



53° Congresso Nazionale  
Società Italiana di Gerontologia e Geriatria  
*"L'Italia? Non è un paese per vecchi..."*

**Firenze, 29 novembre 2008**

**Lettura AIP/SIGG**

# **Psicogeriatria e Medicina**

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## **Psicogeriatría e medicina:**

un messaggio sull'unità dell'approccio alla vita e alle malattie dell'anziano.

Il ruolo storico dell'**AIP** come ponte tra discipline diverse per riconoscere la centralità della cura.

# **L'atteggiamento del medico e il paziente psicogeriatrico**

- Scarsa attenzione
- Pessimismo
- Osservazione attenta e informata

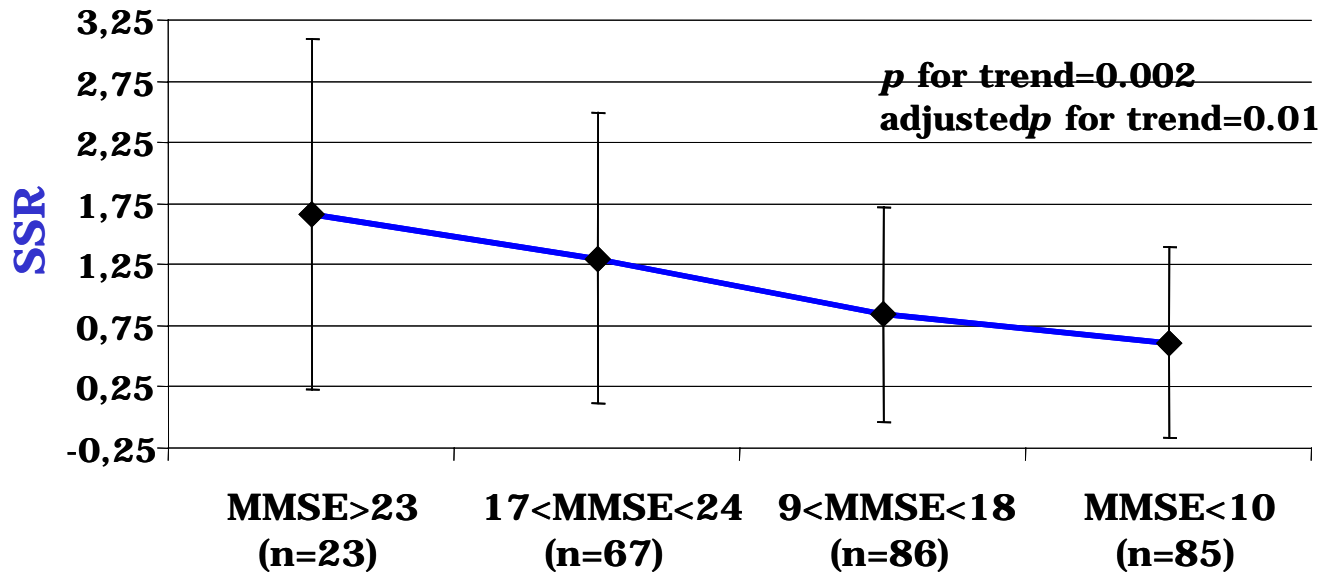
Il medico, un piccolo (grande) uomo che, dove  
guarda, vede.

La formazione clinica: bisogna conoscere l'uomo per riconoscere le tracce anche nelle forme più drammatiche.

# Narrative evidence based medicine

# Le **patologie somatiche** nel paziente affetto da demenza

## Numero di sintomi somatici (dolore e disagio) riferiti spontaneamente in un gruppo di 261 soggetti affetti da demenza



Adjusted *p* for trend: in un modello di regressione lineare multipla (aggiustato per età, depressione e comorbidità).

