



accessible means of making an accurate diagnosis, and a mechanism for providing treatment and careful follow-up. Recent trials indicate that the addition of counseling to pharmacologic therapy confers additional benefit for older, frail patients with depression. Anxiety is more common than depression among older adults and may similarly result in physical and cognitive symptoms, insomnia, agitation, psychosis, and isolation. Clinicians should consider a diagnosis of generalized anxiety, panic, or agoraphobia in older adult patients with any of these symptoms.

MOBILITY

Problems with mobility are common among older persons. Among those over age 65, 20% of men and 32% of women report difficulty with one or more of five specific physical activities (stooping or kneeling, reaching overhead, writing, lifting 10 pounds, or walking two to three blocks). Among these, respondents cite problems with walking most commonly. Difficulties with balance and gait present significant risks for older adults. Approximately 30% of community-dwelling elders fall each year. The annual incidence of falls approaches 50% in patients over 80 years of age. Five percent of falls in older adults result in fracture or hospitalization. Risk factors for falls include a history of falls, fear of falling, decreased vision, cognitive impairment, medications (particularly anticholinergic, psychotropic, and cardiovascular medications), diseases causing problems with strength and coordination, and environmental factors. Effective interventions for people with a history of falls or who are at risk for falling involve addressing multiple contributing factors. Providers should regularly inquire about recent falls or a fear of falling in older patients. For patients who report falling, the assessment should include review of circumstances of the fall(s), measure of orthostatic vital signs, visual acuity testing, cognitive evaluation, and gait and balance assessment. A brief physical examination maneuver called the “timed get up and go” has the patient arise from a sitting position, walk 10 feet, turn, and return to the chair to sit. A time of more than 12 seconds to complete the process, or observation of postural instability or gait impairment, suggests an increased risk of falling. Gait speed, an additional measure of mobility, predicts changes in ability and health status in older adults. Gait speed is measured over a 10-meter span with the patient walking at a comfortable pace. A speed of less than 1.0 m/sec is associated with increased mortality; 0.8 m/sec predicts difficulty navigating outside the home, and a speed of less than 0.6 m/sec predicts a high risk of falls and functional decline. For those found to be at risk for falls, providers should also review all medications for possible causative agents and inquire about home safety. High-risk patients should be evaluated for assistive devices and a supervised exercise program (Table 124-4).

VISION AND HEARING

Problems with vision and hearing are very common among older adults and frequently complicate the management of comorbid conditions and accelerate functional decline. Significant vision loss occurs in 16% to 18% of adults over age 65. Common causes include glaucoma, cataracts, age-related macular degeneration, and retinopathy from hypertension and diabetes. Decreased visual acuity increases fall risk and has been associated with all-cause mortality. Such problems may be detectable with regular

testing via bedside tools such as the Snellen or Jaeger eye chart. Given the implications of vision loss for function and safety, a general ophthalmologic examination every 1 to 2 years is recommended for all older adults. Furthermore, ophthalmologic centers have recognized the multifaceted challenges faced by older adults with vision impairment and have developed specialized low vision clinics offering evaluation by optometrists, occupational therapists, and social workers with a focus on improving quality of life and maintaining independence.

Hearing loss is the third most common ailment in older adults (behind hypertension and arthritis), affecting an estimated 40% to 66% of those over age 75. It is associated with depression, social isolation, poor self-esteem, cognitive decline and functional disability. Pure tone audiometry is the reference standard for screening for hearing loss, but a simple whispered voice test is also highly sensitive and specific. Ideally all older adults would undergo annual hearing screen by questionnaire and handheld audiometry. Unfortunately, the lack of reimbursement for hearings aids under most insurance plans, including Medicare, presents a major barrier for many older adults.

CONTINENCE

UI affects up to 30% of community-dwelling older adults and at least half of those residing in skilled nursing facilities. It occurs more frequently in women, but this gender disparity narrows as the rate of UI in men increases after age 85. The impact of UI on health ranges from increased risk of skin irritation, pressure wounds, and falls, to social isolation, functional decline, and depression. For caregivers of older adults, UI complicates physical care and can contribute to decisions for placement in skilled nursing facilities. Common comorbid conditions include diabetes mellitus, heart failure, arthritis, and dementia.

A systematic approach to the investigation of UI can often reveal a cause and potential solution. It is important to first determine if the incontinence is acute or chronic in nature. Acute causes of incontinence are often attributable to specific medical problems, including infection, metabolic disturbance, or medication effects. The mnemonic DIAPERS recalls the various potential acute causes of UI (*D*, delirium; *I*, infection; *A*, atrophic vaginitis; *P*, pharmaceuticals; *E*, excess urine output from congestive heart failure [CHF] or hyperglycemia; *R*, restricted mobility; and *S*, stool impaction). If the UI is chronic, then further history can characterize the nature of the symptoms from among four types. Urge incontinence from detrusor overactivity is the most common type. Patients with this problem will complain of urinary frequency, nocturia, and a sudden onset of urge to void. Stress incontinence occurs with incompetence of pelvic musculature or urethral sphincter, and is characterized by small amounts of leakage with laughing, sneezing, coughing, or even standing. Overflow incontinence results from urinary retention, often related to prostatic hyperplasia in men or bladder atony in patients with diabetes or spinal cord injury. Patients often have constant dribbling or leakage without a true sense of needing to void. Finally, functional incontinence results from comorbid conditions that limit a patient’s ability to act on or interpret the need to void, mobility problems such as arthritis, and weakness or cognitive problems. Table 124-5 describes the various types of incontinence and suggested approaches. Of course, older adults