CHOOSING WISELY
10 Recomendaciones de Buenas Prácticas Geriátricas

American Geriatrics Society

AGS Geriatrics Healthcare Professionals

Leading Change. Improving Care for Older Adults.

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Julio 22 2015

Geriatría
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No recomendar uso de sondas de alimentación en pacientes con demencia avanzada.

- Promover alimentación oral a tolerancia

- Sin evidencia:
  - Sobrevida
  - Funcionalidad
  - Neumonías Aspirativas
  - Status Nutricional
  - Status General
  - UPP

- Riesgos:
  - Mortalidad Periprocedimiento
  - Contención Física
  - Delirium
  - Prolongación fase terminal

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Does Feeding Tube Insertion and its Timing Improve Survival?

Joan M. Teno, M.D., M.S.[*], **Pedro L. Gozalo, Ph.D.**[*], **Susan L. Mitchell, M.D., M.P.H.**[†], **Sylvia Kuo, Ph.D.**[*], **Ramona L. Rhodes, M.D., M.P.H.**[‡], **Julie P.W. Bynum, M.D., M.P.H.**[§], and **Vincent Mor, Ph.D.**[*]

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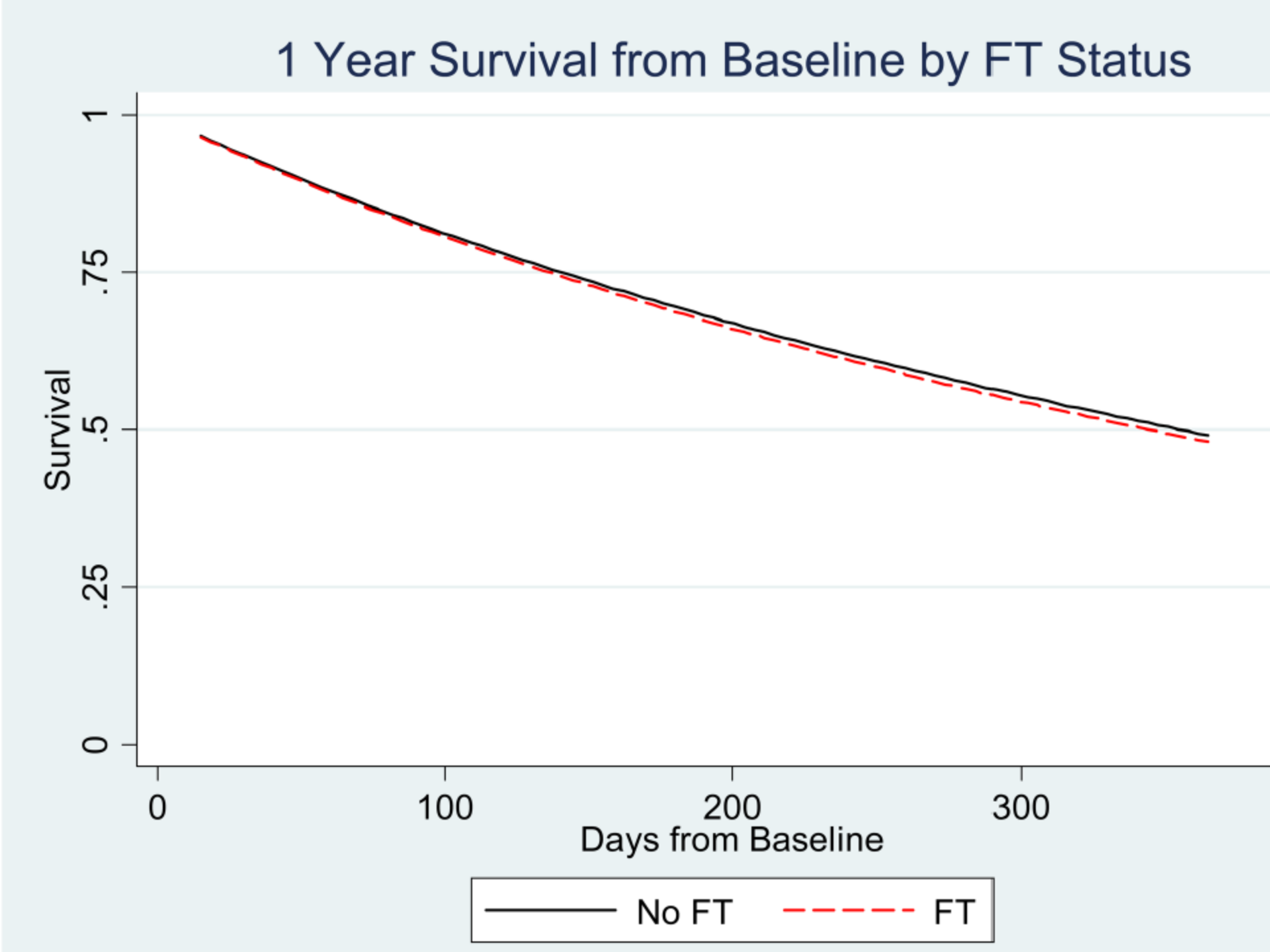
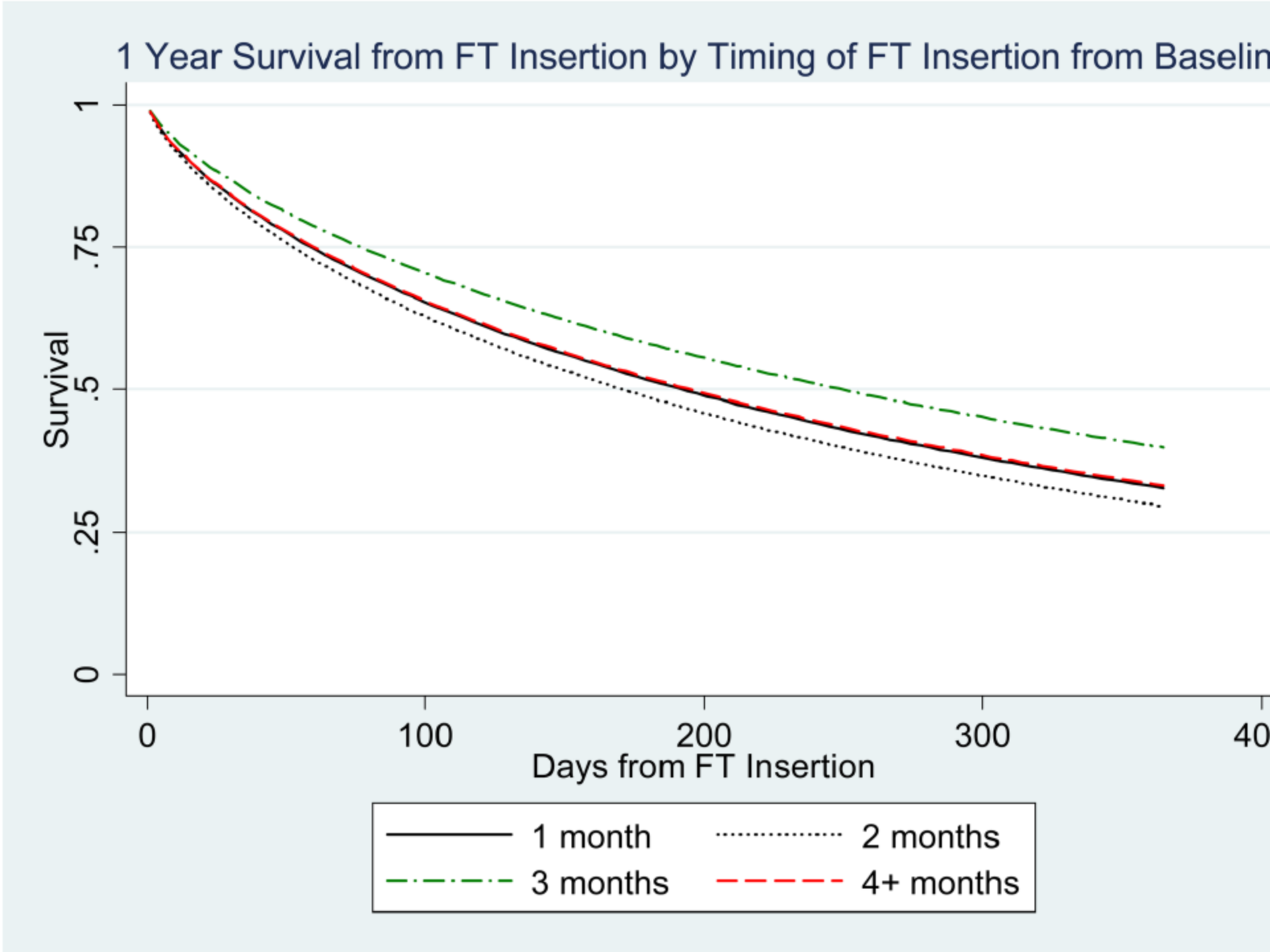
Table 1

Baseline Characteristics of Nursing Home Residents with and Without Feeding Tubes

Characteristics	Without Feeding Tube N = 34,536	With Feeding Tube N = 1,956	*p*-value
Sociodemographics			
Mean age, years	85.0	83.1	P<0.001
Married	24.9	24.6	0.792
Female	78.5	70.5	P<0.001
Race			
Caucasian	89.9	61.7	P<0.001
African American	6.9	30.7	P<0.001
Hispanic	2.1	5.8	P<0.001
American Indian	0.3	0.1	P<0.001
Asian	0.7	1.7	P<0.001


1 Year Survival from Baseline by FT Status
Survival
0
.25
.5
.75
1
0
100
200
300
Days from Baseline
No FT
FT


1 Year Survival from FT Insertion by Timing of FT Insertion from Baselin
Survival
0
.25
.5
.75
1
0
100
200
300
40
Days from FT Insertion
1 month
2 months
3 months
4+ months

Nutrients. 2015 Apr 3;7(4):2456-68

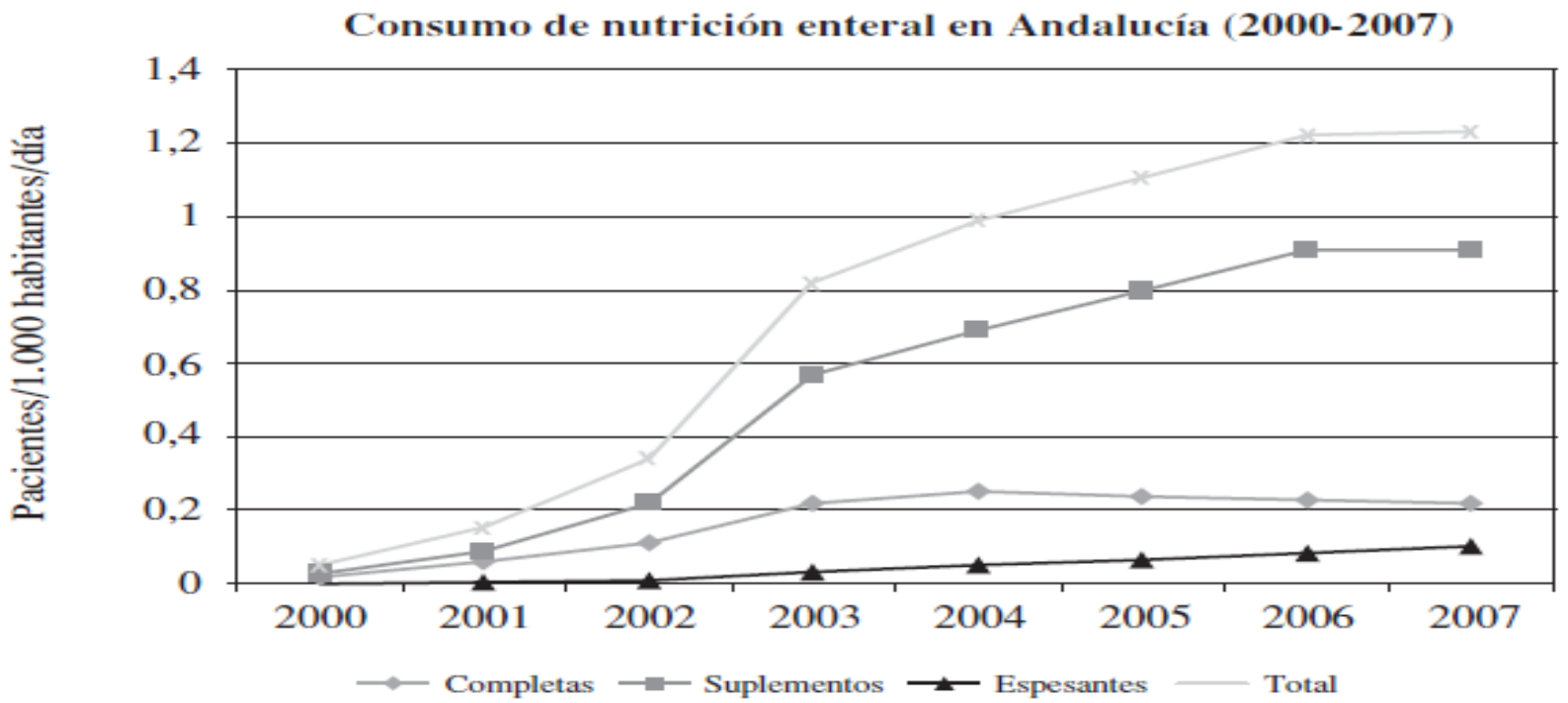
Table 2. Summary of Studies Reviewed.

Author	Study, Design, Country of Study	Population Size	Age Mean SD	Kaplan-Meier Survival Analysis	Predictors for Poor Survival
Higaki *et al.* 2008 [31]	Retrospective study of PEG enteral nutrition Compared outcomes of patients with and without dementia in the elderly Japan	311 46.0% (n = 143) with dementia 54.0% (n = 168) without dementia 78.8	83.7 ± 8 with dementia 78.8 ± 11 without dementia	No significant difference in mortality between patients with dementia and those without dementia (p = 0.62)	-subtotal gastrectomy (OR 2.619, 95% CI: 1.367–5.019) -serum albumin < 2.8 g/dL (OR 2.081, 95% CI: 1.490–2.905) -age > 80 years (OR 1.721, 95% CI: 1.234–2.399) -chronic heart failure (OR 1.541, 95% CI: 1.096–2.168) -male (OR 1.407, 95% CI: 1.037–1.909)
Gaines *et al.* 2009 [32]	Retrospective study of PEG enteral nutrition Compared outcomes for patients with dementia or significant cognitive impairment (SCI) to those without these conditions USA	190 23.7% (n = 45) dementia or SCI 76.3% (n = 145) without dementia or SCI	Median age: 64	No significant difference in mortality in patients with dementia or SCI and those without (p = 0.85)	Predictors for 30-day mortality -increasing age (OR 1.08, 95% CI: 1.04–1.12) -decreasing serum albumin (OR 0.43, 95% CI: 0.22–0.84)

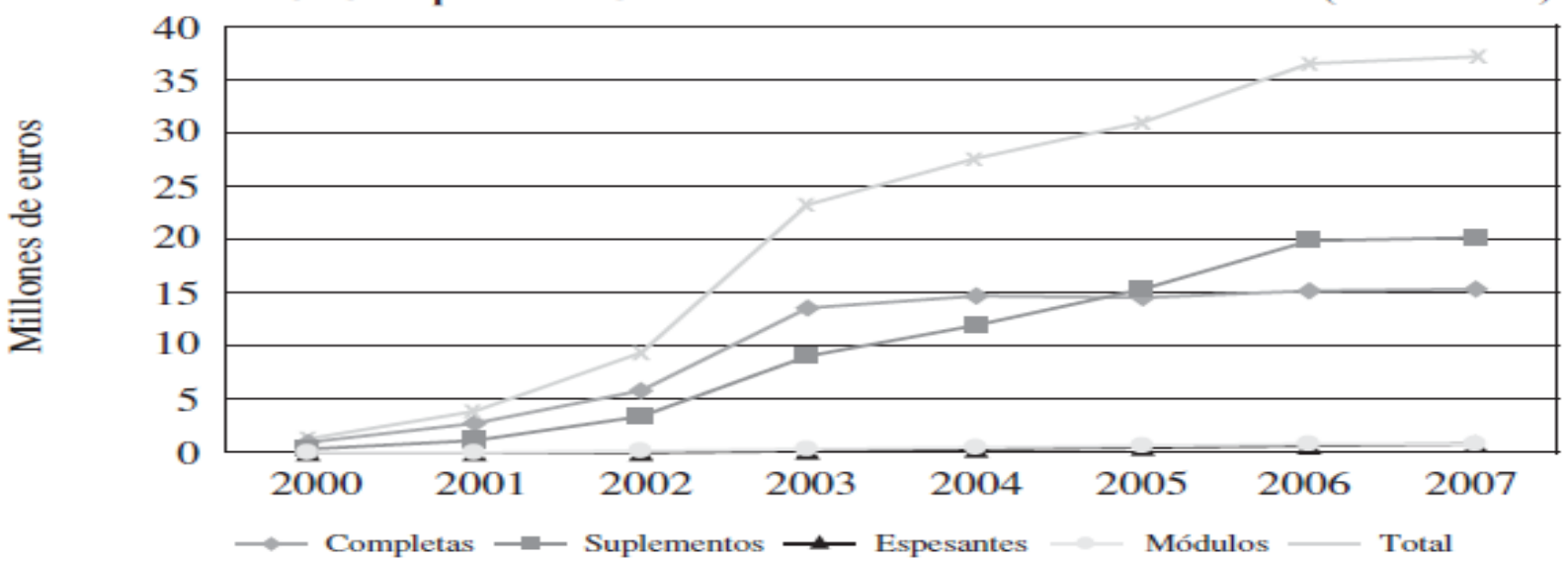
Table 2. *Cont.*

Author	Study Design Country of Study	Population Size	Age Mean SD	Kaplan-Meier Survival Analysis	Predictors for Poor Survival
Malmgren *et al.* 2011 [33]	Retrospective study of PEG enteral nutrition Indications for survival after PEG insertion in patients older than 65 Sweden	191 8.4% (n = 16) dementia 5.8% (n = 11) Parkinson 9.5% (n = 19) miscellaneous 49.7% (n = 95) stroke 18.4% (n = 35) malignant 6.8% (n = 13) neurological diseases	79.0 ± 7	Patients with dementia or Parkinsons had longest median survival	-patients with dementia >80 years of age than those with dementia <80 years of age (p = 0.025)
Blomberg *et al.* 2012 [29]	Observational prospective study of PEG enteral nutrition Outcome of patients following PEG insertion Sweden	484 44% (n = 214) tumours 45% (n = 218) neurological disease including dementia	66.0 ± 14	Mortality higher in patients with neurological disorders than those with tumours (p = 0.002)	-serum albumin < 30 g/L (hazard ration (HR), 3.46; 95% CI 1.75–6.88) -CRP ≥ 10 (HR, 3.47; 95% CI 1.68–7.18) -age ≥ 65 (HR, 2.26; 95% CI 1.20–4.25)
Schneider *et al.* 2014 [30]	Observational prospective study of PEG enteral nutrition Outcomes of patients following PEG insertion Germany	119 57.2% (n = 68) tumours 29.4% (n = 35) neurologic including dementia 13.4% (16) other	63.0 ± 13	Mortality higher in patients with neurological disorders than those with tumours (p = 0.002)	NA

2a)


Consumo de nutrición enteral en Andalucía (2000-2007)
Pacientes/1.000 habitantes/día
1,4
1,2
1
0,8
0,6
0,4
0,2
0
2000
2001
2002
2003
2004
2005
2006
2007
Completas
Suplementos
Espesantes
Total

2b)


Costes de productos de nutrición enteral en Andalucía (2000-2007)
Millones de euros
40
35
30
25
20
15
10
5
0
2000
2001
2002
2003
2004
2005
2006
2007
Completas
Suplementos
Espesantes
Módulos
Total

Ante un paciente con demencia, con manifestaciones conductuales o psicológicas, evitar uso en primera línea de

- Riesgos:
  - Sedación
  - Deterioro Cognitivo
  - > Strokes
  - > Caídas
  - > Mortalidad

SPECIAL ARTICLES

American Geriatrics Society Updated Beers Criteria for Potentially Inappropriate Medication Use in Older Adults

The American Geriatrics Society 2012 Beers Criteria Update Expert Panel

Table 8. First- and Second-Generation Antipsychotics

First-Generation (Conventional) Agents	Second-Generation (Atypical) Agents
Chlorpromazine	Aripiprazole
Fluphenazine	Asenapine
Haloperidol	Clozapine
Loxapine	Iloperidone
Molindone	Lurasidone
Perphenazine	Olanzapine
Pimozide	Paliperidone
Promazine	Quetiapine
Thioridazine	Risperidone
Thiothixene	Ziprasidone
Trifluoperazine	
Triflupromazine	

Antipsychotics, first (conventional) and second (atypical) generation (see Table 8 for full list)	Increased risk of cerebrovascular accident (stroke) and mortality in persons with dementia	Avoid use for behavioral problems of dementia unless nonpharmacological options have failed and patient is threat to self or others	Moderate	Strong
Thioridazine Mesoridazine	Highly anticholinergic and risk of QT-interval prolongation	Avoid	Moderate	Strong

Dementia

Supporting people with dementia and their carers in health and social care

Issued: November 2006 last modified: March 2015

NICE clinical guideline 42

guidance.nice.org.uk/cg42

Antipsychotics, Other Psychotropics, and the Risk of Death in Patients With Dementia: Number Needed to Harm

Donovan T. Maust, MD, MS[1,2]; Hyungjin Myra Kim, ScD[2,3]; Lisa S. Seyfried, MD, MS[1]; Claire Chiang, PhD[1,2]; Janet Kavanagh, MS[1]; Lon S. Schneider, MD, MS[4]; Helen C. Kales, MD[1,2]

JAMA Psychiatry. 2015;72(5):438-445. doi: 10.1001/jamapsychiatry.2014.3018.

