Common Issues in the Elderly: Part 2

Laurence Robbins, MD
Associate Professor of Medicine
University of Colorado School of Medicine
Denver, Colorado
Disclosure Statement

Dr. Robbins has nothing to disclose.
Learning Objectives

1. Discuss diagnosis and management of osteoporosis.
2. Review essentials of decision-making capacity.
3. Identify key issues in geriatric prevention.
4. Manage urinary incontinence and male sexual dysfunction in the elderly.
1. Which patient is least likely to have idiopathic osteoporosis?

A. Slender, 61-inch-tall 71-yo Caucasian woman with a T12 vertebral fracture
B. 86-yo Caucasian man with a hip fracture
C. 65-yo thin, alcoholic Caucasian woman who smokes and has T10-T12 vertebral fracture
D. 67-yo obese African-American woman with a T4 vertebral fracture
1. Which patient is least likely to have idiopathic osteoporosis?

A. Slender, 61-inch-tall 71-yo Caucasian woman with a T12 vertebral fracture

B. 86-yo Caucasian man with a hip fracture

C. 65-yo thin, alcoholic Caucasian woman who smokes and has T10-T12 vertebral fracture

D. 67-yo obese African-American woman with a T4 vertebral fracture

67%

A. 7%

B. 14%

C. 12%

D. 67%
Osteoporosis

- Short stature, slender, Caucasian women are at greater risk for osteoporosis.
- Risk of osteoporosis in men becomes similar to women in advanced age (>80).
- Alcohol and cigarette smoking accelerate this risk.
- Osteoporotic fractures usually begin in vertebrae under greatest anatomical load (T10-T12) and spread caudal and cephalad.
Why Care about Osteoporosis?

• In the US, the majority of patients with fragility fractures do not receive osteoporosis therapy.
• In one study of women > 65 yo with recent hip fracture, 13% were receiving adequate treatment for osteoporosis.
Following a Hip Fracture, Remember the “Rule of 4ths”

- **Dead**
- **Institutionalized**
- **Alive, no change in function**
- **Home with new functional deficits**
## Osteoporosis: WHO Definition

<table>
<thead>
<tr>
<th>T Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt;-1 SD</td>
<td>Normal</td>
</tr>
<tr>
<td>-1 to -2.5 SD</td>
<td>Low bone mass (osteopenia)</td>
</tr>
<tr>
<td>&lt;-2.5 SD</td>
<td>Osteoporosis</td>
</tr>
<tr>
<td>&lt;-2.5 SD plus one or more fractures</td>
<td>Severe or established osteoporosis</td>
</tr>
</tbody>
</table>
Bone Mineral Density Test
DXA (Dual Energy X-ray Absorptiometry)

- The WHO criteria for osteoporosis are based on DXA.
- Hip DXA is the best predictor of hip fracture, which is the most clinically relevant site of fracture.
Who Needs BMD Testing?

<table>
<thead>
<tr>
<th>Patient category</th>
<th>USPSTF</th>
<th>NOF/ISCD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women age $\geq 65$ yo</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Women age 50-64 yo based on risk factors</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Men age $\geq 70$ yo</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Men age 50-69 yo based on risk factors</td>
<td>No</td>
<td>Yes</td>
</tr>
</tbody>
</table>
## Who Needs BMD Testing?

<table>
<thead>
<tr>
<th>Patient category</th>
<th>USPSTF</th>
<th>NOF/ISCD</th>
</tr>
</thead>
<tbody>
<tr>
<td>All men and women with a fragility fracture</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Anyone considering Rx for osteoporosis</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Anyone receiving Rx for osteoporosis</td>
<td>No</td>
<td>Yes</td>
</tr>
</tbody>
</table>
2. Which one of the following is the best test for vitamin D deficiency?

A. Serum ionized calcium
B. Serum 1,25 dihydroxyvitamin D level
C. Serum 25-hydroxyvitamin D level
D. 24-hour urine for calcium, alpha hydroxylase
2. Which one of the following is the best test for vitamin D deficiency?

