



# Clinical Comment

Spring 2001

## GERIATRIC MEDICINE

### Who Should See a Geriatrician?

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Many family physicians, general internists, and specialists within internal medicine spend a good portion of their time seeing patients who are older than the age of 65 years. So it is not surprising for physicians and the public alike to ask questions such as "What is a geriatrician?" and "Who needs to see a geriatrician?" This article answers these questions, in part, by discussing the range of services provided and approaches taken by the geriatricians at the University of Chicago. Additional articles in this issue of *Clinical Comment* highlight some of the exciting and innovative programs in more detail.

Several features of geriatrics care set it apart from most other kinds of general medical care: (1) a focus on function; (2) an increased ability to distinguish normal changes caused by aging from those changes caused by

Table. — People With Difficulty and Those Who Get Help in Basic Life Activities

Age, y	Persons With Any Difficulty		Persons Who Get Help From Others	
	Total Population, %		Total Population, %	Those With a Difficulty Who Get Help, %
55-64	6.0		4.2	69.9
65-74	11.8		8.7	73.4
75-84	26.5		20.3	76.8
85+	57.6		50.0	86.7
65+	20.1		15.7	77.9

Source: LaPlante M., Miller K. "People with disabilities in basic life activities." In: *U.S. Disability Statistics Abstracts*. San Francisco, C.A.: Institute for Health & Aging, University of California; 1992. Abstract No. 3.

disease; (3) a greater awareness of how many common diseases have an altered or non-specific presentation in the elderly; (4) special expertise in the so-called geriatric syndromes; and (5) the practice of working in teams to provide coordinated, comprehensive care. The patients who are most likely to benefit from referral to a geriatrician are the oldest and frailest individuals and those with functional disabilities, multiple geriatric syndromes, and complex psychosocial needs.

The focus on function in geriatrics refers to how geriatricians routinely assess older patients' abilities to perform basic activities of daily living (ADLs) (e.g., bathing, dressing, transferring from a wheelchair to a bed, getting to the bathroom, and feeding) and instrumental activities of daily living (IADLs) (e.g., paying bills, managing medications, shopping, cooking, and using the telephone). Functional status relates to the setting in which a patient can live, what kinds of services may be required to assist a patient, and how multiple medical illnesses may be affecting the patient's quality of life. Functional status is highly correlated with risk of hospitalization, use of medical services,

and mortality; in fact, functional status is a better predictor of these outcomes than most kinds of information collected by physicians.

While many organ systems' functions (or at least their reserves) tend to decline with increasing age, physicians and patients alike often inappropriately attribute problems to "old age." In its most extreme form, this approach can result in ageism and therapeutic nihilism, through which opportunities to ameliorate conditions are overlooked. Accepting fatigue as an inevitable part of aging may mean missing the opportunity to treat depression or hypothyroidism. Accepting pain as a normal accompaniment to conditions such as arthritis may mean pain is undertreated, which in turn, diminishes quality of life. Geriatricians are loath to attribute most problems to aging alone.

Many older patients with common conditions present with altered or nonspecific symptoms. Confusion, or an altered mental status, may be the chief complaint in up to 20 percent of patients older than 85 years when they present to the hospital with a myocardial infarction. Chest pain may be completely absent. Changes in mental status also are frequently seen with



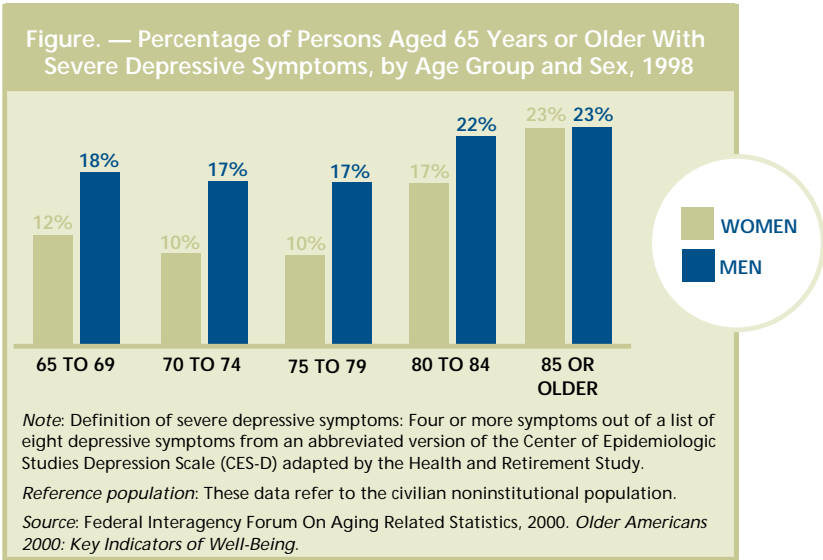
infections, such as pneumonia. Fever can be surprisingly absent, even in the face of serious infections, in the oldest old. Nonspecific declines in function, weight loss, and decreased oral intake — sometimes called failure to thrive — are even more common in older patients with dementia. Sorting out the cause of these presentations requires more time, a heightened index of suspicion, and a comprehensive approach to assessment. Geriatric training assists in the development of skills to identify contributing factors and a strategy to eliminate or modify them to improve symptoms and hopefully enhance quality of life.

