CAGP Newsletter

Canadian Academy of Geriatric Psychiatry

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From the Editor

Many thanks to all of you who have sent submission to this newsletter. As usual, getting people to promise to submit something and then making sure that I actually get these submissions on time is the major challenge in putting out this newsletter. A CAGP member has stepped forward and expressed interest in taking over the chair of the Publications and Communications committee which involves publishing the newsletter. We are currently in discussions to further elaborate how this would work and how we could make it a less onerous job. Having regular columns has certainly helped my job immensely and the columnists have done an absolutely wonderful job. As you know, one of our columnists Dr. Nathan Herrmann has been reprinted in the publication from the United Kingdom for old age psychiatrists. His column in particular keeps getting wonderful reviews from others.

In this issue Dr. Primeau has arranged the ethics column as Dr. Hilderbrandt is away. He and some residents describe an elective in ethics that they have been developing in Montreal.

In this issue also, the pharmacologia column focuses on SSRI's in the elderly. This is an excellent column with great clinical relevance to us in our frail elderly patients. Dr. Carol Cohen from Toronto writes about the diagnosis of dementia in primary care: dilemmas and future directions.

This fall the CAGP meeting will be held on Monday. We had developed a tentative outline of the program and focusing largely on long-term care. It now appears that there is a possibility of a pre-conference program which would likely take place on Sunday if all the kinks get ironed out. The tentative line-up for Monday sounds really interesting. We have Dr. Barry Rovner from the States coming, Dr. Ken Rockwood presenting a workshop on developing a research program. We have Dr. Ira Katz ,who is also a well known geriatric psychiatrist from the States who has confirmed. Dr. Alister Burns initially expressed interest, but we are currently not quite clear whether he will come or not due to the concurrent IPA in Munich that week. Dr. Sandra Black who is a neurologist from Toronto has agreed tentatively to present a session on prevention of Alzheimer=s disease reviewing the evidence for the various agents such as the anti-inflammatories, estrogen, and vitamin E, among others. There will be a French language program as well during the concurrent sessions the details of which are not completely worked out yet. The chair of the CAGP Annual Scientific Meeting will be Dr. Mike Flynn from Halifax. His psychogeriatric team will possibly also be presenting one of the current workshops for or at least a poster one their programming in Halifax.

At the CPA this week this year for the first time there will be a joint academies meeting. This meeting will take place on Tuesday and discussions are still underway between Dr. Susan Abbey who is the chair of the scientific program overall for the CPA, and the various academies and defining how this day will take place. If successful this day might occur at subsequent meetings as well.

Planning for the IPA 1999 is proceeding well. Dr. Sadavoy will comment more on this under the IPA column. Many of our membership are involved in this. Dr. Sadavoy is the chair of the congress, I chair the organizing committee, Dr. Kevin Solomons is head of publications and communications (and is currently preparing various brochures to be mailed out across the world), Dr. Nirmal Kang is looking after the social and entertainment issues and is busy trying to prepare an active, lively social program which will cater to delegates, but as well also to their families. Vancouver is an ideal place for families to come for many reasons, and we are hoping that many people from across the world will come bringing their families. Dr. Nathan Herrmann is the chair of the scientific meeting and has now managed to work out all the major plenary speakers and the major invited symposia. Under current developments still are various pharmaceutical sponsors symposia. Our major sponsors are Eli Lilly, Janssen, Pfizer and Hoechst Marion Roussel. Zeneca is a regular sponsor and Bayer has a major involvement due to their regular sponsorship of the IPA Research Awards.

I will be continuing to publish this newsletter until the summer newsletter is complete, after which point the editorship will change.

As always I would really appreciate having you send information from across the country. I know that it is busy for all of you, but we would really like to hear what's happening with you around various issues including health care reform in the elderly. Many of us are particularly wondering about what's happening in Ontario in light of the closure of so many chronic psychiatric hospitals, many of which have active geriatric programming associated with them.

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President's Column

I would like to extend my sincere thanks to Dr. Lilian Thorpe for agreeing to put together this spring's Newsletter. Her willingness to put in the extra effort before we find a suitable replacement is much appreciated by the Academy and reflects the hard work, dedication, effort and commitment I have seen by my colleagues in the academy over the past four years as President. We have come a long way from an idea in the thoughts of our founding members to an organization still in its infancy, but with a firm foundation and an enviable record of accomplishments.