(Geroldi C. et al, 2000)

# Heart Failure and Risk of Dementia and Alzheimer Disease

## *A Population-Based Cohort Study*

Chengxuan Qiu, MD, PhD; Bengt Winblad, MD, PhD; Alessandra Marengoni, MD;  
Inga Klarin, MD; Johan Fastbom, MD, PhD; Laura Fratiglioni, MD, PhD

*Arch Intern Med.* 2006;166:1003-1008

Demographics, functional, biological, clinical, and cardiac (NYHA functional class, rhythm and echocardiographic characteristics) parameters of elderly patients affected by HF according to MMSE

	MMSE(21-23) N=70 (36%) Mean±SD (%)	MMSE≥24 N=125 (64%) Mean±SD (%)	p
Age (years)	83.0 ± 6.5	77.3 ± 7.2	<0.001
Female	39 (56)	95 (76)	<0.05
BSA (m2)	1.76 ±0.28	1.75±0.21	ns
Geriatric Depression Score (0-15)	4.7 ± 3.2	4.8 ± 3.6	NS
IADL (number of functions lost)	3.8 ± 2.8	1.7 ± 2.1	<0.001
BADL (Barthel Index) before admission	80.6 ± 21.4	93.8 ± 13.9	<0.001
BADL (Barthel Index) on admission	75.3 ± 24.8	89.0 ± 18.8	<0.001
Serum albumin (gr/dl)	4.1 ± .6	4.3 ± .5	<.01
C-reactive protein	2.0 ± 4.9	1.3 ± 2.0	NS
Charlson comorbidity score (0-33)	7.2 ± 1.6	6.5 ± 1.5	<.05
APACHE II score (0-71)	9.6 ± 5.7	7.5 ± 3.5	<.05
APS	2.2 ± 2.4	1.6 ± 1.9	NS
Number of drugs	4.9 ± 1.7	5.1±1.8	NS
<b>NYHA class III-IV</b>	31 (66)	39 (47)	<0.05
<b>EKG</b>			
Atrial fibrillation	36 (53%)	30 (24%)	<0.05
Heart rate (mean, in case of AF)	78±18	75±14	NS

(Sabatini T. et al, 2006)

**Mean MMSE values and dementia prevalence in a population of 709 hospitalized elderly patients grouped according to serum cholesterol levels.**

Cholesterol (mg/dl)	n	MMSE Mean (SD)	Dementia N (%)	OR	Dementia		
					Crude 95% C.I.	Adjusted* OR	Adjusted* 95% C.I.
<129	46	14.7 (11.6)	31 (67.4)	2.1	1.1-4.2	1.5	0.7-3.1
130-154	94	16.3 (10.9)	58 (61.7)	1.7	1.1-2.7	1.2	0.7-2.2
155-209	329	18.9 (9.6)	187 (56.8)	1.3	0.9-1.9	1.2	0.8-1.8
210-264	195	20.5 (9.1)	96 (49.2)	1.0	ref.	1.0	ref.
>265	45	20.0 (9.2)	23 (51.1)	1.1	0.6-2.1	0.9	0.4-1.8

\*Adjusted for age, sex, number of diseases, and disability.

(Rozzini R. et al, 2006)

# Angiotensin converting enzyme (ACE) inhibitors modulate the rate of progression of amnesic mild cognitive impairment

Luca Rozzini<sup>1,2\*</sup>, Barbara Vicini Chilovi<sup>1,2</sup>, Erik Bertoletti<sup>1</sup>, Marta Conti<sup>1</sup>, Ilenia Del Rio<sup>1</sup>, Marco Trabucchi<sup>2</sup> and Alessandro Padovani<sup>1</sup>

