

legislative and professional endorsement of advance directives (AD), few patients have completed their AD should they become incompetent or have transmit their wishes to their informal caregivers in Switzerland. A multicentric study conducted in four regions in Switzerland that included 150 patients with an advanced cancer (with different culture, language and palliative care background) illustrate this paradox. The results of a structured questionnaire that has been completed by the patient and a designated IC will be described.

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O036

### Advance care planning in the older person: From research to clinical practice

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**Background.**– Advance Care Planning (ACP) – the process by which patients, together with their physicians and loved ones, establish goals and preferences for future care – is widely encouraged as a way to improve the quality of dying. However, international literature shows a lack of ACP conversations in older persons and/or their family members.

**Methodology.**– Based on current available guidelines together with the results of recent qualitative research, some of the practical aspects of Advance Care Planning in the older person, especially some important aspects rather neglected in existing guidelines will be addressed.

**Results.**– Before engaging in ACP conversations, physicians should explore if the patient accepts dying as a likely outcome. Also the experiences and fears concerning dying, trust in next of kin and the need for control should be assessed. If not, there is a risk of pseudo-participation which may result in end-of-life decisions not reflecting the patient's true wishes. The health care provider should also have some insight into the different roles family members play in the end-of-life care planning of elderly patients with a short life expectancy. It is important to connect to the specific role a family member plays in the ACP of the patient, to take into account that family members can experience an active role in ACP as burdensome, and to take into account the existing relationship patterns.

**Conclusion.**– ACP is an important tool in end-of-life care planning. Existing guidelines are an important tool however the physician should be aware of the pitfalls and incorporate these in the process of ACP.

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O037

### Evidence-based medicine in geriatrics

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**Session Description/Moderator Details.**– Evidence-based medicine in geriatrics Geriatric patients often have multiple chronic conditions, use many medications and may suffer from cognitive and functional impairments. A study about prevalence of morbidities in the elderly showed, that 82% of patients aged 65 and over had at least one chronic condition; 24% had even four or more conditions [1]. Due to deteriorating organ functions they are prone

to medication-related side effects [2]. Considering these complex problems, arriving at the best treatment for individual older people is complicated. To provide the best care, doctors need to base their decision on the best available evidence. When considering evidence-based medicine in geriatrics, several problems need to be addressed. In the first place, solid evidence concerning elderly is scarce. Often, elderly are excluded from trials because of multimorbidity or merely because of their age. Also, eligible patients should give informed consent for participation in a trial. This is complicated for patients that are not able to do this because of dementia or delirium. Additionally, in trials without age-limit, the numbers are often too small to draw conclusion in a subgroup of older patients. Besides, searching for geriatric information can be difficult, as geriatric information is published in a wide range of journals and not labelled consequently in databases. In this symposium, we aim to highlight several issues in doing research with geriatric patients in order to increase their participation in trials. Also, we provide some tips and tricks in incorporating evidence-based medicine in research and daily practice. Outline of the symposium: the symposium will be chaired by dr. Sophia de Rooij. Each presentation will take 15–20 minutes, leaving 15–30 minutes for general discussion: – what's different about older people? – Key issues in the conduct and reporting of RCTs – addressing comorbidity, frailty, cognition; – search filters for geriatric medicine; – creating evidence from individual patient data; – improving assessment and management of multimorbid elderly in clinical practice; – general discussion.

Short information on the authors: David Stott holds the David Cargill Chair of Geriatric Medicine at the University of Glasgow. He is in the lead of the Cochrane Health Care in Older People's Field. A major emphasis in his current research program is prediction and prevention of late-life cerebrovascular disease and the associated cognitive decline and disability. His research program relies on extensive collaborative links, including with biostatistics (the Robertson Centre), clinical biochemistry and haemostasis at the University of Glasgow, nursing and the professions allied to medicine and with other academic centres of Geriatric Medicine in the UK, the Netherlands and Australia. Furthermore, he contributes actively to both undergraduate and postgraduate teaching and acts as supervisor/advisor for many PhD-students, MScs and MDs. Esther van de Glind is a resident for geriatrics. In 2010, she started her PhD project at the Academic Medical Center (AMC) in Amsterdam with working title: "Evidence-based medicine in geriatrics". This project aims to improve evidence-based medicine in clinical geriatric practice. Part of this is to investigate what is known already and to make evidence better available for the clinician. Lotty Hooft is a clinical epidemiologist, working as a scientific staff member (assistant professor) at the Dutch Cochrane Centre at the AMC, since October 2003. Her focus of research is on improving methodology, report and implementation of results of systematic reviews, including systematic reviews of diagnostic test accuracy. She is also the director of the trial register in the Netherlands and chair of the WHO Best Practice Working Group of the International Clinical Trials Registry Platform (ICTRP). Gunnar Akner is professor in Geriatric Medicine at Örebro University in Sweden and senior consultant geriatrician. He has been involved in clinical research in frail and multimorbid elderly for many years, focusing on overview and integrated management regarding medical drugs, nutrition, physical function/activity, technical aids and ADL-support. He has been the president of Swedish Society for Geriatric Medicine 2000–2005 and Swedish Society for Clinical Nutrition 2006–2011. He was chairman and editor for a systematic review of scientific treatment studies of people 65 years and older published 2003 by the Swedish Council on Health Technology Assessment (<http://sbu.se/en/Published/Vit/Geriatric-care-and-treatment/>). His book "Multimorbidity in Eldery. Analysis, Management and Proposal of a Geriatric care Center" was published in 2011. Gunnar Akner's homepage address is

[www.gunnar-akner.se](http://www.gunnar-akner.se). Sophia de Rooij is a geriatrician and internist and head of the department of Geriatric Medicine at the AMC, which she started in 2002. She received a PhD in 2006, the thesis was entitled: “Aspects of acute hospital admission in the elderly.” She became AMC Principal Investigator in 2006 with delirium as her main topic of research. In 2008, she became one of the eight coordinators of the national Dutch healthcare program for the elderly ([www.kozamc.nl](http://www.kozamc.nl)) in which the Dutch government invested 80 million euro. She is (board) member of several national and international working groups. At the moment she is acting as co-promoter for several PhD-theses.