We are well along the road in preparing for two major activities of the academy: the national educational projects in long-term care led by Dr. Silver, and the IPA Congress in 1999. The Halifax CAGP annual scientific meeting (September 15, 1998) and associated general meeting will provide an opportunity for moving these activities along. We will be electing a new president , vice-president and various board members. I would encourage you to either consider these roles for yourself, or to nominate another member to fill any of these positions.

I have been privileged to act as your President over the past few years and have had the pleasure of meeting and working with so many dedicated, skillful, and experienced individuals. We are on the threshold of the new millennium; the threshold of the century that will bring the challenge of aging and mental health into sharp focus. Our organization and members have the responsibility to meet the challenges to advocate for resources and quality education, produce new knowledge and develop innovative service delivery methods and best practices.

I personally would like to thank all of you for your support in the past. I would also ask each of your to consider how you, as an individual, and we, as an organization, can work better to bring quality of care, self-determination, and autonomy to our seniors with mental health needs.

Serving as your President has been a pleasure.

Yours sincerely,

J.K. Le Clair, MD, FRCP(C)

President
Canadian Academy of Geriatric Psychiatry

Secretary-Treasurer

David Conn, M.B. F.R.C.P.
Secretary-Treasurer, CAGP
Baycrest Center for Geriatric Care, Toronto

Nominations Committee

Call for Nomination of President and Vice-President of the CAGP
1998

Nominating Committee:
J. Sadavoy (Chair)
B. Groulx
K. Solomons

The offices of both president and vice-resident of the CAGP are open for re-election this fall. De. LeClair is not eligible for re-election but other executive and board members are eligible. Nominated candidates must be sponsored by three full members of the CAGP. Nominated candidates must meet the following criteria:

1. Nominees should be full members in good standing with the CAGP
2. Nominees should have served and contributed significantly to the Academy by membership on the board or its councils/committees
3. Nominees should be highly regarded by their peers and Academy members for their integrity, professionalism, and leadership.

The executive and board members and committee heads are as follows:

Executive:

President J. K. LeClair
Vice President M. F. Rivard
Past President J. Sadavoy
Secretary Treasurer D. Conn

Board:

K. Solomons
Martins
D. Harris
F. Primeau

Chair, Education Committee: I. Silver

Chair, Publication & Communication Committee: L. Thorpe

Please submit nominations on the form included in this newsletter, and mail as directed.

CPA Column

International liaison

The faculty of old age psychiatry of the Royal College of Psychiatrist

continue to send up their newsletter. Discussed in the December 1997 issue are difficulties with discharging some patients who are felt not to need an inpatient hospital bed, but whose relatives dispute this move to a long term care facility. This is a particularly conflictual problem that causes many of us great concern at times. In this issue also, Dr. John Tooth of Tasmania describes a very interesting, innovative facility for people with Dementia. Staff wished to have patients live in as normal a situation as possible, but needed to make the residence cost effective by having reduced coverage at night. To facilitate this they had four separate home-like structures with the bedroom wings opening up into a central night nurse station, so that at night only two nurses could look after the 32 residents, but during the day these homes can be separately managed and kept in a more small intimate setting. Lastly Dr. Nathan Herman's article on Vitamin E is reprinted in this journal.

The Royal Australian and New Zealand College of Psychiatrists - Section of Psychiatry of Old Age continues working on drafting bylaws to become a more independent body. They are developing a training program in psychiatry of old age for advance trainees. In New Zealand there are two centres now (Auckland, and Christchurch) that have the ability to offer post fellow-ship training in old age psychiatry. Overall, the reduction of services are very similar to those experienced in North America.

There will be a joint meeting of the International Psychogeriatric Association and Section of Psychiatry of Old Age of the Royal Australian and New Zealand College of Psychiatrists in Cumberland Resort, Lorne, Victoria on the 4th to the 7th of February 2001. Lorne is a beautiful place with excellent weather and surf laden beaches. As February is not a great month in Canada in general, some of us might want to consider going down for this meeting.

The CPA section meeting will be occurring as usual in Halifax during the CPA week. It will likely occur as a breakfast meeting early in the week as the CAGP Scientific meeting will occur on Monday, the joint meeting of the Academies and the CPA will occur on Tuesday, followed by the main body of the CPA. As some people cannot stay all week, we have asked to have the section meeting early. As in the last two years we will be focusing on an educational workshop chaired by Dr. I. Silver. We have been focusing on educational issues as these are generally represented poorly in the rest of the CPA week, and Dr. I. Silver is such a good facilitator that any session he runs will be very successful.

