DIVISION OF ACUTE CARE SURGERY

Geriatric EGS Patient Management Guidelines

Rationale: To assure older adults (>65 years of age) receive age-appropriate care

I. Admission Orders:

- Past medical history/Past surgical history within 24h
- Medication reconciliation by Pharmacy Services within 48h
- Admission nurse to obtain FRAILTY Score in Epic
- Reversal plan for anticoagulation
    - If questionable Factor Xa Inhibitor use, can obtain LMW heparin level to detect presence (not amount) of drug.

Drug Class	Anticoagulant	Reversal Plan
Vitamin K Antagonist	Warfarin (Coumadin)	• Vitamin K 10mg x 1 (use caution in patients with active VTEs and/or prosthetic heart valves) • FFP – Do not use if evidence of heart failure, pulmonary edema, or Jehovah's Witness • PCC (Balfaxar) – If not a candidate for FFP or rapid reversal indicated – repeat INR 30 minutes after administration. Dosing per eStar advisor
Factor Xa Inhibitor	Apixaban (Eliquis) Rivaroxaban (Xarelto) Edoxaban (Savaysa) Betrixaban (Bevyxxa)	• PCC (Balfaxar) – dosing per eStar advisor
Direct Thrombin Inhibotor	Dabigatran (Pradaxa)	• Praxbind – dosing per eStar advisor

- Additional Labs/Tests
    - B12/Vit D/TSH/FT4
    - Hgb A1C
    - Venous lactate– if elevated obtain arterial lactate
    - EKG

II. Admission: ICU vs. Step-down:

- Decision for SICU vs step-down is based on clinical judgment. However, if patient has any of the following, they should be considered for admission to the Surgical ICU:
    - O2 requirement >6L NC

- High risk diagnosis to include but not limited to NSTI, MI, DKA, Bowel ischemia, GI bleed
- Hypotension: SBP < 100

III. Geriatric Consultation when step-down status:

- FRAILTY score of 4 or 5
- Polypharmacy – greater than 5 home medications
- Greater than 2 high risk medications
- Recurrent falls and/or persistent delirium
- Concern for dementia or decision-making capacity
- Multiple high-risk comorbidities such as:
  - COPD COPD Exacerbation
  - Heart failure
  - Hypertension requiring multiple agents
  - Uncontrolled diabetes (A1c > 9)
- Okay to schedule specific geriatric consult work up studies outpatient (i.e. carotid duplex)

IV. Specific Interventions for Geriatric Patient

- Bedside swallow – if concerned, consult Speech therapy
- Documented Pharmacy Medicine Reconciliation within 48 hours of admission
- Delirium minimization (See Trauma Delirium PMG) Trauma Delirium Management
  - Avoid benzodiazepines
  - Reduce antipsychotic dosing by 50%
  - Avoid Haldol >5mg or quetiapine >100mg
  - Avoid anticholinergics
  - Consider narcotic-sparing analgesia regimen
- Consider beginning a medication taper for inappropriate home medications while inpatient and continued upon discharge.
  - https://medstopper.com/ - assists w/ developing taper schedule; ensure patient agrees
- Avoid Haldol & olanzapine in Parkinson's disease – quetiapine preferred if needed
- Avoid tramadol for pain due to increased adverse side effects – low dose oxycodone preferred

- Sleep aids: melatonin 6mg at 18:00 preferred. May add Trazadone 25mg at 20:00 and titrate up. Avoid zolpidem
- Early mobilization and standing orders for OOBTC for all patients who are not on bed rest status.
- Consider PM&R consult to evaluate and provide recommendations for optimizing rehab potential if IPR is recommended.

V. Goals of Care – discussion and documentation in medical record within 24h of admission

- Code Status – mandatory
- Identify if patient has Advance Directives and a Surrogate Decision Maker
- Consider Palliative care consult for:
    - Surrogacy/advanced directive
    - Family conflict concerns
    - Unclear goals of care
    - FRAILTY score of 5

Geriatric Polypharmacy: Medications to Avoid

- Tricyclic antidepressants (i.e amitriptyline, imipramine)
- Promethazine
- Hydroxyzine
- Benztropine
- Scopolamine
- Nitrofurantoin (do not use if Cr Cl < 30mL/min)
- Alpha-1-blockers: terazosin, doxazosin. Tamsulosin is preferred if able.
- Central alpha-agonists: clonidine, guanfacine, methyldopa
    - If clonidine is home med, restart at appropriate dose for current vitals and wean as tolerated – do not stop abruptly if patient has used long term
- Barbiturates
- First generation antihistamines (i.e. chlorpheniramine, diphenhydramine)
- Megestrol: poorly tolerated, lack of efficacy, increased VTE & mortality risk
- Anti-spasmodics (bladder): tolterodine, oxybutynin, dicyclomine
- Opiates: If long acting needed oxycodone ER (Oxycontin) is preferred over Morphine sulfate ER (MS Contin)
- Second generation antipsychotics (example: quetiapine, olanzapine)

    - If absolutely necessary for care & safety, please refer to the Trauma Delirium PMG
- Benzodiazepines: Do not use for insomnia, anxiety, agitation, or delirium. May be appropriate for seizure disorders, palliative care, benzo withdrawal, or peri-procedural.
- Cyclobenzaprine
- Tramadol
- Oral estrogen: If on home oral estrogen, please hold while inpatient d/t increased VTE risk. Consider changing to patch upon discharge.

References:

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