Welcome to the 1st Edition of The Atlantic Frailty Newsletter!

Dear Colleagues,

It has been over four years since our meeting on Dalhousie University campus to discuss strategies to reduce polypharmacy in frail older adults and efforts throughout the Atlantic region (and beyond) to achieve this common goal. This newsletter is an effort to keep those conversations going, to share in our successes and lessons learned, to keep the door to collaboration open, and promote the profile of Atlantic Canadian research and innovation in the field of polypharmacy in frail older adults.

We hope that you find this newsletter informative. This first edition highlights Nova Scotia initiatives and we would like to focus on other Atlantic Regions in our next edition. This will be a biannual newsletter with Fall/Winter and Spring/Summer editions. Thank you to those who contributed their work and ideas to our first edition! Please contact us if you have feedback or ideas for our next edition.

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Upcoming Events

Oct 20 | Evidence-Based Approach to Prescribing Antidepressants for the Frail Elderly Webinar
Dr. Laurie Mallery, Natasha Rodney, & Evan Bezanson
Contact: Nadine MacDonald (cpd@dal.ca); 902-494-1484
For more information please see the event poster.

Nov 4 | Care by Design: Long-Term Care Conference
Contact: Kim Lake (kim.lake@dal.ca); 902-494-1588
Register now | Brochure

Defining Polypharmacy: Survey

Polymedicated, inappropriate medication use, more medications than clinically necessary, more than four medications, simultaneous use of multiple drugs to treat a single condition ... these are some of the terms and definitions used to describe polypharmacy. There is no universally accepted definition of polypharmacy or method to identify those at risk. We want to hear from you! How do you define polypharmacy? How should we identify those at risk? Share your opinion in our brief survey and we will post the results in our next edition:
https://surveys.dal.ca/opinion/s?s=35015
RECENT EVIDENCE REVIEWS

ANTIDEPRESSANTS, MEDICATION SCREENING TOOLS

Systematic Review & Meta-Analysis of Antidepressants for Depression in Frail Older Adults

Laurie Mallery, MD, FRCP; Michael Allen, MD, MSc; Pam McLean-Veysey, BScPharm; Natasha Rodney-Cail, BSc (Pharm); Evan Bezanson, BSc (Pharm); Brian Steeves, MD; Constance LeBlanc, MD, CCFP(EM), FCFP, MAEd; Paige Moorhouse, MD, MPH, FRCP; Tanya MacLeod, MSc; Geriatric Medicine, Dalhousie University; Continuing Professional Development, Dalhousie University; Drug Evaluation Unit, Nova Scotia Health Authority; Lawtons Pharmacy; RK MacDonald Nursing Home

- Antidepressants are the second most commonly prescribed medication in long-term care in Canada (60% antidepressant, 36% serotonin reuptake inhibitor (SSRI)).
- Those with frailty and/or dementia are commonly diagnosed with depression, however it may be difficult to differentiate the symptoms of depression from the physical decline of frailty or symptoms of dementia.
- The use of antidepressants for the neuropsychiatric symptoms (NPS) of dementia is an off-label indication, however, there has been increasing interest in the efficacy and safety of antidepressants for NPS due to concerns about the risks of stroke and death from antipsychotics.
- A review team led by Dr. Laurie Mallery concluded that there is considerable uncertainty about the benefit of antidepressants compared to placebo for depression in frail, older adults with and without dementia and the neuropsychiatric symptoms of dementia. However, there are individual patients who might benefit from antidepressants.
- Fatigue, nausea, constipation, dizziness, and diarrhea were significantly more frequent in those taking antidepressants and may be burdensome side effects in advanced frailty.
- Patients started on antidepressants for depression should be reassessed after 4 to 8 weeks and 9 weeks for those using antidepressants for neuropsychiatric symptoms.

Meta-analysis of response and remission rates for antidepressants for depression

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<th>Response</th>
<th>Remission</th>
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<tr>
<td></td>
<td>ADs</td>
<td>PBO</td>
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<td>Frail older adults</td>
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<tr>
<td>9 studies, n=2641</td>
<td>45%</td>
<td>38%</td>
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<tr>
<td>Frail older adults</td>
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<td>with dementia</td>
<td>45%</td>
<td>37%</td>
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No statistical benefit was found. ADs= Antidepressants; PBO = Placebo; RR = Relative Risk; 95% CI = 95% Confidence Interval. Response defined as ≥ 50% decrease in depression scores or Clinical Global Impression rating of symptoms as “better” or “much better”; Remission defined as depression scores above cut-off criteria on scales (e.g., Hamilton Depression Rating Scale, Cornell Scale for Depression in Dementia and the Montgomery-Åsberg Depression Rating Scale).

Please click here for full review document.

Explicit Medication Screening Tools for the Older Person (STOPP/START criteria) Shows Patient Benefits

Barbara Hill-Taylor, Ingrid Sketris, Kieran A. Walsh, Stephen Byrne; IMPART Research Unit, School of Pharmacy, Dalhousie University, University College Cork, Ireland

An ongoing collaboration between Dalhousie University and the University College Cork, Ireland recently published a systematic review1 of the effectiveness of the STOPP/START criteria2 demonstrating that these tools are useful in the identification of potentially inappropriate prescribing and, when followed by drug regimen modifications, can lead to reduced falls, delirium episodes, hospital length-of-stay, emergency and ambulatory care visits, and medication costs. There was no evidence of improvements in quality of life or mortality. This review used data from four randomized controlled trial studies involving
1,925 older adults. The studies had two possible settings; patients were being admitted to hospital (n=2) or in long-term care (n=2). The authors were unable to conduct a meta-analysis due to variability among study methods (heterogeneity). The rate of potentially inappropriate medication use in the intervention groups, as identified by STOPP, varied from a baseline rate of 0.4 to 0.7 per patient per year to a rate of 0.04 to 0.4 at follow-up.

