Empowering dermatology residents to improve dermatologic care of older adults

Justin Endo, MD, MHPE, FAAD

Associate Professor (CHS)

Department of Dermatology
UNIVERSITY OF WISCONSIN
SCHOOL OF MEDICINE AND PUBLIC HEALTH

Resident comments about challenges caring for older adults

- Patient context?
  - “limitations for patients to understand/carry out plans”
- Implicit biases?
  - “difficulty remembering instructions due to normal aging”
  - “they talk and move slow”

Consider taking an Age implicit association test (IAT)

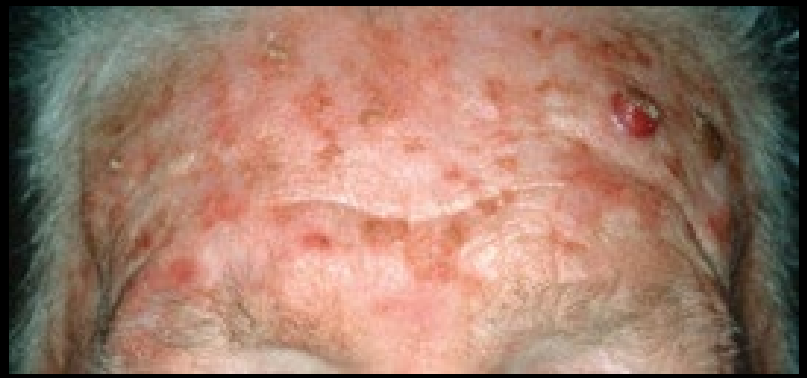
Implicit.Harvard.edu

Learning objectives

- By the end of the didactic, dermatology residents will be able to:
  - Describe the 4 M’s model for managing older patients and apply it to common scenarios
  - Describe what a health care power of attorney document is and how it is activated

Case 1

- 95 yom with dementia
- 1.5 yr persistent, asymptomatic scab
- Bled a few times but not bothersome to pt
- Very large heme crusted plaque, slightly pearly borders
- Clinical differential favors classic basal cell carcinoma



Soyer et al., In: Dermatology. Bolognia ed. Published December 31, 2017.

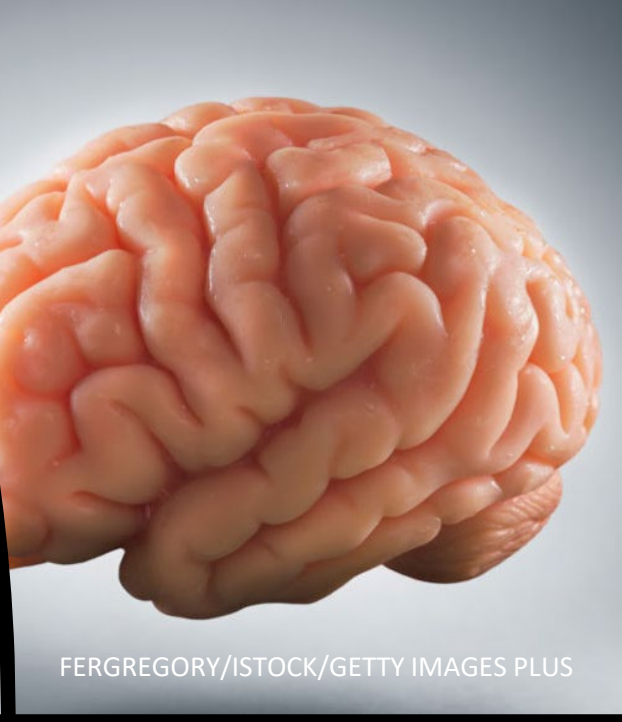
What is a practical framework for managing older adult patients like this case?

The diagnosis might not be the tricky part in older adults…rather, it might be weighing the contextual risks versus benefits of management options.

