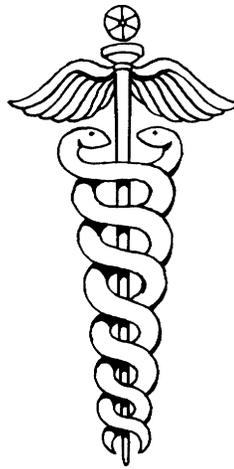


MEDICAL NOTES

VOLUME 1

A Brief Overview A - J



CREATIVE FORECASTING, INC.

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Table of Contents

Alcoholism and Alcohol Abuse.....	7
Alzheimer’s Disease.....	9
Aphasia.....	11
Arthritis <i>Osteoarthritis, Rheumatoid Arthritis</i>.....	13
Atrial Fibrillation and Cardiomyopathy.....	15
Back Pain.....	17
Bladder Problems <i>Urinary Incontinence, Urinary Tract Infections</i>.....	19
Brain Injuries.....	21
Breathing Difficulties <i>COPD, Pulmonary Embolism</i>.....	23
Cardiovascular Disease.....	25
Cerebrovascular Disease <i>Ischemic Strokes, Hemorrhagic Strokes</i>.....	27
Cold and Flu Season.....	29
Coronary Artery Disease and Congestive Heart Failure.....	31
Dehydration.....	33
Dementia and Related Disorders.....	35
Depression vs. Anxiety.....	37
Diabetes.....	39

Table of Contents

Eye Disorders <i>Cataracts, Glaucoma, Macular Degeneration</i>	41
Fibromyalgia	43
Food Allergies	45
Foot Disorders	47
Hearing Loss	49
Hip Fractures	51
HIV / AIDS	53
Huntington’s Disease	55
Infectious Diseases <i>Community Acquired Pneumonia, Klebsiella, MRSA</i>	57
Joint Replacements <i>Hip Replacement, Knee Replacement</i>	59

Editors’ Note: The articles in this book originally appeared in issues of *Creative Forecasting* magazine. The initial sections about the diseases and disorders were written by Valerie J. Shereck, a geriatric nurse practitioner. The Activity Implications sections were written by various Recreational Therapists whose names are listed in each article. We thank all of these professionals for their expertise based on years of experience.



Alzheimer's Disease

Valerie J. Shereck, MSN, ANP-C, Beth Hall, CTRS

Alzheimer's disease (AD) is a disease of the brain that causes problems with memory, thinking, and behavior. It is not a normal part of aging. Nerve cells in the brain die, making it difficult for brain signals to be transmitted properly. AD is also a form of dementia. There are many types of dementia, but AD is the most common. Dementia is a general term for loss of memory and other intellectual abilities that are serious enough to interfere with daily life.

AD gradually gets worse over time. Although symptoms can vary widely, the first symptom that people notice is forgetfulness that can affect their ability to function at home or work or to enjoy their hobbies. AD may cause an individual to become confused, lost in familiar places, misplace things, or have trouble with language.

More than five million Americans have AD. Approximately 13% of those individuals are over the age of 65 and 50% of those individuals are 85 and older. AD accounts for 60% - 80% of cases of dementia.

PROBABLE CAUSES AND RISK FACTORS FOR THE DEVELOPMENT OF AD

- ✓ Age - It is the greatest known risk factor. One in eight people older than the age of 65 will develop AD. Nearly half of people 85 and older have AD.
- ✓ Family History and Genetics - The risk of developing AD increases if a family member has the disease. Certain genes are also associated with the development of AD.
- ✓ Ethnicity - Older Latinos and older African-Americans are at increased risk for developing the disease, more than older Caucasians.

New research has shown that there is an increased risk for developing AD in individuals who have high blood pressure, high cholesterol, or diabetes. There is also growing research that there is a link between serious head injury and the development of AD in later life.

SOME SIGNS AND SYMPTOMS

- ✓ Poor judgment and decision making
- ✓ Inability to manage a budget
- ✓ Losing track of the date or season
- ✓ Difficulty having a conversation
- ✓ Misplacing things and being unable to retrace steps to find them

These signs and symptoms should be differentiated between normal age-related changes when individuals occasionally make a bad decision, miss a monthly payment, forget what day it is but later recall it, occasionally forget words, or lose things from time to time.

10 WARNING SIGNS ACCORDING TO THE ALZHEIMER'S ASSOCIATION

- ❶ Memory loss that disrupts daily life
- ❷ Challenges in planning or solving problems
- ❸ Difficulty completing familiar tasks at home or work or during leisure time

- ❹ Confusion with time or place
- ❺ Trouble understanding visual images or spatial relations such as reading, judging distances, and determining color or contrast that may make driving difficult
- ❻ Problems finding words in speaking or writing
- ❼ Misplacing things and losing the ability to retrace steps
- ❽ Decreased or poor judgment
- ❾ Withdrawal from work or social activities
- ❿ Changes in mood or personality (may become depressed, suspicious, fearful, or anxious)

STAGES OF AD

Individuals with AD live an average of four to eight years after diagnosis but may live as long as 20 years after diagnosis. Generally an individual will go through the following seven stages in the development and progression of their disease process.

