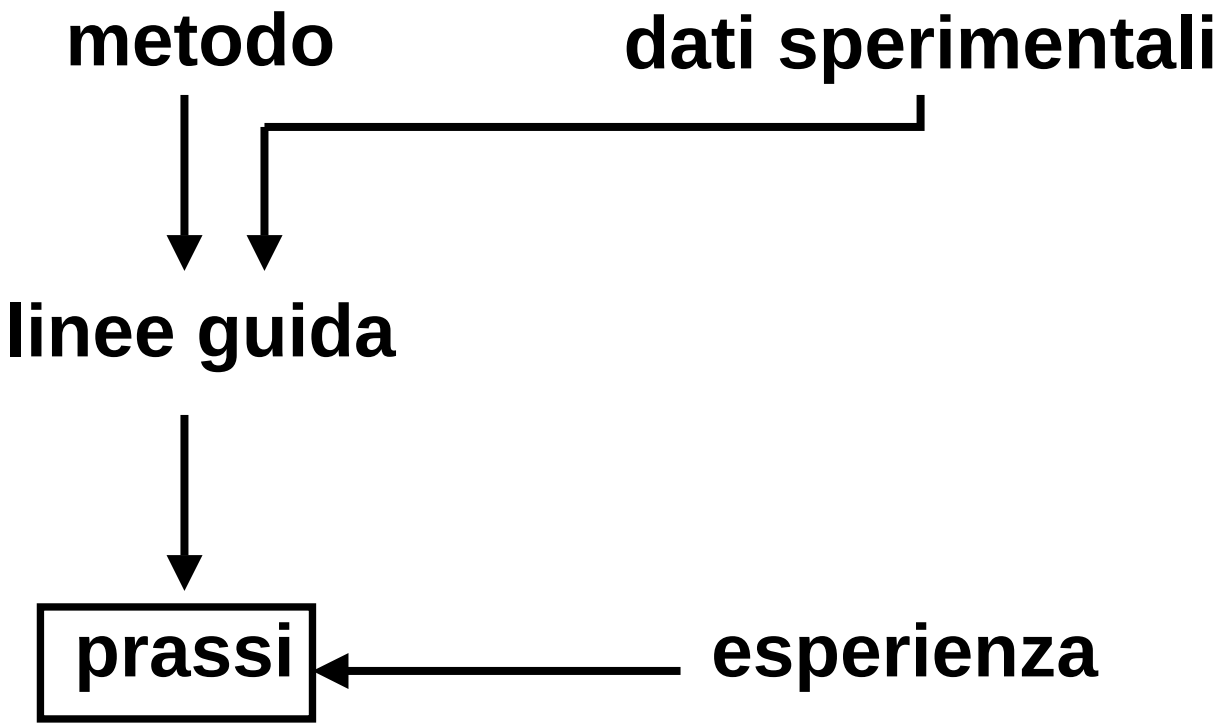
Gruppo di ricerca geriatrica

“Recenti acquisizioni in geriatria”

Journal Club – 2 settembre 2005

La geriatria come metodo e come prassi

Marco Trabucchi


metodo
dati sperimentali
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esperienza

14 LUG. 2005

ELSEVIER

THE LANCET

Volume 366 Number 9480 Pages 95–176 July 9–15, 2005 www.thelancet.com

"If everything has to be double-blinded, randomised, and evidence-based, where does that leave new ideas?"

See Correspondence page 122

Articles

Prenatal detection of Down's syndrome
See page 123

Articles

Factors in risk of hip fracture
See page 129

Articles

Routine use of Hib conjugate vaccine in The Gambia
See page 144

Research Letters

Growth in children after kidney transplantation
See page 151

Seminar

Acute rheumatic fever
See page 155

La geriatria spinge all'innovazione tutta la medicina: il ruolo della ricerca sperimentale e teorica.

D'altra parte, nessuno può negare una condizione di crisi che induce chi ha a cuore la cura dei vecchi a ricercare nuove strade fuori della demagogia o dell'"epidemiologia negativa".

Pensare, studiare, sperimentare…
non denunciare

In the hospital, a degrading shift from person to patient.

