Mal di testa, Ipertensione Arteriosa...Politerapia...

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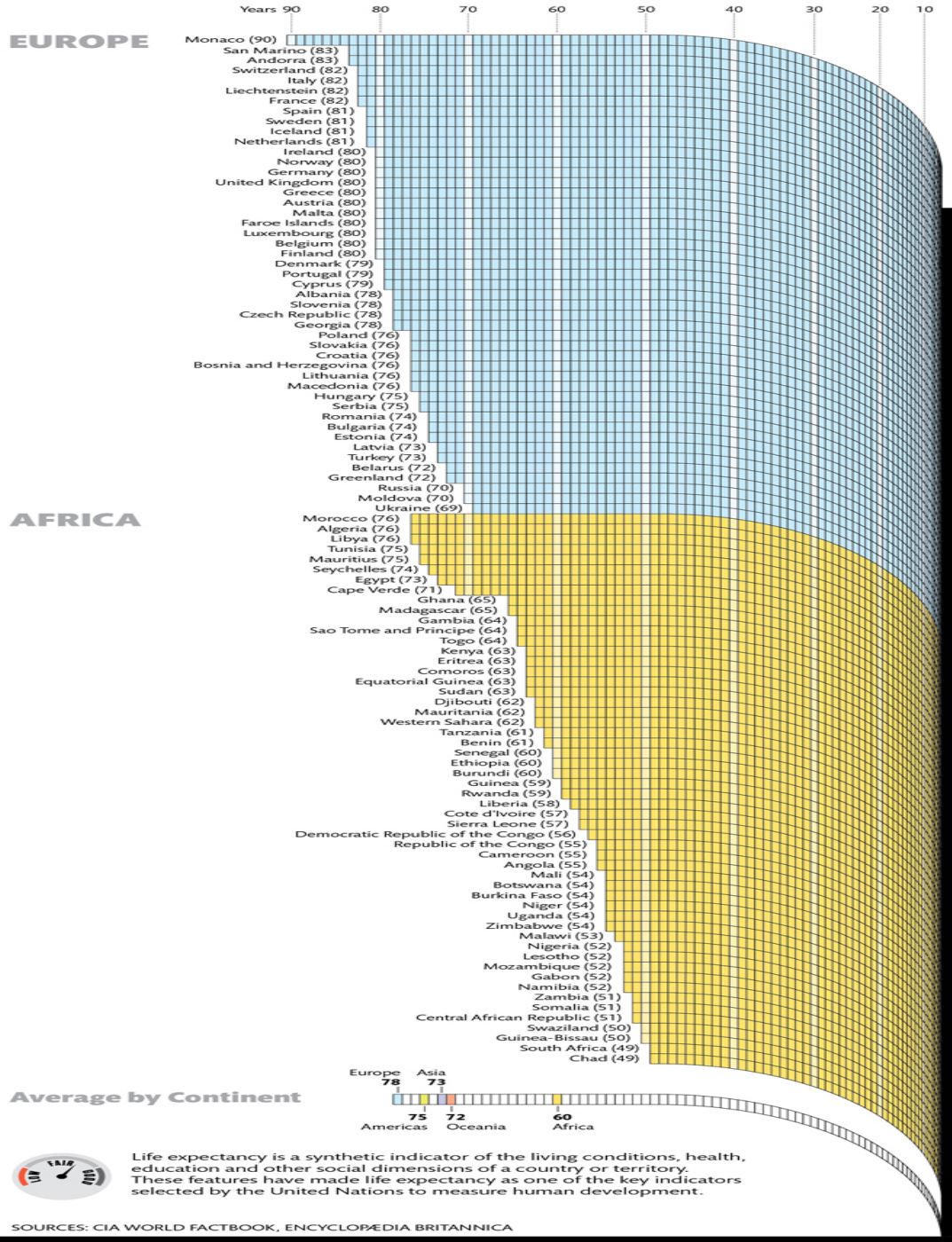
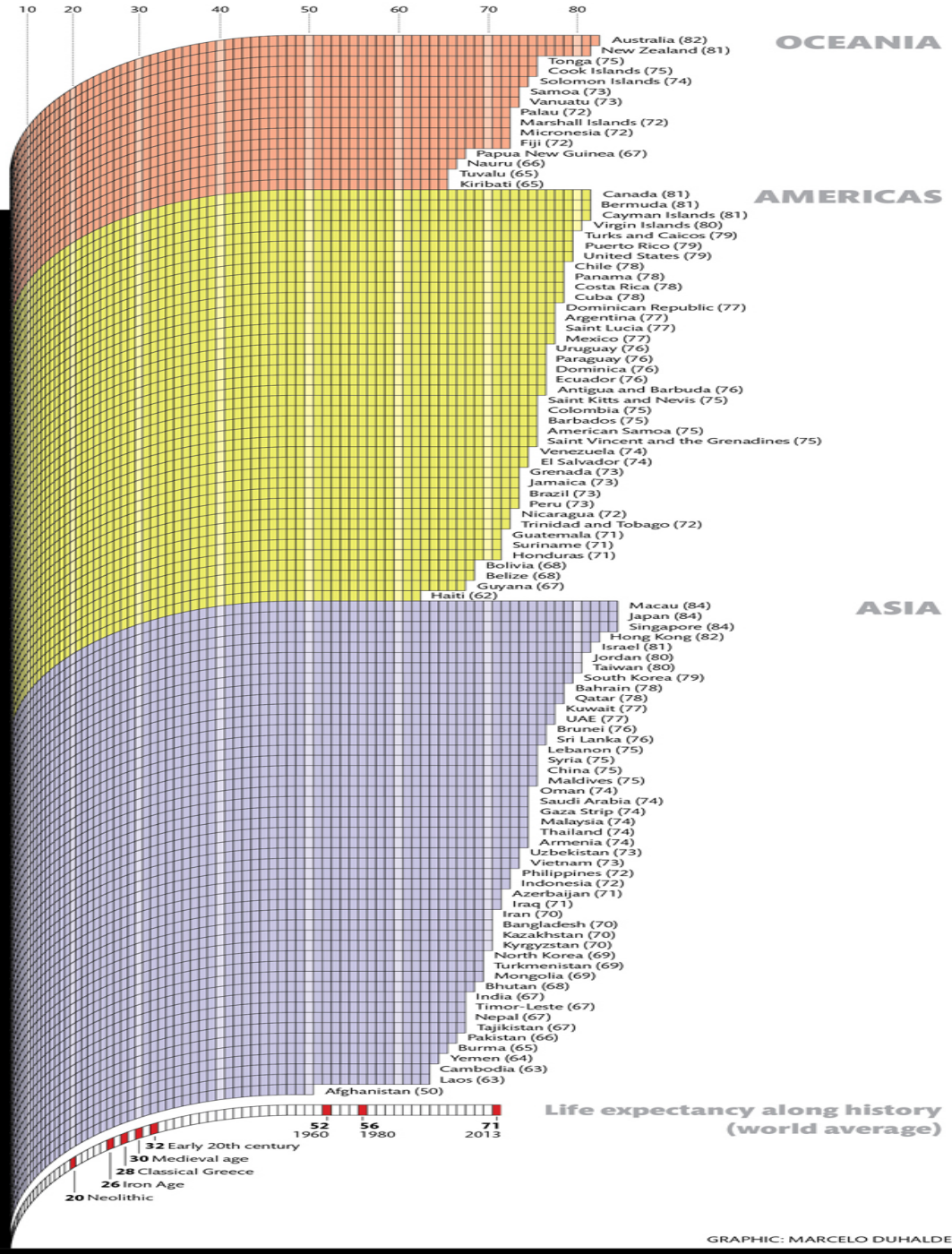
NO

MISCELLANEA
THIS WEEK'S USEFUL INFO

LIFE EXPECTANCY AT BIRTH

This is the average number of years to be lived by a group of people born this year (2013) if mortality at each age remains constant in the future. The entry includes total population of both male and female components.





Life expectancy is a synthetic indicator of the living conditions, health, education and other social dimensions of a country or territory. These features have made life expectancy as one of the key indicators selected by the United Nations to measure human development.

SOURCES: CIA WORLD FACTBOOK, ENCYCLOPÆDIA BRITANNICA

GRAPHIC: MARCELO DUHALDE

"Complesso" discende dal verbo latino complector, che vuol dire *cingere*, *tenere avvinto strettamente*, e, in senso metaforico, *abbracciare*, *comprendere*, *unire tutto in sé*, *riunire sotto un solo pensiero e una sola denominazione*. Altri significati che appaiono nei classici latini sono quelli di *legame*, *nesso*, *concatenazione*. Dal XVII secolo in poi, una situazione, un problema, un sistema è "complesso" se consta di *molte parti interrelate, che influiscono una sull'altra*

Complesso

Complicato

Un problema complicato (da complico, piegare, arrotolare, avvolgere), invece, è uno che si fatica a risolvere perché *contiene un gran numero di parti nascoste, che vanno scoperte una a una*

Gli anziani italiani in cifre

Fasce di età	2023	2028	2033	2038	2043	2023/2043	%
65-74	529.236	551.862	616.513	654.225	626.513	97.277	18,4
75-84	406.514	411.396	427.032	456.035	517.751	111.237	27,4
85+	186.120	202.192	209.630	225.892	240.563	54.443	29,3
90+	67.129	74.878	83.481	88.259	96.824	29.695	44,2
Totale	1.121.870	1.165.450	1.253.175	1.336.152	1.384.827	262.957	23,4

Fonte: elaborazioni IRES su dati Istat

Popolazione in età anziana in Piemonte in alcuni anni dal 2023 al 2043

ITALIA

Età	2023	2030	2040	2050	2060
Popolazione totale	58.888.729	58.083.584	56.506.018	54.361.247	51.178.445
Over 65	14.162.612	15.703.224	18.357.931	18.756.067	17.490.859
Over 65 *(% su popolazione tot.)*	24,05%	27,04%	32,49%	34,50%	34,18%
Over 85	2.254.792	2.484.473	3.007.849	3.897.501	4.699.383
Over 85 *(% su popolazione tot.)*	3,83%	4,28%	5,32%	7,17%	9,18%

Fonte: ISTAT, con elaborazioni

NEURAL REGENERATION RESEARCH
October 2015, Volume 10, Issue 10

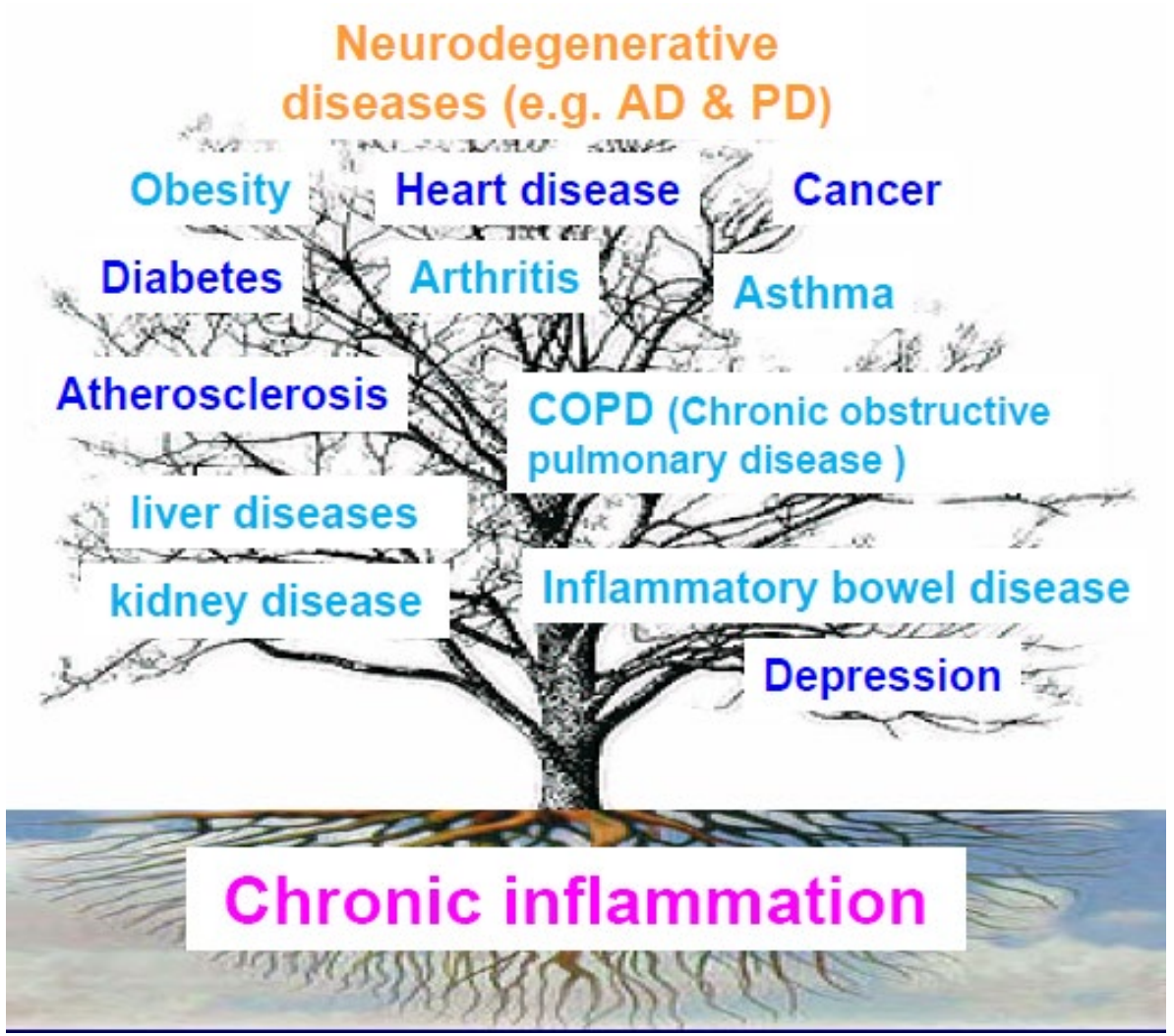
PERSPECTIVE

Neurodegeneration and neuroinflammation: two processes, one target

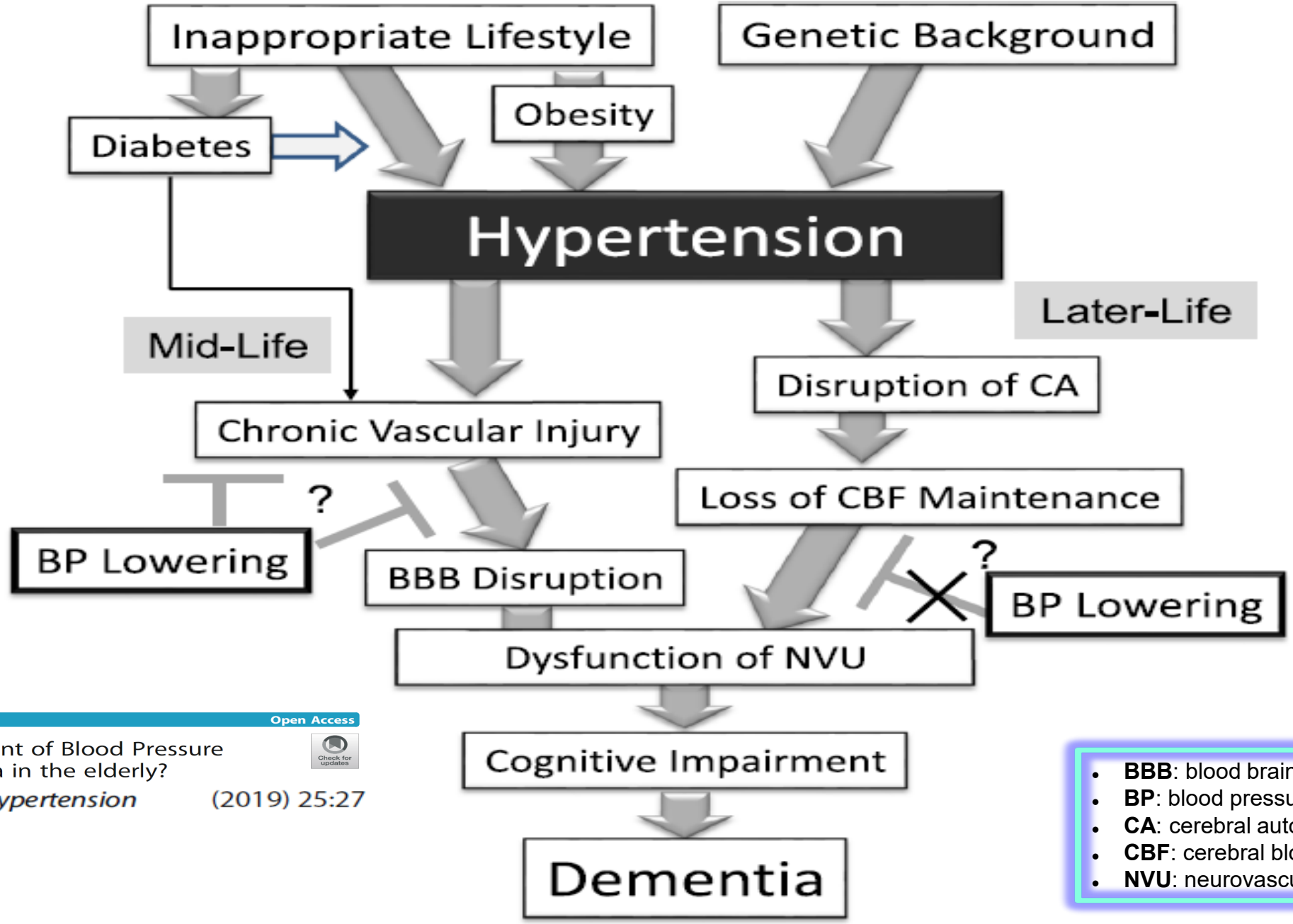
Neurodegenerazione
Neuroinfiammazione
Neuroprotezione

