Managing Pressure Ulcers: Practical Guidelines

By David R. Thomas, M.D.

Managing pressure ulcers is often frustrating for clinicians. First, there has been a lack of consensus about the best treatment options. For example, among 85 specific recommendations published by the Agency for Healthcare Policy & Research, only four level A recommendations (two or more randomized controlled clinical trials) and ten level B recommendations (two or more controlled trials in humans or animals) were made. Second, pressure ulcers are difficult to heal. As few as 13% of pressure ulcers heal by two weeks in acute hospital settings. Healing rates at six months for Stage III pressure ulcers may be as high as 59%, but other patients require a treatment duration of up to one year. Only one-third of Stage IV pressure ulcers heal after six months of therapy.

A careful treatment approach depends on a stepwise clinical plan.

**Assessment**

**Co-morbidity:** The first step in ulcer management begins with an evaluation of the general status of the patient. The presence of co-morbid conditions, such as diabetes, peripheral vascular disease, congestive heart failure, or limitations to mobility, require adjustments to the treatment plan. Risk for development of pressure ulcers can be predicted by co-morbidity or by using a formal instrument such as the Braden or Norton scale.

**Nutritional assessment:** Malnutrition is not good for anyone. Dietary protein appears to be especially important in healing pressure ulcers. Pressure ulcers have shown a greater rate of healing with an enteral feeding contain-

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Stage I - Non-blanchable erythema of intact skin.
Stage II - Superficial, presents as an abrasion, blister or shallow crater.
Stage III - Full thickness skin loss involving damage or necroses of subcutaneous tissue.
Stage IV - Full-thickness wounds with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures.

ing 24% protein compared to 14% protein. However, changes in body weight or in biochemical parameters of nutritional status did not occur between groups. In twelve enterally-fed patients receiving a formula containing either 17% or 25% of calories as protein, the group that received higher protein had greater improvement. Those ingesting 1.8 g/kg of protein had a 73% improvement in pressure ulcer surface area compared to a 42% improvement in surface area in the group receiving 1.2 g/kg of protein. Optimum dietary protein intake in patients with pressure ulcers is unknown, but may be much higher than current adult recommendations of 0.8 g/kg/day. A reasonable protein requirement is therefore between 1.25-1.50 g/kg/day.

The deficiency of several vitamins has significant effects on wound healing, but it is difficult to demonstrate a relationship between vitamin malnutrition and clinical outcome. In patients at risk for development of pressure ulcers, the calculated intake of vitamins C and A, zinc or iron did not predict ulcer development. High doses of vitamin C have not been shown to accelerate wound healing. Zinc supplementation has not been shown to accelerate healing except in zinc deficient patients. High serum zinc levels interfere with healing and supplementation above 150 mg/day may interfere with copper metabolism. When documented or suspected vitamin and mineral deficiencies exist, supplementation may be indicated.

Pain assessment: Except in neurologically impaired patients, chronic ulcers are painful. Each patient should be assessed for pain control and oral or parenteral pain medications should be used to control symptoms.

Wound assessment: The location, size, presence of necrosis or exudate, and the degree of granulation tissue and epithelization affect treatment decisions. A clinical staging protocol should be used. The most common staging protocol, recommended by the National Pressure Ulcer Advisory Panel and used in OBRA nursing home guidelines, derives from a modification of the Shea Scale. Under this schematic, pressure ulcers are divided into four clinical stages.

A Stage I pressure ulcer is defined by non-blanchable erythema of intact skin. The first response of the epidermis to pressure is hyperemia. Blanchable erythema occurs when capillary refilling occurs after gentle pressure is applied to the area. Non-blanchable erythema exists when pressure of a finger in the reddened area does not produce blanching or capillary re-filling. Non-blanchable erythema is believed to indicate extravasation of blood from the capillaries. Diagnosing Stage I pressure ulcers in darkly pigmented skin is problematic. In persons with darker skin, discoloration, warmth, edema, or induration may indicate a Stage I pressure ulcer. Stage II ulcers involve the epidermis or dermis. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater. Stage III pressure ulcers show full thickness skin loss involving damage or necroses of subcutaneous tissue that may extend down to, but not through, underlying fascia. Stage IV pressure ulcers are full-thickness wounds with extensive destruction, tissue necrosis or damage to muscle, bone, or supporting structures. Undermining and sinus tracts may be associated with Stage IV pressure ulcers. No ulcer covered by eschar can be accurately staged until the eschar is removed.

Healing of pressure ulcers occurs by contraction and scar tissue formation. The original architecture of the skin is not replaced as the (continued on page 19)
Pain Management in the GRECC

by Nina Tumosa, Ph.D.

Our pain assessment tool is given to every patient who comes to the GRECC clinic at the VA hospital in St. Louis. The accompanying poem explains why each of these specific questions is asked.

A pain in the GRECC
Is a serious thing
We’ve developed a tool
Where the patient is King.

Are they experiencing pain
And if so, how severe?
Is it mild on the main
Or does it bring them to tears?

The faces are large
And easy to see.
They were developed for kids
Who were unable to read.

They work well for elders.
How can that be?
No need for the glasses
They just sat on, you see.

Are they sad or unhappy?
Or perhaps they are blue?
A yes or a no
As an answer will do.

If yes, then the reason
The doc must pursue.
If no, then on to the
Next question in queue.

How are they feeling?
What’s the level of despair?
Is life excellent, very good,
Good, poor, or merely fair?

What quality of health?
What quality of life?
Do they feel good about things?
Do they have any strife?

Asking these questions
Is part of a plan.
Armed with the answers
Then HELP THEM WE CAN!

We talk over problems.
We check out the pain.
We decide on some changes.
We work as a team.

Patient and doctor
Working together again.
Can you think of a better way
To help relieve pain?

Our pain assessment tool is given to every patient who comes to the GRECC clinic at the VA hospital in St. Louis. The accompanying poem explains why each of these specific questions is asked.

IF YOU HAVE PAIN OR ARE SAD,
TELL YOUR HEALTH PROVIDER.
THEY CAN HELP YOU.
ACROSS
1. Taste buds are this kind of receptor.
5. Hearing loss of greater than 91 decibels is ___.
9. A primary taste sensation.
10. Refers to balance.
11. People with no sense of smell often suffer from this (2 wds).
13. Pain receptor.
14. This type of age-related maculopathy results in most cases of legal blindness.
16. Salivary gland disorders are often ___.
19. A hearing aid can be either a standard analog or digitally ___.
22. This type of hearing loss is associated with mechanical blockage of the ear.
23. Decreased salivary gland output with age results in oral dryness or ___.
26. Refers to taste.
27. Decreased ability to taste.
30. A persistent bad taste which may be associated with poorly fitting dentures.
31. A fifth primary taste sensation may be ___.
32. Inability to smell.
34. A primary taste sensation.
35. The four best known primary scents humans can detect are putrid, floral, peppermint, and ___.
36. Hearing aids ___ conversational speech.

