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PRIMARY CARE GERIATRICS

SIXTH
EDITION

A Case-Based Approach

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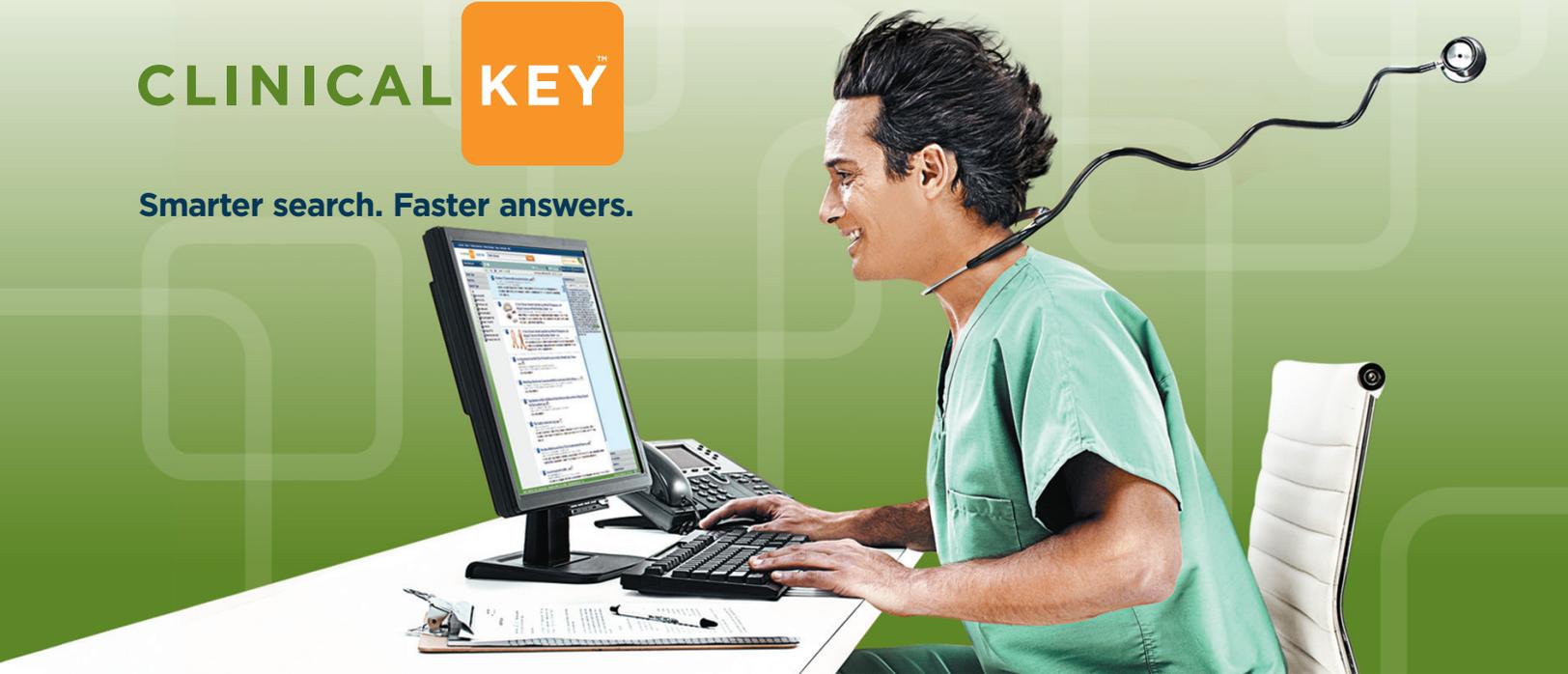
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Ham's

Primary Care Geriatrics

A Case-Based Approach

6TH EDITION

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To my patients and their families and friends,
whose insights, knowledge, sacrifice, and caring
continue to daily rekindle my admiration and
awe of the human spirit, and who have taught
me most of the really important aspects of
growing old and living wisely.

