Updates to monographs in the *Clinical Updates in Women’s Health Care* series are designed to provide important additional information to the content areas covered in the existing monographs. The current list includes Updates to the following titles:

- **Anorectal Disorders** [Update May 2015]
- **Common Dermatologic Conditions** [Update January 2018]
- **Complementary and Alternative Medicine** [Update June 2015]
- **Memory Loss and Dementia** [Update January 2019]
- **Metabolic Bone Disease** [Update October 2019]
- **Obesity** [Update August 2017]
- **Occupational Diseases and Injuries** [Update July 2016]
- **Sleep Disorders** [Update September 2015]
- **Upper Gastrointestinal Tract, Biliary, and Pancreatic Disorders** [Update June 2017]
This monograph is designed to enable the obstetrician–gynecologist to do the following:

- Use office-based tools essential for the care of aging women
- Optimize preservation of function
- Maintain quality of life throughout the aging process

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Credit for *Clinical Updates in Women’s Health Care: Aging Women and the Office Assessment*, Volume XIX, Number 3, May 2020, is initially available through December 2023. During that year, the unit will be re-evaluated. If the content remains current, credit is extended for an additional 3 years.

**Disclosure Statement**

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Many women who have had a long-established relationship with their obstetrician–gynecologist view this physician as their primary care provider. This relationship may continue well into the women’s seventies and eighties, especially if they have relatively few medical comorbidities. This monograph focuses on the performance of a comprehensive assessment to help obstetric–gynecologic providers identify declines in health status and cognitive function as well as deterioration of functional abilities associated with aging. The information provided in this monograph guides the obstetrician–gynecologist through the array of appropriate tools to perform such assessment efficiently. The author, Dr. Myron Miller, is the Director of Geriatric Medicine at Sinai Hospital of Baltimore and has served as a member of the editorial board for Clinical Updates in Women’s Health Care since its inception. He is uniquely aware of what the practicing obstetrician–gynecologist needs as an office compendium to facilitate the care of aging women. Inclusion of links to online resources should be particularly useful. Additionally, the included clinical vignettes contain sage guidance for the evaluation, assessment, and management of a multitude of issues presenting in this patient population.

Russell R. Snyder, MD
Editor
ABSTRACT: This monograph is intended to serve as a practical guide to the office assessment of the aging woman and recognizes the time constraints that characterize current office practice. Obstetrician–gynecologists are increasingly becoming the primary care providers to women in their practices and especially to older women who have been long-time patients. This monograph should serve as a guide to the many tools needed to assess the health and functional and cognitive status of the aging woman. Illustrative cases demonstrate how to use these tools in a time-efficient manner to achieve a positive effect on the well-being of the patient.

Aging, especially after the age of 65 years, is commonly associated with a decline in health and functional ability because of physiologic changes of aging and acute and chronic diseases. At the same time, changes may occur in family structure due to illness or death of a spouse, mobility, living arrangement, and financial stability. These events can interact to affect the ability of the aging person to maintain the level of function necessary for independent living. Physicians who provide care to aging patients must be aware of these life events to address the health needs of their patients effectively. Often, the presence of these confounding factors may not be fully known to the physician.

In recent years, the concept of comprehensive geriatric assessment has become widely accepted and has been shown to be beneficial to the aging patient. The goals of comprehensive geriatric assessment for the obstetrician–gynecologist who serves as a primary care provider are listed in Box 1.

In the past, comprehensive geriatric assessment has been targeted primarily to elderly individuals at high risk of functional decline with the highest risk group being women aged 80 years or older who were experiencing multiple health problems or one or more of the common geriatric syndromes (Box 2). However, recent clinical practice suggests that all individuals aged 65 years or older are likely to benefit from the incorporation of the assessment process into long-term patient management.

Comprehensive geriatric assessment typically involves use of established screening tools, preventive services (such as immunizations or management of an identified disease), and disability and long-term planning including creation of health care proxies and advance directives. As primary care providers for older women, obstetrician–gynecologists are well positioned to take the lead in providing comprehensive geriatric assessment for patients in their practice. In addition to the physician, the process often requires other professionals, including nurses, social workers, physical and occupational therapists, pharmacists, and psychologists, as well as targeted physician referrals.
Box 1. Goals of Comprehensive Geriatric Assessment

- Create a baseline database of
  - health status
  - functional ability and cognitive capacity
  - relevant family, personal, and financial information
- Identify all existing health-related problems and risk factors for disease and screen for significant new problems, including age-appropriate cancer screening
- Implement health promotion strategies
  - Immunizations
  - Lifestyle modifications—weight, alcohol, smoking, and exercise
  - Enhance patient safety—falls reduction, medication management, and home safety
- Identify strengths and resources that can be mobilized to address problems
- Initiate effective management of identified problems
- Develop a long-term management strategy aimed at preservation of function and independence
- Identify needed support systems and best sites of care
- Promote end-of-life planning through creation of advance directives and health care proxy

Box 2. Target Populations of Older Women for Comprehensive Geriatric Assessment

- Those experiencing multiple declines and losses
  - Decreased physiologic reserve
  - Functional decline
  - Cognitive decline
  - Effect of multiple diseases and disability
  - Decreased social supports due to death or move to another location
  - Economic pressure—low income or health-related expenses
- Those with common geriatric syndromes
  - Polypharmacy
  - Falls
  - Incontinence
  - Frailty
  - Cognitive impairment
  - Depression
  - Poor nutritional state
  - Chronic pain
Historically, comprehensive geriatric assessment often was performed in institutional settings, such as specialized inpatient units for the elderly, where a trained multidisciplinary team could efficiently evaluate the patient and initiate appropriate management (1, 2). The target population was the elderly patient admitted to the hospital who often had multiple acute and chronic disorders and whose care needs were greater than the typical hospital inpatient unit could provide. These patients commonly had prolonged inpatient stay and required extensive discharge planning. The comprehensive geriatric assessment units had specially trained staff who could focus not only on the medical care of the patient but also could undertake the extensive evaluation process needed to develop the most appropriate discharge plan and discharge setting.

Based on the positive experience with specialized inpatient units, comprehensive geriatric assessment later expanded to specialized outpatient programs in which a multidisciplinary team could conduct a detailed assessment in a single clinic session and develop a management plan that could be implemented by the patient’s usual health care providers. Because of the scarcity of trained personnel and the cost associated with these clinics, there has been a recent shift to conducting the assessment in the office of the patient’s primary care provider (3, 4). This approach takes advantage of existing patient records and supplements them with additional key pieces of information. Much of the new information can be gathered by office personnel with the use of screening tools. The annual wellness visit that is reimbursed by Medicare can be the starting point for the comprehensive geriatric assessment process. The American College of Obstetricians and Gynecologists’ (ACOG) Committee on Gynecologic Practice has published recommendations regarding the well-woman visit stratified by age (5). The well-woman visit includes the following components that are also part of the comprehensive geriatric assessment: screening, assessment, identification of risk factors, and counseling.

Recognizing the time limitations common in everyday clinical practice, the patient can assist in obtaining necessary information by completing mailed forms at home or while in the physician’s waiting room. If necessary, this can take place over several office visits. It is critical to organize the patient chart so that obtained information is readily accessible and retrievable and subsequent data can be easily compared with the original data set to identify early changes in the patient’s status (Table 1).

**Components of the Assessment Process**

**History and Physical Examination**

The traditional medical history and physical examination are fundamental to the comprehensive geriatric assessment process. In addition to illnesses, obtaining of the history should focus on the identification of the patient’s strengths, such as degree of independence, mobility, access to resources, family support system, living circumstances, and financial stability. History of tobacco, alcohol, and illicit drug use should be documented.
Review of all medications, prescription and over-the-counter, is critical to identify polypharmacy and potential inappropriate or duplicate medication usage. The “brown bag examination” is a useful strategy. For this examination, the patient is instructed to place all medications she is taking, both prescription and over-the-counter, into a bag and to bring the bag with her to the office visit. In the office, the patient is asked if she knows the name of each medication and the reason for taking it. The physician can refer to the Beers Criteria of medications that should be avoided in the older patient and those that

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<td>History</td>
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<td>Activities of daily living</td>
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<td>Instrumental activities of daily living</td>
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should be used with caution and awareness of the risk of adverse effects or adverse drug interactions (6).

