Chronic Condition Management
Objectives

- Develop a basic understanding of client chronic conditions: GERD, Constipation, and UTI

- Gain an awareness of strategies for effective consultation of clients on a wide range of chronic conditions

- Develop greater empathy and understanding of persons with chronic conditions

- Develop skills of cultural sensitivity showing an ability to match appropriate interventions and prevention strategies with appropriate chronically ill populations, allowing the transition coordinators to understand and intervene as an advocate
Gastroesophageal Reflux Disease (GERD)

- A chronic condition in which the stomach contents (food or liquid) leak backwards from the stomach into the esophagus (the tube from the mouth to the stomach)

- Characterized primarily by heartburn, and/or feeling that food is stuck behind the breastbone (increased by bending, stooping, lying down or eating)

- **Concern for Barrett’s esophagitis with severe disease**
GERD – Who is at risk?

- Most prevalent gastrointestinal disorders—affects 14-20% of adults

- 7% of adults have reflux daily
  20% monthly
  60% intermittently

- Worse with aging population
GERD Symptoms

- Bad breath, sour taste in mouth, water brash
- Dental erosions
- Odynophagia (painful swallowing), Dysphagia (difficulty swallowing)
- Cough/increased mucous production - “Reflux laryngitis”
- Hoarseness
- Chest pain—may radiate from neck to throat or back (may mimic heart chest pain)
- Worse in lying position
Consultation of client: Assess for modifiable factors

Contributing factors
- Obesity
- Pregnancy
- Smoking

Food Triggers
- Citrus fruits
- Chocolate
- Caffeine
- Alcohol
- Fatty and fried foods
- Garlic and onions
- Mint flavorings
- Spicy Foods
- Tomato-based foods
GERD referral

- Should see GI Specialist if symptoms persist with lifestyle changes and PPI medication after 6 weeks

- Warning symptoms:
  - Weight loss
  - Dysphagia
  - Chest pain
  - Bleeding/anemia
Treatment

- Lifestyle changes
- Medications
- Surgery
Lifestyle Modifications
Living with GERD

**Dietary**
- ✓ Reduce or eliminate Fatty food, chocolate, spices

**Positioning**
- ✓ Elevation head of bed (order adjustable bed and/or ‘wedge’ cushion to elevate head of bed)
- ✓ Avoid recumbent position – 3 hours after meals

**Smoking cessation!** For more information on quitting, call the Illinois Quit line at: 1-866-784-8937 and ask for information on quitting.
Therapeutic medication regimens for GERD in order of increasing potency

✓ Two types of drugs: Proton pump inhibitors (PPIs) that decrease the amount of acid produced in stomach and H2 Blockers (antagonists) that lower the amount of acid released in the stomach.

✓ Over-the-counter (OTC) antacids and/or H2 receptor blockers (OTC or prescription)

✓ Omeprazole (20 mg daily) or equivalent dose of the other PPI’s

✓ Omeprazole (20 mg twice daily or 40 mg daily) or equivalent doses of the other PPIs

<table>
<thead>
<tr>
<th>Generic H2</th>
<th>Brand Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>cimetidine</td>
<td>Tagamet</td>
</tr>
<tr>
<td>famotidine</td>
<td>Pepcid</td>
</tr>
<tr>
<td>nizatidine</td>
<td>Avid</td>
</tr>
<tr>
<td>ranitidine</td>
<td>Zantac</td>
</tr>
</tbody>
</table>
Follow recommended guidelines, including:

- **Avoid triggers** (alcohol, caffeine, chocolate, alcohol, spicy foods, and tomato type sauces; and medications such as non-steroids which will irritate the lining of the stomach)
- Always **stay upright** for at least 1 hour after eating or drinking anything
- Encourage participant to avoid eating within a few hours of bedtime, reclining within after meals, and wearing tight-fitting clothes as these may increase symptoms
- Raising the head of the bed with 6 to 8 inch ‘wedges’, blocks or telephone books may help reduce symptoms at night
- A **symptom diary** should be considered to correlate offending foods with symptoms. Foods that reduce the tone in esophagus should be avoided, including fatty foods, highly spiced foods, onions and garlic, tomato based sauces, caffeinated beverages such as colas, coffee, mint and chocolate
- Encourage participant to reduce or **eliminate alcohol** intake and eat small meals throughout the day
- Encourage participant to **quit smoking** if he smokes
- Encourage **weight reduction** may help if participant is overweight or obese
- Follow up with primary care provider
Compassionate, knowledgeable care coordinators can improve the likelihood that persons diagnosed with GERD will obtain the appropriate information to make lifestyle changes, good food choices, and improve their own health risks related to GERD.