A. Serum ionized calcium 2%
B. Serum 1,25 dihydroxyvitamin D level 36%
C. Serum 25-hydroxyvitamin D level 62%
D. 24-hour urine for calcium, alpha hydroxylase 0%
Vitamin D Metabolism

- D3 (cholecalciferol) and D2 (ergocalciferol) are both biologically active.
- Both are converted in liver by hydroxylation into 25 OH vit D.
- 25 OH vit D is converted in kidney to 1,25 di-OH vit D.
- 25 OH vit D has low biological activity but is the major form in circulation: best marker for nutritional status re: vit D.
Basic Screening for Secondary Causes of Osteoporosis

- CBC, albumin/total protein, alkaline phosphatase (myeloma, cancer)
- Serum creatinine (CKD)
- Calcium, phosphorus (hyperparathyroid)
- TSH (hyperthyroidism)
- Testosterone (men; hypogonadism)
Who Needs Treatment?

- Postmenopausal women and men > 50 yo
  - Hip or vertebral fracture
  - Prior fractures and low bone mass
  - T score ≤ -2.5 after appropriate evaluation for secondary causes
  - Low bone mass (T score -1 to -2.5) if high risk (eg, glucocorticoid use)

3. Which of the following is the USPSTF recommended daily dose of vitamin D and calcium for non-institutionalized postmenopausal women to prevent fracture?

A. 20 mcg 25-hydroxyvitamin D + 800 mg calcium
B. 400 IU/day of Vitamin D3 + 1000 mg calcium
C. 800 IU/day of Vitamin D3 + 1200 mg calcium
D. None of the above
3. Which of the following is the USPSTF recommended daily dose of vitamin D and calcium for non-institutionalized postmenopausal women to prevent fracture?

A. 20 mcg 25-hydroxyvitamin D + 800 mg calcium
B. 400 IU/day of Vitamin D3 + 1000 mg calcium
C. 800 IU/day of Vitamin D3 + 1200 mg calcium
D. None of the above

D. None of the above

1%  
21%  
60%  
18% ✔
Vitamin D and Calcium: USPSTF

- Recommends against daily supplementation with D3 400 IU or less and calcium 1000 mg or less.
- Concludes that evidence is insufficient to assess benefits/harms of higher doses.
- Guideline does not address vit D and calcium supplements for women or men with established osteoporosis.
Vitamin D and Calcium: USPSTF

• Vit D supplementation can reduce risk of fracture (institutionalized elderly > community dwelling) dose > 800 IU D3.

• No clear benefit (or harm) in cancer or cardiovascular risk.

• NOTE: Nearly all studies of osteoporosis Rx (eg, bisphosphonates) include vitamin D/Ca supplementation.
Vitamin D and Calcium: USPSTF

National Osteoporosis Foundation still recommends calcium and vitamin D supplementation (1200 mg calcium, 800-1000 IU vitamin D3) for all postmenopausal women.
Osteoporosis Prevention & Treatment

- Everyone should be counseled about:
  - Weight-bearing exercise
  - Calcium and vitamin D(?)
  - Smoking cessation
  - Avoiding excessive alcohol intake
  - Fall prevention

- Consider hip protectors.
4. Which of the following has been shown to reduce the risk of hip fracture?

A. Raloxifene
B. Alendronate
C. Ibandronate
D. Calcitonin
E. All of the above
4. Which of the following has been shown to reduce the risk of hip fracture?

- A. Raloxifene
- B. Alendronate
- C. Ibandronate
- D. Calcitonin
- E. All of the above
## FDA-Approved Treatment

<table>
<thead>
<tr>
<th>Antiresorptive (Bone Retaining)</th>
<th>Postmenopausal Osteoporosis</th>
<th>Men</th>
<th>GIOP*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alendronate</td>
<td>+</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>Risedronate</td>
<td>+</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>Zoledronate</td>
<td>+</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>Ibandronate</td>
<td>+</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Raloxifene</td>
<td>+</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Calcitonin</td>
<td>+</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Teriparatide</td>
<td>+</td>
<td>+</td>
<td>+</td>
</tr>
</tbody>
</table>

* GIOP—Glucocorticoid induced osteoporosis

* Anabolic (Bone Forming)
  - Teriparatide: + + +
Bisphosphonates

- Given on an empty stomach with full glass of water
- Contraindications:
  - Esophageal stricture
  - Achalasia
  - Patient unable to stand or sit upright
  - Renal failure with creatinine clearance of < 35 ml/minute
  - Hypocalcemia
Bisphosphonates: Side Effects

