezing, can then cause urine to leak out of your urethra.
    - (ii) Urge
        - The urgent and frequent need to pass urine can be caused by a problem with the detrusor muscles in the walls of the bladder. The detrusor muscles relax to allow the bladder to fill with urine, then contract when you go to the toilet to let the urine out.
        - Sometimes the detrusor muscles contract too often, creating an urgent need to go to the toilet. This is known as having an 'overactive bladder'.
    - (iii) Overflow
        - Overflow incontinence, also called chronic urinary retention, is often caused by a blockage or obstruction to your bladder. Your bladder may fill up as usual, but as it is obstructed you will not be able to empty it completely, even when you try.
        - At the same time, pressure from the urine that is still in your bladder builds up behind the obstruction, causing frequent leaks.
    - (iv) Total
        - Total incontinence occurs when your bladder cannot store any urine at all.
        - It can result in you either passing large amounts of urine constantly, or passing urine occasionally with frequent leaking.
        - Total incontinence can be caused by:
            - A problem with your bladder from birth

- Injury to your spinal cord, which can disrupt the nerve signals between your brain and your bladder
- A bladder fistula, which is a small tunnel-like hole that can form between the bladder and a nearby area, such as the vagina, in women

- Some medicines can disrupt the normal process of storing and passing urine, or increase the amount of urine you produce. These include:
  - Angiotensin-converting enzyme (ACE) inhibitors
  - Diuretics
  - Some antidepressants
  - Hormone replacement therapy (HRT)
  - Sedatives
- Stopping these medications, if advised to do so by a doctor, may help resolve your incontinence.

(7) International Prostate Symptom Score (IPSS)

Reference: www.wikipedia.org
Form accessible from home page of website www.nzgpwebdirectory.co.nz
Disclosure – website created by author

- The International Prostate Symptom Score (IPSS) is an 8 question (7 symptom questions + 1 quality of life question) written screening tool used to screen for, rapidly diagnose, track the symptoms of, and suggest management of the symptoms of the disease benign prostatic hyperplasia (BPH).

(8) Drivers Licence Form DL9

Reference: www.nzta.govt.nz

- ***Medical aspects of fitness to drive*** - A guide for medical practitioners (published July 2009) can be downloaded from website.
- This guide is to assist medical practitioners in assessing the fitness to drive of any individual. It also sets out the responsibilities and obligations of medical practitioners.

(9) Occupational Therapist

Reference: www.otnz.co.nz

- The Occupational Therapy New Zealand website allows you to find a therapist who performs Driver Assessments in your area.

(10) Mobility Parking Permit

Reference: www.mobilityparking.org.nz

- The Mobility Parking website allows you to download an application form, or complete an online application form for a Mobility Parking Permit.

(11) Nutrition & Exercise

Reference: www.bpac.org.nz June 2015

Prevention is better than cure: five tips for keeping older people healthy and out of hospital during winter

Assessing nutritional status

- In older people, the term malnutrition is generally used to describe under-nutrition as a result of insufficient macro and/or micronutrient intake from the diet, and is often more of a concern than obesity in this age group.
- Malnutrition is associated with a number of negative health outcomes including increased infection rates, muscle wasting, impaired wound healing, longer hospital stays and increased morbidity and mortality.
- Strategies for detecting poor nutrition in older people include:
    - Routinely ask patients what their usual diet is like, what they have eaten in the past few days and if they have any concerns about their food intake.
    - Ask patients if they have noticed any change in their bodyweight and regularly weigh patients to detect changes over time.
    - Ask about appetite and consider underlying causes for poor appetite, e.g. pain, depression, social isolation, reduced sense of taste or smell, adverse effects from medicines.
    - Ask about any oral health issues which may be affecting eating, e.g. poorly fitting dentures, tooth ache, gum disease, ulcers.
    - Consider other reasons for difficulties in eating, e.g. weakness or arthritis in the hands or arms, confusion, dementia, COPD.
    - If there is any uncertainty about a patient's nutritional status, consider using a formal assessment such as the Malnutrition Universal Screening Tool (MUST).
    - Laboratory investigation is not required for diagnosing malnutrition, however, testing may be indicated in some patients to detect specific deficiencies, e.g. iron, folate, vitamin B12.