(New York Times, 16 agosto 2005)

Unnecessary Drug Use in Frail Older People at Hospital Discharge

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CONCLUSION: A high prevalence of unnecessary drug use at discharge was found in frail hospitalized elderly patients. Additional studies are needed to identify predictors and prevalence of unnecessary drug use in non-veteran populations so that interventions can be designed to reduce the problem. **J Am Geriatr Soc 53:1518–1523, 2005.**

Prevalence of Unnecessary Drug Use by Department of Veterans Affairs Medication Classes (n = 250 unnecessary medications)

Drug Class	n	Percentage of Total Unnecessary Medications
Gastrointestinal	67	26.8
Histamine 2 receptor antagonists	36	
Laxatives/stool softeners	20	
Proton pump inhibitors	5	
Other	6	
Central nervous system	34	13.6
Tricyclic antidepressants	18	
Benzodiazepines	5	
Other	11	
Therapeutic nutrients/minerals	30	12.0
Ferrous sulfate	17	
Potassium	11	
Other	2	
Cardiovascular	21	8.4
Diuretics	5	
Nitroglycerin patch/nitrates	5	
Pentoxifylline	4	
Other	7	
Vitamins	21	8.4
Genitourinary	19	7.6
Anticholinergic agents	18	
Other	1	
Blood products/volume expanders	13	5.2
Ticlopidine	11	
Other	2	
Musculoskeletal	13	5.2
Quinine sulfate	5	
Nonsteroidal antiinflammatory drugs	5	
Other	3	
Hormones/synthetics/modifiers	10	4.0
Respiratory	8	3.2
Antiinfectives	8	3.2
Antihistamines	3	1.2
Other	3	1.2

(J Am Geriatr Soc 53:1518-1523, 2005)

Potentially Inappropriate Prescribing in Elderly Veterans: Are We Using the Wrong Drug, Wrong Dose, or Wrong Duration?

Mary Jo V. Pugh, PhD,[*†‡] *B. Graeme Fincke, MD,*[†‡] *Arlene S. Bierman, MD, MS,*[§] *Bei-Hung Chang, ScD,*[†‡] *Amy K. Rosen, PhD,*[†‡] *Francesca E. Cunningham, PharmD,*[‖¶] *Megan E. Amuan, MPH,*[†] *Muriel L. Burk, PharmD,*[‖¶] *and Dan R. Berlowitz, MD, MPH*[†‡]

JAGS 53:1282–1289, 2005

Queste analisi sono culturalmente vecchie di decenni e hanno portato solo ad una modesta riduzione di interventi inappropriati e quindi- forse- dannosi: evidentemente sono inutili!

Un impegno per superare la medicina “futile”, cercando di delineare solo quello che è essenziale per la cura, con la durezza di chi ritiene la salute degli anziani più importante del ruolo di critico “giornalistico”.

Un esempio di medicina futile

GIORNALE DI BRESCIA

Sabato 27 agosto 2005

Torace chiuso e cuore aperto: Brescia prima mondiale
L'INTERVENTO CHIRURGICO ALLA CLINICA UNIVERSITARIA

The Conflict Between Biogerontology and Antiaging Medicine—Do Geriatricians Have a Dog in This Fight?

William R. Hazzard, MD

we as geriatricians will remain solidly in the trenches caring for our patients, the most aged, complex, frail, and vulnerable—far removed from the fantasies of eternal life, much less the Fountain of Youth.

JAGS 53:1434–1435, 2005

Io ho ricevuto una serie rilevante di indicazioni dall'analisi accurata dei singoli casi, che mettono davanti alla realtà della condizione clinica dell'anziano, senza le astrazioni dell'EBM.

La variabilità della vita come via per raggiungere conoscenze formalizzate: un impegno delicato e difficile.

Clinical Practice Guidelines and Quality of Care for Older Patients With Multiple Comorbid Diseases

Implications for Pay for Performance

Cynthia M. Boyd, MD, MPH
Jonathan Darer, MD, MPH
Chad Boult, MD, MPH, MBA
Linda P. Fried, MD, MPH
Lisa Boult, MD, MPH, MA
Albert W. Wu, MD, MPH

JAMA. 2005;294:716-724

Treatment Regimen Based on Clinical Practice Guidelines for a Hypothetical 79-Year-Old Woman With Hypertension, Diabetes Mellitus, Osteoporosis, Osteoarthritis, and COPD*

