SOCIETÀ ITALIANA DI GERONTOLOGIA E GERIATRIA

ASSOCIAZIONE ITALIANA PSICOGERIATRIA

Congresso Nazionale SIGG Firenze, 2 dicembre 2010

Riabilitare l'anziano depresso

Giuseppe Bellelli

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Gruppo di Ricerca Geriatrica, Brescia

Perché non possiamo non occuparci di depressione in riabilitazione (geriatrica): le motivazioni di carattere generale

Table 6. Association of Predictive Variables with Mortality in Men in the ILSA Cohort

	Mortality for All Causes ($N = 523$)	Mortality for Diseases of Circulatory System ($N = 185$)
	HR (95% CI)	HR (95% CI)
Age	2.47 (1.85–3.28)	4.59 (2.62–8.07)
Claudication		1.64 (0.90–2.99)
Diabetes	1.27 (0.89–1.79)	
Congestive heart failure	2.19 (1.54–3.12)	2.01 (1.06–3.83)
Stroke		2.78 (1.63–4.73)
Fibrinogen	1.71 (1.31–2.23)	
DS	2.02 (1.58–2.58)	2.49 (1.60–3.87)

Note: ILSA = Italian Longitudinal Study on Aging; HR = hazard ratio; CI = confidence interval; DS = depressive symptomatology.

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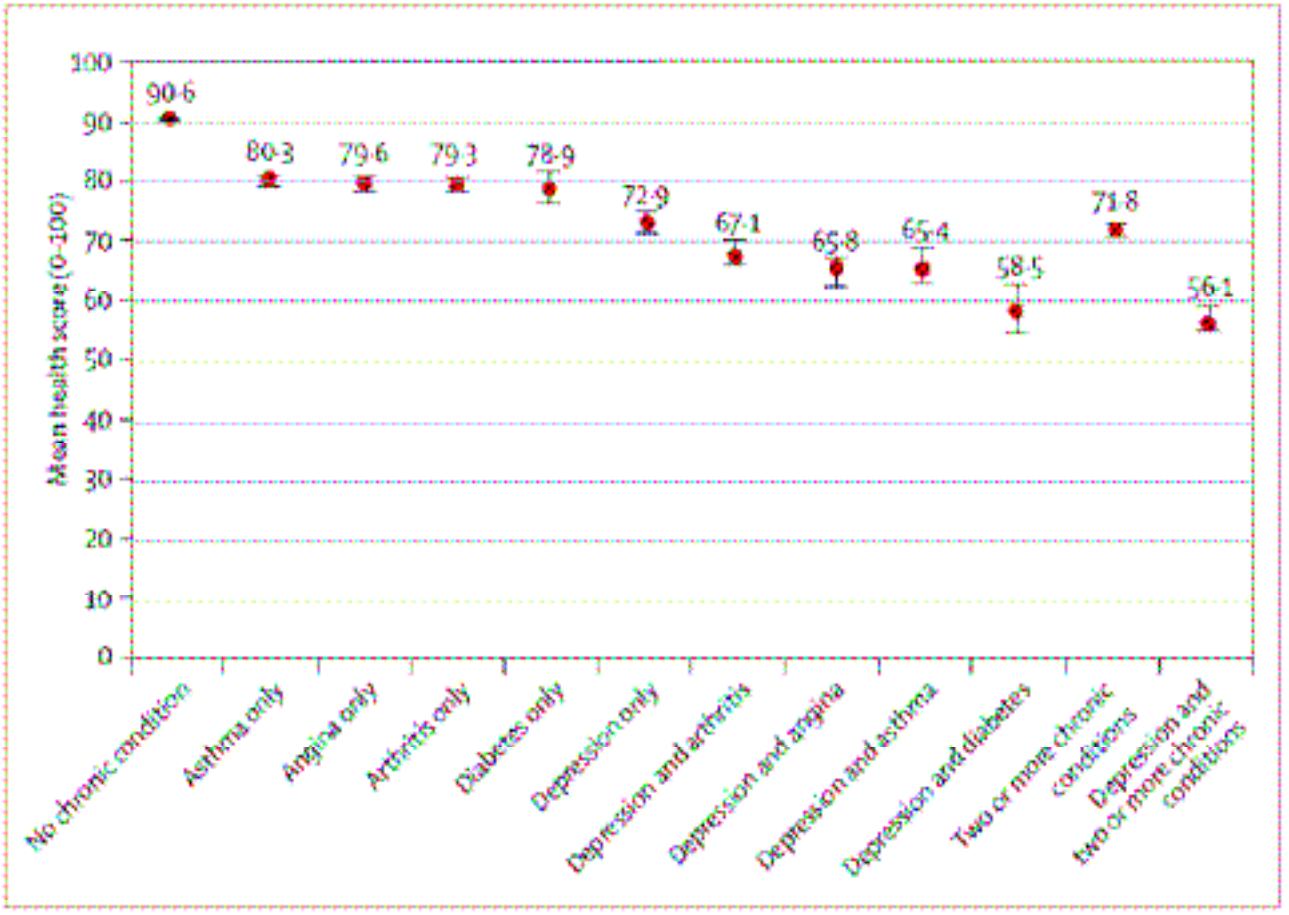
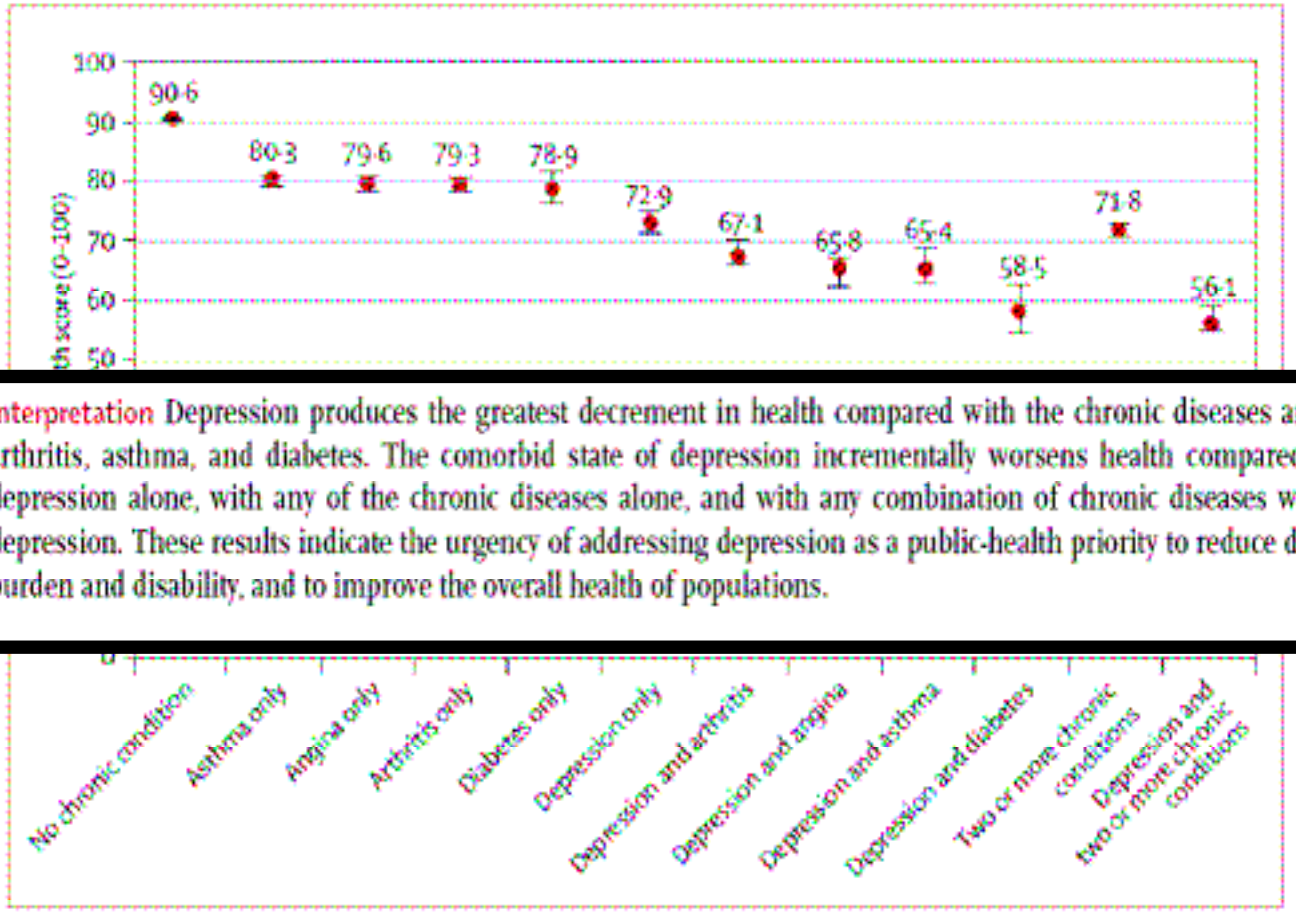


Figure: Global mean health by disease status
Data from WHS 2003.

Moussavi S et al, Lancet 2007; 370:851-58



Interpretation Depression produces the greatest decrement in health compared with the chronic diseases angina, arthritis, asthma, and diabetes. The comorbid state of depression incrementally worsens health compared with depression alone, with any of the chronic diseases alone, and with any combination of chronic diseases without depression. These results indicate the urgency of addressing depression as a public-health priority to reduce disease burden and disability, and to improve the overall health of populations.