Immunization status (eg, for pneumonia, influenza, herpes zoster, and tetanus) should be identified and arrangements made for administration of needed immunizations. The American College of Obstetricians and Gynecologists has published a comprehensive resource on immunization for women, including special populations, that is available at https://www.acog.org/topics/immunization.

A physical examination should include a measurement of blood pressure (BP), heart rate in recumbent and upright positions, and weight and calculation of body mass index (BMI). Presence and degree of pain should be assessed at every office visit by commonly available pain scales (eg, https://paindoctor.com/pain-scales).

The skin should be examined to identify lesions that might indicate skin cancer. The presence of sensory (ie, vision and hearing) impairment should be documented. Visual acuity can be evaluated with the Snellen eye chart or the newer LogMAR eye chart (Box 3) (7). If these are not available, the patient can be asked to read several lines of newsprint-sized text. Hearing ability can be quickly determined with the whisper test during which the examiner stands approximately 3 feet behind and to one side of the patient and softly whispers three words and then asks the patient to repeat the words. The process is repeated on the other side of the patient. Assessments of strength, gait, and mobility and fall risk are essential and can be accomplished using standardized tools (Box 4). The routine physical examination should include an inspection of the oral cavity to determine the status of dentition and the gingiva. Significant loss of teeth or active gingival disease can contribute to nutritional deficiencies and, sometimes, to systemic infection. Women with these findings should be advised to seek dental care. Additional information is provided in ACOG Committee Opinion No. 569, Oral Health Care During Pregnancy and Through the Lifespan, available at https://www.acog.org/-/media/project/acog/acogorg/clinical/files/committee-opinion/articles/2013/08/oral-health-care-during-pregnancy-and-through-the-lifespan.pdf.

**Box 3. Sensory Function Screening**

- **Vision:** Snellen eye chart, LogMAR eye chart, or reading newsprint
- **Hearing:** whisper test
  1. Stand 3 feet to one side of patient and softly whisper three words.
  2. Ask patient to repeat the words.
  3. Repeat on the other side.
Aging Women and the Office Assessment

Laboratory Tests and Imaging Studies

Appropriate laboratory workup should include recommended age-based screening tests as well as specific tests based on the medical history or physical examination findings. Referral for imaging studies, including radiography, computed tomography, or magnetic resonance imaging, will depend on medical history, physical examination, and laboratory findings.

Assessment of Functional Status

Two standardized forms are widely used to assess functional status in a patient: 1) Activities of Daily Living (ADL) form and 2) Instrumental Activities of Daily Living (IADL) form (Box 5) (8, 9). They are available at https://clas.uiowa.edu/socialwork/sites/clas.uiowa.edu.socialwork/files/NursingHomeResource/documents/Katz%20ADL_LawtonIADL.pdf or https://www.alz.org/careplanning/downloads/lawton-iadl.pdf and can be completed by the patient, a caregiver, or a member of the office staff.

Older women who drive should be evaluated periodically for continued ability to drive safely. The woman should be referred to a driver evaluation program if her assessment reveals any of the following:

- History of a motor vehicle accident
- Cognitive impairment

Box 4. Mobility, Gait, Balance, and Falls Risk Assessment

- Timed Get-Up-and-Go-Test
  1. Stand from seated position in chair
  2. Walk 4.5 m (10 ft)
  3. Turn and walk back to chair
  4. Sit

- Normal Performance
  1. Ability to stand without use of chair arms
  2. Narrow-based gait; less than 12 seconds to walk 4.5 m (10 ft)
  3. Smooth turn; no stumbling
  4. Controlled sit without use of chair arms or dropping to chair seat

- Falls Risk Screen
  1. Have you fallen in the past 12 months?
  2. Do you have problems with balance?

- Johns Hopkins Fall Risk Assessment Tool
• Impaired judgment
• Uncorrected vision or hearing deficits
• Motor weakness
• Impaired ability to rotate the neck

Driver evaluation programs often are conducted by occupational therapists and can be located by contacting local motor vehicle bureaus. The National Highway Traffic Safety Administration and the American Medical Association have published an online resource for the assessment of the older driver. It is available at https://www.nhtsa.gov/staticfiles/nti/older_drivers/pdf/811298.pdf.

### Box 5. Functional Assessment Tools

#### Activities of Daily Living*
- Bathing
- Dressing
- Toileting
- Transfer
- Continence
- Feeding

#### Instrumental Activities of Daily Living†
- Ability to use telephone
- Shopping
- Food preparation
- Housekeeping
- Laundry
- Mode of transportation
- Responsibility for medications
- Ability to handle finances

*A full listing of activities and an assessment tool are available at: https://clas.uiowa.edu/socialwork/sites/clas.uiowa.edu.socialwork/files/NursingHomeResource/documents/Katz%20ADL_LawtonIADL.pdf
†A full listing of activities and an assessment tool are available at: https://www.alz.org/careplanning/downloads/lawton-iadl.pdf

### Assessment of Cognitive Status

The incidence of cognitive impairment increases with advancing age. The most common causes of impairment are Alzheimer disease and vascular dementia (10). Vascular dementia often is associated with a history of hypertension, diabetes mellitus, and dyslipidemia. A patient’s cognitive status can be assessed by office staff using validated screening tools,
such as the Folstein Mini-Mental State Examination (MMSE) or the Mini-Cog screen, available at www.heartinstitutehd.com/Misc/Forms/MMSE.1276128605.pdf and www.mini-cog.com, respectively (Box 6) (11).

These assessments should be performed annually even when there is no suspicion of cognitive impairment because they can serve as baseline measurements to identify a possible future onset of cognitive decline. In addition, early stages of Alzheimer disease, such as mild cognitive impairment, may not be clinically evident and may be detected only by screening.

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**Box 6. Mental Function Screening Tools**

- **Cognitive Status**

- **Depression**

- **Anxiety**

- **Caregiver Stress**
Screening for Depression

Depression is a common clinical disorder that is more than twice as likely to occur in women than in men. Prevalence increases with advancing age (12). Depression may be triggered by events common in older women, such as development of significant illness, divorce, or the death of a spouse. Symptoms can be numerous, and depression often can appear as a variety of somatic disorders. Consequently, the U.S. Preventive Services Task Force (USPSTF) has issued recommendations for universal screening of all adult patients (13). A number of depression screening tools have been developed for use in older individuals including the geriatric mood scale, which can be self-administered or administered by office staff (Box 6). This scale is available at https://web.stanford.edu/~yesavage/GDS.english.short.score.html. The Patient Health Questionnaire-2 (PHQ-2; available at https://www.med-iq.com/files/noncme/material/pdfs/LI042%20IG%20tools.pdf) and Patient Health Questionnaire-9 (PHQ-9; available at www.phqscreeners.com/sites/g/files/g10016261/f/201412/PHQ-9_English.pdf) tools have been developed for use by office staff and also are appropriate for self-administration (12). As with cognitive screening, patients should be screened for depression annually. The Generalized Anxiety Disorder-2 (GAD-2) scale form can be used as a screening tool for anxiety and is available at https://integrationacademy.ahrq.gov/sites/default/files/GAD-2_0.pdf (14).

Screening for Urinary Incontinence

Urinary incontinence is a common problem that becomes increasingly prevalent as women age. Large epidemiologic studies have shown that for community-dwelling women older than 65 years, the prevalence of all forms of incontinence may be as high as 55% (15). Another study of women in a managed care plan identified 75% of older women with episodes of involuntary urine loss (16).