DOWN
2. Somatic sense receptors located on the body surface.
3. The first human sense to decline with age.
4. Receptor found only in the eye.
6. This type of glaucoma is the only type that constitutes a medical emergency (2 wds).
7. Licensed professionals who prescribe hearing aids.
8. Taste in the elderly often declines due to ___.
12. Normal, age-related losses in hearing.
15. Side effect that makes aminoglycoside antibiotics bad for elders with hearing loss.
17. Obstruction of the external ear canal often results from accumulation of ___.
18. The one area of the body incapable of experiencing pain.
20. Common geriatric complaint induced by backward head flexion.
21. Elders commonly use this method during conversation to compensate for hearing loss (2 wds).
24. A common form of noise protection is a custom fitted ___ (2 wds).
25. Over 250 of these are known to alter taste.
28. Refers to the sense of smell.
29. A primary taste sensation.
33. A primary taste sensation.
Conundrums: Part III:  
The Ethical Issues Surrounding the “Good” Death

This is the third in a series of essays discussing ethical conundrums of old age by Dr. John E. Morley. The first discussed the right to autonomy and the second discussed the rights of the individual versus the rights of the state. In this final essay, he discusses euthanasia. His essays are deliberately controversial in an effort to solicit letters of both support and disagreement from our readers. We look forward to hearing from you.

The “Good” Death…..

“Enlightenment of a wave is the moment the wave realizes that it is water. At that moment all fear of death disappears.”

In the United States we have industrialized death. Death, mostly violent, is brought into our homes on a daily basis. Slowly we become numbed, treating human death like that of the death of a comic strip character. In many cases burial of the dead has become an event rather than a spiritual good-bye. Scientifically, Kubler-Ross has given us her stages of dying, producing a clinically sterile approach to dying, divorcing it from the individual and spirituality. Technology has allowed us to postpone death for hours, days, or months while suspending living.

While studies show over half of older persons would prefer not to enter an ICU, rarely is their opinion sought. The SUPPORT study has demonstrated that older persons’ advanced directives are rarely documented and even more rarely adhered to. The modern hospice has become as much a fiscal machine as a bridge to the future.

Our obsession with death is demonstrated by the continued best-selling status of “Tuesday’s with Morre.” In this book, Morre, the old teacher, “walks the final trip between life and death and narrates the trip” to Mitch. Morre’s greatest lesson perhaps is that “the truth is once you learn how to die you learn how to live.” This sentiment is perhaps nowhere better captured than by the daily greeting of a Dakota warrior: “It’s a great day to die.” a greeting that exhorts one to live everyday to its full potential. In the sacred text of the Sikh tradition, Guru Granth Sahib, this thought is embodied in the following: “The privilege of life in human form is great and death is the price we pay for the gift of the body.” For death to reach its full meaning, it needs to be seen as a spiritual moving on while leaving life’s baggage behind. As Buddha said, “You don’t need to carry the raft after you’ve already crossed the river.” The concept of death as being an ongoing journey of spiritual growth has been best described by Kathleen Dowling Singh in her book, “The Grace in Dying.” Walt Whitman encapsulates the concept: “Who needs to be afraid of the merge?”

Thus the conundrums of death and interpretation of its meaning are legion and dependent upon which of these interpretations we choose to follow. This will determine our ethical approach to death.

Within modern times the most difficult ethical issue surrounding death is euthanasia. The word is derived from the Greek eu = good and thanatos = death. In general, most modern ethicists have accepted withholding and withdrawal of treatments such as ventilation and the delivery of food and water by artificial means as being acceptable, though such behavior is still prescribed by some religious beliefs – in these cases withdrawal is usually considered more unacceptable than withholding. Mainstream ethics, on the other hand, tends to see both acts as equally acceptable. Many, but not all, ethicists would find giving doses of painkillers sufficient to relieve pain but hasten the time of death as reasonable.

Logic based on our present state of ethical and legal practices would suggest that active killing to prevent terminal suffering would be equally acceptable. Christine Cassel has argued, in fact, that arguments against active euthanasia may appear duplicitous and self-serving. Certainly a society who almost weekly hears “Dead Men Walking” can hardly argue that taking a life is amoral. Against these beliefs are the arguments of St. Augustine and subsequent Catholic ethicists that the sixth commandment “Thou shalt not kill” prevents hu-
mans from removing God’s right to decide when the gift of life should be terminated. Other religious philosophers such as Thomas More in *Utopia* and Martin Luther did not agree. The 1980 Declaration on Euthanasia of the Roman Catholic Church stated that euthanasia is against the law of God.

The euthanasia debate entered the circus arena with the advent of Dr. Kevorkian. To publicize euthanasia this pathologist seems to put little effort into determining whether suffering could be appropriately treated but offered assisted suicide seemingly to all comers. His motives would at the least seem questionable as he has brazenly attempted to carve his place in history. His performance needs to be juxtaposed against that of other more rational physicians such as Timothy Quill.

Ethical arguments against euthanasia become more compelling when seen in a societal perspective. Not only may a person’s religion forbid euthanasia, but society needs to continuously consider the ‘slippery slope’ hypothesis. Our society is extremely heterogeneous. If euthanasia were legalized, could those with dementia, anencephaly or AIDS become part of the modern “killing fields?” The answer is, unfortunately, most probably yes. One needs to look no further than the genocidal disintegration of the Balkans or the title of Phillip Goarevitch’s book on Rwanda, “We Wish to Inform You That Tomorrow We Will Be Killed With Our Families” to recognize the depths of human’s inhumanity to human. The vulnerable and socioeconomically challenged could become more vulnerable. In the Netherlands, 0.8% of all deaths annually are associated with physicians prescribing, supplying, or administering a drug with the explicit purpose of hastening the end of life without an explicit request by the patient. Only 43% of all euthanasia deaths had euthanasia recorded as the cause of death. To me, it is the ‘slippery slope’ argument that most persuades against legalizing euthanasia.

Perceptions, not reality, drive societal beliefs. Finally, it is the first killing that is hard; the more we undertake, the easier it is and the sanctity of life will soon no longer be a societal belief.

Jane Kenyon in “Let the Evening Come” argued for the triumph of natural death.

“Let it come as it will and don’t be afraid. God does not leave us comfortless, so let the evening come.”

This is a modern echo of the twenty-third Psalm:

“The Lord is my Shepherd I shall not want
Though I walk through the Valley of the shadow of death I shall fear no evil.”