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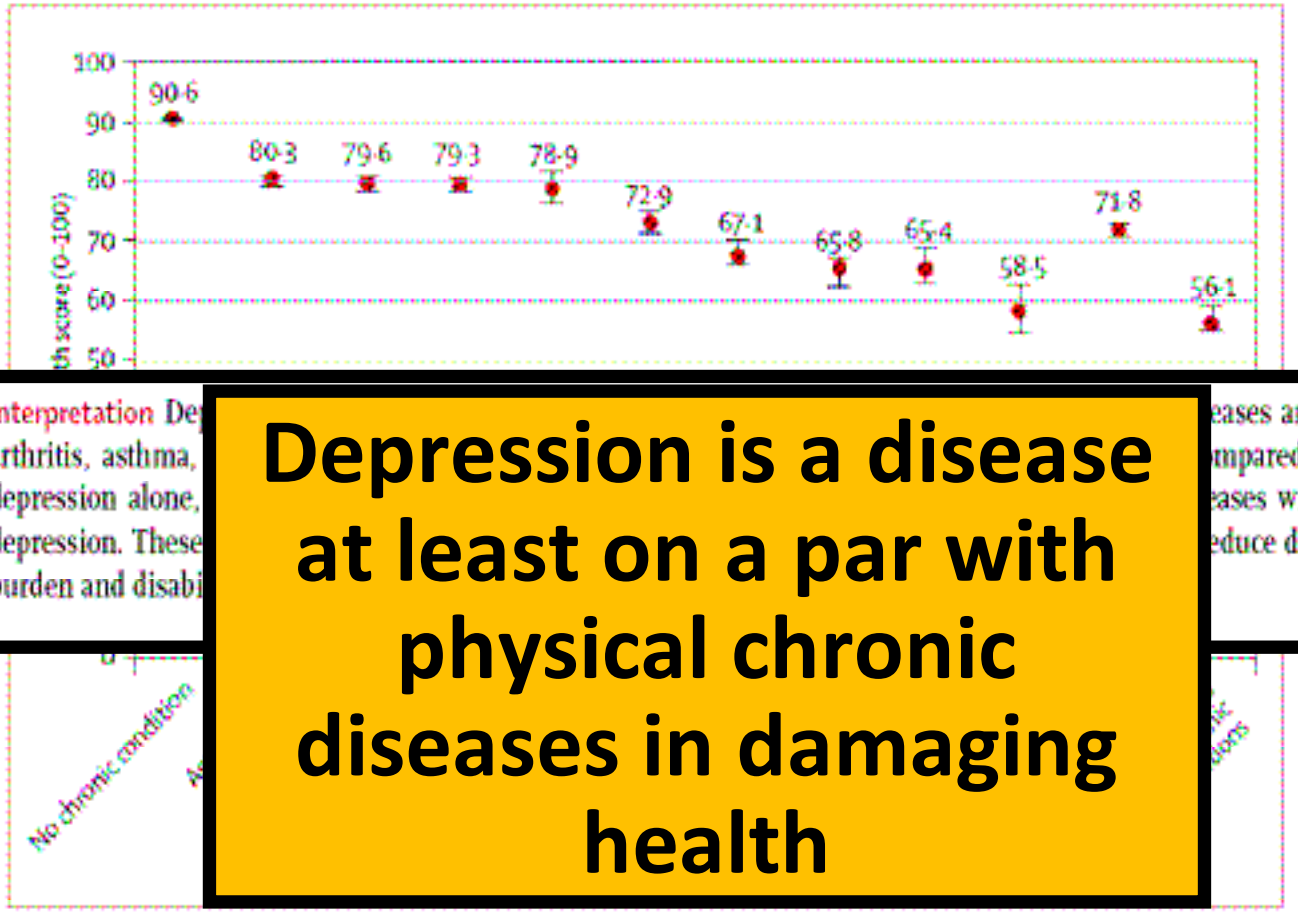

Interpretation De… arthritis, asthma, depression alone, depression. These… burden and disabi… …eases angina, …mpared with …eases without …educe disease

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

Figure: Global mean health by disease status
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La frattura di femore è una condizione predisponente lo sviluppo di depressione

- Subthreshold symptoms of depression, anxiety, pain, and cognitive impairment at baseline, the premorbid level of mobility, and a history of (treated) depression are risk factors for **incident depression after hip fracture.**
- Incident depression was associated with a less favorable outcome at 3 months follow-up.

Voshar R et al, Am J Geriatr Psychiatry 2007; 15:807–814

Perché non possiamo non occuparci di depressione in riabilitazione (geriatrica): le motivazioni di tipo epidemiologico

Prevalence of depression in hip fracture patients

Author(s)	n	Mean age (yr)	Exclusions	Case-finding instrument	Prevalence (%)	Comment
Levitan et al.,'81	24	N/A	--	DSM-III	36	Anxiety 29%
Sharmash et al., '92	50	80	< 60 years	HAS	26	--
Billig et al., '86	50	80	--	GHQ, ZSRDS, DSM-III	28	Dual diagnosis in >50%
Holmes, '96	50	81	--	GMS	16	--
Lyons et al., '89	69	78	MMSE <21	GDS-30	47	High prevalence with 10/11 cut off
Strain et al., '91	139	N/A	--	GDS-30 DSM-III	9	Included adjust disord.
Shepherd, '92	270	81	--	GDS-15	33	Prevalence approximated
Magaziner et al., '90	424	N/A	Severe dementia, NH	CES-D	32	Only 49% given CES-D

Modified from Holmes et al, Age Ageing 2000

Modificazioni delle caratteristiche di utenza negli anni 2003, 2005 e 2007 (Dipartimento di riabilitazione, Ancelle della Carità Cr)

	2003	2005	2007
	Media ± DS (%)	*Media ± DS (%)*	*Media ± DS (%)*
GDS	6,1 ± 3,6	5,8 ± 3,3	6,1 ± 3,7
Depressione assente (GDS < 6/15)	(60,0)	(60,0)	(57,7)
Depressione presente (GDS > 6/15)	(40,0)	(40,0)	(42,3)
BMI (kg/cm^2)	24,4 ± 4,9	25,7 ± 5,4	24,2 ± 5,6
CCI	2,7 ± 2,2	2,5 ± 2,0	–
CIRS Severità (IDS)	–	–	1,8 ± 0,3
CIRS Comorbilità (IDC)	–	–	4,2 ± 1,9
Barthel Index pre-ammissione (0-100)	81,8 ± 22,0	83,5 ± 21,1	80,8 ± 22,3
Barthel Index ingresso	55,6 ± 27,7	56,6 ± 26,0	55,1 ± 27,9
Barthel Index dimissione	74,0 ± 5,7	77,7 ± 25,2	72,6 ± 27,9
Eventi clinici avversi	0,5 ± 0,9	0,5 ± 0,9	0,7 ± 1,0
Nessun evento avverso	(63,4)	(65.5)	(59,5)
1 evento avverso	(25,0)	(21.3)	(21,7)
≥ 2 eventi avversi	(11,6)	(13.2)	(18,7)

Bellelli e Trabucchi, Riabilitare l'anziano, 2009

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La depressione è un marcatore di disabilità futura

Variable	Odds Ratio	Wald Confidence Intervals (95%)	*p* value
Model 1 (n=266)			
Subjective Current Health	.47	.28 - .79	.004*
Depressive Symptoms (HDRS)	1.12	1.02 - 1.25	.024*
Intercept	.434	-	.243
Model 2 (n=245)			
Subjective Current Health	.53	.29 -.98	.042*
Somatic Subscale (HDRS)	1.19	1.04 -1.38	.015*
# of ADL Limitations	1.63	1.10 -2.39	.014*
Change in # of ADL Limitations	1.59	1.07 -2.35	.022*
Intercept	.191	-	.062

Weinberger M et al, Am J Geriatr Psychiatry. 2009; 17: 802–809

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both persistent and new onset disability increase the risk of depression at 1-year

Weinberger M et al, Am J Geriatr Psychiatry. 2009; 17: 802–809

Perché non possiamo non occuparci di depressione in riabilitazione (geriatrica): le motivazioni di tipo organizzativo

Depressive Symptoms as a Predictor of 6-Month Outcomes and Services Utilization in Elderly Medical Inpatients

Christophe J. Bula, MD; Vincent Wietlisbach, BA; Bernard Burnand, MD; Bertrand Yersin, MD

Table 1. Results From Bivariate and Multivariate Cox Proportional Hazard Regression Analysis Predicting 6-Month Risk of Hospital Readmission*

Characteristic	Unadjusted HR (95% CI)	*P* Value	Adjusted HR (95% CI)	*P* Value
Abnormal GDS score (≥6)	1.57 (1.08-2.26)	.02	1.50 (1.03-2.17)	.03
Comorbid illness (per point)†	1.14 (1.02-1.30)	.03	1.12 (1.00-1.26)	.06

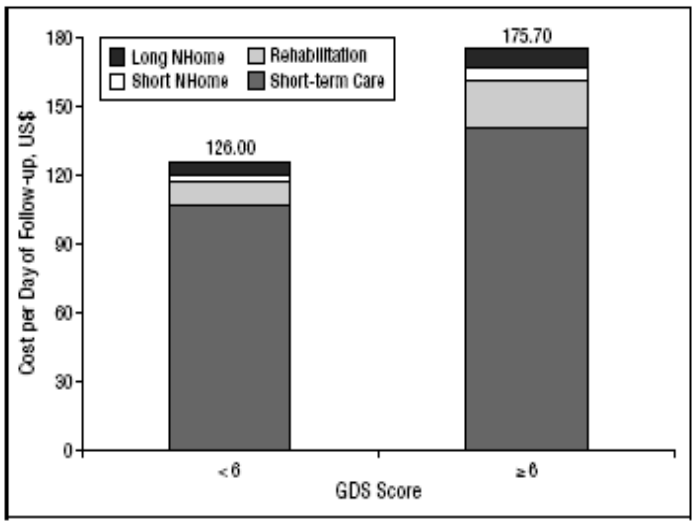

Figure 2. Average costs per day of follow-up and type of inpatient stay for subjects with depressive symptoms (Geriatric Depression Scale [GDS] ≥6) vs without depressive symptoms (GDS, <6). Long NHome indicates permanent nursing home placement; short NHome, short stay in a nursing home.