Neuroinflammation and Neurodegeneration

Inelia Morales, Gonzalo A. Farías, Nicole Cortes and Ricardo B. Maccioni



HUI-MING GAO MD, PhD
Nanjing University

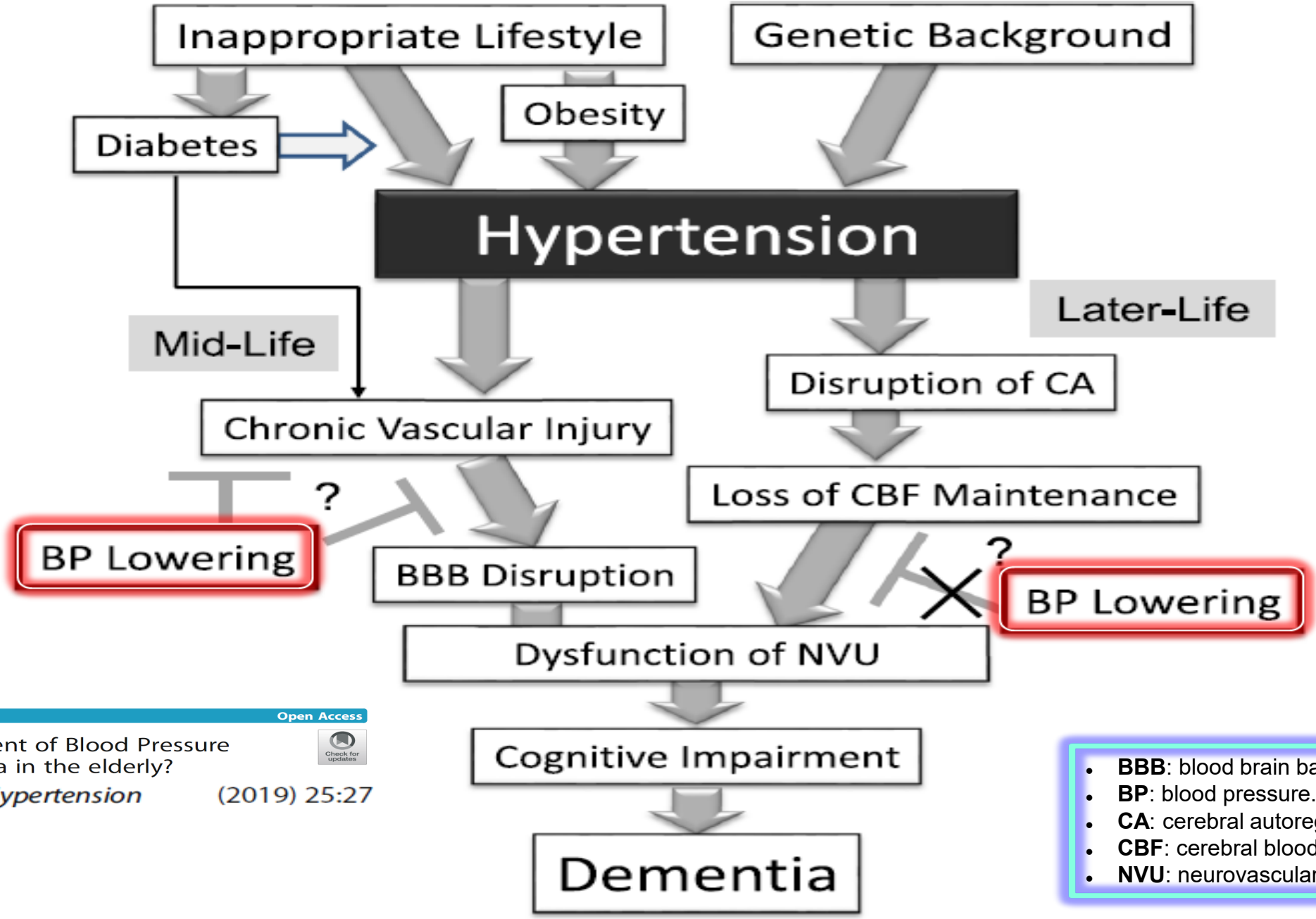


REVIEW Open Access

Could Management of Blood Pressure Prevent Dementia in the elderly?

Mogi *Clinical Hypertension* (2019) 25:27

- **BBB**: blood brain barrier.
- **BP**: blood pressure.
- **CA**: cerebral autoregulation.
- **CBF**: cerebral blood flow.
- **NVU**: neurovascular unit.



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Dementia prevention, intervention, and care: 2020 report of the *Lancet* Commission

Gill Livingston, Jonathan Huntley, Andrew Sommerlad, David Ames, Clive Ballard, Sube Banerjee, Carol Brayne, Alistair Burns, Jiska Cohen-Mansfield, Claudia Cooper, Sergi G Costafreda, Amit Dias, Nick Fox, Laura N Gitlin, Robert Howard, Helen C Kales, Mika Kivimäki, Eric B Larson, Adesola Ogunniyi, Vasiliki Orgeta, Karen Ritchie, Kenneth Rockwood, Elizabeth L Sampson, Quincy Samus, Lon S Schneider, Geir Selbæk, Linda Teri, Naaheed Mukadam

Lancet 2020; 396: 413–46

- The **Lancet Commission** estimates that modifying 12 risk factors might **prevent or delay up to 40% of dementias**.

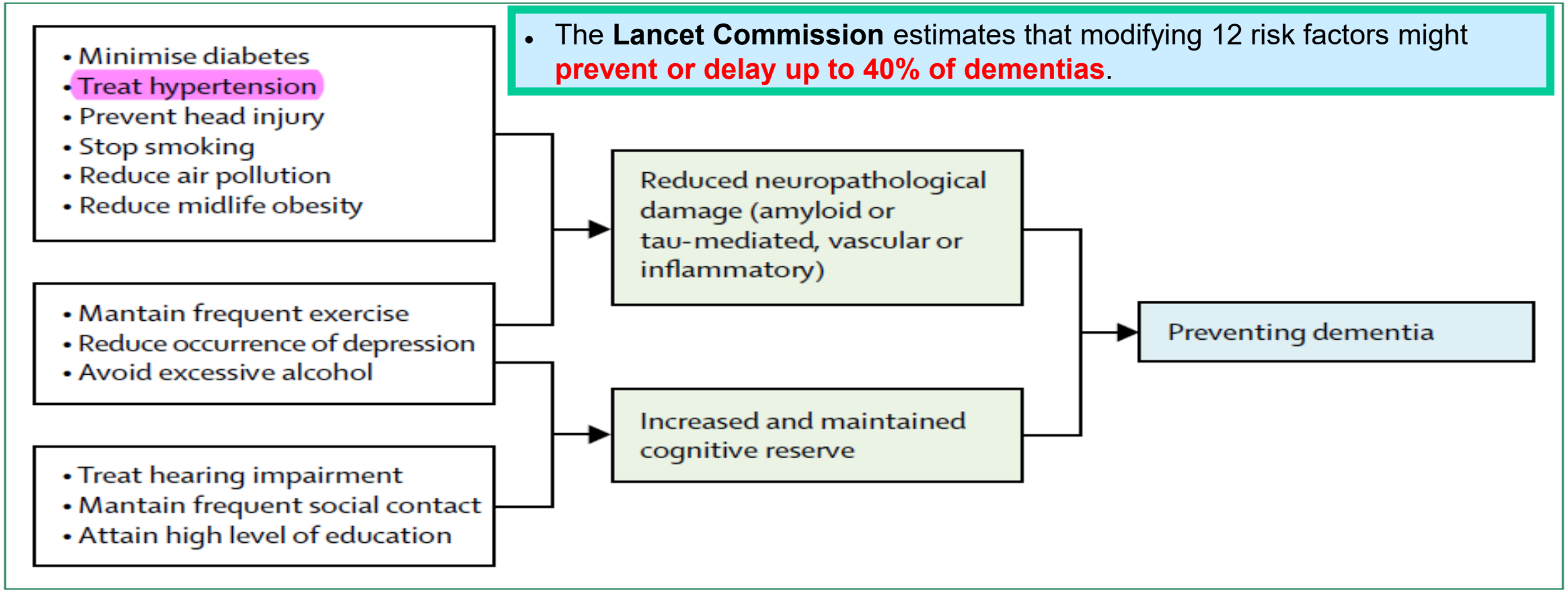
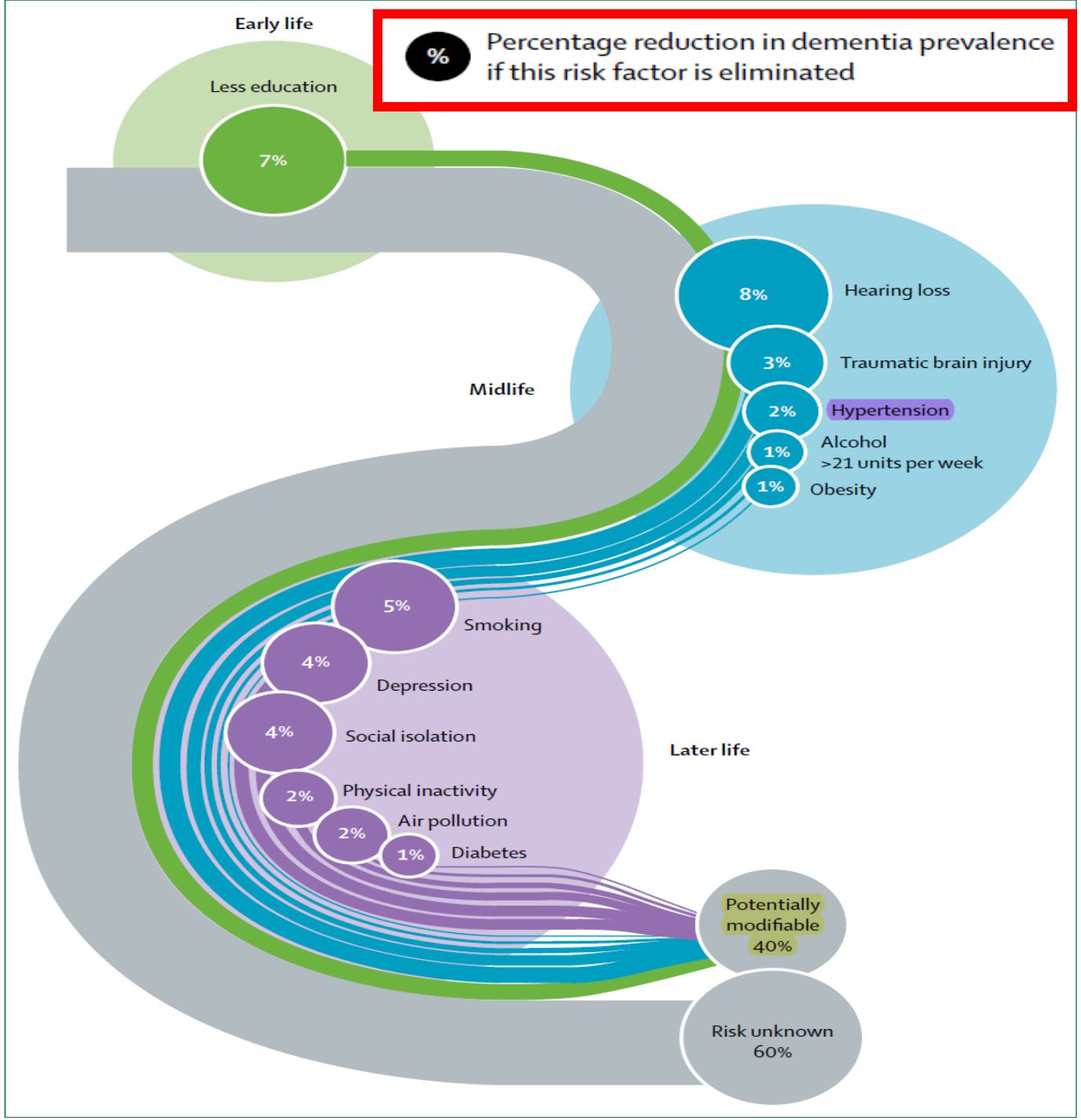


Figure 2: Possible brain mechanisms for enhancing or maintaining cognitive reserve and risk reduction of potentially modifiable risk factors in dementia



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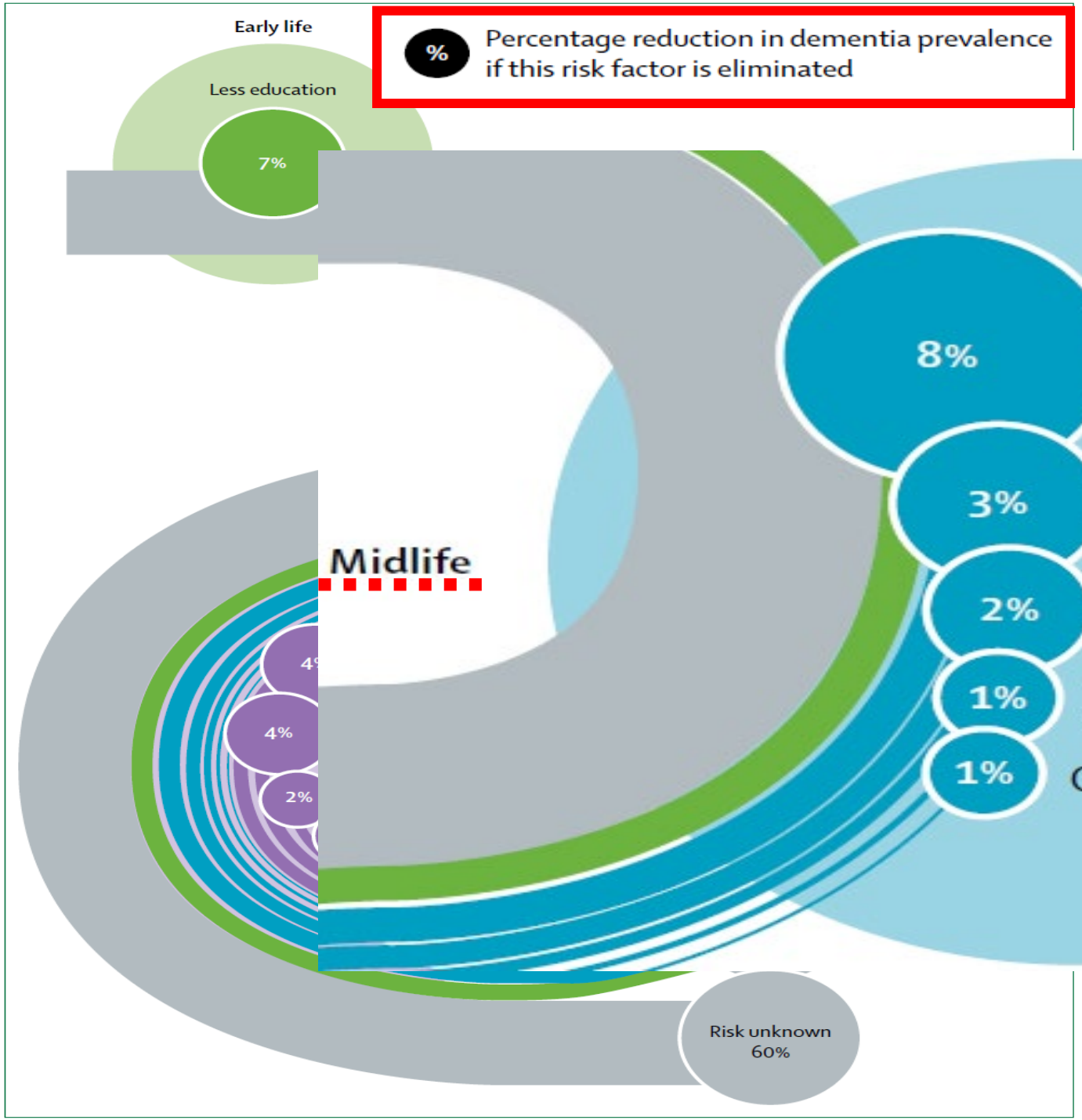


“The sound of silence”: When the brain doesn't hear

Elisa Martinelli*, Pasqualina Sapone*, Pietro Gareri, Massimiliano Massaia **°, Anna Abbaldo*, Angelo Di Stefano*, Filomena Padulo*, Laura Schiara*, Rosaria Carlucci*, Enrico Maria Cotroneo °°, Ilaria Gareri*°, Antonino Maria Cotroneo^**

* Geriatrician - Complex Geriatric Unit Maria Vittoria Hospital Turin - Italy; *° Resident in training, School Of Geriatrics, University Magna Graecia of Catanzaro - Italy ** Geriatrician CDCD Catanzaro Lido, ASP Catanzaro - Italy **° Geriatrician, University of Turin – Italy °° Psychologist, Turin, Italy ^ Director - Complex Geriatric Unit Maria Vittoria Hospital Turin – Italy

Aging Clin Exp Res, 2026 submitted

Review > Neurology. 2019 Jan 15;92(3):134-144. doi: 10.1212/WNL.0000000000006697. Epub 2018 Dec 26.