Women with urinary incontinence often are embarrassed by the condition and may not bring it to the attention of their health care provider unless asked specifically if they experience involuntary loss of urine. This question should be a standard inquiry for all women. The most effective screening tool is simply to ask if the woman experiences involuntary loss of urine in any amount. A positive response should be followed by additional questions regarding circumstances associated with the incontinence. The American College of Obstetricians and Gynecologists recommends basic office evaluation of all women with symptoms of urinary incontinence, including a thorough history, physical examination, assessment of symptom severity, and goals for treatment (17). Careful history taking along with targeted physical examination and basic laboratory studies should allow the physician to categorize the incontinence into the common groupings of stress, urge, overflow, mixed, and functional. Additional evaluation, including screening for urinary tract infection, determination of residual volume, and analysis of data from a 3-day voiding diary (available at urology.ucla.edu/workfiles/Pelvic_Medicine/Voiding_Diary_Instructions.pdf) will help rule out retention, confirm the type of incontinence, and
determine the most effective course of management. Additional specialized urodynamic studies may be necessary if complex conditions are present or the etiology of incontinence is unclear after a basic evaluation (17).

**CASE NO. 1.** A 65-year-old woman wishes to establish care. As part of the new patient intake process, office staff has mailed her a set of forms (including PHQ-2 and GAD-2) to fill out and bring with her to the appointment. The staff also has instructed her to bring all medications she takes, both prescription and over-the-counter, and copies of advance directives and a health care proxy if she has them (additional details are provided in the section “Advance Directives and Health Care Proxy”). The woman arrives at your office accompanied by her daughter. After checking in, her vital signs and weight are measured, her BMI is calculated, and the Folstein MMSE is administered. The patient’s medical history is significant for menopause at age 51 years with frequent hot flushes for 6 years, which gradually diminished in severity; a 5-year history of hypothyroidism treated with 75 micrograms of thyroxine daily; and occasional episodes of urgency urinary incontinence. In addition to thyroxine, she is taking 600 mg calcium citrate and 500 units of vitamin D daily and 25 mg of diphenhydramine each evening because of difficulty falling asleep. She does not recall receiving immunizations in the past for pneumococcal pneumonia, influenza, or herpes zoster. Her last mammography was 3 years ago, and she recalls a normal result. She does not recall having had a dual X-ray absorptiometry (DEXA) examination (detailed discussion of bone density assessment is provided in the section “Osteoporosis”). The review of her completed forms shows normal ADL and IADL results. The MMSE score is 28 (out of 30), PHQ-2 result is positive for depression, and GAD-2 result is negative for anxiety. On physical examination, BP is 137 mm Hg (systolic) and 82 mm Hg (diastolic) (137/82); heart rate is 72 beats per minute, and BMI is 29 (calculated as weight in kilograms divided by height in meters squared). The whisper test demonstrates decreased hearing bilaterally. Otherwise, the general physical examination results are unremarkable. Pelvic examination reveals vaginal atrophy. Specimens are collected for cervical cytology. Laboratory testing is scheduled to include a complete blood count, fasting blood glucose test, hemoglobin A\textsubscript{1c} (Hb A\textsubscript{1c} test), complete metabolic panel, lipid panel, thyroid stimulating hormone (TSH) test, fecal immunochemical test, and urinalysis. The patient is referred to radiology for mammography and baseline DEXA. She is advised to receive age-appropriate immunization (ie, influenza, pneumococcal vaccine, and herpes zoster). Based on the recommendation from the Beers List, she is advised to discontinue the diphenhydramine because of its anticholinergic action and consequent risk of cognitive impairment and confusion. She is referred to audiology for audiometry and a determination of the need for a hearing aid. Her husband died 8 months ago. She lives alone (near her daughter) and states that she is independent, drives, and is able to care for herself. Because she does not have an advance directive or health care proxy designation, she is given information on how to access the forms.

Three weeks later at a follow-up visit, the woman’s BP is 128/78. The test results are reviewed, and positive findings are fasting glucose level of 7.3 mmol/L (132 mg/dL), Hb A\textsubscript{1c} level of 0.072 (7.2%), total cholesterol level of 5.54 mmol/L (214 mg/dL), low-density lipoprotein cholesterol level of 2.85 mmol/L (110 mg/dL), high-density lipoprotein cholesterol level of 1.43 mmol/L (55 mg/dL),
and triglyceride level of 1.4 mmol/L (124 mg/dL). The TSH level is in the normal range. The mam-mography results reveal no pathological findings. The DEXA reveals a T-score of –2.6 at the femoral neck, and fracture risk assessment algorithm (FRAX) shows a 10-year risk of 3% for hip fracture and 14% for major osteoporotic fracture. The patient has completed the advance directive and the health care proxy forms. She has received the influenza vaccine and initial doses of pneumococ-cal and shingles vaccines. She has been fitted with hearing aids in both ears. She states that her mood is brighter, and she is sleeping better. She is referred to a dietitian for a weight-reduction diet. She is started on atorvastatin, 10 mg daily, and alendronate, 70 mg once a week, and is advised to increase her calcium citrate intake to 1,200 mg daily and vitamin D intake to 1,000 units daily. She is advised to try to void voluntarily at the first sensation of bladder fullness. She is scheduled for further follow-up in 3 months with repeat fasting glucose testing, Hb A1C testing, and lipid panel. She is informed that, if she achieved sufficient weight reduction and a normal blood glucose level, she may not need to be started on an oral hypoglycemic agent. This case illustrates how a comprehen-sive assessment process can be performed efficiently in the office setting. The use of patient self-administered forms completed at home and supplemented with data collected in the office by staff allows the physician to focus on additional information from history and physical examination. In this case, significant unsuspected new findings were identified, and appropriate screening and referrals were used to develop a course of management and establish a database for monitoring effectiveness of recommended interventions.

Caregiver Stress

Older women often are the primary caregivers for other family members with chronic illness. The burden of long-term caregiving often is associated with development of a condition known as caregiver syndrome or caregiver stress, which is characterized by chronic stress and depression with accompanying symptoms of exhaustion, fatigue, insomnia, rage, anger, and guilt. The woman may neglect her own health care needs, resulting in a decline in physical and emotional health. Screening tools are available (for example, https://www.healthinaging.org/tools-and-tips/caregiver-self-assessment-questionnaire) and should be used when caregiver stress is suspected (Box 6) (18).

The patient herself may be the recipient of care provided by a caregiver. For the older woman who has a caregiver, brief questioning during an office visit can determine if the caregiver is satisfactorily meeting the needs of the patient.

CASE NO. 2. A 59-year-old established patient comes to the office for an annual well-woman visit. As part of a practice innovation, she was given several assessment forms to be completed at home and brought to the office. After check-in, office staff administers a Mini-Cog screen and measures her BP (135/85; an increase over her previous values); heart rate (78 bpm); and weight (60 kg [132 lb]; a decrease from the last weight measurement of 64 kg [141 lb]). Her mood appears depressed compared with the past encounters, and the results of the depression screen questionnaire indicate
Aging Women and the Office Assessment

depression. Upon prompt, she reveals that her husband, who is 10 years older than her and has a history of diabetes mellitus and hypertension, had a major stroke 7 months ago. After 5 days of hospitalization and 3 weeks in a subacute rehabilitation facility, he was discharged to home care. He has an expressive aphasia and difficulty swallowing food. He has marked leg weakness, spends his time in bed or in a wheelchair, and has developed a small sacral decubitus ulcer. His diabetes has been difficult to control. He sleeps poorly at night and disturb her sleep. Although a home aide comes in for 2 hours each morning to help him bathe and dress, the patient is the sole caregiver to her husband. She had been working as a real estate agent but has had to give up her job because of her husband’s care needs and his inability to stay home alone.