During the CPA week there are tentative plans to have a computer lab set up. We are hoping to have a geriatric psychiatry station with which some of us will help. We will try to have access to the Internet and CD-ROM resources. Dr. Harry Karlinski has already agreed to be of help using his CD-ROM resources addresing the diagnosis of Alzheimer's disease, and Dr. Lonn Myronuk, our computer whiz colleague in Vancouver, has also expressed willingness to be involved.

Also at the CPA will be a joint section symposium on delirium. This will be jointly held with the Section of Consultation -Liaison Psychiatry.
It is important that as many of us as possible still attend the CPA section meetings as it gives us an extra voice at the CPA and allows us one extra forum to meet. There is also available funding from the CPA to cover some of the expenses such as room rental and a light breakfast..

Lilian Thorpe, M.D., F.R.C.P.
Chair, Section on Geriatric Psychiatry, CPA

Membership

Isabel Martins, M.D., F.R.C.P.
Board member, CAGP (portfolio for membership)
St John's, Newfoundland

IPA Column

Joel Sadavoy, M.D., F.R.C.P.
Past president, CAGP, and Canadian Board member of the IPA
Mount Sinai Hospital, Toronto

Training Centres
News from around the Country

Britsh Columbia

The BC Psychogeriatric Association Meeting will be held in the Delta Richmond Hotel on May 29-30, 1998. The key contact is, as usual, Penny McCourt (see meetings calendar at end). Speakers include Drs. Kluge, Kiraly, Lyn Beattie and Duncn Robertson., and the topics focus largely on sociological and ethical issues.

Members wanting to find a reason to visit beautiful British Columbia might use this meeting as an excuse to make that visit.

Ethics Column

An Elective Clinical Ethics Rotation in Psychiatry

From July to December 97, Drs. S. Singh and L. McMurray were the first residents in psychiatry at McGill University (and arguably in Canada) to complete an elective clinical ethics rotation for psychiatry residents at St. Mary's Hospital in Montreal. The residents were supervised by Hazel Markwell, clinical ethicist at St. Mary's, and myself. The following reflection is illuminating and mirrors the current preoccupations of psychiatry residents: striving for professional competence at the same time as providing a more humanistic approach to their practice. It is comforting for those involved in psychiatric education to think that such preoccupations are shared by many residents and will exert a long-lasting influence on their career and practice.

François Primeau, MD, FRCP(C)
Academic supervisor, clinical ethics training director, St. Mary's Hospital

Senior residents of psychiatry, having completed their mandatory clinical rotations, are given the task of choosing subsequent elective learning opportunities. This choice may take into account a myriad of factors, including one's level of interest in a particular area, a perceived lack in some aspect of clinical practice, the presence of charismatic supervisors on a service, a pleasant hospital climate, a reasonable call schedule and maybe even one's desire for the thrill of adventure. The last was perhaps key in our choice as two fourth year residents in psychiatry to be the first to undertake a six month part-time clinical ethics rotation at St. Mary's Hospital (McGill University).

The rotation was structured to enable both academic and clinical objectives in the context of an ethics consultation service. Weekly academic supervision focussed on becoming acquainted with the major ethical theories, including utilitarianism, Kantian deontology, Rawls' theory of justice, and natural law theory. Ethical appoaches to real-life problems such as end-of-life decisions, artificial feeding, and abortion were also illustrated. The very question of what it means to be a person was addressed in one especially thought-provoking session, with ramifications on how we view and make medical decisions with patients of differing levels of disability. A significant amount of time was dedicated to the discussion of what it means to be a physician, of the physician-patient relationship and of our clinical approach and involvement with our patients making medical decisions. Clinical supervision focussed more on the pragmatics of executing an ethics consultation, with an attempt at comparison to the process of standard psychiatric or medical consultation. We learned to better formulate the nature of conflict between patients, families, and caregivers, and to appreciate the different ethical models of conflict resolution. The four classic principles of ethical decision-making (autonomy, beneficence, non-maleficence, and justice) were employed in conflict resolution, but attempts were made to go beyond this somewhat regimented approach by considering the role of emotions and caring in ethical problem-solving.

