Screening in the old persons

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geriatrician

Older population > 75 Years

- Healthy: 65-70%
- Diseases: 5-10%
- Frail: 20-30%

Assess the risk by screening tools

Scales assesment

Vellas B, Garry and al. Rev Med Int Jul 2000

Life expectancy and handicap

75 years

- Life expectancy (L.E.)

  M:9 yr F:11yr

  - L.E. - handicap

    M:3,5 yr F:6,5yr

  - L.E. + handicap

    M:5,5 yr F:4,5yr

Van Oyen: Ouderen in solidarideit 2003

Screening: definition

- Examination of a group to separate well persons from those who have undiagnosed condition(s) or who are at high risk.

- Screening test: a simple test performed on a large number of people to identify those who have or are likely to develop a specified disease

Screening tests

- ✓ Tests quick and objective;
  easy to do;
  global assesment of the risk;
  good evaluation of the patient;

They are not diagnosis tools
Very often detect a risk

- Usefull to check a risk, an event, a pathology

but often, problems of sensitivity and specificity of the test

Poor data after 75 in litterature about the usefulness of classical screening

If we have a classical internistic approach

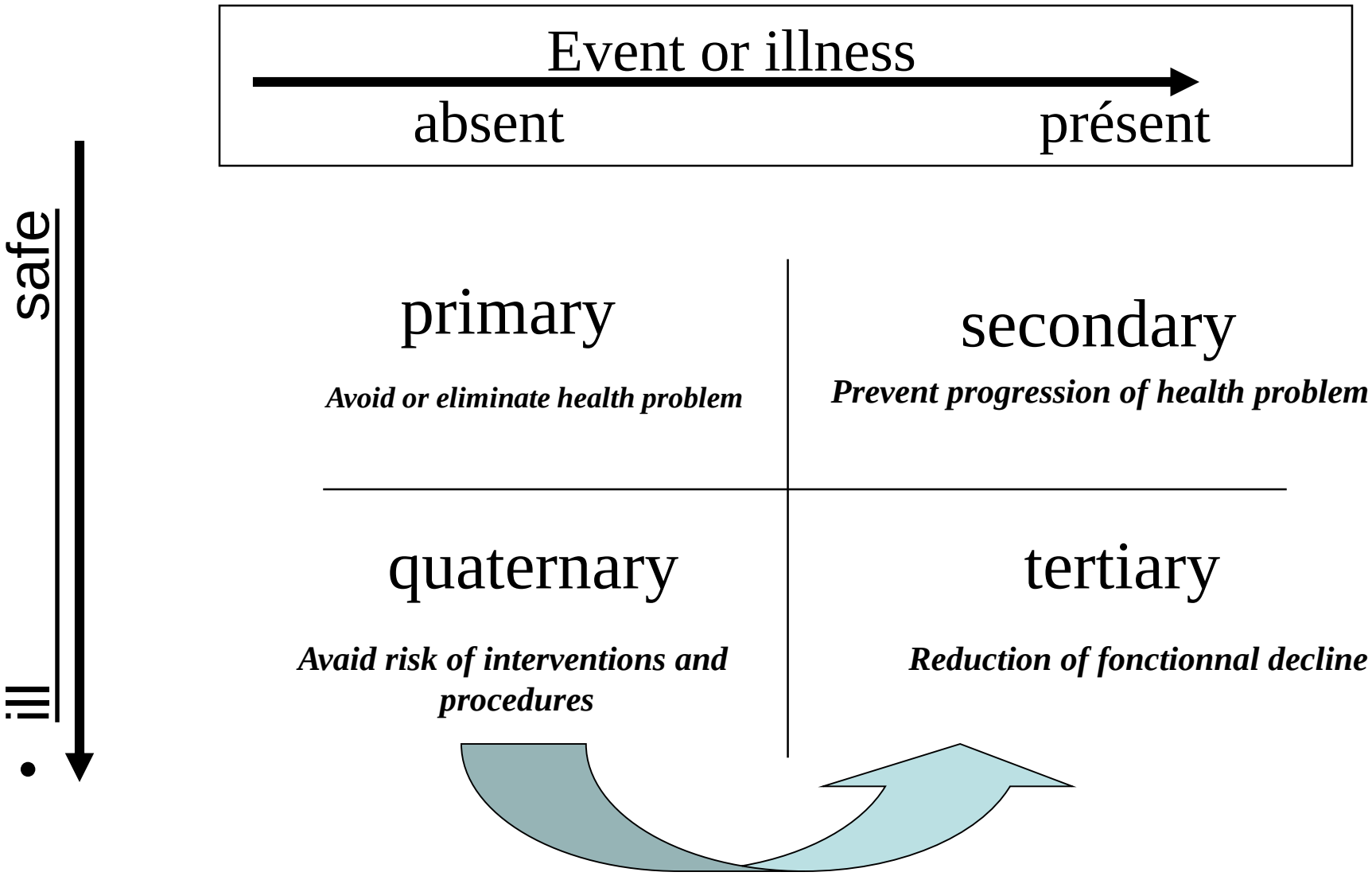
- More than 5 diseases after 80 y
- Increasing of the risk of some diseases (cardiovascular and cancer,…) with age
- Chronical diseases are present
- Life style: can it be changed after so long and for which benefit ?