Exercise can reduce the risk of falls

- Physical activity can increase muscle strength, flexibility, balance and coordination, therefore reducing the risk and harm from falls.
- All adults should be encouraged to undertake moderate intensity aerobic activity for at least 30 minutes per day, on most days of the week.
- Older people should also aim for their weekly exercise to include at least three sessions of flexibility and balance activities and two sessions of muscle-strengthening (resistance) activities.
- Exercises that combine more than one type of physical activity are ideal, e.g. Tai Chi (resistance, flexibility, balance), swimming/aqua aerobics (aerobic, resistance), bowls (flexibility, balance) or golf (aerobic, resistance, flexibility, balance).
- For frail older people, any level of physical activity and reduction in sedentary behaviour is beneficial. Low-intensity resistance exercises such as "chairobics" and repeated sit-to- stand exercises can be suggested.

(12) Sleep

Reference: www.bpac.org.nz August 2015
Melatonin: Is it worth losing any sleep over?

- Sleep disturbances are reported to affect 10–50% of patients presenting to primary care clinics in New Zealand, depending on the definition that is applied.
- People should expect some small changes in the amount of sleep they have as they get older, even in the absence of sleep problems.
- Studies show that total sleep duration decreases by approximately ten minutes per decade of age, and cohorts of adults aged 55 years and older consistently report sleeping an average of seven hours per night.

(13) Supported Living Payment

Reference: www.workandincome.govt.nz

- Supported Living Payment is assistance for people who have, or are caring for someone with a health condition, injury or disability.
- You may be able to get the Supported Living Payment if you are:
    - Permanently and severely restricted in your ability to work because of a health condition, injury or disability, OR
    - Totally blind, OR
    - Caring full-time for someone at home who would otherwise need hospital-level or residential care (or equivalent) who is not your husband, wife or partner.
- You must also be a New Zealand citizen or permanent resident who normally lives here, and who has lived here for at least two years at one time since becoming a New Zealand citizen or permanent resident.

Reference: www.carers.net.nz

- The primary role of Carers NZ is to ensure awareness about carers, their role, and their needs within New Zealand and internationally.
- The organization participate in government reference and working groups, and promote the interests of family carers to decision-makers in health, education, employment, social services, housing, transport, and other important areas.

(14) Advance Care Planning

Reference: www.advancecareplanning.org.nz

- Advance care planning gives everyone a chance to say what's important to them. It helps people understand what the future might hold and to say what treatment they would and would not want. It helps people, their families and their healthcare teams plan for future and end of life care.

(15) Immunisations

Reference: www.immunisation.book.health.govt.nz

- In adults aged 65 years and older, influenza vaccine has been shown to be effective against non-fatal and fatal influenza complications, influenza-like illness and laboratory-confirmed influenza.
- Pneumococcal vaccine recommendation (but not funded) for adults ≥65 years with no risk factors
    - 1 dose of PCV13 **or**
    - 1 dose of 23PPV, given at least 8 weeks after PCV13

  Most older people will not require a further dose of 23-PPV, but those at high risk may be given another dose five years later, e.g. those with chronic obstructive pulmonary disease, diabetes or immunodeficiency.
- Tetanus-containing vaccines at age 65 – Td Booster

(16) Immunisation – Shingles

Reference: www.bpac.org.nz March 2014
The diagnosis and management of herpes zoster and its complications

- Zostavax vaccination is available (unsubsidised) for protection against shingles. A 2012 meta-analysis showed that older adults who had received the zoster vaccine had a 50% reduced incidence of shingles compared with those who had a placebo vaccination.
- The vaccine was most effective in people aged 60 – 69 years (64% reduced incidence of shingles).
- A related meta-analysis was inconclusive as to whether zoster vaccination prevents post-herpetic neuralgia in patients who get shingles despite vaccination.
- A single dose of Zostavax may be considered for people aged over 50 years, irrespective of exposure to chicken pox or previous occurrence of shingles.
- It is contraindicated for immunocompromised people, women who are pregnant, people with active untreated tuberculosis, and people with known anaphylactic reactions to any component of the vaccine.

Reference: www.patient.co.uk

- In the UK, there is a shingles vaccination programme for people aged 70 and 79. The programme began in September 2013.