John A. Hartford Foundation's 4 M's framework of best practices in geriatric care

- Matters Most
- Mentation
- Mobility
- Medications

https://www.webmd.com/healthy-aging/aging-well-20/4ms-health-checklist



Matters Most: Patient-centric, goal-directed care

- “At this time in your life, what is most important to you?”
  - Not take more medicines
  - Be able to take care of my spouse
  - Reduce the number of skin cancer surgeries
  - Make ends meet (fixed income)
  - Focus on my other health issues (e.g., metastatic cancer, declining memory)
  - Only treat skin problems that are causing pain or affecting daily living

Matters Most: Patient-centric care

- Dermatologist's roles with geriatric patients
  - **Curious observer** to facilitate the discussion: how the issue at hand might (or not) be relevant to goals
    - "I noticed that you seemed reluctant about…"
    - "I see you have several other health issues…"
  - **Expert** who can help the patient put their circumstances and management option into perspective
    - Lag-time to benefit of an intervention (e.g., AKs)
    - Life expectancy vs chronologic age (caution about our biases)
    - "Based on the treatment options we discussed, let's decide together which will accomplish your care goals."


Marathonwatch.com

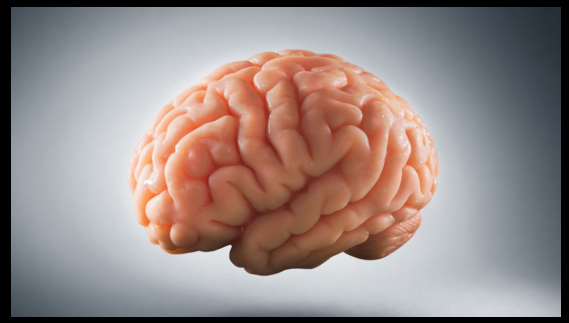

essence.com

Matters Most: Patient-centric care

- Care goals might change over time
  - “Let’s have an ongoing discussion about your goals.”

What % of adults 65+ have dementia/cognitive impairment?

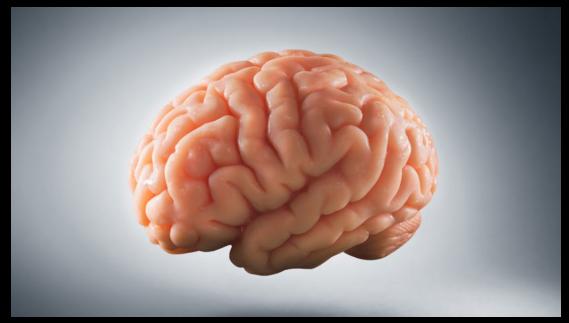
- 10% dementia
- 25% mild cognitive impairment
- **~70% of adults 65+ do NOT have dementia or cognitive impairment**
- Incidence decreasing 13% per decade for 25 yrs in US/Europe (Wolters et al., Neurology 2020)



FERGREGORY/ISTOCK/GETTY IMAGES PLUS

Mentation

- Ability to engage in an informed consent discussion for treatment and procedures OR to DECLINE treatment
- Anticipated ability to tolerate and adhere to procedures/plan
- Decision-making capacity might depend on the complexity, context and stakes of the decision
- “Pseudodementia”: hearing/visual impairment/depression
- Teach-back method
- Partnering with PCP or a geriatrician