- GI upset
- Headache
- Bone pain
- Flu-like symptoms (with IV administration)
Bisphosphonates: Osteonecrosis of Jaw

- Low incidence.
- Most often with IV bisphosphonates.
- Mostly in cancer patients.
- Maintain oral hygiene.
- Regular dental check-up.
Bisphosphonates: Bone Pain–FDA alert

- Severe, sometimes incapacitating
- May occur days, months, or years after beginning bisphosphonates
- Incidence and risk unknown
- May be relieved after discontinuation
Bisphosphonate and Atrial Fibrillation (FDA Safety Review)

- No clear association
- Data from 19,687 patients
- \( \leq 2 \) events in most studies
Bisphosphonates: Long-Term Use Linked to Atypical Fractures

• Low-energy subtrochanteric femoral and pelvic insufficiency fractures.
• Poor healing.
• Consider stopping bisphosphonate after 5-10 years.

J Clin Endocrinol Metab April, 2010, 95(4)
Bisphosphonate Rx: How Long?

- FLEX trial: 1100 women, alendronate therapy averaged 5 years; randomized to continue 5 more years or stop
- Clinical vertebral fracture risk lower for continued treatment, especially in two groups: those without pre-existing fracture & T score < -2.5 or pre-existing fracture & T score < -2.0 (NNT 21 & 17 respectively)
- No data for non-vertebral fracture
5. Which osteoporosis therapy has an analgesic effect in the setting of acute vertebral fracture?

A. Alendronate
B. Calcitonin
C. Estrogen
D. Teriparatide
E. Raloxifene
5. Which osteoporosis therapy has an analgesic effect in the setting of acute vertebral fracture?

A. Alendronate
B. Calcitonin
C. Estrogen
D. Teriparatide
E. Raloxifene

B. Calcitonin
Calcitonin

Calcitonin: Polypeptide hormone

- Intranasal formulation for vertebral fracture complicated by pain for analgesic benefit.
- Weak anti-fracture efficacy.
- Remember to prescribe calcium and vitamin D!
- Increased risk of cancer with long-term use? Limit to six months’ duration.
Raloxifene

- Selective estrogen receptor modulator (SERM)
- Estrogen agonist/antagonist
- Reduces risk of breast cancer
- Does not stimulate endometrium
- Hot flashes
- Has not been shown to reduce hip fracture risk; less potent than bisphosphonates
Teriparatide (PTH) Parathyroid Hormone (1-34)

- Daily SQ injections.
- Reserved for pts with high risk for fractures:
  - Multiple fractures
  - Extremely low BMD eg, < -3
  - Intolerant/unresponsive to other Rx
- FDA black box warning: osteosarcoma (animals); thus, safety and efficacy ? > 2 yrs.
- Consider substituting bisphosphate > 2 yrs.
Denosumab (Prolia)

- Monoclonal antibody against RANKL (receptor that stimulates osteoclastic activity).
- Reduces vertebral, hip, and non-vertebral fractures.
- No long-term safety data; 1%-2% severe hypocalcemia.
- q6 month injection (expensive).
- Role is uncertain.
6. An elderly woman with severe Alzheimer’s Disease is admitted to your service and deemed mentally incapacitated. In order to make further management decisions:

A. Obtain a Power of Attorney
B. Create a living will
C. A & B
D. None of the above
6. An elderly woman with severe Alzheimer’s Disease is admitted to your service and deemed mentally incapacitated. In order to make further management decisions:

A. Obtain a Power of Attorney  
B. Create a living will  
C. A & B  
D. None of the above

D. None of the above (34%)
Power of attorney can be assigned only by someone with the capacity to make decisions (that’s why they call them “advance” directives).
Principles of Decision Making for Incompetent Patients

• Documented advance directives
• Substituted judgment: Someone who knows the patient “attempts to make decisions in the manner that the patient would.”
• Best interest standard: Decisions based on “predicted outcomes that would most likely promote the patient’s well-being” (beneficence).
7. A daughter comes says that she is the patient’s Power of Attorney (signed by the patient 15 years ago when she was out of the country).

