

Quoi de neuf sur le plan thérapeutique ?

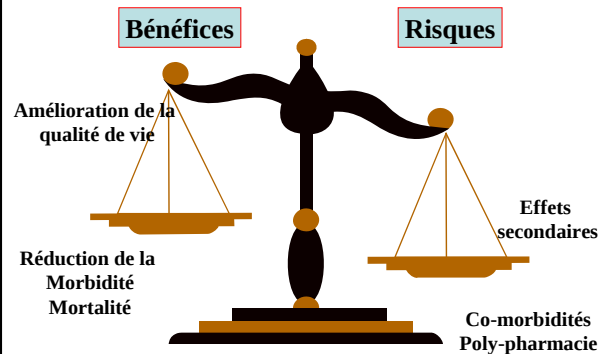
Pr Benoît DE WAZIERES

CHU Nîmes

Quoi de Neuf en Gériatrie

Pr B de WAZIERES
Service de Médecine Interne et Gériatrie
Centre Hospitalier Universitaire
NIMES

Traitement du sujet âgé



Updating the Beers Criteria for Potentially Inappropriate Medication Use in Older Adults

Results of a US Consensus Panel of Experts

Donna M. Puck, PhD, EdD; James W. Cooper, PhD, EdD; William E. Wade, PhD, EdD, FASHW, FCCP; Jennifer A. Walker, PhD; J. Scott Branson, MD; Mark H. Cohen, MD

Arch Intern Med. 2003;163:2716-2724

Table 1. 2002 Criteria for Potentially Inappropriate Medication Use in Older Adults, Independent of Diagnoses or Conditions

Drug	Concern
Phosphopneum (Dacarbazine) and combination products (Dacarbazine with ASA, 5-FU, and Gemtuzumab) (Dacarbazine with ASA and Irinotecan TBI)	Offers few analytic advantages over acastemastrols, yet has the adverse effects of other mast cell stabilizers. It is available without an inflammatory drug, thus may prevent the worst CNS adverse effects.
Peritactone (Lactin)	Requires a preservative that causes more CNS adverse effects, including confusion and hallucinations, than some mast cell free mast cell drugs. Additionally, it is a mixed agonist and antagonist.
Tenoxicam (Tigam)	One of the least effective mast cell drugs, yet it can cause submyeloid adverse effects.
Mast cell stabilizers and antihistamines: methoxycarbonyl (Pantolone), carboxymethyl (Soma), hydroxycarbonyl (Pantolone), methoxycarbonyl (Soma), hydroxycarbonyl (Pantolone), and carboxymethyl (Soma). Do not consider the extended-release version XL.	Most mast cell stabilizers and antihistamines are poorly tolerated by elderly patients, since these cause anticholinergic adverse effects, including confusion. Additionally, their effectiveness is often limited by elderly patients in geriatrics.
Fluticasone (Cortisone)	This inhaled corticosteroid has an extremely long half-life in elderly patients (often days), resulting in prolonged action and increasing the incidence of falls and fractures. Moderate to short-acting inhaled corticosteroids are preferred.
Amphotericin (Amphotericin), amphotericin (Amphotericin), and amphotericin (Amphotericin) (Amphotericin)	Because of its strong anticholinergic and sodium pump-inhibiting effects, it is rarely the first choice of choice for elderly patients.
Amphotericin (Amphotericin)	Because of its strong anticholinergic and sodium pump-inhibiting effects, it is rarely the first choice of choice for elderly patients.
Amphotericin (Amphotericin)	This is a highly additive and sodium pump-inhibiting. Thus, using amphotericin for prolonged periods may become additive and may

[illegible][illegible]

Drug	Comments
Haloperidol (Haldol)	Not an effective oral antipsychotic in acute treatment. May cause confusion and has many disadvantages to other neuroleptic drugs, not been shown to be as better than agents in preventing relapse and may be considerably more toxic. Safer, more effective alternative exist.
Haloperidol (Tardol)	Immediate and long-term use should be avoided in older persons, since a significant number have asymptomatic QT prolongation conditions. These drugs have potential for causing dependence, hypotension, angina, and respiratory infection.
Amphetamine and amphetamine agents	Have the potential to produce a tachycardia, raise blood pressure, and heart failure.
Long-acting oral or subcutaneous, injectable, and non-CNS active agents: Haloperidol, Amphetamine, and Amphetamine (Haldol, Tardol, and Tardol)	Long half-life of drug and risk of producing excessive CNS stimulation, sleep disturbance, and increasing agitation. Safer alternatives exist. May exacerbate breast dysfunction.
Injectable use of standard formulation: Haloperidol (Haldol), amphetamine, and Tardol except in the presence of acute agitation and	Associated with QT interval problems and risk of producing increases in potencies. Lack of efficacy in older adults.
Amphetamine (Haldol)	

