Care of the Aging Medical Patient in the Emergency Room (CampER) Curriculum
Audience Response Questions

These questions are included in the slide presentations as pre-lecture items to assess pre-lecture knowledge. You may use them as audience response questions or as test items. They are included as a separate module document for your ease of review.

Lecture Topic: Special Considerations in Drug Prescribing in the Elderly

1. Mr. AB is a 70 y/o white male who was brought to the ER with history of confusion, lethargy, and no urine output for 1-2 days. On examination, he was found to have dry mouth, lower abdominal pain, and distended urinary bladder. After insertion of a Foley catheter, patient had a urine output of 1800 cc. Patient had no problem before with his urination. He has no fever, no SOB, no meningeal signs. On laboratory evaluation, CBC, BMP, and UA were within normal range. He has DM2 for the last 15 years, which has been fairly well controlled with Metformin 850 mg PO BID and Glipizide ER 10 mg PO QD. He is also on Zocor 80 mg PO QHS for high cholesterol, ASA 81 mg PO QD for CAD chemoprophylaxis, and Amitriptyline 100 mg PO QHS for his lower extremity neuropathic pain. Last week, patient developed some stomach discomfort and, on the advice of his wife, he started taking Cimetidine (Tagamet) 400 mg PO BID, which they had in their medicine cabinet. Which of the following is responsible for the current problem in this patient?
   a. Metformin
   b. Glipizide
   c. Zocor
   d. Amitriptyline
   e. Cimetidine

Answer: D

2. Mr. KK is a frail, 80 y/o man who has been sent to ER from a nursing home with H/O confusion, N/V and palpitations. His condition was stable in the NH until 3-4 days ago, when he developed a cough, for which he was started on erythromycin 500 mg PO BID for 7 days. He has past medical history of CAD, CHF, HTN and ambulatory dysfunction. He is on Lisinopril 10 mg PO QD; Lopressor 50g PO BID; Lasix 40 mg PO BID; Digoxin 0.125 mg PO; Erythromycin 500 mg PO BID; KCl 40 meq PO QD; MV PO QD; ASA 81 mg PO QD. Labs and EKG:

   \[
   \begin{array}{ccc|c|c|c}
   145 & 111 & 37 & 112 & \text{dig: 3.5} \\
   6.5 & 25 & 2 & \text{Ca: 9} \\
   \end{array}
   \]

   \[
   \begin{array}{ccc}
   9 & 10 & 219 \\
   20.9 \\
   \end{array}
   \]

   ![EKG Image]
You may do all of the following, except:
   a.  Slowly infuse calcium chloride
   b.  Give patient Digibind IV
   c.  Give glucose with regular insulin IV
   d.  Give 15 g of Kayexalate PO
   e.  Give Glucagon 2 mg IV

Answer: A

3.  J.K. is a 70 year old Caucasian female who presents to the ED with chief complaint of progressive SOB.  She has a history of HPT, CAD, CHF and high cholesterol currently under the treatment of a cardiologist.  Her condition has been stable for past 6 months except for treatment of low back pain by her family physician during last 6 weeks. Her meds include Lisinopril 10 mg; Coreg 12.5 mg BID; Lasix 40 mg daily; KCL 20 meq once daily; ASA 81 mg daily; Zocor 40 mg once daily; Motrin 400 mg TID.  On PE, vital signs: afebrile, BP 188/105; RR 24; HR 105; O2 sat 92 % on room air, +NVD, Heart-rrr, soft S3, Lungs- bibasilar rales, 2+ leg edema.  Labs: Na 141; CL 91; K 3.8; CO2 29; BUN 55; CR 2.2; Glu 111; CK 100; troponin .02; WBC’s 8,033 with 70% segs; Hb 11.8; Plts 180,000.  EKG sinus tach, NSST T changes.  What is the MOST likely cause of this patient’s signs and symptoms?
   a.  Acute tubular necrosis from Prinivil (lisinopril)
   b.  Motrin(ibuprofen)
   c.  Lasix (furosemide) tachyphylaxis
   d.  Salicylate-induced renal tubular acidosis Type IV
   e.  Zocor (simvastatin)-induced rhabdomyolysis

Answer: B