

MORNING REPORT

AVOID THE PITFALLS OF AGE-BASED PRECONCEPTIONS: SUICIDE ATTEMPT IN A NONAGENARIAN

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A 92-year-old Caucasian woman is a resident in a continuing care retirement community and was transferred to the nursing home section after acute hospitalization for recurrent right-sided malignant pleural effusion for which she had a tunnel pleural catheter inserted. Prior to this, she was in the independent living section and was independent of all basic and instrumental activities of daily living. She is now deconditioned, requires a rollator walker for walking around the facility, and needs some assistance with bathing. She also has a complex medical history of non-Hodgkin's lymphoma, bronchiectasis, chronic obstructive pulmonary disease, atrial fibrillation, and coronary artery disease and is being assessed by her geriatrician/primary care physician on nursing home rounds. Medications include: diltiazem, ipratropium/albuterol nebulizer, apixaban, loratadine, furosemide, salmeterol diskus inhaler. She reports severe acute low back pain over the last 24 hours, radiating to right groin. No recent falls reported. Vital signs: BP-134/65; Pulse: 95/min; Respiratory rate: 16/min; Temp: 98F; Pulse oximetry: 95% on RA. Physical examination normal except for mild tenderness on palpation of right buttock/hip region.

In an older postmenopausal woman with acute onset low back pain, some of the possible differential diagnoses include: vertebral compression fracture with or without a preceding fall or degenerative joint disease of spine. With the history of non-Hodgkin's lymphoma and malignant pleural effusion, one must also think of possible bony metastases.

She had work up with her oncologist which included the following: CT Abdomen/pelvis notable for 'persistently enlarging multiple ill-defined hypodense hepatic lesions concerning for lymphoma involvement versus metastatic disease from another primary malignancy. PET scan revealed lymph nodes suspicious for lymphomatous involvement in head, neck and hepatic regions. There was interval loss of disc space and para-disc osteolysis at L3-4

with significant FDG uptake concerning for infective spondylitis.

After extensive discussion with the patient, her family and physician care team (oncologist, pulmonologist, palliative care physician, and geriatrician/primary care physician), the patient opts for comfort measures and no invasive treatments. She is commenced on a pain regimen of oxycodone extended release and immediate release and this is titrated to moderate effect. Her family encouraged continued active interventions, but were ultimately advised on the poor prognosis, and therefore comfort measures, in keeping with the patient's wishes. She became progressively weaker over the next several weeks, developed loss of appetite and unable to take her usual walks around the nursing unit.

One morning, her nurse found her to be very somnolent during routine rounds. Vital signs: BP: 153/73, Pulse: 102/min; Respiratory rate: 19/min; Temp: 97.8F. Her primary care physician had seen her the day before and she was at her baseline cognitive function with good pain control on the oxycodone regimen. At that time, she had also declined all oral foods and many of her medications including oxycodone, stating that she hoped "she would pass away in her sleep."

With the new somnolence or change in mental status in this older woman with advanced lymphoma, one could easily assume that this is due to her overall functional decline and debility or a sign of metastatic brain involvement. Other possibilities to consider would be adverse effect of her narcotic regimen, though her regimen had not been adjusted in several weeks and she had been tolerating this well previously. Delirium due to an infective process such pneumonia, urinary tract infection or bacteremia secondary to infective spondylitis would also be reasonable differential diagnoses.

As she is being assessed, her nurse finds an empty prescription bottle of hydrocodone/acetaminophen on her

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bedside table. Of note, it is unknown where she got the prescription from as this was not one of her prior or current prescribed medications. Also, the nursing home section, like most nursing home facilities has nurses administering all medications and does not allow medication self-administration by patients. She admits to taking about 10-20 pills the previous night, in the hopes of ending her life quickly as her current situation is “no way to live.” She was transferred by EMS to the hospital emergency department and was found to have features of acetaminophen toxicity (level: 42µg/mL normal: 10 -20), new elevations in liver enzymes with AST: 91 U/L (normal: <35) and ALT; 45 U/L (normal: <55). She was treated with N-acetylcysteine nebulizer solution and promptly discharged back to the nursing facility in accordance with her goals of care for comfort measures only. Hospice services were initiated. Her pain regimen was adjusted to symptom control and she died peacefully about a week later surrounded by her family at her bedside.

Discussion

While suicidal attempts tend to be more prevalent in young adults, suicides disproportionately affect older adults with the highest suicide rates in white men 65 years and older.^{1,2} In spite of this, there is a paucity of data in the literature concerning suicides and suicide attempts in older adults, particularly the oldest old (85 years and above) and those in long term care facilities. As a result and due to other multifactorial reasons, suicide ideation/attempts are not usually the first consideration when assessing the oldest old in long term care facilities, who also tend to have a high chronic disease burden with co-existing cognitive and functional deficits.

In recent studies of older adults with suicidal ideations or self-harm, risk factors identified include: chronic pain, multiple comorbidities, presence of depression/anxiety, cognitive impairment, social isolation, history of previous suicide attempt, alcohol/drug use and functional decline with admission/transition to long-term care settings.¹⁻⁴ Patients with cancer are found to have four times the risk of suicide compared to the general population, with cancers of the head/neck, testes, bladder and hodgkin’s lymphoma having the highest suicide rates.⁵

Our patient has some of the above risk factors, such as the presence of multiple comorbidities, cancer, chronic pain, functional loss, loss of autonomy and recent admission to the nursing home section of a continuing care retirement community. Yet, she is atypical in other ways. In particular, her advanced age (over 90 years), no prior suicide attempt, no prior diagnosis of depression, and the presence of good family support, though her family was not initially in complete agreement with her expressed goals and preference of medical care. In addition, suicide attempts in long-term care facilities with drug overdose is of one of the least utilized methods in this setting.⁶ This is likely as a result of supervision by the health team and specific facility regulations which prevent self-administration of medications. The more commonly reported suicide methods in long term care settings include: fall from a long height, hanging or cutting.⁶ This clinical case illustrates the importance of physicians and the whole health team in carefully assessing older adults for signs of suicidal ideation, particularly those with the above risk factors. It is equally important to recognize that some of the signs may be subtle

and atypical. This also reinforces the need to support further measures and research that address mental health issues in this subset of older patients.

References

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