Stage I: No Impairment in Cognitive Function

Stage II: Very Mild Decline with a Few Minor Memory Lapses

Stage III: Mild Cognitive Decline Friends, family, and co-workers begin to notice difficulties. Symptoms at this stage include difficulty coming up with a correct name for an object, trouble remembering names when introduced to new people, difficulty performing tasks in social or work settings, forgetting material that was just read, losing or misplacing valuable object(s), and problems planning or organizing.

Stage IV: Moderate Cognitive Decline Symptoms at this stage include forgetting recent events, impaired ability to perform challenging mental arithmetic (e.g. counting backwards by sevens), difficulty performing complex tasks such as planning dinner for guests, paying bills, or managing finances, and forgetting own personal history. The person may also become moody and withdrawn.

Stage V: Moderate to Severe Cognitive Decline An individual at this stage needs help with day-to-day activities. He or she is unable to recall own address or phone number and is confused as to where he or she is and what day it is. The person needs help in choosing for the season or occasion but can still eat and use the bathroom independently. He or she has trouble with less challenging arithmetic (counting backward from 40 by subtracting 4.)

Stage VI: Severe Cognitive Decline At this stage, the individual loses awareness of the surroundings and has difficulty remembering personal history. He or she has trouble remembering the name of his or her spouse and needs help with dressing. The person experiences major changes in sleep patterns (sleep during the day, restless at night) and needs help with all aspects of toileting. He or she has trouble controlling bowel and bladder and may have major personality changes such as delusions, compulsions, and repetitive behavior. The individual tends to wander and become lost (six out of 10 people with AD will wander and become lost).

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Stage VII: Very Severe Cognitive Decline An individual at this stage loses his or her ability to respond to the environment or to carry on a conversation. He or she needs help with ADLs (activities of daily living) and reflexes may be abnormal. Swallowing may be impaired, and the person may not be able to sit up without support or hold his or her head up.

TIPS FOR CAREGIVERS

The following are some tips that are recommended by the Alzheimer's Association:

- ✓ Keep a routine.
- ✓ Keep a calm, safe environment.
- ✓ Eliminate clutter, noise, glare, and excessive background noise.
- ✓ Develop soothing rituals with regular daily routines to include comforting objects, gentle music, and reassuring touch.
- ✓ Provide opportunity for exercises and satisfying activities geared to the person's abilities and interests.
- ✓ Monitor personal comfort. Ensure comfortable temperature, check for pain, hunger, thirst, constipation, full bladder, fatigue, and infection or skin irritation.
- ✓ Be sensitive to the person's frustration in not being able to express wants and needs.
- ✓ Do not argue or disagree; try to redirect attention.
- ✓ Simplify tasks and routines.
- ✓ Avoid open-ended questions; ask yes or no questions.
- ✓ Use labels to cue or remind the person.

■ ACTIVITY IMPLICATIONS

Activity and Recreation Professionals working in the gerontological field know that there is an ever increasing number of seniors with the diagnosis of Alzheimer's disease (AD) in our care centers. AD usually causes the individuals to display confused behaviors. The severity of the confused behaviors often can vary from day to day, making it challenging to provide meaningful and enjoyable leisure programs for them. To help all health care professionals provide therapeutic and comforting services, many federal regulations and guidelines have been created. The following excerpts are from the *Centers of Medicare and Medicaid State Operations Manual*, Appendix PP, Federal Tag #248. The first statement is from the Investigative Protocol section and is written in a procedural format to the surveyor. The second statement is from the Overview section which provides educational information about professional components that should be included in the recreational programs.

Adopting the person-appropriate philosophy with people with AD is imperative. This philosophy allows the Activity and Recreation Professionals to create leisure programs that focus on the individuals' remaining abilities and memories. Always ensure any materials or styles of conversation which may appear juvenile are documented within each person's medical records for their therapeutic and comforting effects.

In addition to individualizing the recreation and leisure programs to an individual's remaining abilities, creating a therapeutic schedule or routine of leisure programs is very important, as it gives the person with AD a sense of comfort by experiencing a familiar pattern of leisure programs each day. The following are the seven leisure domains to consider when creating a daily schedule of programs.