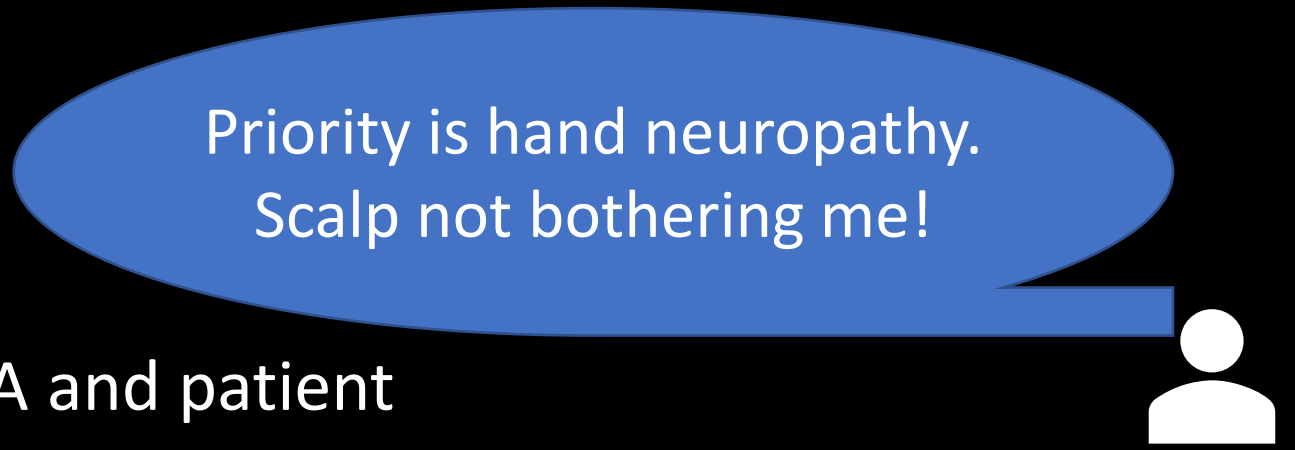


FERGREGORY/ISTOCK/GETTY IMAGES PLUS

Healthcare Power of Attorney (HCPOA)

- What is it?
  - Legal document that identifies proxies (surrogate decision maker) when a person is deemed incapacitated
  - Can be obtained at most clinics or hospitals
  - Must be created and signed while the person is of sound mind
  - Each state has its own document, so caution with templates from the internet
- When does it take effect?
  - Varies by location
  - Usually 2 health care or mental health professionals must evaluate and deem a person incapacitated, sign and “activate” the document
  - If HCPOA is not activated, the proxy cannot make medical decisions on behalf of the person

Case 1 Outcome



- Discussion with activated HCPOA and patient
  - Presumed diagnosis (BCC) and natural history (van Winden et al., JAMA Dermatol 2021)
  - Biopsy and management options such as Mohs surgery, radiation, nonsurgical treatments, expectant management
  - Anticipated ability to tolerate the treatments with dementia
  - End of life
- Decision: expectantly manage, focus on neuropathy symptoms

Mobility: Balance/falls prevention

- 25% of Americans 65+ y/o fall per year*
- Every 19 minutes, an older person dies from a fall*

westernberkspt.com

*Aging.com (National Council for Aging Care)

Mobility: How do these facts affect my derm practice?

- During your examination
- Treatments that might increase fall risk
  - Anticholinergic or sedating medications (more in a bit)
  - Full body phototherapy (if existing balance problems)

Medications:

- Physiologic changes of aging affecting metabolism
  - **Renal decline**
  - More adipose tissue -> **longer t1/2 lipophilic drugs**
  - **Higher risk of delirium**
  - +/- frailty (low plasma proteins)
- Dosing: “Start low, go slow”

www.consumerreports.org

Medications:

- Polypharmacy
  - Many definitions, but generally taking 5+ medications
  - Interactions and adverse reactions
  - $
  - Complexity of multiple regimens
  - Adherence

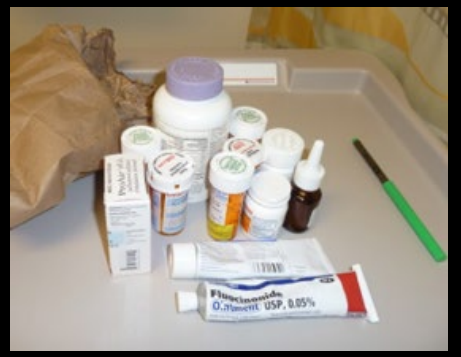
www.consumerreports.org

Medications: Polypharmacy

- Unintended contributing factors that might confuse patients and/or mislead healthcare providers to unintentionally renew duplicate or obsolete medications:
  - Automated, computer-generated pharmacy refill requests
  - Formulary changes
  - Too many cooks in the kitchen (multiple prescribers)

Medications: How YOU can make a difference

- Medication reconciliation
  - Brown bag method (pt brings meds or sends list)
  - Large print (12 point, not all caps)
  - What to Start, Stop, Change
- Topicals
  - Large jars, jar openers
  - Back lotion applicators