Addressing conflict between patient and treating team from an ethical perspective allowed us to take the proverbial "big step back" to examine the doctor-patient relationship in a new light and with the provision of specific principles with which we could engage in conflict resolution. This was in contrast to the many early crisis interventions we performed with our psychiatric patients, often armed with a vague working model, and frequently skirting many metaphysical aspects of patients' decisions including law, religion and culture among others. The experiential medical/psychiatric model of teaching ("learn by doing" and "see one, do one, teach one") was in contrast to the ethical model of teaching emphasizing the awareness of ethical principles evoked by a consultee's question, the development of a particular approach for the question at hand and the observation of data gathering in the field prior to performing a consultation. We began considering the many values hanging in the balance from the very inception of the consultation and engaged in the process of crystallizing our opinions based on ethics and open communication with patients until the conclusion, where we then had to justify our recommendations to colleagues, patients and families.

The biopsychosocial model of psychiatric case formulation remains an important way of understanding our patients' illnesses and of determining the types of interventions we use to alleviate suffering. Although seemingly comprehensive, this model is often narrowed in scope for its heuristic value. Medical consultants, and, arguably some psychiatric consultants, see their work as that of ruling out various illnesses, emphasizing the biological axis of formulation. Further, it is not uncommon for psychiatric consultants to equate the psychological axis of formulation with the coping strategies used by the patient during times of stress and the psychodynamic features of early life relationships which may have led to the development of these coping methods. However, after completing several ethical consultations in the field, we were sensitized to the ways in which patients made decisions based on their personal value systems, which were often different from ours and which sometimes included metaphysical concepts, for which we were ill-prepared by our psychiatric culture. The ethical perspective led us into frank discussions with patients on what was good and bad, right and wrong and whether a given decision would bear favorably or not in the eyes of God.

Similarly, the social axis of the formulation is usually construed as the patient's family life and social network. A new richness to this axis came from our role as ethics consultants insofar as we were more likely to emphasize the interplay between patient and milieu, where many people may have been involved directly or indirectly in the decision-making process. In a medical ethics consultation, the patient's milieu might have included more extended family, religious affiliates, patient advocates, legal representatives, alternative sources of medical information and even surrogate decision-makers. Our place to discuss medical decisions with our patients suddenly broadened outside of us and them.

Our ventures beyond the biopsychosocial model of case formulation into the realms of good and ill served us well during our clinical ethics rotation. One could ask, though, how the experience has contributed to our education in psychiatry. Now we are both solidly back in the psychiatric world, but with a broadened perspective. The philosophical concepts we learned and the insights we gained are in fact directly relevant to diverse aspects of psychiatric practice. For one thing, both the framework of the ethical approach and the process by which it is applied are centered around the humanity of the patient. Although most branches of medicine, including psychiatry, would theoretically endorse a similar position, in practice that ideal is far from the realities of a typical day in the office or on the wards. On the clinical ethics service, we were not only confronted with issues of loss of dignity, autonomy, and life, as is every medical resident, but we also had the time, opportunity, and theoretical tools that enabled us to focus on the human dilemmas rather than on diagnosis, prognosis, treatment, and disposition. Having the luxury of time to dissect those aspects of the doctor-patient encounter provided us with an experience which will continue to influence our ways of relating to our patients.

On a more practical level, our rotation in clinical ethics illuminated our physician-patient relationships by providing concepts and language with which to clarify the responsibilities and obligations of each party in those interactions. Psychiatry is replete with encounters with patients who make irrational choices, sometimes to their own detriment. Clinical supervision on these issues often hinges around the supervisor`s value system, which frequently cannot be articulated, or which is often justified by citing a single ethical principle such as patient autonomy, or by attributing the patient's "error" to psychopathology. Some proceed with electroconvulsive therapy with a coerced signature from an incompetent patient, whereas others refuse to provide the same treatment to a competent patient who requests it. Some encourage open discussion of diagnosis and and treatment at the beginning of psychotherapy, whereas to others this

would be anathema. The frequent inability to adequately explain these kinds of inconsistencies leads to much confusion in residents` attempts to learn psychiatric decision-making. Unfortunately, the end result is often that residents themselves take on a similar stance, practicing according to their value systems, but being unable to explain the rationale behind their actions. With any luck, the instruction we received in the application of theories and principles to concrete clinical situations will help us to be able to make rational and informed decisions, and to be able to explain them to colleagues and to future students.

Although clinical ethics consultation is not specifically a psychiatric activity, the six month rotation we completed has been a definite asset to our psychiatric education; in a way it has been a fast-track to something approaching professional maturity. Our patients have benefitted by being better informed and more deeply respected in their struggles to make decisions that are right for them; we have benefitted from a clearer understanding of the values that influence clinical decision-making. Increasing the exposure of psychiatric resident to ethics may also have benefits for our profession. The future of psychiatry is perpetually being questioned; these days, issues of effectiveness and division of labour are at stake. The information-sharing and self-questioning that comes from exchange with other disciplines such as ethics may also be helpful to psychiatrists in defining the value of what we do and how we do it.

