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REVISIÓN BIBLIOGRÁFICA JUNIO-AGOSTO 2024: Selección de artículos

REVISTAS GERIÁTRICAS

Age and Ageing

Effects of the discontinuation of antihypertensive treatment on neuropsychiatric symptoms and quality of life in nursing home residents with dementia (DANTON): a multicentre, open-label, blinded-outcome, randomised controlled trial

Jonathan M K Bogaerts, Jacobijn Gussekloo, Bianca E M de Jong-Schmit, Saskia Le Cessie, Simon P Mooijaart, Roos C van der Mast, Wilco P Achterberg, Rosalinde K E Poortvliet

Abstract

Background

Based on observational studies and randomised controlled trials (RCTs), the benefit–harm balance of antihypertensive treatment in older adults with dementia is unclear.

Objectives

To assess whether discontinuing antihypertensive treatment reduces neuropsychiatric symptoms (NPSs) and maintains quality of life (QoL) in nursing home residents with dementia.

Design

Open-label, blinded-outcome RCT. Randomisation 1:1, stratified by nursing home organisation and baseline NPS. Trial registration: NL7365.

Measurements

Co-primary outcomes NPS (Neuropsychiatric Inventory-Nursing Home [NPI-NH]) and QoL (Qualidem) at 16 weeks.

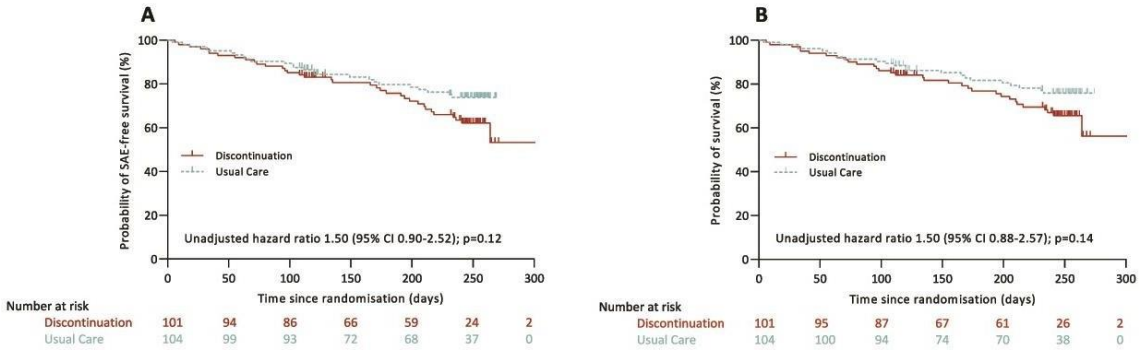
Results

From 9 November 2018 to 4 May 2021, 205 participants (median age 85.8 [IQR 79.6–89.5] years; 79.5% female; median SBP 134 [IQR 123–146] mmHg) were randomised to either

antihypertensive treatment discontinuation (n = 101) or usual care (n = 104). Safety concerns, combined with lacking benefits, prompted the data safety and monitoring board to advice a premature cessation of randomisation. At 16-week follow-up, no significant differences were found between groups for NPI-NH (adjusted mean difference 1.6 [95% CI –2.3 to 5.6]; P = 0.42) or Qualidem (adjusted mean difference − 2.5 [95% CI –6.0 to 1.0]; P = 0.15). Serious adverse events (SAEs) occurred in 36% (discontinuation) and 24% (usual care) of the participants (adjusted hazard ratio 1.65 [95% CI 0.98–2.79]). All 32-week outcomes favoured usual care.

Conclusions

Halfway through this study, a non-significant increased SAE risk associated with discontinuing antihypertensive treatment was observed, and an associated interim analysis showed that significant worthwhile health gain for discontinuation of antihypertensive treatment was unlikely. This unbeneficial benefit–harm balance shows that discontinuation of antihypertensive treatment in this context does not appear to be either safe or beneficial enough to be recommended in older adults with dementia.



Disponible en: https://doi.org/10.1093/ageing/afae133

Archives of Gerontology and Geriatrics

Reducing the drug burden of sedative and anticholinergic medications in older adults: a scoping review of explicit decision criteria

Rodríguez-Ramallo a, Nerea Báez-Gutiérrez b, Ángela Villalba-Moreno c, Didiana Jaramillo Ruiz d, Bernardo Santos-Ramos c, Elena Prado-Mel c, Susana Sanchez-Fidalgo

Abstract

Objectives

To describe the extent, characteristics, and knowledge gaps regarding explicit decision criteria for deprescribing drugs with anticholinergic or sedative properties (Ach/Sed) in older adults.