Time	Medications†	Other
7:00 AM	Ipratropium metered dose inhaler 70 mg/wk of alendronate	Check feet Sit upright for 30 min on day when alendronate is taken Check blood sugar
8:00 AM	500 mg of calcium and 200 IU of vitamin D 12.5 mg of hydrochlorothiazide 40 mg of lisinopril 10 mg of glyburide 81 mg of aspirin 850 mg of metformin 250 mg of naproxen 20 mg of omeprazole	Eat breakfast 2.4 g/d of sodium 90 mmol/d of potassium Low intake of dietary saturated fat and cholesterol Adequate intake of magnesium and calcium Medical nutrition therapy for diabetes‡ DASH‡
12:00 PM		Eat lunch 2.4 g/d of sodium 90 mmol/d of potassium Low intake of dietary saturated fat and cholesterol Adequate intake of magnesium and calcium Medical nutrition therapy for diabetes‡ DASH‡
1:00 PM	Ipratropium metered dose inhaler 500 mg of calcium and 200 IU of vitamin D	
7:00 PM	Ipratropium metered dose inhaler 850 mg of metformin 500 mg of calcium and 200 IU of vitamin D 40 mg of lovastatin 250 mg of naproxen	Eat dinner 2.4 g/d of sodium 90 mmol/d of potassium Low intake of dietary saturated fat and cholesterol Adequate intake of magnesium and calcium Medical nutrition therapy for diabetes‡ DASH‡
11:00 PM	Ipratropium metered dose inhaler	
As needed	Albuterol metered dose inhaler	

Abbreviations: ADA, American Diabetes Association; COPD, chronic obstructive pulmonary disease; DASH, Dietary Approaches to Stop Hypertension.

*Clinical practice guidelines used: (1) Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure VII.[39] (2) ADA[19-32]; glycemic control is recommended; however, specific medicines are not described. (3) American College of Rheumatology[33-36]; recent evidence about the safety and appropriateness of cyclooxygenase inhibitors, particularly in individuals with comorbid cardiovascular disease, led us to omit them from the list of medication options, although they are discussed in the reviewed clinical practice guidelines. (4) National Osteoporosis Foundation[40]; this regimen assumes dietary intake of 200 IU of vitamin D. (5) National Heart, Lung, and Blood Institute and World Health Organization.[37,38]

†Taken orally unless otherwise indicated. The medication complexity score of the regimen for this hypothetical woman is 14, with 19 doses of medications per day, assuming 2 as needed doses of albuterol metered dose inhaler plus 70 mg/wk of alendronate.

‡DASH and ADA dietary guidelines may be synthesized, but the help of a registered dietitian is specifically recommended. Eat foods containing carbohydrate from whole grains, fruits, vegetables, and low-fat milk. Avoid protein intake of more than 20% of total daily energy; lower protein intake to about 10% of daily calories if overt nephropathy is present. Limit intake of saturated fat (<10% of total daily energy) and dietary cholesterol (<200-300 mg). Limit intake of *trans*unsaturated fatty acids. Eat 2 to 3 servings of fish per week. Intake of polyunsaturated fat should be about 10% of total daily energy.

JAMA. 2005;294:716-724

Clinical Practice Guidelines for Older Comorbid Patients

Renzo Rozzini MD, Marco Trabucchi MD*

Department of Internal Medicine and Geriatrics, Poliambulanza Hospital, Brescia, Italy
*Gerontological and Geriatric Society of Italy, President

The interesting paper by Boyd et al (1) is the exact description of practical difficulties faced by many physicians when treating a comorbid old patient also in countries such as Italy with a different reimbursement system.
From a geriatric point of view the reported observations are a progress, since they recognize the peculiarity of elderly patients, but -more in general- they are the description of a failure, stating the difficulties in building a network of guidelines for the treatment of comorbid conditions.
Only clinical experience may handle the complex procedures related with the definition of a treatment in old, frail patients affected by many different diseases (2). However we think that there are clinical models which may help physicians in their decisional process.

continua…

One may be the measurement of performance status (disability) as a parameter to address the therapy (less disabled is the patient, more aggressive may be the treatment, since his biological structure indicates a longer "natural" life expectancy)(3-4). Another is the choice of treating only active diseases and not risk factors (see in the paper by Boyd et al the prescription of alendronate, vitamin D, Calcium, and lovastatin). Finally it may be important to decide if treating diseases or illnesses, i.e. adopting only a palliative attitude directed toward symptoms (i.e. pain, dyspnoea, incontinence)(5); is it really a "life-saving drug" a beta blocker in patients with congestive heart failure whose prognosis is mainly determined by a cancer or a dementia?(6) or in patients with advanced heart failure whose end points of mortality and rehospitalization have been reported to occur in up to 81% of cases at 1 year independently from the treatment?(7) In this perspective will the hypothetical 79 years old woman described by by Boyd et al increase her life expectancy after a long lasting prescription of 12 separate medications? We agree that these indications are rather scanty, but most of them have an accepted scientific background and may make easier the decisional process in very old, frail, and comorbid subjects (8).