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Education Column

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Fellows' Column

1997 CAGP fellow

Pharmacologia

SSRIs AND THE ELDERLY:
THERE IS NO SUCH THING AS A FREE LUNCH!

The SSRIs have revolutionized the treatment of depression in the elderly! They are remarkably safe, exceptionally effective and have unsurpassed tolerability - at least that's what the drug reps tell us as we devour the free pizza at their sponsored CME luncheons. But after a decade of experience with these agents, have we swallowed their claims with impunity, or have they left us with upset stomachs? Several recent studies should be forcing clinicians to begin questioning some of these claims.

One potential advantage of the SSRIs is their lack of alpha adrenergic blockade, thus reducing the potential for orthostatic hypotension and eliminating the serious consequence of falls. Laghrissi-Thode et al (1) therefore studied three groups of subjects in order to determine the effects of antidepressant treatment on elderly patients by measuring body sway on a stable force platform before and after treatment initiation. After one week of treatment, patients treated with sertraline (mean dose 67 mg) had significantly greater degrees of body sway than patients treated with nortriptyline (mean dose 52 mg) and healthy, untreated controls. The authors note that these increases were often clinically noticeable, and this degree of body sway could be associated with increased risks of falls. These changes which occurred in the absence of orthostatic hypotension were no longer statistically significant by the second week of treatment, despite increases in sertraline dose (average dose 103 mg). While a non-randomized, non-blinded pharmacodynamic study that fails to demonstrate a dose-response relationship should be interpreted with caution, it appears prudent for clinicians to monitor elderly patients for gait instability after initiation with SSRI therapy.

Weight loss associated with SSRI therapy might be an unexpected benefit for many younger patients, but may be of significant concern in the elderly. In the first study to raise this alarm, Brymer and Hutner Winograd (2) used a retrospective case control study to examine the effects of fluoxetine compared with nortriptyline, desipramine and untreated controls (both depressed and non-depressed). Subjects in the study were all being treated in a geriatric medical clinic. The only significant weight loss occurred in patients >75 years of age on fluoxetine, who lost 4.6 kg on average. Seven of the 15 patients in this group lost >5% of initial body weight. To address this concern, Goldstein et al (3) re-examined data from the Fluoxetine Collaborative Study, which was a double-blind, placebo-controlled study of fluoxetine in 671 medically stable, geriatric outpatients. Patients treated with fluoxetine lost only (?) 1 kg of initial body weight, leading these authors to conclude that treatment with fluoxetine was safe, as this degree of weight loss was "not clinically relevant." Such "clinically irrelevant" weight loss in a young (average age 68), healthy, outpatient population does little to allay my concerns about significant weight loss in my much older, geriatric, frail, medically ill patients. Whether other SSRIs cause a similar degree of weight loss is unclear.

In a retrospective review of 1,905 psychiatric inpatients, 3.4% developed significant hyponatremia, defined as serum sodium, less than 130 mmol/L (4). In a univariate analysis, greater age, female sex and fluoxetine were the statistically significant variables. In a logistic regression analysis, fluoxetine remained the greatest risk factor for

hyponatremia, but other age-associated factors were also implicated (diuretics, diabetes, renal insufficiency, hypertension, abnormal potassium). The concerns about SSRI-induced hyponatremia were recently reviewed by Liu et al (5) in a study that attempted to document both published and unpublished reports of this adverse drug reaction. They were able to document 736 cases of hyponatremia related to SSRI use, noting the vast majority occurred in patients 65 years of age or older. They also noted that the median time to onset of hyponatremia was 13 days. Hyponatremia, which may present with nausea, anorexia, fatigue, cognitive impairment and result in coma, seizures and death, is a potential adverse drug reaction that clinicians must be aware of following the initiation of therapy with SSRIs.

The question of comparative efficacy was raised in a study by Roose et al (6). In this study, which compared fluoxetine with nortriptyline in elderly patients with significant cardiovascular illness, 82% of nortriptyline completers responded, compared with only 28% of fluoxetine completers. The drop-out rates appeared identical (19% versus 18%, respectively). While the authors of this paper reportedly studied "efficacy," this was essentially a descriptive cohort study that utilized historical control groups from other studies, limiting interpretation of their results. Our research group has just published a meticulous (a.k.a. obsessive) meta-analysis of all available, randomized, control trials of antidepressants in the elderly (7). The results of this analysis suggest similar efficacy for tricyclic antidepressants and SSRIs. More surprisingly, however, there were also no differences between the rates of reported adverse events or study drop-outs. This, despite the fact that the tricyclic antidepressants used most commonly in these studies were the notorious tertiary amines (e.g. amitriptyline, imipramine).

