cronos
Grupo Trabajo Paciente Crónico de la sefh

REVISIÓN BIBLIOGRÁFICA SEPTIEMBRE 2022: Selección de artículos

REVISTAS FARMACÉUTICAS

Paracetamol dosing in hospital and on discharge for older people who are frail or have low body weight

Olivia Reid, Janet Ngo, Samanta Lalic, Elizabeth Su, Rohan A. Elliott

Abstract

Aims:
To describe paracetamol dosing and liver function test (LFT) monitoring in older hospital inpatients who are frail or have low body weight.

Methods:
Retrospective observational study, at a 790-bed metropolitan public health service in Australia. Patients aged ≥70 years, with body weight <50 kg or frailty index based on laboratory data (FI-Lab) score ≥0.3, who were administered paracetamol during an admission with length-of-stay >72 hours, were included. Data were extracted from electronic medical records. Paracetamol doses administered in hospital, and doses prescribed on discharge, were compared against consensus guidelines that recommended ≤60 mg/kg/d for older people weighing <50 kg, and ≤3000 mg/d for frail older people.

Results:
In total, 240 admissions (n = 229 patients, mean age 84.7 years) were analysed. During 150 (62.5%) admissions, higher than recommended paracetamol doses were prescribed. On 138 (57.5%) occasions, patients were prescribed paracetamol on discharge, and 112/138 (81.2%) doses were higher than recommended. Most discharge prescriptions (97/138, 70.3%) were for regular administration. The median daily dose on discharge for patients <50 kg was 83.7 mg/kg (interquartile range 73.6–90.9 mg/kg). For frail patients ≥50 kg, the median daily discharge dose was 3990 mg (interquartile range 3000–4000 mg). LFTs were measured in hospital for 151/200 (75.5%) and 93/166 (56.0%) patients who received paracetamol for >48 hours and >5 days, respectively.

Conclusion:
Majority of paracetamol doses prescribed for frail or low-weight older patients in hospital and on discharge were higher than recommended in consensus guidelines. LFTs were not measured for 44% patients who received paracetamol regularly for >5 days. Further studies are needed to explore long-term outcomes of this practice.

Disponible en: 10.1111/bcp.15394

International Journal of Clinical Pharmacy

Impact of a clinical pharmacist-led stewardship program for the appropriate use of acid suppression therapy in older hospitalized patients: a non-randomized controlled study

Hatice Ikra Dumlu, Mesut Sancar, Ali Ozdemir, Betul Okuyan

Abstract

Background:
The potentially inappropriate use of the proton pump inhibitors is prevalent in older adults.

Aim:
To evaluate the impact of a clinical pharmacist-led stewardship program for the appropriate use of acid suppression therapy in older hospitalized patients.

Method:
This parallel nonrandomized controlled study was conducted at an internal medicine service of a tertiary training and research hospital between September 2019 and August 2021. Older patients (≥ 65 years old and received proton pump inhibitors within 48 h of admission) were allocated to two groups according to their number of medical file records, whether odd or even, two groups: control and clinical pharmacist-led stewardship program for the appropriate use of acid suppression therapy (including medication reconciliation and medication review) during the hospital stay. Primary outcome measures were the rate of appropriate use of proton pump inhibitors during hospitalization and potentially inappropriate proton pump inhibitor use at discharge.

Results:
The rate of appropriate proton pump inhibitor use during hospitalization was significantly higher in the clinical pharmacist-led program (n = 100) than in the control group (n = 97) (46.4% vs. 79.0%; P < 0.001). The rate of potentially inappropriate proton pump inhibitor use at discharge was significantly lower (61.7% vs. 35.1%; P < 0.05) in the clinical pharmacist-led program among the older patients discharged with a proton pump inhibitor prescription.

Conclusion:
A clinical pharmacist-led stewardship program for the appropriate use of acid suppression therapy improved the rate of appropriate proton pump inhibitor use and reduced the potentially inappropriate proton pump inhibitor use during the hospital stay.

