Diagnosing the current state of geriatric medicine

To the Editor:

The past academic year has witnessed significant events in geriatric medicine within the osteopathic medical profession. The changes, some of which are mentioned in this letter, represent significant strides within the profession to respond to the "Geriatric imperative" put forth by Dr Butler in the *Annals of Internal Medicine* in 1979 (91:903-908). Dr. Butler encouraged all healthcare professionals to address the elderly's multifaceted healthcare needs from an academic, demographic, economic, and attitudinal standpoint.

For example, at the last annual meeting of the American College of Osteopathic Internists (ACOI), the membership approved a proposal to establish a section of geriatric medicine within this college. Such a move helps foster geriatrics as an academic discipline with its own body of knowledge and clinical relevance.

Similarly, the joint session of the 1988 AOA annual meeting focused solely on elderly care. Various specialists speaking at this session demonstrated the multidisciplinary nature of clinical geriatrics. This joint session was videotaped and made available to osteopathic physicians nationwide.

Likewise, the AOA recently approved basic standards for residency training in geriatric medicine. This landmark decision marks the end to the long debate

between the American College of General Practitioners in Osteopathic Medicine and Surgery (ACGP) and the ACOI. A model program document currently is being prepared for presentation to the Bureau of Health Professions. This model program marks the first time that the ACGP and ACOI collaborated on a training program for osteopathic physicians. Considering the multidisciplinary nature of geriatric medicine, this new alliance seems quite appropriate.

As part of the profession's continuing strides in geriatric training, the Board of Directors of the National Board of Osteopathic Medical Examiners will include gerontology on part II of the National Boards. The University of Medicine and Dentistry of New Jersey—School of Osteopathic Medicine has created the first osteopathic fellowship in geriatric medicine.

Yet, educational efforts in this specialty are not being confined to the osteopathic medical colleges. Recently, the Great Lakes Geriatric Education Center and the Chicago College of Osteopathic Medicine sponsored the first National Osteopathic Conference on Aging. The conference, held in Chicago, afforded osteopathic geriatric academicians and osteopathic physicians from across the United States an opportunity to share their knowledge and varied experiences.

Clearly, this past academic year has played a pivotal role in the history of geriatric medicine within the osteopathic medical profession. With its expertise in primary care, an emphasis on the holistic approach to healthcare, and a special approach to mus-

culoskeletal disorders, the osteopathic profession has the potential to be a leader in geriatric clinical care.

While these past accomplishments hint at the possibility of our attaining this goal, we must not become overconfident, nor must we rest on our laurels. Challenges confront us.

Specifically, the certification process for geriatric medicine must recognize individuals who have achieved significant knowledge in this discipline. Certification is vital for the credibility of osteopathic geriatricians. Furthermore, geriatric medical training programs must encompass various disciplines and dimensions with an academically sound foundation.

Most important, our contributions to much-needed research in long-overlooked geriatric areas will prove to be the real test of osteopathic medicine's legacy in this field.

If we are to meet the challenges of caring for the elderly in the 21st century, we must remain committed to these goals.

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Physicians need to hear deaf patients' needs

To the Editor:

Congratulations to JAOA for publishing the article, "Hearing-impaired patients in the medical set-

(continued on page 1245)

A NEW CHOICE FOR PEDIATRIC CARE

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Children's Advil® (ibuprofen) Suspension 100mg/5mL

BRIEF SUMMARY OF PRESCRIBING INFORMATION

CONTRAINDICATIONS: Patients hypersensitive to ibuprofen or patients with all or part of the syndrome of nasal polyps, angioedema, and bronchospastic reactivity to aspirin or other nonsteroidal anti-inflammatory agents. Anaphylactoid reactions to ibuprofen have occurred in such patients.

WARNINGS: Risk of GI Ulcerations, Bleeding, and Perforation with NSAID Therapy: Physicians should remain alert for ulceration and bleeding in patients treated chronically with NSAIDs even in the absence of previous GI tract symptoms. In patients observed in clinical trials of several months' to two years' duration, symptomatic upper GI ulcers, gross bleeding or perforation appear to occur in approximately 1% of patients treated for 3-6 months, and in about 2-4% of patients treated for one year.

Except for a prior history of serious GI events and other risk factors known to be associated with peptic ulcer disease, no risk factors have been associated with increased risk. Elderly or debilitated patients seem to tolerate ulceration or bleeding less well than other individuals and most spontaneous reports of fatal GI events are in this population.