RJH

To those who have taught me the most: my
patients, my parents, and my colleagues.

PS

To my University of Cincinnati colleagues in the
Geriatric Medicine Program and the Department
of Family and Community Medicine for their
many years of support and inspiration.

GAW

To my husband, Daniel Francis Schafer, MD,
who is endlessly patient and supportive.

JP

To my husband, Mel Aaron, and our amazing
children, Eric, Marsha, Megan, and Kelsey, who
through their joy and compassion motivate me
to reach higher.

EF

My thoughts on old age . . .

*A gift for old age is to be able to delight in comfort.
Bed, bath, food, drink. To enjoy the simple and
immediate.*

Acknowledge one's disabilities—then try to forget them.

EILEEN M. HAM (1920-2001)

*"I feel like my brain is full of tiny drawers, and this
little man is running around opening drawers trying
to find the thing that I'm trying to remember."*

"Everybody's in a hurry these days, except old folks."

*"Getting old sounds like an accomplishment. But it's
not, because the last few years all you do is sit
around."*

"I'm not like I used to be, but then again, who is?"

**Quotes from GRACE HEDDESHEIMER
(1911-2009) on aging**

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Preface

I am excited to be writing, in 2013, the Preface to the sixth edition of *Primary Care Geriatrics: A Case-Based Approach*—a book that was first published 30 years ago as a pioneering, case-based textbook on geriatric medicine, which at that time was neither thought of nor defined as a medical specialty.

It was conceived from the outset as a case-based book, developed from a project of the American Geriatrics Society (AGS), with an advisory group chaired by the late Isadore Rossman. The first edition aimed to appeal to and inform any clinician tackling the problems of complex elderly patients and needing pragmatic help in categorizing the chaotic and ambiguous presentations of such patients in a primary care setting in order to produce satisfactory outcomes.

I am pleased and proud that our editors and contributors for this edition have maintained the freshness, style, breadth of scope, expertise, and, perhaps most important, enjoyability of previous editions. We know that our book has been appreciated and has a loyal following, perhaps because every clinician likes a “good” case, and the book’s text is driven by the progress of each case. It was after all in this way that we learned the art and science of medicine when we were young apprentices.

Some examples of the types of cases discussed in this edition include patients with the following conditions:

- multiple concurrent problems
- a clinically silent impending medical emergency
- inability to communicate problems or symptoms
- a rich lifetime of social and medical history
- requirement for a surrogate or advocate (often not a family member)
- family or patient in denial about early dementia or imminence of death

This book—although originally designed with the primary care physician (PCP) in mind, and always starting from a primary care site in the community (e.g., office, patient’s home, nursing home, urgent care)—is very suitable for the use of any health professional who wishes to learn more about care of the elderly patient. All clinicians with adult patients—even those with focused specialties—see elderly patients, often regularly, and need to be able to “cover” issues that a good general physician would (especially one who has absorbed the essentials of this book!), making sure that some serious problem (e.g., early dementia, possible sleep apnea) observed while the patient is under his or her watch is suitably referred

for diagnosis and management, including informing a family member in many instances.

This sixth edition also includes other updates:

- The following subjects are now covered in separate chapters: Emergency Care, Persistent Pain, Frailty, Arthritis and Related Disorders, Anemia, and Billing and Coding.
- The chapter questions and all the references for each chapter are now included on Expert Consult (see the inside cover for details on how to access this content online). In the book itself, each chapter cites all the references numerically, but only the Key References are listed. In many chapters Web Resources with Suggested Readings or Web guidelines are included just before the Key References. Additionally, a dermatology quiz and a chapter on dizziness are included exclusively on Expert Consult.
- Phil Sloane has coordinated and largely written the vital opening chapter, Principles of Primary Care of Older Adults, covering the range of the prior first three chapters.