Riesgo de Mortalidad/NNH a 6ms

- Haloperidol
  - *3.8% (95% CI, 1.0%-6.6%; P < .01) /26 (95% CI, 15-99)*
- Risperidona
  - *3.7% (95% CI, 2.2%-5.3%; P < .01) / 27 (95% CI, 19-46)*
- Quetiapina
  - *2.0% (95% CI, 0.7%-3.3%; P < .01) / 50 (95% CI, 30-150)*
- Olanzapina
  - *2.5% (95% CI, 0.3%-4.7%; P = .02) / 40 (95% CI, 21-312)*

Published in final edited form as:

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Managing Behavioral Symptoms in Dementia Using Nonpharmacologic Approaches: An Overview

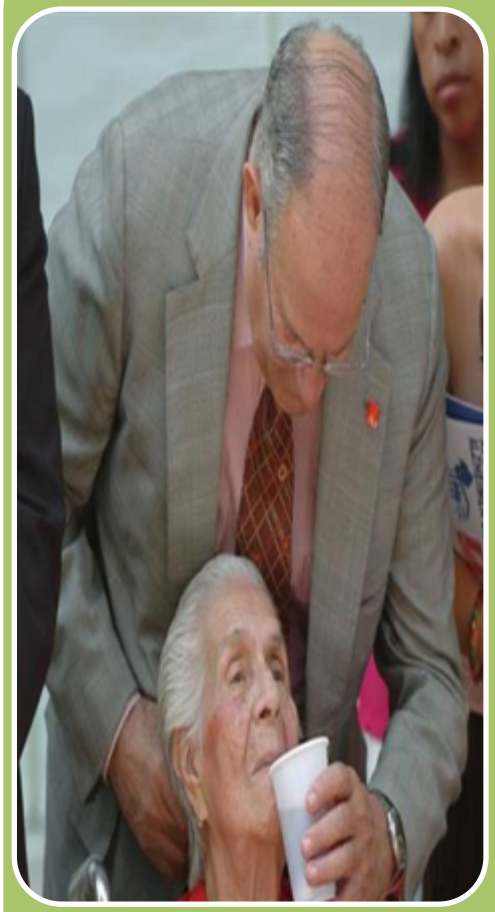
Laura N. Gitlin, PhD[1], **Helen C. Kales, MD**[2] **[Professor, Director]**, and **Constantine G. Lyketsos, MD, MHS**[3] **[Elizabeth Plank Althouse Professor]**

Johns Hopkins University and University of Michigan

Helen C. Kales: kales@umich.edu; Constantine G. Lyketsos: Kostas@jhmi.edu

Domain	Key Strategies
Communication	Allow patient sufficient time to respond to a question Provide one to two step simple verbal commands Use calm, reassuring tone Offer simple choices (no more than 2 at a time) Avoid negative words and tone Use a light touch to reassure, calm, or redirect Identify self and others if patient does not remember names Help patient find words to express him/hers
Simplify environment	Remove clutter or unnecessary objects Use labeling or other visual cues Eliminate noise and distractions while you are communicating or when patient is engaging in an activity Use simple visual reminders (arrows pointing to bathroom)
Caregiver education and support	Understand that behaviors are not intentional Learn how to relax the rules (e.g., no right or wrong in performing activities/tasks as long as patient and caregiver is safe) With disease progression, patient may have difficulty initiating, sequencing, organizing and completing tasks without guidance and cueing Go along with patient's view of what is true and avoid arguing or trying to reason or convince Take care of self; find opportunities for respite; practice healthy behaviors and preventive doctor visits Identify and draw upon a support network
Simplify tasks	Break each task into very simple steps Use verbal or tactile prompt for each step Provide structured daily routines that are predictable

Activities	Introduce activities that tap into preserved capabilities and previous interests Introduce activities involving repetitive motion (washing windows, folding towels, putting coins in container) Set up of the activity and helping patient initiate may be necessary



En adultos muy mayores, evite dar fármacos para bajar Hb Glic <7.5mg/dl

The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

Severe Hypoglycemia and Risks of Vascular Events and Death

Sophia Zoungas, M.D., Ph.D., Anushka Patel, M.D., Ph.D.,
John Chalmers, M.D., Ph.D., Bastiaan E. de Galan, M.D., Ph.D.,
Qiang Li, M.Biostat., Laurent Billot, M.Sc., Mark Woodward, Ph.D.,
Toshiharu Ninomiya, M.D., Ph.D., Bruce Neal, M.D., Ph.D.,
Stephen MacMahon, D.Sc., Ph.D., Diederick E. Grobbee, M.D., Ph.D.,
Andre Pascal Kengne, M.D., Ph.D., Michel Marre, M.D., Ph.D.,
and Simon Heller, M.D., for the ADVANCE Collaborative Group

Events	Severe Hypoglycemia (N=231)	No Severe Hypoglycemia (N=10,909)	Hazard Ratio (95% CI)
	no. of patients with events (%)		
Major macrovascular events	33 (15.9)	1114 (10.2)	
Unadjusted model			4.05 (2.86–5.74)
Adjusted model			3.53 (2.41–5.17)
Major microvascular events	24 (11.5)	1107 (10.1)	
Unadjusted model			2.39 (1.60–3.59)
Adjusted model			2.19 (1.40–3.45)
Death from any cause	45 (19.5)	986 (9.0)	
Unadjusted model			4.86 (3.60–6.57)
Adjusted model			3.27 (2.29–4.65)
Cardiovascular disease	22 (9.5)	520 (4.8)	
Unadjusted model			4.87 (3.17–7.49)
Adjusted model			3.79 (2.36–6.08)
Noncardiovascular disease	23 (10.0)	466 (4.3)	
Unadjusted model			4.82 (3.16–7.35)
Adjusted model			2.80 (1.64–4.79)
Respiratory system events	18 (8.5)	656 (6.0)	
Unadjusted model			3.23 (2.02–5.17)
Adjusted model			2.46 (1.43–4.23)
Digestive system events	20 (9.6)	867 (7.9)	
Unadjusted model			2.97 (1.90–4.63)
Adjusted model			2.20 (1.31–3.72)
Diseases of the skin	6 (2.7)	146 (1.3)	
Unadjusted model			5.02 (2.20–11.40)
Adjusted model			4.73 (1.96–11.40)
Cancer	5 (2.2)	149 (1.4)	
Unadjusted model			3.44 (1.40–8.42)
Adjusted model			2.11 (0.65–6.82)

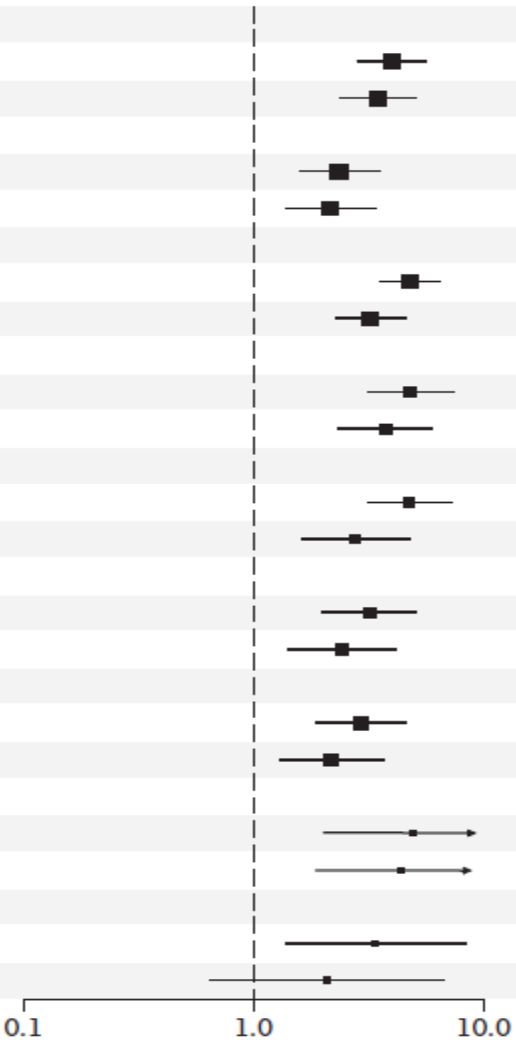


Figure 2. Association of Severe Hypoglycemia with the Risk of an Adverse Clinical Outcome or Death.

The NEW ENGLAND JOURNAL of MEDICINE

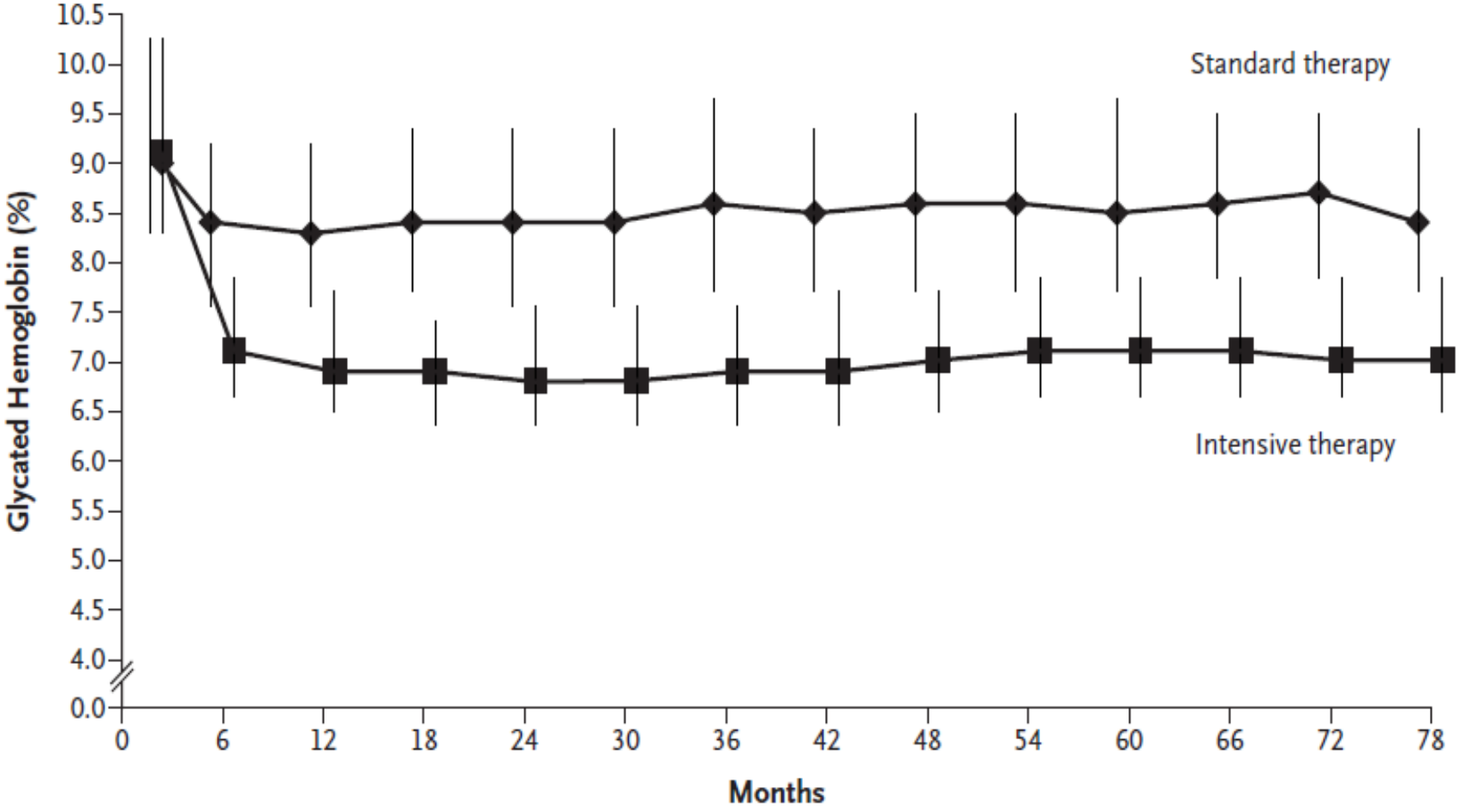
ORIGINAL ARTICLE

Glucose Control and Vascular Complications in Veterans with Type 2 Diabetes

William Duckworth, M.D., Carlos Abraira, M.D., Thomas Moritz, M.S., Domenic Reda, Ph.D., Nicholas Emanuele, M.D., Peter D. Reaven, M.D., Franklin J. Zieve, M.D., Ph.D., Jennifer Marks, M.D., Stephen N. Davis, M.D., Rodney Hayward, M.D., Stuart R. Warren, J.D., Pharm.D., Steven Goldman, M.D., Madeline McCarren, Ph.D., M.P.H., Mary Ellen Vitek, William G. Henderson, Ph.D., and Grant D. Huang, M.P.H., Ph.D., for the VADT Investigators*

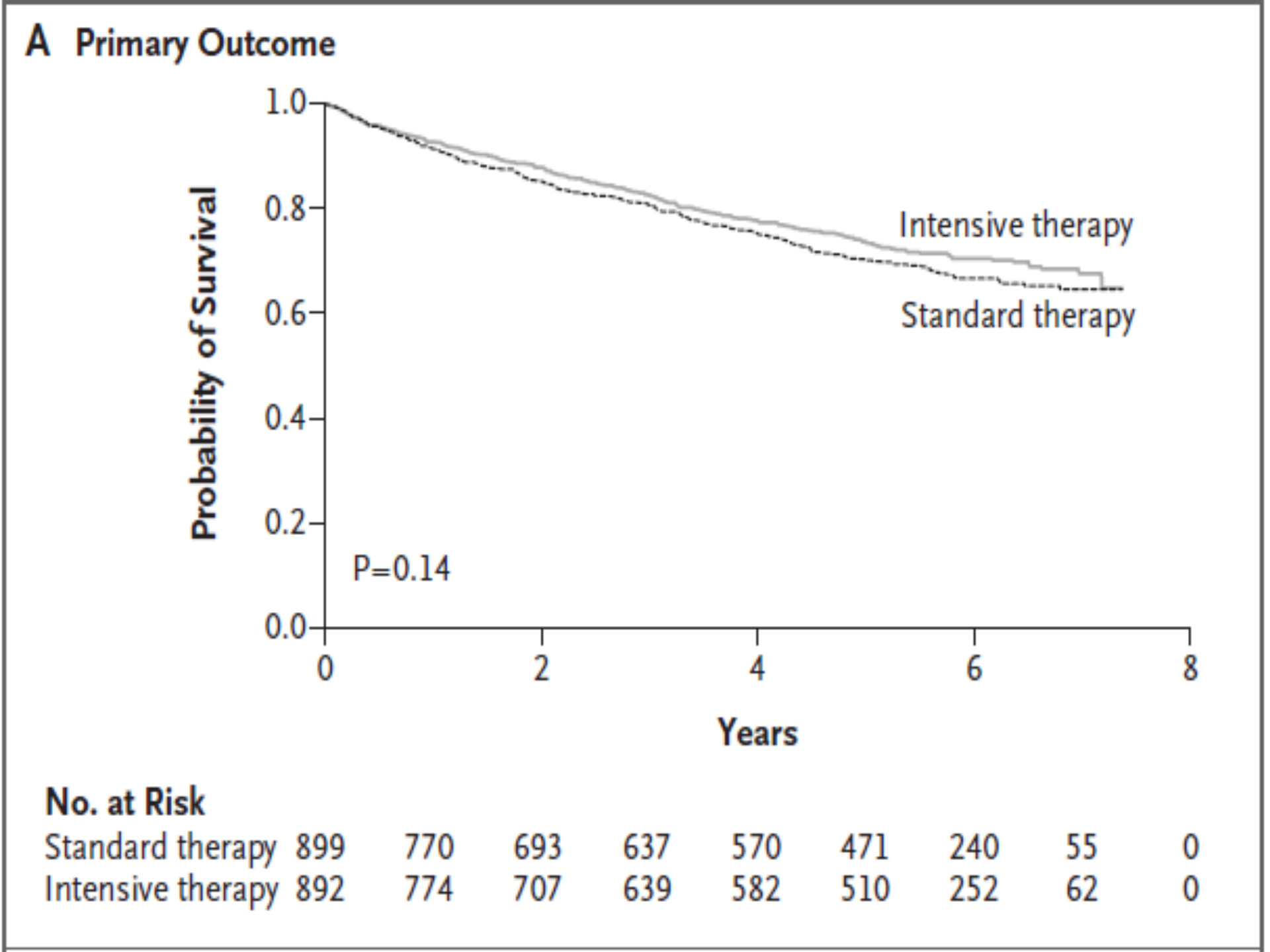
Table 1. Characteristics of the Patients at Baseline and Follow-up.*

Variable	Baseline			Follow-up		
	Standard Therapy (N=899)	Intensive Therapy (N=892)	P Value	Standard Therapy (N=329)	Intensive Therapy (N=344)	P Value
Age (yr)	60.3±9.0	60.5±9.0	0.64			
Sex (no.)			0.98			
Male	873	866				
Female	26	26				
Time since diagnosis of diabetes (yr)	11.5±7.0	11.5±8.0	0.96			
Patients with previous cardiovascular event (no.)	368	355	0.62			
Patients with hypertension (no.)†	650	642	0.83			
Race or ethnic group (no.)‡			0.51			
Non-Hispanic white	572	539				
Hispanic white	136	155				
Black	147	152				
Other	44	46				
Glycated hemoglobin level (%)§	9.4±2.0	9.4±2.0	0.91			
Weight (lb)	214±36	214±36	0.97	223±42	232±44	0.01
Body-mass index	31.2±4.0	31.3±3.0	0.61	32.3±5.0	33.8±6.0	0.01
Blood pressure (mm Hg)						
Systolic	132±17	131±17	0.66	125±15	127±16	0.27
Diastolic	76±10	76±10	0.91	69±10	68±10	0.20
Cholesterol (mg/dl)						
Total	185±53	182±40	0.17	153±40	150±40	0.25
Low-density lipoprotein	108±34	107±30	0.33	80±31	80±33	0.98
High-density lipoprotein	36±10	36±10	0.43	41±12	40±11	0.63
Triglycerides (mg/dl)	223±352	201±162	0.09	159±104	151±173	0.47
Creatinine (mg/dl)	1.0±0.2	1.0±0.2	0.60	1.2±0.5	1.2±0.6	0.54
Tobacco smoking status (no.)			0.82			
Total patients	897	892				
Current	145	154		32	21	
Past	505	494		NA	NA	
Never	247	244		NA	NA	

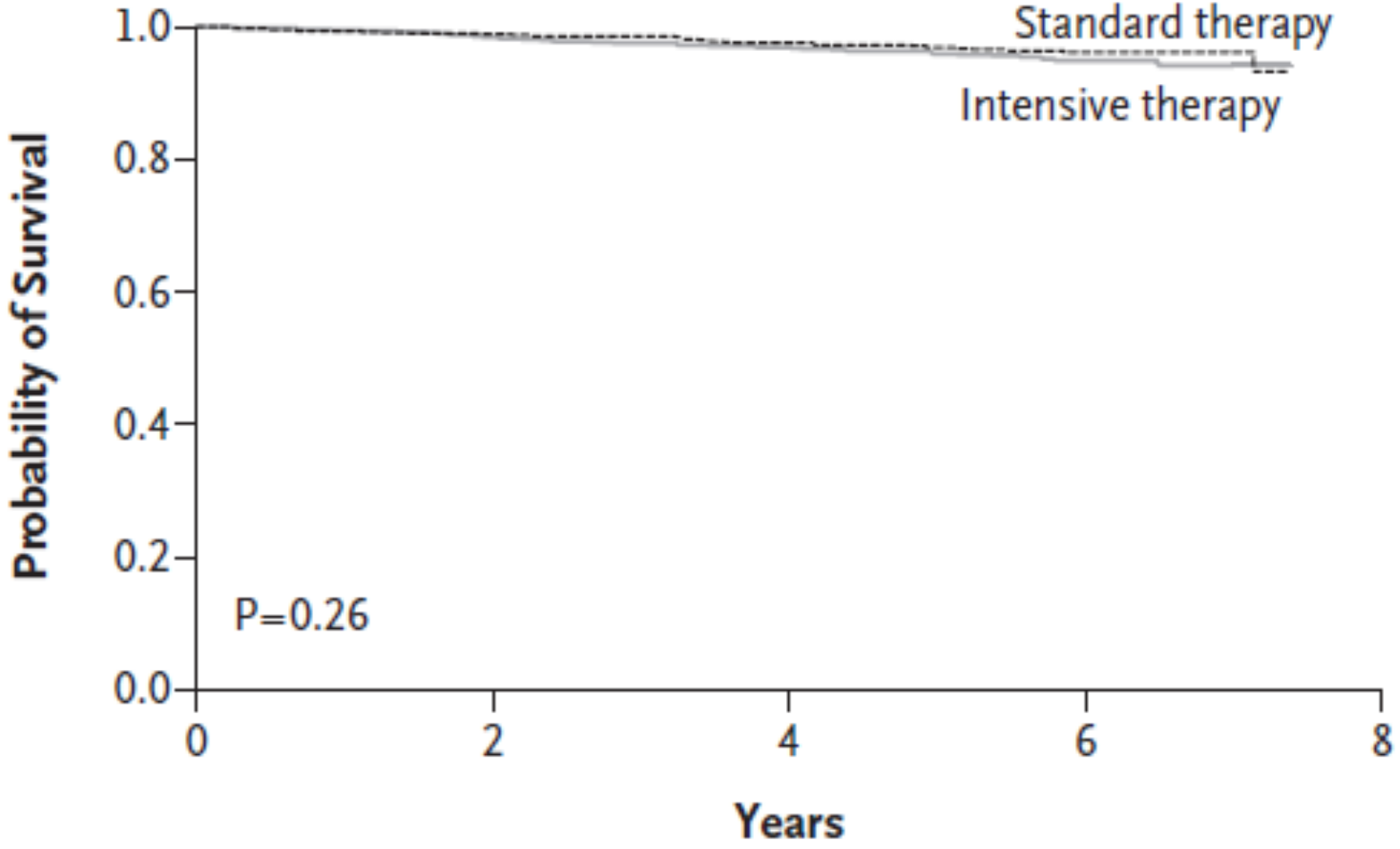


No. at Risk

Standard therapy	899	811	812	759	760	727	727	707	688	667	644	472	329	225
Intensive therapy	892	801	805	763	754	729	706	692	668	661	639	489	340	223


A Primary Outcome
Probability of Survival
1.0
0.8
0.6
0.4
0.2
0.0
Intensive therapy
Standard therapy
P=0.14
0
2
4
6
8
Years
No. at Risk
Standard therapy 899 770 693 637 570 471 240 55 0
Intensive therapy 892 774 707 639 582 510 252 62 0