Haloperidol (Haldol)	Causes more sedation and anticholinergic adverse effects than other alternatives.
Haloperidol (Haldol)	May cause orthostatic hypotension. Safer alternatives exist. May cause orthostatic hypotension.
Clozapine (Clozaril)	Lack of efficacy.
Amphetamine (Haldol)	Potential for renal impairment. Some alternatives available.
Amphetamine (Haldol)	Potential for hypotension, dry mouth, and urinary problems.
Methylphenidate (Ritalin, Velin, and Tardol)	Potential for prostate hypertrophy and cardiac problems.
Thioridazine (Miltex)	Greater potential for CNS and extrapyramidal adverse effects.
Mesoridazine (Seroquel)	CNS and extrapyramidal adverse effects.
Short acting antipsychotic (Prozac and Acton)	Potential for hypotension and constipation.
Clozapine (Clozaril)	Potential for orthostatic hypotension and CNS adverse effects.
Mineral oil	Potential for aspiration and adverse effects. Safer alternatives available.
Clozapine (Clozaril)	CNS adverse effects including confusion.
Phenylethylamine (Haldol)	Potential for hypotension and fast intravenous. Safer alternatives available.
Desferrioxamine (Desferal)	Concurrent blood coagulation effects. Safer alternatives available.
Amphetamine (Haldol)	CNS stimulant adverse effects.
Lithium (Lithium)	Evidence of the carcinogenic (breast and endometrial cancer) potential of these agents and lack of cardioprotective effect in older women.

Agitation

- Parfois possibilité de contact et examen clinique, maintient de la relation avec contact oral
- Dans les cas extrêmes : Contention physique
- Sédation médicamenteuse
 - La voie orale est souvent suffisante
 - Injectable si nécessaire
 - Par voie IM car pratique (mais pas plus rapide!)

Agitation

- Trois critères de choix du médicament
 - Rapidité d'action
 - Absence d'effet indésirable grave après une injection unique
 - Facilite d'emploi, conditionnement urgence

Neuroleptique Injectable

- Butyrophenone. Droleptan[®] Haldol[®]
- Phenothiazines. Nozinan[®]
- Benzamides. Tiapridal[®] Solian[®]
- Diazepine. Loxapac[®]

Neuroleptiques

- Effets anticholinergique
 - Rétention urinaire
 - Glaucome
 - Délire toxique
- Effets cardiovasculaires
 - Hypotension
 - Bradycardie
 - Torsades de pointes/Trouble du rythme Vent.
- Troubles extrapyramidaux
 - akathisie « incapacité de s'asseoir »
 - Dystonies

**Confusion
Malaise et chutes**

Benzodiazépines Injectable

- Clorazepate (tranxene[®])
- Diazepam (valium[®])
- Lorazepam (temesta[®] ref. mais pas en France)

Meprobamate Equanil[®]
Hydroxyzine Atarax[®]

Benzodiazépines

- Dépression respiratoire
- Confusion
- Sédation

Choix dans l'urgence

Revue Prescrire 2004

- Déments
 - Haldol[®] 1 mg (0.7 à 2.4)
 - Tiapridal[®]
- Psychotiques
 - Haldol[®] 5 mg
- Etats confusionnels
 - Haldol[®] 1 à 2 mg toute les deux à quatre heures

Les Nouveaux Antipsychotiques

- Clozapine Leponex[®]
- Tiapride Tiapridal[®]
- Risperidone Risperdal[®]
- Olanzapine Zyprexa[®]
- Quetiapine

Les Nouveaux Antipsychotiques

- Clozapine Leponex[®]
 - Agranulocytose
 - Parkinson

Les Nouveaux Antipsychotiques

- Olanzapine Zyprexa[®]
 - Demi vie longue(51 h chez la PA saine!)
 - Peu de travaux gériatrique
 - Forme galénique
 - Velotab
 - Pas de goutte!
 - Injectable
- Mise en garde de l'AFFSAP 2004
« surmortalité » et donc contre indication chez le sujet âgé dément