Trial Registration NCT05113667 (17 October 2021-registered retrospectively).

Disponible en: https://doi.org/10.1007/s11096-022-01394-8

European Journal of Hospital Pharmacy

Risk factors for emergency department revisit in elderly patients with gastrointestinal bleeding secondary to anticoagulant therapy

Laia López-Vinardell, Ana Juanes, Adrià Riera-Magallon, Mireia Puig, María Antonia Mangues

Abstract

Objective:
To evaluate the frequency of emergency department (ED) revisits among elderly patients with gastrointestinal bleeding secondary to anticoagulant treatment and identify factors associated with an increased risk of ED revisits.

Methods:
A 3-year retrospective observational study was designed, including elderly patients (≥65 years) with atrial fibrillation and undergoing oral anticoagulation therapy who visited the ED for gastrointestinal bleeding. To evaluate the risk factors for 30-day revisit, a multivariate analysis was designed including comorbidities, concomitant treatment, change in anticoagulant treatment and prescription of direct-acting oral anticoagulants.

Results: 80 patients were included. At discharge, anticoagulation therapy was modified in 21 (26.2%) patients; and changed from an oral anticoagulant to heparin in 17 (21.2%) patients and to another oral anticoagulant in 4 (5.0%) patients. Anticoagulant treatment was withdrawn in 5 (6.3%) patients at discharge. Eleven (13.7%) patients revisited the ED 30 days after hospital discharge for bleeding episodes. No differences in the frequency of revisit to the ED were observed in the patients who changed their anticoagulant treatment at discharge. In the multivariate analysis, chronic kidney disease was the only factor significantly associated with revisits at 30 days.

Conclusions: Elderly patients who experience a first episode of gastrointestinal bleeding have a high risk of revisiting the ED for a bleeding episode, with no particular differences between the types of anticoagulant prescribed at discharge.

Disponible en: 10.1136/ejhpharm-2020-002426

European Journal of Clinical Pharmacology

Hospitalisations related to benzodiazepine, Z-drug, and opioid treatment in Italy: a claim on the risks associated with inappropriate use

Irene Mattioli, Alessandra Bettiol, Giada Crescioli, Roberto Bonaiuti, Domenico Prisco, Guido Mannaioni, Niccolò Lombardi, Alfredo Vannacci

Abstract

Purpose:

Benzodiazepines (BZD), Z-drugs (ZD), and opioids share a high risk of abuse. This study assessed and characterised adverse events (AEs) related to BDZ, ZD, and opioids leading to emergency department (ED) visits in the Italian setting.

Methods:

ED accesses related to BDZ, ZD, and/or opioids were analysed from the MEREAFaPS database. Information on AEs, suspected and concomitant medications was retrieved. Multivariate logistic regression was used to estimate the reporting odds ratios (RORs) of hospitalisation according to the different treatments.

Results:

A total of 5,970 pharmacovigilance reports involving BZD/ZD (n = 3,106), opioids (n = 2,767), or their combination (n = 97) were analysed. Compared to opioids, patients with BZD/ZD-related AEs were often younger (51 vs 64 years), more frequently presented 2+ suspected medications (13 vs 3%), and often had a history of abuse (4%). Twenty-three percent of BZD/ZD-related AEs were related to drug abuse (vs 2% of opioid-related ones) and frequently required patient hospitalisation (52% vs 24%), despite the significantly lower clinical complexity of these patients as compared to those on opioids. An increased risk of hospitalisation was found for flurazepam (ROR 1.62; 95% CI, 1.18–2.22), prazepam (2.66; 1.05–6.70), lorazepam (1.26; 1.07–1.49), and morphine (1.76; 1.11–2.79).

Conclusions:

These results indicate that, in Italy, the inappropriate use of BZD/ZD is a relevant heath issue, often leading to serious AEs requiring patients' ED visits and hospitalisation, especially in young women and patients with a history of substance abuse.