Red and orange flags for secondary headaches in clinical practice: SNNOOP10 list

Thien Phu Do [1], Angelique Remmers [1], Henrik Winther Schytz [1], Christoph Schankin [1], Sarah E Nelson [1], Mark Obermann [1], Jakob Møller Hansen [1], Alexandra J Sinclair [1], Andreas R Gantenbein [1], Guus G Schoonman [2]

Affiliations + expand

PMID: 30587518 PMCID: PMC6340385 DOI: 10.1212/WNL.0000000000006697

Abstract

A minority of headache patients have a secondary headache disorder. The medical literature presents and promotes red flags to increase the likelihood of identifying a secondary etiology. In this review, we aim to discuss the incidence and prevalence of secondary headaches as well as the data on sensitivity, specificity, and predictive value of red flags for secondary headaches. We review the following red flags: (1) systemic symptoms including fever; (2) neoplasm history; (3) neurologic deficit (including decreased consciousness); (4) sudden or abrupt onset; (5) older age (onset after 65 years); (6) pattern change or recent onset of new headache; (7) positional headache; (8) precipitated by sneezing, coughing, or exercise; (9) papilledema; (10) progressive headache and atypical presentations; (11) pregnancy or puerperium; (12) painful eye with autonomic features; (13) posttraumatic onset of headache; (14) pathology of the immune system such as HIV; (15) painkiller overuse or new drug at onset of headache. Using the systematic SNNOOP10 list to screen new headache patients will presumably increase the likelihood of detecting a secondary cause. The lack of prospective epidemiologic studies on red flags and the low incidence of many secondary headaches leave many questions unanswered and call for large prospective studies. A validated screening tool could reduce unneeded neuroimaging and costs.

Review > Headache. 2018 Mar;58(3):479-484. doi: 10.1111/head.13252. Epub 2018 Jan 11.

Common Primary and Secondary Causes of Headache in the Elderly

Tara L Sharma [1]

Affiliations + expand

PMID: 29322494 DOI: 10.1111/head.13252

Abstract

Objective/background: Headache in the elderly, defined as individuals aged 65 and older, although less prevalent than younger individuals, can present as a diagnostic challenge, given the increase in potentially fatal diseases within this population.

Methods: These individuals require a complete history, neurological examination, and assessment of potential secondary causes of headaches.

Results: Secondary causes include temporal or giant cell arteritis, subdural hematomas, central nervous system (CNS) tumors, strokes, and CNS infections. Once secondary conditions are ruled out, then primary causes of headache are considered such as tension-type headache, migraine, cluster headache, or hypnic headache.

Conclusion: This article reviews the distinguishing characteristics of the most common types of headache in patients over the age of 65 years old, along with potential diagnostic tests and treatment.

Review > Curr Neurol Neurosci Rep. 2015 Jun;15(6):30. doi: 10.1007/s11910-015-0552-2.

Headaches of the elderly

Thomas P Bravo [1]

Affiliations + expand

PMID: 25893722 DOI: 10.1007/s11910-015-0552-2

Abstract

The prevalence of headache decreases in elderly age groups; however, headache remains a significant issue with unique diagnostic and therapeutic considerations in this population. While primary headache disorders such as migraine and tension-type headache still occur in the majority of cases, secondary headaches are more common with advancing age. Additionally, several rare primary headache disorders, such as hypnic headache and primary cough headache, occur more frequently in an elderly population and have distinct treatments. In this review, we provide an updated overview of the common, concerning, and unique headache disorders affecting the elderly.

› Pain. 1999 Sep;82(3):239-243. doi: 10.1016/S0304-3959(99)00057-3.

Comorbidity of headaches and depression in the elderly

Shuu-Jiun Wang [1], Hsu-Chih Liu, Jong-Ling Fuh, Chia-Yih Liu, Pei-Ning Wang, Shiang-Ru Lu

Affiliations + expand

PMID: 10488674 DOI: 10.1016/S0304-3959(99)00057-3

Abstract

The comorbidity of headache and depression is rarely studied in the elderly. Confounders were seldom controlled in previous studies. From August 1993 to March 1994, we conducted a door-to-door survey to investigate the relationship of headache and depression in a Chinese elderly population (age > or = 65 years old) in two townships of Kinmen, Taiwan. A total of 1421 participants (71%) out of 2003 eligible citizens completed five measurements: a structured headache interview, Geriatric Depression Scale-short form (GDS-S), a survey of chronic medical illness. Cognitive Abilities Screening Instrument and an evaluation of activities of daily living. Headache diagnoses were made according to the criteria of the International Headache Society (IHS), 1988. Depression was defined as a GDS-S score > or = 8. After adjustment for confounding, subjects with more frequent headaches, more severe headaches, diagnoses of IHS migraine or chronic tension-type headaches in the past year, or a lifetime history of any headache including migraine were more likely to be depressed. In addition, the most relevant headache-related predictors of depression were the presence of any reported lifetime headache (odds ratio (OR) = 1.8, P < 0.01) and headache frequency > or = 7 days/month in the past year (OR = 2.0, P = 0.01). This study provided evidence that headache is independently associated with depression in the elderly. A high comorbidity of depression was found in the elderly with IHS migraine or chronic tension-type headaches. Not only the headache profile in the past year but also that in their lifetime was important in predicting current depression in the elderly. 1

› Am J Hypertens. 2016 Sep;29(9):1109-16. doi: 10.1093/ajh/hpw041. Epub 2016 Apr 19.

The Paradoxical Significance of Headache in Hypertension

Pierre-Yves Courand [1], Michaël Serraille [2], Nicolas Girerd [3], Genevieve Demarquay [4], Hugues Milon [2], Pierre Lantelme [5], Brahim Harbaoui [5]

Affiliations + expand

PMID: 27093879 DOI: 10.1093/ajh/hpw041

Abstract

Background: The cardiovascular prognostic value of various types of headache, particularly migraine, in the general population remains controversial. The aim of the present study was to assess their prognostic value for all-cause, cardiovascular and stroke mortalities in hypertensive patients.

Methods: A total of 1,914 hypertensive individuals were first categorized according to the absence or presence of headache and thereafter according to the 3 subtypes of headache: migraine, daily headache, and other headache.

Results: Multiple regression analysis demonstrated that all headache types were predicted by gender (women), diastolic blood pressure, absence of diabetes, secondary hypertension, and a trend for severe retinopathy. After 30 years of follow-up, 1,076 deaths were observed, 580 of whom were from cardiovascular cause and 97 from acute stroke. In a multivariable Cox model adjusted for major confounders, patients having headache had a decreased risk for all-cause mortality (hazard ratio (HR) 0.82; 95% confidence interval (CI) 0.73-0.93) and cardiovascular mortality (HR 0.80; 95% CI 0.68-0.95), but not for stroke mortality (HR 1.00; 95% CI 0.70-1.43). When considering only patients with headache, "daily headache" had a nonsignificant better prognostic value for all-cause and cardiovascular mortality than "other headache" (HR 0.83; 95% CI 0.68-1.01; HR 0.89; 95% CI 0.69-1.16, respectively) and "migraine" (HR 0.85; 95% CI 0.65-1.11; HR 0.78; 95% CI 0.55-1.10, respectively).

Conclusion: Presence of nonspecific headache in hypertensive patients has a paradoxical significance in that it is associated with a high-risk profile but does not result in a worse prognosis over the long term.

Hypertension and Frailty Syndrome in Old Age: Current Perspectives

Izabella Uchmanowicz,[1] Anna Chudiak,[1] Beata Jankowska-Polańska[1] and Robbert Gobbens[2]

The importance of high BP and the effect of lowering BP in older adults remain controversial because of the mixed evidence in this population. For frail elderly patients, consider starting treatment if the SBP is 160 mmHg or higher. If the patient is severely frail and has a short life expectancy, a SPB target of 160–190 mmHg may be reasonable. If the SBP is below 140 mmHg, anti-hypertensive medications can be reduced as long as they are not indicated for other conditions. In general, no more than two anti-hypertensive medications should be prescribed to avoid unnecessary administration of a large number of medications. There is little direct evidence to inform the risks and benefits of using anti-hypertensive medications to treat chronic health conditions when significant frailty is present. Since the frail elderly are vulnerable to poor health outcomes, it is important to assess the risk/benefit ratio of healthcare interventions, including drug therapy. Future clinical trials need to consider modifications to safely include frail older adults, and treatment recommendations for hypertension, specific to the frail elderly, should consider inclusion of evidence beyond randomised controlled trials. Management of hypertension in frail elderly people is a newly emerging problem, and it should be pointed out that work on frailty in this context will only be relevant if effective health promotion, prevention, treatment, rehabilitation, and care interventions can be identified. ■

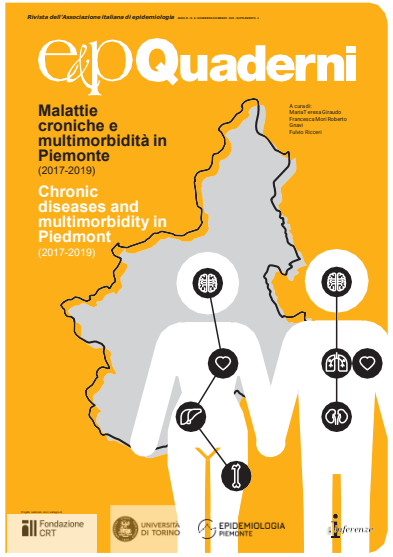
Cardiac Failure Review 2017;2017;3(2):102–7

61-75 anni				
0 patologie	Frequenza n.	155.657	194.727	350.384
	Prevalenza %	40,21	45,89	43,18
1 patologia	Frequenza n.	100.292	120.556	220.848
	Prevalenza %	25,91	28,41	27,22
2 patologie	Frequenza n.	64.891	64.334	129.225
	Prevalenza %	16,76	15,16	15,93
3+ patologie	Frequenza n.	66.248	44.706	110.954
	Prevalenza %	17,11	10,54	13,67

76-85 anni				
0 patologie	Frequenza n.	32.991	65.941	98.932
	Prevalenza %	19,69	29,51	25,30
1 patologia	Frequenza n.	41.217	63.084	104.301
	Prevalenza %	24,61	28,23	26,68
2 patologie	Frequenza n.	35.886	46.187	82.073
	Prevalenza %	21,42	20,67	20,99
3+ patologie	Frequenza n.	57.422	48.255	105.677
	Prevalenza %	34,28	21,59	27,03

86+ anni				
0 patologie	Frequenza n.	12.261	34.311	46.572
	Prevalenza %	23,97	32,03	29,43
1 patologia	Frequenza n.	11.883	29.003	40.886
	Prevalenza %	23,23	27,08	25,83
2 patologie	Frequenza n.	10.099	20.568	30.667
	Prevalenza %	19,74	19,20	19,38
3+ patologie	Frequenza n.	16.907	23.239	40.146
	Prevalenza %	33,05	21,69	25,37

Tabella 1. Prevalenza di 24 patologie croniche e multimorbidità nella popolazione piemontese, per sesso e classi di età, 2019.



deve tenere conto è che oggi i pazienti non devono più subire solo il peso dei sintomi che le malattie da cui sono affetti procurano, ma anche l'onere dei trat- tamenti che queste comportano (sotto forma di pro- cedure e/o terapie).[8] La multimorbidità si porta ac- canto il problema irrisolto della polifarmacoterapia e di conseguenza dei numerosi, e a volte opprimenti e sempre più costosi, controlli (intesi come visite, esa- mi ematochimici, esami strumentali, procedure di in- tervento eccetera) che da questa situazione derivano. Oggi ai pazienti viene chiesto di essere parte attiva nel processo di cura delle proprie condizioni cliniche

medico modifichi il suo modo di agire, adottando una medicina più rispettosa e meno invasiva. In medicina generale sono pochi gli strumenti clinici che permet- tano di identificare tali situazioni. Infatti, ci vuole uno strumento che consenta di valutare rapidamente, ma al contempo rigorosamente, tutti gli aspetti che co- stituiscono le caratteristiche sanitarie e non sanitarie importanti del paziente: un approccio olistico (tipico della medicina di famiglia) che possa al contempo te- nere presente il contesto bio-psico-sociale (Figura 1).[11] Perché, come afferma un editoriale di *JAMA*,[12] c'è un modo semplice per ottimizzare l'*Evidence Based Me-*

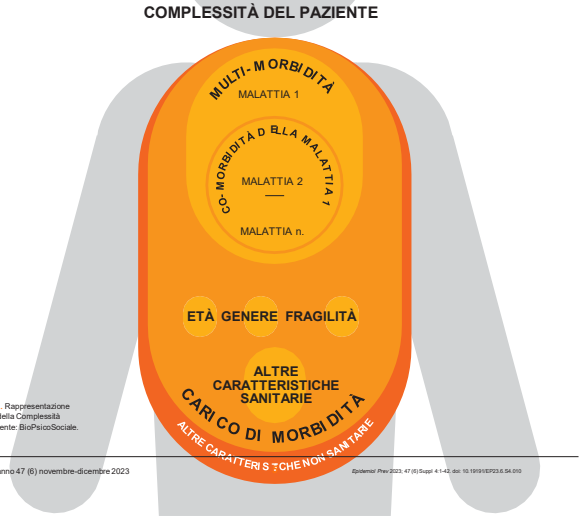


Figura 1. Rappresentazione grafica della Complessità del Paziente: BioPsicoSociale.

Epidemiol Prev 2023; 47 (6) Suppl 4:1-42. doi: 10.19191/EP23.6.S4.010

Politerapia ed eventi avversi

- Interazioni:
  - Farmaco-farmaco
  - Farmaco-malattia
  - Farmaco-alimenti
  - Farmaco-prodotti da banco

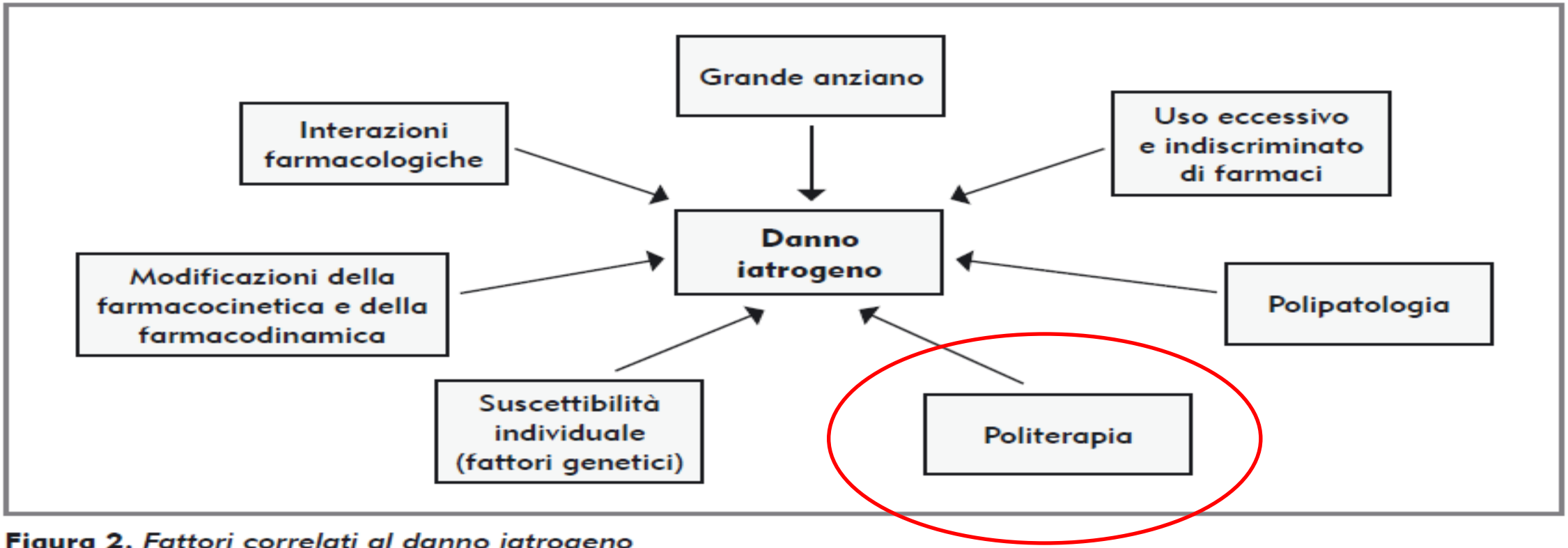


Figura 2. *Fattori correlati al danno iatrogeno*

Gareri et al., *Pratica Medica & Aspetti Legali 2010; 4(1): 7-17*

Adverse Drug Reactions as Cause of Hospital Admissions: Results from the Italian Group of Pharmacoepidemiology in the Elderly (GIFA)

JAGS 2002;50:1962-8
Gambassi et al.