   A. A standard POA gives her the authority to make decisions about her mother’s care
   B. The daughter must apply for guardianship
   C. The POA must be “durable” for medical care
   D. A court must declare patient incompetent first
7. A daughter comes says that she is the patient’s Power of Attorney (signed by the patient 15 years ago when she was out of the country).

A. A standard POA gives her the authority to make decisions about her mother’s care
B. The daughter must apply for guardianship
C. The POA must be “durable” for medical care
D. A court must declare patient incompetent first
Power of Attorney

• Standard power of attorney is null and void if the individual becomes incapacitated.

• “Durable” power of attorney, specifically for medical affairs, allows the named individual to make medical decisions when the grantor is incapacitated.
8. Your demented patient has gangrene involving of her right foot. The surgeons recommend a BKA. You and the surgeon explain the surgery to the patient and believe she understands the pros and cons. The daughter is the DPOA and objects.

A. Proceed with surgery
B. Ask a psychiatrist to evaluate her
C. Call off the surgery
D. Call the patient’s son to get his permission
8. Your demented patient has gangrene involving of her right foot. The surgeons recommend a BKA. You and the surgeon explain the surgery to the patient and believe she understands the pros and cons. The daughter is the DPOA and objects.

A. Proceed with surgery
B. Ask a psychiatrist to evaluate her
C. Call off the surgery
D. Call the patient’s son to get his permission

28%  A. Proceed with surgery
19%   B. Ask a psychiatrist to evaluate her
54%   C. Call off the surgery
0%    D. Call the patient’s son to get his permission
Power of Attorney

• Determining capacity: Capacity to make a given medical decision is an isolated measure. If a patient understands the benefits and risks of an intervention and is consistent in her response, then the DPOA has no authority to overrule the patient.

• Generally a good idea to have two or more physicians independently confirm that the patient understands her decision.
9. Which of the following is true about tube feeding in advanced dementia?

A. Reduces risk of aspiration pneumonia.
B. Once in place, low risk of complications.
C. Most feeding tubes are inserted during acute hospital stay.
D. Improves healing of pressure sores.
E. Reduces mortality.
9. Which of the following is true about tube feeding in advanced dementia?

A. Reduces risk of aspiration pneumonia.  
B. Once in place, low risk of complications.  
C. Most feeding tubes are inserted during acute hospital stay.  
D. Improves healing of pressure sores.  
E. Reduces mortality.

- **C. Most feeding tubes are inserted during acute hospital stay.** (56%)
- **A. Reduces risk of aspiration pneumonia.** (15%)
- **B. Once in place, low risk of complications.** (3%)
- **D. Improves healing of pressure sores.** (25%)
- **E. Reduces mortality.** (1%)
Tube Feeding

- No evidence that feeding tubes reduce the risk of aspiration pneumonia, heal pressure wounds, improve nutritional status, or decrease mortality.
- 2/3 placed during acute hospitalization with little discussion with family.
- Transfer to ER for tube-related complications common.
- Hand feeding often acceptable alternative.

(Cochrane Review 2009)
Case Discussion

A 75-yo woman has a one-month progressive decline in her baseline mental status. She has anorexia, constipation, intermittent nausea, and a 10-lb weight loss. More recently, she became nonverbal and was unable to ambulate at all and was using a wheelchair. She is disoriented and intermittently incontinent of urine.
Case Discussion

Her affect is flat. HEENT exam normal. Neck supple, no goiter. Mucous membranes are dry. Coarse breath sounds in all lung fields. T 38.2°C, pulse 84/min, respiratory rate 20/min, blood pressure 152/81 mm Hg, and oxygen saturation 98% on room air.
10. What test is most likely to help with the diagnosis?

A. Brain MRI
B. Urinalysis
C. EKG and troponin
D. TSH
E. Chest x-ray
10. What test is most likely to help with the diagnosis?

A. Brain MRI
B. Urinalysis
C. EKG and troponin
D. TSH
E. Chest x-ray

D. TSH
Apathetic Hyperthyroidism

- Up to one third of elderly patients with hyperthyroidism do not have symptoms of sympathetic overactivity (tachycardia, tremor, nervousness, heat intolerance, increased appetite, more frequent stools, etc).
- Elderly patients with Graves’ disease less likely to have goiter. Constipation common and 40% have pulse < 100.
11. Which of the following is incorrect for patients > 65 years old according to USPSTF?