Disponible en: 10.1007/s00228-022-03354-7

Farmacia Hospitalaria

Adherencia a los inhaladores en pacientes con asma grave tratados con biológicos anti interleucina 5

Paula Granda, Elena Villamañán, Carlos Carpio, Daniel Laorden, Carmen Sobrino, Alicia Herrero, Santiago Quirce, Rodolfo Álvarez-Sala

Resumen Objetivo

Dado que la mala adherencia a la medicación en el asma grave es difícil de evaluar en la práctica diaria, se recomienda utilizar al menos dos métodos simultáneamente.

Objetivo:

Determinar la prevalencia de la falta de adherencia a los inhaladores mediante el cuestionario Test de Adherencia a los Inhaladores y la ratio de posesión de la medicación obtenida a partir de los datos de dispensación de la farmacia en pacientes con asma grave tratados con biológicos anti interleucina 5 y evaluar su concordancia.

Método:

Estudio observacional retrospectivo transversal de 53 pacientes con asma grave reclutados en la unidad de asma grave de un hospital terciario de Madrid de junio a diciembre de 2020. Se registraron datos demográficos, comorbilidades y el tratamiento concomitante para el asma. La falta de adherencia se definió como una ratio de posesión de la medicación < 80% y/o un valor en los resultados del cuestionario Test de Adherencia a los inhaladores <50. La concordancia se evaluó con el coeficiente kappa de Cohen.

Resultados:

La mediana de edad fue de 61 años (rango intercuartílico 51,8-67,0), y 33 (61%) eran mujeres. Según el ratio de posesión de la medicación, la falta de adherencia al inhalador primario fue del 58,5%. Sin embargo, al utilizar el cuestionario Test de Adherencia a los inhaladores, esta fue del 22,6%. Combinando ambos métodos, se consideró que el 17% de los pacientes presentaban no adherencia a los inhaladores. Asimismo, al identificar la no adherencia por cualquiera de estos métodos, se alcanzó una prevalencia del 64,2%. El cuestionario Test de Adherencia a los inhaladores y la ratio de posesión de la medicación coincidieron en el 53,1% y discreparon en el 46,9% de los pacientes (k=0,137; intervalo de confianza del 95% -0,057 a 0,331; p=0,318).

Conclusiones:
Se observó una alta prevalencia de la no adherencia a los inhaladores en los pacientes con asma frave tratados con biológicos anti interleucina 5. La concordancia entre el cuestionario Test de Adherencia a los Inhaladores y la ratio de posesión de la medicación es menor cuando se evalúa la no adherencia en pacientes con asma grave tratados con biológicos anti interleucina 5. La ratio de posesión de la medicación detecta una mayor proporción de no adherencia en comparación con el cuestionario Test de Adherencia a los Inhaladores.

Disponible en: **10.7399/fh.11808**

REVISTAS GERIÁTRICAS

Age and ageing

Promoting continence in older people

Mathias Schlögl, Martin H Umbehr, Muhammad Hamza Habib, Adrian Wagg,Adam L Gordon, Rowan Harwood

Abstract
The prevalence of urinary incontinence (UI) is strongly associated with increasing age. Twenty five percent of women over 80 years of age have clinically significant symptoms in population surveys, but prevalence is as high as 70% in older hospital in-patients and residents of care homes with nursing. UI substantially affects quality of life and well-being, and generates significant economic burden for health and social care. Sadly, UI is considered as taboo by society, leading to isolation, depression and reluctance to seek help. As with all aspects of care of older people, a multi-modal approach to assessment and management is needed. Key to effective management of incontinence is recognition.

As a minimum, clinicians should actively ask patients about continence, especially in older adults living with frailty. Careful evaluation and establishment of any underpinning diagnosis and aetiological factors requires comprehensive, multimodal, usually multidisciplinary, assessment. A lack of awareness of the problem and what can be done about it exists in both laypeople and clinicians, this needs correcting. An interdisciplinary approach to research and management must be the way into the future.