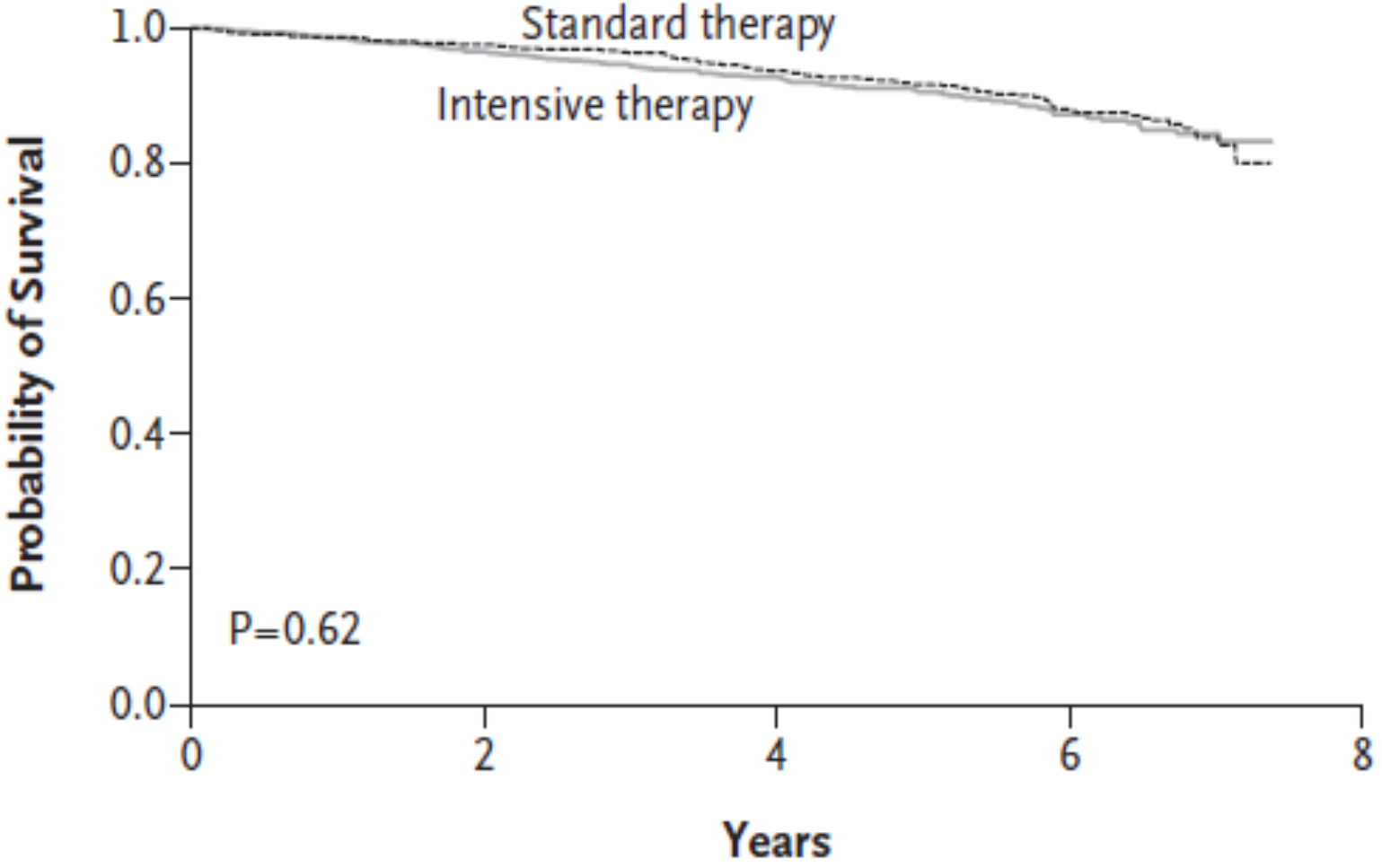
B Death from Cardiovascular Causes



No. at Risk

Standard therapy	899	833	797	767	724	635	320	75	0
Intensive therapy	892	828	786	746	713	646	337	85	0

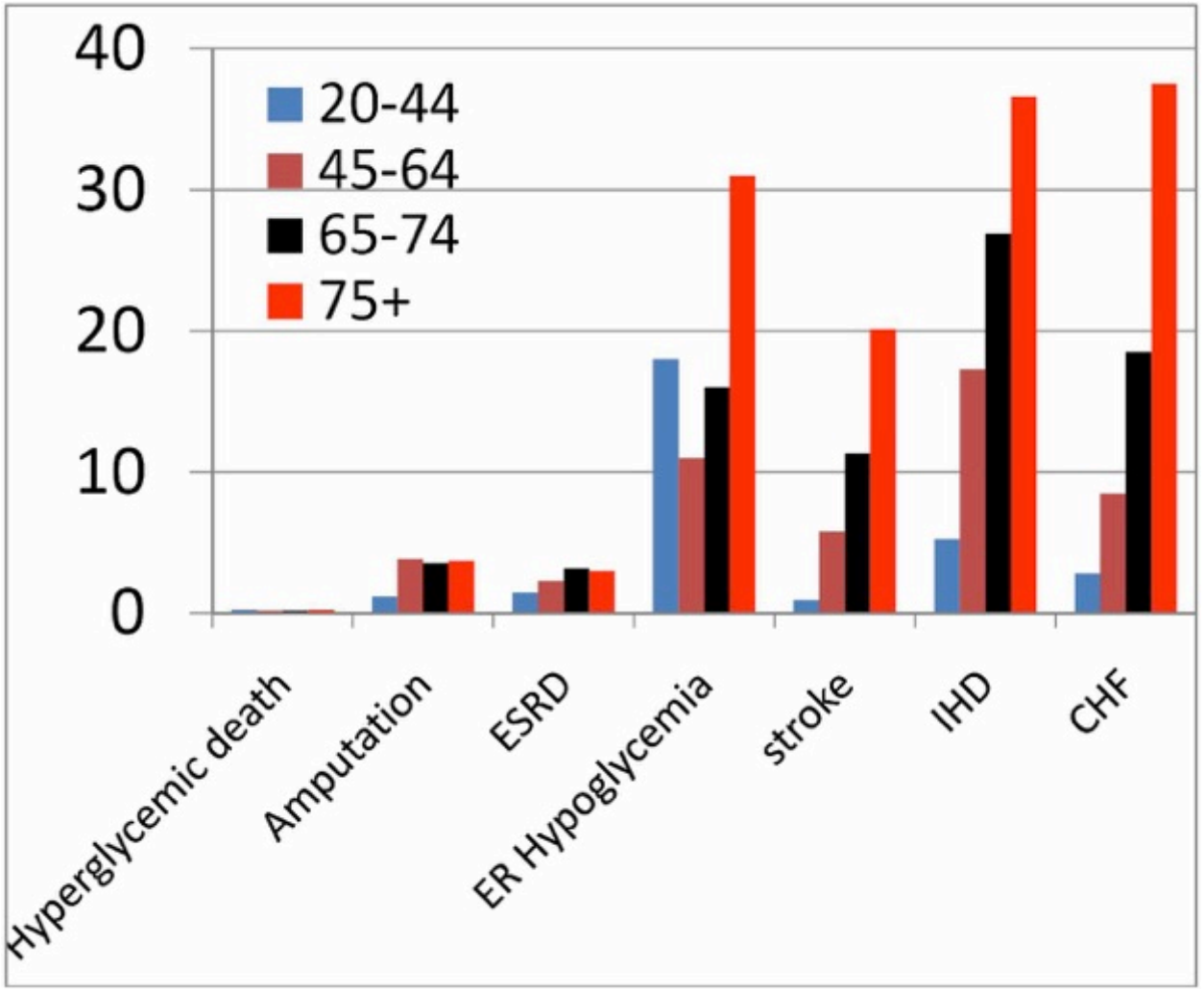
C Death from Any Cause



No. at Risk

Standard therapy	899	836	801	772	727	637	322	76	0
Intensive therapy	892	832	791	752	720	650	341	86	0

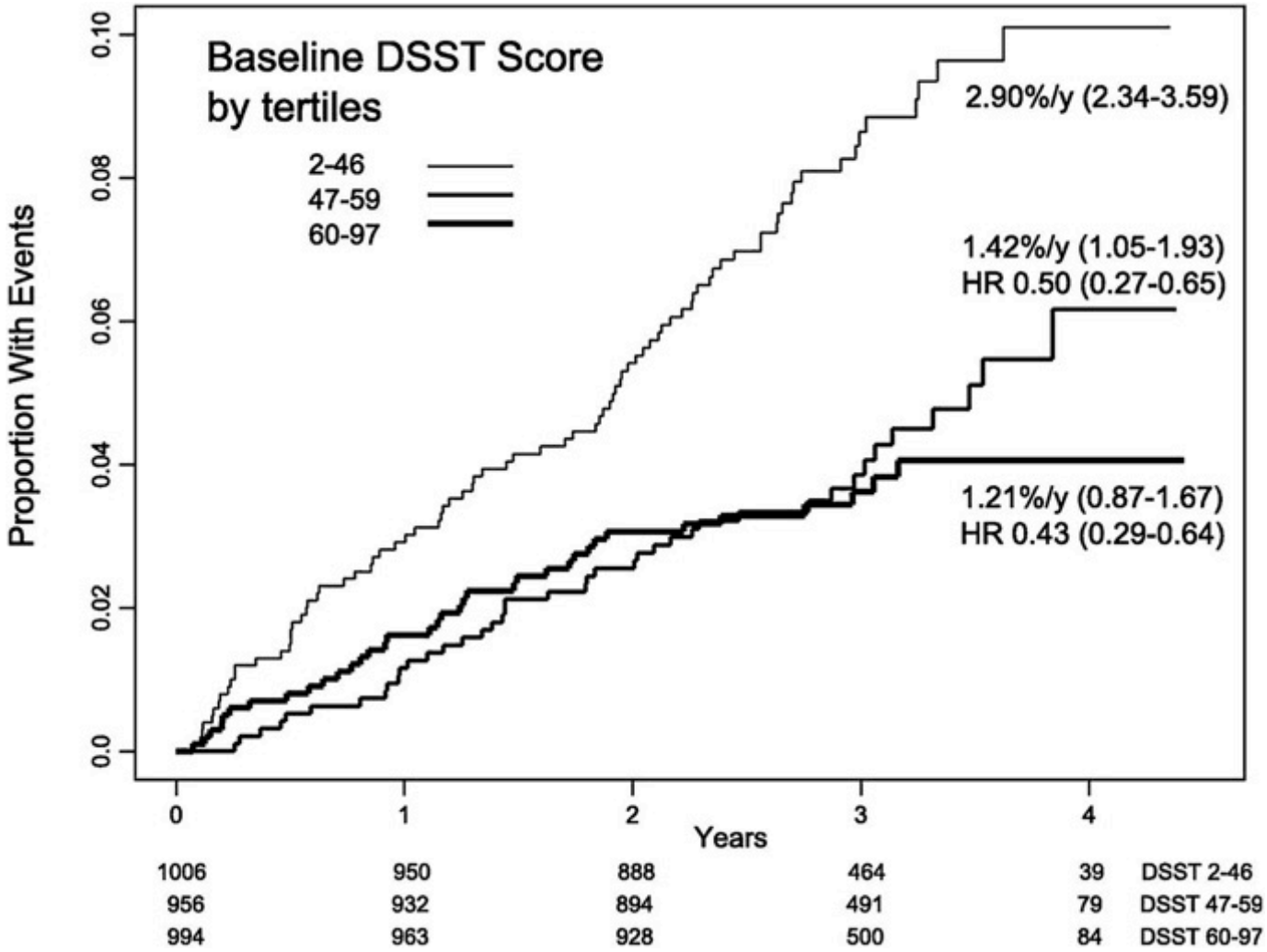
Incidence (per 1,000) of major diabetes complications among adults with diabetes, by age, 2009.



Jeffrey B. Halter et al. Diabetes 2014;63:2578-2589

American Diabetes Association.

Relationship between baseline cognitive function and risk for severe hypoglycemia in the ACCORD trial.

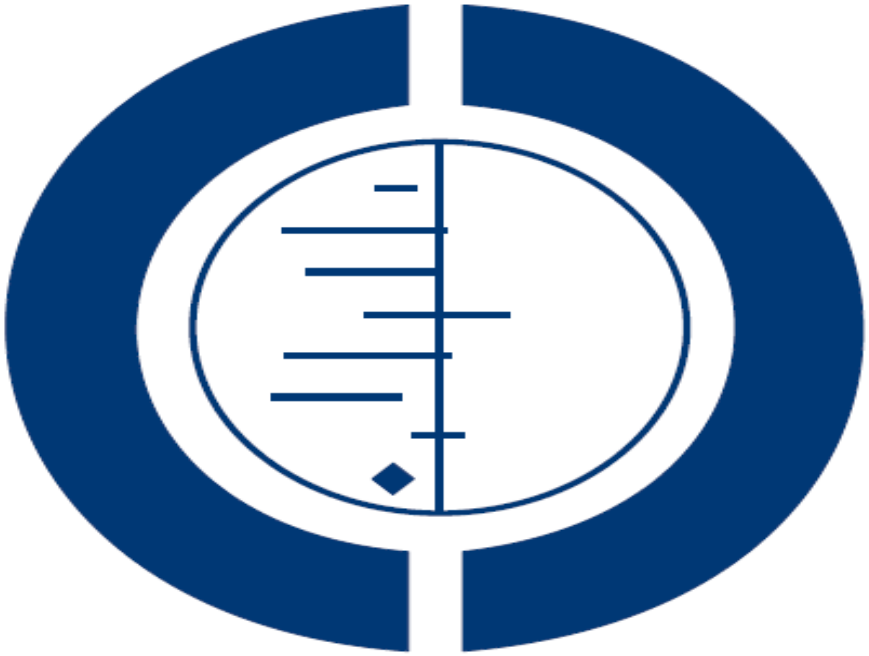


Jeffrey B. Halter et al. Diabetes 2014;63:2578-2589

American Diabetes Association.

Targeting intensive glycaemic control versus targeti conventional glycaemic control for type 2 diabetes mel (Review)

Hemmingsen B, Lund SS, Gluud C, Vaag A, Almdal TP, Wetterslev J



THE COCHRANE COLLABORATION®

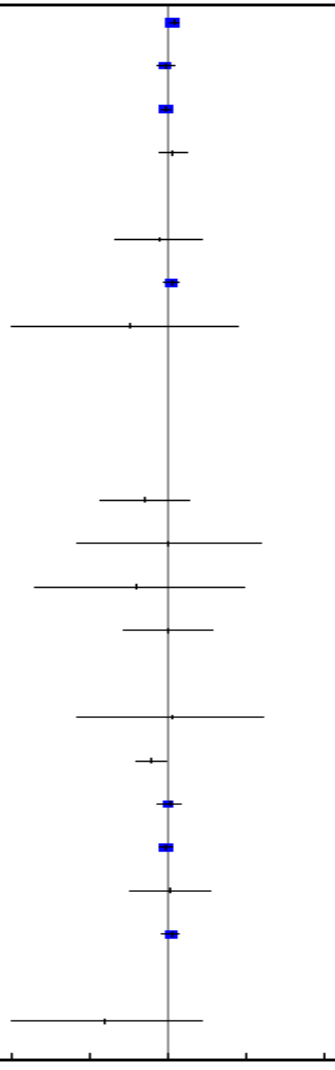
Analysis 1.1. Comparison 1 Intensive glycaemic control versus conventional glycaemic control, Outcome 1 All-cause mortality.

Review: Targeting intensive glycaemic control versus targeting conventional glycaemic control for type 2 diabetes mellitus

Comparison: 1 Intensive glycaemic control versus conventional glycaemic control

Outcome: 1 All-cause mortality

Study or subgroup	Intensive control n/N	Conventional control n/N	Risk Ratio M-H,Random,95% CI	Weight	Risk Ratio M-H,Random,95% CI
ACCORD 2008	391/5128	327/5123		18.5 %	1.19 [1.04, 1.38]
ADDITION-Europe 2011	102/1645	90/1352		7.3 %	0.93 [0.71, 1.23]
ADVANCE 2008	498/5571	533/5569		22.6 %	0.93 [0.83, 1.05]
Araki 2012	51/585	44/588		4.0 %	1.17 [0.79, 1.72]
Bagg 2001	0/21	0/22			Not estimable
Cao 2011	4/92	5/87		0.4 %	0.76 [0.21, 2.73]
DIGAMI 2 2005	153/474	89/306		10.5 %	1.11 [0.89, 1.38]
Fantin 2011	0/35	1/35		0.1 %	0.33 [0.01, 7.91]
Guo 2008	0/166	0/54			Not estimable
IDA 2009	0/51	0/51			Not estimable
Jaber 1996	0/23	0/22			Not estimable
Kumamoto 2000	3/55	6/55		0.4 %	0.50 [0.13, 1.90]
Melidonis 2000	1/24	1/24		0.1 %	1.00 [0.07, 15.08]
Natarajan 2012	0/36	1/42		0.1 %	0.39 [0.02, 9.23]
REMBO 2008	4/41	4/40		0.4 %	0.98 [0.26, 3.64]
Service 1983	0/10	0/10			Not estimable
Stefanidis 2003	1/36	1/39		0.1 %	1.08 [0.07, 16.69]
Steno-2 2008	24/80	40/80		3.8 %	0.60 [0.40, 0.90]
UGDP 1975	52/204	52/210		5.3 %	1.03 [0.74, 1.44]
UKPDS 1998	539/3071	213/1138		18.3 %	0.94 [0.81, 1.08]
VA CSDM 1995	5/75	5/78		0.5 %	1.04 [0.31, 3.45]
VADT 2009	102/892	95/899		7.8 %	1.08 [0.83, 1.41]
Yang 2007	0/57	0/32			Not estimable
Zhang 2011	0/48	3/49		0.1 %	0.15 [0.01, 2.75]



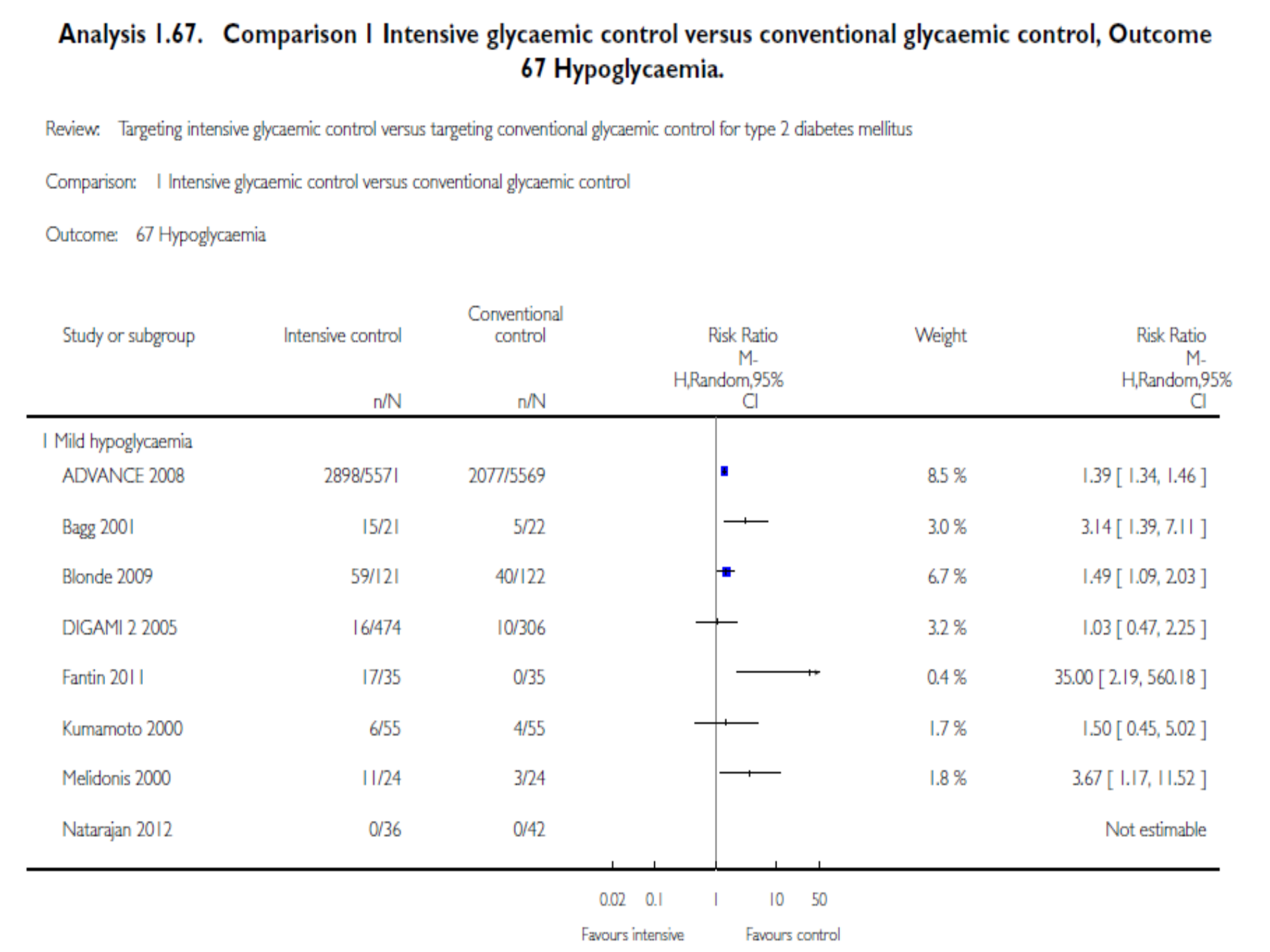
Analysis 1.67. Comparison 1 Intensive glycaemic control versus conventional glycaemic control, Outcome 67 Hypoglycaemia.