(17) Sensory Screening

Reference: Primary Eye Care Issue 29
Taking care of teeth and eyes could help lessen risk of dementia
Citing article - ***Nontraditional risk factors combine to predict Alzheimer disease and dementia***. Neurology July 19, 2011 (77) 227-234

- Having regular eye examinations, visiting the dentist, and maintaining functional hearing could all prevent dementia.
- The researchers wanted to draw attention to the cumulative effects of small deficits, which individually may not be associated with anything, but they can still add up to an important combined risk factor.

- Adjusted for age, sex, education, and baseline cognition, the odds ratio of dementia increased by 3.2% (p=0.021) for each non-traditional deficit accumulated.

(18) Glaucoma

Reference: www.glaucoma.org.nz

- Glaucoma affects 2% population over the age of 40.
- One out of every 10 adults over the age of 70 has glaucoma.
- That means an eye examination for glaucoma every five years from the age of 45 and every three years from the age of 60.
- However, at any age, if you notice changes in your eyesight, then you should have your eyes examined at that time. For example, if you require hobby glasses, it is a good idea to have your eyes checked by an eye health professional, just in case there is an underlying problem.
- In addition if you have risk factors for glaucoma, such as family history, then you may need your eyes checked more frequently.

(19) Macular Degeneration

Reference: www.bpac.org.nz September 2015
Age-related macular degeneration – what should a General Practitioner know?

- In New Zealand, it is estimated that age-related macular degeneration accounts for 48% of cases of blindness among adults aged 50 years and older, and causes an estimated 400–500 new cases of blindness per year.
- The prevalence of age-related macular degeneration in New Zealand is uncertain due to a lack of appropriate studies but it was estimated in 2014 that it affected 10% of people aged 45 – 85 years, and 38% of people aged over 85 years.
- Early changes in age-related macular degeneration can be detected in a regular eye examination by an optometrist.
- Adults are recommended to undergo a general eye examination with an optometrist by the age of 45 years, followed by once every five years until age 60 years, and once every three years thereafter.
- Patients with visual problems may require more frequent examination, as appropriate for their condition.
- Patients with signs of macular degeneration may be directly referred by the optometrist to an ophthalmology clinic.
- The Amsler grid is a tool to assess visual function. It consists of a simple square grid of lines with a central dot, and is available online e.g. www.amd.org/the-amsler-grid
- The Amsler grid can be useful for detecting age-related macular degeneration: patients may see straight lines on the grid as wavy or blurry. A meta-analysis of 12 studies assessing the performance of the Amsler grid for detecting patients with neovascular age-related macular degeneration reported a sensitivity of 0.78 and specificity of 0.97.
- The limitations of the Amsler grid are that patients may have already noticed a problem with seeing straight lines or other changes in vision without the need for

a formal test, or may report seeing a normal Amsler grid despite having age-related macular degeneration due to "filling in" of the visual field; as occurs with the blind spot. Clinical guidelines do not specify its use for diagnosis or monitoring of age-related macular degeneration.

- If clinicians wish to use the Amsler grid, patients should be approximately reading distance from a printout of the grid, and cover one eye while using the grid to assess each eye individually. Patients should wear any reading glasses or corrective lenses they normally use.

(20) Pain

Reference: www.bpac.org.nz February 2008
Dilemmas: Recognition and treatment of pain in elderly people

- Chronic pain affects between 20-50% of elderly people and is more common in women. However, pain is often unrecognised, treated sub-optimally or not treated at all.
- Pain may significantly reduce quality of life and lead to depression, anxiety, increased suicide risk, increased dependence, reduced appetite, impaired gait, sleep disturbances and other problems.

(21) Skin

Reference: www.bpac.org.nz September 2014
"Seventh age itch": Preventing and managing dry skin in older people

- As skin ages, increased transepidermal water loss leads to dry skin (xerosis) and reduced barrier function.
- Dry skin is often itchy and prone to dermatitis. Repeated scratching can lead to chronic wounds and infections, particularly on the lower legs and especially if treatment is delayed.
- Older patients should be asked regularly about skin symptoms and periodically examined for signs of poor skin health.
- Encourage older patients to use emollients (which hydrate and soften the skin) and to avoid products, which irritate the skin, e.g. standard soap, to improve skin health.
- If patients do experience skin rash or injury, e.g. skin tears, they should be advised to seek help for this early on to reduce the risk of complications developing.

