

Optimal prescribing for people who are frail

Practical advice for NMPs

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This patient clearly has a medical syndrome with multiple causes and contributors that is characterized by diminished strength, endurance and reduced physiologic function, bringing about an increased vulnerability for developing increased dependency and/or death



Looks pretty frail to me



What frailty is not

- being old
- being demented or incontinent
- being edentulous, deaf or lonely
- coming from Bridgwater
- **an excuse for poor care**

Clinical Frailty Scale



1 Very Fit – People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.



2 Well – People who have no active disease symptoms but are less fit than category 1. Often, they exercise or are very active occasionally, e.g. seasonally.



3 Managing Well – People whose medical problems are well controlled, but are not regularly active beyond routine walking.



4 Vulnerable – While not dependent on others for daily help, often symptoms limit activities. A common complaint is being "slowed up", and/or being tired during the day.



5 Mildly Frail – These people often have more evident slowing, and need help in high order IADLs (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.



6 Moderately Frail – People need help with all outside activities and with keeping house. Inside, they often have problems with stairs and need help with bathing and might need minimal assistance (cuing, standby) with dressing.



7 Severely Frail – Completely dependent for personal care, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).



8 Very Severely Frail – Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.



9 Terminally Ill – Approaching the end of life. This category applies to people with a life expectancy <6 months, who are not otherwise evidently frail.

Scoring frailty in people with dementia

The degree of frailty corresponds to the degree of dementia. Common **symptoms in mild dementia** include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In **moderate dementia**, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In **severe dementia**, they cannot do personal care without help.

Prescribing to improve frailty

- Treatment x has ‘a positive effect on various measures used to determine frailty including cognition, physical functioning, and psychological wellbeing’.
- Some studies revealed that treatment x ‘may prevent or delay the onset of frailty’
- [J Frailty Aging](#). 2017;6(2):91-96. doi: 10.14283/jfa.2017.7.