Noi sappiamo curare le “medical hot potatoes”?
Sono necessari cultura (linee guida), esperienza, coraggio di scelte anche innovative.

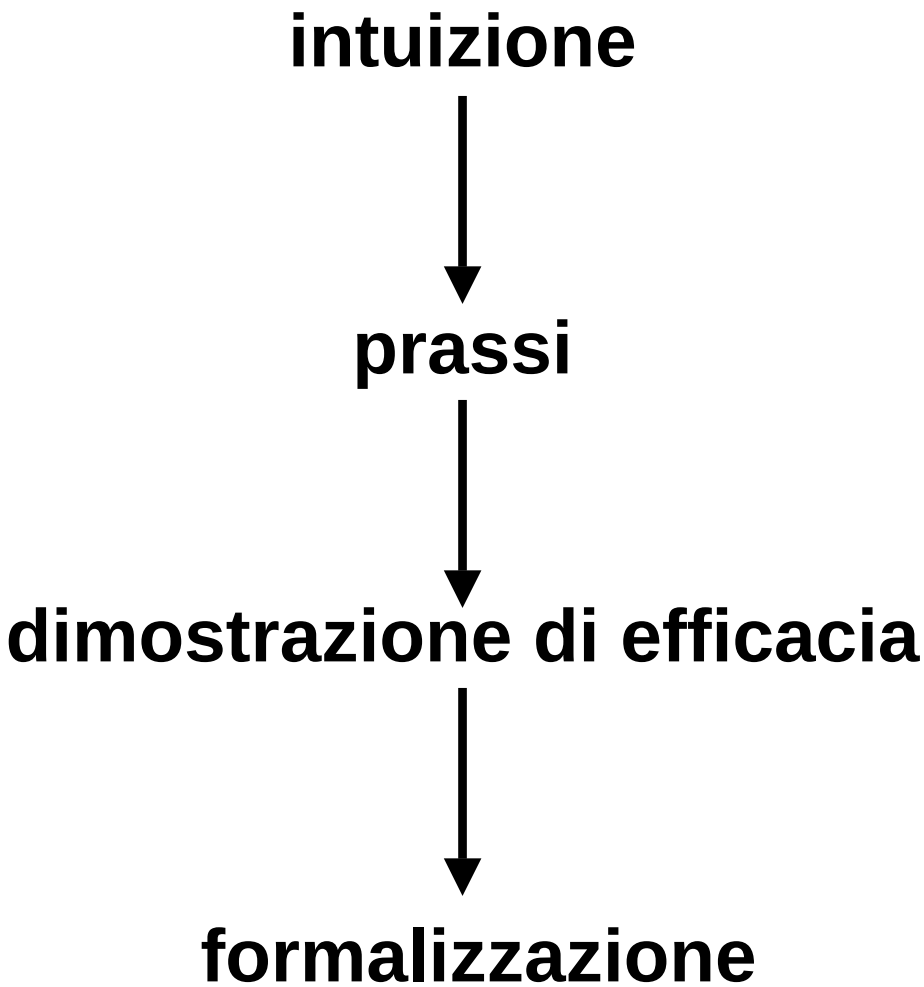
Un esempio di alcune recenti intuizioni, che non sono ancora innovazioni: il trattamento profilattico di una serie di condizioni cliniche nell'anziano ospedalizzato.
L'ascoltatore si metta nella condizione psicologica di sentire affermazioni "eretiche" rispetto alle conoscenze della medicina ufficiale; ma è ben noto che dal politicamente corretto non è mai venuta la rivoluzione.