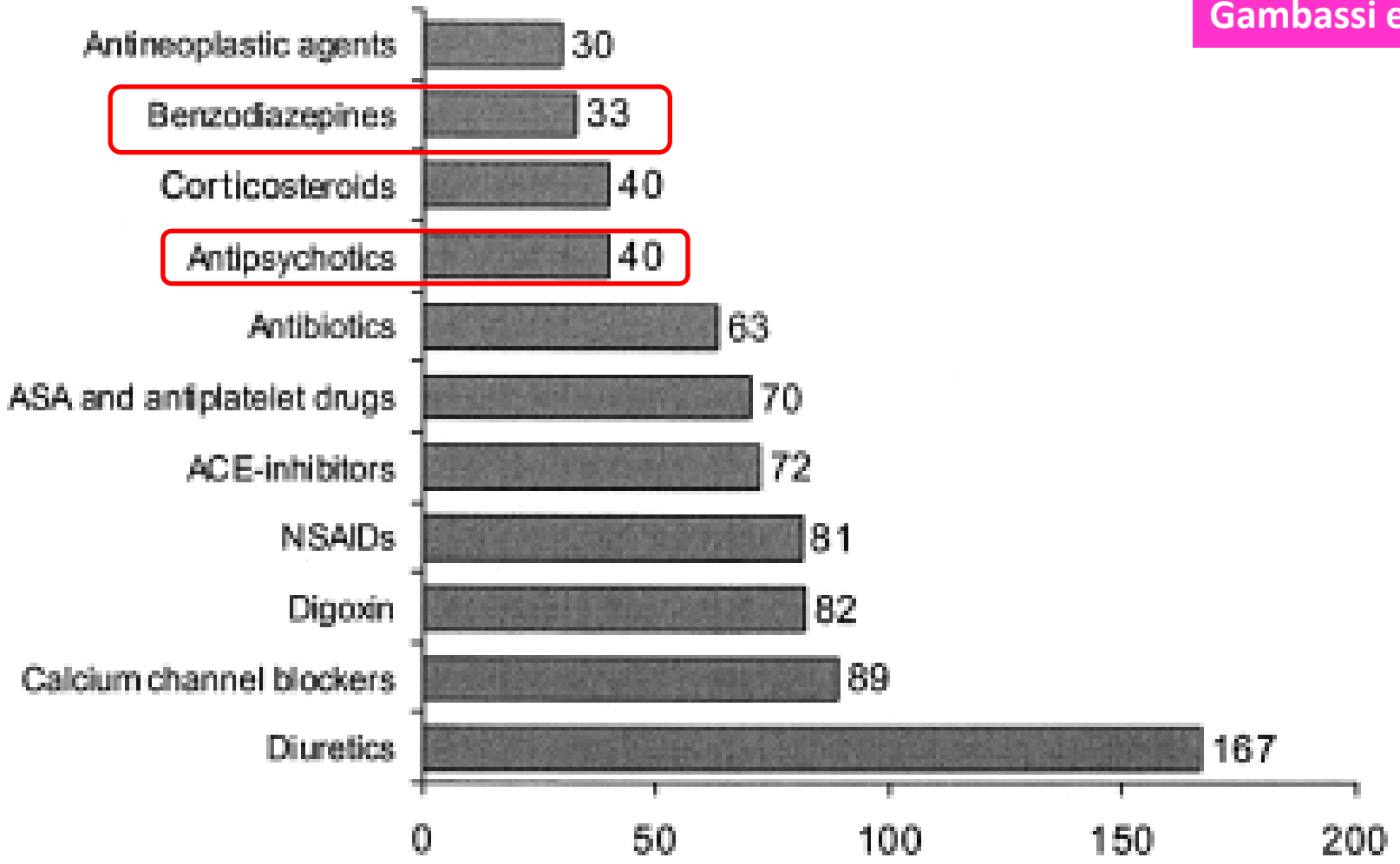


Tabella 5. Prescrizioni dannose: si può notare la netta prevalenza nelle donne vs. gli uomini per quasi tutti i farmaci utilizzati[65]

Farmaco	Donne (%)	Uomini (%)
Estrogeni	18	0.1
Ansiolitici, sedativo-ipnotici e benzodiazepine	12.5	6
Analgesici narcotici e propossifene	5.3	2.2
Miorilassanti	2.9	1.4
Antiistaminici	2.6	1.3
Nitrofurantoina	1.8	0.3
Antispastici	0.8	0.2
Alcaloidi della belladonna	0.65	0.23
Ormoni tiroidei	0.68	0.1
Vasodilatatori	0.36	0.28
Barbiturici	0.22	0.15
Antiemetici	0.25	0.13
Ipoglicemizzanti	0.07	0.07

Cotroneo,Gareri & De Sarro, 2011

10-GEN-2005

Il Messaggero

Quotidiano Roma Direttore: Paolo Gambescia Lettori Audipress 1224000

da pag. 1

Anziani, abuso di farmaci: 150 mila ricoveri l'anno

MASSI A PAG. 10

Uno studio della Società italiana di geriatria. Molti non hanno nessuno per acquistare le medicine prescritte e prendono quelle che hanno in casa

Anziani, 150mila ricoveri per farmaci sbagliati

Cresce ogni anno il numero degli over 65 che finisce in ospedale per terapie errate o cure fai-da-te

CUORE

Le medicine più prescritte ai pazienti che hanno superato i 65 anni sono quelli per la cura e la protezione del cuore: 33% ace-inibitori, 22% calcio-antagonisti, 21% aspirina a basse dosi destinate ai cardiopatici

STOMACO

Dopo il cuore la patologia più frequente tra le persone anziane è quella che interessa l'apparato gastrointestinale. Il 20% delle prescrizioni, infatti, contiene farmaci per pazienti che hanno disturbi di digestione

CERVELLO

Una grande sezione tra i farmaci destinati agli over 65 riguarda le sostanze destinate al sistema nervoso. Alzheimer e altre forme di demenza sono crescita. Questa condizioni impediscono al paziente di curarsi da solo

Figura 3. Modificazioni farmacodinamiche nell'anziano

Sistema colinergico

- Diminuizione neuroni colinergici
- Diminuizione sintesi e rilascio di acetilcolina (Ach)
- Diminuizione densità dei recettori muscarinici

→ **Effetti anticolinergici centrali e periferici**

Sistema adrenergico

- Diminuita produzione di AMPc
- Diminuizione densità dei recettori β
- Diminuita responsività dei recettori α_2

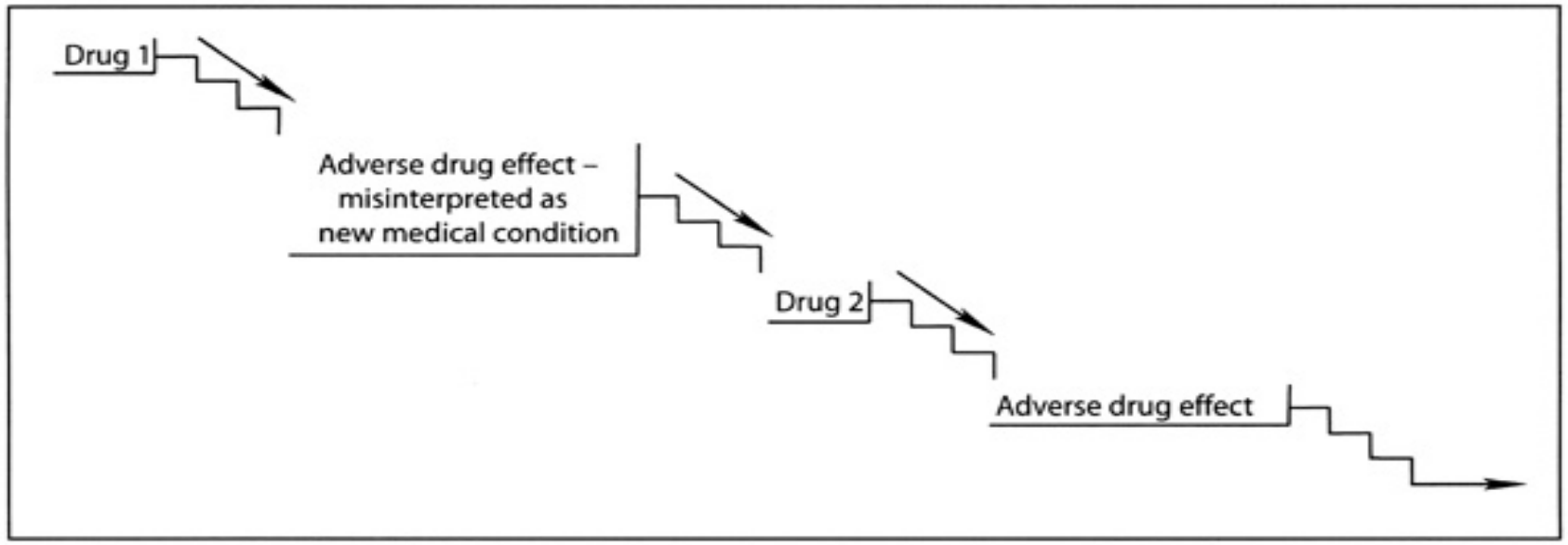
→ **Minore responsività dei barocettori**

Sistema dopaminergico

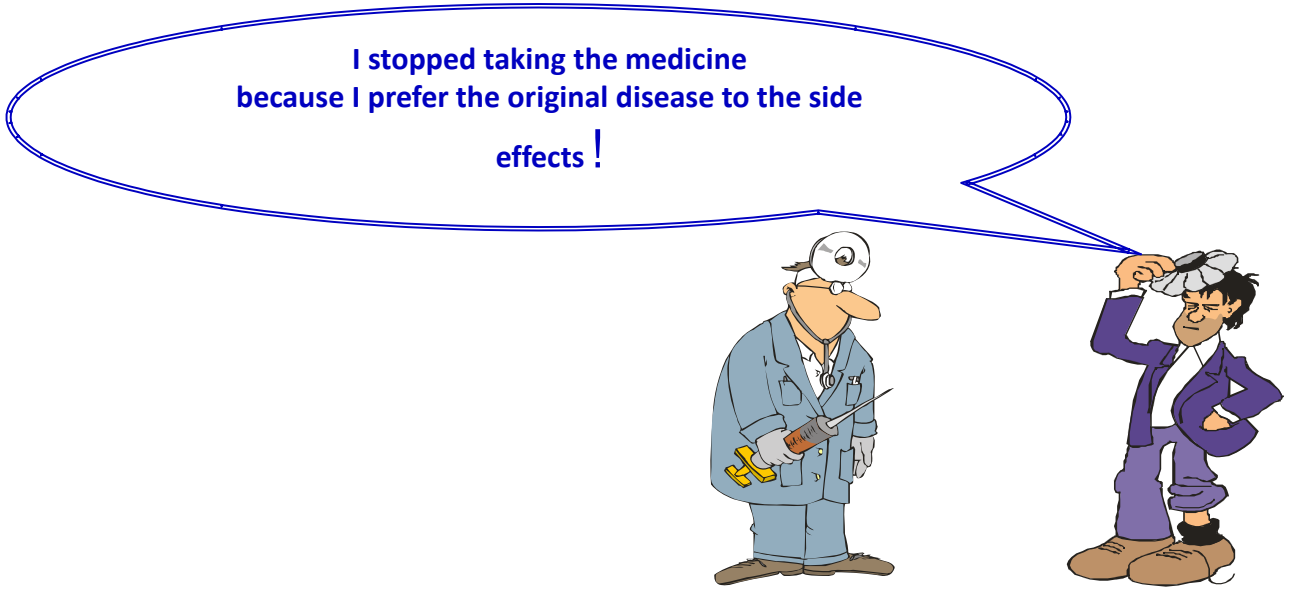
- Diminuizione neuroni colinergici
- Diminuizione sintesi e rilascio di acetilcolina (Ach)
- Diminuizione densità dei recettori muscarinici

→ **Effetti extrapiramidali**

La cascata prescrittiva



1997: Rochon, BMJ



Principi di prescrizione dei farmaci nei pz anziani

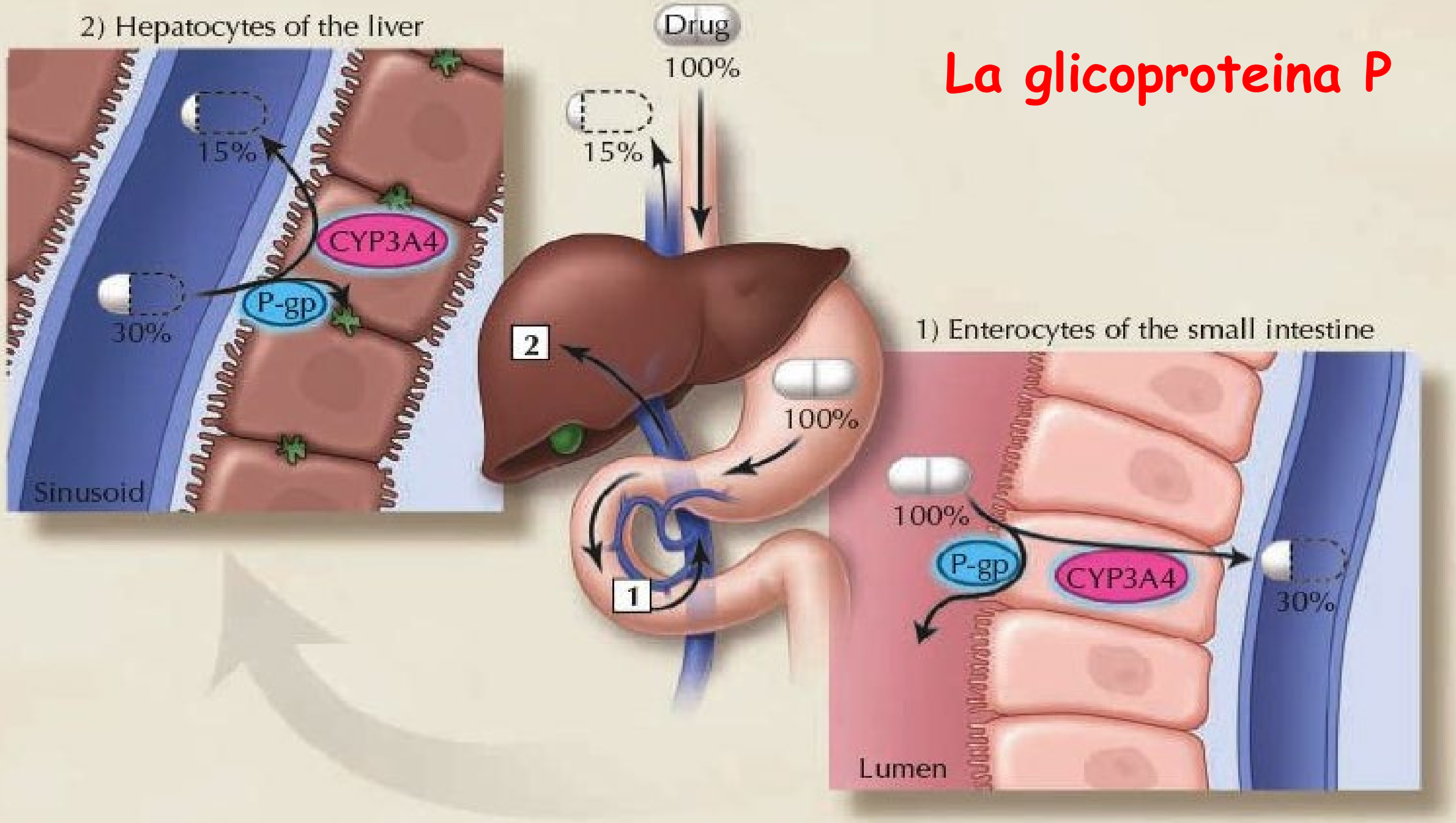
E' necessaria la farmacoterapia?
Se si, quale farmaco è appropriato?
Si chiede al pz di prendere più farmaci di quanti è in grado di tollerare?
Che tipo di prescrizione si dovrebbe usare?
Si dovrebbe modificare la dose standard o il regime posologico?
Quali effetti avversi tendono a prodursi e quali farmaci si dovrebbero evitare se possibile?
Il farmaco dovrebbe avere una confezione ed una dicitura speciali?
E' in grado il pz che vive a casa di gestirsi l'autosomministrazione?
E' necessaria una farmacoterapia continua?