Disabilities that are present in older persons frequently go unrecognized by other specialists or general internists, owing to time constraints or lack of familiarity with the differences in disease manifestation. These include deterioration of ADLs, cognitive disorders, affective disorders, incontinence, falls, and sensory deterioration. Individuals older than 85

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years need assistance with at least one ADL 50 percent of the time (Table). About 12 percent of persons older than 65 years, and up to 50 percent of those older than 85 years, have some form of cognitive impairment. Almost 20 percent of individuals older than 65 years suffer from symptoms of depression and may benefit from treatment (Figure). Up to 15 percent of community-dwelling older adults suffer from incontinence but do not discuss it with their physicians because of embarrassment or the false belief that it is part of the usual course of aging.

Accidents are the fifth leading cause of death in those older than 65 years, and falls comprise two-thirds of these accidental deaths. Hearing loss is one of the most common chronic conditions that affects older adults. The prevalence of hearing loss in persons older than 65 years is 25 percent to 40 percent. These elderly experience a continued decline in hearing throughout each decade



until the prevalence reaches about 80 percent for individuals in their eighth decade. Studies consistently link hearing loss to depression, irritability, social isolation, and diminished physical mobility. Similarly, aging is associated with an increasing prevalence of visual impairment. After the age of 65 years, adults experience a decrease in visual acuity, glare tolerance, and depth perception. Leading causes of visual impairment in older adults include cataracts, macular degeneration, diabetic retinopathy, and glaucoma. All of these conditions are common, underrecognized in routine practice, and most importantly, treatable to a great extent.

From the above description of the challenges of geriatric care, it would be hard for any individual practicing physician to meet the needs of the frailest patients. That is why geriatricians work in teams and closely collaborate with nurses, nurse practitioners, social workers, physical and occupational therapists, nutritionists, and other medical specialists as needed.

Patients evaluated in one of the geriatrics clinics at the University of Chicago will receive a comprehensive medical, sensory, functional, psychological, and social assessment. Similar evaluations have been shown to decrease mortality, increase the probability that a patient will continue to live at home, decrease the likelihood of hospital admission, and enhance functional status. The University of Chicago Section of Geriatrics has a national reputation of providing outstanding comprehensive healthcare to meet the needs of the frailest patients.

Currently, we provide evaluations and longitudinal care at two sites, the Windermere Senior Health Center and the recently opened

Outpatient Senior Health Center at South Shore. These sites offer an array of services including primary care, a frail elders program, memory center evaluations, support groups, diabetes education, and a number of on-site subspecialty consultations. The care team consists of geriatricians who work closely with social workers, nurses, nurse practitioners, physical and occupational therapists, and an audiologist, in addition to phlebotomy, x-ray, and electrocardiographic services.

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Subspecialty services available on-site at the clinics enhance communication and ease transportation difficulties. Represented subspecialties include rheumatology, neurology, dermatology, geriatric psychiatry, and ophthalmology. These relationships allow patients, family members, and referring physicians peace of mind by providing familiar settings and consistent staffing who enjoy interacting with older adults and make a special effort to know patients on an individual level.

All of these services are available for either a one-time consultation or ongoing management of challenging clinical problems. In either case, the consulting geriatrician will provide a comprehensive report to the referring physician and close follow-up care of the patient. In general, patients referred to our clinics are those who: (1) suffer from multiple medical problems; (2) receive care from multiple subspecialists; (3) have undergone recurrent hospitalizations; (4) have experienced functional decline; or (5) present with complaints that are not consistent with classic symptom or disease categories.

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# Geriatric Oncology

## Geriatrics and Oncology: A New Approach to Clinical Research and Patient Care

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Two closely related revolutions are happening, one in demography and the other in oncology. The first revolution is the aging of the population, the “graying of America.” What is less well known is the graying of oncology and the impending increase in the need for

specialized care and services for elderly cancer patients and cancer survivors. Two groups at the University of Chicago are getting together to address these issues.

