Abstracts

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Abstracts are arranged numerically by session and in the order of presentation within each session.

SESSION 5 (SYMPOSIUM)

ENHANCING RECOGNITION OF GERIATRIC SYNDROMES BY PRIMARY CARE HEALTH PROFESSIONALS

Chair: J.E. Morley, *Saint Louis University, St. Louis, Missouri*
Co-Chair: H. Arai, *National Center for Geriatrics and Gerontology, Nagoya, Japan*
B. Vellas, *CHU Toulouse, Toulouse, France*

There is a shortage of geriatricians around the world. In the USA the number of geriatricians has grown smaller. This is in the face of the increased aging of the baby boomer population. Many primary care health professionals have had limited training in geriatrics. There is increasing understanding that early recognition of the new geriatric "giants" – frailty, sarcopenia, anorexia of aging and cognitive dysfunction – can lead to a decrease in disability and hospitalization with appropriate management. This has led to the development of a number of brief comprehensive screening processes for geriatric conditions. Examples of these include the Easy Care in the United Kingdom which has been widely disseminated; the Kihon Checklist (KCL) in Japan; the Gerontopole screen tool in Toulouse, and the Rapid Geriatric Assessment that has been developed as part of the Medicare Wellness Visit in Missouri. Professor Arai will discuss experience with the Kihon Checklist which is used by the Japanese Long-Term Care Insurance system. He will focus on how this index can be used to classify person into robust, frail and prefrail and its predictive value. He will also provide evidence of an exercise intervention for improving outcomes. Professor Vellas will explain the short Gerontopole screening questionnaire used by family practitioners as a tool to find persons in need of a referral to geriatricians. He will report on the outcomes of 1,108 older patients (mean age 82.5) that were screened by their family physicians. The necessary interventions in this group included medical conditions with a new intervention (32%), nutritional intervention (62%), physical activity intervention (57%) and a social intervention (26%). Professor Morley will describe the RGA consisting of 4 rapid screens – the FRAIL for frailty, SARC-F for sarcopenia, SNAQ for anorexia of aging and Rapid Cognitive Screen for MCI and dementia. These tests have been validated in from 2 to 5 continents and are available in up to 30 languages. Over 2,000 persons have undergone the test. Results show that both screening and case finding produce similar deficits. A computer assisted screening and management program has been developed and in addition handouts for lifestyle intervention are available. These examples suggest that high quality geriatric screening can be carried out by primary care health professionals with positive outcomes.

RAPID GERIATRIC ASSESSMENT

J.E. Morley, *Saint Louis University, St. Louis, Missouri*

The Rapid Geriatric Assessment (RGA) is a tool developed to quickly identify four geriatric syndromes viz frailty, sarcopenia, anorexia of aging and cognitive dysfunction as well as to enquire if the person has advanced directives. It was developed to be used in conjunction with the Annual Medicare Wellness Visit. It takes less than 4 minutes to administer.

The components of the RGA are the FRAIL for frailty, SARC-F for sarcopenia, SNAQ for anorexia of aging and the Rapid Cognitive Screen which is derived from the St. Louis University Mental Status Examination. All the screening tools have been validated in multiple continents and are available in up to 30 languages.

We have ongoing educational interventions in rural counties, inner city clinics and academic centers. To date over 2,000 persons have been evaluated either as case finding in physicians' offices or screening in the community. Preliminary results show the prevalence of frailty to be 23%; sarcopenia 32.8%; Anorexia 34.7%, MCI 19.3% and dementia 23.9%. In a group of diabetics both the SARC-F and FRAIL were highly predictive of new disability and hospitalization.

In addition to the screening tool we have developed a computerized assessment and management program for physicians' offices. This program specifically provides a diagnostic plan for each component of the FRAIL, and diagnostic and management programs for the other syndromes. This approach is well accepted by primary care physicians.

We believe that this is a simple intervention secondary prevention program that will enhance the health of older persons.

FAMILY PHYSICIAN SCREENING FOR GERIATRIC SYNDROMES

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The GFST (Gerontopole Frailty Screening Tool) has been developed to help health care professional to target older adults at risk for frailty. The GFST does not aim to measure frailty, but only to detect those at risk to be frail, to refer them to a frailty clinic for more precise assessment of frailty, and to look after the cause of frailty to propose targeted interventions.

The GFST includes few questions: is your patient living alone, had involuntary weight loss in the past 3 months, fatiguability, mobility difficulty, memory complaints, slow