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Editor's view—updated guidance on managing dementia

Dementia guidelines

We are looking to publish more good quality guidelines and guideline summaries in the journal. One challenge with guidelines is that they can be difficult for even the most avid clinicians to assimilate and digest. The Scottish Intercollegiate Guideline Network (SIGN) Guideline on managing dementia is a good example due to its sheer size and scope, but our latest issue includes an approved, more readable summary and commentary [1]. The guideline specifically focussed on areas less well covered in other guidance and was heavily influenced by people with lived experience of dementia and their carers. There is greater focus on seeing the person with dementia and their carer as a dyad, as well as tackling the considerable pre-death grief that accompanies the condition. Although some of the guidance is most relevant to Scotland, almost the entire guideline is equally applicable and pertinent to the rest of the world, so I recommend having a look because there is a big gap between the lived experience of dementia and the ideal care described by the guideline. If you, like me, sometimes worry that guidelines are sometimes used as a poor substitute for thinking, be assured that we will only publish guidelines relevant to our patients. For a comprehensive commentary of what relevant, person-centred guidelines for use in older people's care should look like, check out the sterling work by Martin and colleagues from our editorial board [2].

Treating vascular risk factors in older populations

Bogaerts *et al*. [3] present the results of a fascinating randomised controlled trial of discontinuing antihypertensive therapy in nursing home residents with moderate to severe dementia. The trial was stopped early on advice of its independent data monitoring committee because there was a trend towards worse outcomes in the intervention arm across an impressive range of measures, including objective measures such as deaths and more subjective, but important ones, such as quality of life. This contrasts with the results of a number of deprescribing studies that usually show withdrawing antihypertensives in older, frailer populations is safe, though evidence of benefit is sparse. The authors suggest that in this particular group, stopping antihypertensives may disrupt a fragile homeostasis or worsen vascular disease and function. Despite the early termination and lack of statistically significant difference in the main outcome measures, the authors persuasively argue that there is sufficient evidence that the risk/benefit balance does not justify proactively stopping antihypertensives in this group. Turning to cholesterol management, in a secondary analysis of older participants (aged >75 years) with coronary artery disease participating in a major multicentre trial comparing cholesterol-lowering therapy strategies [4], a strategy of treating to target cholesterol levels resulted in significantly lower doses of statins being prescribed without any significant differences in outcomes. This suggest that the often-recommended strategy of using high-dose statins may be unnecessary, although the authors urge caution because follow-up was limited to three years and results may not be generalisable to the wider older adult population.

Delirium assessment throughout the world

It is pleasing to see how original studies in geriatric medicine are growing in scale in terms of participants recruited and numbers of participating centres. One of the most impressive for size is the World Delirium Awareness Day prevalence study by Nydahl and his many colleagues [5], a truly collaborative international effort that surveyed a whopping 1667 wards or units across the globe, and over 36 000 patients. I expect we will soon publish the main analysis comparing delirium prevalence across countries but, for now, the latest edition includes an interesting world-wide survey of delirium assessment tools and management protocols. They found a correlation between use of management protocols and assessment tools, with wide variation in uptake from barely 20% of wards in Africa to over 90% in North America and Australia. Since delirium is found universally, especially in healthcare environments, it is likely that areas with low uptake are missing out on the chance to identify and treat or prevent this important condition.

What causes unexplained dizziness?

Size is not everything though. Sometimes small studies can provide valuable new insights. Indeed, if there is a large and clinically significant difference to find, then there is no need or justification for recruiting thousands of patients. Castro *et al.* [6] sought to discover why some patients feel dizzy even when there is no medical explanation to account for

their symptoms. They tested 30 such patients and matched controls on a moving platforms and found statistically significant differences between the groups in an array of measures. They conclude that idiopathic dizziness is associated with distorted perception of instability and subtle impairments in balance control, including abnormal and overly cautious stepping responses. There is some evidence the aetiology may be due to cerebral small vessel disease.

Use of POCUS in geriatric medicine

Point of care ultrasound (POCUS) is commonly used in some countries, but is less commonly used in the UK—certainly not within geriatric medicine anyway. A study of POCUS in geriatric care across three centres in Madrid and Manchester concludes it has a useful role and improves outcomes, even suggesting it should be included in training curricula [7]. A major limitation is the high inter-observer variability, meaning the technique is only as good as the operator. Whether access to POCUS improves outcomes and is cost-effective would better be tested in a randomised controlled trial and seems ripe for formal health technology assessment.

Early mobilisation after surgery

The use of bed rest and convalescence as treatments is best confined to the history books, but some habits die hard. Mao *et al*.[8] make an impassioned plea to adopt the practice of early mobilisation and weight-bearing as tolerated after hip fracture surgery throughout the world, and bemoan the slow adoption of it in mainland China. They note the large benefits of early mobilisation in patient outcomes and point out that many of the barriers to best practice identified by a recently published study in *Age & Ageing* [9] also exist in China and in other countries. They make recommendations for changes that could vastly improve outcomes if they were adopted internationally as they have been in much of the Western world.

Detection of anxiety

There are many tools to assess anxiety in older adults. A comprehensive systematic review of available tools [10] identified 23 of them, and found that the best studied was the Geriatric Anxiety Inventory 20-item scale. It concluded that it, along with its short form and the Hospital Anxiety and Depression Scale are supported for use in identifying anxiety in community dwelling older adults based on sensitivity, specificity and ease of use.

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