Les Nouveaux Antipsychotiques

- Risperidone Risperdal®
 - X publications chez la personne âgées
 - Demi vie courte (3 à 24 h)
 - Tolérance (parkinson?)
 - Dose consensuelles
 - 0.25 mg à 2 mg/j

Mise en garde sur les AVC

Les Nouveaux Antipsychotiques

- Les précautions restent les mêmes
 - Syndromes malin
 - Démence a corps de Lewy
 - Jamais de forme retard
 - Dyskinésie, syndrome extrapyramidal

Les Nouveaux Antipsychotiques

- Discuter l'indication
- Bien connaître la molécule
- Faible posologie
- Et réévaluer le tt
- Arrêt si Tp°
- Attention aux associations!
 - Primperan®, motilium®, plitican®, agreal®

Atypical antipsychotic drugs and risk of ischaemic stroke: population based retrospective cohort study

Sudeep S Gill, Pratik A Rochon, Nathan Herrmann, Philip E Lee, Kathi Sykora, Nadia Gossel, Sherrin-Lee T Norman, Jerry H Gorman, Connie Martin, Walter F Vliet, Muhammad Mamdani

Atypical antipsychotic drugs and risk of ischaemic stroke: population based retrospective cohort study

Sudeep S Gill,

- **Objective** To compare the incidence of admissions to hospital for stroke among older adults with dementia receiving atypical or typical antipsychotics.

Atypical antipsychotic drugs and risk of ischaemic stroke: population based retrospective cohort study

Sudeep S Gill,

- **Patients** 32 710 older adults (≥ 65 years) with dementia (17 845 dispensed an atypical antipsychotic and 14 865 dispensed a typical antipsychotic).

Design Population based retrospective cohort study.
Setting Ontario, Canada.

**Atypical antipsychotic drugs and risk of ischaemic stroke:
population based retrospective cohort study**
Sudeep S Gill,

- **Main outcome measures** Admission to hospital with the most responsible diagnosis (single most important condition responsible for the patient's admission) of ischaemic stroke. Observation of patients until they were either admitted to hospital with ischaemic stroke, stopped taking antipsychotics, died, or the study ended

**Atypical antipsychotic drugs and risk of ischaemic stroke:
population based retrospective cohort study**
Sudeep S Gill,

- **Results** After adjustment for potential confounders, participants receiving atypical antipsychotics showed **no significant increase** in risk of ischaemic stroke compared with those receiving typical antipsychotics (adjusted hazard ratio 1.01, 95% confidence interval 0.81 to 1.26). This finding was consistent in a series of subgroup analyses, including ones of individual atypical antipsychotic drugs (risperidone, olanzapine, and quetiapine) and selected subpopulations of the main cohorts.

**Atypical antipsychotic drugs and risk of ischaemic stroke:
population based retrospective cohort study**
Sudeep S Gill,

- **Conclusion** Older adults with dementia who take atypical antipsychotics have a similar risk of ischaemic stroke to those taking typical antipsychotics.

Characteristics	Atypical antipsychotic cohort (n=17 845)	Typical antipsychotic cohort (n=14 865)
Mean (SD) age (years)	82.5 (7.3)	82.7 (7.4)
Men	8431 (36.0)	5727 (38.5)
Long term care	8495 (47.5)	7682 (51.7)
Low income	6608 (37.5)	5007 (33.1)
Urban residence	2807 (15.7)	2673 (18.0)
Mean (SD) frequency of medical contact (days)*	33.3 (26.4)	34.3 (26.8)
Year of entry to cohort:		
1997	598 (3.4)	5452 (36.7)
1998	1686 (8.9)	4670 (30.7)
1999	3696 (20.7)	2680 (18.0)
2000	5589 (31.3)	1321 (8.9)
2001	6374 (35.7)	842 (5.7)
Chronic users†	13792 (77.3)	9929 (66.8)

Table 2 Event rates and hazard ratios for older adults with dementia receiving atypical or typical antipsychotics

	Atypical antipsychotic cohort (n=17 845)	Typical antipsychotic cohort (n=14 865)
Main analysis (full cohorts)		
No (%) of new admissions for ischaemic stroke	204 (1.6)	227 (1.5)
Mean (SD) duration of follow up (days)	227.2 (264.0)	209.1 (306.4)
Crude event rate (No of events per 1000 person years)*	25.5	22.5
Unadjusted hazard ratio (95% CI)	1.00 (0.89 to 1.27)	1.00
Adjusted hazard ratio (95% CI)†	1.01 (0.81 to 1.26)	1.00

* (No of events/total No of days per 365 days) × 1000.

