

Head Shoulders, Knees and Toes: Neurological Presentations and Serious Mimics Pearls For Practice

The Senior With Functional Decline - Geriatrics or Neurology?

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Different kinds of activities of daily living require different functions

Instrumental activities of daily living (IADLs) require higher cortical function

- Personal finances, Transportation, Taking medication
- Cooking, House cleaning, communication, Laundry, Shopping
- Activities of daily living (ADLs) require intact motor, sensory and coordination skills
 - Bathing, Dental Hygiene, Toileting, Eating, Dressing, Transfer and Mobility

When should an older patient see a geriatrician? When should an older patient see a neurologist?

- IADLS go before ADLS
 - Complex older patients with multiple comorbidities related to cognition and function (dementia, mood disorders)
 - Evaluate impact based on cultural and historical context
- ADLS go before IADLS
 - Progressive weakness
 - Progressive sensory loss
 - Insidious onset - can't link onset to a specific event
 - Asymmetric findings
 - Functional decline out of step with changes in cognition



The tree of reasons to refer an older adult to a geriatrician

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Pearls For Practice

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Frailty and Functional decline

- Degree of functional impairment is necessarily linked with dementia
- Distinguish between physical and cognitive impacts on ADLs/IADLs
 - E.g. Can they not take their medications because they're too out of breath to get to counter (physical) or because they're forgetting (cognitive)?

What to include in your referral

Geriatrics

- Results of exams to help consulting physician
 - Cognitive screens: MoCA, MMSE, SLUMS
- Need for capacity assessment: if patient needing placement and refusing to go, elder abuse (if PD/POA established ask family to bring documents)
- Safety issues: driving, leaving stove on, wandering

Neurology

- Results of exams to help consulting physicians
 - Response to pain management, etc
- Presence of:
 - Upper motor neuron signs
 - Wasting
 - Progression - especially disjointed progression in different areas
 - Contemporaneous changes in speech/ swallowing
 - Respiratory symptoms

CLINICAL FRAILITY SCALE

	1	VERY FIT	People who are robust, active, energetic and motivated. They tend to exercise regularly and are among the fittest for their age.
	2	FIT	People who have no active disease symptoms but are less fit than category 1. Often, they exercise or are very active occasionally, e.g., seasonally.
	3	MANAGING WELL	People whose medical problems are well controlled, even if occasionally symptomatic, but often not regularly active beyond routine walking.
	4	LIVING WITH VERY MILD FRAILITY	Previously "vulnerable," this category marks early transition from complete independence. While not dependent on others for daily help, often symptoms limit activities. A common complaint is being "slowed up" and/or being tired during the day.
	5	LIVING WITH MILD FRAILITY	People who often have more evident slowing, and need help with high order instrumental activities of daily living (finances, transportation, heavy housework). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation, medications and begins to restrict light housework.
	6	LIVING WITH MODERATE FRAILITY	People who need help with all outside activities and with keeping house. Inside, they often have problems with stairs and need help with bathing and might need minimal assistance (cuing, standby) with dressing.
	7	LIVING WITH SEVERE FRAILITY	Completely dependent for personal care, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within - 6 months).
	8	LIVING WITH VERY SEVERE FRAILITY	Completely dependent for personal care and approaching end of life. Typically, they could not recover even from a minor illness.
	9	TERMINALLY ILL	Approaching the end of life. This category applies to people with a life expectancy <5 months, who are not otherwise living with severe frailty. Many terminally ill people can still exercise until very close to death.

SCORING FRAILITY IN PEOPLE WITH DEMENTIA

The degree of frailty generally corresponds to the degree of dementia. Common symptoms in mild dementia include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In moderate dementia, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In severe dementia, they cannot do personal care without help.

In very severe dementia they are often bedfast. Many are virtually mute.

Clinical Frailty Scale
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Rockwood K et al. A global clinical measure of fitness and frailty in elderly people. *CMAJ* 2005; 173:483-485.



Geriatric referral in Edmonton has two components:

- Referral letter (or most recent progress note stating rationale for referral)
- Fill out this form on AB referral directory: [Specialized Geriatrics Outpatient Referral](#)

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Consider using [MyL3Plan](#), a free online tool developed by the Office of Lifelong Learning (L3) that can be used to meet and support the 3 activities/action plans required by the PPIP-CPSA and earn up to 36 Mainpro+ certified credits. by completing the following cycles:

- Practice-driven quality improvement using objective data (CQI)
- Personal Development (PD)
- Standards of Practice Quality Improvement (SOP).

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