Contradicted and Initially Stronger Effects in Highly Cited Clinical Research

John P. A. Ioannidis, MD

JAMA. 2005;294:218-228

Antibiotici, gastroprotettori, lassativi, eparine, aloperidolo: i big five di una medicina che vuole garantire all'anziano ricoverato in ospedale una riduzione degli eventi più comuni (infezioni, ulcere da stress, fecalomi, TVP o simili, delirium), anche se non siamo ancora in grado di dimostrare il rapporto costo efficacia di questi interventi.


intuizione
prassi
dimostrazione di efficacia
formalizzazione

Meta-Analysis: Antibiotic Prophylaxis Reduces Mortality in Neutropenic Patients

Anat Gafter-Gvili, MD; Abigail Fraser, MPH; Mical Paul, MD; and Leonard Leibovici, MD

Conclusions

Current Infectious Disease Society of America guidelines (8) do not endorse routine prophylaxis for neutropenic patients. Despite the limitations of the analysis, the benefit demonstrated in our review of reducing mortality probably outweighs detriments, such as cost, adverse effects, and development of resistance. Therefore, prophylaxis, preferably with a fluoroquinolone where resistance permits, should be considered for use in neutropenic patients. Since most trials in our review were of patients with hematologic cancer, prophylaxis should be considered for these patients who are usually at a higher risk for infection. The decision on the type of drug should be based on the local profile of pathogens in neutropenic patients and their susceptibility profiles.

Ann Intern Med. 2005;142:979-995.

Comorbidity Is a Better Predictor of Impaired Immunity than Chronological Age in Older Adults

Steven Charles Castle, MD,† *Koichi Uyemura, PhD,*† *Asif Rafi, MD,*† *Omosalewa Akande, BS,** *and Takashi Makinodan, PhD*†

J Am Geriatr Soc 53:1565–1569, 2005.

Questi dati sono sufficienti per giustificare una “copertura” antibiotica dei pazienti ospedalizzati con un forte carico di comorbilità?

Characteristics of 1250 hospitalized elderly patients according to age stratification.