Setting and Participants

Original studies, clinical trial protocols, grey literature, and Summaries of Product Characteristics.

Methods

Searches targeting explicit decision criteria for deprescribing Ach/Sed were performed across MEDLINE, EMBASE, CINAHL, and Web of Science, including trial registries (clinicaltrials.gov, ICTRP, EU-CTR, ANZCTR) for pertinent articles, study protocols. Additionally, to encompass non-traditional or 'grey literature' sources, Google searches and relevant agency websites were explored, alongside the summary of product characteristics for Ach/Sed.

Results

The initial literature search identified 8,192 unique data sources. After review, 188 original articles or books, 79 internet sources, and 127 SmPCs were included. Examining these sources for explicit criteria for 154 Ach/Sed, overall, 1,271 explicit criteria guidance for identifying clinical scenarios warranting deprescription of Ach/Sed across 145/154 Ach/Sed were identified. These criteria were identified mainly from qualitative research and Summaries of Product Characteristics. Additionally, 455 criteria-based recommendations suggesting approaches for tapering implementation across 76/154 Ach/Sed wereidentified, mostly from sources classified as expert opinions. Significant heterogeneity was found across the approaches for tapering Ach/Sed.

Conclusions

This scoping review provides a comprehensive overview of the literature providing guidance for clinical scenarios where Ach/Sed should be deprescribed and highlights the existing knowledge gaps regarding comprehensive guidance on tapering these drugs which warranties future research and development.

Disponible en: https://doi.org/10.1016/j.archger.2024.105365

The impact of frailty on initiation, continuation and discontinuation of secondary prevention medications following myocardial infarction

Hannah Doody, Justine Ayre, Adam Livori, Jenni Ilomäki, Viviane Khalil, J. Simon Bell, Jedidiah I Morton

Abstract

Aim

To evaluate the association between frailty and initiating, continuing, or discontinuing secondary prevention medications following myocardial infarction (MI).

Methods

We conducted a cohort study using linked health data, including all adults aged ≥65 years who discharged from hospital following MI from January 2013 to April 2018 in Victoria, Australia (*N* = 29,771). The Hospital Frailty Risk Score (HFRS) was used to assess frailty. Logistic regression was used to investigate associations of frailty with initiation, continuation, and discontinuation of secondary prevention medications (P2Y12 inhibitor antiplatelets, beta-blockers, renin-angiotensin-aldosterone system (RAAS) inhibitors, and lipid-lowering therapies) in the 90 days from discharge post-MI, by HFRS, adjusted for age, sex, and Charlson Comorbidity Index.

Results

Increasing frailty was associated with lower probability of initiating and continuing P2Y12 inhibitors, RAAS inhibitors, and lipid-lowering therapies, but not beta-blockers. At at an HFRS of 0, the predicted probabiliy of having all four medications initiated or continued was 0.59 (95 %CI 0.57–0.62) for STEMI and 0.35 (0.34–0.36) for non-STEMI, compared to 0.38 (0.33–0.42) and 0.16 (0.14–0.18) at an HFRS of 15. Increasing frailty was associated with higher probability of discontinuing these medications post-MI. The predicted probability of discontinuing at least one secondary prevention medication post-MI at an HFRS of 0 was 0.10 (0.08–0.11) for STEMI and 0.14 (0.13–0.15) for non-STEMI, compared to 0.27 (0.22–0.32) and 0.34 (0.32–0.36) at an HFRS of 15.

Conclusions

People with higher levels of frailty were managed more conservatively following MI than people with lower levels of frailty. Whether this conservative treatment is justified warrants further study.

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BMC Geriatrics

A quantitative study on the impact of a community falls pharmacist role, on medicines optimisation in older people at risk of falls

Paula Crawford, Rick Plumb, Paula Burns, Stephen Flanagan & Carole Parsons

Abstract

Background

The World Falls guidance includes medication review as part of its recommended multifactorial risk assessment for those at high risk of falling. Use of Falls Risk Increasing Drugs (FRIDs) along with polypharmacy and anticholinergic burden (ACB) are known to increase the risk of falls in older people.