Avoid high risk medications

- Prednisone
- Sedating antihistamines
- Tricyclic antidepressants
- Gabapentin
- Opioids
- Beers Criteria (UpToDate or www.americangeriatrics.org)

Use caution with common, high-interaction medications

Example	Interaction
Warfarin	Antibiotics can alter INR
Terbinafine	CYP interactions
Cyclosporine	CYP interactions
Digoxin	Increased levels with ketoconazole, erythromycin

Justin's 5th "M"

- teaM
  - MA (task delegation)
  - PCP (partnership)
  - Receptionist (intake processes)
  - Care providers
  - Home health or nursing staff, if applicable

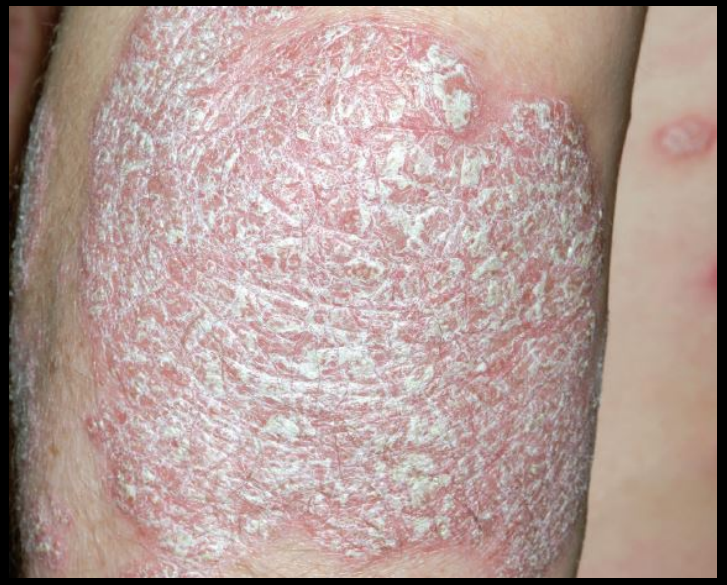
"…**Efficiency** is for things, not people"
-Stephen Covey

Case 2: 76 yo man with poorly controlled psoriasis on scalp, trunk, legs

- **HPI:** Has topical medications but difficulty recalling which “salve” goes where. Depends on family members to drive him to clinic. Somewhat itchy but more bothered by limiting social interactions.
- **PMH:** hypertension, hand and knee osteoarthritis
- **Meds:** clobetasol, desonide, calcipotriene, tazarotene (unclear how often using them)
- **ROS:** no morning joint stiffness/swelling

Case 2, continued

- **SH:** No EtOH or tobacco
- **Exam:** Somewhat thin and frail appearing. Gait somewhat unsteady. Scaly plaques >10 % BSA. Significant induration, scale, and erythema on scalp, chest, back, extremities
- **Labs:**
  - CBC, WNL
  - HBV, HCV neg and liver tests WNL
  - Negative TB test
  - Serum creatinine 1.5 (normal range 0.5-1.5)



Case 2 Questions

1) What are your preferred treatment choices for this patient's psoriasis and why?
2) What treatments might you avoid and why?
3) What strategies might improve communication and clarify medications for patient?

- Has topical medications but difficulty recalling which "salve" goes where
- Gait imbalance
- >10% BSA
- Labs:
  - CBC WNL
  - HBV neg
  - Negative TB test
  - Serum creatinine 1.5 (normal range 0.5-1.5)

Case 2 Take home points
Q1 & 2: Psoriasis treatment options

- Age associated with renal decline
  - Serum creatinine overestimates true renal function, especially thin/frail patients
  - Risk of inadvertent overdosing with methotrexate
- Gait imbalance
  - Caution with phototherapy
- Biologics
  - Severe congestive heart failure is contraindication
  - Age per se is not a reason to withhold medication
  - Historically, older patients excluded from trials

Case 2 Take home points
Q3: Communication and adherence

- Review medications “brown bag”
- Speak in low, slow voice
- 12 point font, 1.5 spacing, not all caps
- Enlist help of caregivers
- Empower RN or MA to educate
- Use the teach back method
- Minimize medication number and frequency
- Consider arthritis impact on medication container use

Case 3: 70 yo non-binary person with chronic "foot fungus rash."