† Adjusted for age, sex, low income status, residence in long term care, frequency of medical contact, year of entry to cohort, history of stroke in past five years, history of atrial fibrillation, hypertension, diabetes mellitus, acute myocardial infarction in past three months, congestive heart failure, number of distinct drugs, chronic use (>7 consecutive prescriptions) of antipsychotics, and baseline use of warfarin, antiplatelet drugs, antihypertensive drugs, angiotensin converting enzyme inhibitors, lipid lowering drugs, antidiabetic drugs, and hormone replacement therapy.

What is already known on this topic

Atypical antipsychotics are commonly used to manage behavioural and psychological symptoms of dementia (BPSD).

Recent evidence from clinical trials suggests an association between atypical antipsychotic use and cardiovascular events (including stroke) among older adults with BPSD.

These data prompted the UK Committee on Safety of Medicines to recommend against the prescribing of atypical antipsychotics to patients with BPSD.

The choice of atypical or typical antipsychotics to manage BPSD should not be based on concerns about the risk of stroke

Findings were consistent for a series of subgroup analyses including ones for patients at high baseline risk of stroke.

The choice of atypical or typical antipsychotics to manage BPSD should not be based on concerns about the risk of stroke.

Risk of myocardial infarction in patients taking cyclo-oxygenase-2 inhibitors or conventional non-steroidal anti-inflammatory drugs: population based nested case-control analysis

John Hippisley-Cox, Carol Compston

BMJ VOLUME 330 11 JUNE 2005 London

9218 cases with a first ever diagnosis of myocardial infarction during the four year study period
86 349 controls matched for age, calendar year, sex, and practice.

A significantly increased risk of myocardial infarction was associated with current use of rofecoxib (adjusted odds ratio 1.32) compared with no use within the previous three years; with current use of diclofenac (1.55); and with current use of ibuprofen (1.24).

What is already known on this topic

The VIGOR study found that rofecoxib was associated with an increased risk of myocardial infarction compared with naproxen.

Uncertainty existed as to whether this reflected a true increase or an apparent increase due to a cardioprotective effect of naproxen.

Rofecoxib has been withdrawn, but uncertainty persists about the cardiovascular safety of the other selective nonsteroidal anti-inflammatory drugs (NSAIDs).

What this study adds

Rofecoxib, diclofenac, and ibuprofen were associated with a higher risk of myocardial infarction; no evidence of a cardioprotective effect for naproxen was found.

The increased risk with rofecoxib in the VIGOR study was genuine; the toxicity of conventional NSAIDs and newer selective NSAIDs is also of concern.

No clinically important interactions occurred between any NSAID and either aspirin or coronary heart disease.

Annals of Internal Medicine

ARTICLE

The Risk for Myocardial Infarction with Cyclooxygenase-2 Inhibitors: A Population Study of Elderly Adults

Julie S. Levinson, Whittori, et al; Nelson M, Sengco, et al; and Ben Sheng, et al

Ann Intern Med. 2005;142:401-409.

Participants: 113 927 elderly persons without previous MI and newly treated with an NSAID between 1 January 1999 and 30 June 2002.

Annals of Internal Medicine

ARTICLE

The Risk for Myocardial Infarction with Cyclooxygenase-2 Inhibitors: A Population Study of Elderly Adults

Julie S. Levinson, Whittori, et al; Nelson M, Sengco, et al; and Ben Sheng, et al

Ann Intern Med. 2005;142:401-409.

Conclusions: These results provide evidence of an increased risk for acute MI in current users of rofecoxib among elderly persons with no history of MI. This risk appears greater at higher doses. Aspirin use mitigates the risk associated with low-dose but not high-dose rofecoxib. There was no evidence of an increased risk with the other NSAIDs.

Annals of Internal Medicine

ARTICLE

The Risk for Myocardial Infarction with Cyclooxygenase-2 Inhibitors: A Population Study of Elderly Adults

Julie S. Levinson, Whittori, et al; Nelson M, Sengco, et al; and Ben Sheng, et al

Ann Intern Med. 2005;142:401-409.