Method

The impact of a community falls pharmacist within a hospital Trust, working as part of a multi-professional community falls prevention service, was evaluated in 92 people aged 65 years or older, by analysing data before and after pharmacist review, namely: number and type of FRIDs prescribed; anticholinergic burden score using ACBcalc®; appropriateness of

medicines prescribed; bone health review using an approved too; significance of clinical intervention; cost avoidance, drug cost savings and environmental impact.

Results

Following pharmacist review, there was a reduction in polypharmacy (mean number of medicines prescribed per patient reduced by 8%; $p < 0.05$) and anticholinergic burden score (average score per patient reduced by 33%; $p < 0.05$). Medicines appropriateness improved (Medicines Appropriateness Index score decreased by 56%; $p < 0.05$). There were 317 clinically significant interventions by the community falls pharmacist. One hundred and one FRIDs were deprescribed. Annual cost avoidance and drug cost savings were £40,689-£82,642 and avoidable carbon dioxide (CO2) emissions from reducing inappropriate prescribing amounted to 941 kg CO2.

Conclusions

The community falls pharmacist role increases prescribing appropriateness in the older population at risk of falls, and is an effective and cost-efficient means to optimise medicines in this population, as well as having a positive impact on the environment.

Disponible en: https://doi.org/10.1186/s12877-024-05189-6

Multidisciplinary medication review during older patient hospitalization according to STOPP/START criteria reduces potentially inappropriate prescriptions: MoPIM cohort study

Sara Ortonobes, Susana Herranz, Marina Lleal, Daniel Sevilla-Sánchez, Rosa Jordana, Oscar Mascaró, Olivia Ferrández, Elisabet de Jaime, Rafael Estrada, Gloria Julia Nazco, Marisa Baré

Abstract

Purpose

Multimorbidity and polypharmacy in older adults converts the detection and adequacy of potentially inappropriate drug prescriptions (PIDP) in a healthcare priority. The objectives of this study are to describe the clinical decisions taken after the identification of PIDP by

clinical pharmacists, using STOPP/START criteria, and to evaluate the degree of accomplishment of these decisions.

Methods

Multicenter, prospective, non-comparative cohort study in patients aged 65 and older, hospitalized because of an exacerbation of their chronic conditions. Each possible PIDP was manually identified by the clinical pharmacist at admission and an initial decision was taken by a multidisciplinary clinical committee. At discharge, criteria were re-applied and final decisions recorded.

Results

From all patients (n = 674), 493 (73.1%) presented at least one STOPP criteria at admission, significantly reduced up to 258 (38.3%) at discharge. A similar trend was observed for START criteria (36.7% *vs.* 15.7%). Regarding the top 10 most prevalent STOPP criteria, the clinical committee initially agreed to withdraw 257 (34.2%) prescriptions and to modify 93(12.4%) prescriptions. However, the evaluation of final clinical decisions revealed that 503(67.0%) of those STOPP criteria were ultimately amended. For the top 10 START criteria associated PIDP, the committee decided to initiate 149 (51.7%) prescriptions, while a total of 198 (68.8%) were finally introduced at discharge.

Conclusions

The clinical committee, through a pharmacotherapy review, succeeded in identifying and reducing the degree of prescription inadequacy, for both STOPP and START criteria, in older patients with high degree of multimorbidity and polypharmacy.

Disponible en: https://doi.org/10.1186/s12877-024-05022-0

Drugs and Aging

Respiratory Syncytial Virus Infection in Older Adults: An Update

Franco Alfano, Tommaso Bigoni, Francesco Paolo Caggiano & Alberto Papi

Abstract

Respiratory syncytial virus (RSV) infection represents one of the most common infections during childhood, with significant morbidity and mortality in newborns and in the early years of life. RSV is a common infection throughout all age groups, largely undetected and underestimated in adults, with a disproportionately high impact in older individuals. RSV infection has a wide range of clinical presentations, from asymptomatic conditions to acute pneumonia and severe life-threatening respiratory distress, including exacerbations of underlying chronic conditions. Overall, the incidence of RSV infections requiring medical attention increases with age, and it is highest among persons ≥ 70 years of age. As a consequence of a combination of an aging population, immunosenescence, and the related increased burden of comorbidities, high-income countries are at risk of developing RSV epidemics. The standard of care for RSV-infected patients remains supportive, including fluids, antipyretics, and oxygen support when needed. There is an urgent need for antivirals and preventive strategies in this population, particularly in individuals at higher risk of severe outcomes following RSV infection. In this review, we describe prevention and treatment strategies for RSV illnesses, with a deep focus on the novel data on vaccination that has become available (Arexvy, GSK, and Abrysvo, Pfizer) for older adults.