Disponible en: https://doi.org/10.1093/ageing/afac199

Low-density lipoprotein cholesterol in oldest old with acute myocardial infarction: Is lower the better?

Hui-Hui Liu, Meng Zhang, Run-Zhen Chen, Jin-Ying Zhou, Jie Qian, Ke-Fei Dou,Hong-Bing Yan, Jian-Jun Li

Abstract

Background

The relationship between low-density lipoprotein cholesterol (LDL-C) and adverse outcomes among the older people remains controversial.

Objective

To further clarify the association between admission LDL-C levels and cardiovascular mortality (CVM) among oldest old individuals (≥80 years) with acute myocardial infarction (AMI).

Methods

All individuals were subdivided according to baseline LDL-C levels (<1.8, 1.8–2.6 and ≥ 2.6 mmol/l) and further stratified by high-sensitivity C-reactive protein (hsCRP) concentrations (<10 and ≥10 mg/l). The primary outcome was CVM. The time from admission to the occurrence of CVM or the last follow-up was analysed in Kaplan–Meier and Cox analyses.

Results

The median age of the overall population was 82 years. During an average of 24.5 months' follow-up, 299 cardiovascular deaths occurred. Kaplan–Meier analysis showed that LDL-C < 1.8 mmol/l group had the highest CVM among oldest old individuals with AMI.

Multivariate Cox regression analysis further revealed that compared with those with LDL-C levels <1.8 mmol/l, subjects with LDL-C levels ≥2.6 mmol/l (hazard ratio: 0.67, 95% confidence interval: 0.46–0.98) had significantly lower risk of CVM, especially in those with high hsCRP levels. Moreover, when categorising according to LDL-C and hsCRP together, data showed that individuals with low LDL-C and high hsCRP levels had the highest CVM.

Conclusions

LDL-C < 1.8 mmol/l was associated with a high CVM after AMI in oldest old individuals, especially when combined with high hsCRP levels, which may need to be confirmed by randomised controlled trials.

Disponible en: https://doi.org/10.1093/ageing/afac202

Long-term outcomes of stroke unit care in older stroke patients: a retrospective cohort study

Max Geraedts, Dijana Ebbeler, Nina Timmesfeld, Manfred Kaps, Klaus Berger,Björn Misselwitz, Christian Günster, Patrik Dröge, Michael Schneider

Abstract

Background

older patients are less frequently treated in stroke units (SUs). Clinicians do not seem convinced that older patients benefit from specialised treatment in SU similarly to younger patients.

Objective

our study aimed to compare older patients' long-term outcomes with and without SU treatment.

Methods

this study used routinely collected health data of 232,447 patients admitted to hospitals in Germany between 2007 and 2017 who were diagnosed with ischaemic stroke (ICD 10 I63). The sample included 29,885 patients aged ≥90 years. The outcomes analysed were 10-, 30- and 90-day, and 1-, 3- and 5-year mortality and the combinations of death or recurrence, inpatient treatment and increase in long-term care needs. Bivariate chi-square tests and multivariable logistic regression analyses were used, adjusting for the covariates age, sex, co-morbidity, long-term care needs before stroke and socioeconomic status of the patients' region of origin.

Results

between 2007 and 2017, 57.1% of patients aged <90 years and 49.6% of those aged ≥90 years were treated in a SU. The 1-year mortality rate of ≥90-year-olds was 56.9 and 61.9% with and without SU treatment, respectively. The multivariable-adjusted risk of death in ≥90-year-olds with SU treatment was odds ratio (OR) = 0.67 (95% confidence interval [CI] = 0.62–0.73) 10 days after the initial event and OR = 0.76 (95% CI = 0.71–0.82) 3 years after stroke.

Conclusions

even very old patients with stroke benefit from SU treatment in the short and long term. Therefore, SU treatment should be the norm even in older patients.