<sup>1</sup>*Department of Neurology, University of Brescia, Italy*

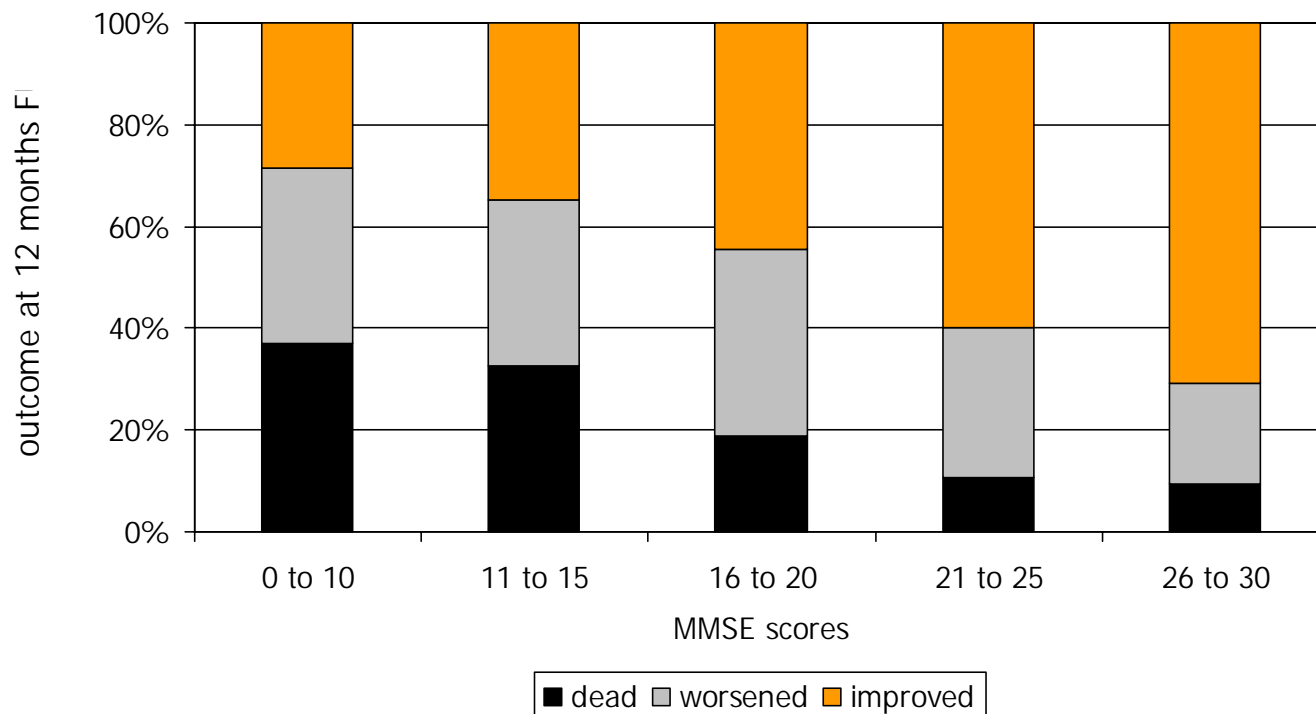
<sup>2</sup>*Geriatric Research Group, Brescia, Italy*

(Int J Geriatr Psychiatry 2006;21:550-555)

The increasingly solid evidence that exercise is associated with reductions in a variety of diseases, improvements in cognition and, based on the epidemiological literature, delays in the onset of age-related neurodegenerative diseases such as Alzheimer's and vascular dementia.

(Ann Neurol, 2007;62(2):A13-A14)

## Outcomes at 12-month follow-up in 316 elderly patients discharged from a RACU after hip fracture rehabilitation



## Caratteristiche funzionali e procedure riabilitative in 80 pazienti ortopedici raggruppati in base a deficit delle funzioni esecutive

	Totale N=80	Integrità funz. esecutive N=60	Deficit funz. esecutive N=20	p
<b>Sessioni di FKT (n°)</b>	33.8±10.1	32.5±8.7	37.9±12.9	.095
<b>Durata sessioni di FKT (minuti)</b>	49.3±11.1	49.0±10.3	50.3±13.6	.657
<b>N° procedure utilizzate</b>				
Complessità A	24.2±8.2	24.0±8.5	25.0±7.6	.663
Complessità B	41.8±10.2	41.4±10.7	43.0±8.2	.535
Complessità C	34.0±10.6	34.6±11.4	32.0±7.5	.352
<b>Difficoltà apprendim procedure/ausili (%)</b>	31.3	<b>25.0</b>	<b>50.0</b>	.029
<b>Ausilio alla dimissione (%)</b>				
1 canadese o un bastone	53.8	<b>63.3</b>	<b>25.0</b>	
2 canadesi	33.7	<b>26.7</b>	<b>55.0</b>	.012
Walker	12.5	<b>10.0</b>	<b>20.0</b>	
<b>Durata degenza (giorni)</b>	21.5±6.4	20.7±5.5	24.1±8.2	.095

# Shifts in Thinking About Dementia

Vladimir Hachinski

**Shift From Thresholds to a Continuum  
of Cognitive Impairment**

*JAMA*. 2008;300(18):2172-2173

La demenza e le patologie somatiche si modulano reciprocamente: un'attenzione con vari livelli di intensività.