Table 3. Crude and Adjusted Rate Ratios of Acute Myocardial Infarction for Current Use of Celecoxib and Rofecoxib according to Dose

	No. Patients	Controls	Adjusted* Rate Ratio (95% CI)
No use	751	36,880	1.00 (reference)
Celecoxib			
Rofecoxib, n	237	2088	
Low-dose use, n (%)	158 (72.5)	1676 (79.8)	0.98 (0.83-1.17)
High-dose use, n (%)	79 (33.3)	1412 (67.8)	0.98 (0.78-1.28)
Rofecoxib			
Rofecoxib, n	238	2098	
Low-dose use, n (%)	118 (49.6)	1041 (49.6)	1.21 (0.95-1.55)
High-dose use, n (%)	120 (50.4)	1057 (50.4)	1.73 (1.39-2.16)

Table 4. Crude and Adjusted Rate Ratios of Acute Myocardial Infarction for Current Use of Anti-inflammatory Agents according to Concomitant Use of Aspirin and Dose of Cyclooxygenase-2 Selective Inhibitors*

Variable	No. Concomitant Use of Aspirin			Concomitant Use of Aspirin			P Value†
	No. Patients	Controls	Adjusted Rate Ratio (95% CI)	No. Patients	Controls	Adjusted Rate Ratio (95% CI)	
No use	440	12,013	1.00 (reference)	203	4997	1.00 (reference)	
MI/MI	32	174	1.00 (0.71-1.42)	10	176	0.93 (0.47-1.83)	0.71
Ibuprofen	19	247	1.29 (0.69-2.45)	5	87	0.80 (0.28-2.33)	0.67
Celecoxib	476	403	1.27 (0.89-1.80)	151	1055	0.89 (0.70-1.13)	0.32
Low-dose	126	861	1.08 (0.88-1.28)	52	1195	0.91 (0.70-1.17)	0.38
High-dose	350	1022	1.16 (0.87-1.57)	99	400	0.83 (0.54-1.27)	0.34
Rofecoxib	141	266	1.37 (0.93-2.00)	46	1122	1.02 (0.68-1.54)	0.94
Low-dose	125	262	1.29 (0.92-1.80)	39	1052	1.00 (0.71-1.40)	0.98
High-dose	16	104	1.73 (0.56-5.60)	7	40	2.36 (0.75-7.96)	0.18
Aspirin use	1	52	0.39 (0.18-0.87)	5	40	1.29 (0.45-3.74)	0.67

*MI/MI = myocardial infarction; MI = myocardial infarction.

Inclusion aux grandes études: L'exemple de l'insuffisance cardiaque

- Sur 20388 patients (Medicare) de plus de 65 ans (78 ans) avec ICC, seuls
 - 18% étaient éligibles pour SOLVD
 - 13% étaient éligibles pour MERIT-HF
 - 25% étaient éligibles pour RALES

Masoudi: Am Heart J 2003;146:250

Etudes de mortalité: Moyenne d'âge

- SOLVD Prevention: 59 ans
- SOLVD Treatment: 61 ans
- VeHeFT-II: 60 ans
- SAVE: 59 ans
- AIRE: 65 ans
- TRACE: 67 ans
- DIG: 63 ans
- RALES: 65 ans**
- CIBIS II: 61 ans
- MERIT-HF: 64 ans
- COPERNICUS: 63 ans
- Val HeFT: 63 ans
- CHARM-added: 64 ans
- CHARM-preserved: 67 ans

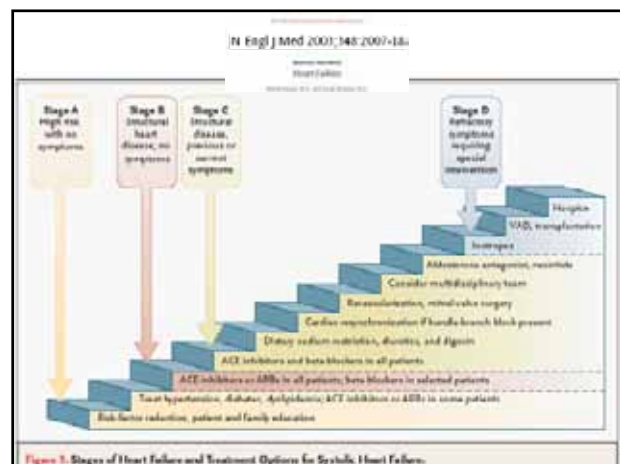
Hyperkalemia and impaired renal function in patients taking spironolactone for congestive heart failure: retrospective study

