Feeback from the European Geriatric Medicine Society conference

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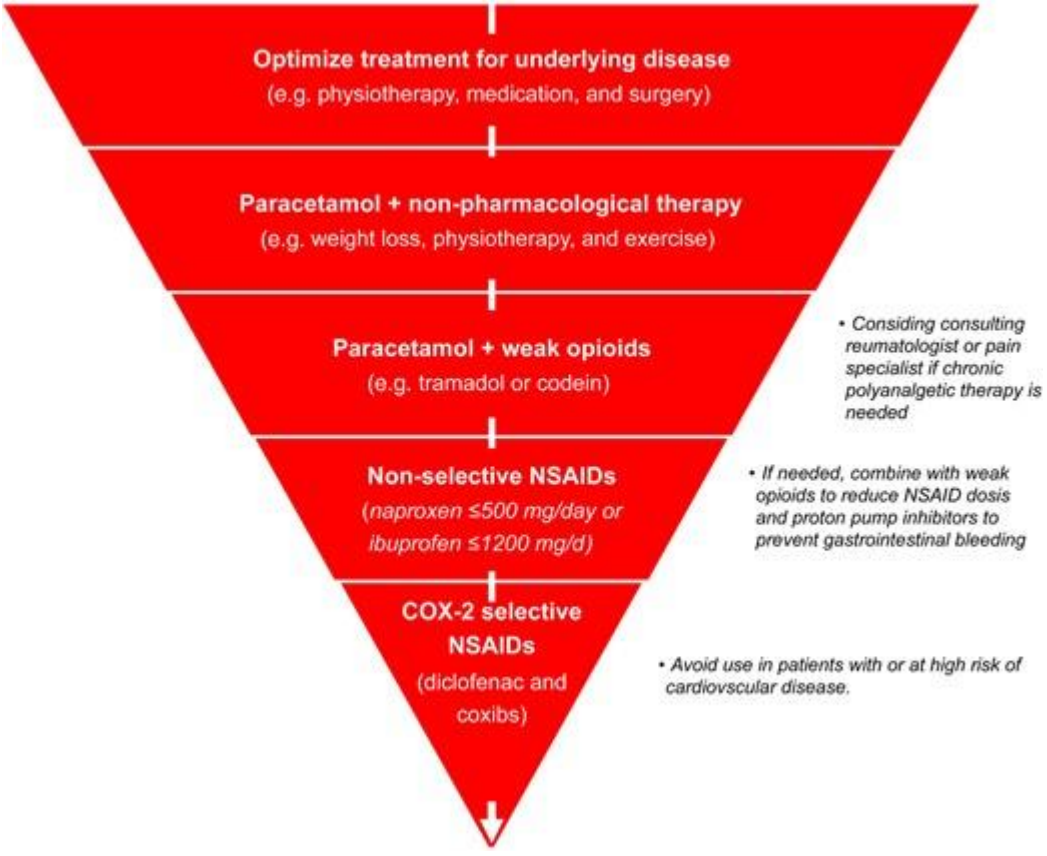
Thank you to NZHPA for support in attending this conference. During my career, I have attended multiple conferences on the care of older people, and each time I do, I come away with new learning experiences. They are interdisciplinary, with attendees from all over Europe, South America and even Oceania.

As with all conferences, the choice of offerings is vast, and the topics of talks I chose was wide ranging. Below is a selection of some I thought were particularly useful to me. I apologize in advance as this report is longer than recommended, but there is so much to share!

Prescription of osteoarthritis drugs in older patients with increased risk of renal adverse events

Many of us will be familiar with the risks associated with use of Non-steroidal anti-inflammatory drugs in older patients with osteoarthritis.

I was surprised to learn that the use of (COX-2 inhibitors) was on the bottom of the stepwise list of the analgesic ladder in those at higher risk of or with cardiovascular disease. Diclofenac is also considered part of the COX-2 family. Equally surprising is the preferential use of tramadol and weak opioids over NSAIDs. The paper is found here. The incorporation of non-pharmacological treatment cannot be emphasised enough.



Summary of presentation:

- Avoid NSAIDs in those with high cardiovascular risk
- Topical diclofenac most helpful for knee osteoarthritis
- PPI protects from upper GI bleed, but NSAIDs often associated with lower GI bleed

Clinical approach:

1. Assess cardiovascular, renal, GI risk factors
2. Avoid in those with high risk.
3. Use NSAIDs with PPI
4. Care of co-Rx with antiplatelets/anticoagulants
5. Monitor for HTN and fluid retention
6. Monitor for clinical response and stop if not helpful
7. Avoid diclofenac! Highest CV risk
8. Lowest dose, shortest duration
9. Renal toxicity "possibly" lower with coxibs than other NSAIDs

STOP if:

- Uncontrolled HTN
- Topical NSAID has not been tried
- Do not use diclofenac, celecoxib or ibuprofen at doses >1200mg/day in patients at high risk of cardiovascular events

START:

- Physical activity at levels appropriate to the patient

Expanding role of SGLT2 inhibitors

This is a topic that has gained a lot of traction for New Zealanders, over the last 3-4 years. We are grateful that empagliflozin now has Pharmac approval for funding of Heart Failure, as it is one of the Four pillars of heart failure therapy.