The woman is advised to see a clinical social worker who may be able to help her identify community resources to lighten her care load. When she returns 4 weeks later her mood has improved. She states that the social worker helped her find an appropriate adult day-care program for her husband. She has been able to return to work part-time and interact socially. This scenario represents a classic case of caregiver stress (18). Because she has been a long-term patient in the practice, the changes in her mood and physical state are quickly recognized and further documented by the results of screening instruments. After the details of her present status are revealed and discussed, an appropriate referral leads to positive measures to help alleviate her stressful home situation.

Elder Abuse

Elder abuse can include physical abuse, sexual abuse, financial exploitation, psychologic and emotional abuse, abandonment, neglect, and self-neglect. Women, especially those with significant physical and cognitive impairments, are at the highest risk of elder abuse (19). Most often the abuser is a family member or caregiver. The woman’s physician and the office’s staff are in the best position to recognize the presence of elder abuse. Indications include physical evidence of bruising or other markers of trauma, decubiti, poor nutrition, change in personal hygiene and attention to clothing, change in personality and social interactions, onset of noncompliance with medications, cancelled or missed appointments, and dominance of a family member or caregiver who accompanies the woman on an office visit. If elder abuse is suspected, asking the following questions without the family member or caregiver present can confirm or refute the suspicion:

- Do you feel safe at home?
- Has anyone neglected you?
- Has anyone threatened or harmed you?
- Has anyone tried to take money from you?

A positive response requires that the physician take prompt action to ensure the safety of the woman. Familiarity with the patient and data from previous assessment help recognize a change in status that calls for intervention. The physician who suspects elder abuse is required by law to contact the nearest Adult Protective Services office. Offices are present in every state.
CASE NO. 3. An 82-year-old established patient with a medical history of well-controlled hypertension and mild congestive heart failure comes to the office for her annual well-woman visit after having missed two previously scheduled appointments, which is unusual for her. Her husband died 3 years ago and, since then, she has been living in her own home with her 43-year-old divorced niece. Geriatric assessment was performed at a previous well-woman visit, and the IADL form revealed that she had difficulty with meal preparation and bill paying. She stopped driving 18 months ago. The Folstein MMSE score was 25.

She is accompanied by her niece to the current visit. While administering a follow-up Folstein MMSE, the office staff notice that the patient’s hair is not well groomed, and her clothing is disheveled compared with her previous visits. The patient’s MMSE score is 23. Her BP is 160/95 (previous values were in the 125–130/80–85 range), and her weight is 51 kg (112 lb), down from 54 kg (120 lb) a year ago. When she is brought into the examination room, her niece comes in with her. The niece is asked to return to the waiting room, and she reluctantly agrees to do so. Your medical assistant helps the patient change into a gown and you begin your examination. You note that the patient is unusually withdrawn, she appears thin, and she has multiple old and recent bruises on her upper arms. On chest examination, there are faint rales at the lung bases bilaterally. There is a 1+ pitting edema of both legs extending to below the knees. You ask if she has been taking her medications as prescribed, and she replies that she has run out of them. Then you ask if she is afraid of anyone and if anyone has been hurting her. After a long pause, the patient discloses that her niece has taken over the house, gets irritated when the patient needs some assistance with bathing and dressing, and has taken the patient’s checkbook. The patient wants to return to her home, and she agrees to let your office contact the local Adult Protective Services on her behalf. She is restarted on antihypertensive medication and diuretics and scheduled for follow up in 3 weeks. This case illustrates risk factors associated with elder abuse (older age, decline in ADL and IADL status, cognitive impairment, and dependence on others) along with clues for recognition of elder abuse (deterioration of previously controlled medical problems, medication noncompliance, change in grooming, fear of another individual, depressed mood, weight loss, or unexplained physical injury). The physician reported the case to the Adult Protective Services office.

Advance Directives and Health Care Proxy

Older patients should be asked if they have created an advance directive and appointed a health care proxy with power of attorney. A woman who has not done so should be counseled and referred to sources that can help with creating these essential documents. Numerous examples of suitable forms are available that can be completed by the patient and do not require the services of an attorney to become legal documents. AARP (formerly known as the American Association of Retired Persons) maintains a web-based resource with a link to accessible forms as required by states (https://www.aarp.org/caregiving/financial-legal/info-2019/what-is-a-living-will.html). The American College of Obstetricians and Gynecologists has described a specific role of advance directives in the end-of-life care planning (Committee Opinion No. 617, End-of-Life Decision Making; available at https://www.acog.org/-/media/project/acog/acogorg/clinical/files/committee-opinion/articles/2015/01/end-of-life-decision-making.pdf.
Specific Disease Screening

Recommendations for specific disease screening have been developed by the USPSTF (a full listing of all USPSTF recommendations can be found at https://www.uspreventiveservicestaskforce.org/Page/Name/recommendations) and by several professional organizations and societies, including ACOG. These recommendations are continuously updated. For some diseases, there is not one universally accepted screening recommendation, and physicians may have to choose which recommendation to follow based on their society memberships, institutional preferences, or personal professional experience. Box 7 lists selected recommendations.

Hypertension

Because development of hypertension is a common occurrence in aging women and is associated with increased risk of heart disease and stroke, screening with measurement of BP should be part of every office visit. The American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines has published updated guidelines on hypertension screening (available at https://www.acc.org/~/media/Non-Clinical/Files-PDFs-Excel-MS-Word/etc/Guidelines/2017/Guidelines_Made_Simple_2017_HBP.pdf).

Box 7. Disease-Specific Screening

Hypertension*

- Normal blood pressure (BP): less than 120 mm Hg systolic and less than 80 mm Hg diastolic
- Increased BP: 120–129 mm Hg systolic and less than 80 mm Hg diastolic
- Stage 1 hypertension: 130–139 mm Hg systolic or 80–89 mm Hg diastolic
- Stage 2 hypertension: 140 mm Hg or greater systolic or 90 mm Hg or greater diastolic

Type 2 Diabetes Mellitus†

- Impaired glucose tolerance: fasting blood glucose level of 5.6–6.9 mmol/L (100–125 mg/dL)
- Type 2 diabetes mellitus: fasting blood glucose level of 7 mmol/L (126 mg/dL) or greater

Cardiovascular Disease and Dyslipidemia‡

- At age 55–65 years: lipid panel every 1–2 years if no cardiovascular risk factors
- In women older than 65 years: annual lipid panel if no risk factors

Osteoporosis

- In any postmenopausal woman with risk factors: dual X-ray absorptiometry and Fracture Risk Assessment Tool

(continued)
Box 7. Disease-Specific Screening (continued)

Thyroid Dysfunction
- Baseline thyroid-stimulating hormone measurement or free thyroxine measurement beginning at age 50 years

Breast Cancer
- Biennial mammography from age 50 years to age 74 years§
- Annual mammography beginning at age 40 years||

Colorectal Cancer
- Beginning at age 50 years¶
- Annual fecal occult blood testing or colonoscopy if risk factors are present

Cervical Cancer#
- Cervical cytology every 3 years from age 21 years to age 29 years and co-testing with a human papillomavirus test every 5 years from age 30 years to age 65 years
- No further screening necessary, if previous screening result negative


Criteria are defined for classification of normal BP, increased BP, stage 1 hypertension, and stage 2 hypertension. Treatment guidelines include special considerations for older patients.

**Diabetes Mellitus**

Type 2 diabetes mellitus is highly prevalent in the older woman. Approximately 27% of women aged 65 years and older have diagnosed or undiagnosed type 2 diabetes mellitus, and it is especially likely in the setting of excess body weight and decreased physical
Aging Women and the Office Assessment

activity. Screening recommendations for type 2 diabetes mellitus in the older woman are available from several organizations, including USPSTF (available at https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/screening-for-abnormal-blood-glucose-and-type-2-diabetes) and The American Diabetes Association (available at https://care.diabetesjournals.org/content/42/Supplement_1). These screening guidelines are summarized in Box 8. Screening methods include fasting plasma glucose test, 2-hour, 75-gram oral glucose challenge, or measurement of Hb A1C level. If screening yields negative results, it should be repeated in 3 years. If the results indicate prediabetes or diabetes mellitus, treatment should be initiated immediately (Fig. 1).