# **Depressione dell'anziano e salute somatica**

Depression is a disease at least on a par with physical chronic diseases in damaging health.

*Lancet* 2007; 370: 851-58 |

# **Gender and depression**

	Total (N=4228)	Females (N=2599)	Males (N=1629)	p
	N (%) / M ± sd	N (%) / M ± sd	N (%) / M ± sd	
Age	79.1 ± 7.9	80.2 ± 7.6	77.2 ± 8.1	.000
Living alone	1045 (24.8)	807 (31.2)	238 (14.6)	.000
Geriatric Depression Scale-GDS*	4.6 ± 3.5	5.1 ± 3.6	3.6 ± 3.2	.000
Depressed (GDS 5+)	1112 (34.8)	807 (40.5)	305 (25.4)	.000
Mini Mental State Examination-MMSE	21.8 ± 8.4	21.4 ± 8.4	22.6 ± 8.4	.000
Severe Dementia (MMSE < 18)	998 (24.3)	673 (26.4)	315 (20.7)	.000
Cumulative Delirium	633 (15.0)	360 (13.9)	273 (16.8)	.016
IADL functions lost (2 wks pre adm.)	3.2 ± 2.9	3.7 ± 2.1	2.3 ± 2.4	.000
IADL functions lost (2+)	3050 (72.2)	2041 (78.6)	1009 (62.1)	.000
Barthel Index (2 wks before adm.)	79.0 ± 27.7	78.2 ± 27.7	80.2 ± 27.8	.024
Barthel Index (on admission)	60.3 ± 37.8	61.1 ± 36.1	59.1 ± 39.2	.098
Funct. status change (before and on adm.)				
Loss of 5+ points in Barthel index score	1907 (45.2)	1132 (43.6)	775 (47.7)	.005
Barthel Index (on discharge)	68.2 ± 35.1	68.2 ± 34.3	68.2 ± 36.3	.987
Charlson score	5.2 ± 1.8	5.1 ± 1.7	5.5 ± 1.9	.000
Charlson score (4+)	1619 (38.3)	895 (34.4)	724 (44.5)	.000
APACHE II score	10.5 ± 5.8	9.1 ± 5.6	11.3 ± 6.0	.000
Acute Physiology Score-APS	4.3 ± 5.0	3.8 ± 4.8	5.0 ± 5.3	.000
APS (4+)	1817 (43.1)	999 (38.5)	818 (50.3)	.000
Serum albumin	3.7 ± 0.7	3.7 ± 0.6	3.6 ± 0.7	.001
Serum albumin (< 3.5g/dl)	1552 (37.3)	912 (35.7)	640 (40.0)	.005
Drugs (n)	5.6 ± 2.9	5.4 ± 2.7	6.3 ± 3.1	.002
Drugs (7+)	985 (33.0)	492 (27.7)	493 (40.8)	.000
Respiratory (pneumonia, COPD)	(21.8)	(18.4)	(27.3)	.000
Diabetes Mellitus	(21.5)	(22.2)	(20.4)	.087
Cardiovascular	(16.3)	(14.1)	(19.9)	.000
Major Stroke	(12.5)	(12.1)	(13.1)	.181
Cancer (with metastasis)	(6.3)	(5.0)	(8.5)	.000
Cancer (without metastasis)	(3.3)	(3.7)	(5.3)	.013
Liver Cirrhosis	(4.5)	(4.3)	(4.6)	.321
Length of stay (days)	6.5 ± 4.1	6.5 ± 3.9	6.6 ± 4.3	.451
DRG Weight	1.29 ± 1.3	1.20 ± 1.1	1.45 ± 1.6	.000
In hospital mortality	271 (6.4)	141 (5.4)	130 (8.0)	.001

Gender differences in 4228 hospitalized elderly patients

(Rozzini R. et al, 2007)

## HIP FRACTURE AND DEPRESSION IN ELDERLY PATIENTS: IS THERE A SEX EFFECT?

### Association Between Hip Fracture and Depression in 766 Elderly Patients Admitted to a Geriatric Rehabilitation Unit

	Total (N = 766)	Women (n = 565)	Men (n = 201)
Fracture Status	n/N (%)		
Not fractured	286/623 (45.9)	219/439 (49.9)	67/184 (36.4)
Fractured	68/143 (47.5)	57/126 (45.2)	11/17 (64.7)

Data are expressed as number of depressed patients over the total number of subjects for each specific group.

