Bariatric Surgery Risks Similar in Old and Young

BY JEFF EVANS
Senior Writer

SAN FRANCISCO — Bariatric surgery may be safe for older patients and provide weight loss benefits and improved comorbidities similar to those achieved by younger patients, according to three new studies presented at the annual meeting of the American Society for Bariatric Surgery.

In February, the Centers for Medicare and Medicaid Services extended coverage for bariatric surgery to beneficiaries of all ages, provided that the surgery was performed at certified facilities.

And although a recent review of Medicare beneficiaries reported significantly higher mortality in patients aged 65 years and older than in younger patients (JAMA 2005;294:1903-8), the new studies do not support that finding.

In a study of 340 Medicare patients who underwent bariatric surgery, individuals aged 65 years and older had similar rates of major and minor complications but lower mortality after surgery than did those younger than 65 years, reported Dr. David A. Provost of the University of Texas Southwestern Medical Center, Dallas.

No deaths occurred in 65 older adult patients who received either laparoscopic adjustable gastric banding (LAGB) or open or laparoscopic Roux-en-Y gastric bypass (RYGB), but 3 (0.1%) of 275 younger patients died. The overall complication rate for patients aged 65 years and older was similar to that observed for patients under 65 years of age.

In a separate retrospective study of 55 patients aged at least 60 years, laparoscopic bariatric procedures caused no deaths and few complications, reported Dr. David Hazzan of the division of minimally invasive surgery at Mount Sinai School of Medicine, New York.

In the first 30 days after surgery, 4 (7%) patients developed complications: upper GI bleeding, an empyema, a urinary tract infection, and a wound infection. No patients had died at 90 days after surgery.

All patients underwent a contrast swallow study on the first day after surgery, and more than 70% were monitored in the surgical or postanesthesia ICU for the first 24 hours after surgery, based on their comorbidities and cardiovascular status.

Another study found that RYGB surgery in patients aged 60 years and older could be safe and effective in resolving comorbidities, even though the older patients lost less excess weight and had more comorbidities than their younger counterparts.

Of 1,002 patients who received bariatric surgery at the Geisinger Medical Center, Danville, Pa., during 2001-2005, 61 patients aged at least 60 years (mean, 62 years old) and 941 younger patients (mean, 43 years old) received laparoscopic or open RYGB surgery, said Dr. Stephanie E. Dunkle-Blatter, of the center.

Surgeons performed laparoscopic RYGB surgery in 32% of the older patients and in 53% of the younger patients. Postoperative body mass index was similar between the two groups (about 36 kg/m^2), despite a larger percentage of excess weight lost in younger patients (53% vs. 46%). At a mean follow-up of nearly 14 months in older patients and almost 17 months in younger patients, a significantly greater percentage of older patients resolved or improved their type 2 diabetes than did younger patients (98% vs. 91%), but a significantly larger percentage of younger patients had improvement or resolution of hypertension than did older patients (83% vs. 76%). The number of prescription medications decreased from about 10 to 5 in older adults and from about 5 to 3 in younger patients.

Rates of major complications were 13% in older adults and 12% in younger patients, while rates of minor complications were 27% and 21%, respectively. However, 90-day mortality rates were similar in the two groups (1.6% vs. 0.53%, respectively).

More bariatric surgery is likely to be performed in older adults in the future, given the aging population and climbing rate of obesity, several speakers noted. ■

Routinely Assess, Reevaluate Dementia Patients' Driving

BY KERRI WACHTER
Senior Writer

SAN JUAN, P.R. — Not all older patients with dementia are dangerous drivers, making individual assessments of fitness to drive crucial for road safety, Dr. John C. Morris said at the annual meeting of the American Association for Geriatric Psychiatry.

About 30% of demented people continue to drive. Yet "we know that all demented drivers—at some point in the course of their dementia—will become unsafe," said Dr. Morris, professor of neurology at Washington University, St. Louis.

Demented drivers have a twofold increased risk of crashing, compared with age-matched nondemented individuals. "In particular, they're at increased risk of fatal crashes," Dr. Morris said.

Driving is a crucial means of transportation for many older adults—losing the ability to drive means losing autonomy. For many older adults, the issue of fairness also comes into play. They don't believe it is fair to have to give up their ability to drive when they have never had an accident.