In summary, Transition Coordinators should:

- Have providers verify treatment protocol for participant.
- Have participant consult with GI Specialist when ‘red flags’ are present.
- Reassure participant that with adherence to therapy, quality of life and relief of symptoms are much improved.
Questions
Bowel movements or stools that are *hard to pass* and/or *infrequent*

Constipation is a frequent health concern for older people in *every health care setting* and in the community

** Constipation is a common, treatable, and preventable condition**
Two or more of the following symptoms present on more than 25% of occasions for at least 12 weeks in the last year:

- Two or less bowel movements per week
- Straining at stool
- Hard stools
- Feeling of incomplete evacuation


**Risk Factors for constipation**

**LEVEL 1 risk:**

Reduced mobility  
Medications (tricyclics, antipsychotics, antihistamines, antiemetics, drugs for incontinence)  
Neuro conditions (Parkinson’s disease, Diabetes Mellitus, Spinal cord injury);  
Dietary factors

**LEVEL 2 risk:**

*Poly-pharmacy (> 5 medications), opiates, calcium channel antagonists, calcium supplements, non-steroidal anti-inflammatory, impaired mobility, nursing home residency, neuro conditions (dementia, autonomic neuropathy), dehydration*

**LEVEL 3 risk:**

Iron supplements, Neuro conditions (stroke), depression, low dietary fiber, renal dialysis, metabolic disturbances, lack of privacy or comfort, poor toilet access.

**Note:** An *objective assessment* should be undertaken in frail people with constipation as these patients are at increased risk of developing complications.
Consultation of clients: Screening for constipation

- Constipation symptoms should be routinely asked about in clients with chronic illnesses and those aged 65+ in view of the high prevalence of the condition in these population.

- Men and women in their eighth decade and beyond should be regularly screened for constipation symptoms, as prevalence increases with advancing age.

- Screen for urinary incontinence because voluntary fluid restriction in an attempt to control urinary incontinence can lead to constipation.
Self Report of constipation: Identifying specific bowel symptoms in individuals reporting constipation is important to guide appropriate management of this common complaint

Assess for 2 classic symptoms of constipation:

1. **Infrequent bowel movement**: Reduced bowel movement frequency is not a sensitive clinical indicator for constipation, though it is specific. Two or fewer bowel movements per week are below normal range.

2. **Difficulty with evacuation (straining)** is a primary symptom.

Participants being prescribed laxatives on a daily basis should be regularly reviewed for symptoms of constipation and the appropriateness of long-term laxative therapy. (Access Medicine)
Consultation:
Assessment of Constipation

Constipation History

- Duration of constipation; Number bowel movements per week, straining? (classic symptoms)
- Fecal incontinence/soiling (does participant wear incontinent briefs? ‘Depends’?)
- Pain?
- Laxative use, prior and current
- Psychological and quality of life impact of bowel problem
Consultation: Assessment of Constipation

General History (assess for RISK FACTORS)

- Mood/cognition
- Symptoms of systemic illness (weight loss, anemia)
- Relevant co-morbidities (e.g., diabetes, neurological disease)
- Mobility
- Diet
- Medications (opioids)
- Toilet access (location of bathroom, manual dexterity, vision)

Abdominal pain, rectal bleeding, and certainly any systemic features such as weight loss and anemia should prompt further investigations for underlying cancer.
Complications of Constipation

- Fecal incontinence
- Fecal impaction
- Stercoral perforation
- Urinary retention
- Acquired mega-colon
- Rectal prolapse
- Diverticular disease
- Impaired quality of life
- Agitation in patients with dementia
Management of Chronic Constipation

Goals: comfortable regular bowel movements (at least every 3 days)

If not contraindicated:

- First line: try and get participant to increase their fluids and fiber foods and exercise. (these are dependent on status and control of other conditions)
- Next, add a fiber supplement such as Metamucil
- Use over the counter Colace with soften stools
- Milk of Magnesia is a gentle laxative that works without causing a lot of cramping
- Warm apple juice is helpful at times

In **high-risk participants** (bedridden individuals, those with neurological disease, and participants with history of fecal impaction)
- PCP may order Senna 2–3 tablets at bedtime and sorbitol or lactulose 30 mL daily, titrating upwards as needed
- If symptoms persist, notify PCP
# Treatment of Constipation

<table>
<thead>
<tr>
<th>Intended Use as per Prescribing Information and Directions for Use</th>
<th>Intended use</th>
<th>How it is available</th>
<th>How it works</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stimulant, laxatives, such as ex-lax</td>
<td>Occasional constipation</td>
<td>Over the counter</td>
<td>Causes muscles in colon to contract</td>
</tr>
<tr>
<td>Fiber supplements such as Metamucil</td>
<td>Occasional constipation</td>
<td>OTC</td>
<td>Bulking agent</td>
</tr>
<tr>
<td>Osmotic laxatives such as MiraLax</td>
<td>Occasional constipation</td>
<td>Over the counter</td>
<td>Draws water into the colon to make stool softer</td>
</tr>
<tr>
<td>CIC-2 chloride channel activator, such as AMITIZA®</td>
<td>Chronic Idiopathic constipation in adults</td>
<td>By prescription</td>
<td>Increases fluid into the intestine to help pass stool</td>
</tr>
<tr>
<td>Probiotics, such as Acidophilus Pearls TM</td>
<td>Support for bowel health</td>
<td>Over the counter</td>
<td>May support growth of good bacteria in the intestinal tract</td>
</tr>
<tr>
<td>Take a stool softener, such as docusate sodium (Colace) daily</td>
<td>Chronic constipation</td>
<td>Over the counter</td>
<td>It makes bowel movement softer and easier to pass</td>
</tr>
</tbody>
</table>
Compassionate, knowledgeable care coordinators can improve the likelihood that persons diagnosed with chronic constipation will obtain the appropriate information to make lifestyle changes, good food choices, and improve their own health risks related to chronic constipation.

