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Selección de artículos

REVISTAS GERIÁTRICAS

Age and Ageing

Strategies to increase the coverage of influenza and pneumonia vaccination in older adults: a systematic review and network meta-analysis

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Abstract

Background

It is urgent to implement interventions to increase vaccination rates of influenza/pneumonia vaccines in older adults, yet the effectiveness of different intervention strategies has not been thoroughly evaluated.

Objective

We aimed to assess the effectiveness of intervention strategies for increasing the coverage of influenza/pneumonia vaccination in older adults.

Methods

PubMed, Web of Science, Cochrane Library, Embase, China Biology Medicine disc, China National Knowledge Infrastructure and Wanfang were searched from 1 January 2000 to 1 October 2022. RCTs that assessed any intervention strategies for increasing influenza/pneumonia vaccination coverage or willingness in older adults were included. A series of random-effects network meta-analysis was conducted by using frequentist frameworks.

Results

Twenty-two RCTs involving 385,182 older participants were eligible for further analysis. Eight types of intervention strategies were evaluated. Compared with routine notification, health education (odds ratio [OR], 1.85 [95%CI, 1.19 to 2.88]), centralised reminder (OR, 1.63 [95%CI, 1.07 to 2.47]), health education + onsite vaccination (OR, 2.89 [95%CI, 1.30 to 6.39]), and health education + centralised reminder + onsite vaccination (OR, 20.76 [95%CI, 7.33 to 58.74]) could effectively improve the vaccination rate. The evidence grade was low or very low due to the substantial heterogeneity among studies.

Conclusions

Our findings suggest that health education + centralised reminder + onsite vaccination may potentially be an effective strategy regardless of cost, but the evidence level was low. More rigorous trials are needed to identify the association between strategies and vaccination rates among older adults and to integrate such evidence into clinical care to improve vaccination rates.

Disponible en: https://doi.org/10.1093/ageing/afae035

Short- and long-term safety of discontinuing chronic opioid therapy among older adults with Alzheimer's disease and related dementia

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Abstract

Background

Limited evidence exists on the short- and long-term safety of discontinuing versus continuing chronic opioid therapy (COT) among patients with Alzheimer's disease and related dementias (ADRD).

Methods

This cohort study was conducted among 162,677 older residents with ADRD and receipt of COT using a 100% Medicare nursing home sample. Discontinuation of COT was defined as no opioid refills for ≥90 days. Primary outcomes were rates of pain-related hospitalisation, pain-related emergency department visit, injury, opioid use disorder (OUD) and opioid overdose (OD) measured by diagnosis codes at quarterly intervals during 1- and 2-year follow-ups. Poisson regression models were fit using generalised estimating equations with inverse probability of treatment weights to model quarterly outcome rates between residents who discontinued versus continued COT.

Results

The study sample consisted of 218,040 resident episodes with COT; of these episodes, 180,916 residents (83%) continued COT, whereas 37,124 residents (17%) subsequently discontinued COT. Discontinuing (vs. continuing) COT was associated with higher rates of all outcomes in the first quarter, but these associations attenuated over time. The adjusted rates of injury, OUD and OD were 0, 69 and 60% lower at the 1-year follow-up and 11, 81 and 79% lower at the 2-year follow-up, respectively, for residents who discontinued versus continued COT, with no difference in the adjusted rates of pain-related hospitalisations or emergency department visits.

Conclusions

The rates of adverse outcomes were higher in the first quarter but lower or non-differential at 1-year and 2-year follow-ups between COT discontinuers versus continuers among older residents with ADRD.

Disponible en: https://doi.org/10.1093/ageing/afae047

Understanding the association between pain and delirium in older hospital inpatients: systematic review and meta-analysis

Nicola White, Juan Carlos Bazo-Alvarez, Michel Koopmans, Emily West, Elizabeth L Sampson

Abstract

Objective

Delirium and pain are common in older adults admitted to hospital. The relationship between these is unclear, but clinically important. We aimed to systematically review the association between pain (at rest, movement, pain severity) and delirium in this population.