	Total N=1250 N (%)/M±sd	<70 N=194 N (%)/M±sd	70-74 N=196 N (%)/M±sd	75-79 N=265 N (%)/M±sd	80-84 N=312 N (%)/M±sd	85-89 N=142 N (%)/M±sd	90+ N=141 N (%)/M±sd
Age	79.1±8.2	65.5±3.9	72.2±1.4	78.0±1.4	83.1±1.4	86.8±0.8	91.4±2.5
Gender (male)	405 (32.4)	94 (48.5)	67 (34.2)	87 (32.8)	83 (26.8)	38 (26.8)	35 (24.8)
Living alone	376 (30.2)	36 (18.7)	61 (31.6)	81 (31.3)	110 (35.4)	36 (25.5)	50 (35.0)
Geriatric Depression Scale-GDS*	5.2.±3.6	4.3.±3.6	4.8±3.6	5.8±3.7	5.4±3.4	5.2±3.7	5.3±3.6
Depressed (GDS 5+)	410 (40.4)	44 (28.4)	65 (36.1)	106 (46.5)	113 (44.3)	44 (41.5)	38 (41.3)
Mini Mental State Examination-MMSE	22.8±7.6	25.8±5.7	24.5±6.2	23.2±7.2	22.1±7.1	19.9±7.9	17.4±9.3
Dementia (MMSE <18)	263 (22.2)	19 (11.1)	23 (11.9)	46 (17.8)	70 (23.5)	47 (34.3)	58 (45.3)
IADL functions lost (2 wks pre adm.)	3.3±2.9	1.6±2.5	2.7±2.8	2.9±2.7	3.8±2.8	4.3±2.8	5.2±2.6
Barthel Index (2 wks before adm.)	83.2±24.4	92.9±17.0	88.4±19.7	86.0±22.1	81.1±24.1	75.8±27.6	69.4±30.4
Barthel Index (<85) (2 wks before adm.)	381 (30.5)	26 (13.4)	47 (24.1)	67 (25.4)	108 (34.5)	60 (42.3)	73 (51.8)
Barthel Index (on admission)	74.1±31.0	86.6±25.4	83.3±25.4	78.4±28.1	70.2±30.3	62.1±32.9	55.2±32.1
Funct. status change (before and on adm.)							
No change in Barthel index score	(70.3)	(84.0)	(82.6)	(71.9)	(64.2)	(58.5)	(56.7)
Change 5-25 points in Barthel index score	(14.5)	(8.8)	(9.2)	(14.8)	(16.6)	(18.3)	(20.6)
Change 30+ points Barthel index score	(15.2)	(7.2)	(8.2)	(13.3)	(19.2)	(23.2)	(22.7)
Barthel Index (on discharge)	76.3±29.9	89.3±23.2	84.9±24.1	79.7±27.9	73.5±28.8	66.1±32.2	56.9±34.4
Chronic diseases (n)	5.4±2.0	4.6±1.7	4.8±1.7	5.4±2.0	5.8±1.9	5.8±2.2	5.9±2.4
Charlson score	7.1±2.9	5.4±2.7	6.5±2.4	6.7±2.4	7.9±2.3	8.0±2.2	8.4±2.1
APACHE II score	8.3±4.8	6.2±3.4	7.1±4.4	8.4±4.9	8.8±4.4	9.8±6.1	9.8±4.9
Acute Physiology Score-APS	1.9±2.9	1.3±2.2	1.6±2.6	1.9±3.1	2.0±2.6	2.6±4.1	2.5±2.9
APS (4+)	253 (20.5)	24 (12.4)	35 (17.9)	49 (19.1)	68 (21.9)	34 (24.3)	43 (30.5)
Serum albumin	4.0±0.7	4.2±0.6	4.1±0.6	4.0±0.8	3.9±0.6	3.9±0.6	3.8±0.6
Serum albumin (< 3.5g/dl)	266 (21.5)	32 (16.7)	26 (13.4)	56 (21.5)	74 (23.7)	33 (23.4)	45 (32.4)
Drugs (n)	4.2±1.9	4.3±1.9	4.2±1.7	4.4±1.9	4.2±1.8	4.2±1.7	3.9±2.1
Major procedures (n)**	3.2±3.0	3.1±3.0	3.3±2.9	3.2±2.7	3.2±3.2	3.2±3.0	3.0±3.5
Length of stay (days)	6.9±3.3	6.8±3.6	6.3±2.8	7.2±3.5	7.2±3.4	7.0±3.3	6.4±3.0
In hospital mortality	55 (4.5)	3 (1.6)	9 (4.6)	8 (3.1)	10 (3.3)	18 (8.7)	13 (9.6)
Six months mortality	209 (16.7)	23 (11.9)	27 (13.8)	35 (13.2)	54 (17.3)	32 (22.5)	38 (27.0)
Six months hospital readmission (1+)	496 (41.5)	73 (38.0)	73 (38.8)	127 (49.5)	131 (43.5)	52 (42.0)	45 (35.2)

*On 1062 patients with MMSE>14; ** Major procedure considered are: endoscopy, CT or MRI, ultrasound (abdomen, heart, peripheral vascular); EMG, EEG.

(Rozzini R et al, 2005)

Haloperidol Prophylaxis for Elderly Hip-Surgery Patients at Risk for Delirium: A Randomized Placebo-Controlled Study

Kees J. Kalisvaart MD, Jos FM. de Jonghe PhD, Marja J. Bogaards PharmD, Ralph Vreeswijk RN, MSc, Toine CG. Egberts PhD, Bart J. Burger MD, PhD, Piet Eikelenboom MD, PhD, Willem A. van Gool MD, PhD

(JAGS 2005, in press)

Results of Patients Who Developed Delirium, According to Study Group: Intention-to-Treat Group

Delirium Characteristic	Haloperidol (n = 32)	Placebo (n = 36)	Mean Difference (95% Confidence Interval)	*P*-value
	Mean ± Standard Deviation			
Highest Delirium Rating Scale score	14.4 ± 3.4	18.4 ± 4.3	4.0 (2.0–5.8)	<.001
Delirium duration, days	5.4 ± 4.9	11.8 ± 7.5	6.4 (4.0–8.0)	<.001
Hospital days	17.1 ± 11.1	22.6 ± 16.7	5.5 (1.4–2.3)	<.001

Note: Because of rounding, percentages may not total 100.

(JAGS 2005, in press)

Questi dati autorizzano un trattamento allargato con neurolettici, tenendo in conto l'alto rischio di delirium dei pazienti ospedalizzati con un elevato tasso di fattori predisponenti e scatenanti (cfr. DELIRIUMS)?