The U.S. population is aging. In 1900, a total of 4.1 percent of the population was 65 years of age or older; today more than 33 million people are 65 years of age or older. By 2030, more than 70 million people, or 20 percent of the population, will fall into this category (Figure 1).<sup>1</sup> Cancer incidence increases dramatically with age. The incidence of cancer in persons 65 years of age and older is tenfold higher than the incidence in people less than 65 years (2,164/100,000 vs. 207/100,000 people, respect-

Figure 1. — Total No. of Persons Aged 65 Years or Older, by Age Group, 1900 to 2050, in Millions

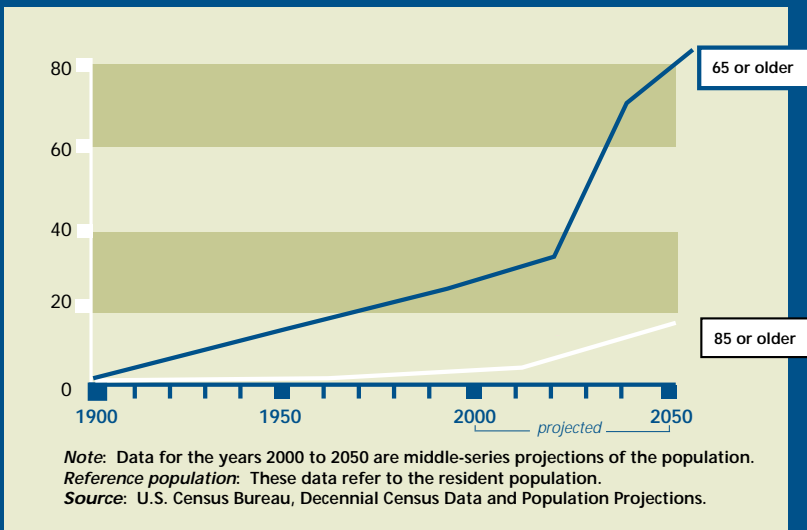
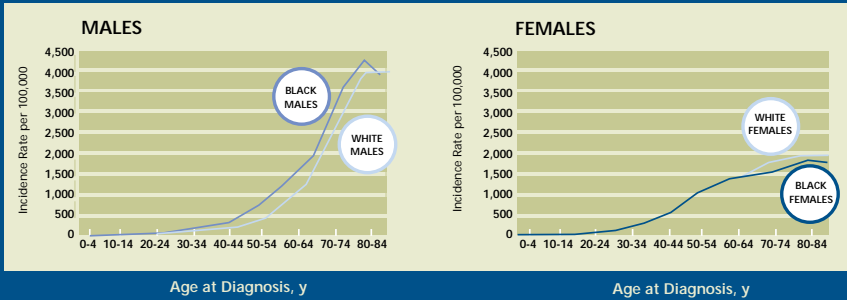


Figure 2. — Average Annual Age-Specific Cancer Incidence: All Sites by Race and Sex, 1987-1991



ively). Mortality from cancer among those 65 years or older is 1,076 per 100,000, nearly 15 times higher than the rate of 69 per 100,000 for those younger than 65 years. (Figure 2).<sup>2</sup> Currently, about 50 percent of all malignancies are diagnosed in those who are elderly. In 20 years, a 12 percent increase in the elderly population will translate into a 60 percent increase in the numbers of cancers diagnosed.<sup>3</sup> These revolutions will challenge us to consider new approaches to screening and diagnosis, new protocols for treating elderly patients, and new systems for providing cancer care to elderly patients.

Over the last two decades, considerable research has shown that although the elderly are at highest overall risk for common malignancies such as breast, colon, and cervical cancer, they are less likely to be screened and are therefore less likely to be diagnosed in early, curable stages of illness. The elderly more commonly present with more advanced disease, and even when matched for stage of disease, they are offered fewer treatment options than those who are younger.<sup>4</sup> The reasons for these findings have been extensively studied and discussed. For example, the relationship between age and the biological behavior of malignancies is complex. The role of early detection for survival is under debate for prostate cancer, but is becoming clearer for breast cancer<sup>5,6</sup>; both diseases

have a peak incidence and mortality rate among the elderly.