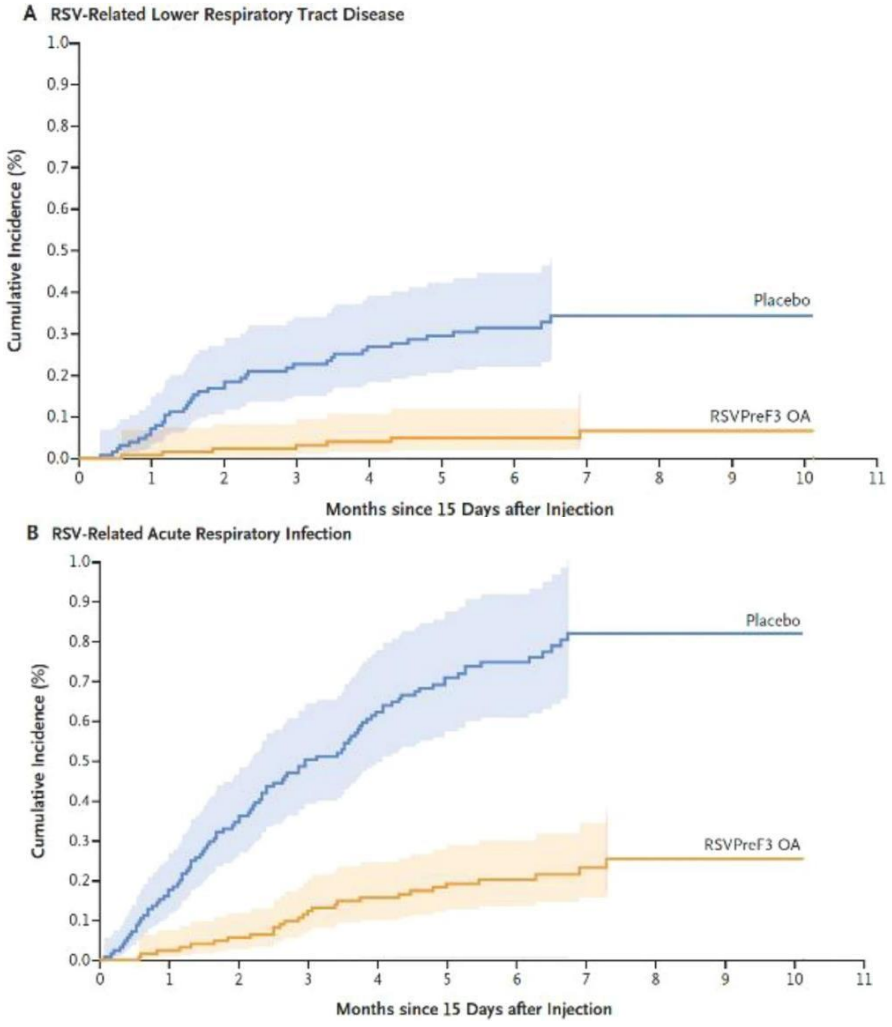

Figura 1. Eficacia de la vacuna RSVPreF3 OA en la reducción de la incidencia de enfermedades del tracto respiratorio inferior por VRS e infecciones respiratorias agudas.

Disponible en: https://doi.org/10.1007/s40266-024-01118-9

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Journal of the American Geriatrics Society

Melatonin does not reduce delirium severity in hospitalized older adults: Results of a randomized placebo-controlled trial

Peter W. Lange MBBS, Alisa Turbić BSc, Cheng Hwee Soh PhD, Daniel Clayton-Chubb MD, Wen Kwang Lim MD, Rachel Conyers PhD, Rosie Watson PhD, Andrea B. Maier

Abstract

Background

Delirium is common in older inpatients, causing distress, cognitive decline, and death. Current therapies are unsatisfactory, limited by lack of efficacy and adverse effects. There is an urgent need for effective delirium treatment. Sleep wake cycle is disturbed in delirium; endogenous Melatonin is perturbed, and exogenous Melatonin is a safe and effective medication for sleep disorders. This study Aims to determine the effect of oral Melatonin 5 mg immediate release (IR) nightly for five nights on the severity of delirium in older (≥65 years) medical inpatients.