Arch Intern Med. 2001;161:2609-2615

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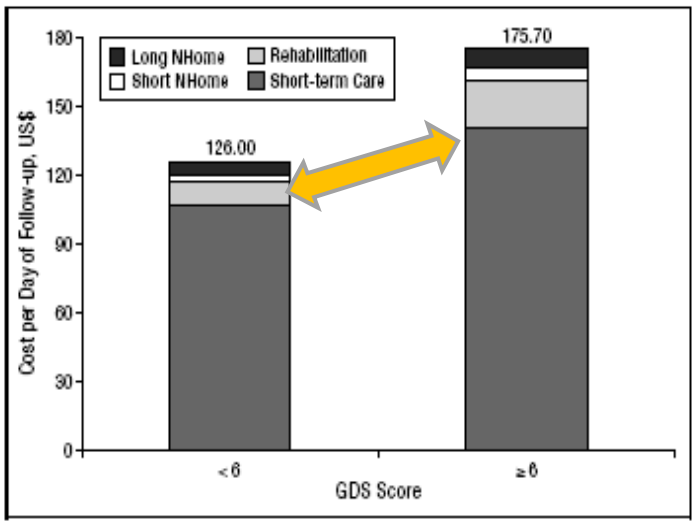

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La sintomatologia depressiva condiziona l'accesso ai servizi di riabilitazione

Table 3. Hospital outcome by GDS-15 score

	Discharge destination				
GDS-15 score	Usual residence	Care home	Other hospital	Community hospital	Death
0–4	290 (83.5%)	8 (2.5%)	16 (4.5%)	14 (4.0%)	19 (5.5%)
5–7	101 (76.0%)	0 (0.0%)	4 (3.0%)	8 (6.0%)	20 (15.0%)
8–10	61 (68.5%)	2 (2.5%)	6 (6.5%)	9 (10.0%)	11 (12.5%)
11–15	30 (62.5%)	1 (2.0%)	6 (12.5%)	5 (10.5%)	6 (12.5%)
Total	482 (78.0%)	11 (2.0%)	32 (5.0%)	36 (6.0%)	56 (9%)

Odds of hospital outcome by GDS-15 score

Cullum S et al, Age Ageing 2008

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Odds of hospital outcome by GDS-15 score

Cullum S et al, Age Ageing 2008

Rehabilitation Therapists' Recognition of Cognitive and Mood Disorders in Geriatric Patients

Robert Ruchinskas, PsyD

Objective: To determine if physical and occupational therapists can recognize 2 known predictors of rehabilitation outcome, cognition and mood, in their geriatric patients.

Design: Survey.

Setting: Urban academic medical center rehabilitation unit.

Participants: One hundred two consecutive geriatric admissions rated by 20 physical and 8 occupational therapists for the presence of cognitive or affective disorders.

Interventions: Not applicable.

Main Outcome Measures: Mini-Mental State Examination, Geriatric Depression Scale, and therapists' ratings.

Results: Both disciplines had low rates of accurate detection of both cognitive abnormalities and symptoms of depression. Patients scoring in the intact range of either domain were more likely to be correctly identified by the therapists than were patients whose results were possibly or probably impaired.

Conclusion: Rehabilitation therapists had difficulty recognizing patients with cognitive and affective disorders. I recommend including a mental health professional on the treatment team, staff inservicing, and/or the use of standardized measures of mood and mental status to increase recognition of these syndromes in geriatric rehabilitation patients.

Table 2: Agreement Between Physical and Occupational Therapists' Ratings and Group Classification by the GDS

	Group		
	Probable Depression	Possible Depression	No Depression
PT ratings (%)	3/8 (13)	29/122	68/88 (88)
OT ratings (%)	0/8 (0)	9/91 (11)	68/86 (88)

Table 4: Mean GDS Score of Groups Rated as Not Depressed, Possibly Depressed, and Probably Depressed by Therapists

	Group		
	Not Depressed	Possibly Depressed	Probably Depressed
Physical therapy	6.27	8.61	8.38
Occupational therapy	5.09	8.13	4.50
Actual GDS score	0.34	10.69	16.38

Arch Phys Med Rehab, 2002

Ma si può (è possibile) riabilitare un anziano depresso?

Elderly Patients with Hip Fracture with Positive Affect Have Better Functional Recovery over 2 Years

Lisa Fredman, PhD, William G. Hawkes, PhD,† Sandra Black, PhD,† Rosanna M. Bertrand, PhD,* and Jay Magaziner, PhD, MSHyg†*

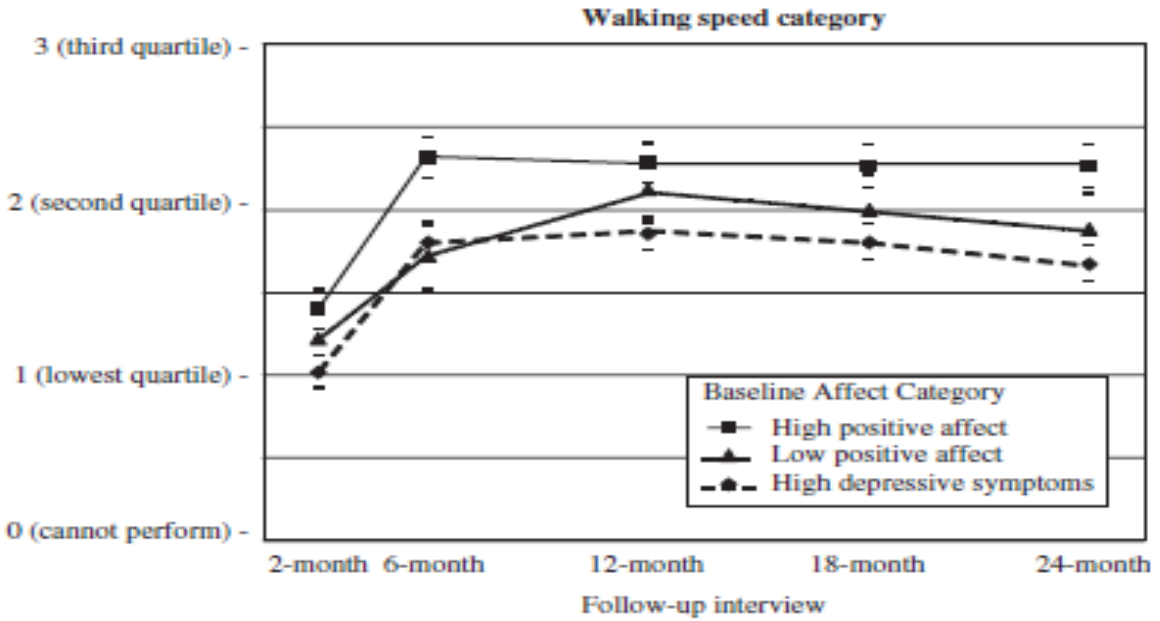
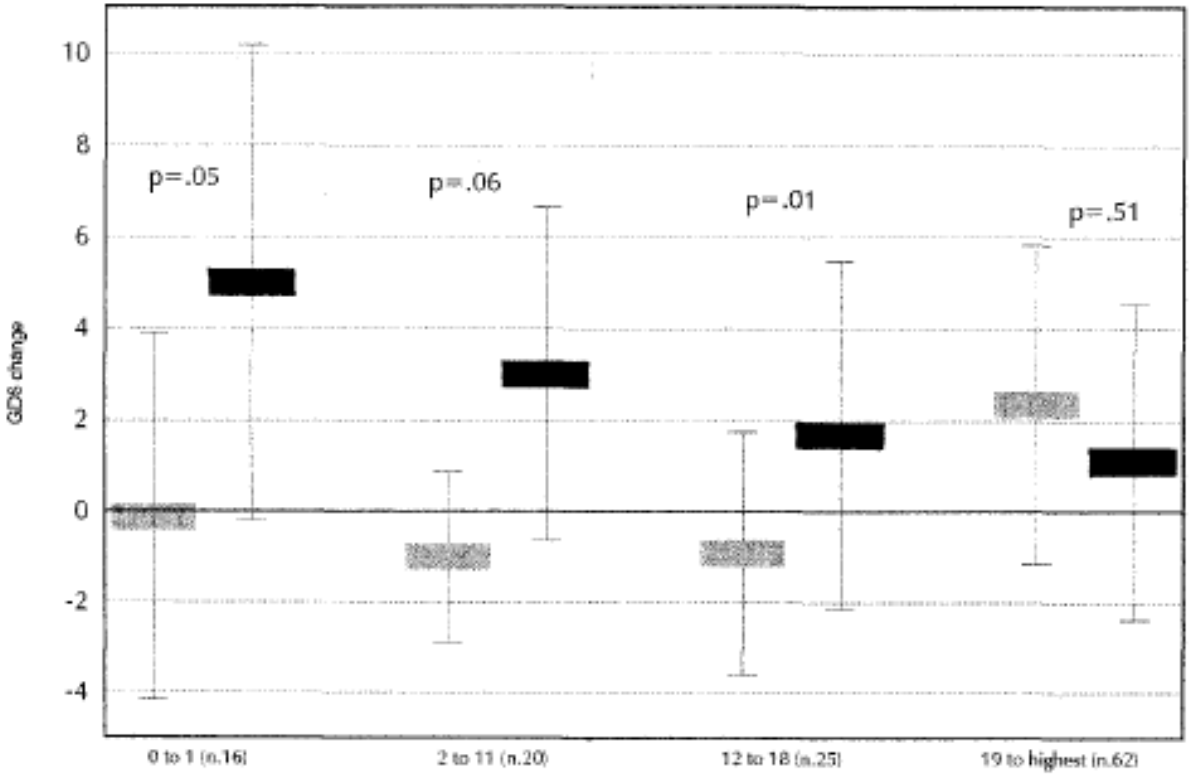


Figure 1. Adjusted usual walking speed, based on five-level ordinal variable, over 24 months after hip fracture.