Review: Targeting intensive glycaemic control versus targeting conventional glycaemic control for type 2 diabetes mellitus

Comparison: 1 Intensive glycaemic control versus conventional glycaemic control

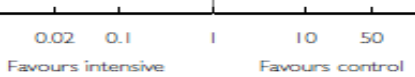
Outcome: 67 Hypoglycaemia

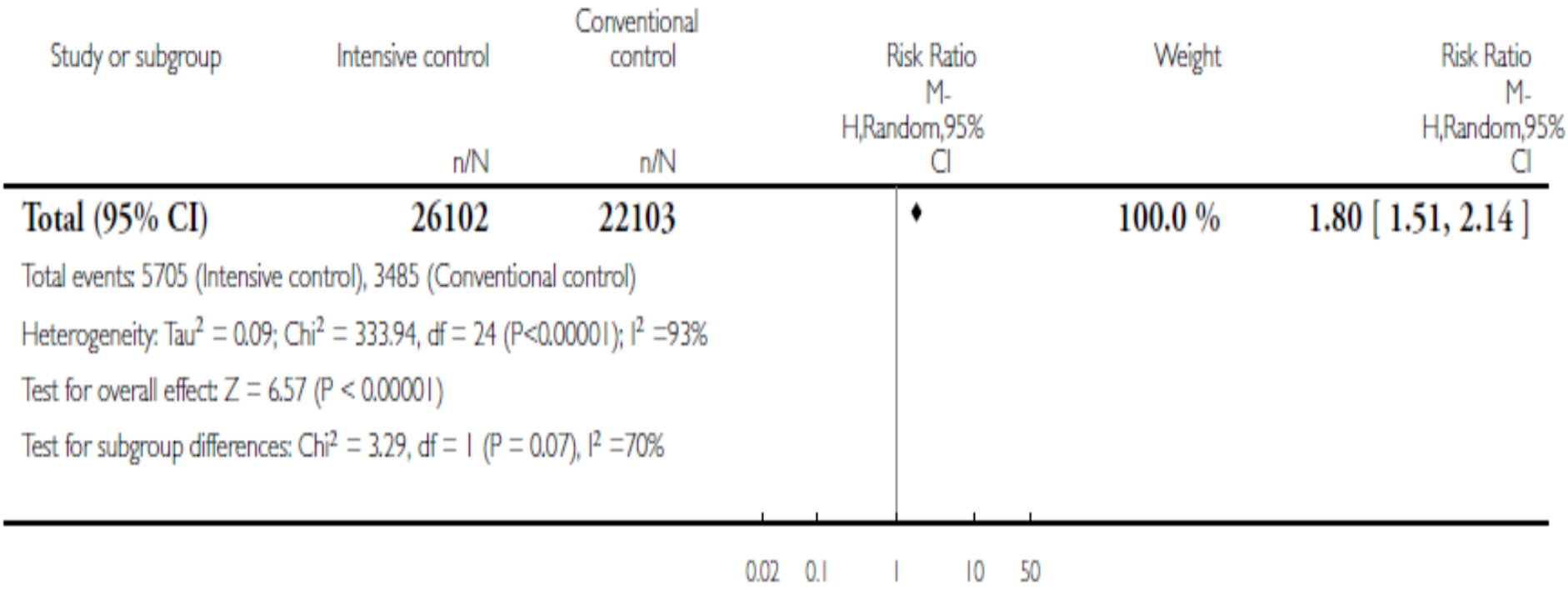
Study or subgroup	Intensive control n/N	Conventional control n/N	Risk Ratio M-H,Random,95% CI	Weight	Risk Ratio M-H,Random,95% CI
1 Mild hypoglycaemia					
ADVANCE 2008	2898/5571	2077/5569		8.5 %	1.39 [1.34, 1.46]
Bagg 2001	15/21	5/22		3.0 %	3.14 [1.39, 7.11]
Blonde 2009	59/121	40/122		6.7 %	1.49 [1.09, 2.03]
DIGAMI 2 2005	16/474	10/306		3.2 %	1.03 [0.47, 2.25]
Fantin 2011	17/35	0/35		0.4 %	35.00 [2.19, 560.18]
Kumamoto 2000	6/55	4/55		1.7 %	1.50 [0.45, 5.02]
Melidonis 2000	11/24	3/24		1.8 %	3.67 [1.17, 11.52]
Natarajan 2012	0/36	0/42			Not estimable



(. . . Continued)

Study or subgroup	Intensive control n/N	Conventional control n/N	Risk Ratio M-H,Random,95% CI	Weight	Risk Ratio M-H,Random,95% CI
Stefanidis 2003	7/36	2/39		1.2 %	3.79 [0.84, 17.07]
Steno-2 2008	64/80	56/80		7.8 %	1.14 [0.95, 1.37]
UGDP 1975	82/204	32/210		6.2 %	2.64 [1.84, 3.78]
UKPDS 1998	478/3071	106/1138		7.7 %	1.67 [1.37, 2.04]
VA CSDM 1995	69/75	44/78		7.6 %	1.63 [1.33, 2.00]
VADT 2009	833/892	694/899		8.5 %	1.21 [1.16, 1.26]
Zhang 2011	31/48	17/49		5.5 %	1.86 [1.20, 2.88]
Subtotal (95% CI)	**10743**	**8668**		**69.6 %**	**1.54 [1.35, 1.75]**
Total events: 4586 (Intensive control), 3090 (Conventional control)					
Heterogeneity: $Tau^2 = 0.03$; $Chi^2 = 86.82$, df = 13 (P<0.00001); I^2 =85%					
Test for overall effect: Z = 6.50 (P < 0.00001)					
2 Severe hypoglycaemia					
ACCORD 2008	830/5128	261/5123		8.1 %	3.18 [2.78, 3.63]
ADVANCE 2008	150/5571	81/5569		7.1 %	1.85 [1.42, 2.42]
Bagg 2001	0/21	0/22			Not estimable
Blonde 2009	1/121	0/122		0.3 %	3.02 [0.12, 73.52]
Cao 2011	6/92	1/87		0.6 %	5.67 [0.70, 46.18]
Fantin 2011	1/35	0/35		0.3 %	3.00 [0.13, 71.22]
IDA 2009	0/51	0/51			Not estimable
Jaber 1996	0/23	0/22			Not estimable
Kumamoto 2000 (1)	0/55	0/55			Not estimable
Melidonis 2000	3/24	0/24		0.3 %	7.00 [0.38, 128.61]
Natarajan 2012	0/36	0/42			Not estimable
Stefanidis 2003	0/36	0/39			Not estimable
Steno-2 2008	10/80	14/80		3.3 %	0.71 [0.34, 1.51]
UKPDS 1998	33/3071	8/1138		3.2 %	1.53 [0.71, 3.30]
VA CSDM 1995	5/75	2/78		1.0 %	2.60 [0.52, 12.99]
VADT 2009	76/892	28/899		5.7 %	2.74 [1.79, 4.18]
Zhang 2011	4/48	0/49		0.4 %	9.18 [0.51, 166.08]
Subtotal (95% CI)	**15359**	**13435**		**30.4 %**	**2.18 [1.53, 3.11]**
Total events: 1119 (Intensive control), 395 (Conventional control)					
Heterogeneity: $Tau^2 = 0.13$; $Chi^2 = 29.08$, df = 10 (P = 0.001); I^2 =66%					
Test for overall effect: Z = 4.30 (P = 0.000017)					




Study or subgroup
Intensive control
n/N
Conventional control
n/N
Risk Ratio M-H,Random,95% CI
Weight
Risk Ratio M-H,Random,95% CI
Total (95% CI)
26102
22103
100.0 %
1.80 [1.51, 2.14]
Total events: 5705 (Intensive control), 3485 (Conventional control)
Heterogeneity: Tau² = 0.09; Chi² = 333.94, df = 24 (P<0.00001); I² =93%
Test for overall effect: Z = 6.57 (P < 0.00001)
Test for subgroup differences: Chi² = 3.29, df = 1 (P = 0.07), I² =70%
0.02
0.1
1
10
50

CONSENSUS REPORT

Diabetes in Older Adults

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Vanessa Jones Briscoe, PHD, NP, CDE[2]
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Peggy Soule Odegard, BS, PHARMD, CDE[10]
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Carrie S. Swift, MS, RD, BC-ADM, CDE[12]

Diabetes Care, volume 35, December 2012

Table 1—*A framework for considering treatment goals for glycemia, blood pressure, and dyslipidemia in older adults with diabetes*

Patient characteristics/ health status	Rationale	Reasonable A1C goal (A lower goal may be set for an individual if achievable without recurrent or severe hypoglycemia or undue treatment burden)	Fasting or preprandial glucose (mg/dL)	Bedtime glucose (mg/dL)	Blood pressure (mmHg)	Lipids
Healthy (Few coexisting chronic illnesses, intact cognitive and functional status)	Longer remaining life expectancy	<7.5%	90–130	90–150	<140/80	Statin unless contraindicated or not tolerated
Complex/intermediate (Multiple coexisting chronic illnesses* or 2+ instrumental ADL impairments or mild to moderate cognitive impairment)	Intermediate remaining life expectancy, high treatment burden, hypoglycemia vulnerability, fall risk	<8.0%	90–150	100–180	<140/80	Statin unless contraindicated or not tolerated
Very complex/poor health (Long-term care or end-stage chronic illnesses** or moderate to severe cognitive impairment or 2+ ADL dependencies)	Limited remaining life expectancy makes benefit uncertain	<8.5%†	100–180	110–200	<150/90	Consider likelihood of benefit with statin (secondary prevention moreso than primary)

Evitar uso de BZD u otros sedantes hipnóticos, en caso de Insomnio, Delirium o Agitación, como primera elección.

- > Accidentes de Tránsito
- Caídas
- Fx de Cadera
- Hospitalizaciones
- Muerte

SPECIAL ARTICLES

American Geriatrics Society Updated Beers Criteria for Potentially Inappropriate Medication Use in Older Adults

The American Geriatrics Society 2012 Beers Criteria Update Expert Panel

Benzodiazepines *Short and intermediate acting:* Alprazolam Estazolam Lorazepam Oxazepam Temazepam Triazolam *Long acting:* Clorazepate Chlordiazepoxide Chlordiazepoxide-amitriptyline Clidinium-chlordiazepoxide Clonazepam Diazepam Flurazepam Quazepam	Older adults have increased sensitivity to benzodiazepines and slower metabolism of long-acting agents. In general, all benzodiazepines increase risk of cognitive impairment, delirium, falls, fractures, and motor vehicle accidents in older adults May be appropriate for seizure disorders, rapid eye movement sleep disorders, benzodiazepine withdrawal, ethanol withdrawal, severe generalized anxiety disorder, periprocedural anesthesia, end-of-life care	Avoid benzodiazepines (any type) for treatment of insomnia, agitation, or delirium	High	Strong

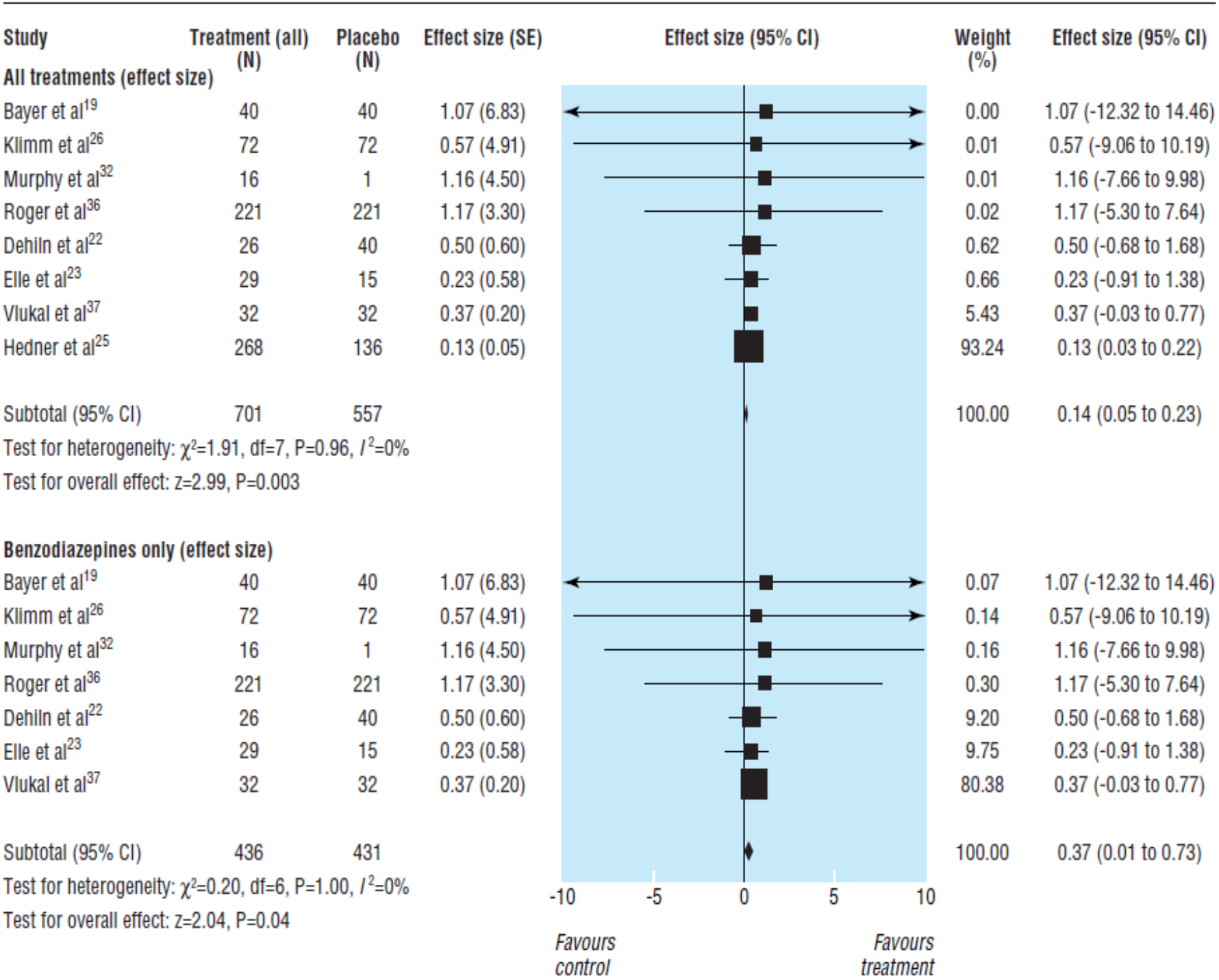
Nonbenzodiazepine hypnotics Eszopiclone Zolpidem Zaleplon	Benzodiazepine-receptor agonists that have adverse events similar to those of benzodiazepines in older adults (e.g., delirium, falls, fractures); minimal improvement in sleep latency and duration	Avoid chronic use (> 90 days)	Moderate	Strong

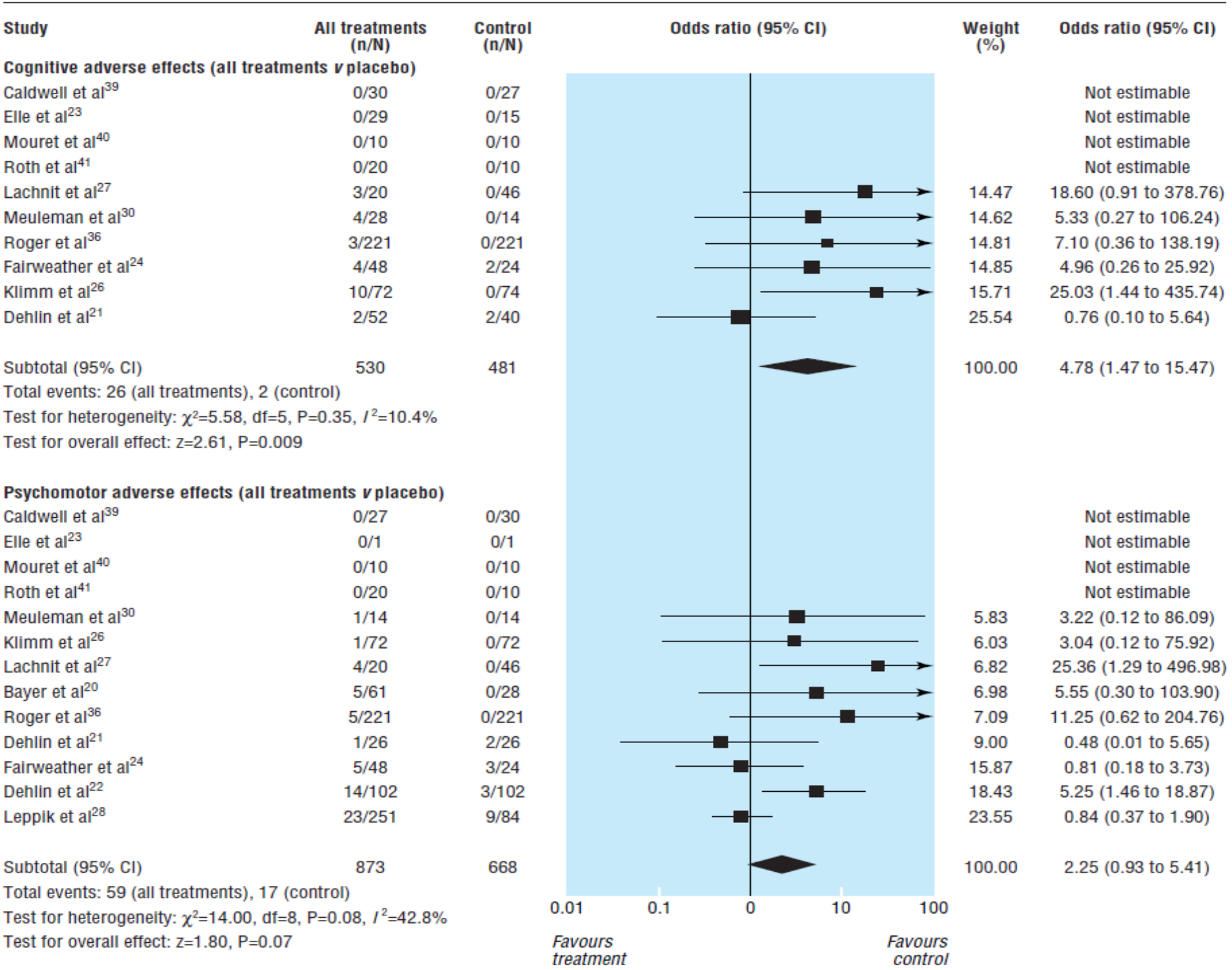
Cite this article as: BMJ, doi:10.1136/bmj.38623.768588.47 (published 11 November 2005)

Papers

Sedative hypnotics in older people with insomnia: meta-analysis of risks and benefits

Jennifer Glass, Krista L Lanctôt, Nathan Herrmann, Beth A Sproule, Usoa E Busto


Study
Treatment (all) (N)
Placebo (N)
Effect size (SE)
Effect size (95% CI)
Weight (%)
Effect size (95% CI)
All treatments (effect size)
Bayer et al[19] 40 40 1.07 (6.83) 0.00 1.07 (-12.32 to 14.46)
Klimm et al[26] 72 72 0.57 (4.91) 0.01 0.57 (-9.06 to 10.19)
Murphy et al[32] 16 1 1.16 (4.50) 0.01 1.16 (-7.66 to 9.98)
Roger et al[36] 221 221 1.17 (3.30) 0.02 1.17 (-5.30 to 7.64)
Dehiln et al[22] 26 40 0.50 (0.60) 0.62 0.50 (-0.68 to 1.68)
Elle et al[23] 29 15 0.23 (0.58) 0.66 0.23 (-0.91 to 1.38)
Vlukal et al[37] 32 32 0.37 (0.20) 5.43 0.37 (-0.03 to 0.77)
Hedner et al[25] 268 136 0.13 (0.05) 93.24 0.13 (0.03 to 0.22)
Subtotal (95% CI) 701 557 100.00 0.14 (0.05 to 0.23)
Test for heterogeneity: χ^2=1.91, df=7, P=0.96, I^2=0%
Test for overall effect: z=2.99, P=0.003
Benzodiazepines only (effect size)
Bayer et al[19] 40 40 1.07 (6.83) 0.07 1.07 (-12.32 to 14.46)
Klimm et al[26] 72 72 0.57 (4.91) 0.14 0.57 (-9.06 to 10.19)
Murphy et al[32] 16 1 1.16 (4.50) 0.16 1.16 (-7.66 to 9.98)
Roger et al[36] 221 221 1.17 (3.30) 0.30 1.17 (-5.30 to 7.64)
Dehiln et al[22] 26 40 0.50 (0.60) 9.20 0.50 (-0.68 to 1.68)
Elle et al[23] 29 15 0.23 (0.58) 9.75 0.23 (-0.91 to 1.38)
Vlukal et al[37] 32 32 0.37 (0.20) 80.38 0.37 (-0.03 to 0.77)
Subtotal (95% CI) 436 431 100.00 0.37 (0.01 to 0.73)
Test for heterogeneity: χ^2=0.20, df=6, P=1.00, I^2=0%
Test for overall effect: z=2.04, P=0.04
-10
-5
0
5
10
Favours control
Favours treatment


Study
All treatments (n/N)
Control (n/N)
Odds ratio (95% CI)
Weight (%)
Odds ratio (95% CI)
Cognitive adverse effects (all treatments v placebo)
Caldwell et al[39] 0/30 0/27 Not estimable
Elle et al[23] 0/29 0/15 Not estimable
Mouret et al[40] 0/10 0/10 Not estimable
Roth et al[41] 0/20 0/10 Not estimable
Lachnit et al[27] 3/20 0/46 14.47 18.60 (0.91 to 378.76)
Meuleman et al[30] 4/28 0/14 14.62 5.33 (0.27 to 106.24)
Roger et al[36] 3/221 0/221 14.81 7.10 (0.36 to 138.19)
Fairweather et al[24] 4/48 2/24 14.85 4.96 (0.26 to 25.92)
Klimm et al[26] 10/72 0/74 15.71 25.03 (1.44 to 435.74)
Dehlin et al[21] 2/52 2/40 25.54 0.76 (0.10 to 5.64)
Subtotal (95% CI) 530 481 100.00 4.78 (1.47 to 15.47)
Total events: 26 (all treatments), 2 (control)
Test for heterogeneity: χ^2=5.58, df=5, P=0.35, I^2=10.4%
Test for overall effect: z=2.61, P=0.009
Psychomotor adverse effects (all treatments v placebo)
Caldwell et al[39] 0/27 0/30 Not estimable
Elle et al[23] 0/1 0/1 Not estimable
Mouret et al[40] 0/10 0/10 Not estimable
Roth et al[41] 0/20 0/10 Not estimable
Meuleman et al[30] 1/14 0/14 5.83 3.22 (0.12 to 86.09)
Klimm et al[26] 1/72 0/72 6.03 3.04 (0.12 to 75.92)
Lachnit et al[27] 4/20 0/46 6.82 25.36 (1.29 to 496.98)
Bayer et al[20] 5/61 0/28 6.98 5.55 (0.30 to 103.90)
Roger et al[36] 5/221 0/221 7.09 11.25 (0.62 to 204.76)
Dehlin et al[21] 1/26 2/26 9.00 0.48 (0.01 to 5.65)
Fairweather et al[24] 5/48 3/24 15.87 0.81 (0.18 to 3.73)
Dehlin et al[22] 14/102 3/102 18.43 5.25 (1.46 to 18.87)
Leppik et al[28] 23/251 9/84 23.55 0.84 (0.37 to 1.90)
Subtotal (95% CI) 873 668 100.00 2.25 (0.93 to 5.41)
Total events: 59 (all treatments), 17 (control)
Test for heterogeneity: χ^2=14.00, df=8, P=0.08, I^2=42.8%
Test for overall effect: z=1.80, P=0.07
0.01
0.1
0
10
100
Favours treatment
Favours control

Med Clin North Am. 2015 March ; 99(2): 431–439. doi:10.1016/j.mcna.2014.11.013.

Sleep Problems in the Elderly

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Technique	Level of Support
Sleep education Information regarding normal sleep changes with age. Designed to normalize current sleep, improve expectations, and reduce anxiety	Low[a]; not an evidence-based practice[b]; not a recommendation[c]
Cognitive therapy Maladaptive thoughts, beliefs, and attitudes can negatively affect sleep. Challenging these thoughts can help promote sleep through a reduction in sleep disruptive thoughts and emotions	Low[a]; not an evidence-based practice[b]; not a recommendation[c]
Sleep hygiene Instruction to avoid or limit sleep disruptive substances and behaviors, including caffeine, alcohol, nicotine, exercising, and heavy meals at night	Low[a]; not an evidence-based practice[b]; not a recommendation[c]
Relaxation strategies Active or passive relaxation techniques all designed to reduce physiologic or mental arousal that may be interfering with sleep	Moderate[a]; not an evidence-based practice[b]; standard recommendation[c]

Stimulus control Behavioral technique based on classic conditioning principals. Instructs individuals to limit their use of the bed to sleep and sex, and to limit the amount of time spent awake in bed	Strong[a]; not an evidence-based practice[b]; standard recommendation[c]
Sleep restriction Behavioral strategy designed to match the amount of time spent in bed with the amount of time asleep. A consistent sleep schedule and time in bed is collaboratively prescribed and adjusted as needed	Strong[a]; evidence-based practice[b]; guideline recommendation[c]
Multicomponent treatment packages Combines several individual components into a treatment package. Usually consists of stimulus control and sleep restriction. Sometimes includes sleep education, cognitive therapy, relaxation techniques, or sleep hygiene recommendations	Strong[a]; evidence-based practice[b]; standard recommendation[c]

Evite uso de antibióticos para bacteriurias.

- Solo si existen síntomas específicos.