In conclusion, aging presents us with multiple ethical conundrums. In most cases, the answers are not black or white. Our own ethical beliefs concerning elders are often shaped by our experiences and our age. To conclude, I would like to share with you an anonymous poem apocryphally found in a room of a nursing home resident after her death, which encapsulates not only the worth of the elder, but also the difficulty younger persons have in seeing who “the elderly” really are:

*When will my doctor kill me?*

(continued on next page)
What do you see nurses?
What do you see?
What are you thinking when you are looking at me?
A crabby old woman, not very wise
Uncertain of habit, faraway eyes.
Who dribbles her food and makes no reply
When you say in a loud voice, “I do wish you’d try.”
Who seems not to notice the things that you do
And forever is losing a stocking or a shoe.
Who unresisting or not lets you do as you will
When bathing and feeding the long day to fill.
Is that what you are thinking,?
Is that what you see?
Then open your eyes, nurse.
You are not looking at me.
I’ll tell you who I am, as I sit here so still.
As I use at your bidding, as I eat at your will.
I’m a small child of ten, with a father and mother,
Brothers and sisters who love one another.
A young girl of sixteen, with wings on her feet
Dreaming that soon now a lover she’ll meet.
A bride soon at twenty, my heart gives a leap
Remembering the vows that I promised to keep.
At twenty-five now, I have young of my own
Who need me to build a secure happy home.

A woman of thirty, my young now grow fast
Bound to each other with ties that should last.
At forty, my young sons now grow and will be gone
But my man stays beside me to see I don’t mourn.
At fifty, once more babies play round my knee.
Again we know children, my loved ones and me.
Dark days are upon me.
My husband is dead.
I look at the future.
I shudder with dread.
For my young are all busy, rearing young of their own.
And I think of the years and the love that I’ve known.
I’m an old woman now and nature is cruel.
It’s her jest to make old age look like a fool.
The body – it crumbles.
Grace and vigor depart.
There is now a stone, where I once had a heart.
But inside this old carcass, a young girl still dwells
And now and again, my battered heart swells.
I remember the joys.
I remember the pain.
And I’m loving and living life all over again.
I think of the years, all too few – gone too fast
And accept the stark fact that nothing can last.
So open your eyes, nurse.
Open and see,
Not a crabby old woman.
Look closer. See me.

- Anonymous

New Video Available
The ACE Unit at Saint Louis University Hospital: Interdisciplinary Team Meeting

For many older persons suffering from an acute illness, hospitalization can have devastating effects, especially loss of function. This loss of function is associated with longer hospital stays, nursing home placement, even an increased mortality rate.

ACE (Acute Care for the Elderly) Units can prevent this functional loss while treating the acute illness. One of the keys to success of an ACE Unit is the daily interdisciplinary team meeting.

This video will show the viewer specific techniques to successfully run a team meeting which is focused and efficient on a daily basis.

To order this video, please send $29.95 + $5.00 shipping/handling to SLUHSC, 1402 S. Grand, Room M238, St. Louis, MO 63104
Ten Years of Excellence in Geriatric Education

We celebrated our Tenth Anniversary among friends this past June. Four hundred participants came to the 1999 Summer Institute from 17 states and Australia. Here are some highlights from the plenary sessions presented at the conference. Seventy-nine workshops also were available for participants to enjoy. We hope this inspires you to join us for our next annual Summer Geriatric Institute on June 14-16, 2000.

Dr. Jeanie Kayser-Jones of the University of California at San Francisco, kicked off the Institute by describing her anthropological studies on eating in the nursing home. In the nursing home she studied, 82% of their patients were malnourished by body mass index. She found that when a resident develops dysphagia and is put on a pureed diet, weight loss occurs even when caloric supplements are given. Her graphic description of a pureed oatmeal cookie left no one wondering why this should occur. Many residents were poorly positioned, making it difficult for them to eat without aspirating. Her studies did demonstrate that family member involvement at mealtime often stops weight loss.

George Grossberg, MD, of Saint Louis University pointed out that studies on preventing Alzheimer’s disease are critical because persons with mild cognitive impairment often go on to develop Alzheimer’s disease.

Several drugs are being extensively studied to determine if they delay onset of this disease. The monoamine oxidase inhibitors, deprenyl and lozambemide, have produced some positive preliminary results. Epidemiological studies have suggested estrogen may protect against Alzheimer’s disease. Non-steroidal anti-inflammatory agents have also been shown in the Baltimore Longitudinal Aging Study to be associated with less dementia. Gingko biloba requires better studies before it can enter mainstream medicine, but many persons are nevertheless using it. The future for Alzheimer’s prevention is very bright indeed.

Marie Bernard, MD, from the University of Oklahoma talked about the development of Departments of Geriatrics and their importance in providing adequate education for medical students in gerontology, highlighting senior mentors programs for medical students. She also discussed the educational opportunities in gerontology offered by AGHE (the Association for Gerontology in Higher Education), a national organization with over 300 institutions as members. AGHE has recently developed a program of merit to allow schools with high quality gerontology programs to be recognized.

Dr. Kathleen Dowling-Singh discussed the importance of having grace at the time of death. She pointed out that dying was the most profound experience in the journey of life, one rich in spiritual opportunities. She said that the process of dying was an “egoectomy” during which the person who dies relaxed has the opportunity to move their awareness beyond ego. She paraphrased
the Buddha, pointing out that enlightenment is like a wave and when a wave realizes it is water, it no longer fears death.

Judith Salerno, MD, from the Office of Geriatrics and Extended Care in the Veteran’s Administration pointed out that 36% of veterans are over 65 years of age compared to 13% of the American population. She briefly summarized the enormous impact that the VA has had on the development of geriatrics and gerontology in the United States. She then highlighted two new major initiatives within the VA. One is to improve end of life care and the other is a focus on pain as the fifth vital sign. Once again, the VA is leading the nation in increasing awareness of the needs of older persons.

Stephen Zang, MD, completed the morning by presenting a technological extravaganza on the management of agitation in the elderly. His take-home points were (1) minimize the disruptive environment, (2) provide optimum reorientation, (3) consider special programs such as the Eden Alternative, (4) avoid anticholinergic drugs such as digoxin, theophylline, cimetidine, ranitidine, and diphenhydramine, and (5) make appropriate use of atypical antipsychotics such as resperidol and olanzapine when behavioral management fails.

Florence Clark, PhD, OTR, FAOTA, of the University of California reported on a multicultural study with well elderly living independently in the community. This landmark study (published in JAMA, November 1997) determined that preventive occupational therapy greatly enhances the health and quality of life of independent living older adults. “Occupational lifestyle redesign,” which works to develop individualized activities that are meaningful and important to the older adult, allowed participants individualized intervention to either maintain or improve their health related quality of life and life satisfaction. Following is a comment from one of the Well Elderly Group participants, Andrew Chu: “Before, I thought to retire meant waiting to die. Now, I don’t think so! I’d like to work if I can; I want to learn.”