Disponible en: https://doi.org/10.1093/ageing/afac197

Non-pharmacologic and pharmacologic treatments for anxiety in long-term care: a systematic review and meta-analysis

Kayla Atchison, Jennifer A Watt, Delaney Ewert, Ann M Toohey, Zahinoor Ismail,Zahra Goodarzi

Abstract

Background

older adults living in long-term care (LTC) commonly suffer from anxiety symptoms and disorders. We completed a systematic review and meta-analysis to identify efficacious treatments for anxiety symptoms for older adults living in LTC.

Methods

we searched five electronic databases (MEDLINE, Embase, PsycINFO, Cochrane Database of Systematic Reviews and Cochrane Central Register of Controlled Trials) to identify treatments for anxiety that have been trialled in LTC. Included studies had to be randomised trials, include residents of LTC, and measure anxiety symptoms as an outcome.

Results

the electronic search returned 6,617 articles, 519 were reviewed in full text, and 80 were included in the descriptive synthesis. Limited studies were meta-analysed (n = 10) due to differences in described treatment and comparator conditions. Limited clinically relevant evidence supporting the use of pharmacologic treatments for symptoms of anxiety in LTC was identified. Of the treatments trialled, music compared with usual care (standardised mean difference, SMD: −0.82; 95% confidence interval (CI): −1.31, −0.34), music compared with social interaction (SMD: −0.41; 95% CI: −0.72, −0.10) and massage compared with usual care (SMD: −4.32; 95% CI: −7.44, −1.19) were found to improve anxiety symptoms, however, significant heterogeneity was detected in two comparisons.

Conclusions

a range of non-pharmacologic treatments that improved anxiety symptoms were identified for use in LTC. Although limited evidence exists to support the use of particular treatments, most non-pharmacologic treatments were low-risk interventions that may be readily implemented. Further research is required to assess the treatment effect on residents of LTC with anxiety disorders or clinically relevant symptoms at baseline.

Disponible en: https://doi.org/10.1093/ageing/afac195

Gerontology

It's all about cognitive trajectory: accuracy of the cognitive charts–MoCA in normal aging, MCI, and dementia

Patrick J. Bernier MD, PhD,Christian Gourdeau MSc,Pierre-Hugues Carmichael MSc,Jean-Pierre Beauchemin MD,Philippe Voyer RN, PhD,Carol Hudon PhD,Robert Laforce Jr MD, PhD

Abstract

Background

The Montreal Cognitive Assessment (MoCA) is an established cognitive screening tool in older adults. It remains unclear, however, how to interpret its scores over time and distinguish age-associated cognitive decline (AACD) from early neurodegeneration. We aimed to create cognitive charts using the MoCA for longitudinal evaluation of AACD in clinical practice.

Methods

We analyzed data from the National Alzheimer's Coordinating Center (9684 participants aged 60 years or older) who completed the MoCA at baseline. We developed a linear regression model for the MoCA score as a function of age and education. Based on this model, we generated the Cognitive Charts-MoCA designed to optimize accuracy for distinguishing participants with MCI and dementia from healthy controls. We validated our model using two separate data sets.

Results

For longitudinal evaluation of the Cognitive Charts-MoCA, sensitivity (SE) was 89%, 95% confidence interval (CI): [86%, 92%] and specificity (SP) 79%, 95% CI: [77%, 81%], hence showing better performance than fixed cutoffs of MoCA (SE 82%, 95% CI: [79%, 85%], SP 68%, 95% CI: [67%, 70%]). For current cognitive status or baseline measurement, the Cognitive Charts-MoCA had a SE of 81%, 95% CI: [79%, 82%], SP of 84%, 95% CI: [83%, 85%] in distinguishing healthy controls from mild cognitive impairment or dementia. Results in two additional validation samples were comparable.

Conclusions

The Cognitive Charts-MoCA showed high validity and diagnostic accuracy for determining whether older individuals show abnormal performance on serial MoCAs. This innovative model allows longitudinal cognitive evaluation and enables prompt initiation of investigation and treatment when appropriate.