- Association « disease and aging » (osteoporosis, sarcopenia, HTA, hypoxémia, malnutrition, cognitive dysfonction,…)
- We don’t know which is the cut off

- Lack of data

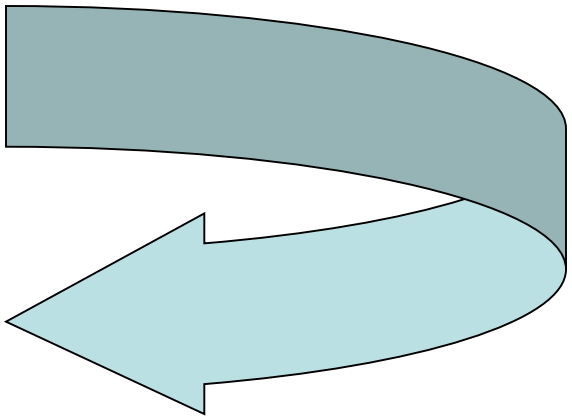
- Frailty is not multimorbidity

Prévention: all the measures used to avoid an event, a risk, an illness



Screening: what is the goal in the old ?

- Prevention of events
  - Morbidity
  - Functionnal decline
  - Mortality



- Treatment, if a pathology is found ??
- Intervention to avoid events

- Life expectancy

Compression of morbidity

Comprehensive geriatric assessment

defined as a multidisciplinary diagnostic and treatment process that identifies medical, psychosocial, and functional limitations of a frail older person in order to develop a coordinated plan to maximize overall health with aging.

Katherine T Ward, David B Reuben, 2019

Can not be considered as a screening tool ?

The presence of frailty has not been widely examined as a determinant of CGA outcome. *Parker and al Age Aging 2018*

General recommandations

Patients 65 years and older should be counseled on smoking cessation, diets rich in healthy fats, aerobic exercise, and strength training

Other types of preventive care include aspirin therapy (discussed after 75); lipid management (discussed after 75); and administration of tetanus and diphtheria, pneumococcal, and influenza vaccines.

Although cancer is the second leading cause of death in patients 65 years and older, a survival benefit from cancer screening is not seen unless the patient's life expectancy exceeds five years.

Therefore, it is best to review life expectancy, functionality, and comorbidities

Am Fam Physician. 2008 Jul 15;78(2):206-215.

Expectancy

Recommendation	Robust (life expectancy ≥ five years; functionally independent)	Frail (life expectancy < five years; significant functional impairment)	Moderately demented (life expectancy of 2 to 10 years)	End of life (life expectancy < two years)
Cholesterol screening	Consider screening for patients 65 to 75 years of age if they have additional risk factors	Consider screening for patients 65 to 75 years of age if they have additional risk factors	Do not screen	Do not screen
Colonoscopy	Consider performing every 5 to 10 years	Do not perform	Do not perform	Do not perform
Fasting blood glucose test	Perform if patient has symptoms, or every three years if patient has risk factors	Perform if patient has symptoms, or every three years if patient has risk factors	Perform if patient has symptoms, or every three years if patient has risk factors	Consider performing if patient has symptoms
Fecal occult blood test	Perform yearly	Consider performing yearly	Consider performing yearly	Do not perform
Herpes zoster vaccine	Administer once for patients 60 years and older	Administer once for patients 60 years and older	Administer once for patients 60 years and older	Administer once for patients 60 years and older
Influenza vaccine	Administer yearly	Administer yearly	Administer yearly	Administer yearly
Lifestyle education	Provide at every visit	Provide at every visit	Discuss periodically with caregiver	Do not provide
Mammography	Perform every one to two years up to 80 years of age	Consider performing every one to two years up to 75 years of age	Consider performing every one to two years up to 70 years of age	Do not perform
Papanicolaou (Pap) smear	Consider performing one to three Pap smears if patient has never had a Pap smear	Do not perform	Do not perform	Do not perform
Pneumococcal vaccine	Administer once	Administer once	Administer once	Consider administering once
Prostate-specific antigen test	Discuss pros and cons with patient	Discuss pros and cons with patient	Discuss pros and cons with caregiver	Do not perform
Tetanus toxoid and diphtheria toxoid vaccine	Administer primary series if not done previously; administer booster every 10 years	Administer primary series if not done previously	Administer primary series if not done previously	Do not administ