In summary, these studies suggest that SSRIs may cause gait instability, significant weight loss and hyponatremia, without the advantages of being more efficacious or better tolerated than the older (and cheaper) tricyclic antidepressants. The length of this article has also not allowed me to expand upon possible adverse cognitive effects of SSRIs, their CYP450 inhibitory effects (and potential for drug interactions), or their significant effects on sexual function (even in the elderly, I dare say!).

So what do I really think about SSRIs for the elderly? SSRIs clearly represent a safe, effective therapeutic option. In spite of the cautions summarized previously, their minimal cardiovascular side-effects, their lack of toxicity in over-dose, and their ease of use (minimal dose titration) make them excellent choices for many older patients. As good clinicians, we must have as many therapeutic options available as possible to treat these serious disorders. This includes the SSRIs, TCAs, MAOIs and atypicals. While all of these agents are effective, they must all be treated with respect and caution in our elderly patients who are so susceptible to side-effects and drug interactions.

N. Herrmann, MD, FRCPC

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Research

Published in the September 1997 issue of International Psychogeratrics is Simpson et al's article on Subcortical Hyperintensities in Late Life Depression: Acute Response to Treatment and Neuropsychological Impairment. This article won first place in the 1997 IPA Bayer research awards in Psychogeratrics which were presented at the IPA 1997 in Jerusalem. This study was an excellent one, which looked at not only the clinical significance of total cerebral white matter-hypertensities, but found specific correlations between poor acute response to depression treatment and frontal deep white matter lesions, pontine reticular formation lesions and basal ganglia lesions. They did not find that response to treatment was related to the total cerebral white matter hyperintensity load.

In this same issue Linden and Barnow studied the wish to die in very old persons. They found that 21.1% of the very old (70 to 105) people said that they wanted to die or felt life was not worth living. The more active suicidal intentions were most correlated with psychiatric pathology, but acute psychiatric pathology was not involved in all cases of old people who said they wished to die.

Tsolaki et al's study, also reported in this issue, of 65 patients with Alzheimer's disease and 69 age match controls, found that patients with a history of depression and a family history of dementia have an up to 7 times higher risk of developing Alzheimer's disease. They did not find that smoking decreased the risk of Alzheimer′s disease. This is interesting since a number of studies have suggested that smoking is inversely correlated with the risk for Alzheimer's disease, and others have suggested that the overall risk of dementia might be higher in smokers.

In the February 1998 issue of the American Journal of Psychiatry our Dr. Alistair Flint and his colleague Dr. Rifat published a two year

outcome of psychotic depression in late life. Flint and Rifat found that these older psychotic patients, even when they remitted and were maintained on an appropriate antidepressant maintenance regimen, had greater rates of relapse.

Regarding education in geriatrics, the February issue of the Royal College of Physicians and Surgeons of Canada Annals report the study by Wells et al. exploring the effect of a mandatory one week rotation in Geriatrics. This is significant, as advocating mandatory exposures to various topic areas is becoming very frequent , yet presenting data attesting to the gain of knowledge in this area is less so. Medical students were surveyed, and it was found that students who had completed the one week rotation were significantly improved in a variety of areas including attitudes, knowledge and management of elderly people. Most interesting was that fact that so many universities have no mandatory rotation at all in geriatric medicine. Mandatory rotations are only reported for the University of Alberta, Dalhousie University, Laval University, University of Montreal, Queen's University, University of Saskatchewan, and the University of Western Ontario. It appears that geriatric medicine training faces as much as, or even more an uphill battle as does geriatric psychiatry training, in general medicine or in general psychiatric residency.

Focus

Diagnosis of Dementia in Primary Care:
Dilemmas and Future Directions

Caring for the elderly is a difficult task in the context of primary care because of the challenges inherent in the assessment and management of the disorders so common among the frail elderly. This is particularly true when dealing with dementia in the primary care setting. As the population ages and more is known about the treatment of dementia, it will be important to better understand how to assist primary care physicians in meeting this challenge.