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International Journal of Geriatric Pshychiatry

Delirium in older COVID-19 patients: Evaluating risk factors and outcomes

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Abstract

Objectives

A high incidence of delirium has been reported in older patients with Coronavirus disease 2019 (COVID-19). We aimed to identify determinants of delirium, including the Clinical Frailty Scale, in hospitalized older patients with COVID-19. Furthermore, we aimed to study the association of delirium independent of frailty with in-hospital outcomes in older COVID-19 patients.

Methods

This study was performed within the framework of the multi-center COVID-OLD cohort study and included patients aged ≥60 years who were admitted to the general ward because of COVID-19 in the Netherlands between February and May 2020. Data were collected on demographics, co-morbidity, disease severity, and geriatric parameters. Prevalence of delirium during hospital admission was recorded based on delirium screening using the Delirium Observation Screening Scale (DOSS) which was scored three times daily. A DOSS score ≥3 was followed by a delirium assessment by the ward physician In-hospital outcomes included length of stay, discharge destination, and mortality.

Results

A total of 412 patients were included (median age 76, 58% male). Delirium was present in 82 patients. In multivariable analysis, previous episode of delirium (Odds ratio [OR] 8.9 [95% CI 2.3–33.6] p = 0.001), and pre-existent memory problems (OR 7.6 [95% CI 3.1–22.5] p < 0.001) were associated with increased delirium risk. Clinical Frailty Scale was associated with increased delirium risk (OR 1.63 [95%CI 1.40–1.90] p < 0.001) in univariable analysis, but not in multivariable analysis. Patients who developed delirium had a shorter symptom duration and lower levels of C-reactive protein upon presentation, whereas vital parameters did not differ. Patients who developed a delirium had a longer hospital stay and were more often discharged to a nursing home. Delirium was associated with mortality (OR 2.84 [95% CI1.71–4.72] p < 0.001), but not in multivariable analyses.

Conclusions

A previous delirium and pre-existent memory problems were associated with delirium risk in COVID-19. Delirium was not an independent predictor of mortality after adjustment for frailty.

Disponible en: **https://doi.org/10.1002/gps.5810**

Archives of Gerontology and Geriatrics

Examining the Combined Effects of Social Isolation and Loneliness on Memory: A Systematic Review

Ji Won Kang, Mark Oremus

Abstract

Background

Some research suggests social isolation and loneliness are important risk factors for reduced successful aging and cognitive health. However, findings are inconsistent and no prior systematic review has investigated whether social isolation and loneliness are associated with the memory domain of cognition. This review examined whether social isolation and loneliness individually and jointly affected the memory of middle- and older-aged adults.

Methods

We used PubMed, PsycInfo, and Scopus to search for comparative studies that examined the impact of both loneliness and social isolation (e.g., social activity, social networks) on memory (including all subtypes) in populations aged ≥ 45 years. Three raters performed data extraction and risk of bias assessment using the Joanna Briggs Institute checklist. Data were synthesized narratively following the Synthesis without Meta-Analysis guideline.

Results

In 12 included articles, higher levels of loneliness and social isolation (combining a range of different indicators) were associated with lower memory performance, where the interaction between loneliness and social isolation had the largest adverse effect on memory, followed by social isolation alone, and followed by loneliness alone.

However, substantial heterogeneity was observed in the composition of the two most common indicators of social isolation (social network size, social activity participation), with the magnitude of most results being clinically non-important. Most articles had moderate risk of bias.

Conclusion

This review found an inverse association between social isolation/loneliness and memory, and outlines future steps to systematically combine the two constructs and measure social isolation in a consistent, multi-modal format.

Disponible en: **https://doi.org/10.1016/j.archger.2022.104801**

Drugs and Aging

ThinkCascades: A Tool for Identifying Clinically Important Prescribing Cascades Affecting Older People

Lisa M. McCarthy, et al.