Per impedire la Cascata prescrittiva:

I medici dovrebbero *SEMPRE* considerare *QUALSIASI* segno o sintomo come possibile conseguenza dell'attuale trattamento farmacologico.

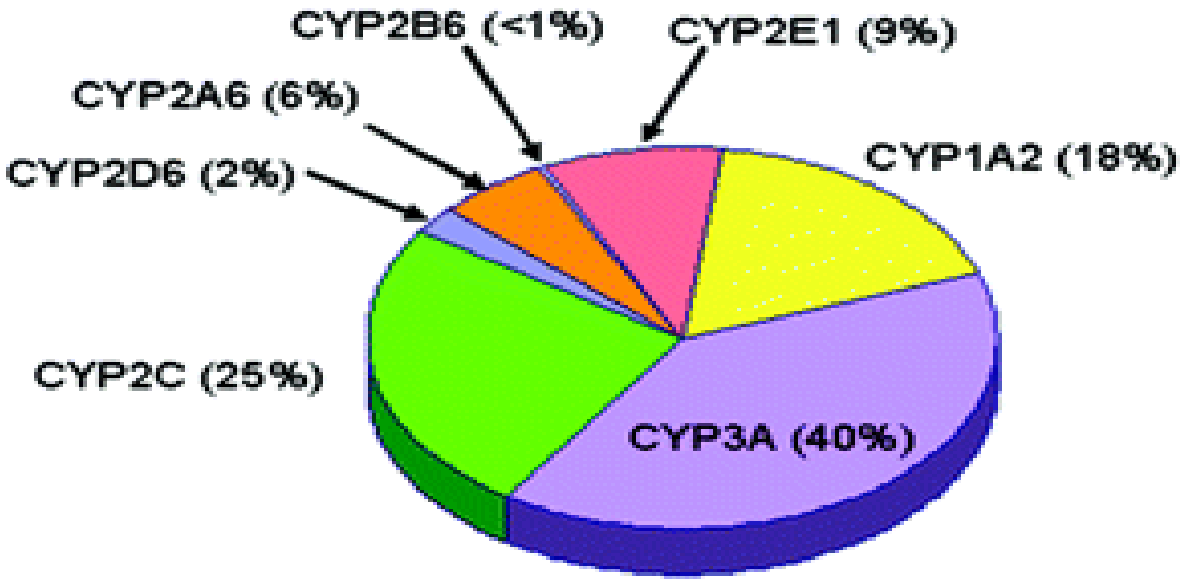
Prima di prescrivere un nuovo farmaco, bisognerebbe rivalutare la necessità del nuovo farmaco, e ***SI DOVREBBE PRENDERE IN CONSIDERAZIONE UN TRATTAMENTO NON- FARMACOLOGICO***

La glicoproteina P



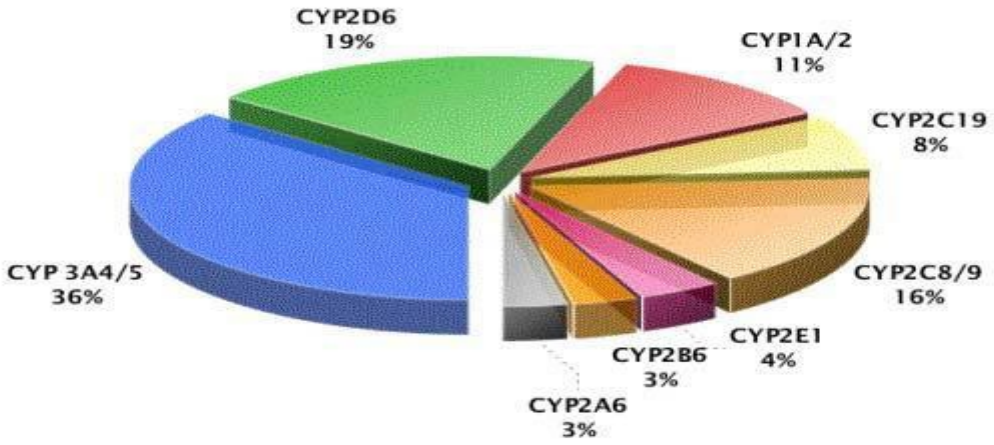
The CYP450 enzymes

P450 enzyme content in the liver



Paine MF et al. Drug Metab Dispos. 2006 May;34(5):880-6
*Shimada T et al. J Pharmacol Exp Ther 1994;*270: 414–423

Proportion of drugs metabolized by P450 enzymes



Wrighton SA et al. Crit Review Toxicology 1992;22:1-22.

DRUGS METABOLIZED BY KNOWN P450'S 2000

Georgetown University Medical Center

1A2	2C19	2C9	2D6	2E1	3A
Clozapine Cyclobenzaprine Fluvoxamine Haloperidol Imipramine Mexiletine Olanzapine Pentazocine Propranolol Tacrine Theophylline	Amitriptyline Citalopram Clomipramine Diazepam Imipramine Lansoprazole Nelfinavir Omeprazole Phenytoin	Celecoxib Diclofenac Flurbiprofen Ibuprofen Losartan Naproxen Phenytoin Piroxicam Torsemide Tolbutamide Warfarin	Amitriptyline Clomipramine Codeine Desipramine Dextromethorphan Imipramine Metoprolol Nortriptyline Oxycodone Paroxetine Propranolol Risperidone Thioridazine Timolol Venlafaxine	Acetaminophen Chlorzoxazone Dapsone Ethanol Enflurane Halothane Isoflurane	Alprazolam Astemizole Buspirone Calcium Channel Blockers Carbamazepine Cisapride Cyclosporine HIV Protease Inhibitors Lovastatin NOT pravastatin Simvastatin Midazolam Pimozide Tacrolimus Triazolam
INHIBITORS					
Cimetidine Ciprofloxacin Erythromycin Fluvoxamine Ofloxacin	Cimetidine Felbamate Fluoxetine Fluvoxamine Ketoconazole Lansoprazole Omeprazole Paroxetine Ticlopidine	Amiodarone Fluconazole Fluoxetine Fluvastatin Metronidazole Paroxetine Zafirlukast	Amiodarone Fluoxetine Haloperidol Indinavir Paroxetine Quinidine Sertraline Terbinafine Ticlopidine	Disulfiram	Amiodarone Cimetidine Grapefruit Juice HIV Protease Inhibitors Itraconazole Ketoconazole Macrolide Antibiotics (NOT Azithromycin) Nefazadone
INDUCERS					
Carbamazepine Rifampin Tobacco	Carbamazepine Norethindrone Rifampin	Phenobarbital Rifampin Secobarbital		Chronic Ethanol Isoniazid Tobacco	Carbamazepine Rifabutin Rifampin Ritonavir St. John's Wort
	Absent in 15-30 % of Asians	Absent in ~ 1% of Caucasians	Absent in 7 % of Caucasians		

www.drug-interactions.com

	Example	Mechanism of action	Outcome
Drug–drug, PK	Gatifloxacin+calcium and antacid	Decrease in absorption of gatifloxacin	Treatment failure[26]
	Ciprofloxacin+olanzapine	Ciprofloxacin inhibits CYP1A2 leading to an increase in Cp of olanzapine	Rigidity, falls
Drug–drug, PD	Ciprofloxacin+glibenclamide	Synergy (hypoglycaemic effect)	Profound hypoglycaemia[27]
	Anticholinergic drug+donepezil	Antagonism	Decreased effect of donepezil
Drug–nutritional status	Low albumin+phenytoin	Increase in free phenytoin concentration	Confusion, somnolence, ataxia[28]
Drug–herbal product	Gingko+aspirin	Decrease in platelet function and adhesion	Increased risk of bleeding[29]
Drug–alcohol	Alcohol+chronic use of bromazepam	Synergy	Increased risk of falls
Drug–disease or drug–patient	Metoclopramide for gastric dysmotility in a patient with Parkinson's disease	Increase in dopamine receptor blockade	Worsening Parkinson's disease[30]

Cp=plasma concentration. CYP=cytochrome P450. PD=pharmacodynamic. PK=pharmacokinetic.

Table: Examples of different types of drug interactions in elderly patients

Lancet 2007; 370: 185–91

Drugs Aging 2006; 23 (12): 1
1170-229X/06/0012-0981/$39.95/0

Adverse Effects of Atypical Antipsychotics in the Elderly

A Review

Pietro Gareri, Pasquale De Fazio, Salvatore De Fazio, Norma Marigliano, Guido Ferreri Ibbadu and *Giovambattista De Sarro*

Table IV. Autonomic and systemic adverse effects of atypical antipsychotics[2-4,36]

Autonomic and systemic adverse effects	Amisulpride	Clozapine	Risperidone	Olanzapine	Quetiapine	Ziprasidone	Zotepine	Aripiprazole	Sertindole
Neuroleptic malignant syndrome	+	+	+	?	?	?	?	?	?
Hypotension	+	−/+ + +	+	+	+ + +	−/+	+	−/+	−/+
Prolongation of corrected QT interval	−/+	−	−/+	−	+ + +	−/+	+	−	+ + +
Gastrointestinal (nausea, vomiting, constipation)	−/+	−/+	−/+	−	+	−/+	−/+ +	−	−/+
Anticholinergic	−	+ + +	−	+	+	−/+	−	−	−
Haematological	−	+ + +	−	−	−	−	−	−	−
Allergic dermatitis	+	−	−	−	−	−	−	−	−
Other effects	−/+	−/+[a]	−/+	−/+	−/+	−/+	−/+	−/+	−/+

a Possible onset of myocarditis.

? indicates no data; **+** indicates mild effect; **+ + +** indicates severe effect; **−** indicates no effect; **−/+** indicates uncertain effect; **−/+ +** indicates range from no effect to a moderate effect; **−/+ + +** indicates range from no effect to a severe effect in case of drug interactions.

The NEW ENGLAND JOURNAL of MEDICINE

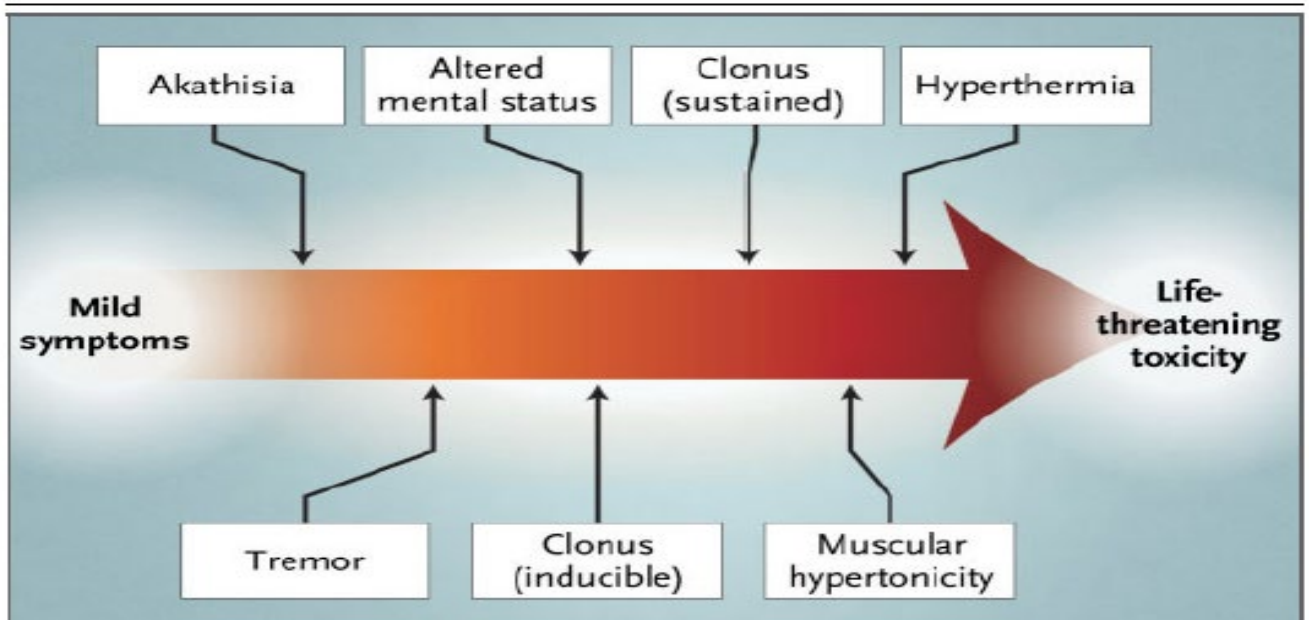
REVIEW ARTICLE

CURRENT CONCEPTS

The Serotonin Syndrome

Edward W. Boyer, M.D., Ph.D., and Michael Shannon, M.D., M.P.H.

N Engl J Med 2005;352:1112-20.



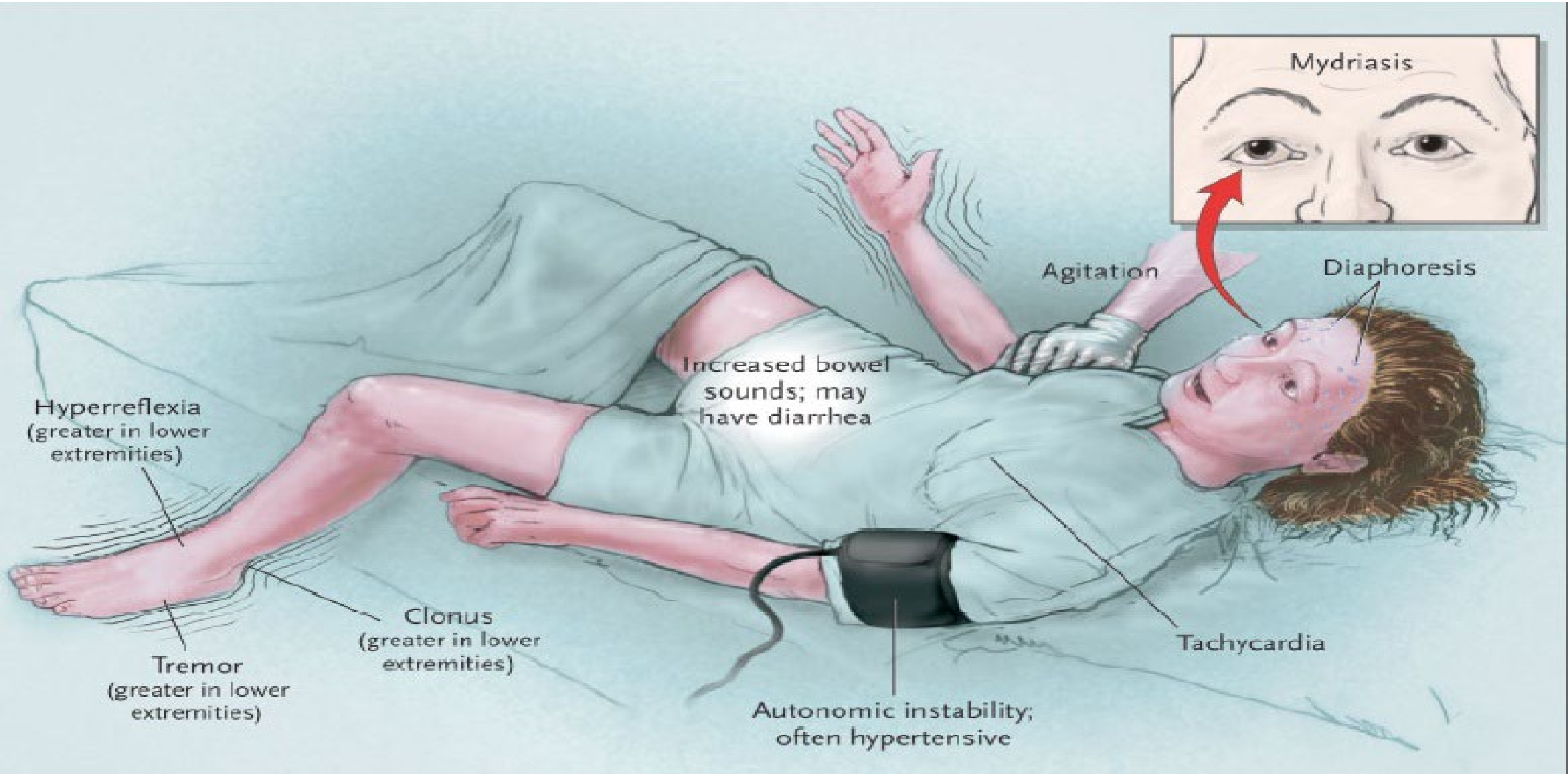

Mydriasis
Agitation
Diaphoresis
Increased bowel sounds; may have diarrhea
Hyperreflexia (greater in lower extremities)
Clonus (greater in lower extremities)
Tremor (greater in lower extremities)
Tachycardia
Autonomic instability; often hypertensive

Table 1. Drugs and Drug Interactions Associated with the Serotonin Syndrome.

