AUSTRALIAN AND NEW ZEALAND SOCIETY FOR GERIATRIC MEDICINE: TESTS, TREATMENTS AND PROCEDURES HEALTH PROFESSIONALS AND CONSUMERS SHOULD QUESTION

ANZSGM is the professional society for geriatricians and other medical practitioners with an interest in medical care of older people. The society acts to represent the needs of its members and the wider community in a bid to constantly review and improve the care of the older people in Australia and New Zealand. Its major functions are around education, policy development and review, and political advocacy.

1. Do not use antipsychotics as the first choice to treat behavioural and psychological symptoms of dementia.

People with dementia may exhibit aggression, resistance to care and other challenging or disruptive behaviours. In such instances, the modest effectiveness of atypical antipsychotics may be offset by the higher risks for adverse events and mortality. Non-pharmacological interventions can be an effective substitute for antipsychotic medications. Use of these drugs should therefore be limited to cases where non-pharmacologic measures have failed and patients pose an imminent threat to themselves or others.

Supporting Evidence

- Ballard CG, Waite J, Birks J. Atypical antipsychotics for aggression and psychosis in Alzheimer's disease. Cochrane Database Syst Rev 2006;(1):CD003476.
- Declerq T, Petrovic M, Azermai M, et al. Withdrawal versus continuation of chronic antipsychotic drugs for behavioural and psychological symptoms in older people with dementia. Cochrane Database Syst Rev 2013;(3):CD007726.
- Ma H, Huang Y, Cong Z, et al. The efficacy and safety of atypical antipsychotics for the treatment of dementia: a meta-analysis of randomized placebo-controlled trials. J Alzheimers Dis 2014;42(3):915-37.
- Richter T, Meyer G, Mohler R, Kopke S. Psychosocial interventions for reducing antipsychotic medication in care home residents. Cochrane Database Syst Rev 2012;(12):CD008634.
- Schneider LS, Tariot PN, Dagerman KS, et al. Effectiveness of atypical antipsychotic drugs in patients with Alzheimer's disease. New England Journal Med 2006;355(15):1525-38.

Resources

- Antipsychotic overuse in dementia – is there a problem? Read about antipsychotic use in dementia on the NPS MedicineWise website.
- Strategies to address distress Read about reasons for and strategies to assist with distress in people with dementia on the NPS MedicineWise website

2. Do not prescribe benzodiazepines or other sedative-hypnotics to older adults as first choice for insomnia, agitation or delirium.

There is strong evidence that use of benzodiazepines is associated with various adverse effects in elderly people such as falls and fractures. Older patients, their caregivers and their providers should recognize these potential harms when considering treatment strategies for insomnia, agitation or delirium. Thus these drugs should be prescribed with caution, and their use monitored closely.

Supporting Evidence

- Allain H, Bentue-Ferrer D, Polard E, at al. Postural instability and consequent falls and hip fractures associated with use of hypnotics in the elderly: a comparative review. Drugs Aging 2005;22(9):749–765.
- Finkle WD, Der J, et al. Risk of fractures requiring hospitalization after an initial prescription for zolpidem, alprazolam, lorazepam, or diazepam in older adults. Journal of the American Geriatric Soc 2011;59(10):1883-90.
- Park SM, Ryu J, Lee DR, et al. Zolpidem use and risk of fractures: a systematic review and meta-analysis. Osteoporosis Int 2016; Apr 22.
- Sithamparanathan K, Sadera A, Leung L. Adverse effects of benzodiazepine use in elderly people: A meta-analysis. Asian J Gerontol Geriatr 2012;7:107–11.
- Stockl KM, Le L, Shang S, Harada ASM. Clinical and economic outcomes associated with potentially inappropriate prescribing in the elderly. American Journal Manag Care 2010;16(1):e1-10.

Resources

- Benzodiazepine dependence: reduce the risk Read about benzodiazepine dependence risk on the NPS MedicineWise website.
- Guide to stopping benzodiazepines Read about the benzodiazepine decision aid on the NPS MedicineWise website.

3. Do not use antimicrobials to treat bacteriuria in older adults where specific urinary tract symptoms are not present.

Studies have found that asymptomatic bacteriuria frequently resolves without any treatment. Antimicrobial treatment studies for asymptomatic bacteriuria in older adults demonstrate no benefits and, in fact, often show increased adverse antimicrobial effects.