Abstract

Background and Objective

Prescribing cascades occur when a drug is prescribed to manage side effects of another drug, typically when a side effect is misinterpreted as a new condition. A consensus list of clinically important prescribing cascades that adversely affect older persons' health (i.e., where risks of the prescribing cascade usually exceed benefits) was developed to help identify, prevent, and manage prescribing cascades.

Methods

Three rounds of a modified Delphi process were conducted with a multidisciplinary panel of 38 clinicians from six countries with expertise in geriatric pharmacotherapy. The clinical importance of 139 prescribing cascades was assessed in Round 1. Cascades highly rated by ≥ 70% of panelists were included in subsequent rounds. Factors influencing ratings in Rounds 1 and 3 were categorized. After three Delphi rounds, highly rated prescribing cascades were reviewed by the study team to determine the final list of clinically important cascades consistent with potentially inappropriate prescribing.

Results

After three rounds, 13 prescribing cascades were highly rated by panelists. Following a study team review, the final tool includes nine clinically important prescribing cascades consistent with potentially inappropriate prescribing. Panelists reported that their ratings were influenced by many factors (e.g., how commonly they encountered the medications involved and the cascade itself, the severity of side effects, availability of alternatives). The relative importance of these factors in determining clinical importance varied by panelist.

Conclusions

A nine-item consensus-based list of clinically important prescribing cascades, representing potentially inappropriate prescribing, was developed. Panelists' decisions about what constituted a clinically important prescribing cascade were multi-factorial. This tool not only raises awareness about these cascades but will also help clinicians recognize these and other important prescribing cascades. This list contributes to the prevention and management of polypharmacy and medication-related harm in older people.

Disponible en: **https://link.springer.com/article/10.1007/s40266-022-00964-9**

REVISTAS MEDICINA GENERAL

Revista Clínica Española

Evaluación de conocimientos, barreras y actitudes en el manejo de la diabetes tipo 2 en pacientes de edad avanzada: estudio Delphi en atención primaria y hospitalaria

R. Gómez-Huelgasa, F. Gómez-Peraltac, F.X. Cosd

Abstract

Objetivo:

Explorar actitudes en la práctica clínica habitual de un grupo multidisciplinar de médicos en España en el manejo de pacientes de edad avanzada o frágiles con diabetes mellitus tipo 2.

Métodos:

Se utilizó una encuesta mixta tipo Delphi y preguntas de opinión, actitud y comportamiento. Se compararon las percepciones en atención primaria (n=211) y en atención hospitalaria (n=80).

Resultados:

Se obtuvo consenso en todos los enunciados. El 87% de participantes consideró que los trastornos psiquiátricos graves condicionan el tratamiento antidiabético, y el 72% que la evaluación psicocognitiva es tan relevante como la del resto de comorbilidades. Los médicos de atención hospitalaria consideraron con mayor frecuencia que la comorbilidad afecta al autocuidado (95,0% vs. 82,9%), que la ausencia de desintensificación es una forma de inercia terapéutica (88,8% vs. 76,3%), que clasificar al adulto mayor como frágil es fundamental para elegir objetivos (96,3% vs. 87,7%), que debe valorarse la desintensificación del tratamiento antidiabético y el control de factores de riesgo cardiovascular en mayores de 80 años (90,0% vs. 78,7%) y que la diabetes mellitus tipo 2 predispone a la sarcopenia (86,3% vs. 71,6%). La utilidad de las guías clínicas fue más valorada entre los participantes de atención primaria (79,1% vs. 72,5%).

Conclusiones:

Existen aspectos susceptibles de mejora en el manejo de pacientes de edad avanzada o frágiles con diabetes mellitus tipo 2: la inercia en la desintensificación del tratamiento, la evaluación psicocognitiva o la identificación de fragilidad y sarcopenia.