Life expectancy is an important factor to consider when deciding on treatments and measuring their effectiveness in elderly patients. Clinical trial evidence to guide treatment decisions has been sparse, since elderly people have been only poorly represented in such research studies for a number of reasons.<sup>7</sup> Geriatric research has noted that comorbidity and functional status often are poorly correlated, but may independently predict survival in community-dwelling, hospitalized, and other clinical populations of elderly.<sup>8</sup> Research also suggests that oncologists, patients, and referring physicians make cancer treatment decisions that may be related to comorbidity and functional status.<sup>9</sup> However, there is a lack of research to specifically address the impact of functional status and comorbidity on elderly cancer patients.<sup>10</sup>

These needs were recognized by the John A. Hartford Foundation (based in New York, N.Y.), which has spearheaded a national effort to stimulate collaborative work between geriatricians and oncologists.<sup>11</sup> In 1999, the University of Chicago was selected as one of 14 centers to pilot interdisciplinary research and training in geriatrics and oncology. Harvey Golomb, MD, Chairman of the Department of



Medicine, Todd Zimmerman, MD, of the Section of Oncology, and Deon Cox-Hayley, DO, of the Section of Geriatrics, served on the Hartford Foundation's advisory board to develop training curricula and guidelines for a new subspecialty in geriatric oncology. In the following year, several projects were launched. Dr. Zimmerman supervised the fellowship research of Andrea Bial, MD, who will join the University of Chicago faculty in the Section of Geriatrics this summer. Dr. Bial's study, "The Evaluation of Depression in Elderly Men With Prostate Cancer," suggests a complex relationship between prostate cancer and depression, one that needs to take treatment modality into account.

Drs. Cox-Hayley, Zimmerman, and Bial, with Miriam Rodin, MD, PhD, of the Section of Geriatrics, Ann Mauer, MD, of the Section of Oncology, and Elizabeth Lamont, MD, research fellow from the Robert Wood Johnson Foundation (which is based in Princeton, N.J.), hosted a continuing medical education conference in March for primary care and oncology physicians and allied professionals entitled "Geriatric Oncology 2001: A New Approach to the Older Cancer Patient." The conference featured several internationally prominent authorities in this emerging field.

Several new initiatives are soon to be launched. Although it is difficult to estimate numbers, it is clear that improvements in cancer treatment are leading to increased numbers of cancer survivors in the population at large, and in the elderly population as well. Little is known about long-term survival and its impact on general health and aging, quality of life, and functional status. Research is sparse, but the results are encouraging. Overall, the five-year survival rate of breast cancer is the same for women 65 years

of age and older as for women younger than 65 years.<sup>12</sup> Comorbidities increase in prevalence with age. However, well elderly, even at advanced ages, appear to tolerate cancer treatment.<sup>13,14</sup> Furthermore, advances in the management of chemotherapy side effects have raised new questions about the long-term quality of life for cancer survivors.<sup>15</sup> Drs. Rodin and Mauer, and Gini Fleming, MD, of the Section of Oncology, with other members of the breast and gastrointestinal tumor groups, will be investigating the long-term effects of chemotherapy on neurological function in elderly cancer survivors.

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To facilitate the care of elderly cancer survivors, the Section of Geriatrics at the University of Chicago is initiating a referral clinic devoted to the special needs of those 65 years of age and older who have undergone cancer treatment. One clinical site will be at the Outpatient Senior Health Center at South Shore, located 7101 S. Exchange Ave., in Chicago. It will be staffed by geriatricians, geriatric nurse practitioners with oncology cross-training, and fellows in the joint geriatric-oncology fellowship. The clinic will provide geriatric primary care, periodic monitoring according to current oncology practice guidelines, close interaction with the patients' primary oncologists, and collaborative follow-up of clinical-trial participants. The clinic provides local-area transportation and shuttle service to the University of Chicago Hospitals for needed laboratory and radiology services. In addition, joint patient conferences including both oncology and geriatric faculty are under development.

Dr. Cox-Hayley, of the Section of Geriatrics, offers an additional component of care, at the Windermere Senior Health Center, located at 5549 S. Cornell Ave., in Chicago. She is an

established authority on palliative care, the branch of medicine concerned with pain control and medical care at the end of life. Palliative care medicine completes the spectrum of care and offers expanded opportunities to cross-train geriatric and oncology fellows in hospital and outpatient settings.