There is growing interest in the dementias in Canada and elsewhere. Patients and families alike are more aware of Alzheimer disease because of extensive media coverage and interest in issues related to again in general. The Alzheimer Society of Canada and its partner organizations at the local level have continued to educate the public about the dementias. This January during Alzheimer awareness month they launched a new campaign outlining the ten warning signs of dementia. They produced pamphlets outlining the warning signs and offering advice on how to pursue a diagnostic work-up if appropriate. In 1997 the Alzheimer Society of Canada issued guidelines on ethical issues related to Alzheimer disease including the difficult topic of communicating the diagnosis. These were developed after extensive community consultation across Canada.

Several studies have documented the difficulties encountered by primary care physicians in making the diagnosis of dementia in their practice. Physicians often fail to use standardized tests of cognition and my not know of the guidelines which are available to guide their choice of diagnostic tests. They may also struggle to communicate the diagnosis of dementia to the patient and their family.

There are also many challenges to be faced in providing care to this patient population. Patients with dementia need monitoring of their physical health on a regular basis as well as help with long term planning, treatment of behavioral problems (so common in dementia) and referrals to the myriad of community services available (Alzheimer day programs, respite care etc.). Caregivers of persons with dementia also need a great deal of support and education on an ongoing basis to assist them in their job and to potentially alleviate or prevent the deleterious effects of caregiving. With the advent of symptomatic therapies for the treatment of dementia, family physicians also have to familiarize themselves with new treatment regimes.

In this climate of change it will become even more important for family physicians in Canada to feel comfortable making the diagnosis of dementia, following patients and their family over time and using specialized physician and community services to assist them in this job. A group of clinicians at Sunnybrook Health Science Centre in Toronto has been examining this issue. "The Dementia Support Network for Primary Care" has been meting on a regular basis. The goals of this group are to provide family MD's with the support necessary to recognize signs and symptoms of early cognitive impairment; establish a probable diagnosis of dementia; identify, address and manage the physical, psychosocial, legal/financial and family issues related to dementia; and to retrieve appropriate up to date information to facilitate these activities.

The Dementia Support Network group has been seeking information from family MD's in this area about their education and service needs with respect to dementia patients. What has become clear is that there may be specific gaps in the knowledge and skills required to make a diagnosis of dementia and manage these patients. However, the attitudes of primary care physicians towards the dementias seems to be of equal or greater importance at this time. Initial inquiries have focused attention of family MD's strong feelings about the challenges inherent in making the diagnosis, communicating this to the patient and family and managing these patients over time. Family physicians expressed the need for more support from each other and specialist services in the hospital and community to enable them to feel more confident and comfortable doing this job. They expressed concerns about the nihilism they often feel in making the diagnosis of dementia and the strong feelings they encounter in patients and families struggling with these illnesses.

As geriatric psychiatrists, members of the Academy will want to consider how to assist their primary care colleagues in caring for dementia patients. They will want to be attuned to their attitudes – positive, negative and ambivalent – towards this patient population and the task of providing care for them in the coming years. Acknowledging and addressing these attitudinal issues will likely be as important as attempts to increase the knowledge and skills of family physicians in managing dementia.

Resources

Lennox, A. (1997) Family Physician CMA Project Report Phase 1. The Alzheimer Society of Canada.
Alzheimer Society of Canada (1997) Tough Choices: Ethical Guidelines.