<https://youtu.be/fv1eIWmxcVQ>



Effects of drugs in older people

Pharmacokinetics

Pharmacodynamics

Hepatic and renal
handling

Drug interactions

- Case 1.
- Mrs A, 87yo
- Found collapsed, 'off legs'
- Admitted confused





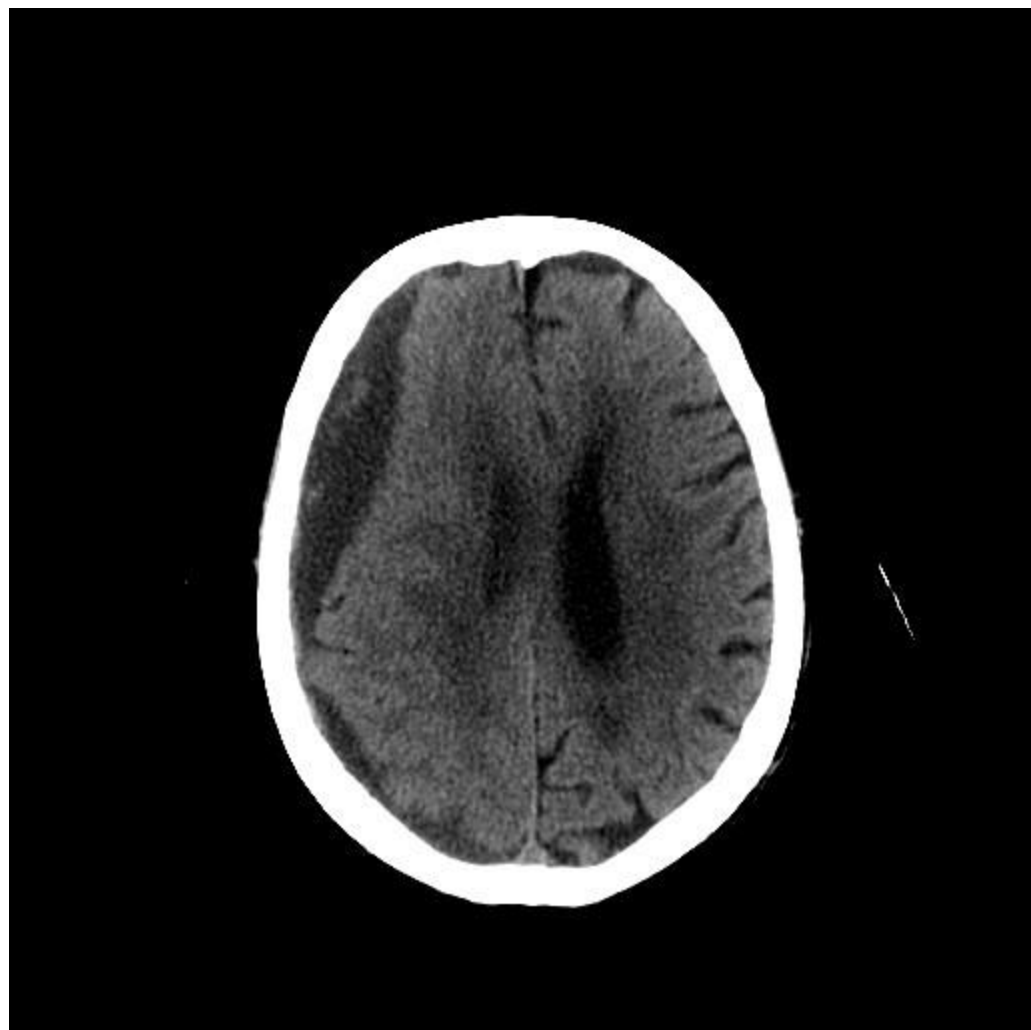
<http://dermis.net>



- Diagnosis and treatment?
- By day 3 she is very confused

- More history –
- GP struggling with BP control
- Feeling dizzy for weeks
- Fallen twice at home
- Not previously confused

- BP 170/86 on ward
- Dropping to 110/77 on standing



Meds

- Ramipril 5mg
- Furosemide 40mg
- Aspirin 75mg
- Amlodipine 5mg
- Ferrous sulphate 200mg
- Betahistine 8mg
- Doxazosin 4mg
- Enoxaparin, flucloxacillin, codeine, haloperidol