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# Memory Disorders

## Multidisciplinary Team Treats Memory Disorders

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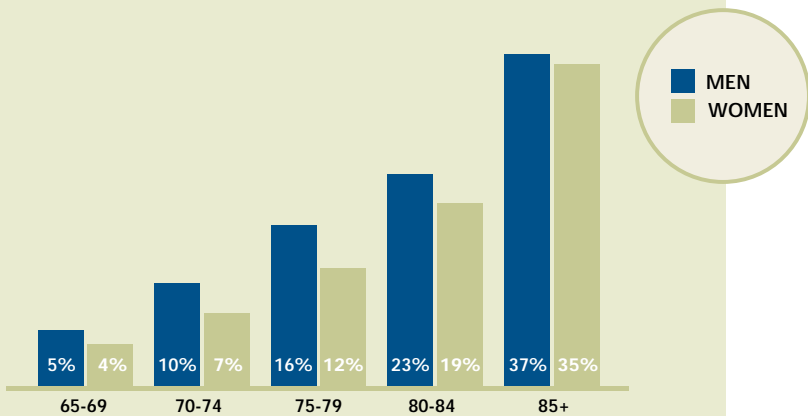
For today's patients with Alzheimer's disease (AD) and other dementias, a sharp contrast exists between the stunning and rapid progress being made in the basic biology of these diseases and what most of these affected patients and their families can expect in their care. Three different genes have been identified that predispose some families to an early-onset (before the age of 60 years)

form of AD. The apolipoprotein E gene has been demonstrated to increase individuals' susceptibility to the more typical, late-onset AD. Investigators all over the world are studying these genes, the proteins that make up the characteristic plaques and tangles found in AD pathology, as well as enzymes and other factors thought to play important roles in the formation of these abnormalities. More importantly, a vaccine against AD has been shown to not only prevent the formation of plaques in young mice, but also to cause regression of plaques in older mice.<sup>1</sup> The hope for effective, disease-modifying therapy, and perhaps even prevention, is greater now than at any other time in the last 20 years.

In contrast, dementia is one of the geriatric syndromes that often go undetected in many primary care settings. In a recent study by



Figure 1. — Percentage of Persons Aged 65 years or Older With Moderate or Severe Memory Impairment, by Age Group and Sex, 1998



*Note:* Definition of moderate or severe memory impairment: Four or fewer words recalled (out of twenty) on combined immediate and delayed recall tests.  
*Reference population:* These data refer to the civilian noninstitutional population.  
*Source:* Federal Interagency Forum on Aging Related Statistics, 2000.  
*Older Americans 2000: Key Indicators of Well-Being.*

University of Chicago geriatrician Shelley Sternberg, MD, and colleagues in Canada, investigators examined the medical records of 252 patients with dementia.<sup>2</sup> Almost 65 percent of the patients had never seen a physician for existing memory problems and therefore, their dementia had not been diagnosed. Those with mild impairment were twice as likely as those with severe impairment to have their dementia undiagnosed. Memory problems are similarly overlooked in the United States. While many authorities call for routine screening for dementia, it is common for patients to have had symptoms of dementia for three or more years prior to the recognition of a memory disorder.<sup>3</sup>

It is important not to dismiss memory and behavioral changes as simply old age. A

thorough evaluation is necessary to determine the extent and cause of memory problems. Alzheimer’s disease is the most common form of dementia, but there are many other reasons

people can have problems with their memory (Figure 1). Many memory problems are treatable, and a supportive and caring team of health-care professionals can help virtually all patients and families.

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The Center for Comprehensive Care and Research on

Memory Disorders at the University of Chicago is staffed by a committed team of highly trained neurologists, geriatricians, psychiatrists, neuropsychologists, social workers, and specialized nurses. This multidisciplinary team approach allows us to evaluate each patient in a very thorough manner to uncover all possible causes of memory or behavioral problems. Because all these specialists work

under one roof, patients and families have easy access to the appropriate specialist for their individual needs, which ensures seamless, thorough care.

As part of a world-renowned academic medical center, our team of physicians and researchers participate in the latest cutting-edge research and bring the most up-to-date knowledge regarding the diagnosis and management of memory disorders to patients more quickly and with more expertise than at other institutions. We are able to handle the most challenging problems, including unusual presentations of memory loss and dementia. The Memory Center also serves as a referral resource for physicians in the greater Chicago metropolitan area. Physicians can refer patients here for diagnostic evaluation, periodic consultation, or comprehensive ongoing care.

Patients evaluated at the Memory Center will be seen independently by several team members in order to clearly understand the full scope of the memory problem and how it affects both the patient and the family. Typically, a neurologist or geriatrician will be designated as the primary physician and will guide patients throughout their care.

Additionally, the patient will see a neuropsychologist to specifically test memory function, a nurse to evaluate how well the patient functions at home, and a social worker to assess the needs of the family. A small number of blood tests will be performed at the Memory Center, and if needed, an imaging study using high-resolution brain scans will be performed at the main campus of the University of Chicago Hospitals. The entire evaluation process generally takes one or two closely timed visits. At the end of the evaluation

period, the team members meet to determine the most accurate diagnosis.