Supporting Evidence

- Mody L, Juthani-Mehta M. Urinary tract infections in older women: a clinical review. JAMA 2014;311(8):844-54.
- Nicolle LE, Mayhew WJ, Bryan L. Prospective randomized comparison of therapy and no therapy for asymptomatic bacteriuria in institutionalized elderly women. American Journal of Medicine 1987;83(1):27–33.
- Nicolle LE, Bradley S, Colgan R, et al. Infectious Diseases Society of America Guidelines for the Diagnosis and Treatment of Asymptomatic Bacteriuria in Adults 2005.
- Zalmanovici Trestioreaunu, Lador A, et al. Antibiotic treatment for asymptomatic bacteriuria. Cochrane Database of Systematic Reviews 2015, Issue 4, Art No CD0009534.

Resources

- Antibiotic resources for clinicians from the Australian Choosing Wisely website
- Decisions and management for asymptomatic bacteriuria from the Australian Choosing Wisely website

4. Do not prescribe medication without conducting a drug regimen review.

Older patients disproportionately use more prescription and non-prescription drugs than other populations. Evidence shows that such polypharmacy increases the risk of adverse drug reactions and hospital admissions. Medication review with follow up is therefore recommended for optimising prescribed medication and improving quality of life in older adults with polypharmacy.

Supporting evidence

- Fried TR, O'Leary J, Towle V, et al. Health outcomes associated with polypharmacy in community-dwelling older adults: a systematic review. Journal of American Geriatric Society 2014;62(12):2261-72.
- Hajjar ER, Cafiero AC, Hanlon JT. Polypharmacy in elderly patients. American Journal Geriatr

Pharmacotherapy 2007;5(4):345-51.
- Jodar-Sanchez F, Malet-Larrea A, Martin JJ, et al. Cost-utility analysis of a medication review with follow-up service for older adults with polypharmacy in community pharmacies in Spain: The conSIGUE Program. PharmacoEconomics 2015;33:599-610.
- Lu WH, Wen YW, et al. Effect of polypharmacy, potentially inappropriate medications and anticholinergic burden on clinical outcomes: a retrospective cohort study. CMAJ 2015;187(4):e130-7.

Resources

- Anticipating the risks of polypharmacy
- Key points for medicines in older people
- Medicines in older people - review and rationalise
- Older, safer, wiser
- Stopping medicines
- The prescribing cascade

5. Do not use physical restraints to manage behavioural symptoms of hospitalized older adults with delirium except as a last resort.

There is little evidence to support the effectiveness of physical restraints to manage people with delirium who exhibit behaviours that risk injury. Physical restraints can lead to serious injury or death and may worsen agitation and delirium. Restraints should therefore be used as a last resort and should be discontinued at the earliest possible time, particularly given that effective non-pharmacological alternatives are available.

Supporting evidence

- Flaherty JH, Little MO. Matching the environment to patients with delirium: lessons learned from the delirium room, a restraint-free environment for older hospitalized adults with delirium. Journal of the American Geriatric Soc 2011;59(S2):S295-300.
- Lach HW, Leach KM, Butcher HK. Evidence-based practice guideline: changing the practice of physical restraint use in acute care. Journal of Gerontological Nursing 2016; 42(2):17-26.
- Mott S, Poole J, Kenrick M. Physical and chemical restraints in acute care: their potential impact on the rehabilitation of older people. Int J Nurs Pract 2005;11(3):95-101.

How was this list created?

Members of the Australian & New Zealand Society for Geriatric Medicine completed an online survey asking them to choose the 5 most relevant 'low value' practices from a list of 11. Respondents were also asked to nominate any additional practices which they regarded as overused, inappropriate or of limited effectiveness in the specialty of geriatric medicine. A total of 196 responses were received.

The list of items were then subject to consideration by the Federal Council. Specifically, members of Federal Council were asked to rate each of these 16 items in terms of their strength in meeting 7 criteria: Is there a reasonable evidence base upon which to drive change? Are older people likely to benefit from work we might do to change practice? Is the problem sizeable? Are there opportunities and a willingness within geriatric medicine to lead practice change? Are there opportunities to collaborate with other organisations with a shared interest in the area? Will this promote a positive profile for ANZSGM? Is this an area of potential conflict with other Societies?

Based on the ratings they assigned to these items the 'Top 5' list items were chosen and reformulated as recommendations for clinicians.

Recommendations from the Australian and New Zealand Society for Geriatric Medicine on treatment of mental and physical disorders in elderly patients.