Mood Improvement in Elderly Women After In-Hospital Physical Rehabilitation

Piera Barbisoni, MD, Bruno Bertozzi, MD, Simone Franzoni, MD, Renzo Rozzini, MD, Giovanni B. Frisoni, MD, Marco Trabucchi, MD

Arch Phys Med Rehabil Vol 77, April 1996



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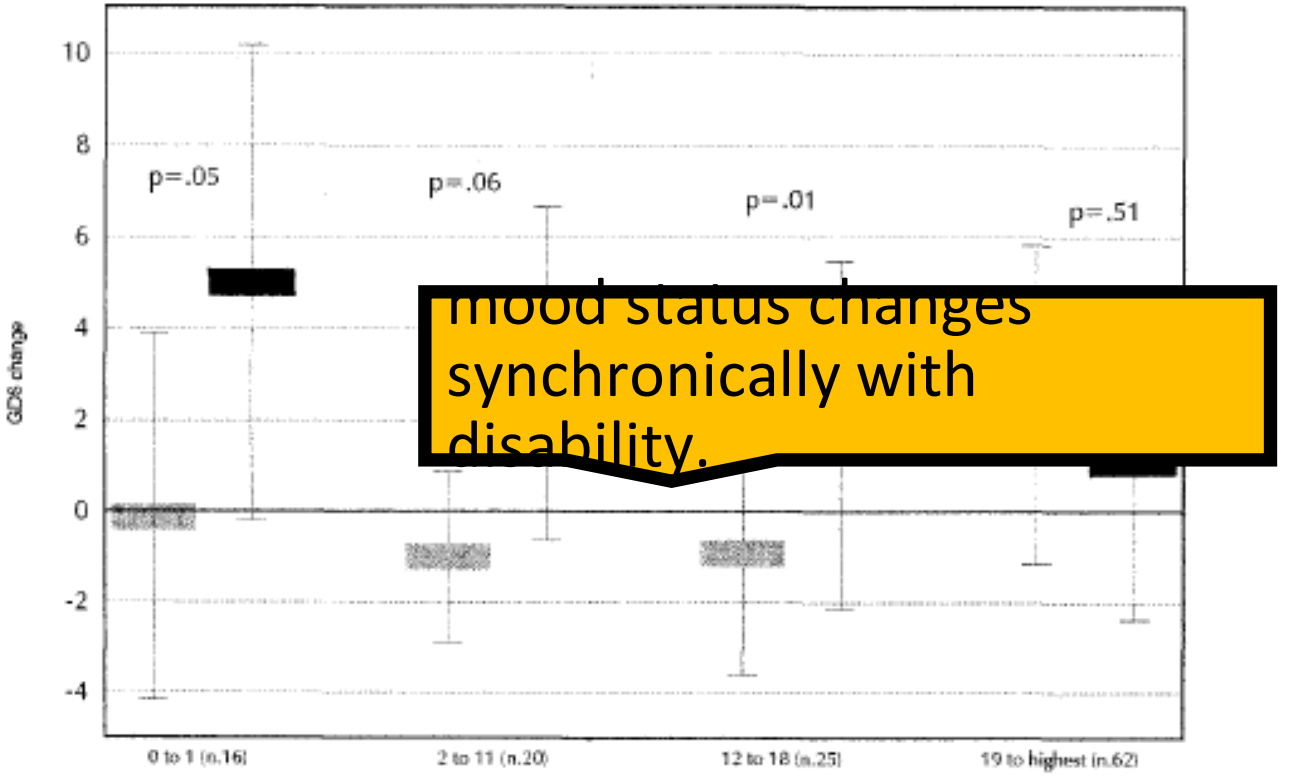

mood status changes synchronically with disability.

ORIGINAL ARTICLE

Factors Affecting Short-Term Rehabilitation Outcomes of Disabled Elderly Patients With Proximal Hip Fracture

Avital Hershkovitz, MD, MHA, Zulicha Kalandariov, MD, Vered Hermush, MD, Rooi Weiss, MD, Shai Brill, MD, MPH

Table 6: Multiple Linear Regression Analysis of Significant Admission and Rehabilitation Predictors of LOS[a]

Predictors	Standardized Coefficient	Standard Error	P
Depression	.284	0.297	.004
MMSE score	−.266	0.214	.007
Albumin level	−.217	3.730	.026

[a] $r^2 = .189$.

Archives of Phys Med Rehab 2007

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*r² = .18

Cognitive function, nutritional status, preinjury functional level, and **depression** were the most important prognostic factors associated with rehabilitation success of older patients with proximal hip fracture.

Archives of Phys Med Rehab 2007

Geriatric Depression, Medical Diagnosis, and Functional Recovery During Acute Rehabilitation

Jeffrey A. Cully, PhD, Jeffrey D. Graham, PhD, Richard A. Heise, PhD, Michael J. Ross, PhD, Cayla R. Teal, PhD, Mark E. Kunik, MD, MPH

Table 2: ANCOVA for Depression and Diagnosis

Source	df	Mean Square	F	Partial η^2
FIM self-care discharge score (n=421)				
LOS	1	42.69	4.60	.011
Age	1	38.64	4.17*	.010
Sex	1	22.82	2.46	.006
Self-care admission score	1	3459.27	373.07†	.475
Diagnosis‡	1	3.54	0.38	.001
Depression	1	91.64	9.88†	.023
Diagnosis by depression	1	20.90	2.25	.005
Error	413	9.27		
FIM body mobility discharge score (n=420)				
LOS	1	139.66	6.72†	.016
Age	1	36.48	1.77	.004
Sex	1	9.66	0.47	.001
Body mobility admission score	1	6821.69	330.76†	.445
Diagnosis‡	1	46.45	2.25	.005
Depression	1	214.02	10.39†	.025
Diagnosis by depression	1	11.56	0.56	.001
Error	412	20.63		

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In stroke and non stroke patients depressive symptoms are related to functional recovery across multiple domains and especially for sphincter control, self-care, and body mobility.

La depressione non impatta sugli outcome in riabilitazione

ORIGINAL ARTICLE

Inpatient Rehabilitation Outcome After Hip Fracture Surgery in Elderly Patients: A Prospective Cohort Study of 946 Patients

Devora Lieberman, MD, Michael Friger, PhD, David Lieberman, MD

Arch Phys Med Rehabil 2006;87:167-71.

Gen Hosp Psychiatry. 2007 ; 29(2): 141–146.

Does depression, apathy, or cognitive impairment reduce the benefit of inpatient rehabilitation facilities for elderly hip fracture patients?

Eric J. Lenze, M.D.[1,2], Elizabeth R. Skidmore, Ph.D.[3], Mary Amanda Dew, Ph.D.[1], Meryl A. Butters, Ph.D.[1], Joan C. Rogers, Ph.D.[3], Amy Begley, M.A.[1], Charles F. Reynolds III, M.D.[1], and Michael C. Munin, M.D.[2]

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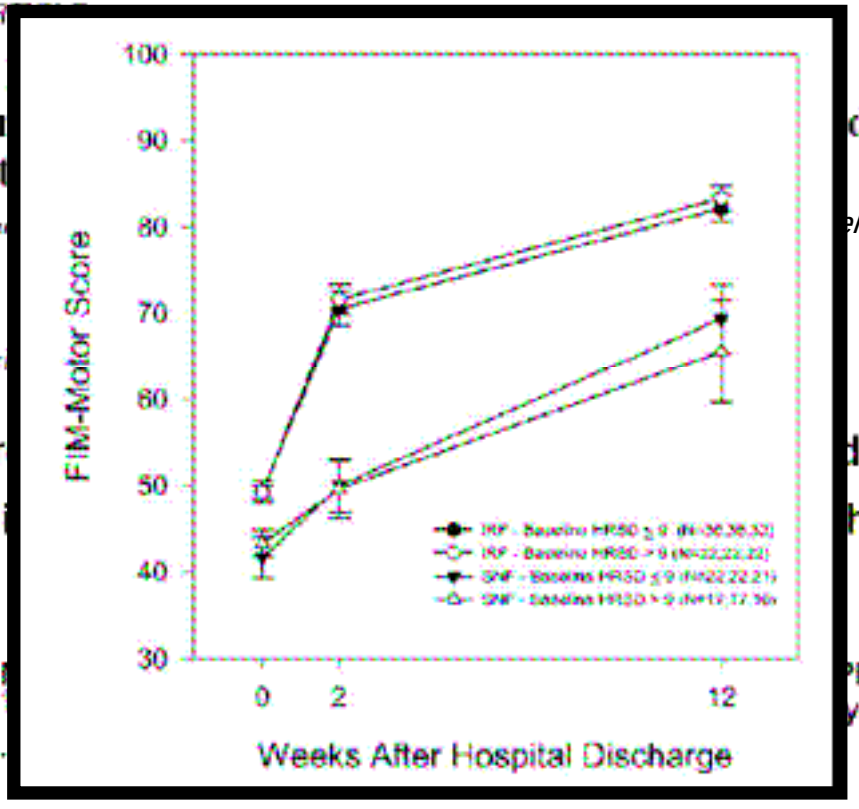

