eConsult Sample Cases from Long-Term Care

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Endocrinology

Provider Question

[Elderly patient] now residing in long term care due to progressive dementia. Hx of vertebral fracture and hip fracture while taking [medication 1]. Continues to ambulate independently with a 4ww and likely at high risk for future fall and potential fracture. [PCP gives CrCl reading]. [Patient] is unable to tolerate swallowing pills whole. LTC guidelines from 2015 suggest [medication 2] may be beneficial for fracture prevention. Transfers for outpatient appointments have become increasingly challenging due to frailty. Could you recommend which treatment might be best in this frail ambulating [patient]?

Specialist Response

Thanks for the eConsult. The history of fragility fractures puts this patient in the severe osteoporosis category. If [patient] has no history of radiation, malignancy in the bone, hyperparathyroidism or hypercalcemia, then [medication 3] could be a treatment option. This is the only medication we have approved for osteoporosis therapy that targets osteoblastic activity to build new bone. It is expensive though (about $1000/month for up to 2 years) and it is not covered by Ontario Drug Benefit. It is administered SC on a daily basis. A simpler and cheaper treatment option would be [medication 2], and it should still offer significant benefit in terms of fracture protection. [Specialist gives suggested dose.] In this patient's case, the cost of [medication 2] should be covered [by ODB].

Dermatology

Provider Question

[Elderly patient] w/ hx of dementia and [PCP lists other chronic conditions], wheelchair bound requiring lift transfer residing in LTC w/ hx of [skin conditions]. Patient and family describe history of the attached image skin lesion noted centrally on low-back progressively accumulating scaly-type keratotic material over last 4 months. [PCP provides picture and detailed description of lesion, suggests Bowen's as possibility]. This patient is very frail and arranging transfer for further assessment or procedure would be quite challenging. If any in-home treatments could be considered as a first step, the patient and family would surely appreciate this option. Your assessment and recommendations are truly appreciated. Thank you!

Specialist Response

The raised portion of this lesion has a "cutaneous horn" appearance. I agree with you that Bowen's Disease (Squamous Cell Carcinoma in-situ) is a possibility. A skin biopsy would provide a histological Dx re. Bowen's or a Squamous Cell carcinoma no longer in-situ. However if a biopsy is problematic in this setting, I suggest the following: The lesion is too large and raised for cryotherapy; try [medication 1] for 3 weeks. This will cause a brisk inflammatory reaction if the lesion is Bowen's disease. This may be painful and the treatment may have to be stopped after 2 weeks. Then treat the area with [medication 2] to decrease the inflammation.

Rheumatology

Provider Question

[Elderly patient] w/ moderate to severe dementia and [PCP lists other chronic conditions] now residing in long term care. Family report pt was dx w/ PMR approx 4-5 years ago when unable to climb stairs. Pt was last seen in rheumatology f/u 3 years ago when [medication 1] had been tapered to [value] daily. Pt has remained on same dose since. Family report no recurrence of PMR since original diagnosis. Oral [medication 2] treatment has been limited by poor renal function [PCP gives CrCl reading]. Recent b/w showed ESR normal and CRP sl. elevated [PCP gives values]; however previous values are not available for comparison. Firstly, could a slow [medication 1] taper be initiated in this pt in an effort reduce overall # risk as pt remains ambulatory and high fall risk? Should b/w be monitored for signs of inflammation if this is pursued? How slowly should [patient] be tapered from [value]? Secondly, should we consider [medication 3] in this pt given high # risk and poor renal function? Your insights are greatly appreciated. Thank you.

Specialist Response

Good evening and thank you for your eConsult: If this patient has been stable with no symptoms suggestive of recurrent PMR then I would definitely be in favour of decreasing [medication 1] slowly. I would probably bring it down by 1 mg/day every couple of months as [patient] has been on it for so long. I would monitor it with ESR, CRP every couple of months and clinical status. [Medication 3] would be a very reasonable consideration, as [patient] is at very high risk for future fractures. Make sure [patient] is getting lots of calcium and vitamin D and that vitamin D level is in the normal range.