

This is the first study to ask Ob-Gyn residents across national residency programs about their geriatrics training. The survey allowed comparison of residents across levels of training. The response rate was low, at 6%, not unusual for a survey performed in this fashion.<sup>8</sup>

Many articles have suggested ways to improve geriatrics education for specialists with a few common themes.<sup>6,9,10</sup> To improve geriatrics education in specialty programs, focused teaching in geriatrics must occur. Ideally, a faculty leader gero-expert should guide each program.<sup>9</sup> One way to achieve resident "buy in"<sup>10</sup> is to make residents more integral to the care process and clinical decisions,<sup>9</sup> focusing on patient function and how to ensure that older adults are in the best health for surgery.<sup>6</sup> Residents in all surgical specialties should be knowledgeable about evaluating older adults undergoing surgery and appropriate preoperative examination. Finally, program faculty and residents need to be asked what they need to learn to be more competent in geriatrics.

Ob-Gyn has a long way to go before residents begin to feel more confident in their knowledge and practice. Gynecologists need to know how to treat aging women. If we do not respond to this need, there is a risk of compromising medical care to our quickly growing geriatric population.

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## HOSPITAL TRANSFERS OF NURSING HOME RESIDENTS WITH DEMENTIA

**To the Editor:** We read with interest the paper by Givens et al.<sup>1</sup> on the hospitalization of nursing home (NH) residents with dementia and pneumonia and the emphasis placed on advance care planning (ACP) as the only modifiable factor to avoid it. From this perspective, the physician's role is markedly reduced, because pneumonia could be treated in the NH independently from the specific medical condition of the resident. To the contrary, we believe that pneumonia in frail elderly adults does not represent the main goal of treatment, because they need interventions directed toward their complex medical conditions.

For decades, studies of infection in elderly adults have centered on changes in microbiology and aspects of drug interactions or toxicity. In this age group, infections are more likely to present with atypical symptoms, such as delirium, than with classically recognized features (e.g., cough, sputum production),<sup>2,3</sup> which is why elderly adults with infectious diseases should be assessed with regard to functional capacity, cognitive impairment, comorbidity, nutritional status, social support, and frailty as important variables needing support and treatment.<sup>2</sup>

Because the topic is of great interest, we would like to contribute to this discussion data obtained from 3,554 elderly adults consecutively admitted to the geriatric ward (Poliambulanza Hospital, Brescia, Italy) during a 36-month period. Individuals underwent a multidimensional evaluation performed after admission including information on demographics, mental and physical health, and functional abilities using a standard protocol.<sup>4</sup> Pneumonia was diagnosed according to clinical signs and chest radiography, and treatment was provided according to American Thoracic Society/Infectious Diseases Society of America guidelines.<sup>5</sup> During the period, 150 elderly adults (mean age  $82.1 \pm 8.2$ ; 74.7% female) were admitted to the ward from NHs, 35 of whom had pneumonia. Three-month mortality, the outcome measure of the analysis, was significantly higher in individuals with pneumonia (48.6%) than in others (27.2%) ( $P = .009$ ).

Table 1 gives the crude and adjusted associations between different variables and 3-month mortality in hospitalized elderly NH residents after controlling for variables significantly associated with 3-month mortality in crude analyses (male, aged  $\geq 80$ , bedridden before admis-

**Table 1.** Three-Month Mortality Risk in 150 Nursing Home Elderly Hospitalized Adults

Variable	n/Events	Crude	Adjusted <sup>a</sup>
		Relative Risk (95% Confidence Interval)	
Male	38/20	3.3 (1.5–7.2)	2.0 (1.0–4.3)
Aged $\geq$ 80	94/33	1.5 (0.8–3.1)	—
Bedridden before admission	81/34	2.8 (1.5–5.9)	1.9 (1.0–4.2)
Acute Physiology and Chronic Health Evaluation II	79/42	4.5 (2.1–9.8)	2.7 (1.2–6.1)
Acute Physiology Subscore $\geq$ 5			
Dehydration (blood urea nitrogen:creatinine $>$ 60)	49/16	1.5 (0.7–3.1)	—
Mini-Mental State Examination score <18	98/36	3.1 (1.8–7.8)	—
Delirium	34/17	2.7 (1.2–6.0)	—
Geriatric Comorbidity Index $\geq$ 2	76/30	2.0 (1.1–4.1)	2.1 (1.1–3.7)
>7 medications	37/21	2.3 (1.4–3.5)	—
Malnutrition (serum albumin < 3.5 g/dL)	84/34	4.1 (1.8–9.1)	—
Chronic obstructive pulmonary disease	46/21	2.4 (1.1–4.9)	—
Pneumonia	35/17	2.8 (1.3–6.2)	—

<sup>a</sup>Adjusted for all variables associated with mortality in crude univariate analyses.

n = number of participants with the considered variables; events = number of participants who died during the 3-month period of follow-up.

sion, Acute Physiology and Chronic Health Evaluation II Acute Physiology Score (APS-APACHE II)  $\geq$  5,<sup>6</sup> urea:creatinine ratio  $>$  60, delirium, severe dementia, pneumonia, chronic obstructive pulmonary disease, malnutrition, Geriatric Index of Comorbidity score  $\geq$  2,<sup>7</sup> and taking  $\geq$  7 drugs). Male sex, being bedridden before admission, and having an APS-APACHE II score of 5 or greater and a Geriatric Index of Comorbidity score of 2 or greater hold an independent association.

In the light of these data, do individuals with advanced dementia and pneumonia receive adequate treatment in NHs? Some probably do, but the hospital could be the right place for others whose complex pathological conditions may require more-intensive treatment. It is of interest that not pneumonia, but being bedridden, and having high comorbidity and physiological impairment were the most important predictors of mortality, which indirectly suggests that antibiotic treatment is only part of global care and that an intensive diagnostic and therapeutic approach are also needed.

The other point concerns the role of ACP. In this context, the main question may be the lack of alignment between medically driven goals of care and do-not-hospitalize orders. ACP that have been written when an individual's condition was not impaired may reflect virtual and not real conditions and not always meet the individual's needs. Finally, this discussion is superfluous if it is thought that individuals with dementia do not deserve expensive hospital treatment. If lowering public expenditure for these citizens is the main goal, physicians should commit decisions to officials responsible for the local budget for Medicare, avoiding sharing the responsibility of deciding what the best treatment is for frail individuals.

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## A PILOT STUDY TO DEVELOP A BRIEF QUESTION-BASED SCREENING TOOL TO IDENTIFY HIGHER-RISK OLDER DRIVERS

To the Editor: Many older drivers are at higher risk of traffic crashes because of diseases, medications, and aging-related impairments, but no single clinical or demographic