PRECAUTIONS: General: Because serious GI tract ulceration and bleeding can occur without warning symptoms, physicians should follow chronically treated patients for the signs and symptoms of ulceration and bleeding.

Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If a patient develops such complaints the drug should be discontinued and the patient should have an ophthalmologic examination.

Fluid retention and edema have been reported with ibuprofen; therefore, the drug should be used with caution in patients with a history of cardiac decompensation or hypertension.

Ibuprofen can inhibit platelet aggregation and prolong bleeding time. CHILDREN'S ADVIL® SUSPENSION should be used with caution in persons with intrinsic coagulation defects and those on anticoagulant therapy.

The antipyretic and anti-inflammatory activity of ibuprofen may reduce fever and inflammation, thus diminishing their utility as diagnostic signs in detecting complications of presumed noninfectious, noninflammatory painful conditions.

Small decreases (usually not exceeding one gram) in hemoglobin and hematocrit with an apparent dose response relationship have been observed following chronic administration. If there are no signs of bleeding, it is probably not clinically important.

To avoid exacerbation of disease or adrenal insufficiency, patients on prolonged corticosteroid therapy should have their therapy tapered slowly when CHILDREN'S ADVIL® SUSPENSION is added to the treatment program.

Aseptic meningitis: Aseptic meningitis with fever and coma has been observed on rare occasions in adult patients on ibuprofen therapy. Although it is more likely to occur in patients with systemic lupus erythematosus and related connective tissue diseases, it has been reported in adult patients who do not have underlying chronic disease. If signs or symptoms of meningitis develop in a patient on CHILDREN'S ADVIL® SUSPENSION, the possibility of its being related to ibuprofen should be considered.

Renal Effects: As with other nonsteroidal anti-inflammatory drugs, long-term administration of ibuprofen to animals has resulted in renal papillary necrosis and other abnormal renal pathology. In humans, there have been reports of acute interstitial nephritis with hematuria, proteinuria, and occasionally nephrotic syndrome.

A second form of renal toxicity has been seen in patients with prerenal conditions leading to reduction in renal blood flow or blood volume. In these patients, administration of a nonsteroidal anti-inflammatory drug may cause a dose dependent reduction in prostaglandin formation and precipitate overt renal decompensation. Patients at greatest risk of this reaction are those with impaired renal function, heart failure, liver dysfunction, and those taking diuretics and the elderly. Those patients at high risk who chronically take CHILDREN'S ADVIL® SUSPENSION should have renal anti-inflammatory drug therapy is typically followed by recovery to the pretreatment state. Since ibuprofen is eliminated primarily by the kidneys, patients with significantly impaired renal function should be closely monitored and a reduction in dosage should be anticipated to avoid drug accumulation.

Information for Patients: Physicians may wish to discuss with their patients the potential risks and likely benefits of treatment with CHILDREN'S ADVIL® SUSPENSION.

Laboratory Tests: Meaningful (3 times the upper limit of normal) elevations of SGPT or SGOT (AST) occurred in controlled clinical trials in less than 1% of patients. A patient with symptoms and/or signs suggesting liver dysfunction, or in whom an abnormal liver test has occurred, should be evaluated for evidence of the development of more severe hepatic reactions while on therapy with ibuprofen. If abnormal liver tests persist or worsen, if clinical signs and symptoms consistent with liver disease develop, or if systemic manifestations occur, CHILDREN'S ADVIL® SUSPENSION should be discontinued.

Diabetes: Each 5 mL of CHILDREN'S ADVIL® SUSPENSION contains 2.5 g of sucrose which should be taken into consideration when treating patients with impaired glucose tolerance. It also contains 350 mg of sorbitol per 5 mL. Although in clinical trials CHILDREN'S ADVIL® SUSPENSION was not associated with more diarrhea than control treatments, should a patient develop diarrhea, the physician may wish to review the patient's dietary intake of sorbitol from other sources.

Drug Interactions: Coumarin-type Anticoagulants: Bleeding has been reported when ibuprofen and other nonsteroidal anti-inflammatory agents have been administered to patients on coumarin-type anticoagulants; the physician should be cautious when administering CHILDREN'S ADVIL® SUSPENSION to patients on anticoagulants.

Aspirin: Concurrent use of aspirin is not recommended. **Methotrexate:** In vitro studies indicate that ibuprofen could enhance the toxicity of methotrexate. Caution should be used if CHILDREN'S ADVIL® SUSPENSION is administered concomitantly with methotrexate.