To read the full review please click here.

References


Researchers Ingrid Sketris and Kieran Walsh present their research article at the International Conference on Pharmacoepidemiology & Therapeutic Risk Management

SALTY PROJECT HIGHLIGHT

Seniors – Adding Life to Years (SALTY) Project
Project lead: Dr Janice Keefe, Nova Scotia Centre on Aging, Mount Saint Vincent University

Late life is a time when older adults and their caregivers are faced with health and social issues that can impact their well-being. Everyone wants to live well in their final years but this may be a challenge, particularly for people in nursing homes settings. SALTY is a four year study, being led by Dr. Janice Keefe at Mount Saint Vincent University, that aims to add quality to late life for people living in nursing homes and for their caregivers, including family, friends, and volunteers who support their care. Funded by the Canadian Institutes of Health Research and other partners, the SALTY Team involves close to 40 investigators, knowledge users and trainees from Nova Scotia, Ontario, Alberta and British Columbia. The study is organized into four interrelated streams: Monitor Care Practice, Map Promising Approaches to Care Relationships, Evaluate Innovative Practice, and Examine Policy Context with the respective work of these Streams being conducted in British Columbia, Alberta, Ontario and Nova Scotia. The researchers directly engage decision makers, knowledge users, LTC staff, residents, and their caregivers throughout the project to keep the research findings relevant to policy and practice.

The project is underway and during its first year will have a full team meeting for two days in Halifax, will be collecting and reviewing relevant policy documents, conducting a scoping review and key informant interviews to learn more about promising practices, evaluating the implementation of the Quality Initiative Project for end of life care, and developing longitudinal indicators to assess quality end of life care. For information on the project and updates visit www.SALTYltc.ca or contact SALTY@msvu.ca

SALTY Team Meeting 2016: Front Row (L – R): Dr. Denise Cloutier, Susan Stevens, Dr. Janice Keefe, Cameron Lynam, Liz Findlay, Lisa Tay; 2nd row: Heather Fifield, Heather Cook, Dr. Leah MacDonald, Mary Kjorven, Alyssa Firlotte, Dr. Deanne Taylor; 3rd Row: Dr. Greta Cummings. Linda Outcalt, Dr. Katie Aubrecht, Carren Dujela, Kaitlyn Delaney, Carmen Grabusic; 4th Row: Dr. Susan Braedley, Judy Nicol, Dr. Ivy Bourgeault, Dr. Kelli Stajduhar, Dr. Elaine Moody, Paula Richardson; 5th Row: Prince Owusu, Jim Mann, Dr. Tamara Daly, Dr. Hugh Armstrong, Brent Parker, Dr. Thomas Lo; Last Row: Dr. Peter Norton, Dr. Pat Armstrong, Dr. Jeff Poss. Missing: Melissa Andrew, Whitney Berta, Fred Burge, Stephanie Chamberlain, Jackie Choiniere, Kaitlyn Delaney, Carole Estabrooks, Pamela Fancey, Alyssa Firlotte, Faye Forbes, Andrea Gruneir, Michael Hillmer, Matthias Hoben, Trevor Janz, Ruby Knowles, Yvonne LePair, Emily Marshall, Margaret McGregor, Kim Norman, Corinne Schalm, James Silvius, Gary Teare, Jayme Waugh
Management of Hypertension in Frail Older Adults

We would like to revisit the locally developed frailty specific guidelines for hypertension that are featured on polypharmacy.ca. This guideline was developed by the Dalhousie University Academic Detailing Service and the Palliative and Therapeutic Harmonization (PATH) Program in 2012 and has been disseminated to thousands of health professionals through conference presentations, local educational initiatives, webinars, and academic detailing visits and was published in the Cleveland Clinic Journal of Medicine in 2014.

Recommendations

- Carefully review the risks and potential, but unproven, benefits of treatment.

Methods for measuring blood pressure

- Decisions about treatment should be based on blood pressure measurements in the seated (not supine) position, while also considering the presence of orthostasis.
- To evaluate orthostasis, measure BP lying, then immediately on standing and after 2 minutes. Ask the patient if they feel lightheaded or dizzy when standing.

Stopping Treatment

- If sitting SBP is <140mmHg, medications can be tapered and discontinued to achieve the targets described in the guideline.
- Before discontinuation, consider if the medications are treating additional conditions, such as rate control for atrial fibrillation or symptomatic management of heart failure.
- We are unable to make treatment recommendations for frail older adults at high risk for cardiovascular events. In particular, whether or not to discontinue treatment for individuals with a history of previous stroke is uncertain (see rationale: High Risk due to Previous Stroke)

Starting Treatment

- Consider starting treatment when SBP is ≥160mmHg.
- Target SBP should be 140 to 160 mmHg while sitting as long as:
  - There is no orthostatic drop to <140 mmHg using the technique described above.
  - There are no adverse effects from treatment that affect quality of life.
  - See above recommendation regarding treatment of high risk individuals with previous stroke.
- In the very frail with short life expectancy, a target SBP of 160 to 190 mmHg may be reasonable.
- The blood pressure target does not need to change when there is a history of diabetes.
- In general, use no more than 2 medications.

We recommend stopping antihypertensive medications that are used for the sole purpose of keeping the systolic blood pressure (SBP) below 140 mmHg, although we are unable to make treatment recommendations for frail older adults with previous stroke.