- **Educational** Programs promote cognitive thought processes in various formats and levels which focus on the individual's memory, recall, association, scanning, judgment, sequencing, and strategic thinking skills.
- **Physical** Programs promote exercise and movement which focus on the individual's overall strength, balance, endurance, range of motion, and/or motor skills.
- **Social** Programs promote social conversations, building of relationships, and enjoyable camaraderie in various group sizes and locations.
- **Recreational** Programs promote leisure pursuits that provide enjoyment usually associated with long-standing activities performed with friends and family (i.e., musicals, movies, table games, entertainment events).
- **Creative Expressive** Programs promote creative expressions in various media and venues which may enhance the individual's self-esteem, ability to communicate, and ability to accomplish tangible projects.
- **Life Skills** Programs promote opportunities of lifelong hobbies, clubs, or daily activities (cooking, gardening) which were previously performed by the individual and may enhance his or her sense of purpose, self-esteem, and meaning in life.
- **Spiritual** Programs promote engagement in religious services and/or practices of each person's preference.

PROGRAM CONSIDERATIONS

- ✓ Communicate with the entire medical team and the family members about the benefits of person-appropriate materials and conversation styles for an individual with AD.
- ✓ Even though some leisure programs may be simple in their format, always talk to the individual with AD in an adult and respectful way.
- ✓ Continuously evaluate if the program categories are interesting to the person and change the leisure programs, as needed.
- ✓ Continuously evaluate if the programs are easy enough for the individual to have successful engagement and challenging enough to respect his or her dignity. **CF**

Aphasia

Valerie J. Shereck, MSN, ANP-C, Barb Hartmann, CTRS, ADC

Aphasia is an impairment of language, which affects the ability to speak or comprehend speech, as well as the ability to read and write. It is always due to damage to the part of the brain that is responsible for language. For most people this area is on the left side of the brain or left hemisphere. Aphasia affects approximately 40% of people with strokes that involve the left hemisphere. The most common cause of aphasia is a stroke, particularly in older individuals. It can also be the result of head injury, brain tumor, infection, or dementia.

Aphasia affects the ability of an individual to communicate and can be quite devastating. Onset is usually sudden as with stroke or head injury, but can also be slow and insidious, as with dementia and brain tumors. Aphasia can be so severe that communication with an individual can be virtually impossible, or it can be very mild.

TYPES OF APHASIA

- ✗ Global - Both expression and comprehension are impaired.
- ✗ Expressive - Comprehension is better than expression.
- ✗ Receptive - Expression is better than comprehension.

Some authorities use the term mixed and global aphasia interchangeably. Global aphasia is the most severe form of aphasia and is applied to individuals who can produce few recognizable words and understand little to no spoken language. Individuals with global aphasia can neither read nor write. People with global aphasia may rapidly improve after initial brain damage occurs; however, if brain damage is severe, the disability may be permanent despite treatment.

Broca's aphasia, also called "non-fluent" aphasia, is a form of expressive aphasia. In this type of aphasia, speech output is severely reduced and limited, mainly to short utterances of fewer than four words. Vocabulary is limited and the formation of sounds by individuals with this type of aphasia is often very laborious and clumsy. Speech is characteristically slow, halting, and effortful. An individual with Broca's aphasia can understand speech relatively well and are able to read, but may be limited in his ability to write.

Wernicke's aphasia or fluent aphasia is a form of receptive aphasia. In this type of aphasia, the chief impairment is the individual's ability to grasp the meaning of the spoken word. A person with Wernicke's aphasia can easily produce and form words; however, his speech is far from normal. The sentences are often poorly constructed and include irrelevant words. In some cases, the speech is referred to as jargon. The individual often has severe deficits in both reading and writing abilities.

Another form of aphasia is anomia aphasia, in which the individual is unable to find the right words for what he wants to talk about; this is particularly true for nouns and verbs.

As a result, speech is fluent in grammar but the message is vague. The person understands speech well and is usually able to read without difficulty. Difficulty in word finding is also evident in his writing.

Aphasia may occur along with other disorders of speech. The most common of these disorders are apraxia and dysarthria. Apraxia is described as impairment in carrying out purposeful movements. A person with severe aphasia often explains himself by the use of pantomime or other gestures. These expressive gestures include waving good-bye, beckoning, saluting, or even brushing teeth. Apraxia greatly limits an individual with aphasia in his ability to compensate for his speech disorder. Dysarthria is a speech disorder that results from weakness, slowness or incoordination of speech mechanisms due to damage. It is a disorder of speech production and not language. This speech disorder is highly consistent. It can occur along with aphasia, but should be distinguished from it.

It is also important for caregivers and family not to confuse aphasia with dementia. Dementia is a condition of impairment of memory, intellect, personality, and insight. Individuals with aphasia may also have dementia, but it is a different disorder. Most individuals with aphasia do not have these other deficits and can become depressed and frustrated if they are treated as if they were demented.

Diagnosis of aphasia is made based upon signs and symptoms, physical exam, history, and neurological exam. A CT scan of the brain or MRI may be ordered. Sometimes, neuropsychological testing may be done.