Methods

PubMed, EMBASE, CINAHL, PsycINFO, Cochrane and Web of Science were searched (January 1982–November 2022) for Medical Subject Heading terms and synonyms ('Pain', 'Analgesic', 'Delirium'). Study eligibility: (1) validated pain measure as exposure, (2) validated delirium tool as an outcome; participant eligibility: (1) medical or surgical (planned/unplanned) inpatients, (2) admission length ≥ 48 h and (3) median cohort age over 65 years. Study quality was assessed with the Newcastle Ottawa Scale. We collected/calculated odds ratios (ORs) for categorical data and standard mean differences (SMDs) for continuous data and conducted multi-level random-intercepts meta-regression models. This review was prospectively registered with PROSPERO [18/5/2020] (CRD42020181346).

Results

Thirty studies were selected: 14 reported categorical data; 16 reported continuous data. Delirium prevalence ranged from 2.2 to 55%. In the multi-level analysis, pain at rest (OR 2.14; 95% confidence interval [CI] 1.39–3.30), movement (OR 1.30; 95% CI 0.66–2.56), pain categorised as 'severe' (OR 3.42; 95% CI 2.09–5.59) and increased pain severity when measured continuously (SMD 0.33; 95% CI 0.08–0.59) were associated with an increased delirium risk. There was substantial heterogeneity in both categorical (I2 = 0%–77%) and continuous analyses (I2 = 85%).

Conclusion

An increase in pain was associated with a higher risk of developing delirium. Adequate pain management with appropriate analgesia may reduce incidence and severity of delirium.

Disponible en: https://doi.org/10.1093/ageing/afae073

Effects of medication management in geriatric patients who have fallen: results of the EMMA mixed-methods study

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Abstract

Background

comprehensive medication management (CMM) can reduce medication-related risks of falling. However, knowledge about inter-individual treatment effects and patient-related barriers remains scarce.

Objective

to gain in-depth insights into how geriatric patients who have fallen view their medication-related risks of falling and to identify effects and barriers of a CMM in preventing falls.

Design

complementary mixed-methods pre–post study, based on an embedded quasi-experimental model.

Setting

geriatric fracture centre.

Methods

qualitative, semi-structured interviews framed the CMM intervention, including a follow-up period of 12 weeks. Interviews explored themes of falling, medication-related risks, post-discharge acceptability and sustainability of interventions using qualitative content analysis. Optimisation of pharmacotherapy was assessed via changes in the weighted and summated Medication Appropriateness Index (MAI) score, number of fall-risk-increasing drugs (FRID) and potentially inappropriate medications (PIM) according to the Fit fOR The Aged and PRISCUS lists using parametric testing.

Results

thirty community-dwelling patients aged ≥65 years, taking ≥5 drugs and admitted after an injurious fall were recruited. The MAI was significantly reduced, but number of FRID and PIM remained largely unchanged. Many patients were open to medication reduction/discontinuation, but expressed fear when it came to their personal medication. Psychosocial issues and pain increased the number of indications. Safe alternatives for FRID were frequently not available. Psychosocial burden of living alone, fear, lack of supportive care and insomnia increased after discharge.

Conclusion

as patients' individual attitudes towards trauma and medication were not predictable, an individual and longitudinal CMM is required. A standardised approach is not helpful in this population.

Disponible en: https://doi.org/10.1093/ageing/afae070

Archives of Gerontology and Geriatrics

The risk of rehospitalization within 30 days of discharge in older adults with malnutrition: A meta-analysis

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Abstract

Introduction

Malnutrition is a global health problem associated with higher rehospitalization risk, subsequently increasing the risks of adverse complications, and mortality in older individuals. Nevertheless, studies investigating this are still scarce, and even fewer reviewed and aggregated. A number of studies have recently assessed the correlation of malnourishment with rehospitalization among older adults.

Objective/Aim

This systematic review and meta-analysis aimed to elaborate the correlation between malnutrition and 30-day rehospitalization in older adults.

Methods

Systematic review was conducted on literatures from Cochrane, ScienceDirect, SpringerLink, Oxford Academic, and MEDLINE according to PRISMA Guideline, investigating the correlation of malnutrition in older adults with rehospitalization, using Malnutrition, Older Adults, and Rehospitalization as keywords. Meta-analysis was done using RevMan, with random-effect analysis model. *P* values of ≤0.05 were considered statistically significant with results reported as risk ratios (RR), mean differences (MD), 95 % confidence intervals (CI) and I2 statistics.