Box 8. Testing Criteria for Diabetes Mellitus and Prediabetes in Asymptomatic Adults

American Diabetes Association

1. Testing should be considered in overweight or obese adults who have one or more of the following risk factors:
   - First-degree relative with diabetes
   - High-risk race or ethnicity (eg, African American, Latino, Native American, Asian American, and Pacific Islander)
   - History of cardiovascular disease
   - Hypertension
   - High-density lipoprotein cholesterol level of less than 0.9 mmol/L (35 mg/dL), triglyceride level greater than 2.82 mmol/L (250 mg/dL), or both
   - Women with polycystic ovary syndrome
   - Physical inactivity
   - Other clinical conditions associated with insulin resistance (eg, severe obesity or acanthosis nigricans)

2. Patients with prediabetes, impaired fasting glucose, or glucose intolerance should be tested yearly.

3. Women in whom gestational diabetes mellitus has been diagnosed should have lifelong testing at least every 3 years.

4. For all other patients, testing should begin at age 45 years.

5. If results are normal, testing should be repeated at a minimum of 3-year intervals, with consideration of more frequent testing depending on initial results and risk status.

U.S. Preventive Services Task Force

The U.S. Preventive Services Task Force recommends screening for abnormal blood glucose as part of a cardiovascular risk assessment in adults aged 40–70 years who are overweight or obese. This recommendation applies to adults aged 40–70 years who are seen in primary care settings and do not have obvious symptoms of diabetes. Individuals who have a family history of diabetes, have a history of gestational diabetes mellitus or polycystic ovary syndrome, or are members of certain racial or ethnic (continued)
Box 8. Testing Criteria for Diabetes Mellitus and Prediabetes in Asymptomatic Adults (continued)

- Identify patients at high risk of developing diabetes mellitus
- Measure fasting plasma glucose or hemoglobin A1C level or perform a 75-g 2-hour glucose challenge

<table>
<thead>
<tr>
<th>Fasting plasma glucose level</th>
<th>Hemoglobin A1C level</th>
<th>75-g 2-hour oral glucose challenge result</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.0–7.9 mmol/L (126–133 mg/dL) or greater</td>
<td>5.6–6.9 mmol/L (100–125 mg/dL)</td>
<td>7.8–11.1 mmol/L (140–199 mg/dL) or greater</td>
</tr>
<tr>
<td>0.057–0.064 of total hemoglobin (5.7–6.4%)</td>
<td>0.065 or greater of total hemoglobin (6.5%)</td>
<td>11.1 mmol/L (200 mg/dL) or greater</td>
</tr>
</tbody>
</table>

**Diabetes mellitus**
- Confirm diagnosis
- Initiate treatment

**Prediabetes**
- Help the patient understand the seriousness of prediabetes
- Determine whether the patient is ready to make changes
- Help the patient identify action-oriented goals to achieve 5–7% weight loss through increased physical activity and healthy food choices
- Assess low-density lipoprotein cholesterol level, blood pressure, aspirin use, and smoking status
- Consider a referral to a lifestyle intervention program based on the Diabetes Prevention Program of the National Institutes of Health
- Consider the use of metformin

**Figure 1.** The decision pathway for diabetes mellitus and prediabetes. This algorithm serves as a guide for action based on results of a diabetes mellitus screen. (Modified from National Diabetes Education Program. Decision pathway for diabetes and prediabetes. Bethesda [MD]: National Institute of Diabetes and Digestive and Kidney Diseases; 2015. Available at: https://www.niddk.nih.gov/-/media/Files/Health-Information/Communication-Programs/NDEP/health-care-professionals/game_plan_decision_pathway_508.pdf?la=en. Retrieved August 2, 2019.)
Cardiovascular Disease and Dyslipidemia

Screening for cardiovascular disease (CVD) uses several factors, including family history, history of hypertension, diabetes mellitus, smoking, and lipid status (Box 9). Several CVD risk calculators are available that will estimate 10-year probability of developing CVD (Box 9). The American Association of Clinical Endocrinologists and the American College of Endocrinology have published joint guidelines for management of dyslipidemia and prevention of CVD, which include lipid screening recommendations (available at https://journals.aace.com/doi/pdf/10.4158/EP171764.GL). Women aged 55–65 years with no evidence of atherosclerotic CVD risk factors should be screened for dyslipidemia at least once every 1–2 years. More frequent lipid testing should be based on individual clinical circumstances and the clinician’s best judgment. Women older than 65 years should be screened yearly if they have one or one atherosclerotic CVD risk factors for dyslipidemia (20). Lipid testing is recommended for all women with multiple CVD risk factors. The U.S. Preventive Services Task Force recommends that adults aged 40–75 years with CVD risk factors be screened for dyslipidemia and have calculation of 10-year CVD event risk to identify those adults who may benefit from statin therapy (21).

Box 9. Cardiovascular Disease Risk Factors and Risk Calculators

<table>
<thead>
<tr>
<th>Risk Factors</th>
<th>Calculators (10-Year Risk of Developing Cardiovascular Disease)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age older than 55 years</td>
<td>Framingham Heart Study</td>
</tr>
<tr>
<td>Hypertension</td>
<td>Heart Risk Calculator</td>
</tr>
<tr>
<td>Premature menopause—spontaneous or postoophorectomy</td>
<td>Cardiovascular Disease Risk Calculator</td>
</tr>
<tr>
<td>Obesity</td>
<td></td>
</tr>
<tr>
<td>Family history of cardiovascular disease</td>
<td></td>
</tr>
<tr>
<td>Physical inactivity</td>
<td></td>
</tr>
<tr>
<td>Dyslipidemia</td>
<td></td>
</tr>
</tbody>
</table>
Osteoporosis

Low bone mass (formerly referred to as osteopenia) and osteoporosis are common disorders in aging women that result in increased risk of fracture. Caucasian women are the racial group at highest risk of fracture, and African American women have the lowest risk (22). Hip fracture, in particular, has a significant adverse effect on function and quality of life and increases the risk of mortality. Therefore, screening has become an essential component of women's health care. The obstetrician–gynecologist plays a key role in prevention of osteoporosis, including appropriate screening (23).

The U.S. Preventive Services Task Force has published a recommendation statement on screening for osteoporosis to prevent fractures (22). The statement recommends DEXA for women in the following situations:

- All women starting at age 65 years
- Women younger than 65 years who have risk factors in addition to the postmenopausal state
- Women with premature menopause, including spontaneous, postchemotherapy, or postoophorectomy menopause

Risk of hip fracture in women with low bone mass should be determined using the Fracture Risk Assessment Tool (also referred to as FRAX calculator; available at https://www.sheffield.ac.uk/FRAX/tool.aspx?country = 9) to estimate the 10-year fracture risk. Appropriate therapy should be initiated in women who have a greater than 3% risk of hip fracture or a greater than 20% risk of any fracture (22). Treatment should be offered to all women found to have osteoporosis on DEXA.

Thyroid Disorders

Thyroid disorders, especially subclinical hypothyroidism and overt hypothyroidism, are common in women, and the prevalence increases with increasing age, reaching 15–20% in women older than 75 years (24). A publication from the USPSTF includes a review of recommendations for screening for thyroid dysfunction (25). The American Association of Clinical Endocrinologists and the American Thyroid Association Task Force on Hypothyroidism in Adults have published clinical practice guidelines for hypothyroidism in adults (24). The American Thyroid Association recommends screening of all adults beginning at age 35 years and every 5 years thereafter, whereas the American Association of Clinical Endocrinologists recommends routine TSH test in older patients, especially women, regardless of age. Screening is recommended in all women with a history of autoimmune disease, such as type 1 diabetes mellitus or pernicious anemia, and in women with a history of previous thyroid surgery or neck irradiation.