(Rozzini R. et al, JAGS 2007;55:1688)

## Rate of antidepressant prescriptions according to age, gender and living site

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	Age groups				total
	<65	65-74	74-84	>84	
	N=875.806	N=106.408	N=68.693	N=19.917	
	%	%	%	%	%
Males	2,5	7,2	12,3	15,5	3,5
Females	5,2	13,9	19,7	19,8	7,7
Urban	4,3	11,8	19,1	22,5	6,8
Suburban	3,7	10,6	16,3	17,5	5,3
Total	3,8	10,8	17,0	18,8	5,7

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% refers to the total number of citizens in each age group (N)

(Rozzini R. et al, 2007)

Le differenze di sesso come strumento per la comprensione del rapporto biunivoco depressione-patologia somatica; l'uomo è più fragile, solo apparentemente più difeso.

# **La struttura clinica della depressione**

Il problema è chiarire se la depressione sia una **comorbidità**, la cui rilevanza potrebbe essere smascherata da una malattia fisica, oppure una condizione psicologica **indicatore di fragilità**, spia di un'incapacità a far fronte ad un evento stressante.

Nel primo caso il trattamento farmacologico potrebbe essere efficace, nel secondo, inutile o negativo.

(R.Rozzini & M.Trabucchi, Arch Int Med, 2003; 163:498-499)

The crucial question is if whether older persons hospitalized for somatic diseases with associated depressive symptoms (i.e., minor depression) derive benefits from drug treatment, as demonstrated for patients affected by major depression, or whether depressive burden is a marker of frailty, revealing the lack of psychic competence toward a distressful event, which is likely to be insensitive to antidepressant drug treatment.

(Rozzini R et al, J Gerontol: Med Sci, 2007;62:796-798)

# Depression Screening and Patient Outcomes in Cardiovascular Care

## A Systematic Review

**Results** We identified 11 studies about screening accuracy, 6 depression treatment trials, but no studies that evaluated the effects of screening on depression or cardiovascular outcomes. In studies that tested depression screening instruments using a priori-defined cutoff scores, sensitivity ranged from 39% to 100% (median, 84%) and specificity ranged from 58% to 94% (median, 79%). Depression treatment with medication or cognitive behavioral therapy resulted in modest reductions in depressive symptoms (effect size, 0.20-0.38;  $r^2$ , 1%-4%). There was no evidence that depression treatment improved cardiac outcomes. Among patients with depression and history of myocardial infarction in the ENRICH trial, there was no difference in event-free survival between participants treated with cognitive behavioral therapy supplemented by an antidepressant vs usual care (75.5% vs 74.7%, respectively).

**Conclusions** Depression treatment with medication or cognitive behavioral therapy in patients with cardiovascular disease is associated with modest improvement in depressive symptoms but no improvement in cardiac outcomes. No clinical trials have assessed whether screening for depression improves depressive symptoms or cardiac outcomes in patients with cardiovascular disease.

*JAMA*. 2008;300(18):2161-2171

[www.jama.com](http://www.jama.com)

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Le difficoltà nel comprendere il rapporto tra depressione e patologia somatica. La sordità dei medici.

“This is effectively the equivalent of saying that people with a diagnosis of diabetes are just a little bit “oversugary” and making them feel bad about taking insulin”.

(Manning CL, BMJ, 2007;335:413)

La maturazione di ogni medico è un processo lento e profondo, ma alla fine la lettura di se stessi permette un aiuto all'altro che soffre. Perché anche nei momenti più drammatici la pietà suggerisce le strade che il medico deve percorrere, superando qualsiasi legge o regolamento formale. Perché forse non conosce i criteri teorici che taluno ritiene siano i regolatori della dignità del vivere, ma certamente conosce i modi concreti per accompagnare e prendersi cura, qui e ora, prima di qualsiasi altro compito. E il paziente sente che in queste circostanze non deve temere.