David R. Thomas, MD, from Saint Louis University, presented a comprehensive review of dementia, including epidemiological factors, clinical groups, and differential diagnoses. He stressed that dementia is a multifactorial decline from a previously attained intellectual function. Evaluation of dementia should include cognitive function testing including mental status tests, screening via standardized questionnaires, and comprehensive assessment of the patient’s cognitive function skills. He also recommended the use of CT head scans, a trial discontinuation of all possible drugs, and formal neuropsychological testing when the diagnosis is in doubt, the findings are equivocal, depressions cannot be excluded, or when brain injury is suspected.

Gerard Magill, PhD, of Saint Louis University, presented an analysis of the ethical issues surrounding intergenerational responsibility in health care. Society has promoted life extension and the resistance of death, while medicine’s recent goals for the elderly have included cost containment resulting in variable quality of life for older adults. Dr. Magill stated that in order to achieve intergenerational equity in the management of scarce resources, reforms need to be implemented.

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A Lesson From Childhood

By Thomas Edes, M.D., Columbia, Missouri

He was still feeling chilly.

Huddled quietly beneath all those blankets, his lanky form almost disappeared in the wrinkles. The wry face and raspy voice told part of the story; the artificial leg propped against the bed told the rest.

He was weak, he was worn, he needed something. From deep in his soul, instinct told him that medicine alone was not enough.

“I know what I need, Doc. But I won’t ask you for it.”

I waited, but he said no more. It was my turn.

“What can I get you, Mr. Light? I’d sure like to help.”

“Well Doc, I need an old squirrel.”

I looked a bit puzzled. He went on.

“When I was a boy, we were caring for an old woman. She got pneumonia. She was very weak and wouldn’t eat. My mother told me to go out and get an old squirrel. They got the energy, you know. So I took my dog, and my shotgun, and my chopping ax. I was lucky – I got an old squirrel. My mother boiled it. The woman wouldn’t eat, but she drank that broth. Pretty soon she got to feeling better. She got stronger. Those squirrels, they got the energy, you know. If they just get one hand on, they can hold on and make it. That’s what I need, Doc.”

A tear rolled out of the corner of his eye. His jaw quivered. We both smiled as I gave him a hug.

“That’s a true story, Doc.”

“It sure is, Mr. Light,” I whispered. “It sure is.”

John Morley Awarded the IPSEN Foundation Longevity Prize

The Ipsen Foundation Longevity Prize, created in 1996, is one of the most prestigious European awards for research in gerontology. This 100,000 FF prize is awarded yearly to a researcher – biologist, geneticist, gerontologist, psychologist, demographer, or statistician – in recognition of an outstanding contribution to the field of longevity. The first three awardees were Cabel Finch (Los Angeles, USA), Vaino Kannisto (Finland), and Roy Walford (Los Angeles, USA). The award ceremony honoring this year’s recipient, John E. Morley of Saint Louis University will be held in Paris in October 1999. Congratulations, Dr. Morley!

M. Louay Omran wins Osler Award

Dr. M. Louay Omran, one of the newest additions to the Division of Geriatric Medicine at Saint Louis University, has been awarded the Osler Award. This award is presented annually to the physician voted as the best teacher of the year by his students, the residents and interns. Named after perhaps the most important figure in medical education in the United States, Sir William Osler, the award is given to one who knows and teaches that “medicine is learned by the bedside and not in the classroom.” Osler was a common-sense teacher; he loved books and emphasized that a patient, a library, and a notebook were the tools of medical education. Dr. Omran exemplifies this philosophy, and like Osler, is very tenderhearted toward his patients and patient with his students. Congratulations Dr. Omran!
Sin and Repentance

School was something of a sanctuary for me as a child. Home, often a place of quick criticism and devaluation, was not the refuge that it might have been. The acceptance and even praise I received at school was heady quaff indeed. I lapped it up like a thirsty puppy, doing my schoolwork eagerly, not only because of the gratifying approval there, but because it was usually fun as well.

Generally, I liked all my teachers in elementary school, but my third grade teacher, Miss B., was my hands-down favorite. She was young and pretty, with sparkling blue eyes. Her benign manner told us that she would rather be there with us than anywhere else. To quiet us, she would lower her soft, throaty voice so much that we had to be dead silent to hear her. Imagine having the power to make 30 squiggly-worm children want to hear every word! She had the gift.

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Miss B. used all kinds of incentives to make us want to do our best for her. Best of all was her giving of “E” for good work or exemplary behavior. An “E” was a small square of paper with a capital E on it. If your work was beyond “good” she might even give a slightly larger square of paper that said “3E’s” or even “5E’s.” Early in the year she informed us that we would be turning in our accumulated E’s (each of us was responsible for keeping track of our own) to vie for the reward: a Saturday morning outing with her. There would be three anointed ones, four if it was a close race. Ordinarily, I did well at my schoolwork; Daddy expected it and I enjoyed it. Idolizing Miss B. as I did, however, I pushed my scrawny little person hard and was duly rewarded: I was one of the chosen for the first outing.

I was thrilled. Miss B. was to take us to the St. Louis Public Library downtown. I thought the day would never come. I had been to the Carpenter Branch Library on South Grand countless times; it was one of my favorite haunts, but never to this main branch. Miss B. assured us that it was beautiful and fascinating. I agreed. Climbing up the long flight of concrete steps outside, then walking into the vaulted vestibule with its glorious domed ceiling was like walking into a cathedral. Miss B. guided us around the front desk area where the walls were lined high over our heads with card catalog drawers. Were there that many books in the whole world? Surely, every single one must be here. On to the reference room which held many more dictionaries, atlases, encyclopedias, and newspapers than were in our entire school. It even had telephone books from Chicago, New York, and cities I had never heard of. The children’s room in the basement was next. We floated down the satiny marble staircase that took us there, sliding our hands along the silky-cool balustrade. I was amazed to see my favorite books there, like Kingsley’s “The Water Babies” and Spyri’s “Heidi.” How did they get here from Carpenter Branch? It flashed into my head suddenly: they were different copies! What a clever idea—that way lots of children could read the same books I did. Think of all the books that must be here that I hadn’t read. Instructed by Miss B. to bring our library

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cards with us, we each checked out a book. Miss B. promised the librarian she would be responsible for returning them. I felt privileged.

The glow of that morning stayed with me, making me love Miss B. and libraries all the more. I daydreamed of what wondrous experience she would devise for the next trip, determined that I would again be one of the chosen. But fate had other plans. Scarlet fever struck me down. The doctor called it scarlettina, a mild form of scarlet fever, he said. Perhaps so, but it kept me home from school for three weeks, an eon as far as earning E’s was concerned. During the worst of my illness, I was miserable enough that I didn’t think about the upcoming trip, but as soon as I began to feel better, I remembered. Patsy, Dolores, and Shirley, my closest rivals (and friends), had no doubt worked as hard as I and had not missed any school. On my return to school, I counted the E’s I had accumulated before my absence and realized I had little chance of being one of the elect this time.