Colorectal Cancer

The risk of colorectal cancer increases with age. Several organizations have developed guidelines for colorectal cancer screening (26, 27). For women with average risk (no personal or family history of inflammatory bowel disease, adenoma, colorectal cancer, or
high-risk genetic syndrome), screening should begin at age 50 years. For African American women, screening is recommended starting at age 45 years. Women at high risk (ie, those with a family history of colorectal cancer or adenomatous polyps or those who might have hereditary syndromes, such as Lynch syndrome) should begin screening at age 40 or 10 years younger than the age of the youngest affected family member at time of diagnosis with follow-up screening at 5-year intervals and at 1- to 2-year intervals for those with Lynch syndrome. A personal history of inflammatory bowel disease, chronic ulcerative colitis, or Crohn disease warrants screening colonoscopy starting 8 years after onset of the colitis and follow-up colonoscopy at 1- to 2-year intervals thereafter.

Stool-based testing for blood as a screening methodology is less invasive and less costly than colonoscopy, but it has lower sensitivity. Fecal occult blood testing using guaiac-based methodology has been replaced with fecal immunochemical testing, which has greater sensitivity in detecting colorectal cancer and adenomas and is easier for the patient to perform because only one stool sample is needed and no dietary or medication restriction is required. Fecal DNA testing is another stool-based screening method with high sensitivity. A positive result of any stool-based test mandates a follow-up colonoscopy.

The increasing prevalence of colon cancer in the adult population has led Medicare to cover the costs of colorectal cancer screening not only for Medicare recipients but for all adults aged 50–85 years. Fecal occult blood testing can be performed once a year and stool DNA testing is covered once every 3 years. Flexible sigmoidoscopy is covered every 4 years by Medicare as is screening colonoscopy for individuals at high risk. Colonoscopy should be performed at 10-year intervals after the initial procedure if there are no abnormal findings. If polyps are found, then the follow-up interval should be 3–5 years depending on the histologic characteristics of the polyps. Although most screening guidelines do not specify an ending age, the USPSTF guidelines state that routine colorectal cancer screening is not recommended for individuals aged older than 86 years (26).

Breast Cancer

Recommendations for breast cancer screening are available from USPSTF and ACOG and include recommendations for age at initiation of screening and age at which periodic screening can be stopped (28, 29). A useful tool to identify women who are at high risk of developing breast cancer is the Gail Model Breast Cancer Risk Assessment tool available at http://www.cancer.gov/bcrisktool (30). This tool estimates 5-year risk and lifetime risk of developing invasive breast cancer and can serve as a means of promoting and enhancing patient–physician communication (Box 7).

The U.S. Preventive Services Task Force 2016 update of the breast cancer screening guidelines recommends biennial screening mammography for women aged 50–74 years, if it is estimated that at the time of mammography the woman has an estimated life expectancy of at least 10 years (28). The American College of Obstetricians and Gynecologists and the American Cancer Society recommend screening mammography annually
starting at age 40 years (29). The American College of Radiology has published screening recommendations for women who are at higher than average risk (31). Screening with use of magnetic resonance imaging may be considered in women with a 20% or greater lifetime risk of breast cancer, such as those with known BRCA1 or BRCA2 gene mutations or with first-degree relatives with these mutations. The decision to terminate routine mammographic screening for women aged 75 years and older will require finding the appropriate balance of benefits and harms, including the woman’s overall health status, comorbidities, estimated life expectancy, and personal preference (29, 32).

**Cervical Cancer**

The incidence of cervical cancer has steadily decreased because of the implementation of screening. Recommendations for cervical cancer screening have undergone change in recent years with the introduction of new screening technologies. Cervical cytology can be accompanied by human papillomavirus (HPV) co-testing.

Joint guidelines for cervical cancer screening were developed in 2011 by the American Cancer Society, the American Society for Colposcopy and Cervical Pathology, and the American Society for Clinical Pathology and were endorsed by the USPSTF (33). In 2015, the American Society for Colposcopy and Cervical Pathology and the Society of Gynecologic Pathology modified the guidelines to incorporate the use of HPV testing in the screening of women for cervical cancer. Current guidelines recommend screening by cervical cytology alone starting at age 21 years and continuing every 3 years through age 29 years. From age 30 years to age 65 years, screening can be done by cytology alone every 3 years or preferably by co-testing (cervical cytology and HPV testing) every 5 years. All testing can be stopped at age 65 years if the woman had three consecutive negative cytology results or two consecutive negative co-testing results in the previous 10 years with the most recent test performed within the past 5 years (34). Women who are HIV positive or who are immunocompromised may need continued screening beyond the age of 65 years. In women who have had a total hysterectomy for reasons other than cervical cancer or moderate to severe cervical dysplasia, there is no need for cervical cancer screening.

**CASE NO. 4.** A 67-year-old established patient is seen for a scheduled annual visit. Her medical history is significant for chronic gastric reflux symptoms controlled by daily ranitidine, chronic low back pain treated with intermittent acetaminophen, and recent onset of episodes of urinary incontinence associated with symptoms of frequency and urgency. Two years previously, she had bilateral cataract surgery with lens implants. On examination today, her blood pressure is 124/78; heart rate, 76 bpm; weight, 69 kg (153 lb); height, 158 cm (5 ft 2 in); and BMI, 28. Her physical examination is unremarkable except for moderate percussion tenderness over the L4–L5 spine area. Pelvic and rectal examinations yield normal results, and a stool sample is negative for occult blood. On review of your office records, you note that her height was 163 cm (5 ft 4 in) 15 years ago and 160 cm (5 ft 3 in) 7 years ago, which prompts a question if her primary care provider had ever ordered a
DEXA scan, but she is uncertain. She then mentions that her primary care provider has retired, and she
wishes to designate you as a primary care provider. You agree to take over her ongoing care as her
primary care provider. You ask her to contact the office of her previous primary provider to transfer her
medical records to your office and schedule a return appointment in 4 weeks for a more detailed medi-
cal history and physical examination. For the appointment, she is instructed to bring all her medica-
tions, both prescribed and over-the-counter, and prefill several health-related forms and questionnaires.

She returns 4 weeks later as scheduled. On review of the medical records sent from the previous
office, you note that, for the past 3 years, she has been treated for systolic hypertension with lisino-
pril, 10 mg daily, with a good response. A DEXA examination has not been previously ordered. The
prefilled intake forms demonstrate that the patient is independent (based on the prefilled ADL and
IADL forms) and she has no depression or anxiety. A Folstein MMSE yields a score of 27. Her medi-
cations include lisinopril, 10 mg, taken once daily; ranitidine, 150 mg, taken once daily; acetamino-
phen, 500 mg, taken as needed; a multivitamin with 600 mg of calcium and 500 units of vitamin D;
and diphenhydramine, 25 mg, for insomnia. She does not have an advance directive and health care
proxy. She states that she lives with her 70-year-old husband in a large, older two-story home and
that maintaining the home is becoming difficult for them. On this examination, BP is 137/88; heart
rate, 68 bpm; weight, 70 kg (155 lb); height, 158 cm (5 ft 2 in); and BMI, 28.3. Vision and hearing
screens yield normal results, dentition is good, lung and heart examinations also yield normal results.
Moderate epigastric tenderness is present on palpation of the abdomen. Back examination reveals
mild kyphosis and moderate tenderness over the L4–L5 area. Extremities are without edema and
she has a good range of motion. Get-up-and-go test yields a normal result. You order a CBC, meta-
boic panel, TSH, urinalysis, and a DEXA scan. She is advised, in addition to the daily multivitamin, to
take a daily tablet of 600 mg calcium citrate and 600 units of vitamin D. She is also advised to take
acetaminophen, 650 mg, twice daily for relief of back pain. She should discontinue diphenhydramine.
She is referred to a gastroenterologist for evaluation and management of her reflux symptoms. She
is advised to prepare advance directives and designate a health care proxy. Another follow-up visit is
scheduled in 4 weeks to review the results of the ordered laboratory tests and DEXA. Blood pressure
will be measured to determine if there is need to change the dosage of lisinopril. The Folstein MMSE
should be repeated in 6 months because of concern for the possible onset of early dementia. Her
urinary incontinence is addressed. Because of the possibility of dementia, an anticholinergic drug is
not prescribed. Instead, you advise voluntary voiding at 3-hour intervals during the awake hours to
diminish the sensation of urgency and episodes of incontinence. This case illustrates the role of the
obstetrician–gynecologist in care of a patient who has transitioned from routine gynecologic care
to comprehensive health care management, including medication management of chronic medical
problems, appropriate referrals, and addressing future care issues.