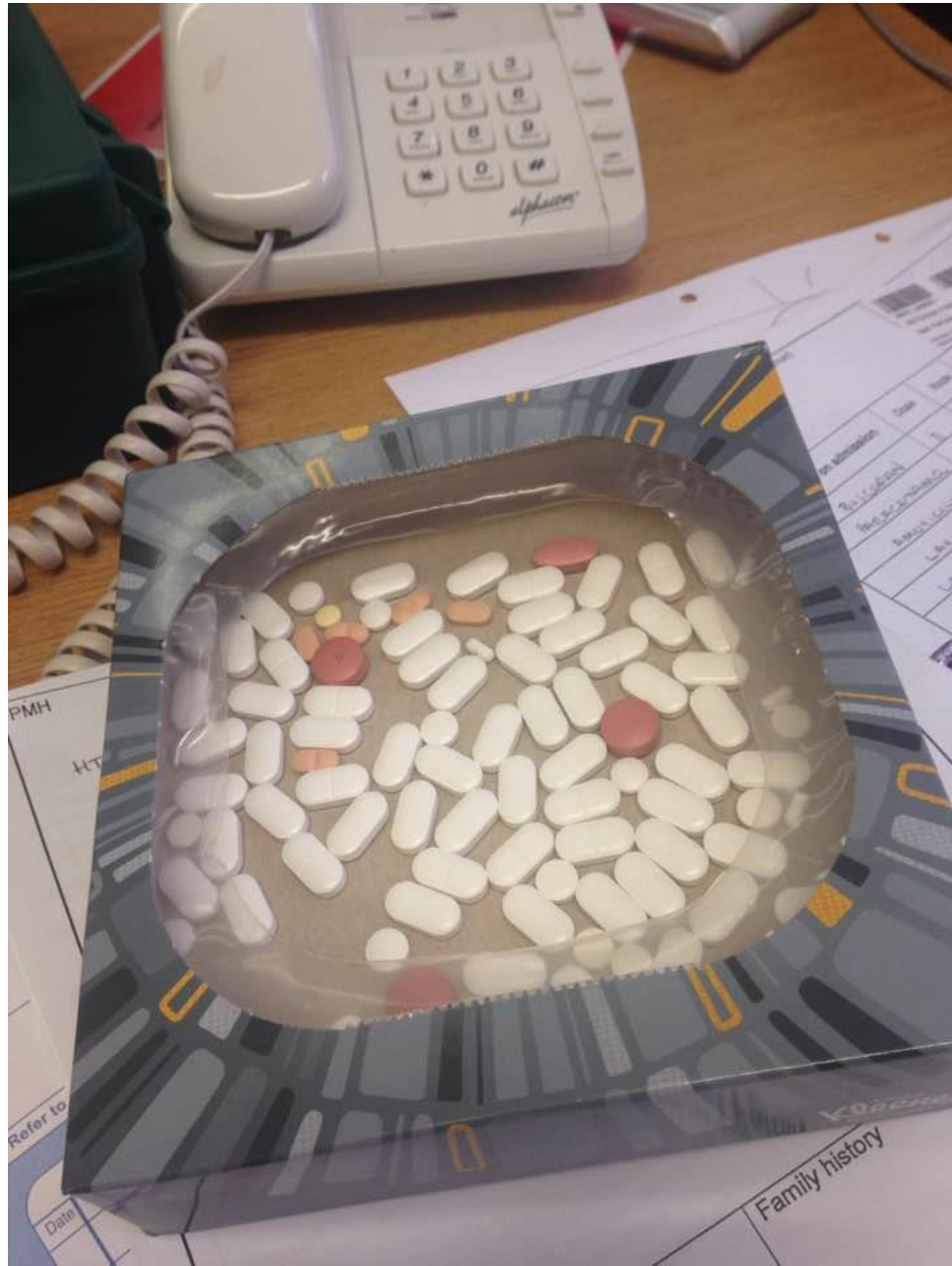
- Stop enoxaparin, all BP meds, betahistine, aspirin and iron, treat legs with emollients and steroids
- Rehab
- BP 183/92 in OPD
- plan...

Get the 'medicine' right

- Common pitfalls:
- Non-recognition of delirium
- 'Simple' problems missed eg constipation, mouth care, dehydration, depression
- Drug side-effects underestimated
- Complexity unacknowledged
- Patients' goals unexplored

- Extent and determinants of error in physicians' prognoses in terminally ill patients
- Christakis et al, WJM 2000

- Physicians are inaccurate in their prognoses for terminally ill patients, and the error is systematically optimistic.



How big a problem?

- Medication related admissions account for 20-30% of admissions for over 65s
- Of these, around 80% are considered preventable



Case 2

- Joe, 80
- Bendroflumethiazide
- Candesartan
- Alendronic acid
- Adcal bd
- Dabigatran
- Bisoprolol
- Atorvastatin

Therapeutic benefit?

- Joe's background
- Ex head of DT at a big school
- Very much loved
- Vascular dementia, poorly mobile, CFS 7
- Multiple hospital admissions
- 'Tablets is the only thing we row about'



General rules of prescribing and deprescribing

- Find out patients wishes/ expectations
- Look at the tablets (not the list)
- Find out which are being taken
- Think about goals

Principle 1 : everything on the chart must earn its place

- Rationalise everything in line with Treatment Escalation Form (TEP)/ ReSPECT/ Advance Care Plan

Explain the decision

- Positively:
- This wasn't a 'wrong' tablet
- But we may agree it has done its job

Case 3

- Annie, 87, symptoms of heart failure
- PMH:
 - T2DM
 - Leg ulcers
 - Angina
 - IHD

Annie

- Insulin
- Dapagliflozin
- Clopidogrel 75 od
- Codeine 30 qds
- Paracetamol
- ISMN long acting 60
- Nicorandil
- Ferrous sulphate 200 tds

Principle 2: is the diagnosis right?