TREATMENT

If brain damage is mild, an individual with aphasia may recover language skills without treatment. However, most individuals require speech and language therapy to rehabilitate their language and communication skills.

Recovery from aphasia, if it occurs, usually is the most pronounced during the first three months after brain injury. The goal of rehabilitation focuses on establishing the most effective communication for each individual. Recovery of language skills is usually a relatively slow process. Although many people make significant progress, few people are able to regain their former, pre-injury communication skills.

Speech and language therapy should start soon after the brain injury. The speech language therapist will utilize exercises to improve and practice communication skills. They may begin with simple tasks such as naming an object and then go on to more complex exercises such as explaining the purpose of an object. The therapist may also utilize gestures or drawings or use books with pictures and words. Group therapy is often used for individuals to try out their communication skills in a safe environment. ☞

HELPFUL HINTS

Because communication skills are impaired and recovery is often slow, the person, as well as family, friends, or caregivers, may become frustrated, stressed, and even angry. There are often local support groups that are available to people with aphasia.

People with Aphasia Should:

- ✓ Carry a card saying they have aphasia and what it is.
- ✓ Carry identification and information on how to contact significant others.
- ✓ Carry a pencil and small pad of paper at all times.
- ✓ Use drawing, diagrams, or photos to help with communication.
- ✓ Use gestures or point to objects.

Caregivers, Family, and Friends of People with Aphasia Should:

- ✓ Be patient at all times.
- ✓ Communicate through simple sentences but do not use baby talk.
- ✓ Ask questions that require only a yes or no answer.
- ✓ Don't finish sentences or correct errors.
- ✓ Avoid interrupting and allow the person to talk.
- ✓ Use gestures, pictures, or drawings.

■ ACTIVITY IMPLICATIONS

According to the American Speech-Language-Hearing Association (ASHA), aphasia is a disorder that results from damage to the parts of the brain that contain language.

A person with aphasia may have difficulty speaking, listening, reading, and writing. Persons with aphasia are challenged with expressing thoughts and feelings verbally or in writing, as well as understanding language communicated by others.

Aphasia can be mild or severe, depending upon the amount of damage to the brain. With severe aphasia, an individual may attempt to verbalize a simple sentence such as "*My wife, Helen, is coming to have lunch with me on Saturday.*" Instead, the sentence might come out as "*Uh . . . Helen . . . yeah . . . Saturday . . . food . . . uh me.*"

A person with aphasia has to deal with emotional instabilities including frustration, anger, and sadness due to a sudden change in the ability to communicate. In these cases, it may be necessary to seek a physician's advice for medication, therapy, or other interventions.

Signs and Symptoms of Aphasia Might Include

- ✓ Using short or incomplete sentences
- ✓ Using unrecognizable words
- ✓ Using nouns (person, place, or thing) more than other words

- ✓ Avoiding using verbs such as is, do, have (auxiliary) or the, a, an (articles), and pronouns such as he, she, we, them in sentences
- ✓ Beginning to misspell words
- ✓ Verbalizing or writing sentences that don't make sense
- ✓ Having difficulty comprehending another person's conversation

One of the misconceptions that people have about aphasia is that persons with aphasia suffer from dementia. Although a person with dementia may have aphasia, it does not mean that aphasia results in dementia.

It is very important for staff, volunteers, and families to know that aphasia affects the way information is accessed through the part of the brain that affects language. This is different than how language is comprehended.

ACTIVITY INTERVENTIONS

- Encourage music groups. Some people with aphasia are able to sing words easier than speaking them.
- Plan groups with humor to exercise vocal cords through laughter.
- The following are suggested communication interventions by speech and language therapists:

Expressive (Verbal response)

- ✓ Naming opposites in which the leader states a word and the resident repeats the opposite (i.e., up / down, in / out).
- ✓ Finishing the sentence (i.e., "I took the dog for a ____.")
- ✓ Question and answer (i.e., "Which is larger, a bush or a tree?")
- ✓ What is the function? (i.e., "What are you doing behind the steering wheel of a car?")

Receptive (Demonstrates an understanding)

- ✓ Using a basket and napkins, place napkins on, in, and beside the basket. Ask "Which napkin is inside the basket?" or "Which one is on top of the basket?"
- ✓ Show pictures from a catalog or magazine and ask questions such as "Which picture shows a hat?" or "Which picture shows a person who is happy?"
- ✓ Provide pictures of various fruits, vegetables, and sweets. Ask "Which one is a sweet food?", "Which one is a fruit?", and "Which one is a vegetable?"
- ✓ Encourage family and residents to work together to develop a booklet that includes helpful words, pictures or photos to assist with communication.

A team approach to providing care is needed for residents with aphasia. Social services may consider having a support group in which families and loved ones are provided education about aphasia. **CF**