Results

Seven literatures were analysed, consisting of 19,340 patients aged 65 or older undergoing hospitalization. Subjects were assessed with screening tools to identify malnutrition. Malnourished subjects are compared to others with normal nutrition; in cohort studies with follow-up period ranging from 3 to 16 months. Malnutrition significantly increased the risks of rehospitalization within 30 days (RR 1.73 [95 % CI 1.10–2.72], $p = 0.02$, I2 = 56 %), overall rehospitalization at all times (RR 1.33 [95 % CI 1.16–1.52], $p < 0.0001$, I2 = 75 %), and overall mortality (RR 2.66 [95 % CI 1.09–6.50], $p = 0.03$, I2 = 94 %).

Conclusion

Malnutrition exhibited significant consequences in older patients regarding the rate of rehospitalization and mortality based on this meta-analysis. Further research is highly encouraged to verify this finding.

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BMC Geriatrics

Effect modification of polypharmacy on incident frailty by chronic kidney disease in older adults

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Abstract

Background

Frailty and polypharmacy are common conditions in older adults, especially in those with chronic kidney disease (CKD). Therefore, we analyzed the association of polypharmacy and incident frailty and the effect modification by CKD in very old adults.

Methods

In non-frail individuals within the Berlin Initiative (cohort) Study, polypharmacy (≥ 5 medications) was assessed according to multiple definitions based on the number of regular and on demand prescription and over the counter drugs, as well as vitamins and supplements. CKD was defined as an estimated glomerular filtration rate < 60 mL/min/1.73m2 and/or an albumin-creatinine ratio ≥ 30 mg/g. Incident frailty was assessed at follow-up using Fried criteria. Logistic regression was applied to assess (1) the association of different polypharmacy definitions with incident frailty and (2) effect modification by CKD.

Results

In this cohort study, out of 757 non-frail participants (mean age 82.9 years, 52% female, 74% CKD), 298 (39%) participants reported polypharmacy. Over the observation period of 2.1 years, 105 became frail. Individuals with polypharmacy had 1.96 adjusted odds (95% confidence interval (CI): 1.20–3.19) of becoming frail compared to participants without polypharmacy. The effect of polypharmacy on incident frailty was modified by CKD on the additive scale (relative excess risk due to interaction: 1.56; 95% CI 0.01–3.12).

Conclusions

This study demonstrates an association of polypharmacy and incident frailty and suggests strong evidence for an effect modification of CKD on polypharmacy and incident frailty. Revision of prescriptions could be a target strategy to prevent frailty occurrence, especially in older adults with CKD.

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Comparative safety of tramadol and other opioids following total hip and knee arthroplasty

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Abstract

Background

Tramadol is increasingly used to treat acute postoperative pain among older adults following total hip and knee arthroplasty (THA/TKA). However, tramadol has a complex pharmacology and may be no safer than full opioid agonists. We compared the safety of tramadol, oxycodone, and hydrocodone among opioid-naïve older adults following elective THA/TKA.

Methods

This retrospective cohort included Medicare Fee-for-Service beneficiaries ≥ 65 years with elective THA/TKA between January 1, 2010 and September 30, 2015, 12 months of continuous Parts A and B enrollment, 6 months of continuous Part D enrollment, and no opioid use in the 6 months prior to THA/TKA. Participants initiated single-opioid therapy with tramadol, oxycodone, or hydrocodone within 7 days of discharge from THA/TKA hospitalization, regardless of concurrently administered nonopioid analgesics. Outcomes of interest included all-cause hospitalizations or emergency department visits (serious adverse events (SAEs)) and a composite of 10 surgical- and opioid-related SAEs within 90-days of THA/TKA. The intention-to-treat (ITT) and per-protocol (PP) hazard ratios (HRs) for tramadol versus other opioids were estimated using inverse-probability-of-treatment-weighted pooled logistic regression models.

Results

The study population included 2,697 tramadol, 11,407 oxycodone, and 14,665 hydrocodone initiators. Compared to oxycodone, tramadol increased the rate of all-cause SAEs in ITT analyses only (ITT HR 1.19, 95%CLs, 1.02, 1.41; PP HR 1.05, 95%CLs, 0.86, 1.29). Rates of composite SAEs were not significant across comparisons. Compared to hydrocodone, tramadol increased the rate of all-cause SAEs in the ITT and PP analyses (ITT HR 1.40, 95%CLs, 1.10, 1.76; PP HR 1.34, 95%CLs, 1.03, 1.75), but rates of composite SAEs were not significant across comparisons.