(22) Melanoma

Reference: www.health.govt.nz

- In the absence of any substantial evidence as to its effectiveness in reducing mortality population-based screening cannot be recommended.
- Clinical assessment of future risk of melanoma take into account:
    - Person's age and sex
    - History of previous melanoma or non-melanoma skin cancer
    - Family history of melanoma

- Number of naevi (common and atypical)
- Skin and hair pigmentation
- Response to sun exposure
- Evidence of actinic skin damage

- Individuals at high risk of melanoma and their partner or carer should be educated to recognise and document lesions suspicious of melanoma; and to be regularly checked by a clinician with six-monthly full body examination supported by total body photography and dermoscopy as required.
- Ministry of Health figures for 2011 show in that year there were 359 deaths caused by melanoma, more than the annual road toll of 305.

(23) CVD Risk Assessment – includes Diabetes Screen

Reference: www.health.govt.nz
Cardiovascular Disease Risk Assessment Updated December 2013
(New Zealand Primary Care Handbook 2012)

- Basic Components required for cardiovascular disease risk assessment include
  - Lipids
    - A single non-fasting TC:HDL ratio is used in the calculation of CVDRA
    - If the TC or the TC:HDL ratio is elevated above 8 mmol/L, repeat the test
  - Hb1Ac
    - Use single non-fasting HbA1c to screen for diabetes at the same time as the lipid profile.
  - Genetic lipid disorders
    - There is possibility of a genetic lipid disorder if TC is ≥8 mmol/L and/or if there is a strong family history of premature coronary heart disease
  - Blood Pressure
    - The risk assessment is based on a sitting blood pressure measurement undertaken in a clinic setting. Repeat a blood pressure measurement if the first is elevated.
    - The average of two seated BP measurements is recommended for the initial risk assessment.

Reference: www.bpac.org.nz September 2014
Communicating cardiovascular risk effectively

- Cardiovascular events are the leading cause of mortality in New Zealand, accounting for almost one-third of deaths annually; every 90 minutes one New Zealander dies of coronary artery disease.
- Stroke is the leading cause of disability among adult New Zealanders; seven out of ten patients that survive a stroke will be disabled long-term.

Reference: www.bpac.org.nz February 2012
The new role of HbA_{1c} in diagnosing type 2 diabetes

- A position statement released by the New Zealand Society for the Study of Diabetes (NZSSD) now recommends the use of glycated haemoglobin (HbA_{1c}) for the diagnosis of type 2 diabetes.
- In addition, HbA_{1c} should also be the test of choice for opportunistic screening in

the majority of people.

(24) Peripheral Vascular Disease

Reference: www.bpac.org.nz April 2014
The ankle-brachial pressure index: An under-used tool in primary care?

- In particular, international guidelines recommend targeted testing for peripheral artery disease for the following groups:
  - All people aged between 50 and 69 years who smoke or have diabetes
  - All people from age 70 years regardless of risk-factor status
  - All people with a Framingham risk score > 10%
- The ankle-brachial pressure index (ABPI) is a non-invasive method for detecting or ruling-out the presence of peripheral artery disease. ABPI is a calculation of the ratio of the patient's systolic blood pressure at their ankle to the systolic pressure in their arm.
- ABPI is generally between 1.0 – 1.4 in healthy people, i.e. the systolic pressure at the ankle is greater than the systolic pressure at the arm.
- An abnormally low ABPI value (i.e. < 0.9) has a sensitivity of 79 – 95% and a specificity of approximately 95% for peripheral artery disease.
- Between one-third and one-half of patients with peripheral artery disease will have some evidence of coronary artery or cerebrovascular disease. A meta-analysis of 16 studies involving over 48 000 patients without a history of coronary artery disease, found that when ABPI indicated the presence of peripheral artery disease the risk of cardiovascular mortality increased by over four times for males and approximately 3.5 times for females, compared with people with an ABPI in the normal range.

(25) Chronic Obstructive Pulmonary Disease (COPD)

Reference: www.bpac.org.nz February 2015
The optimal management of patients with COPD - Part 1: The diagnosis

- A clinical diagnosis of COPD can be considered in anyone aged over 35 years who has had long-term exposure to cigarette smoke, occupational exposure to dust, fumes or gas, or who has typical symptoms of COPD, i.e. breathlessness, cough and/or sputum production.
- Symptoms such as chest tightness, wheezing, and airway irritability are also common, although wheezing is not an indication of disease severity.