Disponible en: 10.1016/j.rce.2021.11.007

JAMDA Journal of the American Medical Directors Association

Factors Associated with Potentially Harmful Medication Prescribing in Nursing Homes: A Scoping Review

Jessica P. Lipori, MSEd, Emily Tu, BA, Theresa I. Shireman, PhD, Lauren Gerlach, DO, MS, Antoinette B. Coe, PharmD, PhD, Kira L. Ryskina, MD, MSHP

Abstract

Objectives:

To summarize current evidence regarding facility and prescriber characteristics associated with potentially harmful medication (PHM) use by residents in nursing homes (NHs), which could inform the development of interventions to reduce this potentially harmful practice.

Design:

Scoping review.

Setting and Participants:

Studies conducted in the United States that described facility and prescriber factors associated with PHM use in NHs.

Methods:

Electronic searches of PubMed/MEDLINE were conducted for articles published in English between April 2011 and November 2021. PHMs were defined based on the Beers List criteria. Studies testing focused interventions targeting PHM prescribing or deprescribing were excluded. Studies were characterized by the strengths and weaknesses of the analytic approach and generalizability.

Results:

Systematic search yielded 1253 articles. Of these, 29 were assessed in full text and 20 met inclusion criteria. Sixteen examined antipsychotic medication (APM) use, 2 anticholinergic medications, 1 sedative-hypnotics, and 2 overall PHM use. APM use was most commonly associated with facilities with a higher proportion of male patients, younger patients, and patients with severe cognitive impairment, anxiety, depression, and aggressive behavior. The use of APM and anticholinergic medications was associated with low registered nurse staffing ratios and for-profit facility status. No studies evaluated prescriber characteristics.

Conclusions and Implications:

Included studies primarily examined APM use. The most commonly reported facility characteristics were consistent with previously reported indicators of poor NH quality and NHs with patient case mix more likely to use PHMs.

Disponible en: https://doi.org/10.1016/j.jamda.2022.06.008

Impact of diabetes on the management and outcomes in atrial fibrillation: an analysis from the ESC-EHRA EORP-AF Long-Term General Registry

Wern Yew Ding, Agnieszka Kotalczyk, Giuseppe Boriani, Laurent Fauchier, Gregory.Y.H. Lip

Abstract

Background:

The prevalence of atrial fibrillation(AF) and diabetes mellitus is rising to epidemic proportions. We aimed to assess the impact of diabetes on the management and outcomes of patients with AF.

Methods:

The EORP-AF General Long-Term Registry is a prospective, observational registry from 250 centres across 27 European countries. Outcomes of interest were as follows: i)rhythm control interventions; ii)quality of life; iii)healthcare resource utilisation; and iv)major adverse events.

Results:

Of 11,028 patients with AF, the median age was 71 (63–77) years and 2537 (23.0%) had diabetes. Median follow-up was 24 months. Diabetes was related to increased use of anticoagulation but less rhythm control interventions. Using multivariable analysis, at 2-year follow-up, patients with diabetes were associated with greater levels of anxiety (p = 0.038) compared to those without diabetes. Overall, diabetes was associated with worse health during follow-up, as indicated by Health Utility Score and Visual Analogue Scale. Healthcare resource utilisation was greater with diabetes in terms of length of hospital stay (8.1 (±8.2) vs. 6.1 (±6.7) days); cardiology and internal medicine/general practitioner visits; and emergency room admissions. Diabetes was an independent risk factor of major adverse cardiovascular event (MACE; HR 1.26 [95% CI, 1.04–1.52]), all-cause mortality (HR 1.28 [95% CI, 1.08–1.52]), and cardiovascular mortality (HR 1.41 [95% CI, 1.09–1.83]).

Conclusion:

In this contemporary AF cohort, diabetes was present in 1 in 4 patients and it served as an independent risk factor for reduced quality of life, greater healthcare resource utilisation and excess MACE, all-cause mortality and cardiovascular mortality. There was increased use of anticoagulation therapy in diabetes but with less rhythm control interventions.

Disponible en: https://doi.org/10.1016/j.ejim.2022.04.026