

Three Medical Practices That Older Patients Should Question: the new old age

Span, Paula

[ProQuest document link](#)

FULL TEXT

Some treatments and procedures become routine despite lacking strong evidence to show that they're beneficial. Recent studies have called a few into question.

An older patient with dementia is in the hospital and has trouble swallowing. A speech pathologist recommends thickening the liquids the patient drinks with starch or gum and specifies how viscous her tea, water or juice should be. Should it resemble honey? Or apricot nectar?

A doctor writes the order, and the discharged patient returns to her home or nursing facility. She may be drinking thickened liquids from then on.

The rationale is that this sludgy stuff prevents patients from drawing liquids into their lungs and from developing aspiration pneumonia. But does the practice work? Some geriatricians have doubted it for years.

Now, a large-scale study from the Feinstein Institutes for Medical Research in Manhasset, N.Y., has found that liquid thickening doesn't actually help such patients.

This happens with some frequency: Medical practices so commonplace they rarely raise eyebrows turn out, after further investigation, to have scant basis in fact.

"There are plenty of things we do in medicine that have no evidence," said Dr. Matthieu Legrand, an anesthesiologist and critical care doctor at the University of California, San Francisco.

They continue, accepted but untested, "because we have always done them, so they just keep on happening."

Dr. Legrand is the lead author of a new study examining another common policy: discontinuing certain blood pressure medications a few days before patients undergo major surgery.

Herewith, a look at three common practices getting closer scrutiny:

Thickened liquids

About a decade ago, geriatricians at U.C.S.F. decided, as a one-day experiment, to try the same thickened liquids they order for patients.

"We got headaches. We got dehydrated," recalled Dr. Eric Widera, among the participants and author of a recent skeptical editorial in JAMA Internal Medicine.

"We couldn't do it for 12 hours. We were asking our patients with dementia to do it for the rest of their lives." Yet, "there wasn't any evidentiary basis" for the policy, Dr. Widera said.

Now, there is—and it doesn't support the practice. The Feinstein researchers analyzed the medical records of nearly 9,000 older patients (average age: 86) hospitalized with dementia and swallowing difficulties. Their hospital diets consisted primarily of either normally thin or thickened liquids.

Matching the groups for key traits, the researchers found no significant difference in length of hospital stay, readmissions or death rates. Those drinking thickened liquids were less likely to need ventilators but were actually more likely to develop pneumonia or other respiratory problems.

Moreover, drinking sludge "really takes a toll on their quality of life," said Dr. Liron Sinvani, a hospitalist and geriatrician and the study's senior author. Many such patients are nearing the end of life.

Some will choke or cough when drinking thin liquids, so thicker liquids make sense. Some don't dislike thickened ones. "We can't say 100 percent, this is a wrong practice," Dr. Sinvani said. "But we can question it. It's not clear that

what we're doing is best for people.”

Interrupted blood pressure regimens

Between 25 percent and 50 percent of patients undergoing surgery are taking blood pressure medications called ACE inhibitors (benazepril, lisinopril and other -prils) or angiotensin II receptor blockers (candesartan, olmesartan and other -sartans), Dr. Legrand said. “For older adults, it’s a higher number,” he added.

For many kinds of surgery, patients are routinely advised to stop those drugs before the scheduled operation.

Doctors fear that blood pressure will drop too low during the procedure, causing complications like heart failure, stroke or kidney problems.

If patients forget or confuse their instructions and don’t stop the drugs on time, doctors may actually postpone or cancel operations. Without the medications, though, patients’ blood pressure could rise dangerously.

To determine what really happens, a study randomized 2,200 patients (average age: 68) undergoing a variety of noncardiac surgeries at 40 hospitals in France. Half of the patients continued using ACE inhibitors or ARBs until the day of surgery; half were told to stop taking ARBs 48 hours before the operations.

During the procedures, blood pressures were more apt to fall in the group continuing the drugs. “But the rate of complications was exactly the same,” about 22 percent in each group, said Dr. Legrand, lead author of the study, published in JAMA.

The groups had comparable rates of postsurgery heart attacks, strokes, sepsis, respiratory and kidney complications, intensive care admissions and deaths. A large international study and another in Britain recently reached similar conclusions.

Cardiac surgery is different, Dr. Legrand cautioned. Those patients are at higher risk; in most hospitals, they’re told to continue their blood pressure drugs.