(26) Chronic Kidney Disease

Reference: www.bpac.org.nz February 2015
The detection and management of patients with chronic kidney disease in primary care

- Chronic kidney disease is a general term used to describe any long-term condition that affects kidney structure and function, e.g. diabetic nephropathy, IgA nephropathy or polycystic kidney disease.

- However, declining kidney function is also a natural part of the ageing process. It is estimated that by the age of 70 years approximately 30% of the population will meet classification criteria for CKD.
- The clinical challenge of CKD is to distinguish patients with progressively declining renal function due to disease from those with uncomplicated, age-related declining renal function.
- Patients with untreated progressive CKD are at extremely high risk of experiencing a cardiovascular event, and if they live long enough they are likely to require dialysis and/or kidney transplantation.

(27) Osteoporosis

Reference: www.bpac.org.nz October 2008
Prevention of osteoporosis

- Peak bone mass is achieved by around age 30-35 years and from then on starts to decline. The higher the peak bone mass achieved, the lower the impact of subsequent bone loss.
- The contribution of individual risk factors towards the development of osteoporosis has not yet been quantified.
- Clinicians must make pragmatic decisions on who to refer for a DEXA scan based on major risk factors such as:
  - Age
  - Female gender
  - Low BMI
  - Untreated premature menopause
  - Family history of maternal hip fracture before the age of 75 years
  - Conditions affecting bone metabolism (primarily inflammatory conditions, hyperthyroidism and prolonged immobility)
  - Chronic steroid use

Reference: www.bpac.org.nz November 2013
Risedronate now fully subsidised: What is its place in practice?

- Risedronate has been fully subsided in New Zealand without restriction since 1 September 2013. It is indicated for the treatment of osteoporosis and for the prevention of glucocorticoid-induced osteoporosis.
- Oral risedronate, taken once weekly, is likely to become the treatment of choice for patients with osteoporosis or at risk of osteoporotic fractures, due to its unrestricted subsidy access compared to alendonate or zoledronic acid and its superior efficacy and simpler dosing regimen compared to etidronate.

(28) Polypharmacy

Reference: www.bpac.org.nz October 2014
Polypharmacy in primary care: Managing a clinical conundrum

- Among older patients polypharmacy is associated with falls and fractures, dehydration and acute kidney injury (AKI), delirium, hypoglycaemia, malnutrition, hospitalisation and death.

- Polypharmacy has traditionally been defined by the number of medicines that a patient is taking simultaneously, typically five or more.
- Defining polypharmacy purely by an arbitrary number of medicines, however, fails to acknowledge that the potential risk of adverse effects of medicines can vary widely. For example, an emollient prescribed for dry skin poses a much lower risk to a patient (if any) compared to prescribing a non-steroidal anti-inflammatory drug (NSAID) or diuretic.
- Recently, polypharmacy has been further categorised to account for both its positive and negative aspects.
- Balancing the potential benefits and harms of prescribing multiple medicines is a challenge that all prescribers face on a daily basis.
- Polypharmacy is not necessarily harmful and for many patients, taking multiple medicines does increase life expectancy and improve quality of life. For example, in patients with established coronary artery disease the appropriate use of several concurrent medicines, e.g. an angiotensin converting enzyme (ACE) inhibitor, a calcium channel blocker, a diuretic, a statin and an antiplatelet, reduces the risk of a vascular event by between two-thirds and three-quarters.

Reference: www.bpac.org.nz June 2015
Prevention is better than cure: five tips for keeping older people healthy and out of hospital during winter

- Patients taking ten or more medicines continuously are considered to be at high risk of inappropriate polypharmacy.
- Regular medicine reviews of patients taking multiple medicines increases the likelihood that clinicians will identify medicines that are no longer providing the patient with optimal benefit and will also ensure that prescribers are aware of all the medicines and over the-counter-products (OTC) that a patient might be taking.

Reference: www.bmj.com

- Before starting an elderly person on a new drug, think what you can stop.
- This principle is implied in the name of the **STOPP/START criteria**, the second version of which was published in *Age and Ageing 2014;0:1-6*
    - The 114 criteria were agreed on by 19 experts from 13 European countries, with a view to minimising inappropriate prescribing in older people
- The American Geriatrics Society promotes its own system, known as **Beers criteria** - *Journal of the American Geriatric Society 2012;60:616-31*
- Criteria like these need to be used where most needed—general practices, community pharmacies, and nursing homes.