After a thorough evaluation, the Memory Center team will develop an individually tailored, comprehensive care plan for each patient and family. The care plan is summarized in a report made available to patients, families, and physicians who refer patients to the Memory Center. The care plan helps guide the ongoing care of the patient over the long-term course of the memory disorder.

Our unique multidisciplinary approach allows us to serve patients and families by (1) performing initial evaluation of suspected memory problems; (2) providing second opinions; (3) assessing and managing behavioral problems or psychiatric problems that often accompany memory disorders; (4) serving as the primary care source for patients with memory problems; and (5) being available as a “one-stop” resource for referring physicians, patients, and their families.

These services can be provided either through continued follow-up with the Memory Center team, continued follow-up with one of the geriatricians based in the Memory Center, or through direct communication with the patient's family physician, whichever the family and patient prefer.

In addition, the special expertise in memory disorders of several nationally known faculty members can be brought to bear on some of the more difficult issues that face physicians, patients, and families in dementia care. Jim Mastrianni, MD, PhD, is a neurologist and co-director of the Memory Center. Dr. Mastrianni's area of expertise is Prion disease

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Memory Center team members meet to determine each patient's diagnosis and create an individually tailored, comprehensive care plan.

and other atypical forms of dementia. These unusual forms of dementia strike younger patients and have unusual features (e.g., myoclonus and other neurological findings) and a more rapid course. Maria Caserta, MD, PhD, is a geriatric psychiatrist and associate director of the Memory Center. Her clinical expertise is particularly helpful in managing psychiatric manifestations of many dementias, including psychotic features, depression, and anxiety. Greg Sachs, MD, chief of geriatrics and co-director of the Memory Center, is nationally known for his work on ethical issues in the care of patients with dementia, including care near the end of life.

Dr. Sachs and his colleagues in geriatrics run an innovative program to provide palliative care to patients with dementia (Palliative Excellence in Alzheimer Care Efforts — The PEACE Program). Through the PEACE Program, funded by a major grant from the Robert Wood Johnson Foundation (based in Princeton, N.J.),

physicians, patients, and families have access to a special type of consultative care that focuses on managing symptoms, providing support, and helping to achieve a peaceful death, often with the use of hospice.

Finally, the Memory Center faculty and staff work closely with the local chapter of the Alzheimer's Association and other community resources to provide referrals to other services, including adult day care, respite care, and in-home services. These often are the kinds of services that a busy practitioner may not have the time or assistance to locate for patients and families.

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# Geriatric Medicine

## New Senior Health Center Focuses on Total Health of the Elderly

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The University of Chicago (U of C) Hospitals' Windermere Senior Health Center (5549 S. Cornell Ave.) is a well-established center to serve the healthcare needs of the elderly on the south side of Chicago. To build on these services, and in response to the growing elderly population on the south side, the U of C opened the Outpatient Senior Health Center at South Shore (OSHC) (7101 S. Exchange Ave.) on July 31, 2000. The OSHC was designed specifically for the elderly and has initiated innovative programs in the care of older adults.

### FRAIL ELDER'S PROGRAM

Different medical specialists use different tools. Cardiologists may use cardiac catheterization. Gastroenterologists may use endoscopy. The tool of the geriatrician is the comprehensive geriatric assessment (CGA). CGA has been defined as a multidimensional — usually interdisciplinary — diagnostic process designed to quantify an elderly individual's medical, psychosocial, and func-

tional capabilities and problems. The intent is to arrive at a comprehensive plan for therapy and long-term follow-up.<sup>1</sup> This process has its origin in Britain in the 1930s.

The American Geriatric Society, American College of Physicians, and National Institutes of Health all have endorsed CGA as a means to enhance the care of the elderly. Those most likely to benefit are the frail elders, who often have medical complexity, atypical presentation of illnesses, and significant cognitive and functional problems. These patients often are socially isolated, economically deprived, and at high risk for iatrogenesis and inappropriate institutionalization.<sup>2</sup> CGA programs have been implemented in hospitals, at home, and in outpatient settings. Overall, CGA programs have been shown to decrease mortality and institutionalization and improve physical and cognitive functioning. Factors shown to be important in the success of CGA programs are appropriate identification of frail elders and control over medical recommendations and ambulatory follow-up.