Table 2. Diagnosis of asymptomatic bacteriuria based on IDSA guidelines[7]
Lack of signs and symptoms of urinary tract infection
Diagnosis based on urine specimen collected in manner that minimises contamination
For asymptomatic men – single voided urine specimen with one bacterial species isolated in quantitative count ≥100 000 cfu/mL
For asymptomatic women – two consecutive voided urine specimens with isolation of same bacterial strain in quantitative counts ≥100 000 cfu/mL
For men or women – single catheterised urine specimen with one bacterial species isolated in quantitative count ≥100 cfu/mL

Table 1. Factors associated with the presence of asymptomatic bacteriuria

Physiological	Pathological
Age	Neurological disease, eg. Alzheimer disease, Parkinson disease, stroke
Gender (female more than male)	Diabetes mellitus, primary biliary cirrhosis
	Reduced mobility
	Urinary tract abnormality (eg. calculi, prostate enlargement, high PVR volume)
	Indwelling urinary catheter
	Constipation

Table 4. IDSA guidelines for the management of asymptomatic bacteriuria where treatment is not recommended[7]

Patient category	Strength of recommendation and level of evidence
Institutionalised elderly	A–I
Patients with an indwelling catheter	A–I
Women with diabetes	A–I
Premenopausal nonpregnant women	A–I
Community dwelling elderly	A–II
Patients with spinal cord injury	A–II

Infectious Diseases Society of America Guidelines for the Diagnosis and Treatment of Asymptomatic Bacteriuria in Adults

Lindsay E. Nicolle,[1] Suzanne Bradley,[2] Richard Colgan,[3] James C. Rice,[4] Anthony Schaeffer,[5] and Thomas M. Hooton[6]

[1]University of Manitoba, Winnipeg, Canada; [2]University of Michigan, Ann Arbor; [3]University of Maryland, Baltimore; [4]University of Texas, Galveston; [5]Northwestern University, Chicago, Illinois; and [6]University of Washington, Seattle

Table 2. Prevalence of asymptomatic bacteriuria in selected populations.

Population	Prevalence, %	Reference
Healthy, premenopausal women	1.0–5.0	[31]
Pregnant women	1.9–9.5	[31]
Postmenopausal women aged 50–70 years	2.8–8.6	[31]
Diabetic patients		
Women	9.0–27	[32]
Men	0.7–11	[32]
Elderly persons in the community[a]		
Women	10.8–16	[31]
Men	3.6–19	[31]
Elderly persons in a long-term care facility		
Women	25–50	[27]
Men	15–40	[27]
Patients with spinal cord injuries		
Intermittent catheter use	23–89	[33]
Sphincterotomy and condom catheter in place	57	[34]
Patients undergoing hemodialysis	28	[28]
Patients with indwelling catheter use		
Short-term	9–23	[35]
Long-term	100	[22]

[a] Age, ⩾70 years.

Table 4. Randomized clinical trials of treatment of asymptomatic bacteriuria in elderly populations.

Population	Age, years[a]	Study description	Duration of follow-up	Outcomes	Reference
Ambulatory women	85.8	Randomized trial of single-dose TMP or cefaclor (500 mg t.i.d. for 3 days); culture repeated at month 6	6 months	At 6 months, bacteriuria was present in 64% of untreated vs. 35% of treated patients; antimicrobial given for symptomatic UTI, 16.4% vs. 7.9% (P = NS)	[73]
Institutionalized women	83.5	Randomized, trial; patients were monitored monthly and re-treated if results were positive for subjects randomized to therapy	12 months	Rate of symptomatic UTI, 0.92 cases per patient-year for the no therapy group vs. 0.67 cases per patient-year for the therapy group (P = NS); mortality at 12 months, 18% vs. 39% (P = .11; 95% CI, −0.05 to +0.47); therapy recipients had significantly more adverse drug-related events and reinfections with resistant organisms	[74]
Institutionalized veterans	80[b]	Randomized trial; patients were monitored every 2 weeks and were re-treated if results were positive	24 months	Rates of symptomatic UTI and mortality were similar	[77]
Ambulatory and institutionalized women	81.9	Randomized, placebo-controlled trial of TMP vs. single-dose norfloxacin administered every 14 days; cultures were performed every 6 months	9 years	Similar mortality rates at 9 years (RR, 0.92; 95% CI, 0.50–1.47).	[78]
Institutionalized incontinent women and men	84.5	Randomized trial of norfloxacin given every 7 days	3 days	At 3 days, no difference in continence	[79]

NOTE. RR, relative risk; TMP, trimethoprim; UTI, urinary tract infection.

[a] Data are mean age, unless otherwise indicated.

[b] Median age.

No prescriba colinesterásicos en pacientes con demencia, sin evaluar utilidad o seguridad, periódicamente.

- Modestos Beneficios en:
  - Deterioro cognitivo
  - Declinación funcional
  - Alteraciones conductuales
- Pobres resultados:
  - Institucionalización
  - Calidad de vida
  - Necesidad de cuidadores

- Privilegiar manejo no farmacológico
- Si no se ve respuesta en 12 sems de terapia, suspender
- Considerar riesgos adversos

Papers

Cholinesterase inhibitors for patients with Alzheimer's disease: systematic review of randomised clinical trials

bmj.com 2005;331:321

Table 3 Patients with adverse events in the donepezil and placebo groups (actual data because testing for significance is not appropriate for rare effects owing to insufficient power)

Characteristics of trial				% of patients with adverse events on cholinesterase inhibitor (placebo)						
Study	Dose	No of patients taking cholinesterase inhibitor	No of patients taking placebo	Diarrhoea	Nausea	Vomiting	Weight loss or anorexia	Insomnia	Urinary tract infection	Other adverse events
Donepezil										
Rogers et al 1996[5]	1 mg	42	40	0 (3)	7 (5)		—	—	2 (5)	—
	3 mg	40		3 (3)	0 (5)		—	—	8 (5)	—
	5 mg	39		10 (3)	10 (5)		—	—	3 (5)	—
Rogers et al 1998a[6]	5 mg	157	153	6 (3)	7 (8)	3 (5)	2 (2)	8 (5)	6 (13)	—
	10 mg	158		13 (3)*	22 (8)*	6 (5)	5 (2)	18 (5)*	4 (13)	—
Rogers et al 1998b[7]	5 mg	154	162	9 (7)	4 (4)	3 (2)	2 (2)	—	—	Muscle cramps: 6 (1)*
	10 mg	157		17 (7)*	17 (4)*	10 (2)*	7 (2)*	—	—	Muscle cramps: 8 (1)* (10 mg) fatigue: 8 (2)*
Burns et al 1999[8]	5 mg	271	274	10 (4)*	7 (7)	4 (4)	4 (1)	7 (4)	—	—
	10 mg	273		16 (4)*	24 (7)*	16 (4)*	8 (1)*	8 (4)*	—	—
Greenberg et al 2000[9]†	5 mg	N/A	N/A	—	—	—	—	—	—	—
Homma et al 2000[10]	5 mg	136	132	4 (3)	4 (1)	1 (2)	1 (2)	—	—	Cold syndrome: 7 (2)
Feldman et al 2001[11]	10 mg	144	146	13 (5)*	7 (4)	7 (3)	7 (4)	—	6 (4)	Headache: 12 (4)* Arthralgia: 7 (1)*
Mohs et al 2001[12]	10 mg	214	217	17 (5)*	9 (4)*	—	6 (4)*	8 (3)	13 (7)*	Headache: 9 (3) Dyspepsia: 6 (1)
Tariot et al 2001[13]	10 mg	103	105	15 (10)	9 (4)	15 (14)	19 (10)*	—	16 (20)	Peripheral oedema: 24 (13)*
Winblad et al 2001[14]	10 mg	142	144	7 (7)	11 (9)	—	—	10 (7)	6 (7)	Vertigo: 8 (2)*
AD2000 Collaborative Group 2004[15]	5 mg or 10 mg	283	283	—	—	—	—	—	—	—
Holmes et al 2004[16]	10 mg	41	55	—	—	—	—	—	—	—

Table 4 Patients with adverse events in the trials on rivastigmine and galantamine (actual data because testing for significance is not appropriate for rare effects because of insufficient power)

Study	Dose	No of patients: Cholinesterase-inhibitor	No of patients: Placebo	% of patients with adverse events on cholinesterase inhibitor (placebo) colsep="0": Diarrhoea	Nausea	Vomiting	Weight loss or anorexia	Dizziness	Other adverse events colsep="0"
Rivastigmine colsep="0"									
Agid 1998[17]	4 mg	136	133	7 (2)*	17 (6)*	10 (3)*	—	6 (7)	— colsep="0"
	6 mg	133		12 (2)*	31 (6)*	18 (3)*	—	20 (7)*	— colsep="0"
Corey-Bloom 1998†[18]	1-4 mg	233	235	—	8 (3)*	5 (2)*	—	8 (4)	Dyspepsia: 6 (1)* Sinusitis: 1 (1) colsep="0"
	6-12 mg	231		—	20 (3)*	16 (2)*	—	14 (4)*	Dyspepsia: 5 (1)* Sinusitis: 4 (1)* colsep="0"
Forette 1999[19]	6-12 mg twice daily	45	24	—	58 (8)*	38 (4)*	18 (0)*	27 (0)*	Headache: 16 (4) colsep="0"
	6-12 mg thrice daily	45		—	58 (8)*	31 (4)*	16 (0)*	9 (0)	Headache: 20 (4)* colsep="0"
Rösler 1999[20]	1-4 mg	243	239	10 (9)	17 (10)*	8 (6)	3 (2)	10 (7)	Headache: 7 (8) colsep="0"
	6-12 mg	243		17 (9)*	50 (10)*	34 (6)*	14 (2)*	20 (7)*	Headache: 19 (8)* colsep="0"
Potkin 2001[21]	3-9 mg	20	7	—	—	—	—	—	— colsep="0"
Galantamine colsep="0"									
Raskind 2000[22]	24 mg	212	213	12 (10)	37 (13)*	21 (8)*	12 (5)*	14 (11)	— colsep="0"
	32 mg	211		19 (10)*	44 (13)*	26 (8)*	11 (5)*	19 (11)*	— colsep="0"
Rockwood 2001[23]	24-32 mg	261	125	—	32 (11)*	15 (4)*	12 (2)*	15 (4)*	Agitation: 6 (1)* Somnolence: 8 (1)* colsep="0"
Tariot 2000[24]	8 mg	140	286	5 (6)	6 (5)	4 (1)	6 (3)	—	— colsep="0"
	16 mg	279		12 (6)*	13 (5)*	6 (1)*	7 (3)	—	— colsep="0"
	24 mg	273		6 (6)	17 (5)*	10 (1)*	9 (3)*	—	— colsep="0"
Wilcock 2000[25]	24 mg	220	215	7 (7)	37 (12)*	20 (4)*	8 (1)*	11 (5)*	Anorexia: 10 (0)* colsep="0"
	32 mg	218		13 (7)*	40 (12)*	17 (4)*	5 (1)*	12 (5)*	Anorexia: 11 (0)* colsep="0"
Wilkinson 2001[26]	18 mg	88	87	2 (2)	17 (3)*	17 (5)*	—	5 (3)	Headache: 6 (5) colsep="0"
	24 mg	56		5 (2)	18 (3)*	7 (5)	—	4 (3)	Headache: 11 (5)
	36 mg	54		4 (2)	37 (3)*	17 (5)*	—	7 (3)	Headache: 15 (5)*

Neuroepidemiology

Neuroepidemiology 2005;24:168–169
DOI: 10.1159/000083613

Does Donepezil Improve Well-Being for Dementia due to Alzheimer's Disease?

Jacqueline Birks
on behalf of the Cochrane Neurological Network

Events/treatment	Events/placebo	OR	95% CI	p
CIBIC-plus improvement	6 months			
97/390	53/409	2.18	1.53–3.11	<0.0001
25%	13%			
Adverse events	6 months			
453/554	427/559	1.57	1.13–2.20	0.008
82%	76%			
Drop-outs	6 months			
111/482	88/394	1.09	0.79–1.50	0.61
23%	22%			

Screening for Cognitive Impairment in Older Adults: An Evidence Update for the U.S. Preventive Services Task Force

Investigators:
Jennifer S. Lin, MD, MCR
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AHRQ Publication No. 14-05198-EF-1
November 2013

Figure 8. Meta-Analyses for AChEIs and Memantine on Global Cognitive Function, Measured by the ADAS-Cog (Key Question 4)

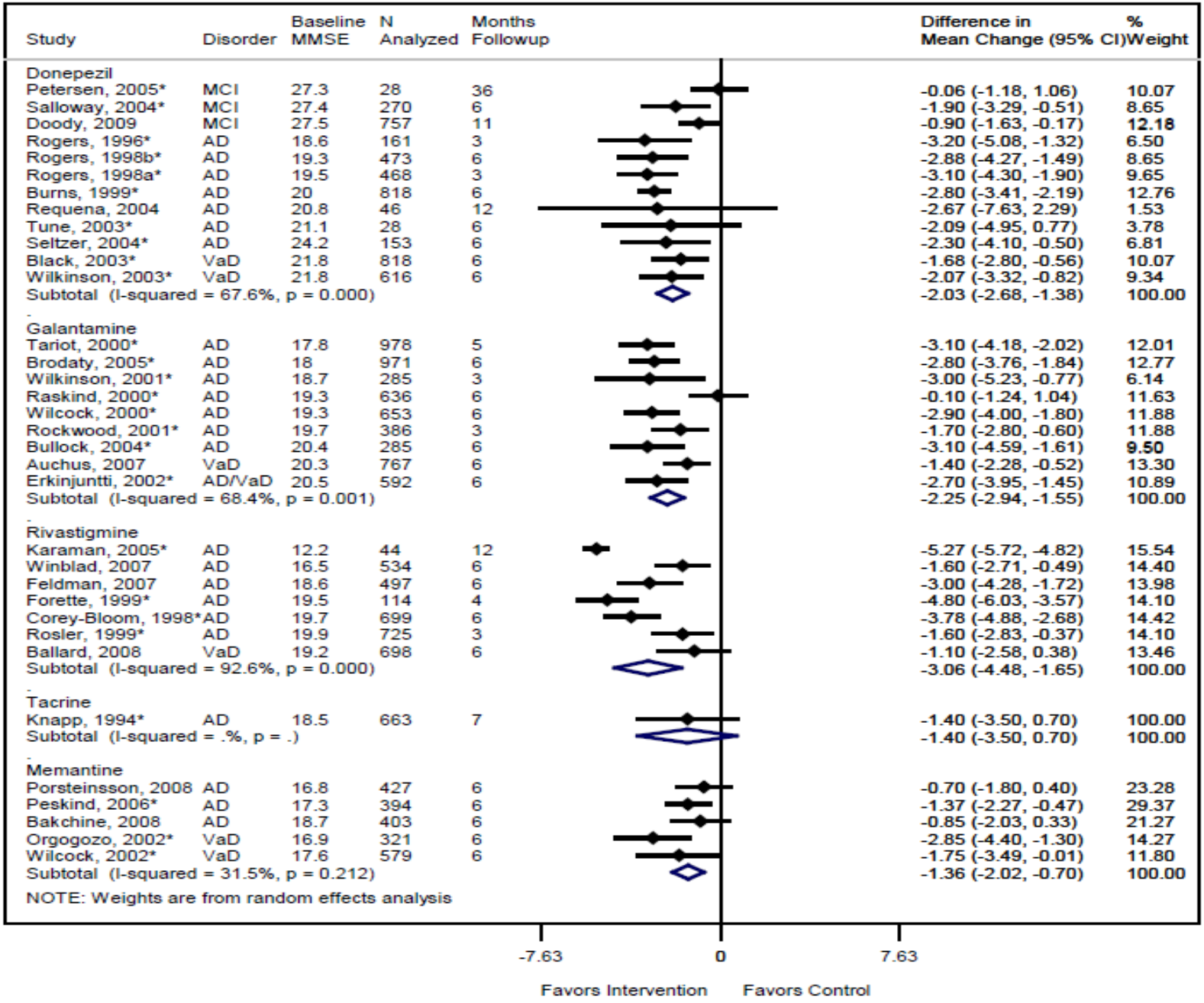


Figure 10. Meta-Analyses for AChEIs and Memantine on Withdrawals Due to Adverse Events (Key Question 5)

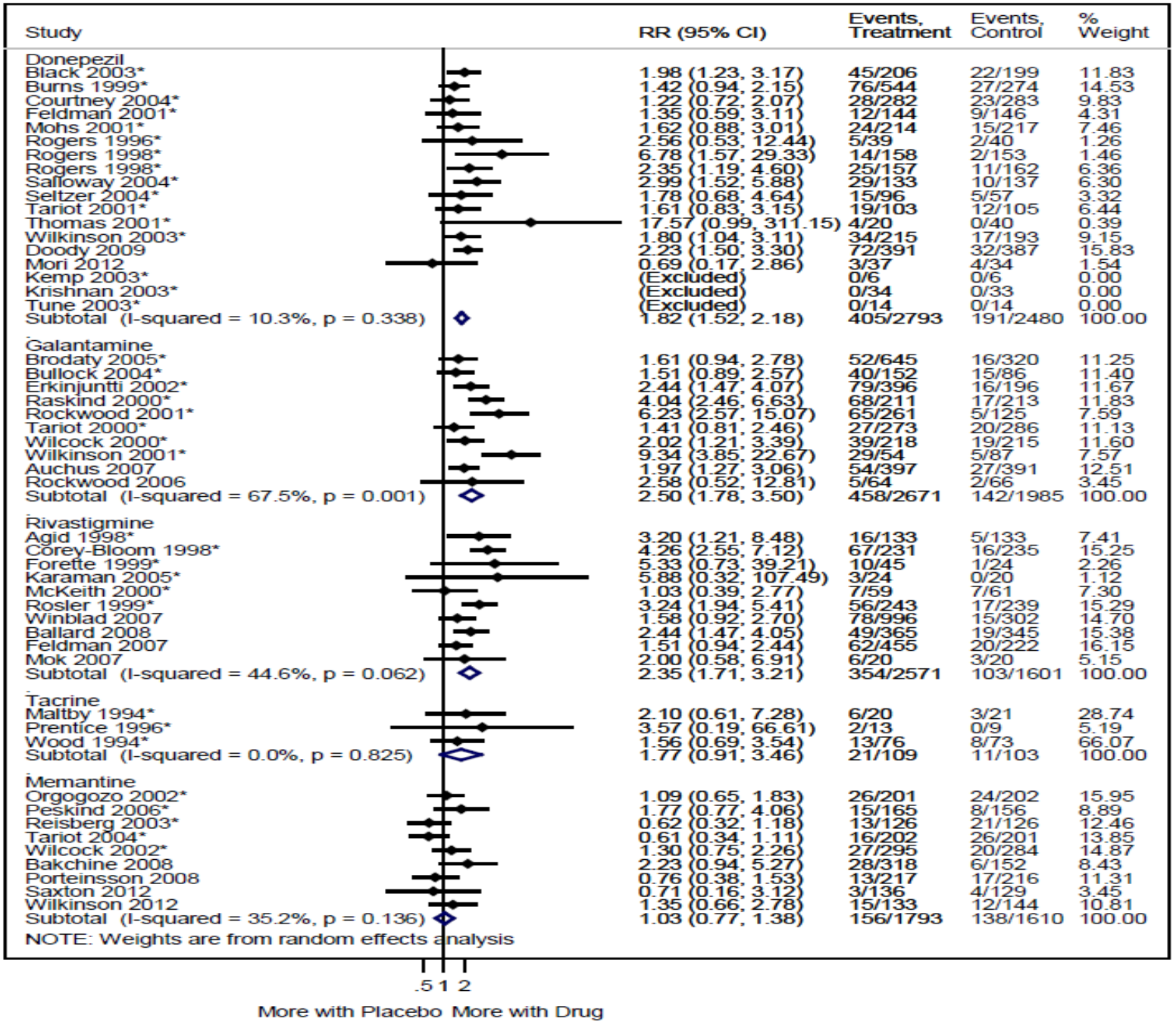


Figure 11. Meta-Analyses for AChEIs and Memantine on Serious Adverse Events (Key Question 5)

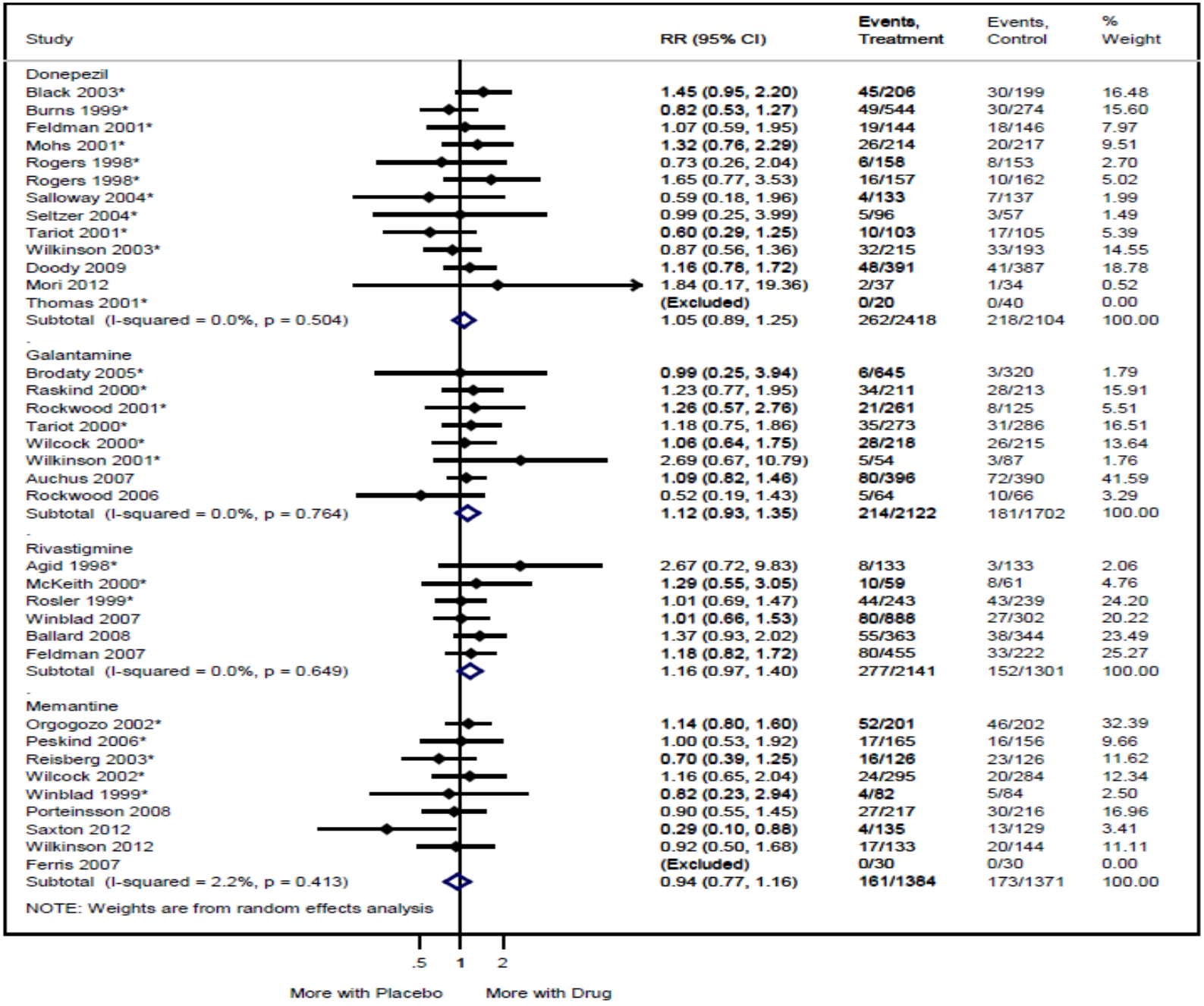


Figure 13. Meta-Analyses for Psychoeducational Caregiver Interventions on Caregiver Burden (Key Question 4)