Methods

This was a double-blinded, randomized controlled trial in general internal medicine units of a tertiary teaching hospital. Older inpatients with Confusion Assessment Method positive, hyperactive or mixed delirium within 48 h of admission or onset of in-hospital delirium were included. The primary outcome was change in delirium severity measured with the Memorial Delirium Assessment Scale (MDAS). A previous pilot trial showed 120 participants randomized 1:1 to Melatonin or Placebo would provide 90% power to demonstrate a 3-point reduction in the MDAS.

Results

One hundred and twenty participants were randomized, 61 to Melatonin 5 mg and 59 to Placebo. The medication was well tolerated. The mean MDAS improvement was 4.9 (SD 7.6) in the Melatonin group and 5.4 (SD 7.2) in the Placebo group, *p*-value 0.42, a non-significant difference. A post-hoc analysis showed length of stay (LOS) was shorter in the intervention group (median 9 days [Interquartile Range (IQR) 4, 12] vs. Placebo group 10 [IQR 6, 16] *p*-value = 0.033, Wilcoxon Rank Sum test).

Conclusions

This trial does not support the hypothesis that Melatonin reduces the severity of delirium. This may be due to no effect of Melatonin, a smaller effect than anticipated, an effect not captured on a multidimensional delirium assessment scale, or a type II statistical error. Melatonin may improve LOS; this hypothesis should be studied.

Disponible en: https://doi.org/10.1111/jgs.18825

Which older adults are at highest risk of prescribing cascades? A national study of the gabapentinoid–loop diuretic cascade

Matthew E. Growdon MD, MPH, Bocheng Jing MS, Earl J. Morris PharmD, PhD, W. James Deardorff MD, W. John Boscardin PhD, Amy L. Byers PhD, Kenneth S. Boockvar

Abstract

Background

Prescribing cascades are important contributors to polypharmacy. Little is known about which older adults are at highest risk of experiencing prescribing cascades. We explored which older veterans are at highest risk of the gabapentinoid (including gabapentin and pregabalin)–loop diuretic (LD) cascade, given the dramatic increase in gabapentinoid prescribing in recent years.

Methods

Using Veterans Affairs and Medicare clAims data (2010–2019), we performed a prescription sequence symmetry analysis (PSSA) to assess loop diuretic initiation before and after gabapentinoid initiation among older veterans (≥66 years). To identify the cascade, we calculated the adjusted sequence ratio (aSR), which assesses the temporality of LD relative to gabapentinoid initiation. To explore high-risk groups, we used multivariable logistic regression with prescribing order modeled as a binary dependent variable. We calculated adjusted odds ratios (aORs), measuring the extent to which factors are associated with one prescribing order versus another.

Results

Of 151,442 veterans who initiated a gabapentinoid, there were 1,981 patients who initiated a LD within 6 months after initiating a gabapentinoid compared to 1,599 patients who initiated a LD within 6 months before initiating a gabapentinoid. In the gabapentinoid–LD group, the mean age was 73 years, 98% were male, 13% were Black, 5% were Hispanic, and 80% were White. Patients in each group were similar across patient and health utilization factors (standardized mean difference <0.10 for all comparisons). The aSR was 1.23 (95% CI: 1.13, 1.34), strongly suggesting the cascade's presence. People age ≥85 years were less likely to have the cascade (compared to 66–74 years; aOR 0.74, 95% CI: 0.56–0.96), and people taking ≥10 medications were more likely to have the cascade (compared to 0–4 drugs; aOR 1.39, 95% CI: 1.07–1.82).

Conclusions

Among older adults, those who are younger and taking many medications may be at higher risk of the gabapentinoid–LD cascade, contributing to worsening polypharmacy and potential drug-related harms. We did not identify strong predictors of this cascade,

suggesting that prescribing cascade prevention efforts should be widespread rather than focused on specific subgroups.

Disponible en: https://doi.org/10.1111/jgs.18892

International Journal of Geriatric Psychiatry

Non-Pharmacological Interventions in the Management of Dementia-Related Psychosis: A Systematic Review and Meta-Analysis

Alice Burnand, Tasmin Rookes, Farah Mahmood, Nathan Davies, Kate Walters, Stephen Orleans-Foli, Madiha Sajid, Victoria Vickerstaff, Rachael Frost

Abstract

Objectives

As populations age globally, there is an increasing prevalence of dementia, with an estimated 153 million living with dementia by 2050. Up to 70% of people with dementia experience dementia-related psychosis (D-RP). Antipsychotic medications are associated with many adverse effects in older people. This review **Aim**s to evaluate the evidence of non-pharmacological interventions in managing D-RP.