Le possibili interpretazioni

- L'effetto della depressione sugli outcome è variabile in funzione del tempo
- La gravità dei sintomi depressivi (e/o della sindrome depressiva) è più importante della loro presenza/assenza
- La complessità il fenomeno «depressione»: non cogliamo il problema nelle sue sfaccettature e probabilmente definiamo depressione qualcosa che ne è profondamente diverso

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The role of depressive symptoms in recovery from injuries to the extremities in older persons. A prospective study

Gertrudis I. J. M. Kempen[1]*, Robbert Sanderman[2], Winnie Scaf-Klomp[2] and Johan Ormel[3]

Table 3. Hierarchical multiple regression analyses: disability at baseline, depressive symptoms at baseline, age, gender, chronic medical morbidity, level of injury, cognitive functioning 8 weeks post-injury and depressive symptoms 8 weeks post-injury on disability at 8 weeks, 5 months and 12 months post-injury

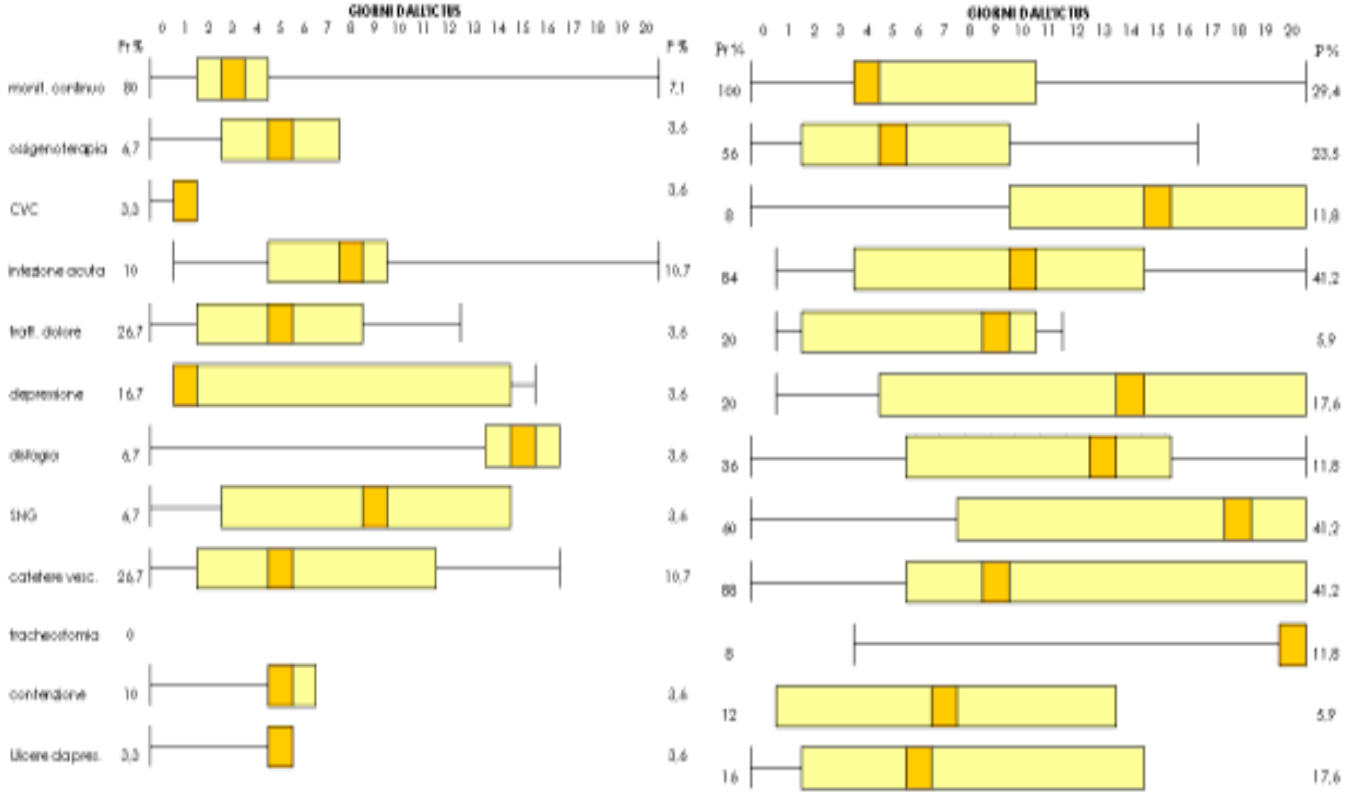
	Level of Disability[a]											
	8 weeks post-injury				5 months post-injury				12 months post-injury			
	β	p-value	β	p-value	β	p-value	β	p-value	β	p-value	β	p-value
Disability at baseline[a]	0.509	0.000	0.479	0.000	0.593	0.000	0.570	0.000	0.559	0.000	0.542	0.000
Depressive symptoms at baseline[b]										0.361	−0.053	0.459
Age										0.002	0.197	0.001
Gender (1 = male, 2 = female)										0.032	0.113	0.049
Number of chronic medical conditions										0.315	0.044	0.452
Level of injury[c]										0.049	−0.113	0.049
Cognitive functioning 8 weeks post-injury[a]										0.268	−0.060	0.327
Depressive symptoms 8 weeks post-injury[b]											0.147	0.032
R^2											0.541	
F-value										0.000	23.7	0.000
R^2 change											0.013	
F-change											4.7	0.032

β, Standardised regression coefficient; R^2, Amount
[a]Higher scores indicate poorer function.
[c]1 = hip fracture, 2 = other fracture, 3 = any fracture.
[b]Higher scores indicate better function.

Non è tanto la sintomatologia depressiva a determinare il mancato recupero funzionale quanto la persistenza dei sintomi depressivi nel tempo

INTERNATIONAL JOURNAL OF GERIATRIC PSYCHIATRY
Int J Geriatr Psychiatry 2003; **18**: 14–22.

Analisi dei processi: Complessità Medico-Infermieristica

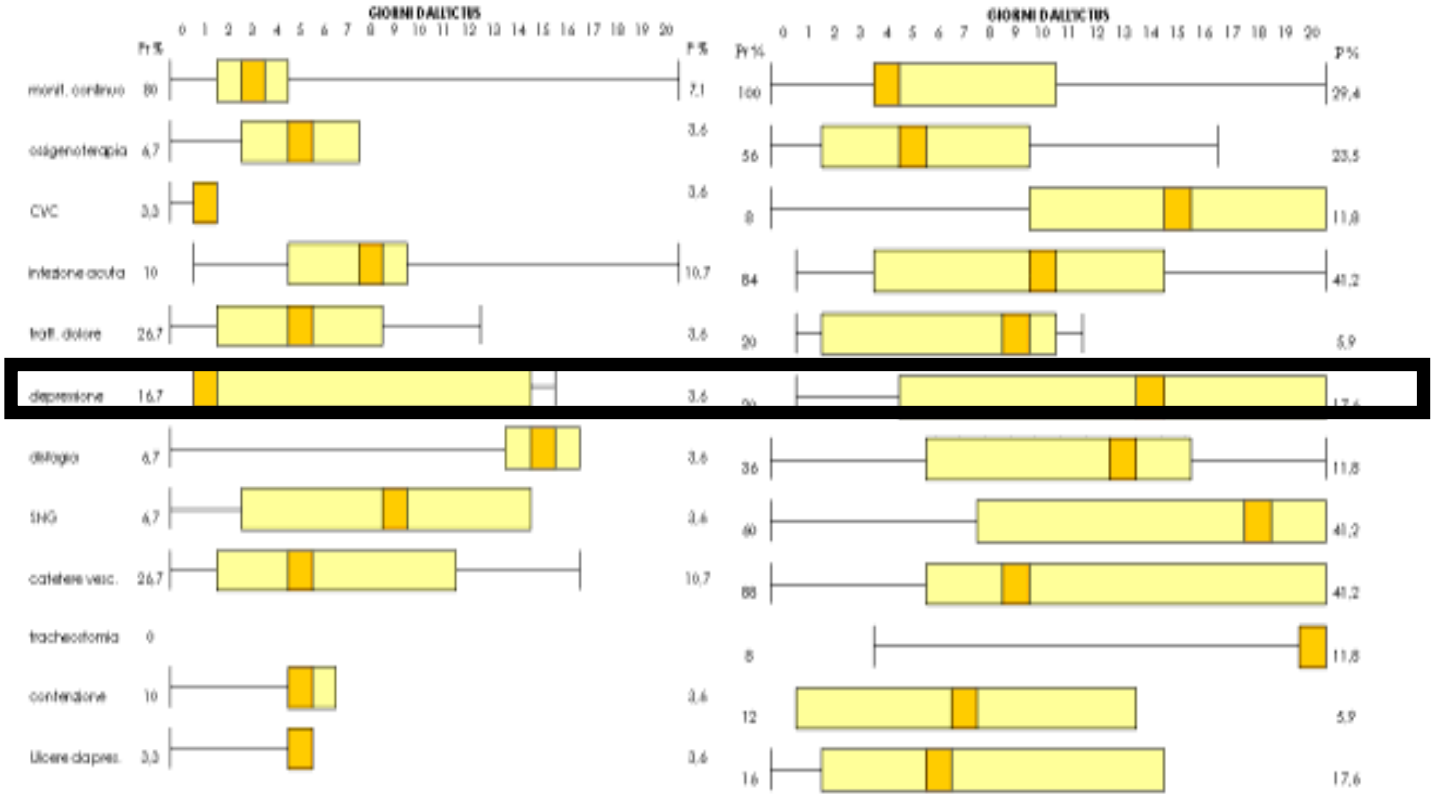


LIEVI (NIHSS ≤7)