An outline of the unchanged basic format of the book follows (this is mainly for new readers):

- Three “Units” are included: Principles and Practice, Geriatric Syndromes and Common Special Problems, and Selected Clinical Problems of the Organ Systems.
- Each clinical chapter (Chapters 10 and 15-53) has core text with the following subheadings to assist readers when using the text for reference: Prevalence and Impact, Risk Factors and Pathophysiology, Differential Diagnosis and Assessment, Management, and Summary.
- In virtually all chapters, cases and discussions of the case (both set in a font that differs from that used in the core text), generally in several numbered parts, are interspersed with the core text at appropriate points. Although the case and its discussion illustrate the text in all chapters and show the text “in action,” the text itself does stand alone. With few exceptions, all the core information—as in a conventional textbook—is in the text itself.

I must heartily thank my friend Phil Sloane for his assistance with this book. Without his firm insistence that it would take the two of us to organize and edit a second edition, there would have been no subsequent volumes in this series of *Primary Care Geriatrics*; it has become a very durable book. He has worked with me on every subsequent edition. He is the single most

important link in the long chain of authors, editors, and publishers who have worked to continue this book's success over these last 25 years.

Gregg Warshaw, a longtime friend and colleague, joined Phil and me as third co-editor for our third edition in 1997, and the three of us have now continued working together through four editions. For this book, he graciously agreed to lead this initiative and chair the editorial group and oversee the entire project; he has earned the gratitude of all of us for his efficient, considerate, firm, and effective leadership. Thanks, Gregg.

I would be remiss in not thanking our publishers who have not only once again produced a pleasing layout for our rather complicated format but also patiently endured waiting for some very late drafts from this physician, who wished to do clinical care for the remainder of his working life and ended up overcommitted but enjoying the life of a primary care geriatrician and "dementologist" (a word invented by Phil to describe the *really* challenging Lewy and Pick's patients I am following); however, it was regular ward attending in acute medicine (I learned a lot) that took me over the top.

It is a privilege to be a doctor—indeed any health care provider—a privilege won through years of education, training, and a lot of sleep deprivation. Particularly rewarding is the field of primary care geriatrics. Whether your patients are friends or strangers, they are trusting you with their physical and mental health and, even more, their stories—the history of who they were as well as who they are now, which often are very different pictures.

I hope so much that using this book will help you on your journey of knowledge, empathy, and appreciation of the stories that the old will tell you, in their words, by their symptoms, and in their very faces, and that it will empower you to help our elders to a more dignified, pain-free, and serene last stage of their lives. I also hope that you, the PCP, will experience the joy and satisfaction of knowing that you are responsible for achieving the best outcome for a life entrusted to your care.

Richard J. Ham, MD

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—*Richard Ham*

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—*Philip Sloane*

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—*Gregg Warshaw*

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—*Jane Potter*

In gratitude for the wisdom bestowed upon me from my patients, their families, and my colleagues over the past 30 years at NYU, Dartmouth, and throughout the world.

—*Ellen Flaherty*

A Note on Level of Evidence Ratings

Where A through D ratings are used, they correspond (as appropriate) to:

A, Evidence from well-designed meta-analysis, or well-done synthesis reports such as those for the Agency for Healthcare Policy and Research or the American Geriatrics Society; B, evidence from well-designed controlled trials, both randomized and non-randomized, with results that consistently support a specific action; C, evidence from observational studies or controlled trials with inconsistent results; D, evidence from expert opinion or multiple case reports.

A, Supported by one or more high-quality randomized clinical trials (RCTs) in an appropriate population, without contradictory evidence from other clinical trials; B, supported by one or more high-quality nonrandomized cohort studies or low-quality RCTs; C, supported by one or more case series and/or poor-quality cohort and/or case-control studies; D, supported by expert opinion and/or extrapolation from studies in other populations and/or settings; X, the preponderance of evidence supports the treatment being ineffective or harmful.