Method

The search of Medline, EMBASE, Web of Science, CINAHL, PsycINFO, and Cochrane included randomised controlled trials that evaluated non-pharmacological interventions. Data extraction and assessment of quality were assessed independently by two researchers. Heterogenous interventions were pooled using meta-analysis.

Results

A total of 18 articles (n = 2040 participants) were included and categorised into: sensory-, activity-, cognitive- and multi-component-orientated. Meta-analyses showed no significant impact in reducing hallucinations or delusions but person-centred care, cognitive rehabilitation, music therapy, and robot pets showed promise in single studies.

Conclusions and Implications

Future interventions should be developed and evaluated with a specific focus on D-RP as this was not the Aim for many of the included articles.

Disponible en: https://doi.org/10.1002/gps.6129

REVISTAS FARMACÉUTICAS

European Journal of Clinical Pharmacology

Risk of renal impairment in atypical antipsychotics: a systematic review and meta-analysis

Leong Tung Ong, Nicholas Ming Zher Chee & Audrey Joe Chii Loh

Abstract

Background

Atypical antipsychotics are associated with several adverse effects including metabolic syndrome, weight gain, QTc interval prolongation, and extrapyramidal effects. This study aims to investigate the risk of renal impairment in patients receiving atypical antipsychotics.

Methods

A systematic literature search was conducted via PubMed and Ovid SP and Web of Science to retrieve studies reporting the risk of renal impairment in patients receiving atypical antipsychotic treatment. The pooled risk ratio (RR) of renal impairment and the subgroup analysis was calculated using the random-effects generic inverse variance method in Cochrane Review Manager.

Results

A total of 4 studies involving 514,710 patients (221, 873 patients on atypical antipsychotics/CKD and 292, 837 controls) were included in this meta-analysis. Patients on atypical antipsychotics exhibited an increased risk of renal impairment, with a pooled risk ratio of 1.34 (95%CI 1.23–1.47). Subgroup analysis demonstrated that atypical antipsychotic use was associated with an increased risk of both acute kidney injury (AKI) (RR 1.51, 95%CI 1.34–1.71) and chronic kidney disease (CKD) (RR: 1.23, 95%CI 1.12–1.35).

Conclusions

Patients receiving atypical antipsychotics have an increased risk of renal impairment. Quetiapine carries the highest risk of renal impairment encompassing both AKI and CKD.

Disponible en: https://doi.org/10.1007/s00228-024-03714-5

Statin treatment for primary and secondary prevention in elderly patients—a cross-sectional study in Stockholm, Sweden

Björn Wettermark, Camelia Kalantaripour, Tomas Forslund & Paul Hjemdahl

Abstract

Age is a major risk factor for atherosclerotic cardiovascular disease (CVD) and death, but

there has been a debate about benefit-risk of statin treatment in the elderly with limited evidence on benefits for primary prevention, while there is strong evidence for its use in secondary prevention.

Methods

This is a cross-sectional study based on the regional healthcare database VAL containing all diagnoses and dispensed prescription drugs for all 174,950 inhabitants ≥ 75 years old in the Stockholm Region. Prevalence and incidence were analyzed by sex, age, cardiovascular risk, substance, and the intensity of treatment.

Results

A total of 35% of all individuals above the age of 75 in the region were treated with statins in 2019. The overall incidence in this age group was 31 patients per 1000 inhabitants. Men, individuals 75–84 compared to ≥ 85 years of age, and those with higher cardiovascular risk were treated to a greater extent. Simvastatin was used primarily by prevalent users and atorvastatin by incident users. The majority was treated with moderate-intensity dosages and fewer women received high intensity treatment.

Conclusions

Statins are widely prescribed in the elderly. Physicians seem to consider individual cardiovascular risk when deciding to initiate statin treatment for elderly patients, but here may still be some undertreatment among high-risk patients (especially women and elderly 85 + years) and some overtreatment among patients with low-risk for CVD.

Disponible en: https://doi.org/10.1007/s00228-024-03724-3

Predicción de reacciones adversas a medicamentos en pacientes geriátricos ingresados en unidades de cuidados intensivos

Fabiana Angelo Marques Carizio, Isabella do Vale de Souza, Thalita Zago Oliveira, Luana Sueli Silva, Natalia Chaguri Alves Rodrigues, Maria Olívia Barbosa Zanetti, Fabiana Rossi Varallo, Leonardo Régis Leira-Pereira

Introducción

El manejo de pacientes críticos en unidades de cuidados intensivos (UCI) enfrenta el desafío de la polifarmacia, que puede llevar a reacciones adversas a medicamentos (RAM), particularmente en pacientes ancianos.