Medicine (Baltimore) 2003;82(10):1191-2

BMJ 2003;327:1191-2

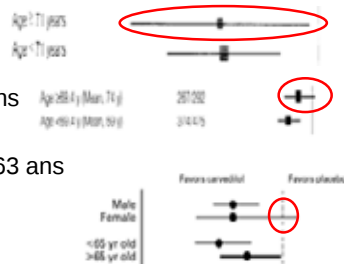
Comment

Taking spironolactone for congestive heart failure is associated with considerably more frequent side effects than previously thought. Age, lower LVEF, and higher NYHAFC are predictors of hyperkalaemia and azotaemia.



Bêta-bloquants

- CIBIS II: 61 ans
Bisoprolol
- MERIT-HF: 64 ans
Métoprolol
- COPERNICUS: 63 ans
Carvédilol



Inclusion aux grandes études:
L'exemple de l'insuffisance cardiaque

COMORBIDITES (pourcentage)

Démence	36
Chutes	30
Diabète	23
Anémie	20
BPCO	19
Dépression	17
Cancer	9
Parkinson	4
Néphropathie	1

Gambassi G ; Am Heart J 2000 ; 139 : 85 - 93

Inclusion aux grandes études: L'exemple de l'insuffisance cardiaque

- Donc pour le traitement de l'insuffisance cardiaque du sujet âgé, le clinicien est en permanence hors AMM

Traitement anticoagulant dans la fibrillation auriculaire

La FA est un modèle de la problématique bénéfice risque car

- Le risque d'AVC est bien connu mais variable selon certains facteurs de risques dont l'âge...
- Les effets secondaires des AVK sont aussi bien connus mais variables selon certains facteurs de risques dont l'âge...

ORIGINAL CONTRIBUTION

A Risk Score for Predicting Stroke or Death in Individuals With New-Onset Atrial Fibrillation in the Community: The Framingham Heart Study

Thomas J. Wang, MD
Joseph M. Mangano, PhD
Daniel Levy, MD
Ramachandran S. Vasan, MD
Philip A. Wolf, MD
Ralph B. D'Agostino, PhD
Martin G. Larson, PhD
William B. Kannel, MD
Emelia J. Benjamin, MD, ScM

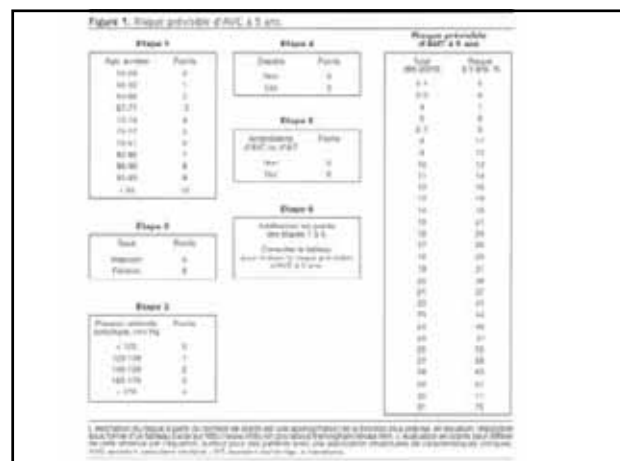
Context: Prior risk stratification schemes for atrial fibrillation (AF) have been based on individuals with established AF, and have focused on stroke as the principal outcome.

Objective: To derive risk scores for stroke alone and stroke or death in community-based individuals with new-onset AF.

Design, Setting, and Participants: Prospective, community-based, observational cohort in Framingham, Mass. We identified 484 participants with new-onset AF. 30 of whom were not treated with warfarin at baseline. Risk scores for stroke (ischemic or hemorrhagic) and stroke or death were developed with competing risks warfarin initiation occurred during follow-up. Event rates were estimated in two sets of individuals, as defined by the risk score and a previously published risk scheme.

Main Outcome Measures: Stroke and the combination of stroke or death.

Results: During a mean follow-up of 4.6 years from onset of warfarin use, stroke alone occurred in 83 participants and stroke or death occurred in 114 participants. Risk scores for stroke and stroke or death that excluded the following risk conditions (advanced age, no male sex, previous systolic blood pressure, prior stroke or transient ischemic attack and diabetes) with the risk score, A-B, of the cohort had a c-statistic 0.66 and 0.68, respectively.