Conclusions

Postoperative tramadol was associated with increased rates of all-cause SAEs, but not composite SAEs, compared to oxycodone and hydrocodone. Tramadol does not appear to have a superior safety profile and should not be preferentially prescribed to opioid-naïve older adults following THA/TKA.

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Drugs and Aging

Clinician and Family Caregiver Perspectives on Deprescribing Chronic Disease Medications in Older Nursing Home Residents Near the End of Life

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Abstract

Introduction

Nursing home (NH) residents with limited life expectancy (LLE) who are intensely treated for hyperlipidemia, hypertension, or diabetes may benefit from deprescribing.

Objective

This study sought to describe NH clinician and family caregiver perspectives on key influences on deprescribing decisions for chronic disease medications in NH residents near the end of life.

Methods

We recruited family caregivers of veterans who recently died in a Veterans Affairs (VA) NH, known as community living centers (CLCs), and CLC healthcare clinicians (physicians, nurse practitioners, physician assistants, pharmacists, registered nurses). Respondents completed semi-structured interviews about their experiences with deprescribing statin, antihypertensive, and antidiabetic medications for residents near end of life. We conducted thematic analysis of interview transcripts to identify key themes regarding influences on deprescribing decisions.

Results

Thirteen family caregivers and 13 clinicians completed interviews. Key themes included (1) clinicians and caregivers both prefer to minimize drug burden; (2) clinical factors strongly influence deprescribing of chronic disease medications, with differences in how clinicians and caregivers weigh specific factors; (3) caregivers trust and rely on clinicians to make deprescribing decisions; (4) clinicians perceive caregiver involvement and buy-in as essential to deprescribing decisions, which requires time and effort to obtain; and (5) clinicians perceive conflicting care from other clinicians as a barrier to deprescribing.

Conclusions

Findings suggest a need for efforts to encourage communication with and education for family caregivers of residents with LLE about deprescribing, and to foster better collaboration among clinicians in CLC and non-CLC settings.

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European Geriatric Medicine

Long-term antipsychotic use, orthostatic hypotension and falls in older adults with Alzheimer's disease

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Abstract

Purpose

Antipsychotic use in Alzheimer disease (AD) is associated with adverse events and mortality. Whilst postulated to cause/exacerbate orthostatic hypotension (OH), the exact relationship between antipsychotic use and OH has never been explored in AD—a group who are particularly vulnerable to neuro-cardiovascular instability and adverse effects of medication on orthostatic blood pressure (BP) behaviour.

Methods

We analysed longitudinal data from an 18-month trial of Nilvadipine in mild–moderate AD. We assessed the effect of long-term antipsychotic use (for the entire 18-month study duration) on orthostatic BP phenotypes measured on eight occasions, in addition to the relationship between antipsychotic use, BP phenotypes and incident falls.

Results

Of 509 older adults with AD (aged 72.9 ± 8.3 years, 61.9% female), 10.6% (n = 54) were prescribed a long-term antipsychotic. Over 18 months, long-term antipsychotic use was associated with a greater likelihood of experiencing sit-to-stand OH (ssOH) (OR: 1.21; 1.05–1.38, p = 0.009) which persisted on covariate adjustment. Following adjustment for important clinical confounders, both antipsychotic use (IRR: 1.80, 1.11–2.92, p = 0.018) and ssOH (IRR: 1.44, 1.00–2.06, p = 0.048) were associated with a greater risk of falls/syncope over 18 months in older adults with mild–moderate AD.

Conclusion

Even in mild-to-moderate AD, long-term antipsychotic use was associated with ssOH. Both antipsychotic use and ssOH were associated with a greater risk of incident falls/syncope over 18 months. Further attention to optimal prescribing interventions in this cohort is warranted and may involve screening older adults with AD prescribed antipsychotics for both orthostatic symptoms and falls.