**Abstract 1.**– What’s different about older people? – Key issues in the conduct and reporting of RCTs. Randomised clinical trials are a powerful tool used to determine the effects of health care interventions. However, the evidence gathered in such studies often is of restricted value for older people. The classic problems of old age, including disability, dementia, frailty and multimorbidity become particularly common after the age of 80 years. Many clinical trials exclude older people with such problems. The issues are complex and often not easy to resolve. For example, while frailty is an important concept, it is of limited utility as a descriptor in trials, as there are no simple widely adopted operational criteria for describing this problem. When planning an intervention trial relevant to elderly people the selection of appropriate outcomes is more complex than that for younger subjects. In older age, disease incidence and life expectancy should not be the only endpoints considered. Also, loss of ability to live independently is an important adverse outcome that may merit specific reporting. Impact on informal carers should also be considered. Adverse effects from medical interventions are particularly common in later life, often presenting non-specifically such as with falls, immobility, cognitive problems, and incontinence. Particular emphasis should be paid to reporting such adverse events in studies in older people. In this talk, prof Stott will share his experiences in doing research in vulnerable elderly and he will give an insight into the various ways of how to deal with this challenges.

**Abstract 2.**– Search filters for geriatric medicine Geriatric patients need a specific treatment provided by doctors who base this treatment on sound evidence. However, evidence on many geriatric topics can be hard to find. We developed a highly sensitive and a highly specific search strategy to find geriatric evidence in Medline quickly and easily. A reference set was used to create the search strategies and to test their performance. Each of the 2000 articles in this reference set was labeled as relevant, not relevant or possibly relevant for geriatric medicine. From the relevant articles, we identified search terms to compose different search strategies. We compared the retrieved result of the different search strategies with the reference set to calculate the sensitivity, specificity, precision, accuracy and number-needed-to read (NNR). Our search strategies had very good operating characteristics with a sensitivity of 94.8% and a specificity of 88.7% and a NNR of 1.37. The search strategies are useful to both the clinician who wishes a quick answer to a clinical question and to the researcher who wants to find as many articles as possible without missing too much relevant information. In this presentation, we will explain how we developed our search filter and illustrate its application in daily practice. Furthermore, we will show the results of a validation study that we performed by using the references found by the students of last year’s EAMA course [3].

**Abstract 3.**– Creating evidence from individual patient data. Well-conducted systematic reviews are the best quality evidence we have. In geriatrics, extrapolating the results of a systematic review to our patient group can be difficult, as these SRs are based on trials that include at best only small groups of elderly patients. In an individual patient data meta-analysis, original trial data concerning a particular group are taken together and analysed. In this presentation, we provide ways to conduct an IPD meta-analysis developed by the Cochrane Collaboration Individual Patient Data

Meta-analysis Methods Group. Also, we will share our own experiences in conducting an IPD meta-analysis.

**Abstract 4.**– Improving assessment and management of multimorbid elderly in clinical practice The present care of elderly people with complex health problems and complex treatment/care is suboptimal in many ways. First, the general educational level in Geriatric Medicine is low in all parts of the health care system. Second, the scientific knowledge regarding treatment is very low for elderly people 75 years and over. Also, medical records are not designed to provide easy overviews of multiple chronic health issues and how they develop over time. Neither is the organization suited for dealing with multimorbid elderly. Taken together, this gives rise to lacking integration and coordination of medical management and care over time and thus, unnecessary low quality of care for multimorbid elderly and also imposes great health risks. Moreover, integrated clinical research is not stimulated. To improve the situation and prepare for the extreme demographic challenges, the medical system must switch focus from “single disease management” to “multiple disease management”. Therefore, the knowledge area of Geriatric Medicine must get a much stronger impact on the general health care system than today. A proposal for a developmental unit for Geriatric Medicine will be presented emphasizing: integrated, targeted and coordinated routine care assessment and management emphasizing patient participation and co-responsibility; elective primary care with easy access to hospital care within the same organization; staff teams educated and trained in Geriatric Medicine; new problem-based medical record integrating clinical management with clinical research, especially treatment research.

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O038

### Development and validation of a multidimensional prognostic index for mortality based on a comprehensive geriatric assessment (MPI-SVAMA) in community-dwelling older subjects

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**Introduction.**– Mortality and institutionalization prediction is crucial to optimize care processes for older people. To develop and validate a Multidimensional Prognostic Index (MPI-SVaMA) to assess mortality and institutionalization risks from data collected using the Regional “Multidimensional Evaluation Form for Aged and Adult Individuals” (SVAMA).

**Methods.**– Twelve thousand and twenty community-dwelling subjects older than 65 years (M=4415, F=7605; mean