I was devastated. It wasn’t fair! Was it my fault that I got sick and missed three weeks of school? I could easily have earned enough E’s had I been well. There had to be a way to overcome this unjust turn of events. Little sinner that I was, an evil idea took root and flourished in my mind. I would produce my own E’s.

I didn’t think of it as cheating at first. After all, I was hard-working; and smart; and deserving; and I had to go with Miss B. That Miss B. might have kept track of how many E’s she had given to whom did not occur to me. That I would be denying one of my just-as-hard-working-and-smart-and-deserving friends the privilege she had earned, simply did not enter my mind. The demons of my desire refused space to every other thought. I made the E’s methodically, one by one, first practicing from the genuine article, until I thought I had enough to guarantee victory. As the day of reckoning approached, an odd sensation subliminally presented itself within me somewhere. I succeeded in keeping it from surfacing until the fateful morning that Miss B. said, “Turn in your E’s.” I pulled out the envelope which she had provided each of us for the purpose. The unfamiliar feeling, no longer subliminal, crept from the pit of my stomach to my chest. As she collected the envelopes, she said, “I’ll count these and tell you after lunch who will be going.”

Miss B. wasted no time. After taking afternoon attendance, she said, in a serious, but not hostile voice, “Doris, would you step out into the hall with me for a moment, please?” I rose from my seat with difficulty and followed her out the door. She held my envelope in her nicely groomed hand. I watched her open the envelope and take out some of the little squares of paper. My heart pounded. She leaned over, bent at the waist so that her eyes were almost level with mine. I looked into her lovely blue eyes, a bit sad now, then quickly away. The single strand of pearls at her neck swung lightly back and forth, belying the heaviness of the moment.

“Doris,” she said simply, “These are not my E’s.” My heart stopped. The feeling was immense now, and raging. I couldn’t speak. Why couldn’t I just die?

“Doris,” she said again, “These are not my E’s. Are they?”

My inner demon, still unconquered, succeeded in moving me to whisper, “Yes, they are.”

We stood there, silently immobile, for an eternity. Finally, she gently took my chin, turning my face up to hers so that I had to look into her clear eyes again.

“Are you sure?” she asked, softly. I managed to nod once.

I seemed somehow to have reached my seat again. Staring down at my desk I heard Miss B. say, “Children, I’ve counted the E’s. Dolores, Patsy, Shirley, and Doris will be coming with me this time.”

What had I done? How could I ever look at her again? My guilt was so consuming that I have no recollection of ensuing events. Did my classmates know? Where did we go on that trip? Did Mama suspect? I almost certainly threw up sometime during this ordeal, my standard reaction to unpleasant situations. I had committed a serious breach of faith.
The University of the Third Age (U3A) is an international organization. As part of its mission, U3A helps its members to become citizens of the world. The Saint Louis University Chapter of the U3A has identified an international project that it feels its members and their friends may be interested in hearing about and perhaps participating in.

Operation Christmas Child

The U3A in Action

The U3A Advisory Council invites you to participate in OPERATION CHRISTMAS CHILD. This charitable activity is sponsored by the Christian organization, Samaritan’s Purse.

Each year, Samaritan’s Purse, in cooperation with Life Care Centers of America, distributes shoe boxes full of toys and personal items to children in war-torn countries. The public is invited to participate as well. The U3A will serve as one of the collection agencies for filled shoeboxes and/or money for this worthy cause.

WHEN: Charitable donations will be collected by the U3A group between October 16th and November 11th.

WHERE: A collection site will be set up at Saint Louis University, Division of Geriatric Medicine (address below).

On October 16th, donations may be made in person to U3A volunteers at the next U3A conference. A tax letter will be issued to you at that time.

Between October 17th and November 10th, donations may be mailed or dropped off at: U3A Operation Christmas Child, Division of Geriatric Medicine, Saint Louis University, 1402 S. Grand Boulevard, St. Louis, MO 63104

On November 11th, last minute donations may be delivered to U3A members at the Advisory Council meeting on the 6th floor of the Compton Heights Hospital between 1 and 3 p.m. Tax letters will be issued on that day.

If you mail your package(s) in, tax letters will be sent to the name and address on the return address label on the outside of the package (if mailed) or to the name and address that is written on the check if the donation is in the form of a check.

WHAT: Donations may be a gift box containing these four things:

1) A shoe box with the box and the lid wrapped separately in holiday paper
2) Age-appropriate gifts (see instructions below)
3) One check for $5 made payable to Samaritan’s Purse to cover shipping and handling
4) A short note of greeting to the child with your address and perhaps a picture of yourself (to allow a thank you note to be sent if the child is old enough to write one)

OR

A check made payable to Samaritan’s Purse to assist in shipping and handling.

OR

A check made payable to U3A-Operation Christmas Child with instructions indicating the age of the child you would like a U3A volunteer to purchase items for and whether you prefer to donate the gifts to a girl or a boy.

The age ranges of appropriate gifts are: Infant, 2-4 years, 5-9 years, 10-14 years.

Allowable gifts include: Soap, combs/brushes, toothpaste and tooth brushes, t-shirts, underwear, socks, school supplies, prepackaged hard candy or gum, trucks, flash lights, Legos, dolls, hair clips, stuffed toys.

Please observe the following restrictions. Do not send any liquids, toys resembling weapons, old or used items, food items, or any glass.

If you have any questions about this program, call Nina Tumosa at (314) 894-6510.

Shopping List

♦ A shoe box with the box and the lid wrapped separately in holiday paper
♦ Soap
♦ Combs or brushes
♦ Toothpaste
♦ Tooth brushes
♦ T-shirts
♦ Underwear
♦ Socks
♦ School supplies
♦ Pre-packaged hard candy
♦ Gum
♦ Trucks
♦ Flash lights
♦ Legos
♦ Dolls
♦ Hair clips
♦ Stuffed toys

NO liquids
NO toys resembling weapons
NO old or used items
NO food items
NO glass
against someone whom I cared about deeply. Surely, she knew it. But this wise and loving teacher chose to teach me something—two things—infinitely more important than anything to be found in our worn, third grade textbooks:

You will suffer the consequences of your actions, and

To be trusted, you must be trustworthy.

She did it without rancor or meanness, never making me feel that she no longer accepted me, which made my pain all the more dreadful. Forgiveness can be cruel.