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Journal of the American Geriatrics Society

Deprescribing medications among patients with multiple prescribers: A socioecological model

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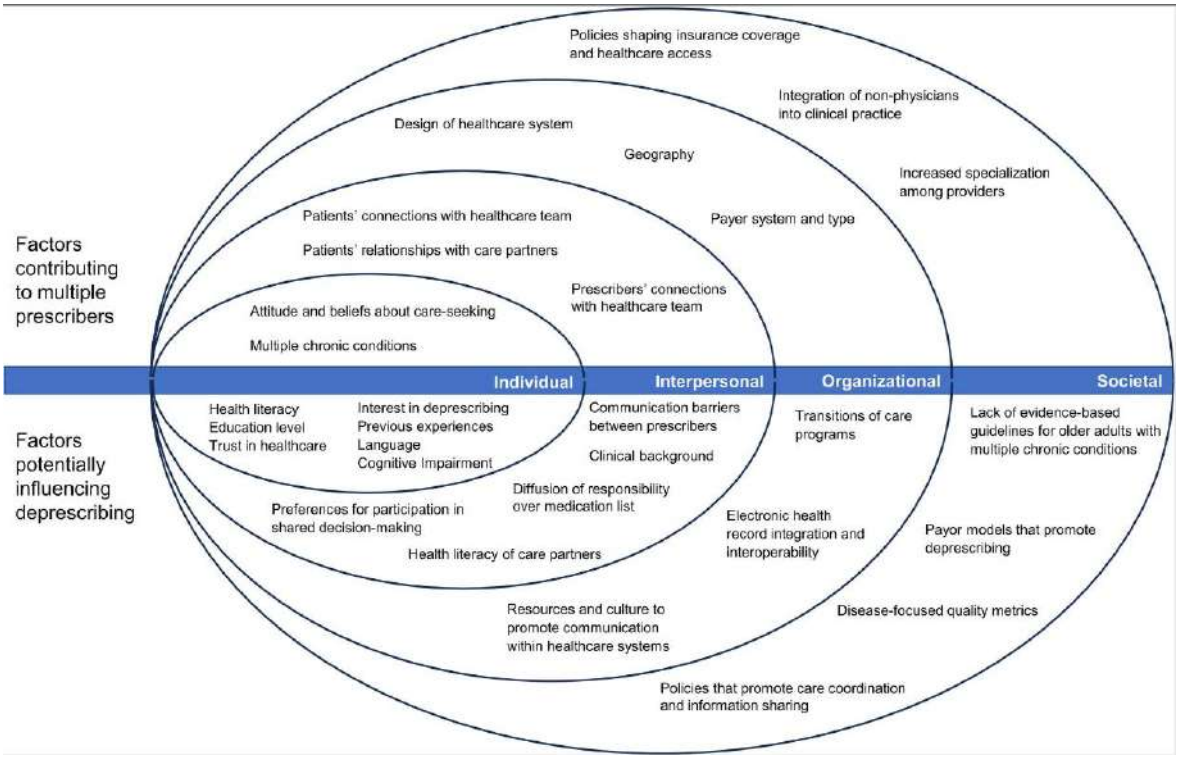
Abstract

Deprescribing is the intentional dose reduction or discontinuation of a medication. The development of deprescribing interventions should take into consideration important organizational, interprofessional, and patient-specific barriers that can be further complicated by the presence of multiple prescribers involved in a patient's care. Patients who receive care from an increasing number of prescribers may experience disruptions in the timely transfer of relevant healthcare information, increasing the risk of exposure to drug–drug interactions and other medication-related problems. Furthermore, the fragmentation of healthcare information across health systems can contribute to the refilling of discontinued medications, reducing the effectiveness of deprescribing interventions. Thus, deprescribing interventions must carefully consider the unique characteristics of patients and their prescribers to ensure interventions are successfully implemented. In this special article, an international working group of physicians, pharmacists, nurses, epidemiologists, and researchers from the United States Deprescribing Research Network (USDeN) developed a socioecological model to understand how multiple prescribers may influence the implementation of a deprescribing intervention at the individual, interpersonal, organizational, and societal level. This manuscript also includes a description of the concept of multiple prescribers and outlines a research agenda for future investigations to consider. The information contained in this manuscript should be used as a framework for future deprescribing interventions to carefully consider how multiple prescribers can influence the successful implementation of the service and ensure the intervention is as effective as possible.

