Malnutrition – cause for concern in the older Irish person

Malnutrition has been identified as a serious health issue among older people affecting many clinical outcomes, frequently presenting with an acute or chronic illness, prompting early detection and intervention to limit its effects.

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In 2006, 11% of Irish people were aged over 65 years and it is estimated that by 2050, one in four will be aged over 65.[1,2] While it is true that any age group can become malnourished – due to social circumstances or illness – older people are particularly at risk with a reported 20-60% of admissions to gerontology wards in the UK at risk of malnutrition and a staggering 70% of these cases presenting undiagnosed at time of admission.[3] Malnutrition leads to a host of health issues such as weakness, lethargy, reduced mobility, development of pressure sores, increased risk of falls as well as an increase in gastrointestinal problems due to reduced secretions and malabsorption. Other consequences include increased risk to infection, delayed wound healing, impaired respiratory function, muscle weakness and depression.[4,5,6]

Economic impact of malnutrition in the elderly

The combination of malnutrition itself and its side-effects leads to an increase in morbidity and mortality rates, longer hospital stays for patients and higher healthcare costs, both to the service user and the state. Malnutrition in older people is estimated to cost the Irish state a staggering €1.5 billion each year, which equates to over 10% of the total healthcare budget. The average length of stay is 16.7 days for patients at risk of malnutrition versus 10.1 days for patients not at risk.[2,7] Also, 31% of malnourished patients require the use of home care services compared to just 12% of individuals not at risk of malnutrition.[8] The economic impact of treating malnourished patients in the community is also significant. Malnourished patients were found to have twice as many GP visits and three

times more hospital admissions than well-nourished patients. The cost of managing a malnourished patient averaged at €1,735 compared to €750 for a well-nourished patient over a six month period. The main contributors to the increased costs were GP visits, hospital admissions and prescriptions.[9]

Risk factors

Risk factors which lead to the development of malnutrition in older people include social isolation, poly-pharmacy, low income and lack of personal interest or motivation.[10,2] Swallowing and taste difficulties frequently lead to decreased appetite and insufficient intake causing malnutrition. The three most significant factors associated with malnourishment are swallowing difficulties (71%), taste difficulties (57%) and residency in a nursing home (58%).[11] Studies in other countries such as New Zealand have shown that social factors also play a significant role in contributing to malnutrition. Widowed or older people living alone were more likely to be at risk of malnutrition than those with partners or spouses. Depressive symptoms were also found to have an effect on nutritional status, as well as old age and a low Mini Mental State Examination (MMSE) score. In one study of 134 participants it was found that 78% presented with two or more co-morbidities and poly-pharmacy was present in all patients. 27% exhibited depressive symptoms and 33% showed some form of cognitive difficulties based on MMSE scores, demonstrating a relationship between increasing age, co-morbidities, and poly-pharmacy with decreased dietary intake.[12]

Screening tools

The purpose of screening is to identify patients at risk of malnutrition and assist healthcare professionals to create an action plan to prevent its development. The screening tool chosen needs to suit the profile of the patient and clinical setting in which it is to be used. Numerous screening tools are available to nurses and include the Subjective Global Assessment (SGA), Malnutrition Universal Screening Tool (MUST), Nutritional Risk Screening 2002 (NRS-2002), the Mini Nutritional Assessment (MNA) and MNA-Short Form.
When the SGA, MUST, NRS-2002 and MNA were compared it was found the MUST and NRS-2002 showed high specificity for recognising older people at risk of malnourishment. The MNA identified more patients at risk than other tools but was more time consuming to complete and requires user training. The NRS-2002 and the MUST tools are suitable for screening patients on admission but are not specific to any particular age group. The SGA tool is a comprehensive tool for assessing nutritional risk in older patients, however, it was found to be time-consuming.[13,14] The MST is best suited to the acute care setting or quick assessments in residential care settings, but not suitable for detecting gradual nutritional changes over time. It has also been found that the NRS-2002 and the MNA-SF were the most effective in predicting clinical outcomes when compared with the MUST.15 ESPEN (2002) have recommended the MUST, NRS-2002 and the MNA for clinical use. The MUST was originally developed for use in the community but in recent times has been approved for use in the hospital because of its high reliability and predictive validity. The NRS-2002 contains some elements of MUST, but also includes age as a risk factor. Finally, the MNA is the most effective at identifying the possibility of malnutrition in the frail older person.[16] Many screening tools require comprehensive user training to ensure accuracy, especially the SGA. The provision of in-service training and dissemination of information on screening tools of choice will ensure consistency in their use and the provision of more cohesive and team focused patient care.