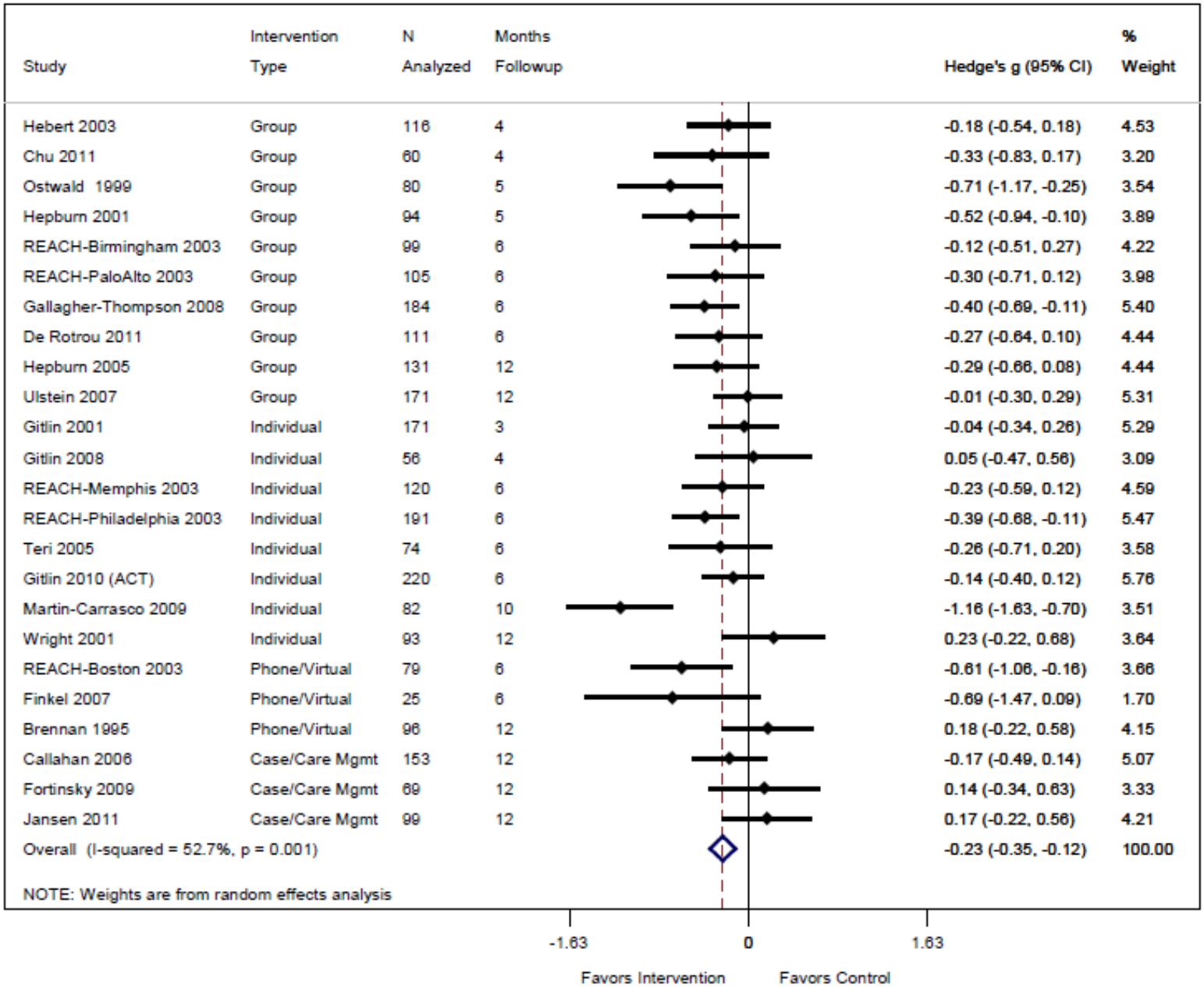
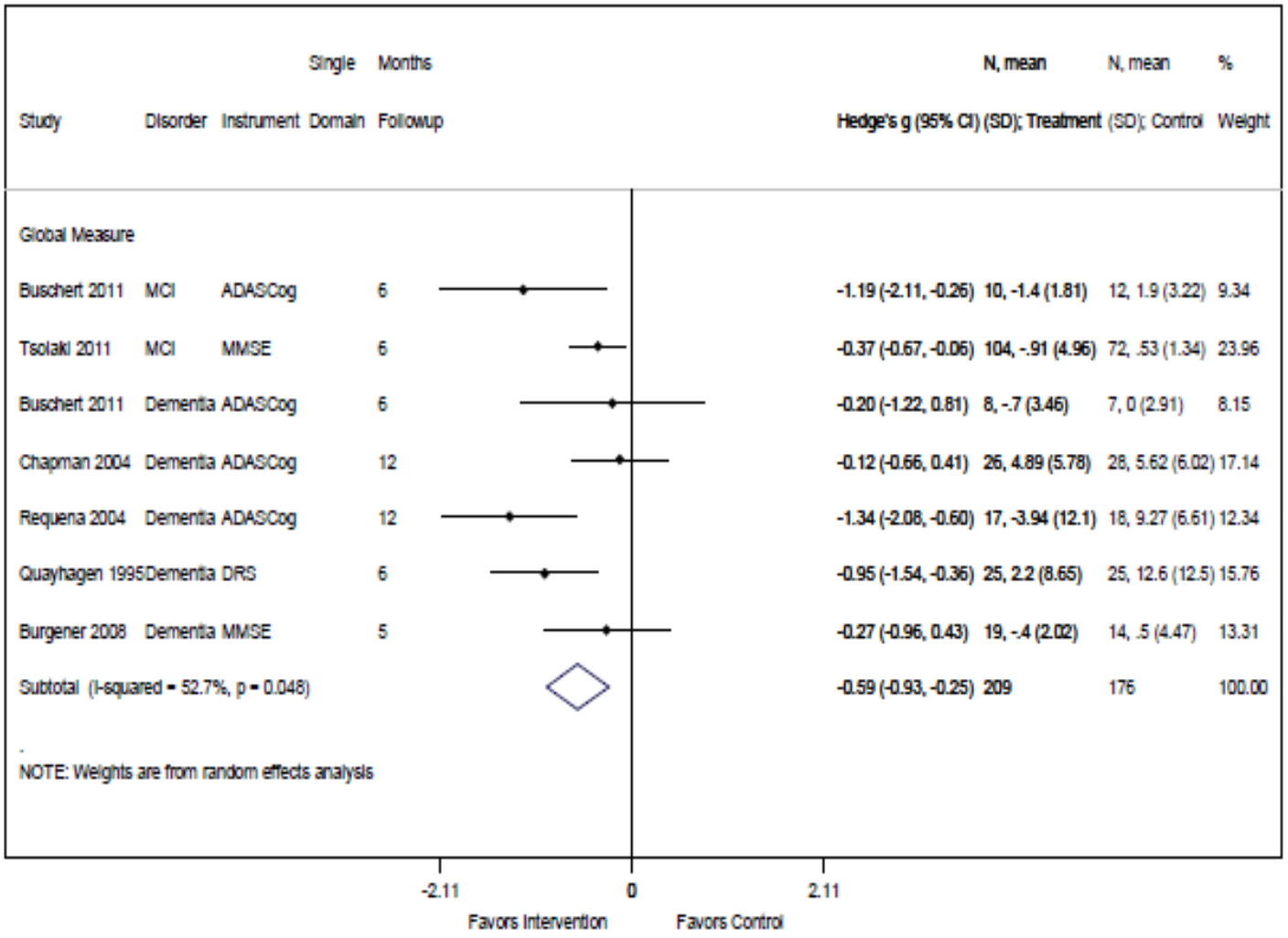


Figure 15. Meta-Analyses for Cognitive Stimulation Interventions on Global Cognitive Function* (Key Question 4)



No recomendar screening de Ca. Próstata, Colon o Mama, sin evaluar riesgos, pronóstico o beneficios de terapia.

The NEW ENGLAND JOURNAL of MEDICINE

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Prostate-Cancer Mortality at 11 Years of Follow-up

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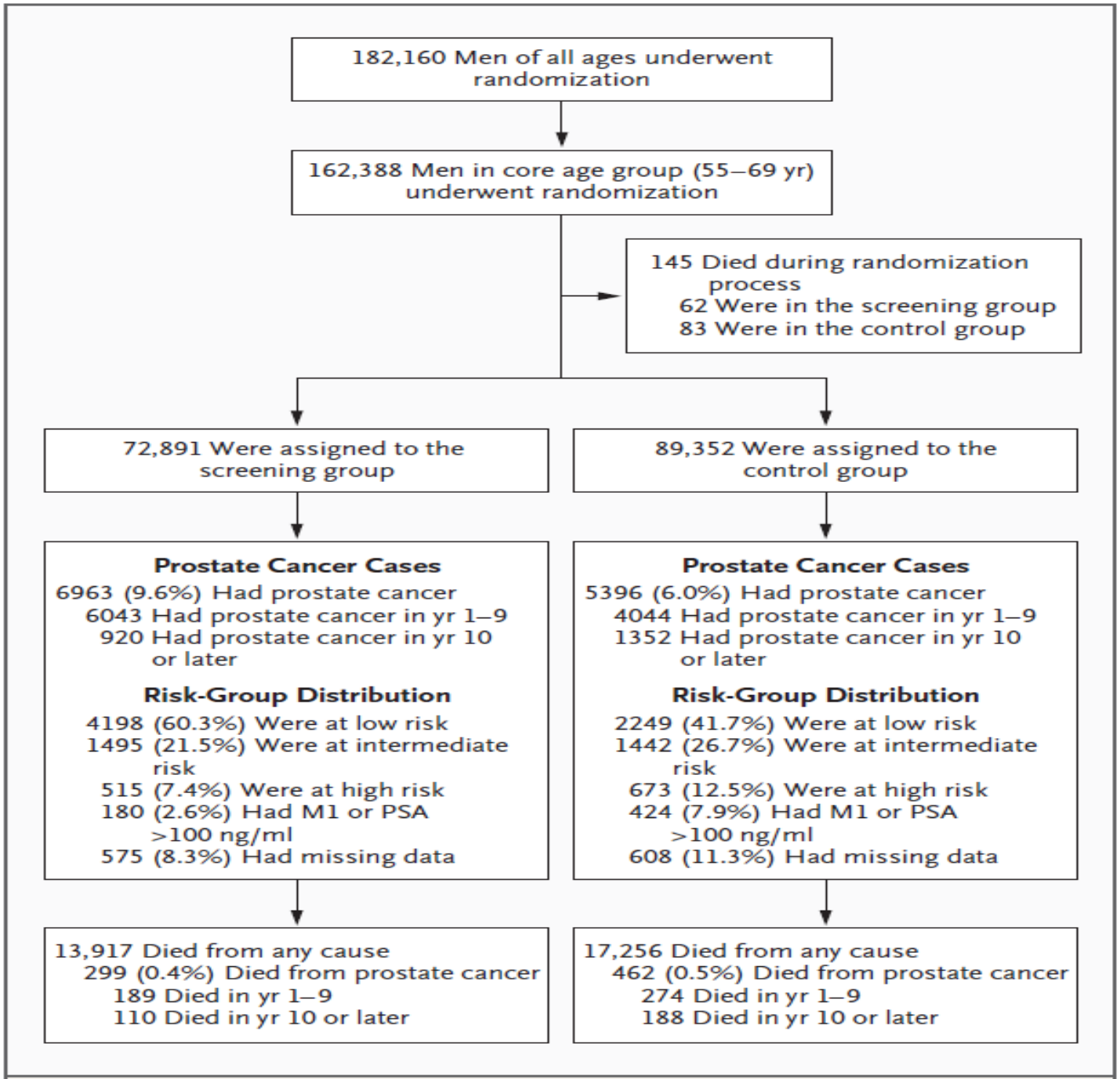

Figure 1. Enrollment and Outcomes.

Table 2. Prostate-Cancer Incidence in Men 55 to 69 Years of Age, According to Study Period.*

Study Years	Screening Group (N=72,891)			Control Group (N=89,352)			Rate Ratio (95% CI)†	Rate Difference per 1000 Person-Yr (95% CI)‡	Rate Difference per 1000 Men‡
	Prostate Cancers	Person-Yr	Rate per 1000 Person-Yr	Prostate Cancers	Person-Yr	Rate per 1000 Person-Yr			
	no.			*no.*					
1–9	6043	580,502	10.41	4044	731,204	5.53	1.88 (1.81 to 1.96)	4.80 (4.49 to 5.12)	37.6
8–9	1410	113,850	12.38	1174	145,293	8.08	1.56 (1.44 to 1.69)	4.30 (3.51 to 5.10)	6.2
10–11	541	88,999	6.08	916	114,462	8.00	0.78 (0.70 to 0.87)	−1.92 (−2.65 to −1.20)	−2.8
1–11	6584	669,501	9.83	4960	845,666	5.87	1.68 (1.62 to 1.75)	3.97 (3.68 to 4.26)	34.8
≥12	379	51,141	7.41	436	61,726	7.06	1.03 (0.90 to 1.19)	0.35 (−0.65 to 1.35)	0.3
Total	6963	720,643	9.66	5396	907,392	5.95	1.63 (1.57 to 1.69)	3.71 (3.44 to 3.99)	35.1

Table 3. Mortality from Prostate Cancer among Men 55 to 69 Years of Age, According to Study Period.*

Study Years	Screening Group			Control Group			Rate Ratio (95% CI)†	P Value	Rate Difference per 1000 Person-Yr (95% CI)‡	Rate Difference per 1000 Men‡
	Deaths from Prostate Cancer	Person-Yr	Rate per 1000 Person-Yr	Deaths from Prostate Cancer	Person-Yr	Rate per 1000 Person-Yr				
	no.			*no.*						
1–9	189	608,852	0.31	274	745,912	0.37	0.85 (0.71 to 1.03)	0.09	−0.06 (−0.12 to 0.01)	−0.47
8–9	71	122,867	0.58	118	151,319	0.78	0.74 (0.55 to 0.99)	0.04	−0.20 (−0.40 to 0.00)	−0.35
10–11	56	97,994	0.57	111	120,900	0.92	0.62 (0.45 to 0.85)	0.003	−0.35 (−0.57 to −0.12)	−0.47
1–11	245	706,846	0.35	385	866,812	0.44	0.79 (0.67 to 0.92)	0.003	−0.10 (−0.16 to −0.04)	−0.95
≥12	54	57,387	0.94	77	66,241	1.16	0.80 (0.56 to 1.13)	0.21	−0.22 (−0.58 to 0.14)	−0.12
Total	299	764,233	0.39	462	933,052	0.50	0.79 (0.68 to 0.91)	0.001	−0.10 (−0.17 to −0.04)	−1.07

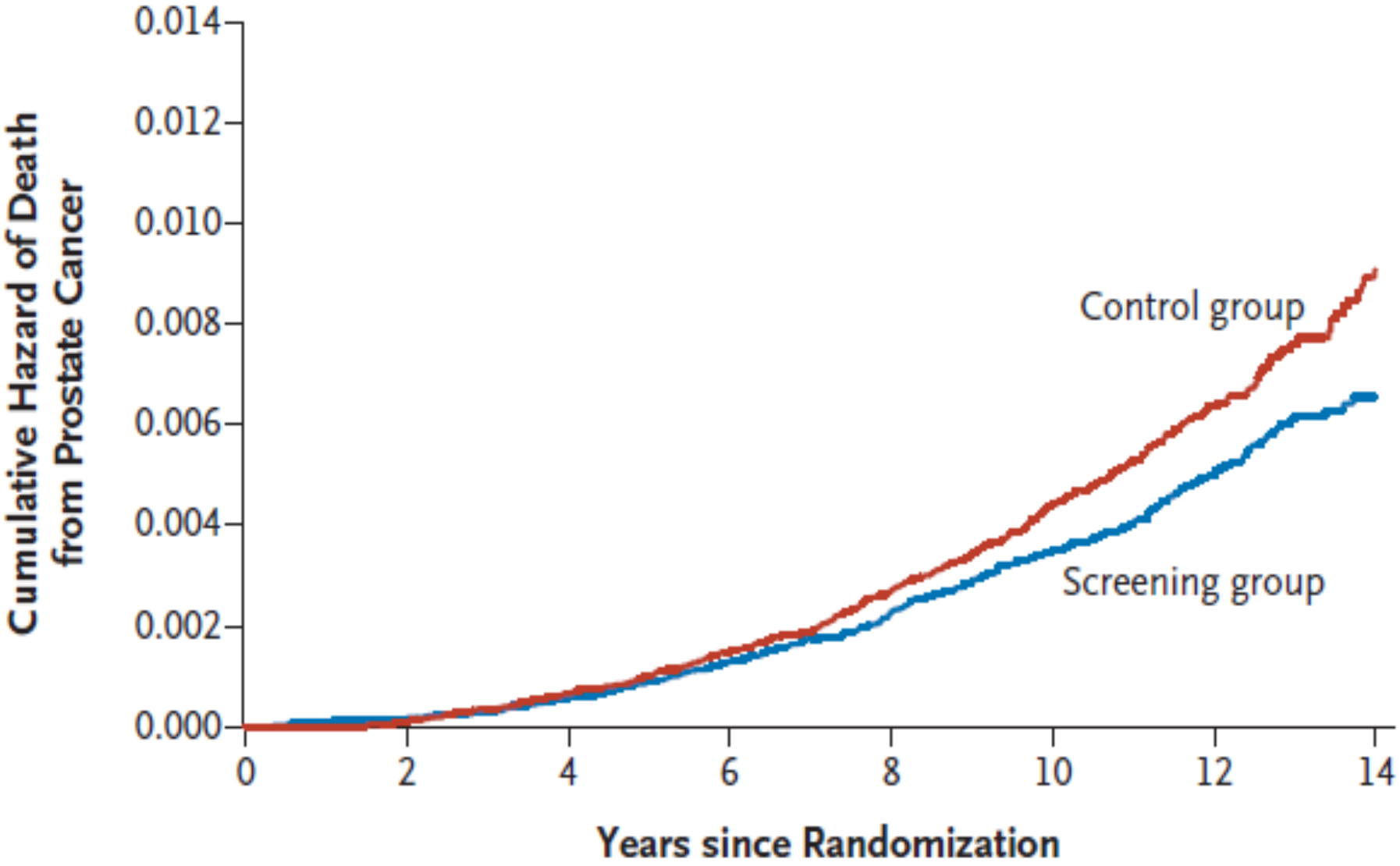

Figure 2. Cumulative Hazard of Death from Prostate Cancer among Men 55 to 69 Years of Age.

- A 11 años
  - NNI : 1055
  - NND 37

- Sin diferencia en mortalidad x todas las causas

Figure 1A: Forest plot of relative risk of prostate cancer death per centre.

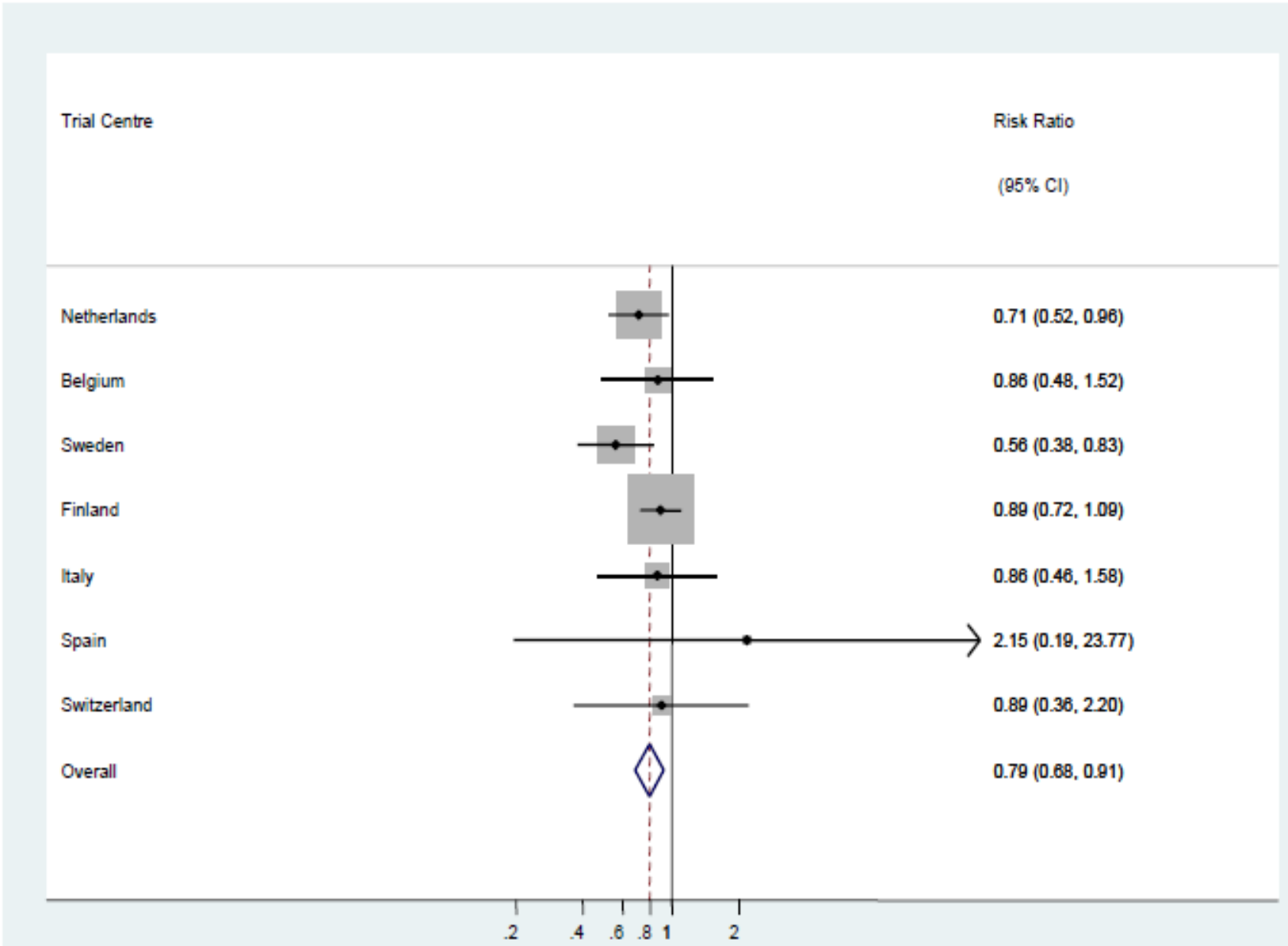

Table 5A: All cause and prostate cancer mortality by age at randomization (excluding France)

	Intervention arm			Control arm			Rate ratio (95% CI)		Rate difference per1000 person years (95% CI
	Deaths	Person years	Rate per 1000 p.years	Deaths	Person years	Rate per 1000 p.years			
All causes									
Core age group	13917	764233	18.2	17256	933053	18.5	0.99	(0.97-1.01) p=0.50	
All ages	16737	874644	19.1	20026	1042672	19.2	1.00	(0.98-1.02) p= 0.85	
Prostate cancer									
<=54	6	66010	0.09	9	64334	0.14	0.65	(0.23 - 1.83)	-0.05 (-0.17 – + 0.07)
55-59	94	378539	0.25	144	480748	0.30	0.81	(0.62 – 1.05)	-0.05 (-0.12 – +0.02)
60-64	106	226339	0.47	136	261588	0.52	0.92	(0.71 - 1.18)	-0.05 (-0.18 – +0.07)
65-69	99	159355	0.62	182	190717	0.95	0.67	(0.53 - 0.86)	-0.33 (-0.52 – +0.15)
70+	59	44402	1.33	51	45285	1.13	1.18	(0.81 - 1.72)	0.20 (-0.26-0.66)
Core age group	299	764233	0.39	462	933053	0.50	0.79	(0.68-0.91) p=0.001	-0.10 (-0.17 – -0.04)
All ages	364	874644	0.42	522	1042672	0.50	0.83	(0.72-0.94) p=0.005	-0.08 (-0.14 – -0.02)

BMJ

BMJ 2012;345:e8441 doi: 10.1136/bmj.e8441 (Published 8 January 2013)

RESEARCH

Time lag to benefit after screening for breast and colorectal cancer: meta-analysis of survival data from the United States, Sweden, United Kingdom, and Denmark

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Table 1| **Trial characteristics**

	Sample size (No)	Age range (years)	Follow-up range (years)	Absolute risk reduction (95% CI)		Intervention
				At 8 years	At 12 years	
Colorectal cancer screening (fecal occult blood test)						
Minnesota (annual)[20,21]*	30 964	50-80	≤18	0.08 (–0.04 to 0.21)	0.23 (0.06 to 0.40)	11 rounds, annual
Minnesota (biennial)[20,21]*	30 981	50-80	≤18	–0.09 (–0.23 to 0.05)	0.04 (–0.14 to 0.23)	6 rounds, biennial
Nottingham[18]	150 251	45-74	11 (8-18)	0.09 (0.02 to 0.16)	0.13 (0.04 to 0.22)	2-5 rounds, biennial
Funen[17]†	61 933	45-75	≤10	0.10 (–0.02 to 0.22)	—	5 rounds, biennial
Goteborg[19]	68 308	59-65	(11-19)	0.003 (–0.08 to 0.09)	0.07 (–0.04 to 0.19)	2-3 rounds (rescreened 1, 2, or 10 years)
Breast cancer screening (mammography)						
Health Insurance Plan-New York[26]†	61 004	40-64	≤10	0.10 (0.00 to 0.20)	—	4 rounds, annual
Combined Swedish trials[22]‡	110 385	55-74	16 (14-22)	0.10 (0.04 to 0.16)	0.14 (0.06 to 0.21)	—
Malmo I[22,24]§	25 299	45-70	19 (18-20)	0.023	0.095	6-8 rounds, every 18-24 months
Ostergotland[16,22]§	44 743	40-74	17 (16-19)	0.029	0.052	2-4 rounds, every 24-33 months
Stockholm[22,25]§	26 532	40-65	15 (14-16)	0.032	0.030	2 rounds, every 28 months
Goteberg[22,23]§	13 811	40-59	13 (13-14)	0.070	0.10	4-5 rounds, every 18 months

*Annual and biennial groups share a common control group (n=15 394) which was split for the meta-analysis.