In summary, Transition Coordinators should:

- Have providers verify treatment protocol for participant
- Have participant consult with GI Specialist when ‘red flags’ are present and/or treatment protocol is not effective
- Reassure participant that with adherence to therapy, quality of life and relief of symptoms are much improved
Questions
Urine Tract Infection (UTI)

Definition:
The presence of bacteria in the urethra, bladder or kidney. *The majority of UTIs in older adults are asymptomatic.*
If you have ever had a urinary tract infection (UTI), you're not likely to soon forget how uncomfortable this problem is!

One woman in five has a UTI at some time, and men and children also can be affected, sometimes seriously

UTIs account for about 10 million doctor visits each year; only respiratory infections occur more often
UTI is most common cause of bacterial infection in older adults

10 times more common in women than in men

The prevalence of bacteriuria is 2% to 3% in young women and increases to more than 10% for women older than age 65 years and 20% at 80 years or more
Women: Genetic predisposition, Loss of estrogen effect in menopause, Cystocele, Increased residual volume

Men: Prostatic hypertrophy (BPH), Bacterial prostatitis; Prostatic calculi; Urethral strictures; External urine collecting devices

Both: Genitourinary abnormalities; Bladder diverticulae; Urinary catheters (intermittent, indwelling); Associated illnesses Neurologic disease with neurogenic bladder dysfunction; Diabetes; Persons who self-catheterize
Nausea, vomiting, and loss of appetite
Bladder cramps or spasms
Itching, a feeling of warmth during urination
Low back pain
Chills
Flank pain
Foul-smelling urine
Low-grade fever (*may not occur in older patients*)
Male patient with a urethral discharge
Diagnosis

- **Urine Analysis (U/A):** Clean catch urine sample

- **Urine Culture & Sensitivity** urine sample testing used to determine the appropriate antimicrobial drug
Treatment

- Appropriate antimicrobials medications are the treatment of choice for most initial UTIs

- Note: Recurrent infection, either relapse or reinfection, occurs by 4 to 6 weeks for at least 50% of therapeutic courses. Thus, high microbiological recurrence rates are the norm.

**The goal of treatment is to ameliorate symptoms, not to sterilize the urine. Post-therapy urine cultures should be obtained only when symptoms persist or recur. (Access Medicine)**
**Anti-infectives**

**First line**
- Nitrofurantoin 50–100 mg four times a day
- TMP/SMX 160/800 mg, twice daily  
  TMP 100 mg twice daily
- Amoxicillin 500 mg three times daily

**Other**
- Amoxicillin/clavulanic acid 500 mg three times daily or 875 mg twice daily
- Norfloxacin 400 mg twice daily
- Ciprofloxacin 250–500 mg twice daily
- Ofloxacin 200–400 mg twice daily
- Levofloxacin 500 mg once a day
- Cephalexin 500 mg four times a day
- Cefaclor 500 mg
- Cefadroxil 1 g once a day or twice daily
Other Agents

- Other Bladder Agents
  - Pyridium (for dysuria - painful urination) 200 mg.
    TID x 2 days

- Prevention
  - Cranberry juice
Goals: The goal of treatment is to ameliorate symptoms.

- Take medications as directed
- Drink plenty of water every day. Some providers suggest drinking cranberry juice, which may inhibit growth of some bacteria by making the urine more acid. Vitamin C supplements may also have the same effect
- Provide good supply of catheter products

Special Tips for Women to Avoid UTIs:

- Urinate when you feel the need. Don't resist nature's call to empty your bladder
- Take showers instead of tub baths
- After a bowel movement, wipe from front to back to prevent bacteria around the anus from entering the vagina or urethra
- Avoid using feminine hygiene sprays and scented douches, which may irritate the urethra
- Clean the genital area before sexual intercourse and urinate afterward to wash out bacteria
Compassionate, knowledgeable care coordinators can improve the likelihood that persons diagnosed with UTIs or recurrent UTIs will obtain the appropriate information to ameliorate symptoms and make lifestyle changes which prevent recurrent UTI episodes.

In summary, Transition Coordinators should:

- Have providers verify treatment protocol for participant
- Have participant consult with Urologist (male participant) or UroGynecologist (female participant) when treatment protocol is not effective
- Reassure participant that with adherence to treatment protocol, quality of life and relief of symptoms are much improved
Questions
Resources

- American College of Gastroenterology, patient education & resource center: [http://patients.gi.org](http://patients.gi.org)

- American Urological Association, patient education: [http://urologyhealth.org](http://urologyhealth.org)
References

- Access Medicine
- Current Medical Diagnosis and Treatment
- Harrisons Online
- Medscape online
- Center for Disease Control
  - cdcinfo@cdc.gov