Figure 1 Description of the factors that contribute to having multiple prescribers and that can influence the successful implementation of a deprescribing intervention at the different levels of the socioecological model.



Disponible en: https://doi.org/10.1111/jgs.18667

Fall risk and cardiovascular outcomes of first-line antihypertensive medications in nursing home residents

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Abstract

Background

Little evidence exists about the comparative effects of first-line antihypertensive medications (i.e., renin-angiotensin-aldosterone converting enzyme inhibitors (RAASi), amlodipine, or thiazide diuretics) in older adults with limited life expectancy. We compared the rates of injurious falls and short-term cardiovascular events between different first-line antihypertensive medication classes in adults receiving care in nursing homes (NH).

Methods

This was a retrospective cohort of Medicare fee-for-service beneficiaries receiving care in NHs. Patients newly dispensed first-line antihypertensive medications were identified using Part D claims (2015–2018) and linked with clinical assessments (i.e., Minimum Data Set). Fall-related injuries (FRI), hip fractures, and major adverse cardiac events (MACE) outcomes were identified using hospitalization claims. Patients were followed from the date of antihypertensive dispensing until the occurrence of outcomes, death, disenrollment, or 6-month follow-up. Inverse-probability-of-treatment-weighted (IPTW) cause-specific hazards regression models were used to compare outcomes between patients who were new users of RAASi, amlodipine, or thiazides.

Results

Our cohort included 16,504 antihypertensive users (RAASi, n = 9574; amlodipine, n = 5049; thiazide, n = 1881). Mean age was 83.5 years (± 8.2), 70.6% were female, and 17.2% were non-white race. During a mean follow-up of 5.3 months, 326 patients (2.0%) experienced an injurious fall, 1590 (9.6%) experienced MACE, and 2123 patients (12.9%) died. The intention-to-treat IPTW hazard ratio (HR) for injurious falls for amlodipine (vs RAASi) use was 0.85 (95% confidence interval (CI) 0.66–1.08) and for thiazides (vs RAASi) was 1.22 (95% CI 0.88–1.66). The rates of MACE were similar between those taking anti-hypertensive medications. Thiazides were discontinued more often than other classes; however, inferences were largely unchanged in as-treated analyses. Subgroup analyses were generally consistent.

Conclusions

Older adults with limited life expectancy experience similar rates of injurious falls and short-term cardiovascular events after initiating any of the first-line antihypertensive medications.

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Safety of subcutaneous versus intravenous ceftriaxone administration in older patients: A retrospective study

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Abstract

Background

Antibiotics play a central role in infection management. In older patients, antibiotics are frequently administered subcutaneously. Ceftriaxone pharmacokinetics after subcutaneous administration is well documented, but little data are available on its safety.

Methods

We compared the occurrence of adverse events associated with ceftriaxone administered subcutaneously versus intravenously in ≥75-year-old patients. We used data from a single-center, retrospective, clinical-administrative database to compare the occurrence of adverse events at day 14 and outcome at day 21 in older patients who received ceftriaxone via the subcutaneous route or the intravenous route at Rennes University Hospital, France, from May 2020 to February 2023.

Results

The subcutaneous and intravenous groups included 402 and 3387 patients, respectively. Patients in the subcutaneous group were older and more likely to receive palliative care. At least one adverse event was reported for 18% and 40% of patients in the subcutaneous and intravenous group, respectively (RR = 2.21). Mortality at day 21 was higher in the subcutaneous route group, which could be linked to between-group differences in clinical and demographic features.

Conclusions

In ≥75-year-old patients, ceftriaxone administered by the subcutaneous route is associated with less-adverse events than by the intravenous route. The subcutaneous route, which is easier to use, has a place in infection management in geriatric settings.

Disponible en: https://doi.org/10.1111/jgs.18786

Geriatrics and Gerontology International

Factors associated with the introduction of visiting-pharmacist services in older adults in Japan: A nested case–control study

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Abstract

Aim

To investigate the factors associated with introducing visiting-pharmacist services for community-dwelling older adults in Japan.

Methods

We conducted a nested case–control study using claims data in a cohort from a city in Tokyo. Patients aged ≥65 years who received visiting-pharmacist services for the first time between April 2014 and March 2020 were considered case patients. A maximum of four controls to each case patient were randomly selected on the basis of sex, age, health insurance systems, and month–year. Medical and long-term care service usage and patient condition were assessed using claims data from the index and preceding months, along with long-term care needs certification data. Multivariable conditional logistic regression analysis was conducted to estimate the adjusted odds ratios with 95% confidence intervals for factors associated with visiting-pharmacist service introduction.