GRAVI (NIHSS ≥8)

Bernardini SIGG Lombardia 2009

Analisi dei processi: Complessità Medico-Infermieristica



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Bernardini SIGG Lombardia 2009

Le possibili interpretazioni

- L'effetto della depressione sugli outcome è variabile in funzione del tempo
- La gravità dei sintomi depressivi (e/o della sindrome depressiva) è più importante della loro presenza/assenza
- La complessità il fenomeno «depressione»: non cogliamo il problema nelle sue sfaccettature e probabilmente definiamo depressione qualcosa che ne è profondamente diverso

RESEARCH ARTICLE

International Journal of Geriatric Psychiatry

Moderate to severe depressive symptoms and rehabilitation outcome in older adults with hip fracture

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Table 2 Independent predictors of failure to recover walking independence at discharge in 280 patients consecutively admitted to a Department of Rehabilitation and Aged Care Unit after hip fracture surgery in unadjusted and adjusted multiple logistic regression models

	Failure to recover walking independence at discharge							
	Unadjusted				Adjusted			
	OR	Wald χ^2	95% CI	*p*	OR	Wald χ^2	95% CI	*p*
Age	1.1	11.953	1.1–1.1	0.001	1.1	7.256	1.0–1.1	0.007
Female gender	0.5	4.661	0.2–0.9	0.031	0.5	1.796	0.2–1.4	0.180
Living alone	0.5	7.550	0.3–0.8	0.006	0.6	2.194	0.3–1.2	0.139
Mild depressive symptoms	1.0	0.002	0.6–1.7	0.968	1.6	1.743	0.8–3.3	0.187
Moderate to severe depressive symptoms	4.6	18.745	2.3–9.1	<0.0001	3.2	6.611	1.3–7.8	0.010
Mini Mental State Examination	0.9	14.198	0.8–0.9	<0.0001	1.0	0.308	0.9–1.1	0.579
Charlson Comorbidity Index	1.4	13.254	1.2–1.6	<0.0001	1.2	3.753	1.0–1.6	0.053
Albumin serum levels	0.4	11.559	0.2–0.8	0.016	0.3	5.404	0.1–0.8	0.020
Walking ability before fracture[a]	0.8	25.339	0.7–0.8	<0.0001	0.8	8.510	0.7–0.9	0.004
Number of drugs	1.2	5.842	1.1–1.4	0.001	1.1	3.132	1.0–1.3	0.077
Antidepressants	2.1	4.861	1.1–4.2	0.027	1.8	2.179	0.8–4.2	0.140

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Table 3 Independent predictors of adverse events at 1 year in 280 patients consecutively admitted to a Department of Rehabilitation and Aged Care Unit after hip fracture surgery in unadjusted and adjusted multiple logistic regression models

	Adverse events at 1 year							
	Unadjusted				Adjusted			
	OR	Wald χ^2	95% CI	*p*	OR	Wald χ^2	95% CI	*p*
Age	1.1	13.808	1.1–1.2	<0.0001	1.1	6.464	1.0–1,1	0.011
Female gender	0.6	1.179	0.3–1.4	0.278	0.5	1.640	0.2–1.4	0.200
Mild depressive symptoms	1.0	0.009	0.5–2.0	0.924	2.1	3.010	0.9–4.9	0.083
Moderate to severe depressive symptoms	5.0	20.089	2.5–10.2	<0.0001	3.6	7.331	1.4–9.1	0.007
Mini Mental State Examination	0.9	12.413	0.4–1.9	<0.0001	0.9	2.120	0.9–1.0	0.145
Albumin serum levels	0.4	3.539	0.2–1.0	0.060	0.3	4.584	0.1–0.9	0.032
Failure to recover walking independence at Discharge	4.9	22.808	2.6–9.5	<0.0001	2.5	5.659	1.2–5.2	0.017
Number of drugs	1.1	3.082	1.0–1.3	0.079	1.0	1.194	0.9–1.2	0.784
Antidepressants	1.5	1.471	0.8–2.9	0.225	1.8	2.079	0.8–4.0	0.149

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Failure to recover walking independence at discharge mediates the relationship between moderate to severe depressive symptoms and the long-term outcomes

Table 3 Independent predictors … after hip fracture surgery in un… …are Unit

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Adverse effects of depression and cognitive impairment on rehabilitation participation and recovery from hip fracture

Eric J. Lenze[1]*, Michael C. Munin[2], Mary Amanda Dew[1,3], Joan C. Rogers[1,4], Karen Seligman[1], Benoit H. Mulsant[1,5] and Charles F. Reynolds III[1]

Table 1. Correlations among demographic and clinical variables

	Ham-D	MMSE	Rehab partic	Motor FIM efficiency	Age	Length of stay	CIRS	Admission motor FIM	Change in motor FIM
Ham-D	—	−0.23	−0.46[c]	−0.44[c]	0.10	0.57[c]	0.17	−0.18	−0.18
MMSE		—	0.47[c]	0.52[c]	−0.23	−0.27[a]	−0.23	0.50[c]	0.50[c]
Rehab partic			—	0.57[c]	0.16	−0.32[a]	−0.32[a]	0.48[c]	0.60[c]
Motor FIM efficiency				—	−0.09	−0.71[c]	−0.24	0.49[c]	0.64[c]
Age					—	0.23	−0.12	−0.27[a]	0.10
Length of stay						—	0.02	−0.40[b]	−0.19
Admission motor FIM							—	—	0.15

INTERNATIONAL JOURNAL OF GERIATRIC PSYCHIATRY
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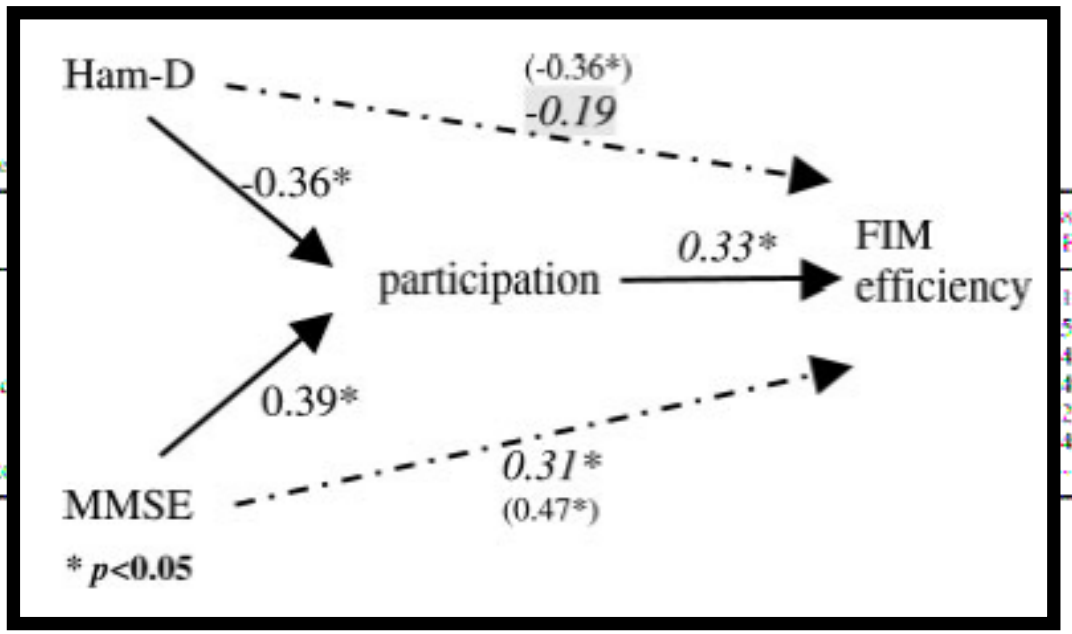

Table 1. Corre

	sion FIM	Change in motor FIM
Ham-D	18	−0.18
MMSE	50*	0.50*
Rehab partic	48*	0.60*
Motor FIM effic	49*	0.64*
Age	27*	0.10
Length of stay	40*	−0.19
Admission moto	-	0.15

INTERNATIONAL JOURNAL OF GERIATRIC PSYCHIATRY
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Participation can improve during treatment