Below is a summary of the key points learned:

In older adults:

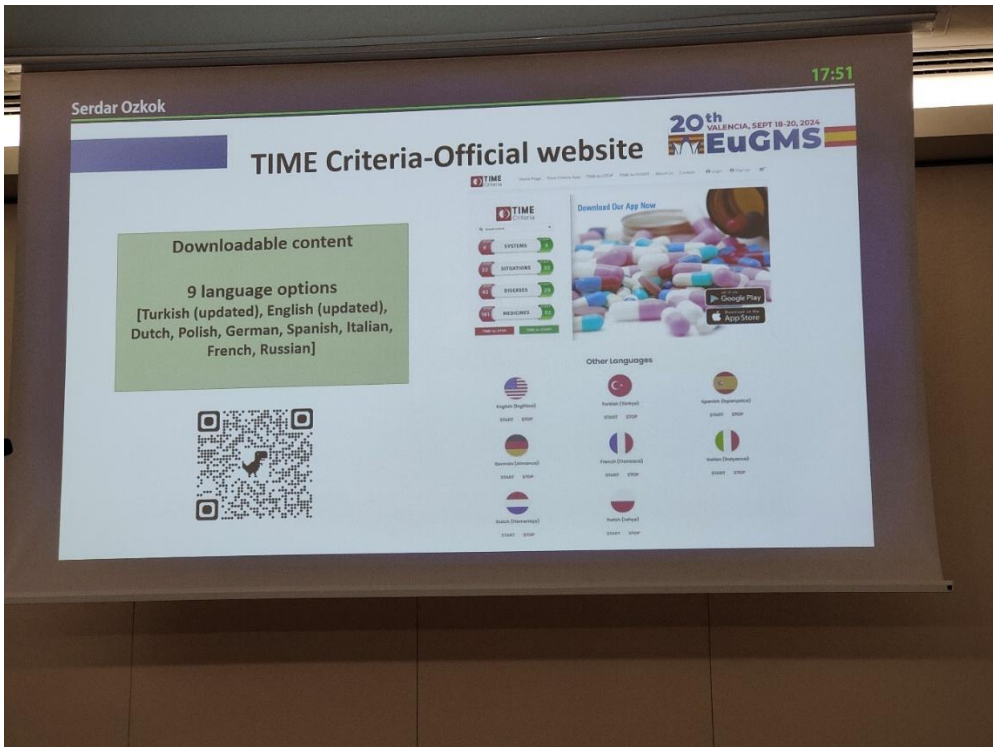
1. Decrease in MACE, cardiovascular death, and all cause mortality
2. No effect on age
3. In those with T2DM, 20% discontinuation rate
4. AKI with SGLT2i<placebo
5. 6 fold increase in risk of genital tract infections
6. Risk of amputation increased only with canagliflozin
7. Fractures, UTI, volume depletion, hypoglycaemia, diabetic DKA similar between SGLT2i and placebo
8. Risk of dementia reduced after2 yrs use (observational study): https://www.bmj.com/content/386/bmj-2024-079475)
9. Risks: weight loss in those who do not need it, urogenital infections, ketoacidosis
    a. Monitor function and QOL! (quality of life)

- Efficient therapy in older adults with T2DM, HF, renal impairment, prevention of hospitalisation, decreased mortality
- Can be prescribed in frail older people
- Can simplify therapy
- Exhibit anti-inflammatory effects
    - Potential use in cancer!
        - This point has very significant implications

Prescribing/Deprescribing

As a pharmacist, I was particularly interested in the multiple talks on deprescribing, and the work/research that is being done here to optimise medications. There are multiple tools that are being developed for distribution to clinicians. Turkish researchers have developed a tool called TIME criteria (time to Start and Time to Stop medication)

Here is a summary of the information, including a QR code for reference:



Perhaps the highlight of this conference was a very engaging talk by Prof. Dr. med Martin Wehling, on **Represcribing – the FORTA-List as a clinically validated tool**

It is safe to say that Prof Wehling firmly believes in removing most medications from the long list of polypharmacy present in many patient's profiles. He hints that forgetfulness in patients may actually save them from 'toxicity' as they do not take many of their prescribed medications, some of which will undoubtedly be contributing to a long list of side effects suffered. He argues that a number of guidelines recommend an average of 3 drugs per diagnosis listed, and based on 3.4 diagnoses (?), that means 10 medications, and there is a good chance that 1 or 2 of those at least will be psychotropic in nature.

His argument lay in the comparison of potentially inappropriate prescribing (PIP) versus potential prescribing omission (PPO). Many of us are aware of the Beers Criteria, STOPP/START, etc. With

increasing polypharmacy, and increasing age, we come to a crossroads of increased medications in people with decreased organ function. He recommends using the Garfinkel method of deprescribing: stop almost all meds! He argues that negative criteria (e.g. Beers) are not clinically proven in the real world, and that what really matters is optimising medication. The **FORTA-List** is such a tool that can help: Evidence based and real-life oriented. It is available on Google Play and Apple Store for download. Use of this app requires critical thought – it is not a replacement.

- **A**: A-bsolutely indispensable
- **B**: B-eneficial, but with some limitations
- **C**: C-areful, with a questionable safety or efficacy profile
- **D**: D-on't, should be generally avoided

I came all the way to Europe for a conference to hear about a small, yet highly significant trial, on the potentially inappropriate medication vs potential prescribing omissions that had been done in New Zealand. It shows that Māori were more likely to be hospitalized by omissions of appropriate prescribing than being on potentially inappropriate medication. The study can be found here. This has changed the way I focus on multiple medication management.

In conclusion, I remain amazed by the resilience of our older population, of the importance of patient-oriented evidence that matters (POEMs), and the importance of optimizing medications by means of ensuring that our vulnerable patients are on the right drugs for the right reason.

If anyone is interested in references or learning more about some of these lectures I attended, please feel free to reach out to tonya.cockcroft@pihanga.co.nz.