A COMPARISON OF RATE CONTROL AND RHYTHM CONTROL IN PATIENTS WITH ATRIAL FIBRILLATION

THE ATRIAL FIBRILLATION FOLLOW-UP INVESTIGATION OF RHYTHM MANAGEMENT (AFFIRM) INVESTIGATORS*

None of the presumed benefits of rhythm control noted above were confirmed in this study. The implication is that rate control should be considered a primary approach to therapy and that rhythm control, if used, may be abandoned early if it is not fully satisfactory. Our data also suggest that continuous anticoagulation is warranted in all patients with atrial fibrillation and risk factors for stroke, even when sinus rhythm appears to be restored and maintained.

N Engl J Med, Vol. 347, No. 23 - December 5, 2002

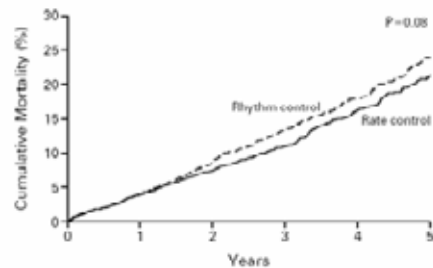


Figure 1. Cumulative Mortality from Any Cause in the Rhythm-Control Group and the Rate-Control Group. Time zero is the day of randomization. Data have been truncated at five years.

THE NEW ENGLAND JOURNAL OF MEDICINE

ORIGINAL ARTICLE

Amiodarone versus Sotalol for Atrial Fibrillation

Bramah N. Singh, M.D., D.Sc., Steven H. Singh, M.D., Domenic J. Reels, Ph.D., X. Charlene Tang, M.D., Ph.D., Becky Lopez, R.N., Crista L. Harris, Pharm.D.

Sotalol Amiodarone Atrial Fibrillation Efficacy Trial (SAFE-T)

N Engl J Med 2005;352:1941-72.

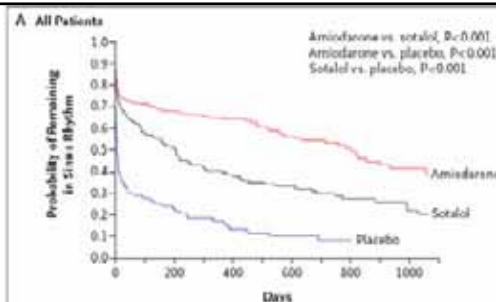


Figure 2. Kaplan-Meier Estimates of the Time to Recurrence of Atrial Fibrillation among Patients in Whom Sinus Rhythm Was Restored on Day 28.

Table 1. Baseline Characteristics of the Patients.*

Characteristic	Amiodarone Group (N=267)	Sotalol Group (N=263)	Placebo Group (N=137)	P Value†
Age—yr	67.3±9.4	66.6±8.9	67.7±9.8	0.68
Male sex—no. (%)	243 (91.0)	237 (90.1)	116 (84.7)	0.27

ORIGINAL INVESTIGATION

Oral Cyanocobalamin Supplementation in Older People With Vitamin B₁₂ Deficiency

A Dose-Finding Trial

Thomas J. P. M. Evans, MSc, Liene C. P. G. M. de Groot, PhD, Robert Clarke, MB, Jim Schoenck, MD, Per M. Ueland, MD, Willem H. J. Hoogwerf, MD, PhD, Wja A. van Schaoven, PhD

Arch Intern Med. 2005;165:1167-1172

Daily doses of 647 to 1032 µg of cyanocobalamin

Conclusion: The lowest dose of oral cyanocobalamin required to normalize mild vitamin B₁₂ deficiency is more than 200 times greater than the recommended dietary allowance, which is approximately 3 µg daily.

Vitamin E and Donepezil for the Treatment of Mild Cognitive Impairment

Ronald C. Petersen, Ph.D., M.D., Ronald G. Thomas, Ph.D., Michael Grundman, M.D., M.P.H.,

N Engl J Med 2005;352.

CONCLUSIONS

Vitamin E had no benefit in patients with mild cognitive impairment. Although after three years, the rate of progression to Alzheimer's disease was not lower among patients treated with donepezil than among those given placebo, donepezil therapy was associated with a lower rate of progression to Alzheimer's disease during the first 12 months of treatment.