"It's very important for older adults—if they are safe to drive—to be able to continue to do so," Dr. Morris said. As a starting point, ask not only the patient but also family and caregivers about problematic driving behaviors whenever you evaluate an older adult. In particular, ask about the following unsafe behaviors that are typically exhibited by older adults with dementia:

► Failing to stay in their lane or to maintain proper distance.
► Driving at improper speeds (too fast or too slow).
► Ignoring or failing to comprehend road signs.
► Failing to signal, check traffic, or react to other drivers.
► Becoming lost.
► Having accidents (even "fender benders").
► Receiving citations.

Physicians do a fairly good job of evaluating a patient's ability to drive safely, Dr. Morris said. According to one study, physicians are accurate roughly three-quarters of the time in determining whether a person has the ability to drive safely (J. Am. Geriatr. Soc. 2005;53:94-8).

Age alone appears to be a risk factor for unsafe driving as well. Studies indicate that periodically monitoring older patients for driving ability is important. At-risk drivers should be reevaluated about every 6 months.

Here's the approach that Dr. Morris and his colleagues at Washington University's Alzheimer's disease research center use when dealing with the issue of dementia and driving:

► Routinely ask the patient and family if the patient is driving and, if so, about any problems or risks.
► Assess any comorbid factors, such as medications and visual impairment.
► If the patient with dementia wishes to drive and reportedly can do so safely, require confirmation with a road test.
► If the patient performs safely on the road test, allow continued driving until a follow-up road test is performed in 6-12 months.
► If the patient is determined to be an unsafe driver following a road test, initiate driving cessation.

"How do we get an older person to stop driving?" Dr. Morris asked. Appealing to the older driver's judgment usually does not work, but it is very important to maintain the patient's dignity during this process, he said. Going over with the patient and family the reasons why he or she should stop driving is sometimes helpful. "It has more weight coming from a physician," said Dr. Morris, who also gives his patients a written reminder—a prescription—that they may not drive.

It's important that the family work to provide an alternative means of transportation for the patient. In extreme situations, when the patient is determined to continue driving, the family may have to consider simply selling the car. ■

Novel Compound Boosts Function, Lean Body Mass in the Elderly

BY PATRICE WENDLING
Chicago Bureau

PITTSBURGH — Treatment with the investigational drug capromorelin brings growth hormone levels in the elderly back into the normal range for young adults, and improves some measures of function, results from a phase II trial showed.

These results suggest the possibility that chronic treatment with the oral growth hormone secretagogue could prolong the capacity for independent living in older men and women, Dr. George Merriam and his associates reported at the International Congress of Neuroendocrinology.

He presented data from a double-blind, multicenter study in which 395 generally healthy men and women with some functional limitations were randomized to 12 months of treatment with placebo or one of four active doses of capromorelin: 10 mg three times weekly, 3 mg twice daily, 10 mg daily at bedtime, or 10 mg twice daily.

Their ages ranged from 65 to 84 years, and all had a body mass index of less than 30 kg/m^2. Functional limitations could include two falls within the past year or decreased grip strength or reduced gait speed.

Each dose of capromorelin stimulated an acute rise in growth hormone levels, reported Dr. Merriam, of the University of Washington in Seattle. Capromorelin stimulated a dose-related increase in circulating IGF-I levels, with the greatest increases at the highest dose. These increases were sustained for the duration of treatment, but returned to baseline after the drug was discontinued.

Patients on active treatment gained a mean of 1.6 kg more than placebo after 6 months, and 1.3 kg after 12 months. This reflected an increase of 1.4 kg in lean body mass after 6 months and 1.6 kg after 12 months.

Tandem walk times improved significantly at 6 months and even more so at 12 months, compared with placebo. Stair climbing power improved significantly at 12 months. Nonsignificant trends toward improvement were seen in the 6-minute walk, chair rises, and tandem stand tests.

The drug was generally well tolerated. Insomnia and statistically significant increases in fasting glucose levels were reported in the active treatment groups. But glucose levels remained within the normal range, said Dr. Merriam who has no financial interest in Pfizer Inc., which is developing the drug and sponsored the study.

The physical function results are similar to those recently reported for Merck's investigational growth hormone secretagogue, MK677, which has a similar structure to capromorelin, he said. But both drugs face an uphill regulatory battle because the Food and Drug Administration does not consider aging to be a disease.

"These are very encouraging data, but they're not the sort of thing that can be sent into the FDA and get an approval from," Dr. Merriam said. "It's too small, too limited a study." ■