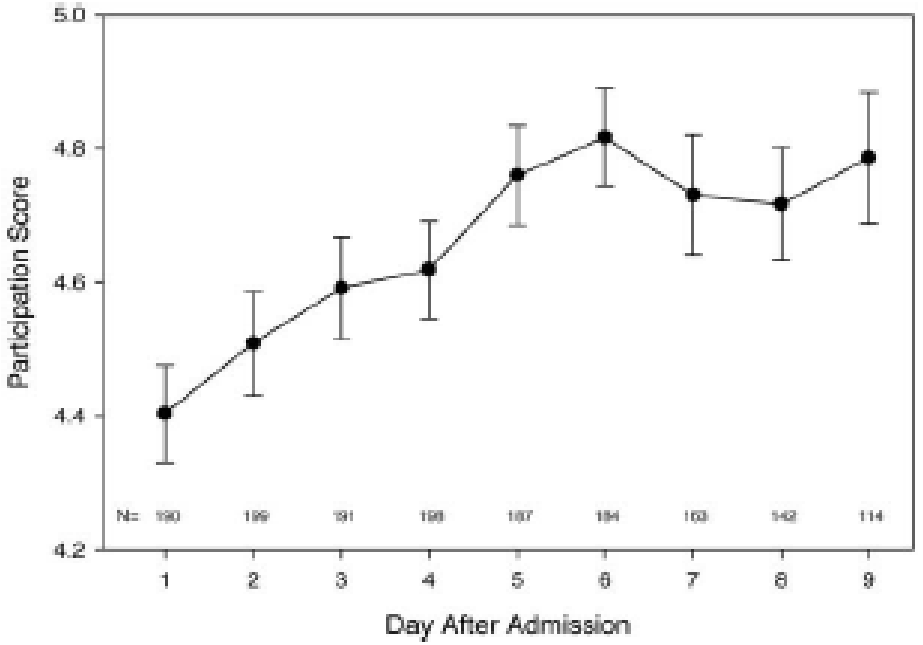
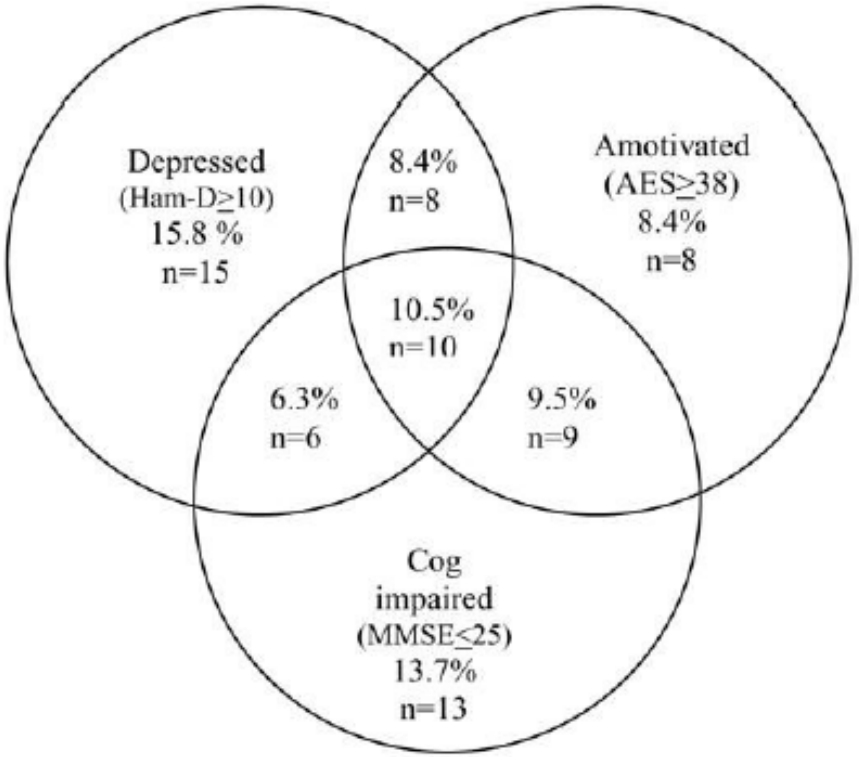


Fig 1. Trajectory of mean PRPS scores over the first 9 days of hospitalization. Note that decreasing sample size is due to subjects being discharged or participation score unavailable that day. Graph is shown with standard error.

Lenze et al **Arch Phys Med Rehabil Vol 85, March 2004**

Is depression or apathy?



Lenze et al, Gen Hosp Psych 2007

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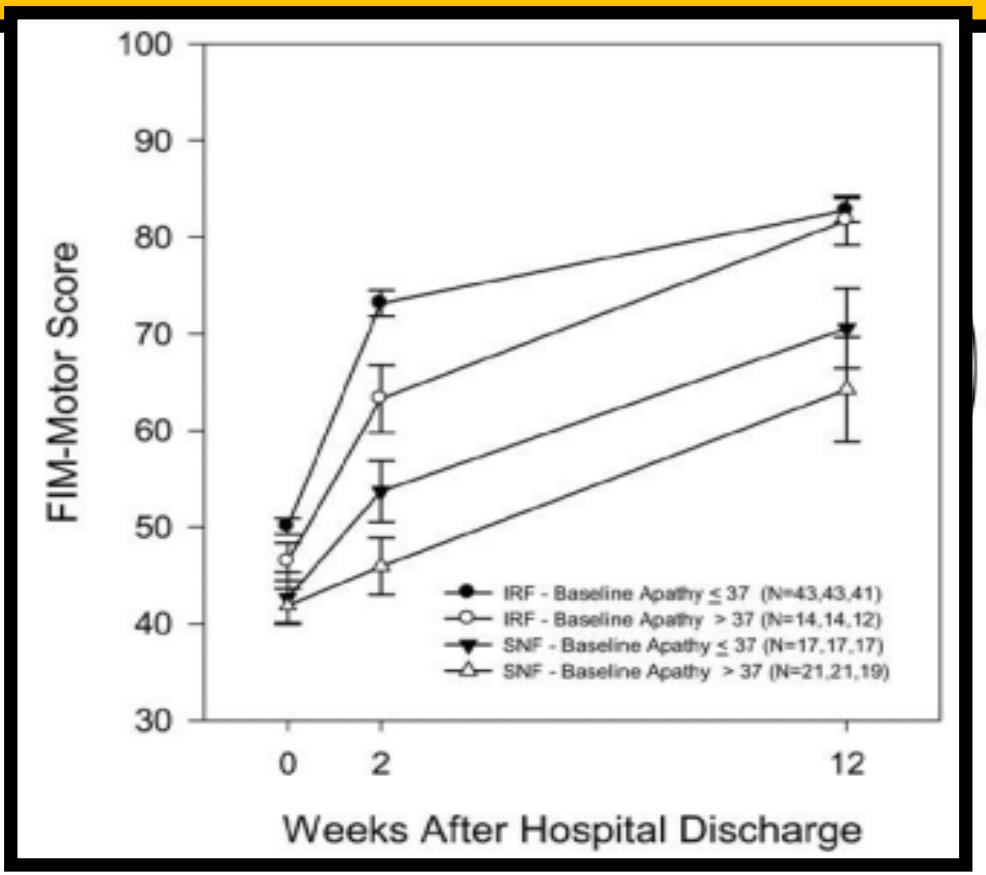

Lenze et al, Gen Hosp Psych 2007

Depression and delirium: 1+1 doesn't always make 2

Table 1. Characteristics of 1,534 Patients Admitted to a Rehabilitation and Aged Care Unit from 2002 to 2005

Characteristic	No Delirium, No Depression (n = 938)	Depression, No Delirium (n = 575)	Delirium Alone (n = 10)	Overlap Syndrome (n = 11)	P-Value
Age, mean ± SD	77.1 ± 6.9	79.2 ± 6.8	83.0 ± 5.3	81.6 ± 5.6	<.001
Male, n (%)	277 (29.5)	104 (18.1)	2 (20.0)	1 (9.1)	<.001
Deceased, n (%)	122 (13.0)	46 (8.0)	3 (30.0)	—	<.001
Nursing home residence before admission, n (%)	11 (1.2)	7 (1.2)	—	—	.02
Albumin serum level, g/dL, mean ± SD	3.2 ± 0.4	3.3 ± 1.0	3.3 ± 0.6	3.4 ± 0.3	.10
Body mass index, kg/m^2, mean ± SD	26.1 ± 16.9	25.5 ± 7.9	22.8 ± 4.1	27.3 ± 6.0	.75
C-reactive protein, mg/dL, mean ± SD	3.0 ± 4.4	2.6 ± 3.4	3.3 ± 3.4	1.2 ± 2.3	.40
Charlson Comorbidity Index, mean ± SD	2.4 ± 2.1	2.8 ± 2.0	3.7 ± 2.7	4.1 ± 2.5	<.001
Number of drugs at discharge, mean ± SD	4.7 ± 1.9	5.1 ± 1.9	4.9 ± 2.1	4.6 ± 2.2	.001
Mini-Mental State Examination score (range 0–30), mean ± SD	25.3 ± 4.1	23.7 ± 4.2	19.4 ± 7.3	21.0 ± 4.9	<.001
Geriatric Depression Scale score (range 0–15), mean ± SD	3.4 ± 1.8	8.4 ± 2.0	3.9 ± 1.8	10 ± 2.5	<.001
Barthel Index (range 0–100), mean ± SD					
1 month before	87.6 ± 17.7	81.2 ± 19.9	72.5 ± 24.8	72.1 ± 21.8	<.001
On admission	65.3 ± 23.3	61.3 ± 25.2	35.2 ± 21.8	45.9 ± 26.8	<.001
At discharge	85.0 ± 18.2	79.8 ± 21.0	59.3 ± 25.0	63.7 ± 30.7	<.001
Rehabilitation and Aged Care Unit length of stay, days, mean ± SD	22.2 ± 9.4	23.7 ± 8.5	28.5 ± 18.3	30.0 ± 13.6	<.001
Death within 1 year, n (%)	58 (6.2)	52 (9.0)	2 (20.0)	4 (36.4)	<.001

Turco R et al, J Am Geriatr Soc 2010

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APIGRA-IPER 2

Analisi delle problematiche PsIcoGeriatriche nella Riabilitazione dell'Anziano *(APIGRA-2)*

Sezione Riabilitazione Geriatrica

Progetto *APIGRA – IPER 2* *Scheda Raccolta Dati # 2 / 3*

Complessità Clinica e Valutazione Primo Livello

COMPLESSITA' CLINICA

	No	Si
Demenza	☐	☐
Ictus	☐	☐
Altra Malattia Neurologica	☐	☐
Altre Malattie Somatiche	☐	☐
Malattia psichiatrica magg.	☐	☐