**Frailty**

Frailty is a clinical state most often seen in individuals of advanced age and characterized
by diminished physiologic reserve of multiple organ systems, which leads to a decreased
ability to withstand the stress of disease or injury with consequent increased risk of
morbidity and mortality. Risk factors for frailty are increased age, female sex, presence of
chronic disease, self-perceived poor health, low educational level, and low economic status. Clinical and laboratory features of frailty have been identified and formal assessment tools have been created that allow the physician to screen for and recognize the presence of frailty. The Fried criteria for frailty are the most commonly used clinical assessment tools and include the following (35) five criteria:

1. Easy exhaustion and persistent fatigue
2. Weakness and decreased muscle strength as measured by hand grip strength using a dynamometer
3. Slow walking speed measured over a distance of 4.5 m (15 feet)
4. Low level of physical activity
5. Unintentional weight loss of greater than 4.5 kg (10 lb) or 5% of body mass in the previous year

The presence of three or more of the criteria establishes a diagnosis of frailty and the presence of one or two of the criteria meet the definition of prefraility. Biologic markers of frailty include increased blood levels of interleukin-6 and C-reactive protein, impaired immune system function, and neuroendocrine system dysfunction. Strong evidence exists that a diagnosis of frailty and, to a lesser degree, prefraility is associated with loss of independence, increased fall risk, increased susceptibility to acute illness, slow recovery from illness, disability, increased use of health care resources, increased risk of hospitalization and institutionalization, and mortality. Sarcopenia or loss of skeletal muscle mass is common with associated decrease in strength and exercise tolerance (35).

CASE NO. 5. An 81-year-old woman is an established patient, and her last well-woman examination was 9 months ago. At that time, she reported that she tired easily and was unsteady on her feet but had not fallen. Her medical history was remarkable for right hip pain and bilateral knee pain associated with walking. The pain was ascribed to osteoarthritis involving her hips and knees and she had been advised to take acetaminophen, 500 mg, four times daily, which gave her some relief. Her other medications include alendronate, 70 mg, once per week for DEXA-confirmed osteopenia along with 600 mg of calcium citrate and 500 units of vitamin D twice daily. Screening instruments yielded negative results for cognitive impairment and depression. Her weight at that time was 58 kg (128 lb), which was a decrease of 1.8 kg (4 lb) from the previous recorded weight, and blood pressure was 124/72. She appeared alert and physical examination results were unremarkable. Laboratory testing was ordered and yielded normal results, except for serum albumin level of 36 g/L (3.6 g/dL), Hb level of 11.4 g/dL (114 g/L), and hematocrit of 0.34 (34%), indicating mild anemia. A stool specimen was negative for occult blood. She was advised to continue her current medications and to schedule a follow-up visit in 12 months.

She is brought to your office 3 months early by her daughter who lives nearby and who scheduled an appointment out of concern for her mother who had fallen twice in the past 6 weeks. On questioning, the patient states that both falls had taken place in her home after she felt weakness in her legs, but she does not report any apparent injury. She mentions that her feeling of weakness,
fatigue, and unsteadiness have worsened and that she rarely leaves her house because of fear of falling. She spends most of the day sitting and sleeping in her chair, and her mood is depressed. On examination, her weight is 54 kg (118 lb), and she reports a poor appetite; BP is 118/65 when sitting and 112/60 after standing for 3 minutes. She has difficulty getting onto and off the examination table and needs assistance. Her grip strength is reduced and there is atrophy and marked weakness of the quadriceps muscles bilaterally. She needs assistance to rise from a chair to do the get-up and go test, and it takes her 25 seconds to walk 10 feet. The patient's history and findings from the physical examination point to the diagnosis of frailty. You recommend referral to physical therapy for muscle strengthening exercises and possible use of assistive devices to aid in walking. The help of a dietitian also should be enlisted for increased caloric and protein intake. You also recommend consideration of suitable alternative housing because this patient is at high risk of progressive functional decline. You advise that an advance directive be prepared as well as designation of a health care proxy.

Established Benefits of Geriatric Assessment

Several reports have documented that geriatric assessment can lead to improved outcomes for the older individual (36–38). These benefits include improved diagnostic accuracy with identification of previously unrecognized problems and initiation of appropriate treatment. A significant benefit is reduction in polypharmacy with avoidance of inappropriate drug use and drug interactions. Problem identification and management can lead to improved functional status and, in turn, can lead to improved independence and quality of life.

Several studies provide evidence that geriatric assessment can facilitate the patient’s ability to remain living in her own home with a decreased likelihood of the need to transition to a more restrictive environment (36–38). Patients who underwent geriatric assessment also use less health care resources, including fewer emergency room visits. Decreased morbidity and mortality of these patients also have been reported.

In recent years, comprehensive geriatric assessment has been used in older individuals who are scheduled for elective surgery with a focus on the identification of those who exhibit frailty or prefrailty (39). Several screening tools to identify frailty are available but a common one is based on the Fried criteria (35).

Frailty is a significant risk factor for poor surgical outcomes (40–45). For older women scheduled for elective surgery, the preoperative identification of frailty or prefrailty provides an opportunity for initiation of intervention measures that can improve the surgical outcomes. Furthermore, awareness of the presence of frailty or prefrailty allows for more focused monitoring in the intraoperative and postoperative periods. Timely preoperative office-based comprehensive geriatric assessment with a focus on identification of frailty has the potential to identify risk factors, initiate intervention, and increase the likelihood of reduced risk of complications in intraoperative and postoperative periods, such as
delirium and poor wound healing. Information gathered during the comprehensive geriatric assessment is an important element in discharge planning (including an assurance that the patient is discharged to the optimal care setting).

In addition to geriatric assessment before elective surgery, a report indicates that appropriate screening of older individuals before emergency abdominal surgery had a beneficial effect on surgical outcomes (46). A brief assessment tool to identify risk factors that might affect the outcome of urgent abdominal surgery was administered in patients aged 70 years and greater at time of the patients’ admission to the hospital (46). Those patients who were identified with features of frailty had greater likelihood of postoperative complications, greater length of hospital stay, and greater postoperative mortality. The preoperative recognition of such high-risk patients can lead to focused intraoperative and postoperative care with the potential to implement measures that can reduce the risk of an adverse outcome.

Key Points

Comprehensive office-based geriatric assessment is a practical approach to guide the gathering of information essential for the care of the older woman. Through use of readily available tools, efficient use of standardized forms, and use of trained office staff, the assessment process can be conducted within the office setting in a time frame compatible with office scheduling routines. The gathering and organization of data gained from the assessment process allows the ob-gyn to identify previously unknown patient information, to implement preventive health care measures, manage identified issues, and provide the basis for long-term planning as a joint process that involves the patient and physician. The following key points should be useful for office assessment of the aging woman:

- Use comprehensive geriatric assessment to create a database for all patients of the practice aged 65 years or older
- Use standardized forms that can be self-administered by the patient either at home or in the office to collect baseline data
- Train office staff to administer the forms that require assistance
- Organize the patient chart so that serial data can be easily monitored to identify significant change over time
- Use specific physical examination tools to collect data on functional and cognitive status
- Order appropriate laboratory and radiologic testing based on assessment findings
- Offer appropriate preventive care
• Screen based on current recommendations
• Recognize the presence of risk factors predictive of present or future problems
• Refer when indicated
• Counsel based on findings
• Establish long-term goals of care

Resources


The following list is for information purposes only. Referral to these sources and websites does not imply the endorsement of the American College of Obstetricians and Gynecologists. This list is not meant to be comprehensive. The exclusion of a source or website does not reflect the quality of that source or website. Please note that websites are subject to change without notice.