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Research

Letters

Upcoming Events

Date	Name of Meeting	Location	Contact
April 23-25 1998	Alzheimer Society of Canada 20th Anniversary mtg	Vancouver, BC	Alzheimer Canada 1998 Annual Conference Attn: Linda Leduc, 1320 Yonge St., Suite 201, Toronto M4T 1X0 Tel: (416) 925-3552
May 6-10 1998	American Geriatrics Society 55th Annual Scientific Meeting	Seattle, Washington USA	GSA, 770 Lexington Ave, Suite 300, NY, NY 10021, USA (212) 308-1414
May 21-23 1998	IPA Regional Meeting	Istanbul,Turkey	IPA: 3127 Greenleaf Avenue Wilmette, IL 60091 USA, Tel: (708) 966-0063 Fax: 966 -9418.
May 29-30 1998	BC Psychogeriatric Association Meeting	Richmond, BC	Penny McCourt, 528 Wentworth Street, Nanaimo, BC, V9R 3E4. Tel: 250-755-1322, Fax: -754-2967
May 30-June 4 1998	American Psychiatric Association (APA) Annual Scientific Meeting	Toronto, ON	APA: 1400 K Street NW, Washington, DC, 20005, USA Tel: (202)682-6237 Fax: -6345
June 14-17 1998	Canadian College of Neuropsychopharmacology 21st Annual Meeting	Montreal	Rachelle Mena, CCNP Secretariat, 1E7.22 Walter MacKenzie Center, 8440-112 St., Edmonton, T6G2B7 Tel: (403)492-6672, Fax -6672
July 12-18 1998	XXIst CINP (Collegium Internationale Neuro-psychopharmacologium) Congress	Glasgow, Scotland	Congress Central Office Bellway House, 813 South Street, Glasgow, Scotland, UK, G14OBX Tel:44(0)141954-4441
Sept 15 1998	Canadian Academy of Geriatric Psychiatry Annual Scientific Meeting	Halifax	Dr. Michael Flynn, Dartmouth Hospital, Halifax, Nova Scotia
Sept 16 1998	Joint CPA and Academies Meeting	Halifax	CPA: 260-441 McLaren, Ottawa, Ontario, K2P 2H3. Tel: (613) 234-2815, Fax: 234-985
Sept 15-18 1998	Canadian Psychiatric Association Meeting	Halifax	CPA
Sept 14-19 1998	IPA Regional Meeting	Munich, Germany	IPA
Sept 24-25 1998	1998 Institute of Psychiatry Short Course in Old Age Psychiatry	London, UK	Lee Wilding, Conference Office, Institute of Psychiatry, De Crespigny Park, Denmark Hill, London, UK, SE58AF. Tel: 0171 919 3170 Fax 0101 740 5172
Oct 15-18 1998	Canadian Association on Gerontology Annual Meeting	Halifax	Canadian Association on Gerontology 500-1306 Wellington St. Ottawa K1Y 3B2 Tel:(613)728-9347 Fax: -8913
Feb 21-25, 1999	Pan-American Congress on Gerontology	San Antonio, Texas, USA	Dr. Roger McCarter, Dept. of Physiology, U Texas Health Science Center, San Antonio, Texas. Tel: (210)567-4329
Spring 1999	IPA Regional Meeting	Beijing, China	IPA
August 6-9 1999	XIth World Congress of Psychiatry	Hamburg, Germany	DGPPN Secretariat, Düsseldorf, Bergische Landstrasse 2, D-40629 Düsseldorf, Germany

Aug 15-20, 1999	IXth IPA Congress	Vancouver, B.C.	Venue West Conference Services Ltd., 645 The Landing, 375 Water Street, Vancouver, BC, V6B 5C6 Tel: (604)681-5226 Fax:-2503 Congress@venuewest.com
Spring 2001	IPA Regional Meeting	Australia	IPA
July 1-6 2001	International Association on Gerontology, 17th World Congress	Vancouver, B.C.	Dr. Gloria Gutman, Director, Gerontology Research Center, 515 Hastings St., Vancouver, B.C.
Summer 2001	IPA Meeting	Nice, France	IPA

The CAGP Newsletter is supported by a grant from Pfizer Continuing Medical Education

Call for Nominations to the Board of the CAGP
1998

Nominating Committee
J. Sadavoy (Chair)
B. Groulx
K. Solomons

There are four Board positions to be filled by a full member of the CAGP in the fall of 1998. To comply with our by-laws, at least one of these positions must be filled by a member from the prairie provinces and one member from Quebec. The other two positions may be filled by members in any region of Canada. Each nominee must have sponsoring signatures from three full members of the CAGP

Nominee to the Board **Name _____**

Address _____

1 Name (printed)_____ (signed)_____

Address _____

2 Name (printed)_____ (signed)_____

Address _____

3 Name (printed)_____ (signed)_____

Address _____

Please submit nominations on this form and mail to Dr. Joel Sadavoy by March 31, 1998. Address: Suite 925,

600 University Avenue, Toronto, Ontario M5G 1X5

Nomination for President **Name** _____

Address _____

Nominating Members

1 Name (printed)_____ (signed)_____

Address _____

2 Name (printed)_____ (signed)_____

Address _____

3 Name (printed)_____ (signed)_____

Address _____

Nomination for Vice President **Name** _____

Address _____

Nominating Members

1 Name (printed)_____ (signed)_____

Address _____

2 Name (printed)_____ (signed)_____

Address _____

3 Name (printed)_____ (signed)_____

Address _____

Please submit nomination on this form and mail to Dr. Joel Sadavoy by March 31, 1998. Address: Suite 925, 600 University Avenue, Toronto, Ontario M5G 1X5