But for other operations, “patients don’t necessarily have to stop their medications,” he said. “This is a conversation they can have with their doctors.”

Spine implant for back pain

The Food and Drug Administration reported in 2020 that about 50,000 spinal cord stimulators, devices intended to reduce chronic pain using electrical impulses, were being implanted annually —and that over four years the agency had received 108,000 reports of patient injuries, including 497 deaths, and malfunctioning stimulators.

Annual implantations are likely to have risen since, as doctors seek substitutes for prescription opioids. Do these stimulators work?

Here the dilemma is not lack of evidence but contradictory claims and conflicting findings, with researchers arguing about methodologies and results —a confusing landscape for patients desperately seeking relief.

Pain doctors consider a treatment effective if it reduces pain by half in 50 percent of patients. Potentially confounding such results, however, is the potent placebo effect.

For patients, “the more you have invested, the more likely you are to see an effect,” said Dr. Rita F. Redberg, a cardiologist at the University of California, San Francisco, and a co-author of a recent study in JAMA Neurology. A surgically implanted generator, with wires inserted into the space around the spinal column, constitutes a major investment. Such studies are not easily blinded, as in most clinical drug trials; patients know they have received stimulators.

The new study analyzed insurance claims data for 7,500 patients (average age: 64) suffering chronic pain, most after failed back surgery. “We did careful matching so we could compare outcomes,” Dr. Redberg said.

Over two years, the 1,260 patients using spinal cord stimulators didn’t have lower use of opioids, or most other pain treatments, than did those pursuing conventional medical management without implantation.

“They wanted to feel better, but they didn’t,” Dr. Redberg said. Moreover, about one patient in five had the device removed or required a second surgery to repair or relocate it.

Two Cochrane reviews, meta-analyses by an independent network of researchers, have found “low to very low certainty evidence” that stimulation reduces pain intensity and “little to no sustained benefit” for low back pain.

Pain specialists and professional organizations were quick to criticize the new study’s methodology, however.

“That’s a very imprecise criteria to judge someone’s pain relief by —the amount of medication they take,” said Dr. Konstantin Slavin, a neurosurgeon at the University of Illinois, Chicago, and president of the International Neuromodulation Society.

“That doesn’t correlate with patients’ self-reported experiences.”

Although the technology is improving rapidly, supporters acknowledge that spinal cord stimulation has limitations. It may help some patients with nerve pain but won’t relieve arthritis pain, pointed out Dr. Lawrence Poree, director of the Neuromodulation Service at U.C.S.F.

“When patients have the expectation of being pain-free with spinal cord stimulation, that just doesn’t happen,” Dr. Slavin said. But “improved ability to function, to enjoy life, we definitely can accomplish that.”

Patients should probably proceed with caution. The F.D.A. recommends a stimulation trial for several days, with the generator taped to the body. Only those experiencing substantial pain relief should go ahead with implantation, Dr. Poree said.

For now, disputes continue. “We all want to help patients with pain,” Dr. Redberg said. “This is not the way to do it.”

DETAILS

Subject:	Patients; Pneumonia; Back pain; Surgery; Blood pressure; Dementia; Chronic pain; Medical research; Drugs; Hospitals; Spinal cord; Medical practices; Physicians; Narcotics
Business indexing term:	Subject: Hospitals Physicians
Location:	United States--US; California; San Francisco California
Identifier / keyword:	Elderly; Medicine and Health; Dementia; Heart; Surgery and Surgeons; Spine (Body Part); Pain; Research; Feinstein Institutes for Medical Research
Publication title:	New York Times (Online); New York
Publication year:	2024
Publication date:	Sep 14, 2024
Section:	health
Publisher:	New York Times Company
Place of publication:	New York
Country of publication:	United States, New York
Publication subject:	General Interest Periodicals--United States
e-ISSN:	15538095
Source type:	Blog, Podcast, or Website
Language of publication:	English

Document type: News

ProQuest document ID: 3104415683

Document URL: <https://proxy.lib.umich.edu/login?url=https://www.proquest.com/blogs-podcasts-websites/three-medical-practices-that-older-patients/docview/3104415683/se-2?accountid=14667>

Copyright: Copyright 2024 The New York Times Company

Last updated: 2024-09-17

Database: Global Newsstream

LINKS

[Availability at University of Michigan](#)

Database copyright © 2024 ProQuest LLC. All rights reserved.

[Terms and Conditions](#) [Contact ProQuest](#)