H₂ Antagonists: In studies with human volunteers, coadministration of cimetidine or ranitidine with ibuprofen had no substantive effect on ibuprofen serum concentrations.

Furosemide: Ibuprofen can reduce the natriuretic effect of furosemide and thiazides in some patients. During concomitant therapy with CHILDREN'S ADVIL® SUSPENSION, the patient should be

observed closely for signs of renal failure as well as to assure diuretic efficacy.

Lithium: Ibuprofen produced an elevation of plasma lithium levels (15%) and a reduction in renal lithium clearance (19%) in a study of 11 normal volunteers during the period of concomitant drug administration. Patients should be observed carefully for signs of lithium toxicity. Read package insert for lithium before its use.

Pregnancy: Administration of ibuprofen is not recommended during pregnancy or for use by nursing mothers.

Infants: Safety and efficacy of CHILDREN'S ADVIL® SUSPENSION in children below the age of 12 months have not been established.

ADVERSE REACTIONS: The most frequent type of adverse reaction occurring with CHILDREN'S ADVIL® SUSPENSION is gastrointestinal. In clinical trials among adults involving chronic administration of ibuprofen, the percentage of patients reporting one or more gastrointestinal complaints ranged from 4% to 16%.

Incidence Greater Than 1% (but less than 3%), Probable Causal Relationship

Gastrointestinal: Nausea, epigastric pain, heartburn, diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of the GI tract (bloating and flatulence).

Central Nervous System: Dizziness, headache, nervousness.

Dermatologic: Rash (including maculopapular type), pruritus.

Special Senses: Tinnitus.

Metabolic/Endocrine: Decreased appetite.

Cardiovascular: Edema, fluid retention (generally responds promptly to drug discontinuation) (see PRECAUTIONS).

Reactions occurring in 3% to 9% of adult patients treated with ibuprofen.

Precise Incidence Unknown (but less than 1%), Probable Causal Relationship

Gastrointestinal: Gastric or duodenal ulcer with bleeding and/or perforation, gastrointestinal hemorrhage, pancreatitis, melena, gastritis, hepatitis, jaundice, abnormal liver function tests.

Dermatologic: Vesiculobullous eruptions, urticaria, erythema multiforme, Stevens-Johnson syndrome, alopecia.

Central Nervous System: Depression, insomnia, confusion, emotional lability, somnolence, aseptic meningitis with fever and coma.

Special Senses: Hearing loss, amblyopia (blurred and/or diminished vision, scotomata and/or changes in color vision) (see PRECAUTIONS).

Hematologic: Neutropenia, agranulocytosis, aplastic anemia, hemolytic anemia (sometimes Coombs' positive), thrombocytopenia with or without purpura, eosinophilia, decreases in hemoglobin and hematocrit (see PRECAUTIONS).

Cardiovascular: Congestive heart failure in patients with marginal cardiac function, elevated blood pressure, palpitations.

Allergic: Syndrome of abdominal pain, fever, chills, nausea and vomiting, anaphylaxis, bronchospasm (see CONTRAINDICATIONS).

Renal: Acute renal failure in patients with preexisting significantly impaired renal function (see PRECAUTIONS), decreased creatinine clearance, polyuria, azotemia, cystitis, hematuria.

Miscellaneous: Dry eyes and mouth, gingival ulcers, rhinitis.

Precise Incidence Unknown (but less than 1%), Causal Relationship Unknown

Central Nervous System: Paresthesias, hallucinations, dream abnormalities, pseudotumor cerebri.

Dermatologic: Toxic epidermal necrolysis, photoallergic skin reactions.

Special Senses: Conjunctivitis, diplopia, optic neuritis, cataracts.

Hematologic: Bleeding episodes (eg, epistaxis, menorrhagia).

Metabolic/Endocrine: Gynecomastia, hypoglycemic reactions, acidosis.

Cardiovascular: Arrhythmias (sinus tachycardia, sinus bradycardia).

Allergic: Serum sickness, lupus erythematosus syndrome, Henoch-Schönlein vasculitis, angioedema.

Renal: Renal papillary necrosis.

OVERDOSAGE: Patients with a history of ingestion of greater than 100 mg/kg should have induced emesis or gastric lavage. Multiple dose oral administration of activated charcoal may be useful.

Supportive therapy may include oxygen, respiratory support, and parenteral fluids. Because the drug is acidic and excreted in the urine, administration of sodium bicarbonate and induction of diuresis may be beneficial.