Objetivo

Determinar si las puntuaciones de gravedad y pronóstico utilizadas habitualmente en la UCI están relacionadas con la predicción de reacciones adversas a los medicamentos (RAM) en pacientes ancianos ingresados en la UCI de un hospital universitario brasileño.

Métodos

Estudio de cohortes en esta UCI, utilizando las puntuaciones APACHE II, SAPS 3, GerontoNet ADR Risk Score y BADRI para evaluar gravedad, riesgo de RAM y pronóstico de los pacientes. Diariamente, se evaluó la gravedad clínica (mediante puntuación SOFA) y las RAM (mediante factores desencadenantes).

Resultados

Se identificaron 1.295 factores desencadenantes (mediana 30/paciente, IQR = 28), con 15 sospechas de RAM. No hubo correlación entre la gravedad del paciente y las RAM al ingreso (p=0,26), durante la hospitalización (p=0,91) o el seguimiento (p = 0,77). Tampoco hubo asociación entre muerte (p=0,28) o peor pronóstico y RAM (p>0,05). Las mayores puntuaciones del BADRI se correlacionaron con un mayor número de RAM (p=0,001).

Conclusiones

Los datos sugieren que el uso de puntuaciones clínicas de gravedad y pronóstico utilizadas en las UCI no es suficiente para guiar los esfuerzos activos de farmacovigilancia.

Disponible en: https://10.1016/j.farma.2024.03.004

Cuestionarios validados de adherencia a la medicación y factores asociados en pacientes crónicos: revisión sistemática

Aldana Intilangelo, Sofía Majic, Valeria Palchik, María Luz Traverso

Objetivo

Identificar cuestionarios validados para evaluar la adherencia a la medicación y sus factores asociados en pacientes adultos con enfermedades crónicas.

Método

Se realizó una revisión sistemática de publicaciones científicas que describen cuestionarios validados de adherencia a la medicación en PubMed y Scopus durante mayo 2022. La estrategia de búsqueda combinó el MeSH Heading «Medication adherence» con las palabras claves: «Questionnaire» y «Validation»; sumando «Spanish» para rescatar cuestionarios en nuestro idioma. Se seleccionaron revisiones sistemáticas, metaanálisis o artículos científicos con texto completo disponibles en español o inglés; publicados desde enero de 2000 a abril de 2022; que presentaban aplicación y validación de un cuestionario de adherencia a la medicación en adultos con enfermedades crónicas y publicaciones de la validación inicial del cuestionario, recuperadas a través de las citas bibliográficas de las publicaciones antes identificadas, aun cuando sean previas al año 2000.
Se siguieron directrices de las guías PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-Analyses) para representar el proceso de búsqueda, inclusión y exclusión de las publicaciones recuperadas.

Resultados

Se rescataron 97 registros en PubMed y 3 sumando «Spanish»; en Scopus se rescataron 334 registros y 13 con «Spanish». Se rescataron 118 registros a través de identificación de citas bibliográficas. A partir de su análisis, se identificaron 14 cuestionarios validados, aplicados en inglés y/o español en pacientes adultos con enfermedades crónicas. De cada cuestionario se describieron: denominación, autores, año de publicación, dimensiones (factores barreras yfacilitadores), cantidad y modo de redacción de los ítems, escala de respuesta, forma de administración, idioma y enfermedades de la validación inicial. De las validaciones posteriores se presentan solo las realizadas en inglés y/o español. Hasta el momento, 6 dedichos cuestionarios fueron validados en español y solo para determinadas enfermedadescrónicas.

Conclusiones

Se identificaron 14 cuestionarios validados, 6 de ellos cuentan con validación en idioma español. Los mismos están diseñados para evaluar adherencia a la medicación en forma integral, siendo útiles para ser aplicados en servicios farmacéuticos hospitalarios y comunitarios. Esta revisión provee herramientas para desarrollar y validar un cuestionario propio, adecuando la redacción al idioma y al contexto del sistema de salud local.