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Discussion

It is clear the cost of malnutrition to the Irish Government is of great concern. Malnutrition leads to longer hospital stays, greater demand on resources and a higher rate of GP visits.[7,9,17] These are important facts considering one in four Irish people will be aged over 65 years by 2050. Many contributing factors to the development of malnutrition among the elderly exist, including functional loss such as loss of taste and smell, decreased appetite, lack of motivation and dementia and social issues such as social isolation and depression. The effects of malnutrition are numerous, affecting skin integrity, continence and social functioning. Screening is the most effective method to detect those at risk of malnutrition. The National Institute for Health and Clinical Excellence recommends routine screening for malnutrition on admission to hospital and residential care settings, and the inclusion of screening at outpatient clinics and GP appointments with follow-up for those identified at risk.[18] ESPEN (2002) Guidelines indicate that screening should be followed by a detailed assessment, examination of the patient and implementation of an action plan, with subsequent monitoring to ascertain effectiveness.[16] The results of screening and formulation of patient action plans must be communicated to other members of the multi-disciplinary team and/or primary care team. It is important that nurses link the results of nutritional screening to formulate an individual action plan to guide clinical judgement and patient care which is specific to each patient's situation and needs.
Nutritional status is reliant on more than just the food eaten, it also incorporates the environment during mealtimes and the extent to which the patient is involved in their nutritional planning, as these factors impact greatly on the patient's willingness to comply. Meal planning should be carried out in a multi-disciplinary manner. The need to prescribe costly dietary supplements may be avoided by simple measures, such as ensuring the patient's environment is conducive to a relaxed mealtime and that other healthcare professionals are aware of the concept of 'protected mealtimes'.[19,20] In some situations, the provision of additional eating aids such as large cutlery may assist the patient in achieving a higher food intake. The

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accurate recording of food and weight charts enables other multi-disciplinary team members to monitor the patient's progress. Therefore, the quality of nursing documentation on patient's nutritional status is a crucial part of recording, communicating and the reporting of on-going nutritional patient care.

Conclusion

Malnutrition in older people has been identified as a serious health issue affecting many clinical outcomes. Malnutrition can often present alongside acute or chronic illness and so prompt detection and intervention are necessary to limit its effects. Once identified, the causes of malnutrition must be investigated. Malnutrition is not just an issue in the acute setting but also in residential care homes and in community dwelling older persons. It is the responsibility of all healthcare professionals to increase public awareness of the causes and effects of malnutrition and address these factors appropriately. Research to identify the true prevalence of malnutrition in older Irish people is required and systematic ways to combat this healthcare concern which is likely to increase as the population ages.