DOSAGE AND ADMINISTRATION: Juvenile arthritis: 30-40 mg/kg day in 3 or 4 divided doses. Fever: 5 mg/kg if baseline temperature is 102.5°F or below or 10 mg/kg if baseline temperature is greater than 102.5°F every 6-8 hours (children); 400 mg every 4-6 hours (adults).

RA and OA: 1200-3200 mg per day in 3 or 4 divided doses.

Mild to moderate pain in adults: 400 mg every 4 to 6 hours.

Dysmenorrhea: 400 mg every 4 hours.

HOW SUPPLIED: 4 and 16 oz. bottles.

Caution: Federal law prohibits dispensing without prescription.

References:

1. Watson PD, Galletta G, Braden NJ, Alexander L. Ibuprofen, acetaminophen, and placebo treatment of febrile children. *Clin Pharmacol Ther.* 1989;46:9-17.
2. Independent Clinical Study: Reduction of Fever in Children, Multiple Dose. Data on file, Medical Department, Whitehall Laboratories.
3. Independent Clinical Study: Juvenile Arthritis. Data on file, Medical Department, Whitehall Laboratories.

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ting" (JAOA 1989;89:780-782). Articles such as this not only provide valuable insight for the medical community, but they also heighten physician sensitivity and respect for the deaf patient.

For the past 10 years, my mother (who teaches the deaf), my hearing-impaired brother, and I have given lectures to students at the Philadelphia College of Osteopathic Medicine on understanding the deaf patient. These lectures have proved stimulating, prompting many students to study sign language.

Deafness encompasses more than hearing loss. Linguistic abilities are altered. Up to 25% of communication is lost. Because of this, the deaf person is misinformed and misunderstood, often treated as a second-class citizen. An invisible disability, impaired hearing is not readily recognized; therefore, the deaf person's needs go silently unaddressed.

The authors of this superb article have taken an important step in communicating the deaf patient's special needs and the ways in which physicians can meet them.

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DO involvement key to our profession's future

This letter was sent to Dr Marcelino Oliva, immediate past president of the AOA. Because it presents an important challenge to the profession, Dr Oliva agreed to share it with JAOA readers.

A disproportionate number of osteopathic hospitals face declining occupancy rates and financial difficulties. Meanwhile, the number of osteopathic medical graduates is at a record high. Where will these up-and-coming osteopathic physicians continue their medical training and practice the healing arts if the number of osteopathic hospitals and institutions continues to decline? The answer to this question rests with today's practicing DOs. We must take an active role in the changing healthcare system in the United States.

Government supported HMOs continue to mushroom. Yet, many of the newer HMOs, PPOs, and other closed panel healthcare programs exclude osteopathic physicians and hospitals. Furthermore, too many major insurance companies, labor groups, and large corporate entities do not receive input from local, state, or national osteopathic associations. It seems that individual osteopathic physicians practicing at the local level are not consulted either.

Over the years, I have been trying to remedy this problem. While serving as president of the Wayne County Osteopathic Association a few years ago, I sent a letter to the medical directors and directors of medical education of all the osteopathic hospitals along the Interstate 94 corridor, from Lake Michigan to Lake Erie. In that letter, I petitioned the individuals at these institutions to address the upcoming crisis in medical training programs. I asked if it would be possible to establish an osteopathic consortium or the like for this pur-

pose. No one responded to my letter.

Because of my involvement in serving Detroit innercity residents, I was asked about 10 years ago to participate in the development of a statewide healthcare program for the Michigan Conference of Teamsters Health and Welfare Fund. At the time, I was the only osteopathic physician on this panel; I still serve in this capacity. I am also the medical director of the largest Teamsters clinic in Michigan. As such, I helped establish an affiliation between this clinic and an osteopathic hospital corporation to develop clinical rotations in family practice medicine and other specialties. Patients from this clinic are referred primarily to osteopathic specialists and hospitals.

In part, I believe my early and continued involvement in this program has enabled Michigan DOs to fully participate in the Plan A Teamster clinics statewide. As a result, hundreds of thousands of patients visit osteopathic physicians and hospitals in Michigan each year.

Every practicing osteopathic physician should become involved in similar healthcare groups in any way possible. For example, we can speak to community service organizations on health-related issues or donate our services to community health projects.

The opportunities available to today's osteopathic physicians—unlimited licensure, modern hospital facilities, outstanding medical training institutions—are the result of our forebearers' sacrifices. We must pass this hard-won legacy, which we inherited,