A. Flu shot annually
B. Pneumovax every 5 years
C. Pneumovax once after age 65
D. Tdap if first booster for tetanus, then Td only every 10 years
11. Which of the following is incorrect for patients > 65 years old according to USPSTF?

A. Flu shot annually 1%
B. Pneumovax every 5 years 94% ✅
C. Pneumovax once after age 65 4%
D. Tdap if first booster for tetanus, then Td only every 10 years 1%
Immunization for Elderly

Per USPSTF, give one pneumococcal vaccine after age 65 (whether or not one received prior to age 65).
12. The USPSTF’s stand on screening for abuse of the elderly or vulnerable adult is:

A. Screen all patients age > 80.

B. Screen all vulnerable patients age > 65.

C. Screen women age > 85.

D. Screen patients with dementia age > 70.

E. Insufficient evidence to recommend screening.
12. The USPSTF’s stand on screening for abuse of the elderly or vulnerable adult is:

A. Screen all patients age > 80.

B. Screen all vulnerable patients age > 65.

C. Screen women age > 85.

D. Screen patients with dementia age > 70.

E. Insufficient evidence to recommend screening.
Identifying At-Risk Elders

• Elder abuse and neglect not well studied; little data to identify best screening tool or effectiveness of screening.

• Despite lack of evidence for screening, most states have statutes protecting elders from abuse or neglect (including self-neglect).

• Adult protective services (APS) protects community dwelling; long-term care ombudsman programs (LTCOP) focus on nursing homes, assisted living, personal care homes.
Identifying At-Risk Elders

- Cognitively impaired women age > 80 at greatest risk.
- Sedation (overmedication), skin tears, dehydration (Na > 147), malnutrition, fractures, pressure sores may be clues.
- AMA recommended screening geriatric patients for abuse in all practice settings.
Screening Tools

• Interview elderly patients by themselves.
• Ask about family composition and living arrangements.
• Ask directly about abuse, neglect, or exploitation.
  1. Do you feel safe where you live?
  2. Who prepares your meals?
  3. Who handles your checkbook?
13. The most common cause of lack of sexual activity in older heterosexual couples is:

A. Female partner’s lack of interest
B. Female partner’s medical condition
C. Male partner’s lack of interest
D. Male partner’s medical condition
E. A and D
13. The most common cause of lack of sexual activity in older heterosexual couples is:

A. Female partner’s lack of interest  5%
B. Female partner’s medical condition  8%
C. Male partner’s lack of interest  5%
D. Male partner’s medical condition  35%  [Correct answer]
E. A and D  47%
Reason for Cessation of Sexual Intercourse (2000 Interview Cohort)

- No partner
- Partner's illness, loss of desire or capability
- Own illness, loss of desire or capability

N Beckman et al., BMJ, 2008; 337:a279.
14. The most common reason for cessation of sexual intercourse reported by men:

A. Lack of interest
B. Erectile dysfunction
C. Performance anxiety
D. Premature ejaculation
E. Anorgasmia
14. The most common reason for cessation of sexual intercourse reported by men:

A. Lack of interest  6%
B. Erectile dysfunction  92%
C. Performance anxiety  2%
D. Premature ejaculation  0%
E. Anorgasmia  0%
NSHAP: Sexual Problems in Men

REPORT PROBLEM  BOTHERED BY PROBLEM

Percent

Erectile Difficulty  Climax too soon  Anorgasmia

ST Lindau et al., NEJM, 2007; 357: 762-74.
15. What are the physical demands of sexual intercourse for men?

A. HR & BP response = Bruce stage 1 (5 METs)
B. HR & BP response = Bruce stage 2 (7 METs)
C. HR & BP response = Bruce stage 3 (10 METs)
D. HR & BP response = Bruce stage 4 (13 METs)
15. What are the physical demands of sexual intercourse for men?