- Diabetes – does she still have it? weight loss may mean there's no diabetes now
- Iron, did she ever actually have iron deficiency (low ferritin not low serum iron)
- Angina – many frail people no longer get angina as mobility falls, and don't need nitrates
- Heart failure – does Annie have left ventricular systolic dysfunction i.e. low ejection fraction. If not, this is diastolic HF and NICE guidance does NOT APPLY

Case 4, Ibtesham, 79

- Frail, CFS 6, lives with his wife
- Falls
- PMH: ca prostate, polymyalgia

- Several admissions
- Inco, LTC

Ibtesham's meds

- Finasteride
- Tamsulosin
- Omeprazole

Denosumab monthly

Accrete D3

Principle 3: Is the drug 'stranded on the beach'?

- Tamsulosin /doxazosin after a long term catheter has been put in. They cause falls! (but maybe continue finasteride as it might make catheterisation easier, and has almost no side effects).
- Osteoporosis medications after steroids have stopped.
- PPI after aspirin or NSAID or steroids have stopped.

Josie, 84, worried re memory

Paracetamol

Codeine

Pregabalin

Solifenacin

Amitriptyline 10mg



Principle 4: is the drug actually working?

- Try using NNT : the NNT for anticholinergics for urinary problems e.g. Tolterodine, solifenacin, oxybutinin, trospium etc is 9. This means urinary anticholinergics are NOT WORKING in 8 out of 9 people taking them.
- NNT for gaba drugs is at best 3 – so they don't work in at least 2/3 people, and there are no trials of treatment longer than 14 weeks. Planned weaning is wise.
-

92yo Gelda

- HTN 190/85
- 197/88
- 203/96

Otherwise well

Started amlodipine

- Feeling 'bleugh'

You are viewing BNF. If you require BNF for Children, use [BNFC](#).

For AMLODIPINE

Common or very common

Asthenia; constipation; diarrhoea; dyspepsia; dyspnoea; gastrointestinal disorders; joint disorders; muscle cramps; oedema; vision disorders

Uncommon

What does common/ very common mean?

- Common – more than 1 in 100
- Very common – more than 1 in 10

Principle 5 – if the patients says there's
a side effect, there's a side effect

Janie's mum, CFS6, dementia, 92

- They've said she's got to go to hospital!
- Her BP is dangerously high!
- She always goes loopy in hospital!

Janey's mum is at home, carers bd

- What questions do you want to ask?

Why am I doing this?

- Ok she's on:
- Candesartan, felodipine, atenolol, donepezil, mirabegron

Principle 6: check our motives

- Why am I doing this?
- Why *am* I doing this?
- Why am I doing this? Etc etc

What are we trying to fix?

- Why is Janie's mum having a BP check?

(because she's on Mirabegron)

Principle 7: is one drug being given for the side effects of another?

- Classics are amlodipine or other CCBs with diuretics especially loops. Aim to stop both.
- Amlodipine with laxatives, stop the former and you won't need the latter.
- More subtle, very important, nicorandil with wound dressing or pile cream. It causes ulceration from mouth to anus and skin ulcers which will never heal.
- Iron and antiplatelets - if the antiplatelet is causing enough bleeding to have to take iron, it's probably just not worth it. ...
-

Principle 8: is this drug good enough for my patient?

- Lots of drugs don't work as well as some would like you to think
- The evidence base in the very frail/old is extremely poor. (eg all the heart failure trials were done in mainly men in their sixties)
- We don't want to deny people effective medications but must work out which medications will actually bring benefit to our patients.

Sections

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FIGURES REFERENCES RELATED DETAILS

anemia.


Conclusion:

Low-dose aspirin increased incident anemia and decline in ferritin in otherwise healthy older adults, independent of major bleeding. Periodic monitoring of hemoglobin should be considered in older persons on aspirin.

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National Institutes of Health and Australian National Health and Medical

https://www.acpjournals.org/doi/10.7326/M23-0675#pane-pcw-details



Latest

KEYWORDS

- Anemia
- Aspirin
- Blood
- Clinical trials
- Elderly
- Ferritin
- Hemoglobin
- Hemorrhage



Courage!

- Stand alongside your patient
- Listen to their goals and fears



Life is mostly froth and bubble –
Two things stand like stone:
Kindness in another's trouble,
Courage in your own.

[Adam Lindsay Gordon](#)