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CIALIS* (TADALAFIL) REPUBLIC OF IRELAND ABBREVIATED PRESCRIBING INFORMATION Presentation Tablets 2.5mg, 5mg, 10mg, or 20mg of tadalafil. Also contains lactose. **Uses** Treatment of erectile dysfunction in adult males. **Dosage and Administration** *Adult men:* The recommended dose is 10mg orally, taken at least 30 minutes prior to sexual activity. In those patients in whom tadalafil 10mg does not produce an adequate effect, 20mg might be tried. Maximum dosing frequency, once per day. 10mg or 20mg tadalafil is not recommended for continuous daily use. In patients who anticipate a frequent use of Cialis (ie, at least twice weekly), a once daily regimen with the lowest doses of Cialis might be considered. The recommended dose is 5mg taken once a day at approximately the same time of day. The dose may be decreased to 2.5mg once a day based on individual tolerability. The appropriateness of continued use of the daily regimen should be reassessed periodically. *Elderly:* Dosage adjustment not required. *Impaired renal or hepatic function:* In patients with severe renal impairment the maximum recommended dose is 10mg. Once a day dosing of Cialis is not recommended in patients with severe renal impairment. In men with hepatic impairment the recommended dose is 10mg. There are no available data about the administration of doses higher than 10mg of tadalafil to patients with hepatic impairment. There is limited clinical data on the safety of Cialis in patients with severe hepatic impairment; if prescribed, a careful individual benefit/risk evaluation should be undertaken by the prescribing physician. Once a day dosing has not been evaluated in patients with hepatic impairment; therefore, if prescribed, a careful individual benefit/risk evaluation should be undertaken by the prescribing physician. *Diabetes:* Dosage adjustment not required. *Use in children and adolescents:* Cialis should not be used in individuals below 18 years of age. Not indicated for use by women. In clinical trials, Cialis demonstrated improvement in patients' erectile function and the ability to have successful sexual intercourse up to 36 hours following dosing. **Contra-indications** Known hypersensitivity to any ingredient. Patients using any form of organic nitrates. In men with cardiac disease for whom sexual activity is inadvisable. Physicians should consider the potential cardiac risk of sexual activity in patients with pre-existing cardiovascular disease. Patients with myocardial infarction within the last 90 days, patients with unstable angina or angina occurring during sexual intercourse, patients with New York Heart Association class 2 or greater heart failure in the last 6 months, patients with uncontrolled arrhythmias, hypotension (<90/50mmHg), or uncontrolled hypertension, patients with a stroke within the last 6 months. Cialis is contra-indicated in patients who have loss of vision in one eye because of non-arteritic anterior ischaemic optic neuropathy (NAION), regardless of whether this episode was in connection or not with previous PDE5 inhibitor exposure. **Warnings and Special Precautions** Prior to any treatment for erectile dysfunction, physicians should consider the cardiovascular status of their patients, since there is a degree of cardiac risk associated with sexual activity. Tadalafil has vasodilator properties, resulting in mild and transient decreases in blood pressure. It augments the hypotensive effect of nitrates. *Tadalafil (2.5mg and 5mg):* In patients receiving concomitant antihypertensive medicines, tadalafil may induce a blood pressure decrease. When initiating daily treatment with tadalafil, appropriate clinical considerations should be given to a possible dose adjustment of the antihypertensive therapy. Serious cardiovascular events were reported either post-marketing and/or in clinical trials. Although most of the patients in whom these events have been observed had pre-existing cardiovascular risk factors, it is not possible to determine whether these events are related directly to these risk factors, to Cialis, to sexual activity, or to a combination of these or other factors. Visual defects and cases of NAION have been reported in connection with the intake of Cialis and other PDE5 inhibitors. In case of sudden visual defect, patients should be advised to stop taking Cialis and consult a physician immediately. Due to increased tadalafil exposure (AUC), limited clinical experience, and the lack of ability to influence clearance by dialysis, once a day dosing of Cialis is not recommended in patients with severe renal impairment. There is limited clinical data on the safety of single-dose administration of tadalafil in patients with severe hepatic insufficiency (Child-Pugh class C); if prescribed, a careful individual benefit/risk evaluation should be undertaken by the prescribing physician. Use with caution in patients who have conditions that might predispose them to priapism, or in patients with anatomical deformation of the penis. Patients who experience erections lasting 4 hours or more should be instructed to seek medical assistance. If priapism is not treated immediately, penile tissue damage and permanent loss of potency may result. It is not known if Cialis is effective in patients who have undergone pelvic surgery or radical non-nerve-sparing prostatectomy. Cialis should not be administered to patients with hereditary problems of galactose intolerance, the Lapp lactase deficiency, or glucose-galactose malabsorption. In patients who are taking alpha$_1$-blockers, concomitant administration of Cialis may lead to symptomatic hypotension in some patients. The combination of tadalafil and doxazosin is not recommended. Caution should be exercised when prescribing Cialis to patients using potent CYP3A4 inhibitors (ritonavir, saquinavir, ketoconazole, itraconazole, and erythromycin) as increased tadalafil exposure (AUC) has been observed if the drugs are combined. The safety and efficacy of combinations of tadalafil and other PDE5 inhibitors or other treatments for erectile dysfunction have not been studied. Patients should be informed not to take Cialis with such combinations. **Pregnancy and Lactation** Not indicated for use by women. There are limited data from the use of tadalafil in pregnant women. Animal studies do not indicate direct or indirect harmful effects with respect to pregnancy, embryonal/foetal development, parturition, or postnatal development. As a precautionary measure, it is preferable to avoid the use of Cialis during pregnancy. Available pharmacodynamic/toxicological data in animals have shown excretion of tadalafil in milk. A risk to the suckling child cannot be excluded. Cialis should not be used during breast-feeding. **Driving, etc** No studies on the effect on the ability to drive and use machines have been performed. Although the frequency of reports of dizziness in placebo and tadalafil arms in clinical trials was similar, patients should be aware of how they react to Cialis before driving or operating machinery. **Undesirable Effects** Very common (≥1/10), common (≥1/100 to <1/10), uncommon (≥1/1,000 to <1/100), rare (≥1/10,000 to <1/1,000), very rare (<1/10,000), and not known (events not reported in registration trials cannot be estimated from post-marketing spontaneous reports). *Very common:* Headache. *Common:* Dizziness, flushing, dyspepsia, nasal congestion, back pain, myalgia. *Uncommon:* Hypersensitivity reactions, blurred vision, sensations described as eye pain, tachycardia, palpitations, hypotension (more commonly reported when tadalafil is given to patients who are already taking antihypertensive agents), hypertension, abdominal pain, gastro-oesophageal reflux, rash, hyperhidrosis (sweating), chest pain[1]. *Rare:* Stroke[1] (including haemorrhagic events), syncope, transient ischaemic attacks[1], migraine[3], visual field defect, swelling of eyelids, conjunctival hyperaemia, myocardial infarction, urticaria, Stevens-Johnson syndrome[3], exfoliative dermatitis[3], prolonged erections, priapism[3], facial oedema[3], seizures, transient amnesia, NAION[3], retinal vascular occlusion[3], sudden hearing loss[2], unstable angina pectoris[3], ventricular arrhythmia[3], epistaxis, sudden cardiac death[1, 3]. [1]Most of the patients in whom these events have been reported had pre-existing cardiovascular risk factors. [2]Sudden decrease or loss of hearing has been reported in a small number of post-marketing and clinical trial cases with the use of all PDE5 inhibitors, including tadalafil. [3]Post-marketing surveillance reported adverse reactions not observed in placebo-controlled clinical trials. Adverse reactions reported with tadalafil were transient, and generally mild or moderate. Adverse reaction data are limited in patients >75 years. A slightly higher incidence of ECG abnormalities, primarily sinus bradycardia, has been reported in patients treated with tadalafil once a day as compared with placebo. Most of these ECG abnormalities were not associated with adverse reactions. *For full details of these and other side-effects, please see the Summary of Product Characteristics, which is available at http://www.medicines.ie/.* **Legal Category** POM **Marketing Authorisation Numbers and Holder** EU/1/02/237/001 EU/1/02/237/002 EU/1/02/237/003 EU/1/02/237/004 EU/1/02/237/005 EU/1/02/237/006 EU/1/02/237/007 EU/1/02/237/008. Eli Lilly Nederland BV, Grootslag 1-5 3991, RA Houten, The Netherlands. **Date of Preparation or Last Review** March 2011. **Full Prescribing Information is Available From** Eli Lilly and Company Limited Lilly House, Priestley Road Basingstoke, Hampshire, RG24 9NL. Telephone: Basingstoke (01256) 315 000 E-mail: ukmedinfo@lilly.com *or* Eli Lilly and Company (Ireland) Limited Hyde House, 65 Adelaide Road, Dublin 2, Republic of Ireland. Telephone: Dublin (01) 661 4377. E-mail: ukmedinfo@lilly.com. *CIALIS (tadalafil) is a trademark of Eli Lilly and Company. **Reference 1**. Cialis Summary of Product Characteristics. Eli Lilly and Company Limited.