ORIGINAL INVESTIGATION

Antithrombotic Therapy Practices in US Hospitals in an Era of Practice Guidelines

Victor F. Tapson, MD, FCCP; Thomas M. Hyers, MD, FCCP; Albert L. Waldo, MD; David J. Ballard, MD; Richard C. Becker, MD; Joseph A. Caprini, MD, MS, FACS, RVT; Roger Khetan, MD; Ann K. Wittkowsky, PharmD, CACP; Kevin J. Colgan, MA; Alicia C. Shillington, PhD; for the NABOR (National Anticoagulation Benchmark and Outcomes Report) Steering Committee

Arch Intern Med. 2005;165:1458-1464

Una decisione che richiede coraggio e intuizione clinica, in attesa di studi caso-controllo mirati su ampie popolazioni di anziani ospedalizzati.

IF a hospitalized vulnerable elder has peptic stress ulcer risk factors, THEN the patient should receive prophylaxis with either an H_2-blocker, sucralfate, or a proton-pump inhibitor.

Ann Intern Med. 2005;143:274-281.

Lo stress indotto dall'ospedalizzazione e dalle pratiche cliniche è sempre un "peptic stress ulcer risk factor"?

La prevenzione della stipsi:
una pratica “ovvia”, anche se non documentata.

Dall’intuizione alla pratica, alla dimostrazione del valore qualitativo

Quality of Care Is Associated with Survival in Vulnerable Older Patients

Takahiro Higashi, MD, PhD; Paul G. Shekelle, MD, PhD; John L. Adams, PhD; Caren J. Kamberg, MSPH; Carol P. Roth, RN, MPH; David H. Solomon, MD; David B. Reuben, MD; Lillian Chiang, MD; Catherine H. MacLean, MD, PhD; John T. Chang, MD, MPH; Roy T. Young, MD; Debra M. Saliba, MD, MPH; and Neil S. Wenger, MD, MPH

Results: **The 372 vulnerable older patients were eligible for a mean of 21 quality indicators (range, 8 to 54) and received, on average, 53% of the care processes prescribed in quality indicators (range, 27% to 88%). Eighty-six (23%) persons died during the 3-year follow-up. There was a graded positive relationship between quality score and 3-year survival. After adjustment for sex, health status, and health service use, quality score was not associated with mortality for the first 500 days, but a higher quality score was associated with lower mortality after 500 days (hazard ratio, 0.64 [95% CI, 0.49 to 0.84] for a 10% higher quality score).**

Ann Intern Med. 2005;143:274-281.

EDITORIAL

Improving Patient Care Can Set Your Brain on Fire

Sankey V. Williams, MD

Ann Intern Med. 2005;143:305-306.

Predictors of Overall Quality of Care Provided to Vulnerable Older People.

Lillian C. Min, David B. Reuben, Catherine H. MacLean, Paul G. Shekelle, David H. Solomon, Takahiro Higashi, John T. Chang, Carol P. Roth, Caren J. Kamberg, John Adams, Roy T. Young, Neil S. Wenger

(JAGS 2005, in press)

These findings have important clinical implications. First, overall care needs to be improved for patients with greater need for processes that are central to the care of vulnerable patients: careful history taking (e.g., circumstances of a recent fall, treatment preferences for aggressive care such as ventilator dependence), counseling (e.g., issues of safety for a newly diagnosed patient with dementia, potential side effects of newly prescribed medications), and medication prescribing (e.g., avoidance of sedatives associated with falls, prescription of calcium and vitamin D for osteoporosis). Many of these care behaviors require more time than simple care acts such as ordering a laboratory test, suggesting that competing time demands during office visits may contribute to lower overall quality scores for vulnerable older people.

(Min LC et al, JAGS 2005, in press)

Attenzione al rischio che la medicina della profilassi possa ridurre la personalizzazione della cura. “Now doctors need to be bold and honest with their patients about homoeopathy’s lack of benefit, and with themselves about the failings of modern medicine to address patients’ needs for personalised care” (Lancet 2005;366:690).

The Intersection Between Geriatrics and Palliative Care: A Call for a New Research Agenda.

Nathan E. Goldstein, R. Sean Morrison

(JAGS 2005, in press)

Una medicina della profilassi
Una medicina mirata ai fattori causali
Una medicina palliativa
Una medicina del counseling
La medicina di sempre, con un occhio nuovo!