Many years later (I was married with children), Miss B. and I met at a local department store. She had the same serene air about her that she had had all those years ago. She was a little heavier and apparently had shrunk substantially, since she was several inches shorter than I. My shame leaped up full blown in my belly as though my wayward act had occurred yesterday. I almost slinked away, but something stopped me.

“Miss B.?” I said.

“Y es.” She turned toward me. Her smile was quick. It still lit up her face.

“You’ve had so many children in your classes, I know you couldn’t possibly remember all of them, but I was once in your third grade class at Meramec School years ago.”

“Really,” she said. “Tell me your name. I confess I don’t do well at connecting grown-up faces with little ones, but I remember lots of names when my memory’s jogged.”

What if she only remembers the bad stuff, I thought, my palms sweaty. Or worse, what if she doesn’t remember me at all? That might be better, though: just a nothing rather than a little cheat.

“Doris Spruss?” I said, a question in my voice. “My maiden name was Spruss.”

The light of recognition clicked on in a moment. Without a shadow of change in her welcoming face, she said, “Of course I remember. You were one of my bright ones. Teachers tend to remember those and the ones that give us a lot of trouble.”

I must have blanched, but her expression didn’t alter. We exchanged pleasantries for a few minutes, covering 20 or more years of our lives in a dozen brief sentences. And all the while I was thinking, “Should I confess; tell her how I had suffered by my iniquities? What a watershed experience I believed it to be?” For better or worse, I could not. Cowardice won the day.

We said our good-byes then. She told me how much she enjoyed meeting her grown-up students and I told her how dearly I had loved her in third grade. At least I accomplished that.

I like to think that in her wisdom, she knew all: the sin and the penance leading to the absolution of an honest life. I feel better, having put it down on paper. Perhaps I am closer now to achieving redemption.

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Surely, she knew it. But this wise and loving teacher chose to teach me something—two things—infinitely more important than anything to be found in our worn, third grade textbooks.
Saint Louis University Again Rated as One of the Top 10 Geriatric Hospitals in the United States

The July 19, 1999 issue of US News and World Report again lists Saint Louis University Hospital in the top 10 best American hospitals for geriatric care. To be eligible for ranking, a hospital had to meet at least one of three requirements: Affiliation with a medical school, membership in the Council or Teaching Hospitals, or having a minimum of 9 out of 17 key technologies readily available. Of the 1,985 American hospitals deemed eligible, Saint Louis University Hospital was ranked in the top 10 best in quality of geriatric care. Factors used to determine this ranking included reputation, hospital mortality rates, technology scores, discharge planning including patient education, and the availability of services such as adult day care, geriatric acute care and clinics, and transportation to health facilities.

The annual US News and World Report survey first began in 1988. It is designed to inform people about those hospitals best equipped to care for their special medical needs. Saint Louis University has a highly successful geriatrics and geriatric psychiatry research program, as well as acute (Acute Care for the Elderly [ACE] Unit), subacute (Life Care Center of St. Louis), nursing home, home care, outpatient, and assisted living care programs. A broad spectrum of continuing medical education (CME) programs are offered each year to healthcare professionals by the Saint Louis University Division of Geriatric Medicine. All of these programs make Saint Louis University an excellent resource for geriatric care.

Saint Louis University Partners with GeriMed to Develop Glidepaths

Glidepaths are a novel approach to developing critical pathways for disease management in older persons. This concept recognizes that different approaches to disease management are appropriate for the frail older person compared to the robust older person. Similarly, persons with dementia and those who are at the end of life will benefit from alternative strategies to enhance quality of life.

Saint Louis University has joined with GeriMed of America, Incorporated to develop a series of glidepaths to enhance the care of elderly persons. Development of these glidepaths will be evidence-based. This evidence will then be presented to a panel of experts who will use a modified Delphi approach to complete the glidepaths. The concept of glidepaths has been pioneered by Michael Wasserman, M.D., of GeriMed.
In persons with pain, care should be taken to treat depression when present. Transcutaneous electrical nerve stimulation works wonders for some persons. Old-fashioned local treatments to painful areas as well as more modern methods such as ultrasound can make a difference for many persons. Chiropractic manipulation for back pain together with mobilization has had a high success rate.

Patients need to be empowered to demand adequate pain relief from health professionals. Health professionals have the tools to treat pain. Treating pain represents a major component of enhancing an individual’s quality of life. We have to do better.

This is particularly important in persons with arthritis who wake up in the morning with stiffness and pain. Long-acting pain medicines such as Tylenol ER®(extended release) that work through the night need to be taken before going to bed.

In pain non-responsive to other modalities (see PAINFUL mnemonic below) opiates should be used. In persons with pain, opiates rarely lead to addiction. Opiates are appropriate to treat non-cancer pain such as arthritis. In older persons, there is never a need to withhold use of opiates to remove untreatable pain. Unfortunately in some states, regulators still hound doctors who prescribe “excessive” opiates. Sadly, this is often the nursing home physician who is giving good care.

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Patients need to be empowered to demand adequate pain relief from health professionals. Health professionals have the tools to treat pain. Treating pain represents a major component of enhancing an individual’s quality of life. We have to do better.
Questions? FAX: (314) 909-0443

Living Longer....Living Stronger

This column seeks to answer questions, provide information, and to challenge each of you to live longer and stronger. In each issue, Dr. John E. Morley pens some of his suggestions.

Q Should I take Vitamin E to live longer?

This is a tough question. There is little data to support that taking vitamins such as C and E, which are free radical scavengers, will extend life in the general population. However, in persons with atherosclerotic heart disease, the CHAOS study demonstrated a remarkable decrease in deaths in those persons taking Vitamin E. Vitamin E protects against heart disease by preventing platelets from sticking together and thus stopping clot formation. There are some studies that suggest that Vitamin E may slow down the development of Alzheimer’s disease. Thus, it would seem that taking Vitamin E at the least, does no harm and may be useful. In women with coronary artery disease, Vitamin E may be particularly useful.

Erectile dysfunction is an extremely common problem as men get older, as so ably demonstrated by Senator Dole’s television spots. There are numerous causes, but in most cases, in an older male it is due to atherosclerosis. The penile artery is of similar size to the coronary artery and is easily blocked by atheroma. Prescription drugs are another common reason for impotence. Numerous other causes, many of which are treatable, have been identified. Physicians have a number of tests that they can do to identify your ability to have an erection and the possible causes of impotence. The availability of new treatments such as Viagra, have made it easy to treat impotence in most cases. Consult your doctor about your problem, who may in turn refer you to a specialist in this area such as an endocrinologist, urologist, or geriatrician.

Q I’m a 62 year-old male who is contemplating remarriage. However, I no longer have sleep erections and I’m uncertain whether I will be able to have intercourse on my wedding night. What should I do?

Q I’m in my sixties and have a lot of trouble sleeping. What can I do to improve my sleep?