Drugs associated with the serotonin syndrome

Selective serotonin-reuptake inhibitors: sertraline, fluoxetine, fluvoxamine, paroxetine, and citalopram
Antidepressant drugs: trazodone, nefazodone, buspirone, clomipramine, and venlafaxine
Monoamine oxidase inhibitors: phenelzine, moclobemide, clorgiline, and isocarboxazid
Anticonvulsants: valproate
Analgesics: meperidine, fentanyl, tramadol, and pentazocine
Antiemetic agents: ondansetron, granisetron, and metoclopramide
Antimigraine drugs: sumatriptan
Bariatric medications: sibutramine
Antibiotics: linezolide (a monoamine oxidase inhibitor) and ritonavir (through inhibition of cytochrome P-450 enzyme isoform 3A4)
Over-the-counter cough and cold remedies: dextromethorphan
Drugs of abuse: methylenedioxymethamphetamine (MDMA, or "ecstasy"), lysergic acid diethylamide (LSD), 5-methoxydiisopropyltryptamine ("foxy methoxy"), Syrian rue (contains harmine and harmaline, both monoamine oxidase inhibitors)
Dietary supplements and herbal products: tryptophan, *Hypericum perforatum* (St. John's wort), Panax ginseng (ginseng)
Other: lithium

Drug interactions associated with severe serotonin syndrome

Zoloft, Prozac, Sarafem, Luvox, Paxil, Celexa, Desyrel, Serzone, Buspar, Anafranil, Effexor, Nardil, Manerix, Marplan, Depakote, Demerol, Duragesic, Sublimaze, Ultram, Talwin, Zofran, Kytril, Reglan, Imitrex, Meridia, Redux, Pondimin, Zyvox, Norvir, Parnate, Tofranil, Remeron

Phenelzine and meperidine
Tranylcypromine and imipramine
Phenelzine and selective serotonin-reuptake inhibitors
Paroxetine and buspirone
Linezolide and citalopram
Moclobemide and selective serotonin-reuptake inhibitors
Tramadol, venlafaxine, and mirtazapine

N Engl J Med 2005;352:1112-20.

Altre possibili interazioni "inutili"

- TCA + L-DOPA

(ridotta biodisponibilità del precursore della DA)

- TCA (amitriptilina, clomipramina) + selegilina
- SSRI + selegilina o con antiparkinsoniani

(rischio di sindrome serotoninergica)

- TCA + anticolinergici
- TCA + oppiacei, alcool, ansiolitici, ipnotici, farmaci da banco contro il raffreddore

(depressione del SNC)

- Antidepressivi e antipsicotici

Interferenze con la clozapina (inibizione enzimatica CYP3A4 e CYP1A2)

Table 13
The mean dosages, the plasma half-life and side effects of some tricyclics in the elderly[a]

Drug	Mean dosage/day (mg/die)	Plasma half-life (hours)	Side effects				
			Sedation	Hypotension	Cardiac	Antimuscarinic	Seizures
Imipramine	30–100	10–25	+	+ +	+ +	+ +	+
Desipramine	30–125	12–24	–	+ +	+ +	+ +	+
Chlorimipramine	30–100	17–28	+	+ +	+ +	+ +	+
Trimipramine	75–150	9–25	+	+ +	+ +	+ +	+
Amitriptyline	30–100	10–22	+ + +	+ +	+ + +	+ + +	+
Nortriptyline	25–75	20–50	+	+	+	+ +	+
Doxepin	75–150	12–23	+ +	+ +	+ +	+ + +	+
Dothiepin	75–150	18–21	+ +	+ +	+ +	+ +	+

[a] One can note that nortriptyline appears as one of the best tolerated tricyclics in old people.

- Alterazione della memoria a breve termine
- Aumento dei tempi di reazione
- Alterazione dell' elaborazione delle informazioni
- Allungamento dei tempi di recupero
- **Potrebbero favorire la progressione delle lesioni della sostanza bianca, a sua volta connessa a depressione nella terza età** (favorita dall'azione α-litica)

Venlafaxine–Propafenone Interaction Resulting in Hallucinations and Psychomotor Agitation

Pietro Gareri, Pasquale De Fazio, Luca Gallelli, Salvatore De Fazio, Alessandro Davoli, Giuseppe Seminara, Antonino Cotroneo, and Giovambattista De Sarro

The Annals of Pharmacotherapy ■ *2008 March, Volume 42*

CONCLUSIONS: To prevent the onset of clinical disturbances during venlafaxine treatment, we suggest careful evaluation of concomitant treatment with CYP2D6 or P-glycoprotein inhibitors (eg, propafenone) and, when possible, venlafaxine serum concentration monitoring.

TABELLA 3 - INTERAZIONI FARMACOCINETICHE TRA SSRI E NUOVI ANTIPSICOTICI

SSRI	Antipsicotico	Effetto sui livelli ematici	Meccanismo
Citalopram/ Escitalopram	Clozapina Risperidone	Modificazioni non significative Modificazioni non significative	
Fluoxetina	Clozapina Risperidone Olanzapina Quetiapina	Aumento (fino al 100%) Aumento (fino al 75%) Lieve aumento (< 30%) Lieve aumento (< 30%)	Inibizione CYP2D6 Inibizione CYP2D6 e CYP3A4
Fluvoxamina	Clozapina Olanzapina Risperidone	Aumento (5-10 volte) Aumento (fino al 100%) Lieve aumento (< 30%)	Inibizione CYP1A2, CYP2C19 e CYP3A4 Inibizione CYP1A2 Inibizione CYP3A4
Paroxetina	Clozapina Risperidone	Lieve aumento (< 30%) Aumento (fino al 45%)	Inibizione CYP2D6 Inibizione CYP2D6
Sertralina	Clozapina Risperidone Olanzapina	Modificazioni non significative Lieve aumento (< 30%) Modificazioni non significative	Inibizione CYP2D6

FACTS NEWS & VIEWS n. 1, novembre 2006

TABELLA 2 - INTERAZIONI FARMACOCINETICHE DEGLI SSRI CON GLI INIBITORI DELLE COLINESTERASI

Inibitori delle colinesterasi	Farmaco interagente	Meccanismo	Effetto clinico
Tacrina	■ Fluvoxamina	Inibizione del CYP1A2	Ridotta clearance della tacrina
Rivastigmina	–	–	–
Galantamina	■ Paroxetina, fluoxetina, fluvoxamina	Inibizione del CYP2D6 Inibizione del CYP3A4	Aumento delle concentrazioni di galantamina Aumento delle concentrazioni di galantamina
Donepezil	■ Paroxetina	Inibizione del CYP2D6	Aumento delle concentrazioni di donepezil

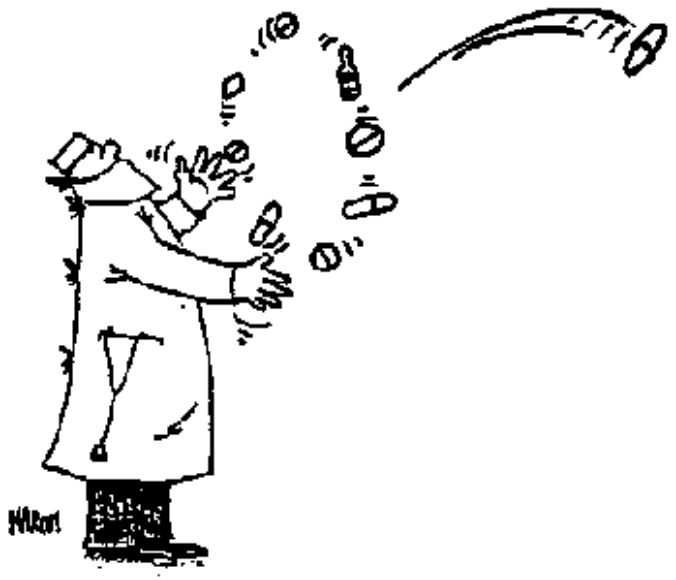
Arch. Gerontol. Geriatr. Suppl. 1 (2007) 199–206
0167-4943/$ – see front matter

ANTICHOLINERGIC DRUG-INDUCED DELIRIUM IN AN ELDERLY ALZHEIMER'S DEMENTIA PATIENT

P. GARERI[a,b], P. DE FAZIO[c], A. COTRONEO[d], R. LACAVA[b], L. GALLELLI[a], S. DE FAZIO[a] and G. DE SARRO[a]*

Il problema della prescrizione dei farmaci nel paziente anziano

- Scelta del farmaco
- Combinazione di farmaci
- Uso di più farmaci in pz con comorbilità spesso complesse
- Farmaci non sempre testati negli anziani
- Mancanza di linee guida per gestire pazienti complessi



Condizioni mediche che possono interferire con la cinetica dei farmaci

Insufficienza cardiaca congestizia
IRC
Cirrosi epatica
Febbre
Sepsi
Ustioni (di un certo grado)
Anemia
Shock

$$\text{Interactions} = \frac{[\text{Drug count}] \times ([\text{Drug count}] - 1)}{2}$$

Number of prescribed drugs	Interactions
1	0
2	1
3	3
4	6
5	10
6	15
7	21
8	28
9	36
10	45

Farmaci potenzialmente inappropriati

- **Digitale** (dose pro die > 0.125mg/die)
- **Benzodiazepine a lunga emivita plasmatica** (diazepam, N-demetildiazepam, clordiazepossido)
- **Antidepressivi triciclici** (amitriptilina, imipramina)
- **Fenotiazine con struttura piperidinica** (tioridazina)
- **Butirrofenoni** (aloperidolo)
- **Antipsicotici atipici** (clozapina, risperidone, olanzapina, quetiapina, aripiprazolo, paliperidone)
- **Alcaloidi della belladonna, semisintetici, composti dell'ammonio quaternario** (butilscopolamina)

- **Antiistaminici per uso sistemico** (prometazina, difenidramina)
- **Metildopa; Nifedipina; Disopiramide**
- **α_1-bloccanti adrenergici** (doxazosina, terazosina)
- **α_2-agonisti presinaptici** (clonidina)
- **Lassativi** (picosolfato sodico, bisacodile)
- **Antidiarroici** (loperamide)
- **Procinetici** (metoclopramide)
- **Antiaritmici classe III** (amiodarone)
- **FANS**
  - Derivati dell'acido salicilico (aspirina)
  - Derivati dell'acido acetico (indometacina)
  - Derivati dell'acido propionico (naproxene)
  - Oxicam (piroxicam, tenoxicam)

Cotroneo,Gareri & De Sarro, 2012

Box 2. Medications with anticholinergic effects

Alprazolam
Amantadine
Amitriptyline
Ampicillin
Atropine
Azathioprine
Captopril
Cefamandole
Cefoxitin
Chlorazepate
Chlordiazepoxide
Chlorthalidone
Cimetidine
Clindamycin
Codeine
Corticosterone
Cycloserine
Cyclosporin
Desipramine
Dexamethasone
Diazepam
Digoxin
Diltiazem
Diphenhydramine
Dipyridamole
Dyazide
Flunitrazepam
Flurazepam
Furosemide
Gentamycin
Hydralazine
Hydrochlorathiazide
Hydrocortisone
Hydroxyzine
Imipramine
Isosorbide
Keflin
Lanoxin
Methyldopa
Nifedipine
Oxazepam
Oxybutynin chloride
Oxycodone
Pancuronium bromide
Phenelzine
Phenobarbitol
Piperacillin
Prednisolone
Ranitidine
Theophylline
Thioridazine
Ticrocillin
Tobramycin
Triamterene
Valproic acid
Vancomycin
Warfarin

Data from Tune LE, Egeli S. Acetylcholine and delirium. Dement Geriatr Cogn Disord 1999;10:342–4.

Box 1. Risk of delirium with certain commonly used drugs

High risk
- Opioid analgesics
- Antiparkinsonian agents (particularly anticholinergic agents)
- Antidepressants (particularly anticholinergic agents)
- Benzodiazepines
- Centrally acting agents
- Corticosteroids
- Lithium

Medium risk
- Alpha-blockers
- Antiarrhythmics (lidocaine [lignocaine] has the highest risk)
- Antipsychotics (particularly sedating agents)
- β-Blockers
- Digoxin
- Nonsteroidal anti-inflammatory drugs
- Postganglionic sympathetic blockers

Low risk
- ACE inhibitors
- Antiasthmatics (highest risk with aminophylline and lowest risk with inhaled agents)
- Antibacterials
- Anticonvulsants
- Calcium channel antagonists
- Diuretics
- H_2-antagonists

Data from Bowen JD, Larson EB. Drug-induced cognitive impairment. Defining the problem and finding the solutions. Drugs Aging 1993;3(4):349–57.

Aging Clinical and Experimental Research
https://doi.org/10.1007/s40520-020-01719-5

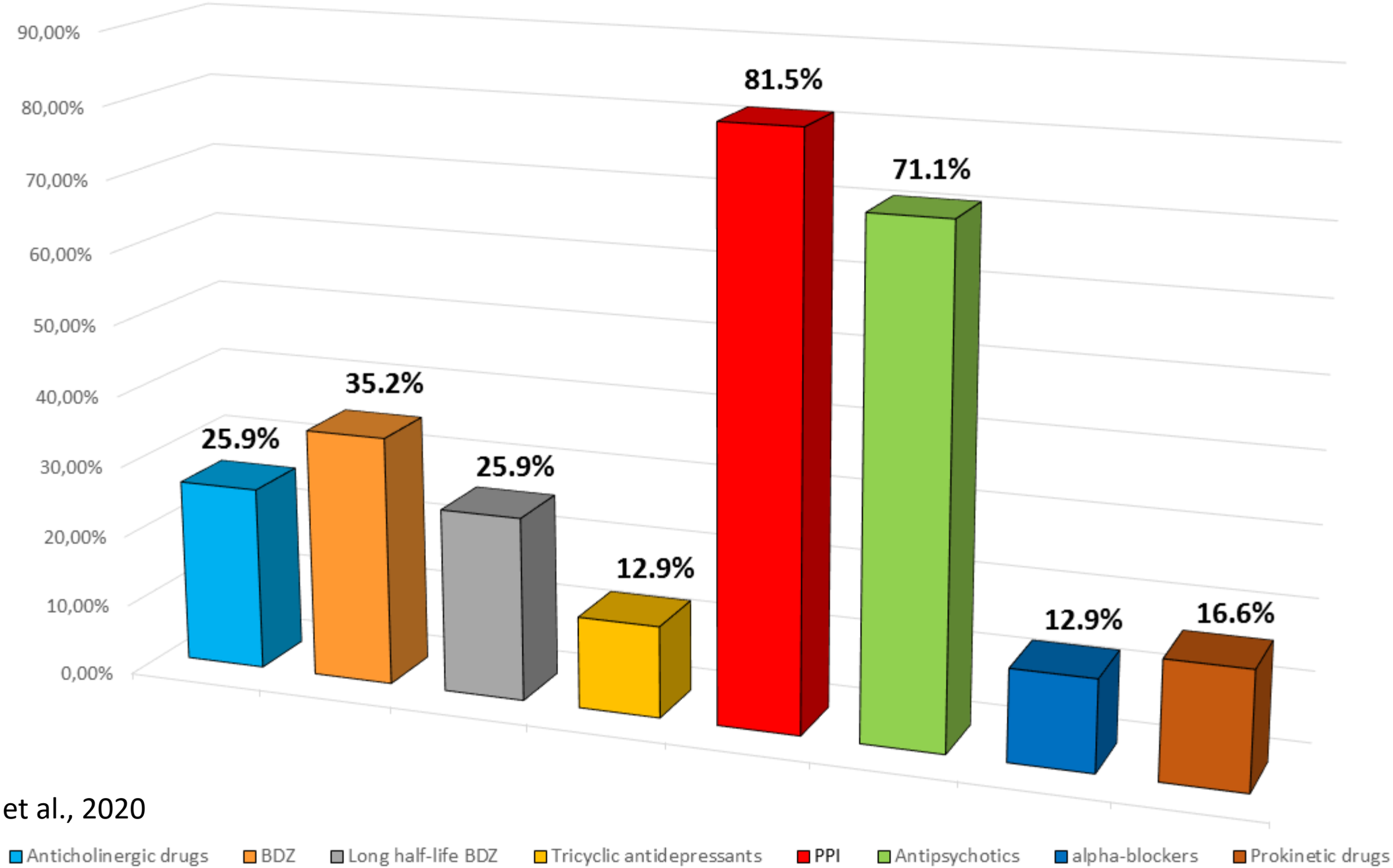
ORIGINAL ARTICLE

The risk of polypharmacy and potentially inappropriate drugs in residential care dementia patients: tips from the PharE study

Pietro Gareri[1] · Antonino Maria Cotroneo[2] · Maria Teresa Pontieri[3] · Caterina Palleria[4] · Giovambattista De Sarro[4]

Received: 21 August 2020 / Accepted: 16 September 2020

Aims The aims of the present study, conducted in two regions of Italy, Calabria and Piedmont, were to assess the use of inappropriate drugs according to the Beers Criteria and to study the possible drug–drug interactions.
Methods Data were obtained retrospectively from 972 residential care patients between 2016 and 2018. Mean age was 82.4 ± 8.4 years, with a prevalence of women (64.8%). Activities of daily living, instrumental activities of daily living, Mini-Mental State Examination, Cumulative Illness Rating Scale, Neuropsychiatric Inventory Scale and number and kind of drugs were recorded. A classification of potential inappropriate drugs was made according to the Beers criteria. Data were collected through an Excel file able to gather the main information. In the case of suspected adverse event, Naranjo Scale was applied. The study of possible drug–drug interactions was made by Micromedex 2.0.
Results Functional and cognitive impairments, comorbidities and number of drugs were assessed. The bivariate relationship between number of drugs and glomerular filtration rate assessed by CKD-EPI showed that the higher was the number of drugs used, the worst was kidney function assessment ($p = 0.0001$). The most frequent inappropriate drugs were anticholinergic drugs, tricyclics antidepressants, long-half-life benzodiazepines, antipsychotics and proton pump inhibitors.
Conclusions These data are very interesting and show the need for an accurate choice of drugs in elderly people and for starting a wise deprescribing procedure.