The frail elders program at the OSHC has been designed to maximize patient and family involvement with a dedicated interdisciplinary team. The core team members are the geriatric nurse practitioner, social worker, and geriatricians, who are all on site at the OSHC. All new patients are evaluated for appropriateness for the frail elders pro-

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AND COGNITIVE  
FUNCTIONING.**



gram. In collaboration with a research team at the University of California, Los Angeles, a new telephone screening tool for frailty is being used to identify frail elders. Patients found to be frail are then evaluated by the nurse practitioner, social worker, and geriatrician. Team meetings are held weekly to discuss the patients and may include participation by a representative of the patient's homecare agency. On the subsequent visit, team members meet with the patient, family, and caregivers to set priorities and goals of care and map out a treatment plan. Patients may participate in the program on a consultative basis, having close communication with the primary physician, or they may seek primary care at the OSHC.

#### FALLS PREVENTION PROGRAM

To build on the basis of the frail elders program, a new falls prevention program has been designed for the OSHC. Falls carry significant morbidity and mortality in the elderly and are a recognized geriatric syndrome. One-third of people 65 years of age and older who live in the community fall each year. Accidents are the fifth leading cause of death in the elderly and falls account for two-thirds of these accidents. Elderly patients who are hospitalized for a fall have only a 50 percent survival rate at one year. Ninety percent of hip fractures are the result of a fall.

The geriatric literature has shown that reducing risk factors for falls can significantly decrease the incidence of falls.<sup>3</sup> Beneficial interventions have decreased the use of sedative-hypnotic medications, removed environmental hazards, and offered training in safe transfer techniques (e.g., getting out of a chair or the bathtub). In addition, the literature has shown that the risk of falls can be reduced by exercises such as balance and resistance training that target muscle weakness in the lower extremities.<sup>4</sup> With a core team that includes a clinical nurse specialist, physical

therapist, and geriatrician, the falls prevention program will target elders who have fallen to try to prevent additional falls. Patients referred to the program will receive an evaluation by all team members using validated standardized tools. A formal history of falls, assessment of gait and balance, and review of medications and neurological status will be completed. The interdisciplinary team will meet and develop a set of recommendations with input from the patient, family, and caregivers. Home safety evaluations also will be completed as necessary. Linkages with neurology and endocrinology for both podiatric as well as on site osteoporosis screening will enhance the comprehensiveness of the program. For ongoing therapy, special group programs to serve elderly who have fallen will be developed.

#### WELL ELDERS PROGRAM

Well elders also are a focus of care at the OSHC. Elders who have chronic problems such as arthritis or hypertension but are still functional and active can participate in the well elders program. This program is a collaboration between geriatricians and the nurse practitioner. The emphasis is on maintaining function and preventing disability. An innovative program under development will have well elders act as volunteers to provide support through a telephone buddy system for those elders who are more frail and are isolated at home or are acting as caregivers themselves.

#### REFERENCES

1. Rubenstein LZ. Geriatric assessment: an overview of its impacts. *Clin Geriatr Med*. 1987;3(1):1-15.
2. Solomon D, Brown AS, Brummel-Smith K, et al. National Institutes of Health consensus development conference statement: geriatric assessment methods for clinical decision-making. *J Am Geriatr Soc*. 1988;36:342-347.
3. Tinetti ME, Baker DI, McAvay G, et al. A multifactorial intervention to reduce the risk of falling among elderly. *N Engl J Med*. 1994;331(13):821-827.
4. Province MA, Hadley EC, Hornbrook MC, et al. The effects of exercise on falls in elderly patients: a preplanned meta-analysis of the FICSIT trials. *JAMA*. 1995;273:1341-1347.

## ANNOUNCEMENTS

### CONTINUING MEDICAL EDUCATION CALENDAR

For more information about the courses listed below, call (773) 702-1056.

#### June 2001

##### Intensive Review of Asthma

June 1 • University of Chicago Medical Center  
Conference Director: Julian Solway, MD

##### Chicago Area Medical Schools

##### OB/GYN Review Course

June 4-9 • Holiday Inn City Center, Chicago  
Conference Director: Arthur Herbst, MD

##### Inflammatory Bowel Disease: Highlights and Insights from Digestive Disease Week

June 9 • The Gleacher Center, Chicago  
Conference Director: Stephen Hanauer, MD

##### 3rd Annual Indiana Pediatric Day

June 12 • Radisson Hotel, Merrillville  
Conference Director: Herbert T. Abelson, MD

##### 8th Annual Primary Care Orthopaedics Course

June 20-23 • The Drake Hotel, Chicago  
Conference Director: Sherwin Ho, MD

#### July 2001

##### Advances in Obstetrics and Gynecology

July 19-22 • Four Seasons Hotel, Palm Beach, FL  
Conference Director: Eric Bieber, MD