As we get older, many of us need less sleep. When one has sleep difficulties, it is important to use good sleep hygiene techniques. The bed should only be used for sleeping and sex, of course. One should not read or watch television in bed. Make sure that the bedroom is dark and quiet. (The use of white noise may help.) If you cannot fall asleep after half-an-hour, you should get up and only go back to bed when really tired. If you find you are thinking about your problems when you go to bed, try setting aside time during the day to do this, and don’t do it in bed. If you wake up at night because of the need to urinate, stop drinking fluids 2-4 hours before going to bed. Do not drink alcohol before going to bed. If these sleep hygiene tips fail to help, you may want to consider trying the herbal medicine, valerian. It is as effective as most of the prescription sleeping tablets, and has less side effects. Taking it with a glass of warm milk with a tablespoon of sugar in it may further enhance sleep.
Ten Years of Excellence
(continued from page 9)

Areas for reform that he recommends are: society needs to be further educated, especially about the meaning of aging, medicine’s goals need to be directed to reducing morbidity and disability, resource allocation will be dependent upon inter-generational solidarity, and gender equity in caregiving will reduce familial burdens.

Fran E. Kaiser, MD, presented an update on menopause, as a guide to a “galaxy of change.” Sharing this century’s demographics of female menopausal history, she stated that while there were 5 million women over the age of 50 in 1900, there will be over 50 million women over the age of 50 in the year 2000. She stressed that menopause is not a disease but it is a “gateway” to other changes that can be associated with disease states. The results of estrogen deficiency concomitant with menopause include urogenital atrophy, loss of vaginal lubrication, osteoporosis, increased risk of heart disease, alterations in skin, and cognitive changes. Treatment of these diseases requires the physician to collaborate with the patient on weighing the risk versus benefit ratio of hormone replacement therapy.

John E. Morley, MB, BCh, from Saint Louis University, regaled the Summer Geriatric Institute participants with his perspectives on successful aging throughout time. Framing his initial commentary around Greek mythological perspectives on aging in the time of Prometheus, he engaged the participants as time travelers through the ages. He highlighted the relevance of Francis Bacon’s philosophy, the artistry of Renoir, and others to emphasize the influence of age-related changes on the perspectives and work of elders from the past. Continuing this discussion, he stressed the importance of meaningful, balanced, and comprehensive care. He discussed a range of technological, diagnostic, and community resources available currently such as Acute Care for the Elderly (ACE) Units, Geriatric Evaluation and Management Units (GEMUs), and Delirium Intensive Care Units and those to be anticipated in the next century to sustain the quality of life to older adults. He concluded by predicting the high technology changes that will occur in geriatrics over the next millennium.

Penelope Roughan, MD, from the University of South Australia, presented on Women’s Issues in 1999: The International Year of the Older Person. She presented an historical review of women’s status through the ages via ethnographic clips spanning the centuries. She stated that growing old is a luxury that only a few from each generation experienced until this century. The plight of women who were “past their prime” in earlier eras was highlighted through narrative examples, including those accused of witchcraft. Many unhappy myths from the past influence the current experience of aging throughout the world, often making this later chapter in life one to dread. She proposed, however, that the increased numbers of aging women around the world represent a force to be reckoned with in the next decades.
Managing Pressure Ulcers: Practical Guidelines

(continued from page 2)

pressure ulcer heals. Thus, the modified Shea scale cannot be used to describe improvement or deterioration of pressure ulcers. A validated instrument to measure change in ulcer status over time, the Pressure Ulcer Scale for Healing, has been developed to aid in assessment.

Managing tissue loads

Positioning: Pressure relief is critical in the management of pressure ulcers. When the head of the bed is elevated, sacral pressure increases dramatically. Elevation of the head of the bed completely negates all pressure reducing devices and should be minimized. Heels and trochanters are particularly susceptible to pressure, but removing pressure from the heel and trochanteric areas is difficult.

Support surfaces: Pressure-relieving devices have a therapeutic role in treating pressure ulcers. Support surfaces and mattress overlays can be divided into static or dynamic types. When the patient can re-position without assistance, a static surface can be effective. If the patient is unable to spontaneously re-position, a dynamic surface is required.

Patients who have pressure ulcers on sitting interfaces should not sit.

Sitting: Patients who have pressure ulcers on sitting interfaces should not sit. All patients who sit for extended periods should have a pressure-reducing cushion. Even in the presence of a cushion, patients should be re-positioned hourly to relieve tissue loads.

Managing the ulcer

Debridement: Necrotic debris increases the possibility of bacterial infection and delays wound healing. The preferred method of debriding the wound remains controversial. Options include mechanical debridement with gauze dressings, sharp surgical debridement, autolytic debridement with occlusive dressings, or application of exogenous enzymes. Unless clinically infected, heel ulcers occur in poorly vascularized tissues and are better left undebrided.

Surgical sharp debridement produces the most rapid removal of necrotic debris and is required in the presence of infection. Mechanical debridement also can be accomplished by allowing saline gauze to dry before removal. Re-moistening of gauze dressings in an attempt to reduce pain at dressing changes can defeat the debridement effect.

Thin portions of eschar can be removed by occlusion (continued on page 20)
under a semipermeable dressing. Thicker eschar can be loosened under occlusion for several days before surgical debridement. Both autolytic and enzymatic debridement require periods of several days to several weeks to achieve results. Penetration of enzymatic agents is limited in eschar and requires either softening by autolysis or cross-hatching by sharp incision prior to application.

Enzymes evaluated in pressure ulcer trials include streptokinase/streptodornase (SK/SD) combination, collagenase, papain, and trypsin. Collagenase reduced necrosis, pus, and odor compared to inactivated control ointment, and produced debridement in 82% of pressure ulcers at four weeks compared to petrolatum. Papain produced measurable debridement in four days compared to the control vehicle ointment. Trypsin in balsam of Peru and castor oil were not better than mechanical gauze debridement.

Wound cleansing: Although the guidelines recommend cleansing with each dressing change, cleansing the wound results in mechanical and chemical trauma. When and how to clean the wound remains controversial. Normal saline without preservative is the best agent for wound cleaning. Any chemical cleansing agent will delay epithelization, but some are worse than others. Antiseptic agents are toxic to fibroblasts, including Betadine™, Hibiclens™, pHisoHex™, benzalkonium chloride, Granulex™, acetic acid, and Dakien’s solution. Other commercial cleansing agents containing preservatives may be cytotoxic. All mechanical or chemical cleaning agents should be discontinued when the wound is clean.

Wound Dressings: A moist wound environment is essential to promote cellular migration and tissue repair. Moist wound healing allows experimentally-induced wounds to resurface up to 40% faster than air-exposed wounds. Any therapy that dehydrates the wound such as dry gauze, heat lamps, air exposure, or liquid antacids is detrimental to chronic wound healing.