Cotroneo et al., 2020

Table 2 Kind of potentially inappropriate drugs used

	n	*n*	*n*	*n*	*n*
Anticholinergic drugs	Biperiden (108)	Oxatomide (18)	Amitriptyline (90)	Chlorimipramine (36)	
PPI	Lansoprazole (287)	Omeprazole (253)	Pantoprazole (235)	Esomeprazole (35)	
Conventional AP drugs	Haloperidol (48)	Promazine (185)	Levomepromazine (22)	Levosulpiride (98)	
SGA	Risperidone (57)	Olanzapine (108)	Quetiapine (137)	Aripiprazole (19)	Clozapine (17)
Tricyclic antidepressants	Amitriptyline (90)	Chlorimipramine (36)			
Short half-life benzodiazepines	Lorazepam (37)	Alprazolam (53)			
Long-half-life benzodiazepines	*N*-Demethyl-diazepam (94)	Diazepam (117)	Clonazepam (41)	Flurazepam (21)	
α-Blockers	Doxazosin (89)	Terazosin (37)			
Prokinetic drugs	Levosulpiride (98)	Metoclopramide (64)			

Number of drugs reported in the graphs

PPI proton pump inhibitors, *AP drugs* antipsychotic drugs, *SGA* secondary generation antipsychotic drugs

Cotroneo et al., 2020

Table 3 Some interesting case reports pointing out the adverse events registered and the possible pharmacokinetic and pharmacodynamic interactions

		Gender and age (reported in parenthesis) M = males; F = females	Kind of interaction/AE AE = adverse event; PK = pharmacokinetics; PD = pharmacodynamics
Amiodarone hepatotoxicity	1 case report	M (82)	AE
Clarithromycin–warfarin interaction (> INR ratio = 18)	1 case report	F (85)	PK
Ciprofloxacin–warfarin interaction (> INR ratio = 12)	1 case report	M (82)	PK
Hyperactive delirium induced by combination treatment of amitriptyline + oxycodone/naloxone	2 case reports	1M (83); 1F (81)	PD
Hyperactive delirium induced by combination treatment of chlorimipramine + oxycodone/naloxone	2 case reports	1M (83); 1F (78)	PD
Demethyl-diazepam–fluvoxamine (excessive sedation)	2 case reports	F (80; 80)	PD
Olanzapine-induced diabetes mellitus	1 case report	F (65)	AE
Hyperactive delirium induced by combination treatment of biperiden + diazepam	2 case reports	1M (75); 1F (70)	PD
Digitalis intoxication (0.0625 mg/day) in renal failure	1 case report	1F (98)	Drug/disease

Cotroneo et al., 2020

geriatrics

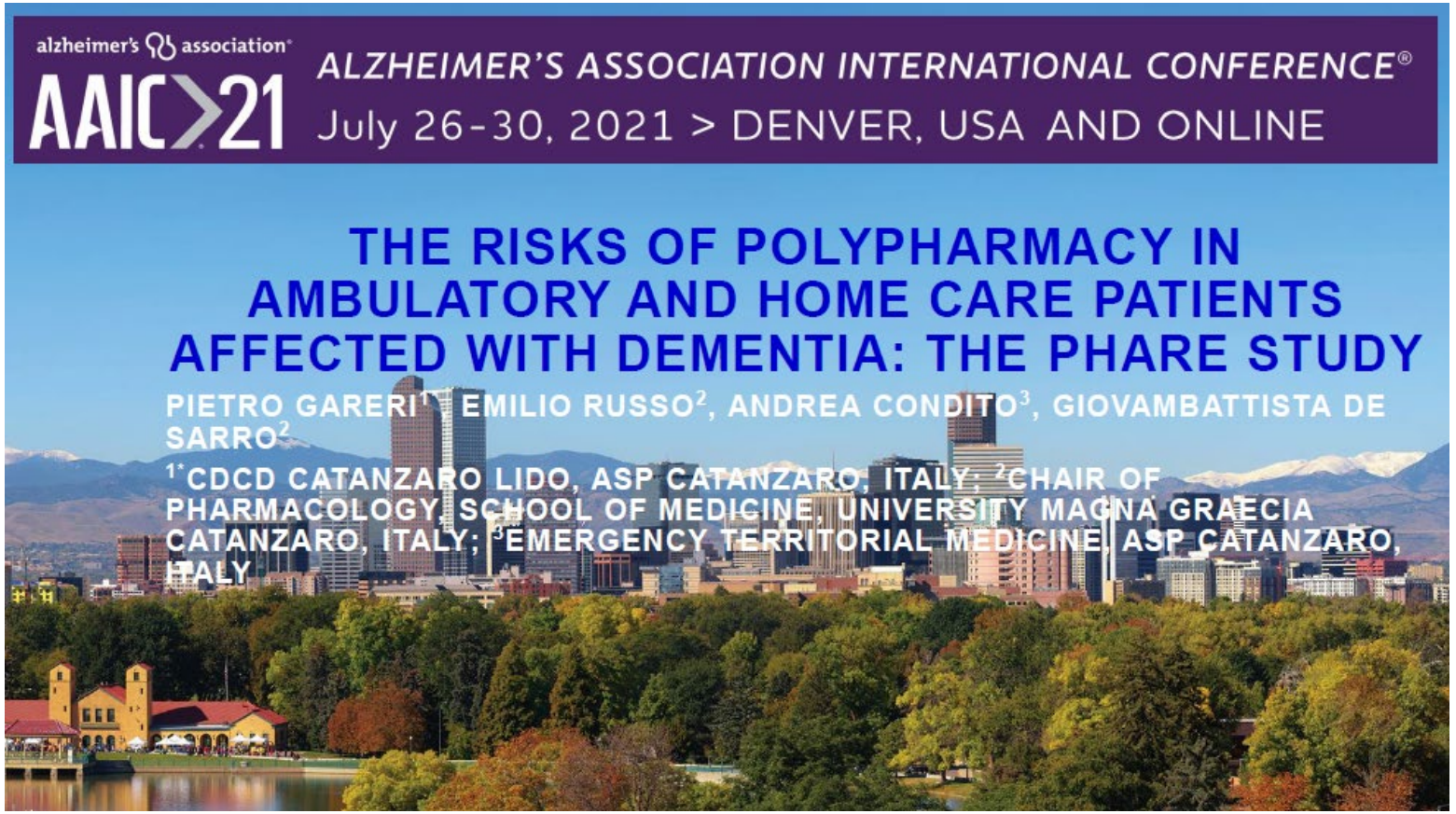
MDPI

Case Report

The Art of Safe and Judicious Deprescribing in an Elderly Patient: A Case Report

Pietro Gareri [1], Luca Gallelli [2,3,*], Antonino Maria Cotroneo [4], Valeria Graziella Laura Manfredi [5] and Giovambattista De Sarro [2,3]

Received: 30 July 2020; Accepted: 18 September 2020; Published: 21 September 2020



Age and Ageing 2008; **37:** 673–679
doi: 10.1093/ageing/afn197
Published electronically 1 October 2008

STOPP (Screening Tool of Older Persons' potentially inappropriate Prescriptions): application to acutely ill elderly patients and comparison with Beers' criteria

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Abstract

Introduction: STOPP (Screening Tool of Older Persons' potentially inappropriate Prescriptions) is a new, systems-defined medicine review tool. We compared the performance of STOPP to that of established Beers' criteria in detecting potentially inappropriate medicines (PIMs) and related adverse drug events (ADEs) in older patients presenting for hospital admission.
Methods: we prospectively studied 715 consecutive acute admissions to a university teaching hospital. Diagnoses, reason for admission and concurrent medications were recorded. STOPP and Beers' criteria were applied. PIMs with clear causal connection or contribution to the principal reason for admission were determined.
Results: median patient age (interquartile range) was 77 (72–82) years. Median number of prescription medicines was 6 (range 0–21). STOPP identified 336 PIMs affecting 247 patients (35%), of whom one-third ($n = 82$) presented with an associated ADE. Beers' criteria identified 226 PIMs affecting 177 patients (25%), of whom 43 presented with an associated ADE. STOPP-related PIMs contributed to 11.5% of all admissions. Beers' criteria-related PIMs contributed to significantly fewer admissions (6%).
Conclusion: STOPP criteria identified a significantly higher proportion of patients requiring hospitalisation as a result of PIM-related adverse events than Beers' criteria. This finding has significant implications for hospital geriatric practice.

Keywords: *inappropriate prescribing, elderly, STOPP, screening tool*

Criteri STOPP - Prescrizioni inappropriate in pazienti con età ≥65 anni

B. SISTEMA NERVOSO E FARMACI PSICOTROPI

1. Antidepressivi triciclici in soggetti con demenza: **rischio di peggioramento dei disordini cognitivi.**
2. Antidepressivi triciclici in soggetti con glaucoma: **probabile peggioramento del glaucoma.**
3. Antidepressivi triciclici in soggetti con difetti di conduzione cardiaca: **effetti pro-aritmici.**
4. Antidepressivi triciclici in soggetti con stipsi: **probabile peggioramento della stipsi.**
5. Antidepressivi triciclici con oppiacei e bloccanti dei canali del calcio: **rischio di stipsi grave.**
6. Antidepressivi triciclici in pazienti con iperplasia prostatica o storia clinica di ritenzione urinaria: **rischio di ritenzione urinaria.**
7. Uso a lungo termine (>1 mese) di benzodiazepine a lunga durata d'azione (clordiazepossido, flurazapam, nitrazepam, clorazepato) e di benzodiazepine con metaboliti a lunga durata d'azione (diazepam): **rischio di prolungata sedazione, confusione, disturbi dell'equilibrio e cadute.**
8. Uso a lungo termine (>1 mese) di neurolettici come ipnotici a lunga durata d'azione: **rischio di confusione, ipotensione, effetti extrapiramidali, cadute.**
9. Uso a lungo termine (>1 mese) di neurolettici in pazienti con Parkinsonismo: **probabile peggioramento dei sintomi extrapiramidali.**
10. Fenotiazine (clorpromazina, flufenazina, proclorperazina) in pazienti con epilessia: **possono abbassare la soglia delle crisi epilettiche.**
11. Anticolinergici (triesifenidile, biperidene, metixene, bornaprina) per trattare gli effetti collaterali extrapiramidali dei neurolettici: **rischio di tossicità anticolinergica.**
12. Antidepressivi (SSRI) in pazienti con una storia di iponatremia clinicamente significativa: **non iatrogeni se iponatremia nei 2 mesi precedenti è <130 mmol/L.**
13. Uso prolungato (>1 settimana) di antistaminici di prima generazione (difenidramina, clorfeniramina, idroxizina, prometazina): **rischio di sedazione e di effetti collaterali anticolinergici.**

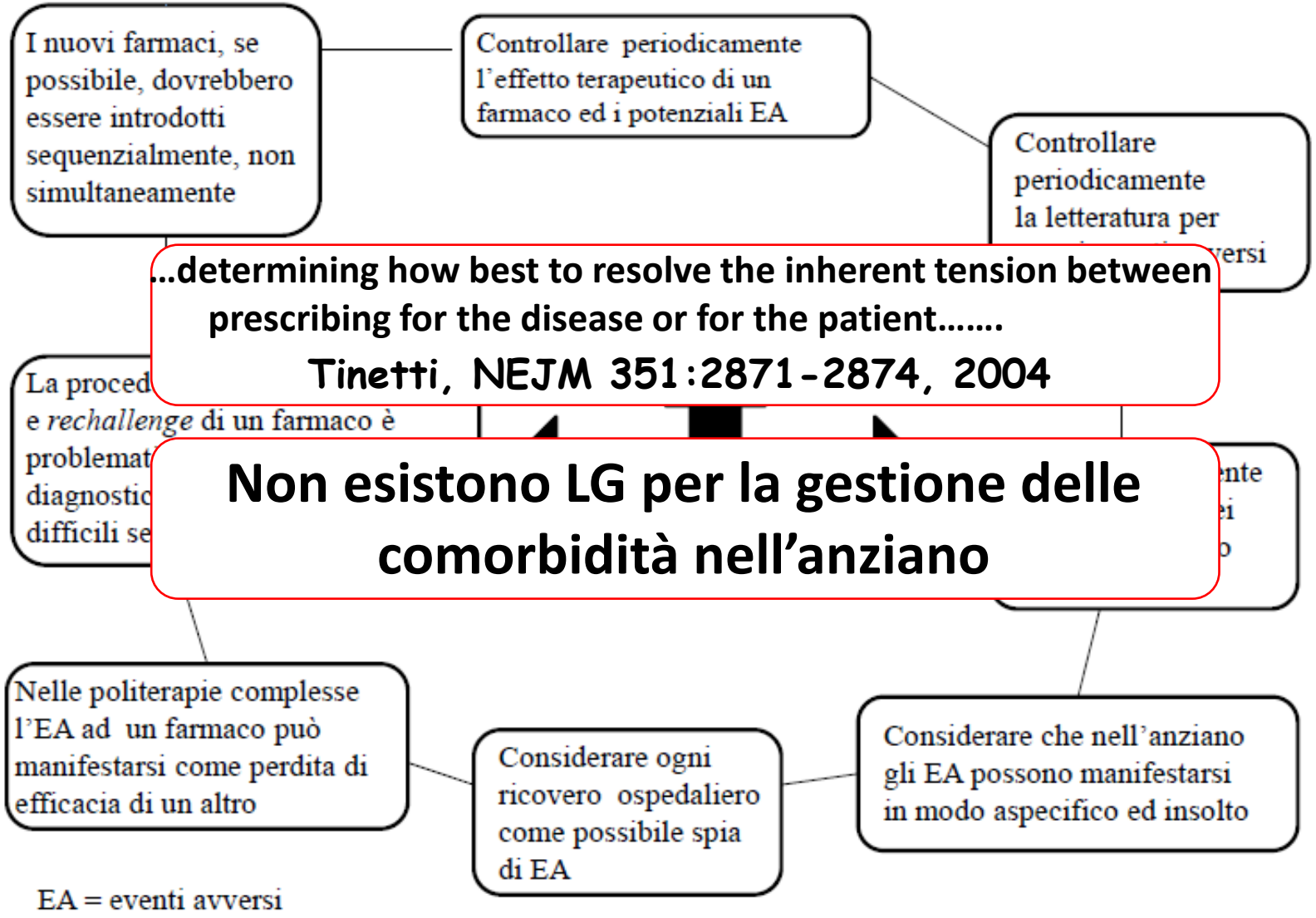
I. FARMACI ANALGESICI

1. Uso a lungo termine di potenti oppiacei (morfina o fentanile) come prima terapia nel dolore da lieve a moderato: **non indicato dalla scala analgesica della OMS.**
2. Uso regolare di oppiacei per più di 2 settimane in soggetti con stipsi cronica senza concomitante uso di lassativi: **rischio di stipsi grave.**
3. Uso a lungo termine di oppiacei in soggetti con demenza, se non indicati per cure palliative o controllo di dolore da moderato a grave: **rischio di peggioramento dei disordini cognitivi.**

INTERFERENZE FARMACI-ALIMENTI

Alimento	Farmaco	Conseguenze
Latte-latticini	Tetracicline	↓assorbimento
Latte-latticini	Digitale	↑ tossicità
Vegetali a foglie verdi	Ant. Vit. K	antagonismo
Vino, formaggi, banane, Lievito	MAOI	crisi ipertensive
Caffeina ad alte dosi	BDZ	↓eff. ansiolitico
Caffeina ad alte dosi	Xantinici	↑tossicità
Soja, fitati	Ferro os, Calcio	↓assorbimento
Dieta iposodica	Litio	↑tossicità
Dieta iperproteica	Teofillina	↓livelli ematici
Pesce (istamina)	Isoniazide	prurito, eritema
Alcool	Clorpropamide	flushing
	Metronidazolo	nausea↕ dolore
	Disulfiram	eff. antabuse
	Psicofarmaci	eff. sedativi

Do we need strong guidelines for deprescribing?