†Studies did not publish cancer specific mortality data to 12 years' follow-up.

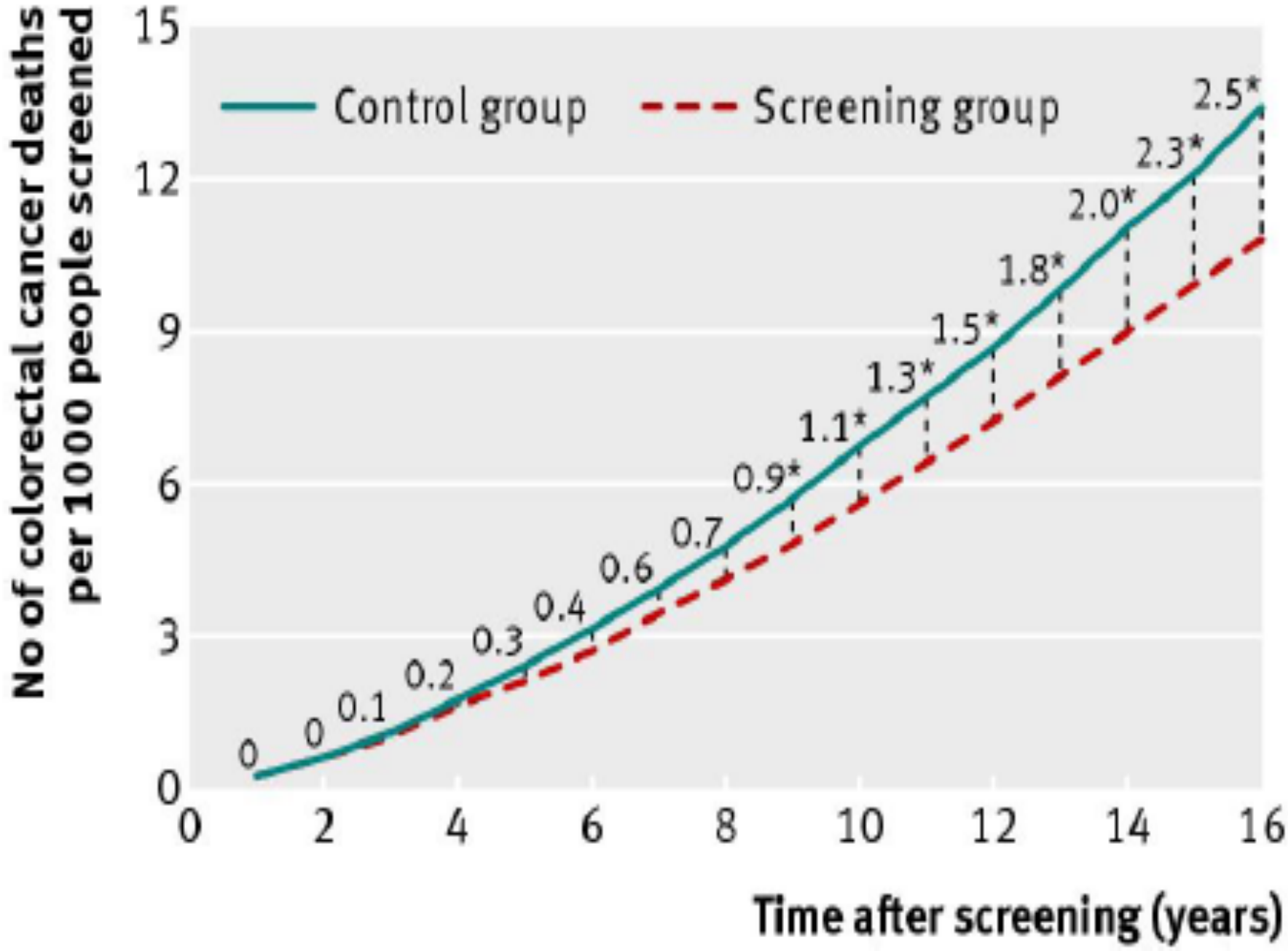
‡Absolute risk reductions apply to patients aged 55-74 years only.

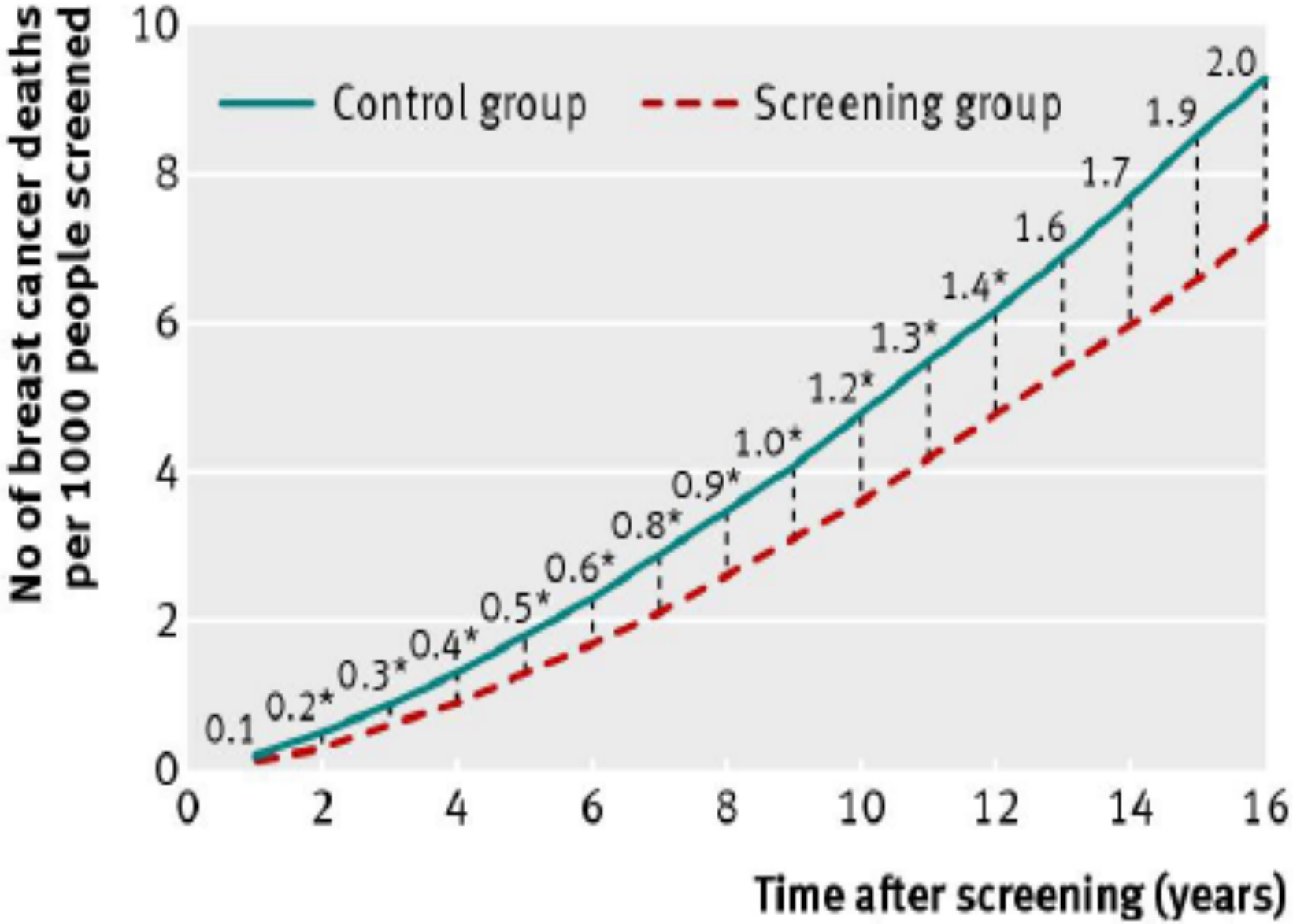
§Absolute risk reductions apply to all women, including those aged 40-54 years. Because we did not have access to the underlying data, we were unable to calculate confidence intervals for the published absolute risk reductions at eight and 12 years.

Table 2| **Time lag to benefit (years) at specific thresholds of absolute risk reduction, for colorectal and breast cancer screening**

	Absolute risk reduction (95% CI)*				
	0.0001	0.0002	0.0005	0.001	0.002
Colorectal cancer screening (fecal occult blood test)					
Minnesota (annual)	2.8 (0.5 to 8.7)	3.5 (1.0 to 9.1)	5.3 (2.2 to 10.5)	7.4 (4.0 to 12.6)	13.7 (9.5 to 19.0)
Minnesota (biennial)	9.9 (3.4 to 24.0)	10.4 (2.4 to 22.1)	11.6 (6.0 to 20.6)	13.3 (8.2 to 20.4)	15.6 (11.5 to 20.6)
Nottingham	2.2 (0.6 to 5.2)	3.3 (1.2 to 7.4)	6.1 (2.7 to 11.7)	10.4 (5.2 to 18.7)	15.7 (11.0 to 21.7)
Funen	2.2 (0.4 to 6.7)	2.9 (0.7 to 7.9)	4.9 (1.8 to 10.8)	7.3 (3.8 to 12.6)	9.5 (7.6 to 11.7)
Goteborg	8.2 (3.0 to 18.8)	9.1 (4.1 to 17.7)	11.0 (6.4 to 17.8)	13.4 (8.9 to 19.2)	16.5 (12.7 to 21.0)
Summary	3.7 (1.2 to 8.7)	4.8 (2.0 to 9.7)	7.3 (3.8 to 12.7)	10.3 (6.0 to 16.4)	14.6 (9.6 to 21.2)
Breast cancer screening (mammography)					
Health Insurance Plan-New York	2.9 (0.8 to 7.3)	3.7 (1.4 to 8.2)	5.7 (2.9 to 10.0)	7.9 (5.1 to 11.6)	9.7 (8.6 to 11.0)
Combined Swedish trials (age 55-64 years)	1.0 (0.4 to 2.2)	1.9 (0.8 to 3.8)	4.3 (2.0 to 8.2)	8.9 (4.2 to 16.6)	16.2 (11.5 to 22.2)
Combined Swedish trials (age 65-74 years)	5.3 (0.4 to 25.7)	6.3 (0.9 to 24.2)	8.8 (2.4 to 23.7)	12.0 (5.1 to 24.4)	15.8 (10.5 to 22.8)
Summary	1.8 (0.6 to 4.1)	3.0 (1.1 to 6.3)	6.2 (2.3 to 13.3)	10.7 (4.4 to 21.6)	15.9 (9.4 to 25.2)

*One death from colorectal or breast cancer prevented per 10 000 people screened (0.0001), per 5000 people screened (0.0002), per 2000 people screened (0.0005), per 1000 people screened (0.001), and per 500 people screened (0.002).


No of colorectal cancer deaths per 1000 people screened
15
12
9
6
3
0
Control group
Screening group
0
0
0.1
0.2
0.3
0.4
0.6
0.7
0.9*
1.1*
1.3*
1.5*
1.8*
2.0*
2.3*
2.5*
0
2
4
6
8
10
12
14
16
Time after screening (years)


No of breast cancer deaths per 1000 people screened
10
8
6
4
2
0
Control group
Screening group
0.1
0.2*
0.3*
0.4*
0.5*
0.6*
0.8*
0.9*
1.0*
1.2*
1.3*
1.4*
1.6
1.7
1.9
2.0
0
2
4
6
8
10
12
14
16
Time after screening (years)

CLINICAL GUIDELINE

Annals of Internal Medicine

Screening for Lung Cancer: U.S. Preventive Services Task Force Recommendation Statement

Virginia A. Moyer, MD, MPH, on behalf of the U.S. Preventive Services Task Force*

Ann Intern Med. 2014;160:330-338.

Table. Screening Scenarios From CISNET Models*

Screening Scenario†				Benefit		Harm‡			CT Screens per Lung Cancer Death Averted, *n*
Minimum Pack-Years at Screening, *n*	Minimum Age at Which to Begin Screening, *y*	Time Since Last Cigarette, *y*	Population Ever Screened, %	Lung Cancer Deaths Averted, %	Lung Cancer Deaths Averted, *n*	Total CT Screens, *n*	Radiation-Induced Lung Cancer Deaths, *n*	Overdiagnosis, %§	
40	60	25	13.0	11.0	410	171 924	17	11.2	437
40	55	25	13.9	12.3	458	221 606	20	11.1	506
30	60	25	18.8	13.3	495	253 095	21	11.9	534
30	**55**	**15**	**19.3**	**14.0**	**521**	**286 813**	**24**	**9.9**	**577**
20	60	25	24.8	15.4	573	327 024	25	9.8	597
30	55	25	20.4	15.8	588	342 880	25	10.0	609
20	55	25	27.4	17.9	664	455 381	31	10.4	719
10	55	25	36.0	19.4	721	561 744	35	9.5	819

Evite uso de orexígenos o suplementos calóricos, en terapia de anorexia o caquexia.

- Optimizar red de apoyo, asistencia alimentación, directrices.

Causes of weight loss in the elderly

Medications (eg, digoxin, theophylline, SSRI's, antibiotics)
Emotional (eg, depression, anxiety)
Alcoholism, elder abuse
Late life paranoia or bereavement
Swallowing problems
Oral factors (tooth loss, xerostomia)
Nosocomial infections (eg, tuberculosis, pneumonia)
Wandering and other dementia related factors
Hyperthyroidism, hypercalcemia, hypoadrenalism
Enteral problems (eg, esophageal stricture, gluten enteropathy)
Eating problems
Low salt, low cholesterol and other therapeutic diets
Social isolation, stones (chronic cholecystitis)

Reproduced with permission from: Morley, JE. Anorexia of aging: physiologic and pathologic. Am J Clin Nutr 1997; 66:760. Copyright ©1997 American Society for Nutrition.

SPECIAL ARTICLES

American Geriatrics Society Updated Beers Criteria for Potentially Inappropriate Medication Use in Older Adults

The American Geriatrics Society 2012 Beers Criteria Update Expert Panel

Megestrol	Minimal effect on weight; increases risk of thrombotic events and possibly death in older adults	Avoid	Moderate	Strong

Table 9. Drugs with Strong Anticholinergic Properties

Antihistamines	Antiparkinson agents	Skeletal Muscle Relaxants
Brompheniramine	Benztropine	Carisoprodol
Carbinoxamine	Trihexyphenidyl	Cyclobenzaprine
Chlorpheniramine		Orphenadrine
Clemastine		Tizanidine
Cyproheptadine		
Dimenhydrinate		
Diphenhydramine		
Hydroxyzine		
Loratadine		
Meclizine		

[Intervention Review]

Protein and energy supplementation in elderly people at risk from malnutrition

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Editorial group: Cochrane Metabolic and Endocrine Disorders Group.
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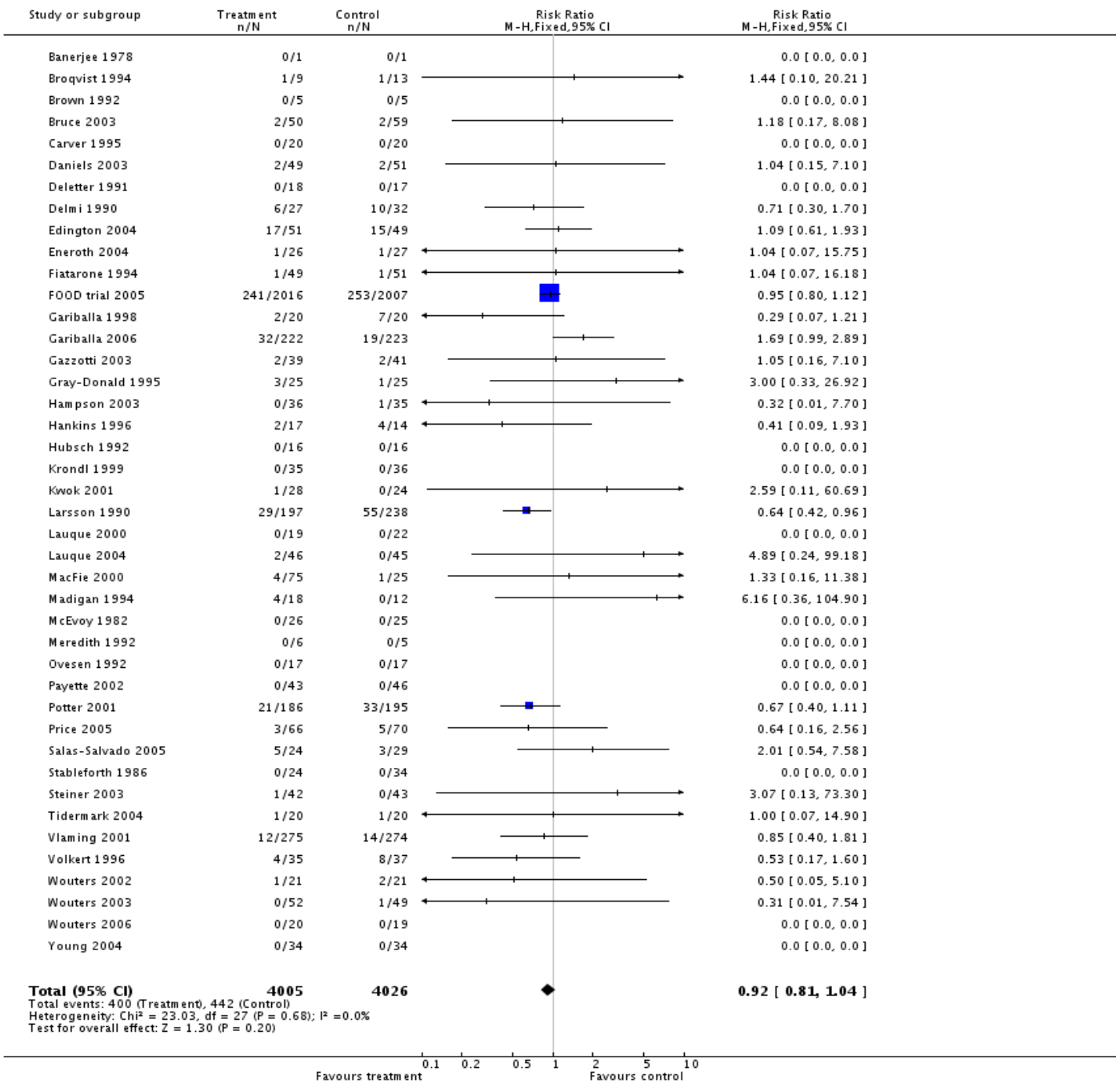
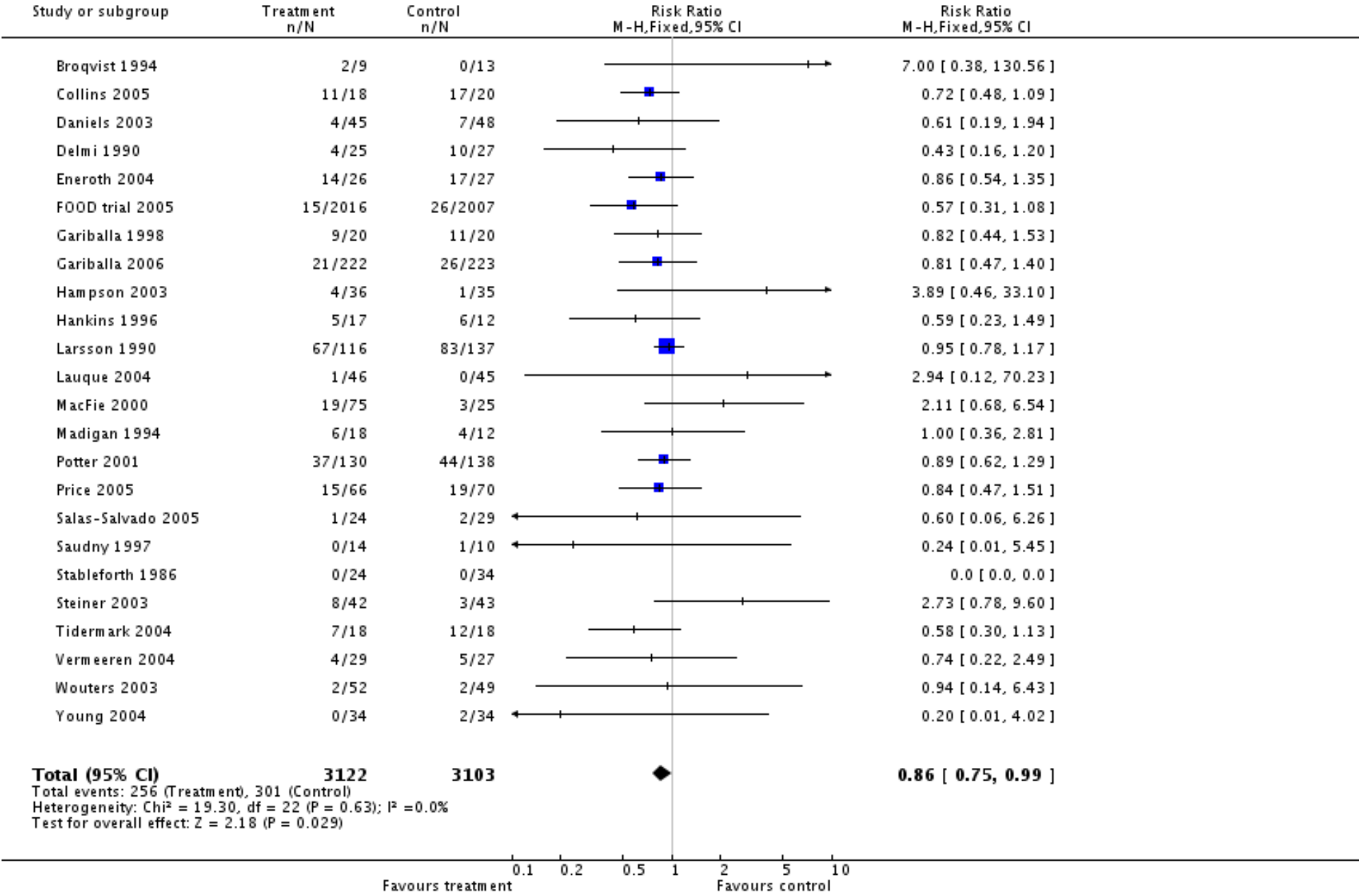
Review: Protein and energy supplementation in elderly people at risk from malnutrition
Comparison: 1 Oral protein and energy versus routine care
Outcome: 1 Mortality