The rapid development of topical wound dressings in the last 20 years has left the physician with a confusing number of choices. Saline-moistened gauze that is not allowed to dry is an effective wound dressing. When moist saline gauze has been compared to occlusive-type dressings, healing of pressure ulcers has been similar with both dressings. The use of occlusive-type dressings has been shown to be more cost effective than traditional dressings primarily due to a decrease in nursing time for dressing changes.

Oclusive dressings can be divided into broad categories of polymer films, polymer foams, hydrogels, hydrocolloids, alginates, and biomembranes. Each has several advantages and disadvantages. No single agent is perfect. Comparative qualities among available agents are shown in Table 1 (on page 21).

All of the occlusive dressings offer pain relief. Only absorbing granules or polymers fail to reduce pain. Polymer films are impermeable to liquid but permeable to gas and moisture vapor. Because of low permeability to water vapor, these dressings are not dehydrating to the wound. Non-permeable polymers such as polyvinylidene and polyethylene can be macerating to normal skin. Most films have an adhesive backing that may remove epithelial cells when the dressing is changed. Polymer films do not eliminate deadspace and do not absorb exudate.

Hydrogels are hydrophilic polymers that are insoluble in water but absorb aqueous solutions. They are poor bacterial barriers and are non-adherent to the wound. Because of their high specific heat, these dressings are cooling to the skin, aiding in pain control and reducing inflammation. Most of these dressings require a secondary dressing to secure them to the wound.

Hydrocolloid dressings are complex dressings similar to ostomy barrier products. They are impermeable to moisture vapor and gases and are highly adherent to the skin. Their adhesive-ness to surrounding skin is higher than some surgical tapes, but they are non-adherent to wound tissue and do not impair epithelization of the wound. The adhesive barrier is frequently overcome in highly exudative wounds. Hydrocolloid dressings cannot be used over tendons or on wounds with eschar formation. Several of these dressings include a foam padding layer that may reduce pressure to the wound.

Only the hydrocolloid and biomembranes offer bacterial resistance. The biomembranes are
Summary

Pressure ulcers remain recalcitrant wounds in debilitated patients. Preventive strategies, detailed in the AHCPR prevention of pressure ulcers guideline, are the most effective interventions. A great deal of controversy remains. A number of clinically important questions lack definitive research for resolution. A stepwise approach can help promote understanding these complex wounds.

References for this article and copies of the Pressure Ulcer Scale for Healing mentioned on page 19 are available at www.cyberounds.com.
Coming Programs and Opportunities

Special Program for Retirees
The University of the Third Age
October 16, 1999

These one-day conferences are held in St. Louis at the Margaret McCormick Doisy Learning Resources Center on the Saint Louis University Medical Campus. U3A meetings enable healthy elders to explore successful aging in an academic environment. Sponsored by the Saint Louis University Health Sciences Center in cooperation with the GRECC at the VA Medical Center. The theme for the October 16th conference will be Meeting the Challenge of the New Millennium, and the keynote speaker will be Dr. Sue McDaniel. Contact (314) 577-8462 for more information.

Special Programs for Health Providers

Second Annual HDL Conference
August 28, 1999

This one-day conference, held at the Frontenac Hilton in St. Louis, will discuss the importance of the management of hypertension, diabetes, and lipids in the older person. CME credits will be available. For more information, please contact Dr. Nina Tumosa at 314-894-6510.

Eighteenth Annual GRECC Conference
September 9-10, 1999

This conference will present research, education, and clinical advances in the field of geriatric optometry. Rehabilitation, glaucoma, and low vision will be discussed. The conference will be held at the University of Missouri-St. Louis, JC Penney Building. For more information, please contact (314) 894-6510.

The Eleventh Annual Saint Louis University Symposium for Medical Directors in Nursing Homes
December 11, 1999

This symposium will be held at the Saint Louis University Health Sciences Center. For more information or to be added to the mailing list, please call (314) 577-8462.

The Eleventh Annual Saint Louis University Summer Geriatric Institute
June 14-16, 2000

The three-day interdisciplinary conference will be held in St. Louis at the Margaret McCormick Doisy Learning Resources Center on the Saint Louis University Medical Campus. The conference theme will be “Steps to Success in Teamwork.” Sponsored by the Saint Louis University Health Sciences Center in cooperation with the Missouri Gateway Geriatric Education Center, the VA Medical Center, and the Center for Interdisciplinary Geriatric Assessment. For more information, contact (314) 909-1894 or FAX (314) 909-0443.

Clinical Lecture Series
Beginning on September 8, 1999 and running through May 31, 2000, this annual series covers a variety of clinical areas and is directed to an interdisciplinary audience. Lectures are held on Wednesdays between 3 and 4 p.m., alternating locations between Auditorium C of the Learning Resource Center at Saint Louis University and Room 3S1 in Building 50 at the St. Louis Veterans Affairs Medical Center (VAMC) at Jefferson Barracks. To be placed on the mailing list, please call (314) 894-6510 or fax (314) 894-6614. Sponsored by the GRECC - St. Louis, the Division of Geriatric Medicine, and the Missouri Gateway Geriatric Education Center (MOGGEC).

Research Lecture Series
A companion series to the clinical lecture series listed above, these talks cover a variety of research topics including basic research and clinical and social issues, and are directed at an interdisciplinary audience. Lectures are held on Wednesdays between 4 and 5 p.m., immediately following the clinical lectures.
Is there something missing?
Yes, we usually offer them in each issue of Aging Successfully, but this time we ran out of room. If you are looking for information on our educational tools, Geropady, Safe and Sound, or Senior Safety Solitaire, please call Carolyn Phelps at 314-909-1894.

Donations and Bequests
The Geriatric Medicine Education and Research Fund at Saint Louis University School of Medicine welcomes contributions to further geriatric research, education and training. If you wish to make a donation in honor of an individual, indicate this in your correspondence. An appropriate acknowledgment will be sent to the honoree or family in your name. Contributions are deductible for income tax purposes to the extent allowed by law.

Donations and bequests can be directed to:

Geriatric Education and Research Fund
Division of Geriatric Medicine
Saint Louis University
School of Medicine
1402 S. Grand Boulevard, Room M238
St. Louis, Missouri  63104

Please direct inquiries to Carolyn Phelps at (314) 909-1894.

CYBEROUNDS
Dr. John Morley edits the geriatric section of Cyberounds, an internet-based educational program for physicians and other health professionals. Registration is free. Besides regular updates on geriatrics, Cyberounds provides an opportunity to directly ask questions of the Saint Louis University faculty concerning all areas of geriatrics and gerontology. The internet address for Cyberounds is: www.cyberounds.com
We look forward to meeting you in cyberspace!
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