Organizzazione medica

Tina Modotti: Concha Michel e i suoi-assistenti, Messico 1928

Le sfide quotidiane del geriatra

?

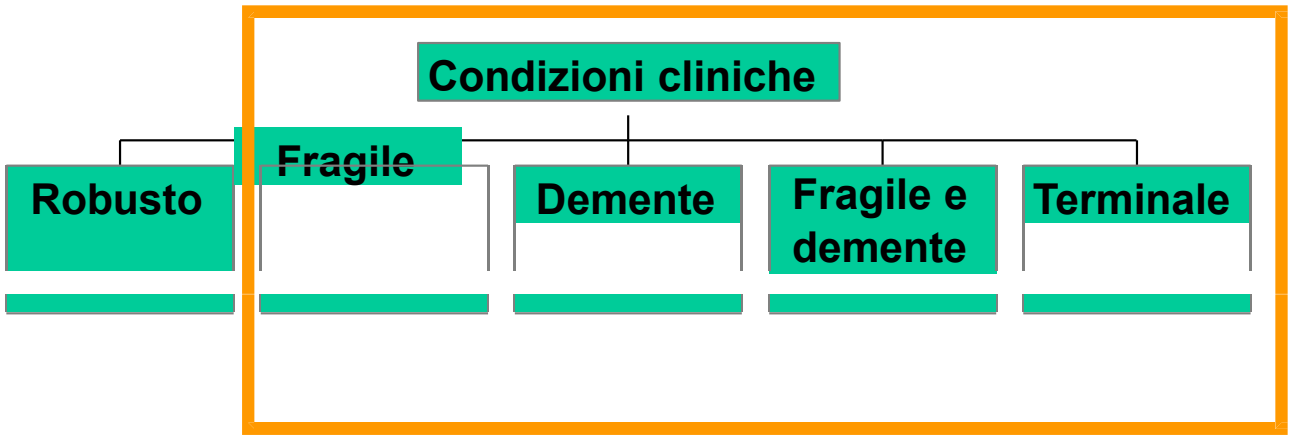
VARIABILITA' INDIVIDUALE
APPROCCI TERAPEUTICI non INDENTIFICATI

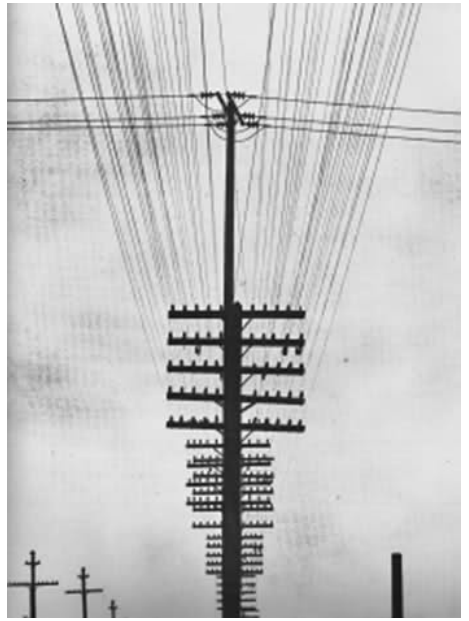
INACCURATEZZA DEGLI
INDICI - DIAGNOSTICI
- PROGNOSTICI

NESSI DI CAUSALITA' RELATIVI ALL'INSORGENZA DELLE PATOLOGIE

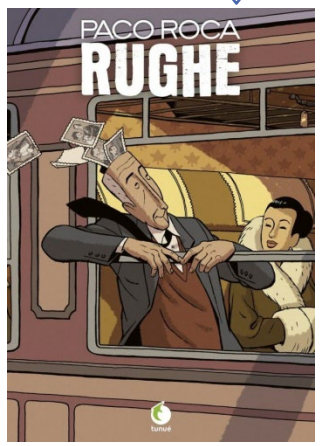
SEVERITA' DELLA MULTIMORBIDITA' IN RELAZIONE ALL'ASPETTATIVA DI VITA

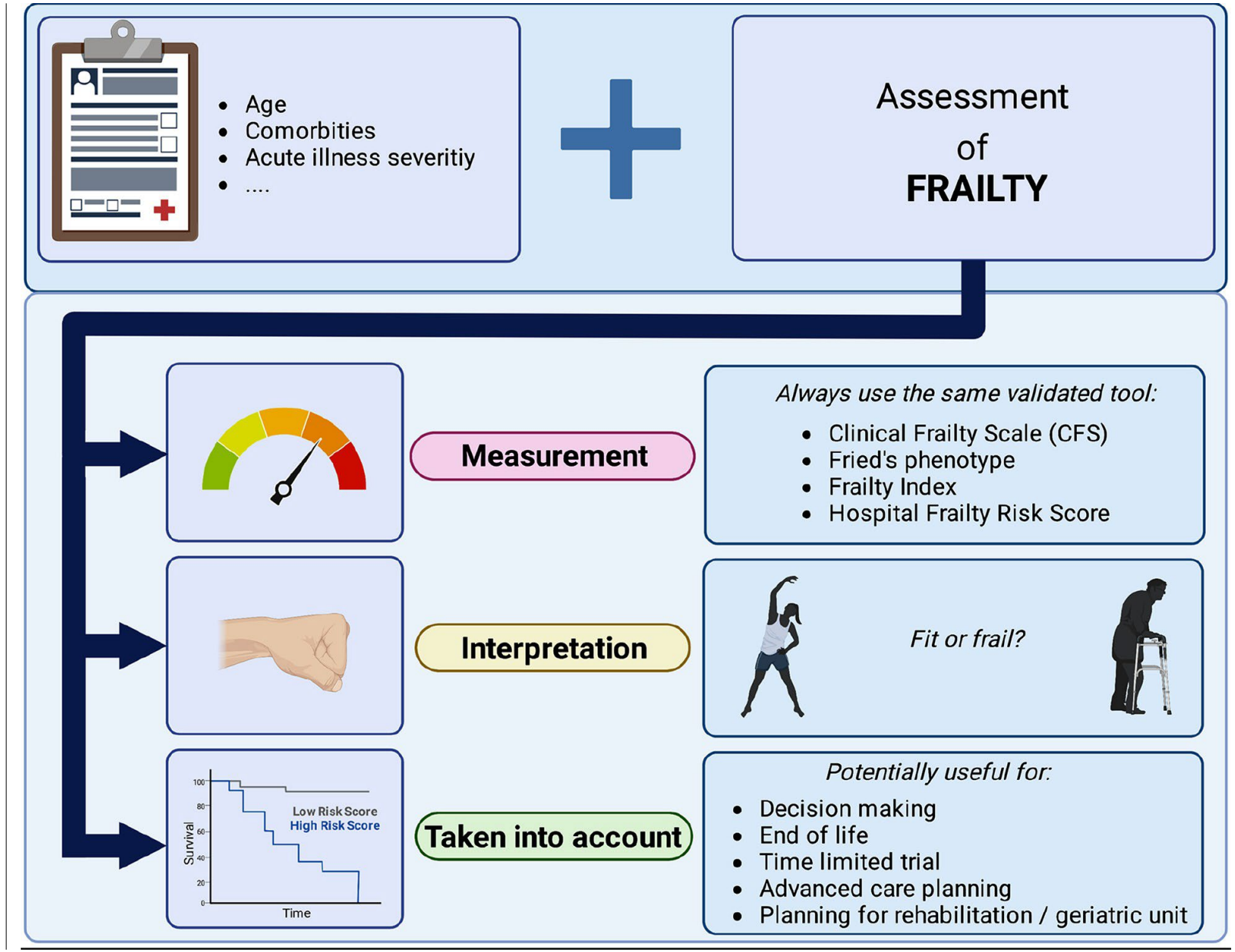
IDENTIFICIAZIONE DEI PAZIENTI PIU' A RISCHIO DI MORTE



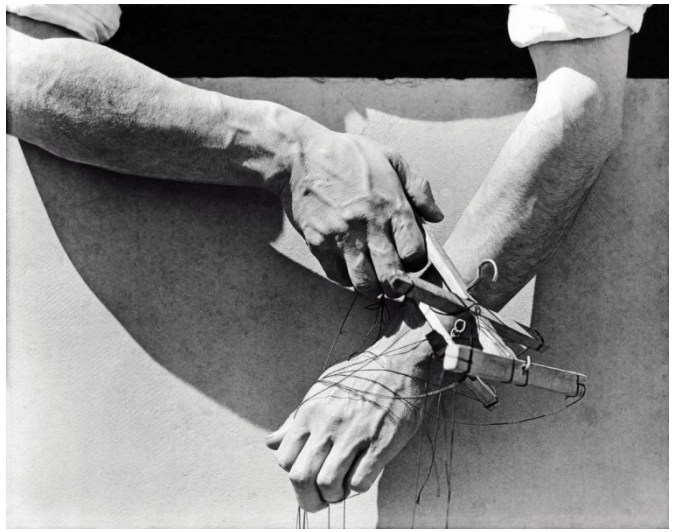


Tina Modotti: Pali del telegrafo 1926



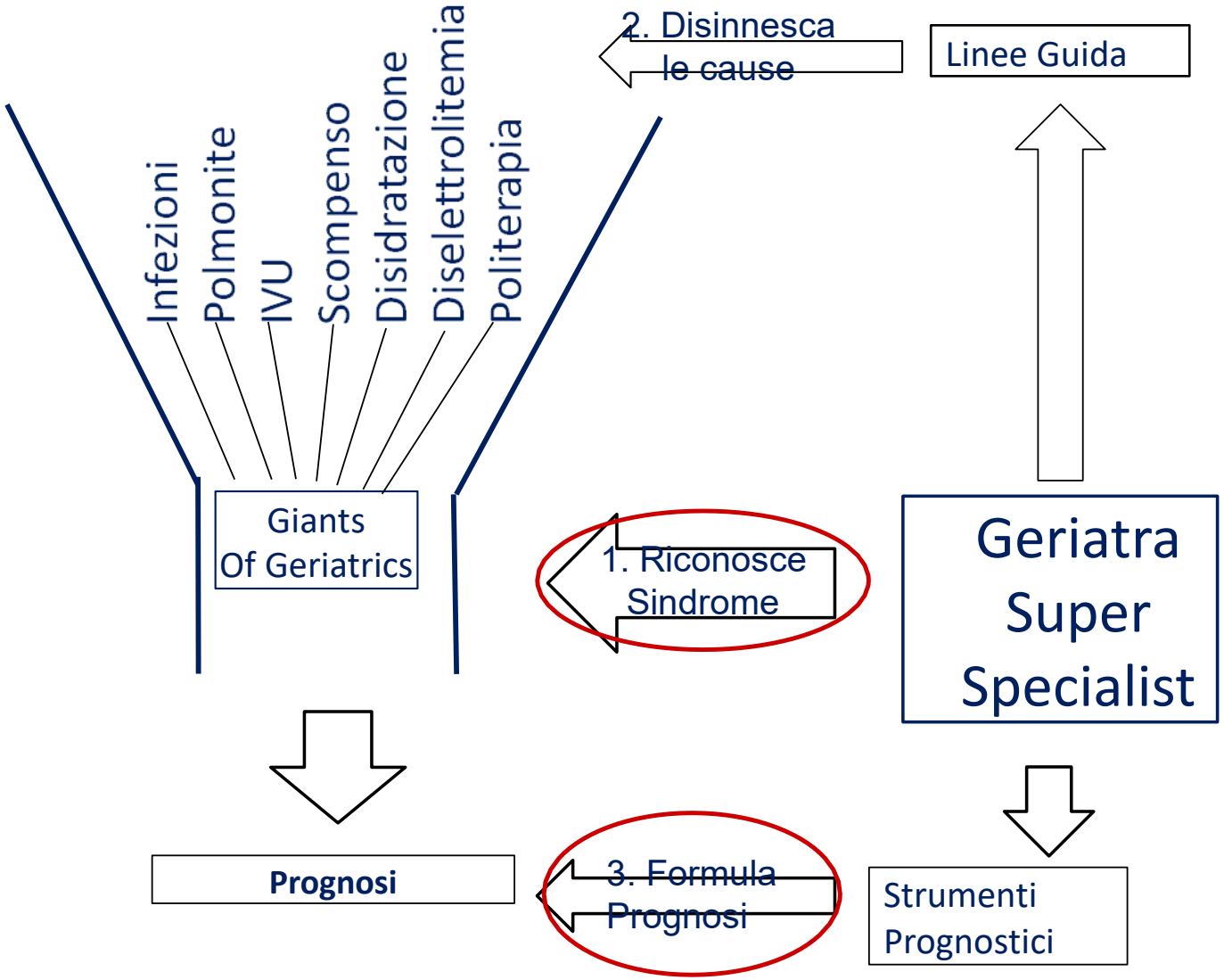

Age
Comorbities
Acute illness severitiy
....
Assessment
of
FRAILTY
Measurement
Always use the same validated tool:
Clinical Frailty Scale (CFS)
Fried's phenotype
Frailty Index
Hospital Frailty Risk Score
Interpretation
Fit or frail?
Taken into account
Low Risk Score
High Risk Score
Survival
Time
Potentially useful for:
Decision making
End of life
Time limited trial
Advanced care planning
Planning for rehabilitation / geriatric unit

Questione culturale



Tina Modotti: mani del burattinaio Louis Bunin Messico 1929

Tina Modotti: mani di un lavoratore dell'edilizia Messico 1926



I pazienti anziani e molto anziani con ipertensione tendono ad avere un rischio maggiore di effetti avversi della terapia antipertensiva: i farmaci devono essere iniziati e prolungati con cautela.

La misurazione della pressione arteriosa in posizione seduta e in piedi fa parte della procedura per i pazienti anziani, al fine di rilevare l'ipotensione ortostatica e prevenire le cadute.

Nel caso di pazienti fragili, l'indicazione o l'obiettivo pressorio dipende dall'entità della fragilità: il fattore decisivo è la massima conservazione possibile della qualità di vita.

Nei pazienti anziani e molto anziani in forma, mirare a un obiettivo di 130-139 mmHg di sistolica e 70-79 mmHg di diastolica. È importante che il farmaco antipertensivo sia ben tollerato.

Suggerimenti per ottimizzare la terapia nell'anziano (1)

- Per ciascun farmaco bisogna valutare il rapporto rischio/beneficio
- Rivedere tutti i farmaci assunti dal paziente ad ogni visita e le motivazioni della sua assunzione (vale la pensa proseguire il farmaco?)
- Considerare il rischio complessivo di danno potenziale farmaco-indotto
- Dare priorità alla sospensione di farmaci che presentano il rapporto beneficio/danno più basso e la più bassa probabilità di reazioni avverse da sospensione o sindromi da rimbalzo della malattia
- Implementare il regime di interruzione e monitorare i pazienti per migliorare i risultati o prevenire l'insorgenza di eventi avversi

Suggerimenti per ottimizzare la terapia nell'anziano (2)

- Studiare i possibili meccanismi di interazione farmaco-farmaco, farmaco-OCT, farmaco-alimenti, farmaco-malattia;
- prestare costante attenzione alla letteratura scientifica e rileggere periodicamente la scheda tecnica del farmaco;
- avere contezza del possibile ruolo dei sistemi informatici e della opportunità di promuovere un lavoro di squadra (medico-infermiere-farmacista);
- criteri di Beers e STOPP;
- ruolo della farmacogenomica

Impariamo a pensare un futuro aperto a cambiamenti radicali e a guardare lontano, sempre considerando le conoscenze del passato un "sapere fluido".

GRAZIE PER L'ATTENZIONE