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FOCUS ON: MEN'S HEALTH

Men's attitudes towards chlamydia screening: a narrative review

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Chlamydia trachomatis is a sexually transmissible infection (STI) that affects significant numbers of men. Research on men's perspectives on chlamydia screening (or testing) has been limited. The authors conducted a narrative review to examine: (1) what factors encourage or discourage men from attending health services for chlamydia screening, and/or from accepting screening once it has been offered to them, and (2) where men want chlamydia screening services to be located.

A narrative review of the recent peer-reviewed literature (published between 1999 and 2009) on men's attitudes towards chlamydia screening. To be included, articles had to explore men's perspectives on screening (which could be ascertained through quantitative or qualitative studies, or from relevant discussion papers or reviews).

Forty-eight articles were included in all. Men's attitudes towards chlamydia screening are influenced by their knowledge about the infection, their perceived vulnerability to the infection, the degree of embarrassment and shame that they associate with screening and the stigma that they associate with screening. Men prefer to be offered urine testing for chlamydia. Men want to be offered screening by non-judgemental professionals. Men's attitudes towards screening for chlamydia in general practice, genito-urinary medicine clinics, home and outreach settings are also explored in this review.

Several factors influence men's attitudes towards screening. Two central themes underlie and influence many of these factors: men's needs to make positive impressions on others, and men's identification with particular ideals of masculinity. The review concludes with suggestions for future research on this topic.

Erectile dysfunction and testosterone deficiency syndrome: the 'portal to men's health'

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Can J Urol. 2012 Oct;19(5 Suppl 1):18-27.