Role of multivitamins and mineral supplements in preventing infections in elderly people: systematic review and meta-analysis of randomised controlled trials

Alia F. Khalil, Alexander J. Valleron

BMJ 2005;330:871-6, originally published online 31 Mar 2005.

Conclusion The evidence for routine use of multivitamin and mineral supplements to reduce infections in elderly people is weak and conflicting. Study results are heterogeneous, and this is partially confounded by outcome measure.

Routine oral nutritional supplementation for stroke patients in hospital (FOOD): a multicentre randomised controlled trial

Lancet 2005; 365: 255-63

The FOOD trial Collaboration¹

Interpretation We could not confirm the anticipated 1% absolute benefit for death or poor outcome from routine oral nutritional supplements for usually well-nourished stroke patients in hospital. Our results would be compatible with a 1% or 2% absolute benefit or harm from oral supplements. These results do not support a policy of routine oral supplementation after stroke.

Effect of timing and method of enteral tube feeding for dysphagic stroke patients (FOOD): a multicentre randomised controlled trial

The FOOD trial Collaboration¹

Interpretation Early tube-feeding might reduce case-fatality, but at the expense of increasing the proportion surviving with poor outcome. Our data do not support a policy of early initiation of FFG feeding in dysphagic stroke patients.

Effect of timing and method of enteral tube feeding for dysphagic stroke patients (FOOD): a multicentre randomised controlled trial

Lancet 2005; 365: 758-72

The FOOD trial Collaboration¹

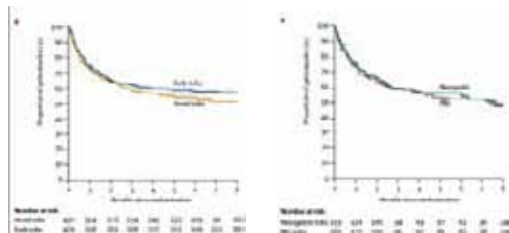


Figure 5: Kaplan-Meier survival curves (A) early versus delayed and (B) PEG versus nasogastric tube

Prise en charge des cancers solides et des hémopathies malignes du sujet âgé : l'oncogériatrie, une discipline en devenir. Seconde partie : traitement des cancers solides (partie 2) et des hémopathies malignes du sujet âgé

S. Lohrer^{1,2,3,4}, F. Giraudeau^{2,3,4}, P. Macqueron^{2,4}, R. A. Casassus^{2,4}, E. Sinau^{2,4}, J.F. Beusson^{2,4}, P. Pignatelli^{2,4}

la revue de
médecine interne

Community-acquired meticillin-resistant *Staphylococcus aureus*: an emerging threat

Nicole Tenckhoff, John S. Francis, Eric L. Nuermberger, William R. Nelson

Lancet Infect Dis 2005;
5: 275-86

New strains of *S aureus* displaying unique combinations of virulence factors and resistance traits have been associated with high morbidity and mortality in the community. Severe invasive pulmonary infections in young, otherwise healthy people have been particularly noteworthy.

Community-acquired pneumonia as the initial manifestation of serious underlying diseases

Miquel Falguera, MD,* Mariela Martín, MD,* Agustín Ruiz-González, MD,* Ricard Pifarré, MD,* Mercè García, MD^b

A Prescribing Cascade Involving Cholinesterase Inhibitors and Anticholinergic Drugs

Isidore E. Gil, MD, MSc, FRCP, Mohammad Hammad, PharmD, MSc, PhD, Cary Fagles, MD, FRCP, David E. Stewart, PhD, Jason E. Bromberg, PhD, Alexander Kopp, MD, Kenneth J. Schulman, MD, MSc, FRCP, Philip S. Ikin, MD, FRCP, Philip S. Ikin, MD, FRCP, MSc, PhD, FRCP

Arch Intern Med. 2005;165:836-843

Methods: A population-based retrospective cohort study was carried out in Ontario, Canada. Participants included 44804 older adults with dementia (20491 were dispensed a cholinesterase inhibitor and 24303 were not), enrolled between June 1, 1999, and March 31, 2002. Sub-

- Adults with dementia who were dispensed cholinesterase inhibitors had an increased risk of subsequently receiving an anticholinergic drug (4.5% vs 3.1%; $P < .001$; adjusted hazard ratio, 1.55; 95% confidence interval, 1.39- 1.72), relative to those not receiving cholinesterase inhibitors.

Affiche Vaccin Pneumocoque