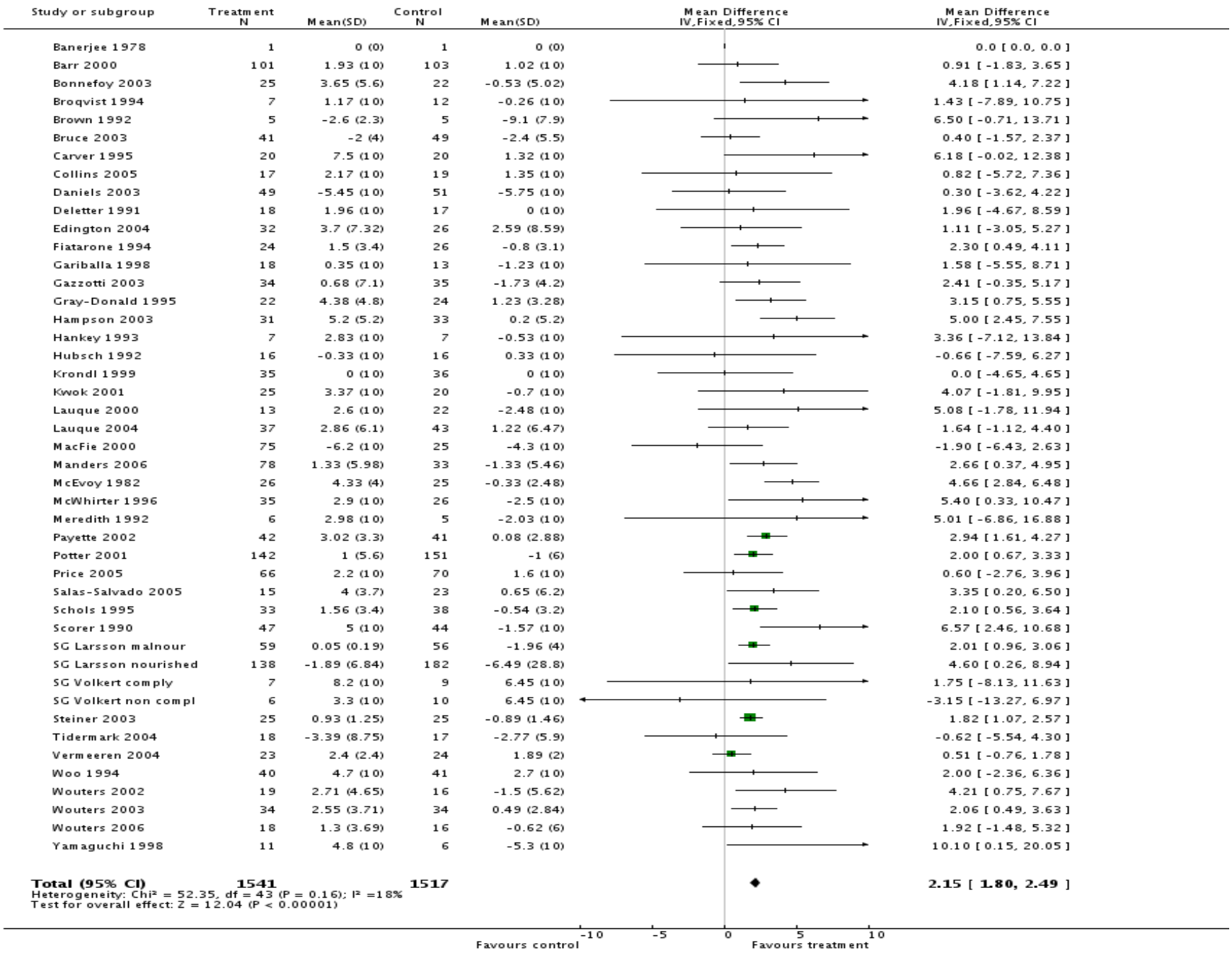


Review: Protein and energy supplementation in elderly people at risk from malnutrition
Comparison: 1 Oral protein and energy versus routine care
Outcome: 10 Participants with complications

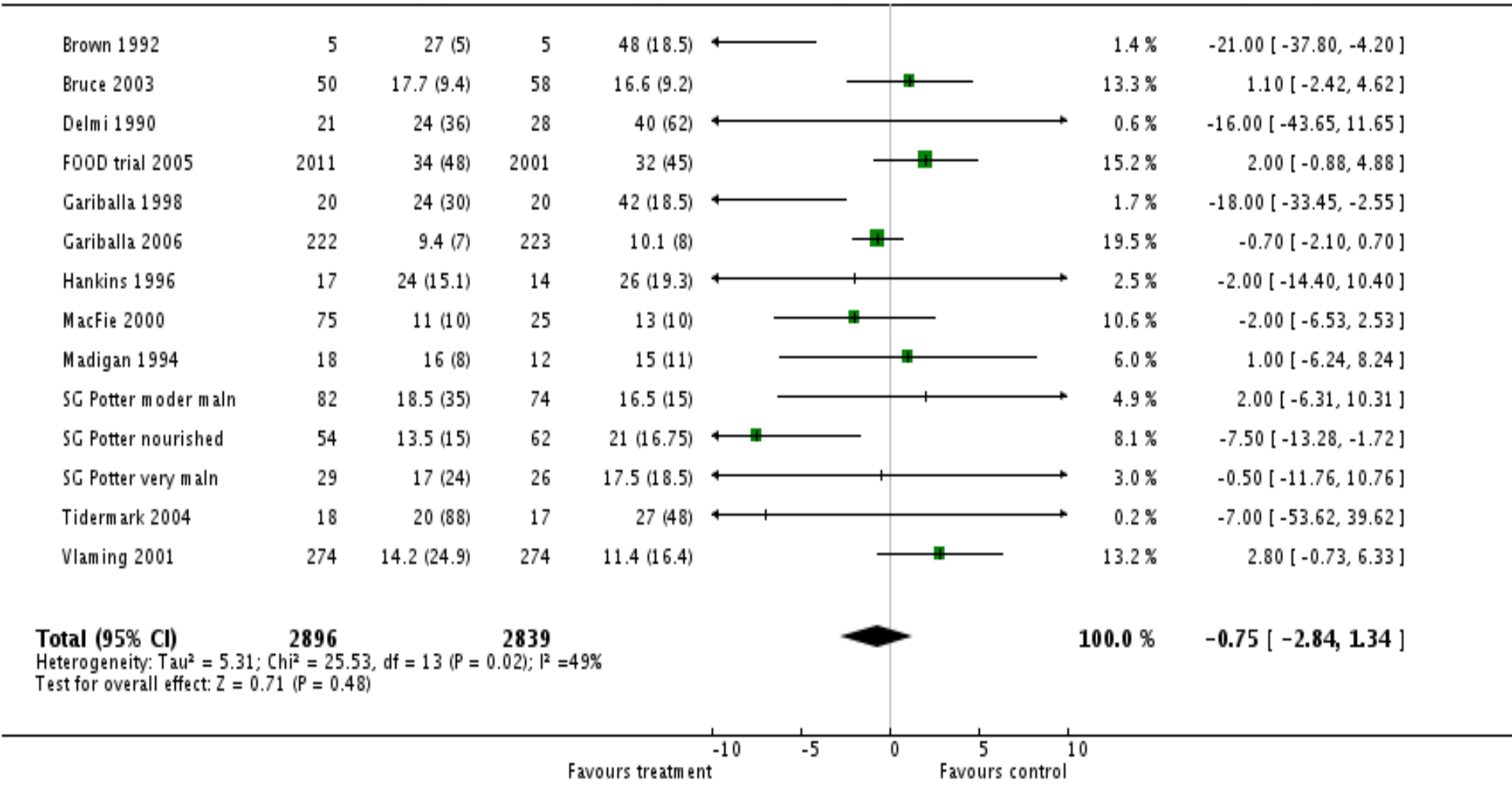


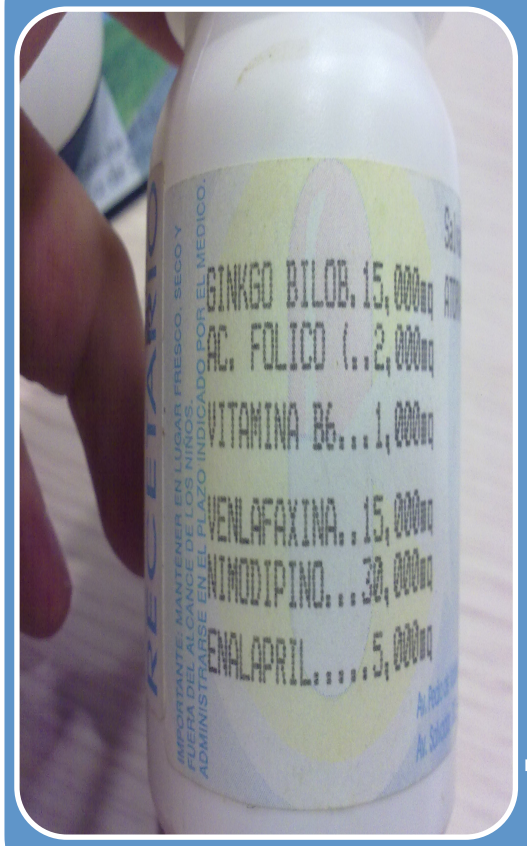
Total events: 256 (Treatment), 301 (Control)
Heterogeneity: Chi² = 19.30, df = 22 (P = 0.63); I² =0.0%
Test for overall effect: Z = 2.18 (P = 0.029)

Review: Protein and energy supplementation in elderly people at risk from malnutrition
Comparison: 1 Oral protein and energy versus routine care
Outcome: 12 % Weight change



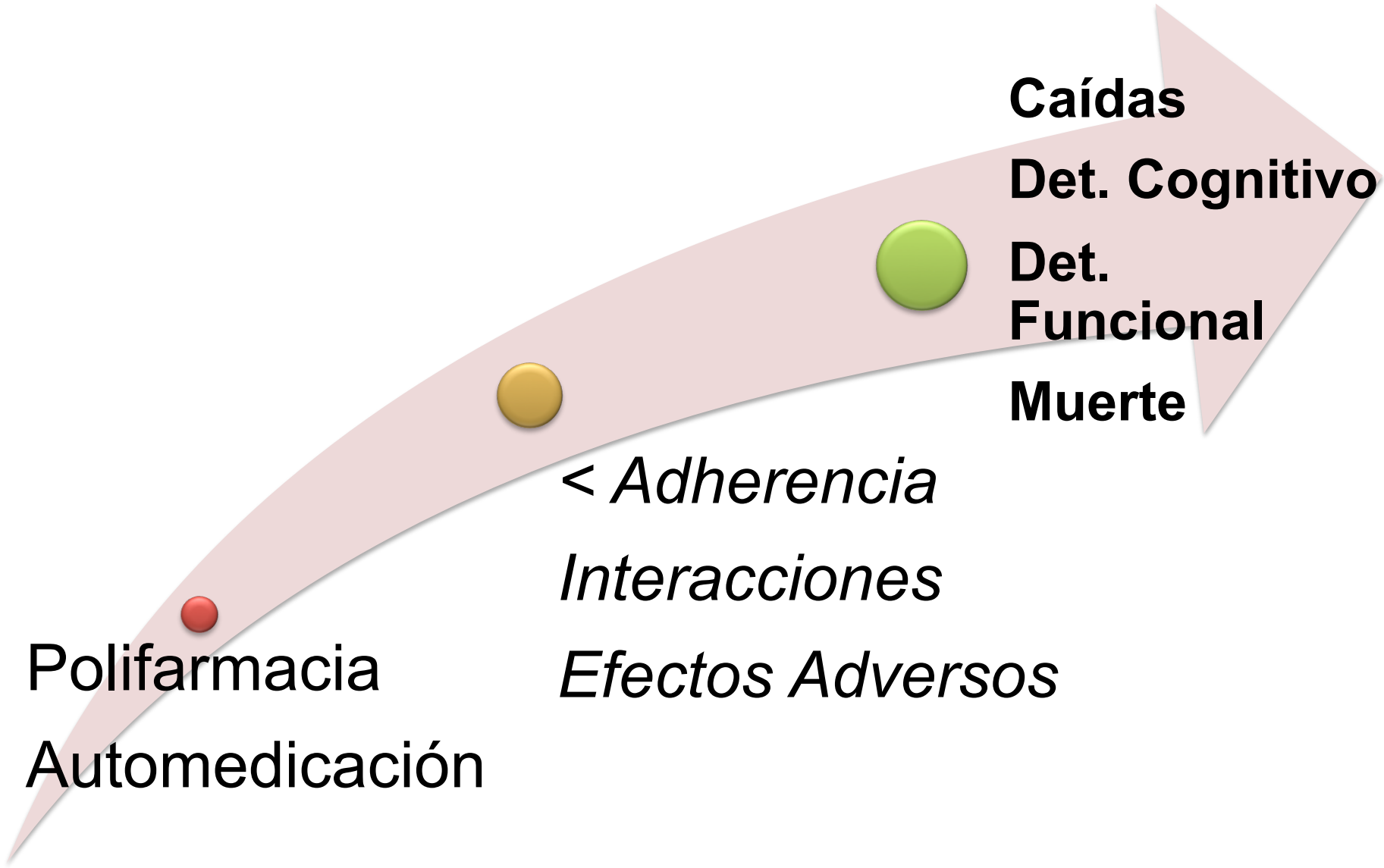
Review: Protein and energy supplementation in elderly people at risk from malnutrition
Comparison: 1 Oral protein and energy versus routine care
Outcome: 17 Length of Stay





No prescriba medicamentos, sin evaluar régimen terapéutico .

AM es población de alto riesgo:



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Clinical Consequences of Polypharmacy in Elderly

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Summary of Observational Studies of Polypharmacy in Older Adults

Author/Year	Setting/Country/Sample	Polypharmacy Results	Most Common Types of Medication Class/Individual Medications
Qato 2008	Ambulatory/USA/N=2976	37.1% men and 36% women aged 75+ used at least 5 RX medications; 46% took an OTC medication and 52% dietary supplements	hydrochlorthiazide, atorvastatin, levothyroxine, lisinopril, metoprolol, simvastatin, atenolol, amlodipine, metformin, furosemide
Rossi, 2007	Ambulatory/USA/ N=128	58.6% took 1+ unnecessary drugs	central nervous system, gastrointestinal, vitamins
Hajjar 2005	Hospital/USA/n=384	37.2% ≥ 9 drugs 41.4% 5-8 drugs 21.4% 1-4 drugs; 58.6% took 1+ unnecessary drugs	gastrointestinal, central nervous system, and therapeutic nutrients/minerals H_2 blockers, laxatives, genitourinary antispasmodics, tricyclic antidepressants
Nobili , 2011	Hospital/Italy/n=1332	Admission-51.9% on 5+; Discharge-67% on 5+	antithrombotics, gastrointestinal diuretics, acei, beta-blockers, lipid and non-insulin glucose lowering rxs, digoxin
Dwyer , 2009	Nursing Home/USA/N= 13,507	39.7% on 9+ meds	laxatives, acid/peptic disorders, antidepressants, antipsychotics/antimanics, non-narcotic pain relievers, antipyretics, antiarthritics
Bronskill, 2012	Nursing Home/Canada/n=64,395	15.5% on 9+ medications	diuretics, ppi, aceI, beta-blockers, benzodiazepines, ssris, ccb, antipsychotics, statins, opioids

Abbreviations- acei(ACE Inhibitors), ccb(Calcium Channel Blockers), otc(Over-the-Counter Products), ppi(Proton Pump Inhibitors), rx(prescriptions), ssri(Selective Serotonin Reuptake Inhibitors)

CONSECUENCIAS

Efectos Adversos e Interacciones

Altos Costos

< Adherencia

Desnutrición

Declinación funcional

Caídas

Incontinencia

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Managing medications in clinically complex elders: "There's got to be a happy medium"

Michael A. Steinman, MD and **Joseph T. Hanlon, PharmD, MS**
Division of Geriatrics, University of California, San Francisco and the San Francisco VA Medical Center (Dr. Steinman); the Division of Geriatric Medicine, Department of Medicine; Department of Epidemiology, and Department of Pharmacy and Therapeutics, University of Pittsburgh, Pittsburgh, PA; the Geriatric Research Education and Clinical Center (GRECC) and Center for Health Equity Research and Promotion (CHERP), Veterans Affairs Pittsburgh Healthcare System (VAPHS), Pittsburgh, PA (Dr. Hanlon)

Selected barriers to medication adherence and targeted solutions

Barrier	Potential solutions
Forgetting, limited organizational skills	Pill organizers, medication calendars, blister packs, electronic dispensing devices, simplify regimen and reduce pill burden, encourage active family involvement, internet-linked adherence aids and reporting systems
Patient believes drug not needed, ineffective, or that he/she is taking too many drugs	Work collaboratively with patient to address concerns and establish shared goals of care, assess effectiveness, educate patient including with literacy-appropriate written materials, simplify regimen and reduce pill burden
Difficulty taking (e.g., opening pill bottles, swallowing)	Consider substituting with medication easier for patient to use (eg, liquid if trouble swallowing; ordering easy-off caps), simplify regimen and reduce pill burden, pill cutters, oral dosing syringes, insulin syringe magnification, spacer for inhalers
Cost	Substitute with lower-cost medications (eg, generic vs. brand-name drug), reduce unnecessary medications, assess prescription drug insurance and direct patient to application for low-income subsidy, prescription drug assistance programs.

Evite la contención física en AM con Delirium hiperactivo hospitalizados o con alteraciones conductuales..

REVIEW

Restraint free care in older adults with dementia

Valerie T. Cotter

University of Pennsylvania School of Nursing, Philadelphia, PA USA

Keio J Med 2005; 54 (2): 80–84

- From 1995-2004: 112 patient death or injury in restraints
- From 1995-2001: 237 deaths, 73 injuries from bed rail entrapment
  - 53% occurred in nursing homes
  - 20% occurred in hospitals
  - 35 deaths involved air pressure mattresses

JCAHO Sentinel Event Statistics, 2002; 2004

Physical

- Iatrogenic outcomes: Increased risk for falling, pressure ulcers, incontinence, muscle deconditioning, acute functional decline
- Serious injuries: Hip fracture, head trauma

Psychological, Behavioral

- Combativeness, aggression
- Increased disorientation
- Regression, dependency

Lofgren et al, 1989; Strumpf et al, 1997

Fig. 2 Negative consequences associated with restraints.

- Impaired memory, language, judgment, visual perception
- Behaviors in moderate to severe stages such as agitation, anxiety, psychosis or pacing
- Psychoactive medications
- Impaired function in activities of daily living
- Gait apraxia, unsteadiness

Fig. 3 Restraints and dementia.

- Restraint education and unit-based nursing consultation showed reduction in restraint prevalence without increases in staff, psychoactive drugs or serious fall-related injuries
  - 3 months post-intervention, decline 20% (7% restraint education only; 7% control)
  - 6 months post-intervention decline 18% (4% restraint education only; 6% control)

Evans et al, 1997

Fig. 5 Reducing restraints in nursing homes: education and gerontologic nurse specialist intervention.

From: **Risk Factors for Delirium at Discharge: Development and Validation of a Predictive Model**

Arch Intern Med. 2007;167(13):1406-1413. doi:10.1001/archinte.167.13.1406

Table 3. Independent Risk Factors for Delirium at Discharge in 491 Subjects

Risk Factor	Adjusted OR (95% CI) [a]
Dementia, by diagnosis or mBDRS ≥4 (n=96)	2.3 (1.4-3.7)
Vision impairment (n=189)	2.1 (1.3-3.2)
ADL impairment >1 (n=97)	1.7 (1.2-3.0)
Charlson score[41] ≥4 (n=140)	1.7 (1.1-2.6)
Restraint use during delirium (n=75)	3.2 (1.9-5.2)

Abbreviations: ADL, activities of daily living[34,35]; CI, confidence interval; mBDRS, modified Blessed Dementia Rating Scale[42,43]; OR, odds ratio.

[a] Adjusted ORs derived from overall multivariable continuation ratio model analysis.

Table Title:

Independent Risk Factors for Delirium at Discharge in 491 Subjects

Avoiding Restraints in Hospitalized Older Adults with Dementia

By: Valerie T. Cotter, DrNP, ANP/GNP-BC, FAANP and Lois K. Evans, PhD, RN, FAAN

University of Pennsylvania School of Nursing

CONSIDERAR:

- Necesidades de El/La paciente
- Datos Biográficos (Familia)
- Valorar factores posibles para delirium
- Aplicar Herramientas periódicamente, x ej CAM
- Evaluar preparación del lugar para manejar eventos.

MANEJO:

- Evitar contenciones o Barandas
- Comunicación clara y calmada
- Buscar razón de la Alt. Conductual
- Herramientas de seguridad preventivas
- Modificaciones ambientales
- Prevención de caídas
- Mayor Vigilancia
- Familia
- Instruir al personal

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