Erectile dysfunction (ED) and testosterone deficiency syndrome (TDS) are closely related. In addition to affecting men's sexual health, both conditions also affect other male health issues. Screening for ED, especially in younger men, should become standard clinical practice for the primary care physician. Possible systemic effects and associated effects of TDS are now well documented. Testosterone replacement therapy (TRT) is very safe and effective in the right man.

Erectile dysfunction in general medicine practice: prevalence and clinical correlates

Chew KK, et al The Keogh Institute for Medical Research, QEII Medical Centre, Perth, Australia. Int J Impot Res. 2000 Feb;12(1):41-5.

Erectile dysfunction (ED) is a common problem in general medical practice affecting especially the elderly and those with cardiovascular disease and diabetes mellitus. A study was undertaken by questionnaire distributed to consecutive adult male attendees at 62 general medical practices. 1240 completed questionnaires were available for analysis. The mean age of participants was 56.4 (range 18-91 y). 488 men (39.4%) reported ED: 119 (9.6%) 'occasionally', 110 (8.9%) 'often', and 231 (18.6%) 'all the time' (complete ED). Among 707 men aged 40-69 240 (33.9%) reported ED and 84 (11.9%) had complete ED. The prevalence of complete ED increased with age, rising from 2.0% in the 40-49 age group to 44.9% in the 70-79 age group. Only 11.6% of men with ED had received treatment. Hypertension, ischaemic heart disease, peripheral vascular disease and diabetes mellitus were frequently associated with ED. 40% of diabetic men aged 60 or older had ED all the time

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Revatio – paediatric use

Pfizer Healthcare Ireland have announced the launch of Revatio (sildenafil as citrate) Powder for Oral Suspension for paediatric patients (aged 1-17 years) with pulmonary arterial hypertension, making it the only PDE5-inhibitor to be approved for the treatment of children (aged 1-17 years of age) with this disease[1] .RevatioPowder for Oral Solution is also indicated for the treatment of adult patients with PAH classified as WHO functional class II and III, to improve exercise capacity.[i]

Pulmonary arterial hypertension (PAH) is a rare, progressive disease characterized by high blood pressure in the pulmonary arteries, leading to heart failure and premature death.[2] Pulmonary arterial hypertension can occur with no known underlying cause, or it can be found in association with other disorders such as connective tissue disease or congenital heart disease.[iii]

Revatio is indicated for paediatric patients, aged 1 to 17 years of age, with pulmonary arterial hypertension. The powder for oral suspension formulation is prepared at a strength of 10 mg/mL of sildenafil with a 1 mL dosing volume to support a 10 mg dose, or 2 mL dosing volume to support a 20 mg dose which is bioequivalent to the 20 mg tablet strength. Higher than recommended doses should not be used in paediatric patients.

Revatio (sildenafil as citrate) is the only treatment for pulmonary arterial hypertension available in tablet, oral suspension and intravenous formulations. The new oral suspension formulation provides a convenient, alternative for the treatment of pulmonary arterial hypertension in patients unable to swallow the tablet form of the drug.

Pfizer launches new Fentadur Analgesic Patch

Pfizer Healthcare Ireland recently announced the launch of Fentadur transdermal patch, indicated for the management of severe chronic pain which can be adequately managed only with opioid analgesics. Fentadur contains fentanyl and is available in five dosing strengths:

- Fentadur 12 micrograms/ hour transdermal patch (1.38mg fentanyl)
- Fentadur 25 micrograms/ hour transdermal patch (2.75mg fentanyl)
- Fentadur 50 micrograms/ hour transdermal patch (5.50mg fentanyl)
- Fentadur 75 micrograms/ hour transdermal patch (8.25mg fentanyl)
- Fentadur 100 micrograms/ hour transdermal patch (11mg fentanyl)

The dosing of Fentadur is individual and based on the patient's opioid history. It should also take into account the medical status of the patient, and the degree of severity of the disorder. The required fentanyl dosage should be assessed regularly and titrated individually until analgesic efficacy is attained. If analgesia is insufficient at the end of the initial application period, the dose may be increased after 3 days until the desired effect is obtained for each patient. Dose adjustment should normally be performed in 12mcg/hour or 25mcg/hour increments. The transdermal patch should be changed every 72 hours and a new skin area should be selected for each application.

Fentadur is a prescription only medication and is GMS reimbursable. Full prescribing information is available on www.medicines.ie.

Should you have any medical queries about Fentadur please contact the Pfizer Medical Information Department Freephone 1800 633 363. An up to date approved Fentadur SPC is available on www.medicines.ie.

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The Easy Feed system is available to purchase now in 250ml bottles and 1 litre bottles at all major retailers. For more information visit www.smanutrition.ie