A. HR & BP response = Bruce stage 1 (5 METs)
B. HR & BP response = Bruce stage 2 (7 METs)  
C. HR & BP response = Bruce stage 3 (10 METs)
D. HR & BP response = Bruce stage 4 (13 METs)
Physical Demands of Sex
(Palmieri et al. Am J Cardiol. 2007;100:1795-1801)

• 19 men (55 +/- 8 yrs) treadmill exercise (Bruce protocol) vs sexual intercourse
• HR & BP response with sex = Bruce stage II (7 METs or 75% of max exercise HR & BP: 6 min, 12% grade, 2.5 mph)
• Exercise duration predicted intercourse duration (each minute on treadmill added one minute to duration of sex)
Impairments in Physical Activity
Non-institutionalized Adults ≥ 70 Yrs Old

Sexual intercourse with a known partner in familiar place = the ability to climb 1-2 flights of stairs
16. No USPSTF guideline re: screening for urinary incontinence. However, reasons for screening include:

A. Effectiveness of pelvic floor exercise and biofeedback for women
B. Effectiveness of pelvic floor exercise and biofeedback for men after prostate surgery
C. Modest benefit of drug treatments
D. All of the above
16. No USPSTF guideline re: screening for urinary incontinence. However, reasons for screening include:

A. Effectiveness of pelvic floor exercise and biofeedback for women

B. Effectiveness of pelvic floor exercise and biofeedback for men after prostate surgery

C. Modest benefit of drug treatments

D. All of the above

74% ✓
14%
1%
11%
17. The most common cause of urinary incontinence in women is:

A. Urge
B. Stress
C. Overflow
D. Functional
17. The most common cause of urinary incontinence in women is:

- A. Urge (25%)
- B. Stress (60%)
- C. Overflow (4%)
- D. Functional (11%)
Urge Incontinence

• Most common type of urinary incontinence

• Signs and symptoms:
  – Abrupt urgency
  – Frequency
  – Nocturia
  – Volume of leakage may be large or small
Bladder Filling Physiology: Urge

![Graph showing bladder filling physiology with overactive and normal states.](image)
18. The most effective drug for urge incontinence is:

A. Oxybutynin.
B. Tolterodine.
C. Darifenacin (Enablex).
D. Trospium (Sanctura).
E. All are equally effective.
18. The most effective drug for urge incontinence is:

A. Oxybutynin.
B. Tolterodine.
C. Darifenacin (Enablex).
D. Trospium (Sanctura).
E. All are equally effective.

- A: 27%
- B: 1%
- C: 1%
- D: 1%
- E: 70%
Urge Incontinence

- Urge incontinence meds more effective when combined with behavioral therapy.
- Usually do not ablate detrusor overactivity.
- Efficacy similar; differ by side effects, cost.
- Lack of response to one agent does not preclude response to another.
- In men, check PVR before starting antimuscarinic medication to avoid making urinary retention worse.
19. An 80-yo complains of discomfort in his legs at night when trying to sleep, relieved by standing and walking. His only medication is prophylactic aspirin. The test most likely to reveal a treatable cause of his symptoms is:

A. Serum ferritin  
B. Serum calcium  
C. TSH  
D. CPK
19. An 80-yo complains of discomfort in his legs at night when trying to sleep, relieved by standing and walking. His only medication is prophylactic aspirin. The test most likely to reveal a treatable cause of his symptoms is:

A. Serum ferritin  
B. Serum calcium  
C. TSH  
D. CPK

73%  
10%  
9%  
8%
Restless Legs Syndrome

- Marked disagreeable discomfort in the lower extremities that occurs only at rest and is immediately relieved by movement.
- 20% of pts > 80 yo; sleep disturbance freq.
- Check serum ferritin; if low, give 2-month trial of iron replacement.
- RX: Pramipexole 0.125 mg, Sinemet CR 50/200, clonazepam 0.5-1.0 mg, or oxycodone 5 to 10 mg hs.
<p>| | | | | | | | | | | | | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>D</td>
<td>8</td>
<td>A</td>
<td>15</td>
<td>B</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>C</td>
<td>9</td>
<td>C</td>
<td>16</td>
<td>D</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>D</td>
<td>10</td>
<td>D</td>
<td>17</td>
<td>A</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>B</td>
<td>11</td>
<td>B</td>
<td>18</td>
<td>E</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>B</td>
<td>12</td>
<td>E</td>
<td>19</td>
<td>A</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>D</td>
<td>13</td>
<td>D</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>C</td>
<td>14</td>
<td>B</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>