Test Your Clinical Skills

Complete the answer sheet at www.clinicalupdates.org under “Test Your Clinical Skills” and receive 5 continuing medical education credits. The answers appear on page 31.

Directions: Select the one best answer or completion.

1. Which of the following is not one of the five goals of the comprehensive geriatric assessment?
   A. Create information base
   B. Develop long-term management strategy
   C. Initiate management of identified problems
   D. Prepare the patient for end of life

2. The purpose of the “brown bag examination” is to
   A. assess the patient’s diet
   B. identify drugs the patient is taking
   C. reduce cost of more extensive examination
   D. save time compared to more extensive examination

3. The author suggests that if a geriatric patient desires to drive and has impaired ability to rotate the neck, she should be referred to
   A. neurologist
   B. rheumatologist
   C. occupational therapist
   D. physical therapist

4. According to a study cited in this monograph, what percentage of older women have involuntary urine loss?
   A. 25
   B. 45
   C. 55
   D. 75

5. A 55-year-old patient lives with her 85-year-old mother. The patient reports insomnia, exhaustion, anger, and fatigue. The most likely etiology of her symptoms is
   A. Caregiver stress
   B. Depression
   C. Generalized anxiety disorder
   D. Menopause

6. According to the author, which of the following is the best person to identify elder abuse?
   A. Daughter
   B. Financial manager
   C. Physician
   D. Spouse

7. What percentage of women older than 65 years have diagnosed or undiagnosed diabetes mellitus?
   A. 10
   B. 15
   C. 27
   D. 40
8. A 67-year-old woman has a normal Hb A1C screening result. When should this test be repeated?
   A. In 1 year
   B. In 2 years
   C. In 3 years
   D. Never

9. A 67-year-old woman with one risk factor for atherosclerotic CVD has normal lipid levels on screening. When should these lipids levels be evaluated again?
   A. In 1 year
   B. In 2 years
   C. In 3 years
   D. Never

10. The USPSTF recommends discontinuing colon cancer screening
    A. at age 70 years
    B. at age 76 years
    C. at age 85 years
    D. never

11. Screening for breast cancer with magnetic resonance imaging is recommended for women with what lifetime risk of breast cancer?
    A. 12%
    B. 20%
    C. 25%
    D. 30%

12. A diagnosis of prefrailty is established when how many of the Fried criteria are present?
    A. Two
    B. Three
    C. Four
    D. Five

13. How much body mass must be lost in the previous year to meet one of the Fried criteria?
    A. 5%
    B. 10%
    C. 15%
    D. 20%

14. In the study by Zattoni et al cited by the author, which of the following was not mentioned as being increased in patients with frailty after urgent surgery?
    A. Length of hospital stay
    B. Postoperative complications
    C. Postoperative mortality
    D. Use of narcotics


Studies were reviewed and evaluated for quality according to the method outlined by the U.S. Preventive Services Task Force:

I  Evidence obtained from at least one properly designed randomized controlled trial.

II-1 Evidence obtained from well-designed controlled trials without randomization.

II-2 Evidence obtained from well-designed cohort or case–control analytic studies, preferably from more than one center or research group.

II-3 Evidence obtained from multiple time series with or without the intervention. Dramatic results in uncontrolled experiments also could be regarded as this type of evidence.

III Opinions of respected authorities, based on clinical experience, descriptive studies, or reports of expert committees.

Answers

Each monograph in *Clinical Updates in Women’s Health Care* is an overview of a topic of importance to obstetrician–gynecologists in practice. Upcoming titles include the following:

- Systemic Lupus Erythematosus
- Anorectal Disorders

If not previously completed, earn CME credits for back issues of *Clinical Updates in Women’s Health Care*. Online access to the complete title list is available at www.clinicalupdates.org.

**Updates**

Also available at www.clinicalupdates.org are the following content updates:

- **Anorectal Disorders** (May 2015)
- **Common Dermatologic Conditions** (January 2018)
- **Complementary and Alternative Medicine** (June 2015)
- **Memory Loss and Dementia** (January 2019)
- **Metabolic Bone Disease** (October 2019)
- **Obesity** (August 2017)
- **Occupational Diseases and Injuries** (July 2016)
- **Sleep Disorders** (September 2015)
- **Upper Gastrointestinal Tract, Biliary, and Pancreatic Disorders** (June 2017)

**List of Titles**

**2020**
- *Overactive Bladder* (Vol. XIX, No. 1, January 2020)
- *Multiple Sclerosis* (Vol. XIX, No. 2, March 2020)

**2019**
- *Surgical Considerations* (Vol. XVIII, No. 1, January 2019)
- *Evaluation and Management of Lipid Disorders* (Vol. XVIII, No. 2, March 2019)
- *Migraine and Other Headache Disorders* (Vol. XVIII, No. 4, July 2019)
- *Back Pain* (Vol. XVIII, No. 5, September 2019)
- *Diabetes Mellitus* (Vol. XVIII, No. 6, November 2019)

**2018**
- *Common Dermatologic Conditions* (Vol. XVII, No. 1, January 2018)
- *Incidental Radiologic Findings* (Vol. XVII, No. 4, July 2018)
- *Perioperative Pain Management* (Vol. XVII, No. 6, November 2018)

**2017**
- *Liver Disease: Reproductive Considerations* (Vol. XVI, No. 1, January 2017)
- *Structural Heart Disease* (Vol. XVI, No. 2, March 2017)
Gynecologic and Obstetric Care for Breast Cancer Survivors (Vol. XIV, No. 4, July 2017)
Mood and Anxiety Disorders (Vol. XVI, No. 5, September 2017)
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Challenging Patient Encounters (Vol. XV, No. 5, September 2016)
Liver Disease: General Pathophysiology, Diagnosis, and Management
(Vol. XV, No. 6, November 2016)
Liver Disease: General Pathophysiology, Diagnosis, and Management Supplement
(Vol. XV, No. 6, November 2016)

2015
Metabolic Bone Disease (Vol. XIV, No. 2, April 2015)
Benign Breast Disease (Vol. XIV, No. 3, July 2015)
Hormone Therapy and Alternative Therapies for Menopause (Vol. XIV, No. 4, October 2015)
Lower Gastrointestinal Tract Disorders (Vol. XIV, No. 5, November 2015)

2014
Nutrition (Vol. XIII, No. 3, July 2014)
Adverse Drug Reactions (Vol. XIII, No. 4, October 2014)
Memory Loss and Dementia (Vol. XIII, No. 5, November 2014)

2013
Obesity (Vol. XII, No. 1, January 2013)
Exercise (Vol. XII, No. 2, April 2013)
Allergies (Vol. XII, No. 4, October 2013)
Thyroid Disorders (Vol. XII, No. 5, November 2013)

2012
Sleep Disorders (Vol. XI, No. 3, July 2012)
Upper Gastrointestinal Tract, Biliary, and Pancreatic Disorders (Vol. XI, No. 4, October 2012)
Anemia (Vol. XI, No. 5, November 2012)

2011
Complementary and Alternative Medicine (Vol. X, No. 4, October 2011)

2010
Anorectal Disorders (Vol. IX, No. 1, January 2010)
Anorectal Disorders Supplement (Vol. IX, No. 1, January 2010)
Occupational Diseases and Injuries (Vol. IX, No. 3, July 2010)

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