Results

A total of 22 949 participants (4591 cases and 18 358 controls) were included, with a median age of 85 years; 59.3% were women. The adjusted odds ratios (95% confidence intervals) of the three most related factors were 27.61 (23.98–31.80) for physicians' home visits, 5.83 (5.08–6.70) for hospitalization, and 4.97 (4.16–5.95) for designated-facility admission. Factors such as prescribing ≧10 medications, visiting nursing, and cancer were positively associated. In contrast, low household income and a high need for support due to cognitive function or disability were negatively associated.

Conclusions

This study provides insights into the introduction of visiting-pharmacist services for older adults in Japan.

Disponible en: https://doi.org/10.1111/ggi.14838

REVISTAS FARMACÉUTICAS

European Journal of Clinical Pharmacology

Failure to reduce benzodiazepine prescriptions through the implementation of a psychological intervention for insomnia in an Italian mental health service

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Abstract

Purpose

Despite the evidence of higher effectiveness of psychological interventions for insomnia compared to pharmacological ones, drug prescriptions for insomnia remain frequent. This study has assessed patterns of prescriptions of BZDs for insomnia before and after the delivery of a training in psychological interventions to professionals working in the services of a Department of Mental Health in northern Italy.

Methods

The intervention consisted in two training sessions about psychological interventions for insomnia delivered to professionals of the participating services. The prevalence of users with a prescription of BZDs for insomnia in an index period after the delivery of the training was compared to the prevalence in an index period before the training.

Results

Among 727 people assessed for BZDs prescription at pre-intervention, 306 (42.1%, 95% CI 0.39–0.46) had a prescription, and 344 (49.2%, 95% CI 0.45–0.53) had a prescription among 699 people assessed at post-intervention, corresponding to a significant odds ratio of 1.33 to be prescribed with BZDs in the second index period compared to the first one. Psychological interventions were offered to a small group of patients.

Conclusion

Prescribing attitudes of BZDs for insomnia were not modified after the training and delivery of a psychological intervention in a mental healthcare outpatient setting. Prescribing habits should be addressed more directly in training, and professionals should be more aware of risks of BZDs assumption. The failure in changing drug prescriptions in this study should prompt more real-world studies of the application of evidence-based strategies, particularly in outpatient mental health settings.

Disponible en: https://doi.org/10.1007/s00228-024-03677-7

Revista Española

Manejo terapéutico, adherencia y resultados clínicos de la insuficiencia cardiaca en Andalucía. Protocolo ANDALIC

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Objetivo
Describir las características clínicas, manejo terapéutico, adherencia, persistencia y resultados clínicos, así como la asociación entre estas variables, en una cohorte de pacientes con insuficiencia cardiaca en la comunidad autónoma de Andalucía.

Diseño
Estudio observacional, poblacional, retrospectivo y de cohortes. Serán incluidos los pacientes dados de alta en un hospital andaluz con diagnóstico de insuficiencia cardiaca entre 2014 y 2023. Dichos datos serán extraídos de la Base Poblacional de Salud de Andalucía.

Análisis
El análisis estadístico incorporará las siguientes estrategias: 1) análisis descriptivo de las características de la cohorte poblacional, las medidas de adherencia y los resultados clínicos, 2) análisis bivariantes para estudiar la asociación de las covariables con la adherencia, persistencia y resultados clínicos, 3) análisis de regresión logística multivariante y regresión de Cox incluyendo las covariables relevantes y 4) modelos regresión de Poisson multivariante para la evaluación de cambios en el tiempo.

La realización de este estudio permitirá obtener información relevante para el manejo de la insuficiencia cardiaca en Andalucía, así como identificar los factores que pueden influir en los resultados clínicos. Estos hallazgos podrían ser fundamentales tanto para el desarrollo de estrategias optimizadas que mejoren la atención médica y la calidad de vida de los pacientes, como para la mitigación de la carga sanitaria de la insuficiencia cardiaca en la región.

Disponible en: 10.1016/j.farma.2024.03.002