##### Intensive Review of Asthma

July 27 • University of Chicago Medical Center  
Conference Director: Julian Solway, MD

#### August 2001

##### Controversies in Obstetrics and Gynecology

August 9-11 • Lake Powell, AZ  
Conference Director: Eric Bieber, MD

#### September 2001

##### Advances in Non-Invasive Vascular Diagnosis

September 20 • The Fairmont Hotel, Chicago  
Conference Director: Hisham Bassiouny, MD

### JOIN US FOR INDIANA PEDIATRIC DAY

Please join us on June 12 for the Third Annual Indiana Pediatric Day, a free educational event featuring talks on common issues encountered in pediatric practice. University of Chicago physicians will present practical information on a wide variety of topics including asthma, cardiac problems in young athletes, celiac disease, and more.

The event satisfies four hours of category 1 continuing medical education credit. Continental breakfast and a light lunch will be served. For more information or to register, please contact Brenda Gardner at (773) 702-0448 or send an e-mail message to bgardner@uchospitals.edu.

**Third Annual Indiana Pediatric Day**  
**Tuesday, June 12, 2001**  
**The Radisson Hotel at Star Plaza**  
**800 East 81st Avenue**  
**Merrillville, Indiana 46410**

#### Programs:

##### "Asthma Update for the Office Pediatrician"

Amy Goldstein, MD  
Instructor of Pediatrics  
Section of Pediatric Pulmonary and  
Critical Care Medicine

##### "Sudden Death In Young Athletes"

Frank J. Zimmerman, MD  
Assistant Professor of Pediatrics  
Director of Pediatric Electrophysiology  
Section of Pediatric Cardiology

##### "Minimally-Invasive Surgery In Children"

Donald Liu, MD  
Assistant Professor of Surgery  
Surgeon-in-Chief, Section of  
Pediatric General Surgery

##### "The Challenge In Diagnosing Celiac Disease"

Stefano Guandalini, MD  
Professor and Section Chief,  
Section of Pediatric Gastroenterology,  
Hepatology, and Nutrition

##### "Human Brain Malformations"

Williams B. Dobyns, MD  
Professor, Departments of Human  
Genetics, Pediatrics, and Neurology



## NEW APPOINTMENTS

### Department of Medicine

#### Emergency Medicine

Geoffrey Korn, MD  
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(773) 702-9500

#### Endocrinology

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#### Gastroenterology

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Clinical Instructor of Medicine  
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Clinical Instructor of Medicine  
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Amit Shah, MD

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William Sweatt, MD

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Clinical Instructor of Medicine  
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### Department of Neurology

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Axel Rosengart, MD

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### Department of Obstetrics and Gynecology

#### Maternal-Fetal Medicine

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### Department of Pediatrics

#### Hematology and Oncology

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#### Neurology

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### Department of Radiology

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### Department of Surgery

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#### Neurosurgery

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#### Orthopaedic

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#### Transplant

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## UNIVERSITY OF CHICAGO TO BUILD NEW CHILDREN'S HOSPITAL

Gary C. Comer, founder of Lands' End clothing-catalogue company, and his wife, Frances, have made a \$21-million donation to help build the University of Chicago Comer Children's Hospital. Construction of the state-of-the-art \$130-million facility is scheduled to begin in the fall of 2001 and will be completed in early 2004.



Artist's rendering of the new University of Chicago Comer Children's Hospital.

The 242,000 square-foot, 155-bed, seven-story hospital will provide a modern, yet child-friendly setting for all inpatient children's health services, including nationally recognized programs in cardiac services, neurology, neurosurgery, oncology, transplantation and other medical and surgical specialties.

and newborn surgical patients. Patient rooms will be big enough to accommodate family members, and there will be more common spaces for families, including sleeping areas, a family kitchen, and laundry facilities.

The new hospital will include two 30-bed medical/surgical units, which will include predominantly private rooms. It also will feature a two-story, 30-bed pediatric intensive care unit, with ample space for each bed. The neonatal intensive care unit, at 55 beds already the largest in the Midwest, will expand to 65 beds and double the space per bed. The new hospital will add six surgical suites, with operating rooms, preoperative areas, and recovery rooms designed to suit the specific needs of pediatric

The Comer Children's Hospital will be built one block north of the current children's hospital, filling one side of Maryland Avenue from 57th to 58th Streets. The new facility will connect to Bernard Mitchell Hospital (the adult inpatient hospital), the Duchossois Center for Advanced Medicine (which houses pediatric and adult specialty clinics), and the nearby Ronald McDonald House.

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