J Am Geriatr Soc. 2002;50(11):1892–1893

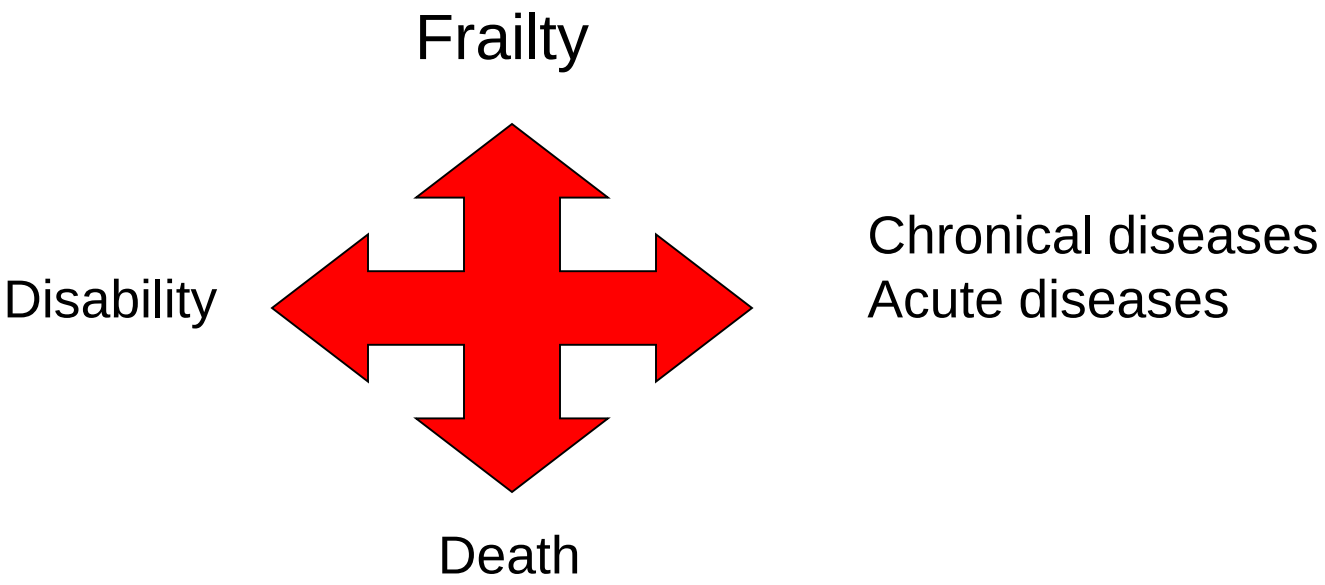
Table 1. Screening recommendations for older people

SAZLINA SG 2015

	Recommendations	*Evidence/ recommendation grade
High blood pressure or hypertension	Screening is recommended at regular clinic visits in view of strong evidence on the benefit of treatment in individuals with hypertension	Level I/A
Type 2 diabetes	Screening of asymptomatic older people with underlying hypertension or other cardiovascular disease is recommended at any point of contact	Level II-1/B
Dyslipidaemia	It is recommended that older people with one or less CAD risk factor (other than age) for annual screening Those with multiple risk factors (hypertension, diabetes and cigarette smoking) to be screened at any point of clinical contact	Level I/A
Tobacco use	Older people should be screened for tobacco use at any point of clinical contact Brief counselling for smoking cessation and pharmacotherapy should be provided to those who use tobacco	Level I/A
Colorectal cancer	FOBT beginning at 50 years of age and to be continued until 75 years every 2 years is recommended	Level I/A

	Recommendations	*Evidence/ recommendation grade
Breast cancer	Older women up to 69 years of age with no risk factor for breast cancer would be benefitted from biennial screening mammography, but they must be fully informed about the benefits and harms of screening	Level I/B
Lung cancer	Insufficient evidence to recommend for or against screening for lung cancer with low dose chest CT screening in high risk individuals (based on age and smoking status)	Level I/I
Prostate cancer	It is not recommended to screen older men for prostate cancer If patients request for the test, they must be fully counselled about the benefits and harms from screening	Level I/D
Cervical cancer	Women aged 65 years and more with three successive negative smears in the past 10 years is not recommended for cervical cancer screening	Level III/D
Depression	Screening older people for depression in is recommended if clinical staff to assist primary care physicians in providing depression care is available	Level I/B

- The principle action in geriatric medecine is to try to prevent functionnal decline in general but especially in some specific acute situations or heavy disease (cancer, surgical procedures, chronical diseases,…)



A CGA, with or without screening, and with follow-up, should be used in older cancer patients, in order to detect unaddressed problems, improve their functional status, and possibly their survival. *Extermann M 2005*

Marije Hamaker and colleagues present a valuable systematic review on frailty screening methods to predict outcomes of comprehensive geriatric assessment (CGA) in elderly patients with cancer.
The authors describe the diagnostic accuracy of several currently available screening methods, reporting that most of them have “insufficient discriminative power”, a conclusion based on the poor specificity and low negative predictive value (NPV) of the two most sensitive screening methods (G8 and the Triage Risk Screening Tool [TRST]). *Lancet 2013*

So the question is: can we consider that a screening is efficient or should we choose a CGA for all > 75 ????