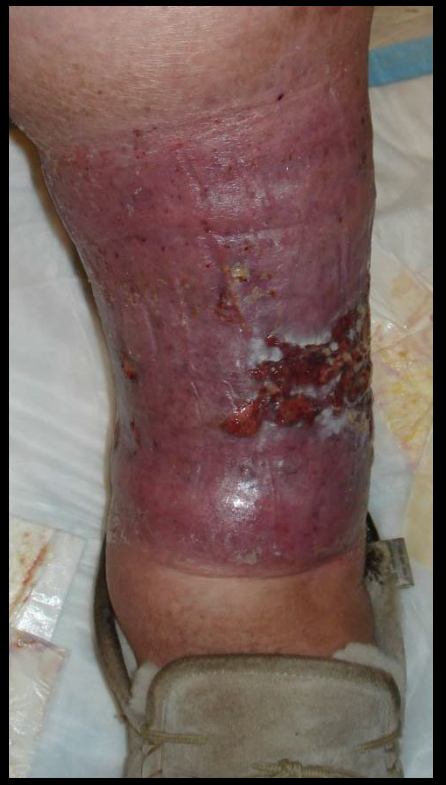
- **HPI:** Recent rash on legs extremely itchy. PCP gave oral prednisone and sent referral to you since he is not getting better. Also, got topical nystatin for tinea pedis.
- **PMH:** Peripheral neuropathy, CHF, hypertension, hyperlipidemia, BPH, stroke with mild cognitive impairment, OA, history of falls
- **SH:** No EtOH

Case 3, continued

Meds:

- Digoxin 0.25mg
- Aspirin 81 mg
- Amlodipine 10 mg
- Simvastatin 20mg
- Diphenhydramine 50mg BID
- Duloxetine 30 mg BID
- Hydroxyzine 50mg qAM
- Prednisone 60mg (2 week taper)
- Ibuprofen 300mg TID
- Vitamin E and neomycin cream for legs

Exam (both legs):



Case 3 Questions

Your clinical suspicion is high for stasis dermatitis, less likely tinea pedis

1) What potential medication harms exist for his skin regimen?

2) How might you treat this patient's stasis dermatitis while minimizing polypharmacy?

3) How would you manage tinea pedis in this patient, if that was the diagnosis?

4) BONUS: Why might older pts be at higher risk for dermatitis, fungal infections?

Meds:

- Digoxin 0.25mg
- Aspirin 81 mg
- Amlodipine 10 mg
- Simvastatin 20mg
- Diphenhydramine 50mg BID
- Duloxetine 30 mg BID
- Hydroxyzine 50mg qAM
- Prednisone 60mg (2 week taper)
- Ibuprofen 300mg TID
- Vitamin E and neomycin cream for legs

Case 3 Take home points
Q1: Potential harms

- Sedating medications have higher risk of CNS effects
- Anti-cholinergic medications (e.g., Atarax, Benadryl) exacerbate
  - Delirium
  - Urinary retention
  - Constipation
  - Falls
- 15x Increased GI bleed risk: NSAID + prednisone
- Remember high-interaction medications (digoxin)

Case 3 Take home points
Q2: Minimizing polypharmacy

- Stop extraneous over-the-counter medicaments
- Talk with PCP about potential iatrogenesis (amlodipine → edema)

Case 3: Take home points
Q3: Treating refractory fungus

- Confirm “fungus” with scraping
- If KOH +
  - Caution with terbinafine (CYP450, duloxetine)

Case 3: Take home points
Q4: Why might older pts be at higher risk for dermatitis, fungal infections?

- Inflammaging: Th2>Th1 imbalance
- Barrier dysfunction with aging

Summary

- The 4M’s framework provides guidance in managing older adults
  - Matters Most
  - Mentation
  - Mobility
  - Medications