Disponible en: https://doi.org/10.1016/j.farma.2024.01.001

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Annals of pharmacotherapy

Sodium-Glucose Co-Transporter 2 Inhibitors and the Risk of Genitourinary Infections at HbA1c ≥10%: A Population Health-Based Retrospective Review

Bryce Ashby, PharmD, Marina Kawaguchi-Suzuki, PharmD, PhD and Ryan Wargo, PharmD

Abstract

Background

Sodium-glucose co-transporter 2 inhibitors (SGLT2i) are first-line treatment for type 2 diabetes. Evidence has shown a 3- to 5-fold increase in the risk of genitourinary infections with their use due to inhibition of renal glucose reabsorption, resulting in glucosuria. Increased glucosuria is thought to increase the risk of genitourinary infections at a greater degree in patients with a significantly elevated HbA1c (≥10%), and initiation of SGLT2i is often delayed in these patients. While a limited body of evidence exists indicating that A1c level is not an independent risk factor for SGLT2i-induced genitourinary infection, pragmatically this concern remains a barrier to SGLT2i utilization.

Objective

Evaluate the real-world genitourinary (GU) infection rate in patients receiving SGLT2i with a baseline HbA1c ≥10% compared to patients with a baseline HbA1c <10%.

Methods

This retrospective cohort study evaluated data from 5542 adult patients treated between January 2013 and January 2023, who were prescribed an SGLT2i. Data collected included sex, age, race/ethnicity, renal function, date of SGLT2i start, number of SGLT2i orders, name and dose of SGLT2i, HbA1c, and a predetermined set of diagnosis codes related to bacterial and fungal genitourinary infections. The primary outcome was the overall GU infection rate after SGLT2i initiation within groups of baseline HbA1c of ≥10% and <10%, and the secondary outcome was total GU infections within these same groups.

Results

The primary outcome was equivalent between those with HbA1c <10% and HbA1c ≥10% (0.0064 ± 0.0565 vs 0.0030 ± 0.0303 infection per month [mean ± standard deviation]; $P < 0.0001$ for both lower and upper bounds). There was no statistically significant difference in total GU infections between the same groups (0.027 ± 0.21 vs 0.015 ± 0.14, $P = 0.11$).

Female gender and prior recurrent infection were associated with increased GU infection after SGLT2i.

Conclusion and relevance

A baseline HbA1c ≥ 10% was not significantly associated with an increased risk of GU infection following the initiation of SGLT2i compared to those with a baseline HbA1c of <10%.

Disponible en: https://doi.org/10.1177/10600280241264585

Off-Label Reduced Dose Apixaban in Older Adults With Atrial Fibrillation and Associated Outcomes

Ashley M. Campbell, PharmD Elizabeth Pae, PharmD and Jessica DeAngelo, PharmD, MBA

Abstract

Background:

Apixaban is commonly used to prevent stroke in older adults with nonvalvular atrial fibrillation (AF). Although its package insert has specific dose reduction criteria, providers may dose reduce outside of these parameters based on clinical scenarios.

Objective:

The primary objective was to determine the incidence of apixaban off-label reduced dosing, while secondarily determining the safety and efficacy outcomes associated with such dosing.

Methods:

A retrospective analysis of patients aged 65 and older with orders for apixaban for AF was institutional review board (IRB)-approved and conducted across 3 academic medical centers. Patients receiving off-label reduced-dose apixaban (ie, "underdosed") were matched to a cohort of patients dosed according to the package insert at the standard dosing (5 mg twice daily) using stratified random sampling. Secondary outcomes included 1-year incidence of major bleeding, clinically relevant non-major bleeding (CRNMB), stroke or transient ischemic attack (TIA), and mortality. The Fisher exact tests were used to compare between-group differences.

Results:

Of the 1172 patients meeting initial inclusion criteria, 201 (17%) were dosed off-label, with 175 (15%) "underdosed." The 147 "underdosed" patients with documented follow-up were matched with 139 patients receiving standard Food and Drug Administration (FDA)-labeled dosing. There were no significant differences in incidence of stroke (2.7% vs 2.2%), major bleeding (0% vs 0.7%), and CRNMB (2.7% vs 1.4%) in the off-label reduced dosing versus standard dosing groups. All-cause mortality was higher in the off-label reduced-dose group (16 [10.9%] vs 2 [1.4%], $P < 0.05$).

Conclusion and Relevance:

Older adults with nonvalvular AF are commonly prescribed lower-than-recommended doses of apixaban. However, no significant association was found between empiric off-label reduced dosing and stroke or bleeding outcomes.

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