(29) Cervical Screening

Reference: www.nsu.govt.nz

- All women who have ever been sexually active should have regular cervical smear tests from the time they turn 20 until they turn 70. These include:
    - All women who have been immunised against HPV
    - Women who are single

- Lesbians
- Disabled women
- Women who have been through menopause
- Women who are no longer having sex

(30) Breast Screening

Reference: www.nsu.govt.nz

- BreastScreen Aotearoa is New Zealand's free national breast screening programme for women aged between 45 and 69.

(31) Bowel Screening

Reference: www.bowelscreeningwaitemata.co.nz

- Men and women aged 50 to 74 who live in the Waitemata District Health Board area and who are eligible for publicly funded health care are being invited to take part in a FREE BowelScreening programme to check for early signs of bowel cancer.
- BowelScreening is part of a four-year pilot running from October 2011 to December 2015 to test whether bowel screening should be introduced throughout New Zealand. During the pilot most people will be screened twice.

Reference: www.nzherald.co.nz 6th July 2015

- A pilot screening programme is running in the Waitemata health district for people aged 50 to 74. It began in late-2011 and was to run until December this year, but in the Budget in May, the Government granted the Waitemata DHB $12.4 million to extend the scheme until December 2017.
- Health Minister Jonathan Coleman indicated that the beginnings of a national programme could be in place from early 2017. "I expect to take a business case to cabinet by the end of the year which will consider a potential staged roll out of a national bowel screening programme from 2017"
- Organised screening programmes overseas have been shown to reduce bowel cancer mortality.
- New Zealand has one of the developed world's highest rates of bowel cancer registration and deaths. Around 3000 cases are registered each year and there are about 1200 deaths from the disease.
- Bowel cancer is our most commonly registered cancer and our second most common cause of cancer death.
- Survival rates are better for patients in whom the disease is detected at an early stage.

(32) Prostate Cancer

Reference: www.health.govt.nz
Prostate Cancer Management and Referral Guidance
Published September 2015

- This document has an 'Algorithm for supporting men with prostate-related concerns' and detailed explanatory notes.
    - If aged 50 to 70 years, or over 40 years with a family history of prostate cancer, obtain informed consent before testing by discussing
        - The benefits and risks of PSA and/or DRE
        - The implications of further testing if the PSA or DRE is abnormal

  Note: Carefully consider each man's individual context when discussing benefits and risks.

(33) Mental Health including Loneliness and Social Isolation

Reference: www.bpac.org.nz February 2008
Dilemmas: Depression in elderly people

- Depression in elderly people can be a significant cause of disability and is under-recognised and often complex to treat.
- A SSRI such as citalopram can be used initially for most depressed older people, in addition to psychological and other therapies.
- If an elderly person is feeling lonely, or would just like more social contact, it's important to do something about it, and 'Age Concern' can help. Their Accredited Visiting Service is a befriending service that provides regular visits to older people who would like more company. Visitors are volunteers who are keen to spend time with an older person for about an hour each week to enjoy conversation and shared interests and activities.

(34) Smoking

Reference: www.bpac.org.nz October 2014
Smoking cessation beyond the ABC: Tailoring strategies to high-risk groups

- Smoking rates are declining in New Zealand as more and more people are successfully quitting. However, rates remain unacceptably high among deprived communities, Māori and Pacific peoples and in people with mental health disorders.
- It is often helpful to think of smoking as a chronic relapsing disease, thereby acknowledging the difficulties of smoking cessation and the likelihood of relapse. Ideally, health professionals should be providing smoking cessation support in the ABC format to every patient who smokes, at every consultation.

(35) Alcohol and Drugs

Reference: www.bpac.org.nz November 2010
Investigation of hazardous drinking

- Approximately 20–25% of New Zealanders consume alcohol at a harmful or hazardous level; however, these problems will remain undetected in many of these people.

- A simple screening question, followed by a more in-depth questionnaire if required, can be a successful approach to identifying a patient with alcohol issues, within a general practice consultation.
- Laboratory tests are not routinely recommended for screening for hazardous drinking in primary care.

Reference: www.bpac.org.nz February 2015
Overuse of benzodiazepines: still an issue?

- Benzodiazepines may be considered as a short-term treatment for insomnia and anxiety; zopiclone, a benzodiazepine-like medicine, is indicated for the treatment of insomnia only.
- Benzodiazepines are also used in the treatment of epilepsy and as sedatives during medical procedures.
- Long-term use of these medicines for insomnia or anxiety is discouraged, as they are associated with dependency, an increased risk of falls and dementia in elderly people, cognitive difficulties and an increased risk of motor vehicle accidents.
- Data from New Zealand show that patients are currently being prescribed large volumes of benzodiazepines and zopiclone.

(36) Gambling

Reference: www.choicenotchance.org.nz

- Know the signs - Any of these signs can point to a problem with your own / someone else's gambling:
  - Chasing your losses
  - Hiding your gambling
  - Feeling guilty about gambling
  - Losing track of time
  - Repeated ATM withdrawals
  - Gambling because stressed or lonely
  - Feeling regret after gambling
  - Borrowing money
  - Losing interest in other stuff
- The free Gambling Helpline (0800 654 655) is confidential and available 24/7. Their staff are trained to deal with a whole range of issues related to gambling and one call may be all that's needed to get back on track.

(37) Disability Allowance

Reference: www.workandincome.govt.nz

- You may get a Disability Allowance if you:
  - Have a disability that is likely to last at least six months
  - Have regular, ongoing costs because of your disability which are not fully covered by another agency
  - Are a New Zealand citizen or permanent resident
  - Normally live in New Zealand and intend to stay here.

It also depends on how much you and your spouse or partner earn.

(38) High User Health Card

Reference: www.health.govt.nz

- The High Use Health Card offers the same benefits of a Community Services Card, for general practitioner visits and prescription charges.
- A High Use Health Card entitles frequent health service users to reduced costs for some doctor visits and some prescriptions. The card is valid for 1 year.
- To qualify for a High Use Health Card, a patient must have received at least 12 health practitioner consultations within the last 12 months for a particular ongoing medical condition(s). Evidence of this may be required.
- Only a medical/general practitioner can submit a High Use Health Card application.
- Medical/general practitioners can order application forms for the High Use Health Card from Wickliffe Ltd, Freephone 0800 259 138.
- Both the medical/general practitioner and the patient (or guardian of the patient) must sign the application form on visit 12.
- All 12 patient visits must be within 12 months of the date the medical/general practitioner signed the application form.
- The medical/general practitioner sends the completed High Use Health Card application form to the Ministry of Health, Private Bag 3015, Whanganui Mail Centre, Whanganui 4540.
- In practice; the High User Health Card is infrequently used now, due to changes in General Practice funding.

(39) Medical Alarm

Reference: www.stjohn.org.nz

- Medical alarms help seniors and people with disabilities to continue enjoying their independence for longer. They also provide reassurance for families and friends.
- St John is New Zealand's leading medical alarm provider, but there are regional differences in providers.
- Medical alarms are monitored directly by St John.

(40) Medic Alert Emblem

Reference: www.medicalert.co.nz

- Clinically endorsed, internationally recognised, functional and fashionable. MedicAlert®'s trusted emblem range includes medical condition and age appropriate products designed and intended to give you confidence.
- MedicAlert® is leading the way with Electronic Health Records that ensure your most up to date health information is always accessible in an emergency.
- In New Zealand particularly, MedicAlert® has one of the most advanced access systems globally via the Patient Centric Health Portal called ManageMyHealth.
- With MedicAlert® - You receive worldwide protection. Where ever you go - MedicAlert® goes with you.

PEER REVIEW

- **General Practitioners**
  - Dr Harsha Dias - Featherston Medical Centre
  - Dr Simon Garlick - Eastmed Doctors
  - Dr Douglas Horne - Westview Medical Centre
  - Dr Alastair Leggat - Westview Medical Centre
  - Dr Caroline Meade - Milford Family Medical Centre
  - Dr Bhavana Patel - Clendon Family Health Centre

- **Geriatrician**
  - Dr Geoff Green - Middlemore Hospital

- **Practice Nurses**
  - Caroline Campbell - Westview Medical Centre
  - Emma Robertson - Westview Medical Centre
  - Nicole Waters - Papakura Marae Clinc

- **Urologist**
  - Dr Mischel Neill - North Shore Hospital

CONTRIBUTION AFTER INITIAL PUBLICATION 15/9/2015

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