ICD9 ☐

ICD9 ☐

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SEVERITA' D-AA

	Ammissione		Dimissione	
	Psich.	Somia	Psich.	Somia
Hamilton Depressione	☐	☐	☐	☐
Hospital Anxiety Scale	☐		☐	
Apathy Evaluation Scale	☐		☐	

Note

Bruno Bernardini, Giuseppe Bellelli, Luigi Baratto*, Marisa Gardella**

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Analisi delle problematiche PsIcoGeriatriche nella Riabilitazione dell'Anziano *(APIGRA-2)*

Sezione Riabilitazione Geriatrica

Progetto *APIGRA – IPER 2* *Scheda Raccolta Dati # 2 / 3*

Complessità Clinica e Valutazione Primo Livello

COMPLESSITA' CLINICA

	No	Si
Demenza	☐	☐
Ictus	☐	☐
Altra Malattia Neurologica	☐	☐
Altre Malattie Somatiche	☐	☐
Malattia psichiatrica magg.	☐	☐

ICD9 ☐

ICD9 ☐

ICD9 ☐

ICD9 ☐

SEVERITA' D-AA

	Ammissione		Dimissione	
	Psich.	Somia	Psich.	Somia
Hamilton Depressione	☐	☐	☐	☐
Hospital Anxiety Scale	☐		☐	
Apathy Evaluation Scale	☐		☐	

Note

Bruno Bernardini, Giuseppe Bellelli, Luigi Baratto*, Marisa Gardella**

VALUTAZIONE 1° LIVELLO

ANAMNESI PSICHIATRICA

	No	Si
FAMILIARE		
Anamnesi positiva per MPM *	☐	☐
Anamnesi positiva per alcolismo / uso droghe	☐	☐
Fragilità Sociale	☐	☐
PERSONALE		
Anamnesi positiva per alcolismo / uso droghe	☐	☐
Storia di violenza / abuso fisico-morale subito	☐	☐
Problemi con la Legge	☐	☐
Difficoltà inserimento / adattamento lavorativo	☐	☐
Presa in carico da parte servizi psichiatrici	☐	☐
Tentativo di suicidio	☐	☐
Stressfull Life Events ultimo anno	☐	☐

* MPM = Malattia Psichiatrica Maggiore

Ristrutturazione

Opzionale

SINTOMI / SEGNI ASSOCIATI

	Ammissione		Dimissione	
	No	Si	No	Si
Dolore	☐	☐	☐	☐
Disturbi comportamentali	☐	☐	☐	☐
Disturbi del Sonno	☐	☐	☐	☐
Anoressia	☐	☐	☐	☐
Altri disturbi comport. alimentare	☐	☐	☐	☐
Segni extrapiramidali	☐	☐	☐	☐

INDICATORI DI TRANSIZIONE D-AA ORIENTATI

	No	Si
Trattamento con farmaci Antidepressivi	☐	☐
Trattamento con Benzodiazepine	☐	☐
Trattamento con farmaci Tranquillanti Maggiori	☐	☐
Trattamento Neuropsicologico	☐	☐
Supporto Psicologico	☐	☐
Terapia Occupazionale	☐	☐
Altro	☐	☐
Pittsburg Rehab. Partic. Scale	☐	

VALUTAZIONE 1° LIVELLO

ANAMNESI PSICHIATRICA

	No	Si
FAMILIARE		
Anamnesi positiva per MPM *	☐	☐
Anamnesi positiva per alcolismo / uso droghe	☐	☐
Fragilità Sociale	☐	☐
PERSONALE		
Anamnesi positiva per alcolismo / uso droghe	☐	☐
Storia di violenza / abuso fisico-morale subito	☐	☐
Problemi con la Legge	☐	☐
Difficoltà inserimento / adattamento lavorativo	☐	☐
Presa in carico da parte servizi psichiatrici	☐	☐
Tentativo di suicidio	☐	☐
Stressfull Life Events ultimo anno	☐	☐

Ristrutturazione Cognitiva

* MPM = Malattia Psichiatrica Maggiore

SINTOMI / SEGNI ASSOCIATI

	Ammissione		Dimissione	
	No	Si	No	Si
Dolore	☐	☐	☐	☐
Disturbi comportamentali	☐	☐	☐	☐
Disturbi del Sonno	☐	☐	☐	☐
Anoressia	☐	☐	☐	☐
Altri disturbi comport. alimentare	☐	☐	☐	☐
Segni extrapiramidali	☐	☐	☐	☐

INDICATORI DI TRANSIZIONE D-AA ORIENTATI

	No	Si
Trattamento con farmaci Antidepressivi	☐	☐
Trattamento con Benzodiazepine	☐	☐
Trattamento con farmaci Tranquillanti Maggiori	☐	☐
Trattamento Neuropsicologico	☐	☐
Supporto Psicologico	☐	☐
Terapia Occupazionale	☐	☐
Altro	☐	☐
Pittsburg Rehab. Partic. Scale	☐	

VALUTAZIONE 1 ° LIVELLO

ANAMNESI PSICHIATRICA

FAMILIARE

	No	Sì
Anamnesi positiva per MPM *		
Anamnesi positiva per alcolismo / uso droghe		
Fragilità Sociale		

PERSONALE

	No	Sì
Anamnesi positiva per alcolismo / uso droghe		
Storia di violenza / abuso fisico-morale subito		
Problemi con la Legge		
Difficoltà inserimento / adattamento lavorativo		
Presa in carico da parte servizi psichiatrici		
Tentativo di suicidio		
Stressfull Life Events ultimo anno		

Holmes & Rahe score

* MPM = Malattia Psichiatrica Maggiore

SINTOMI / SEGNI ASSOCIATI

	Ammissione		Dimissione	
	No	Sì	No	Sì
Dolore				
Disturbi comportamentali				
Disturbi del Sonno				
Anoressia				
Altri disturbi comport. alimentare				
Segni extrapiramidali				

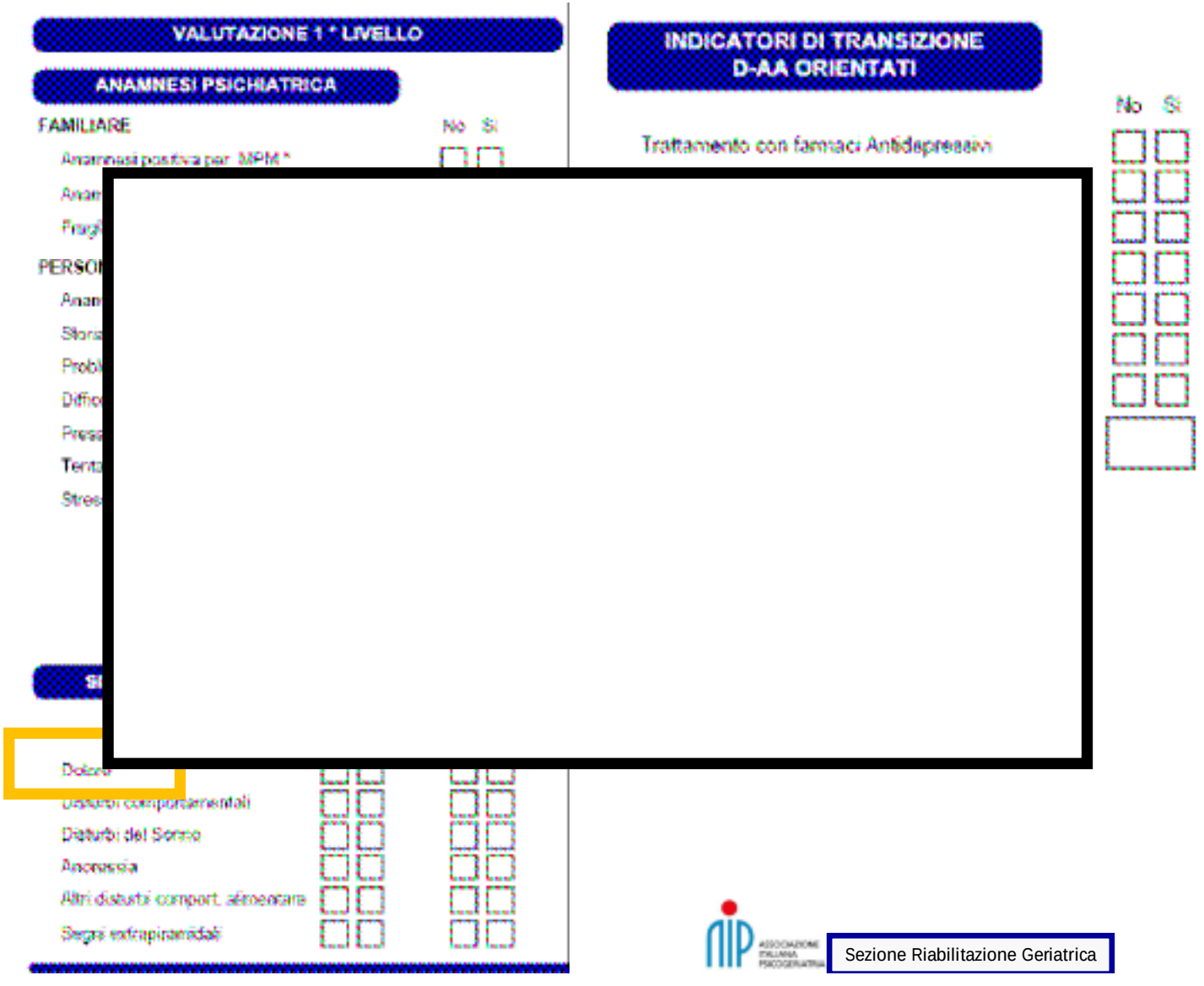
INDICATORI DI TRANSIZIONE D-AA ORIENTATI

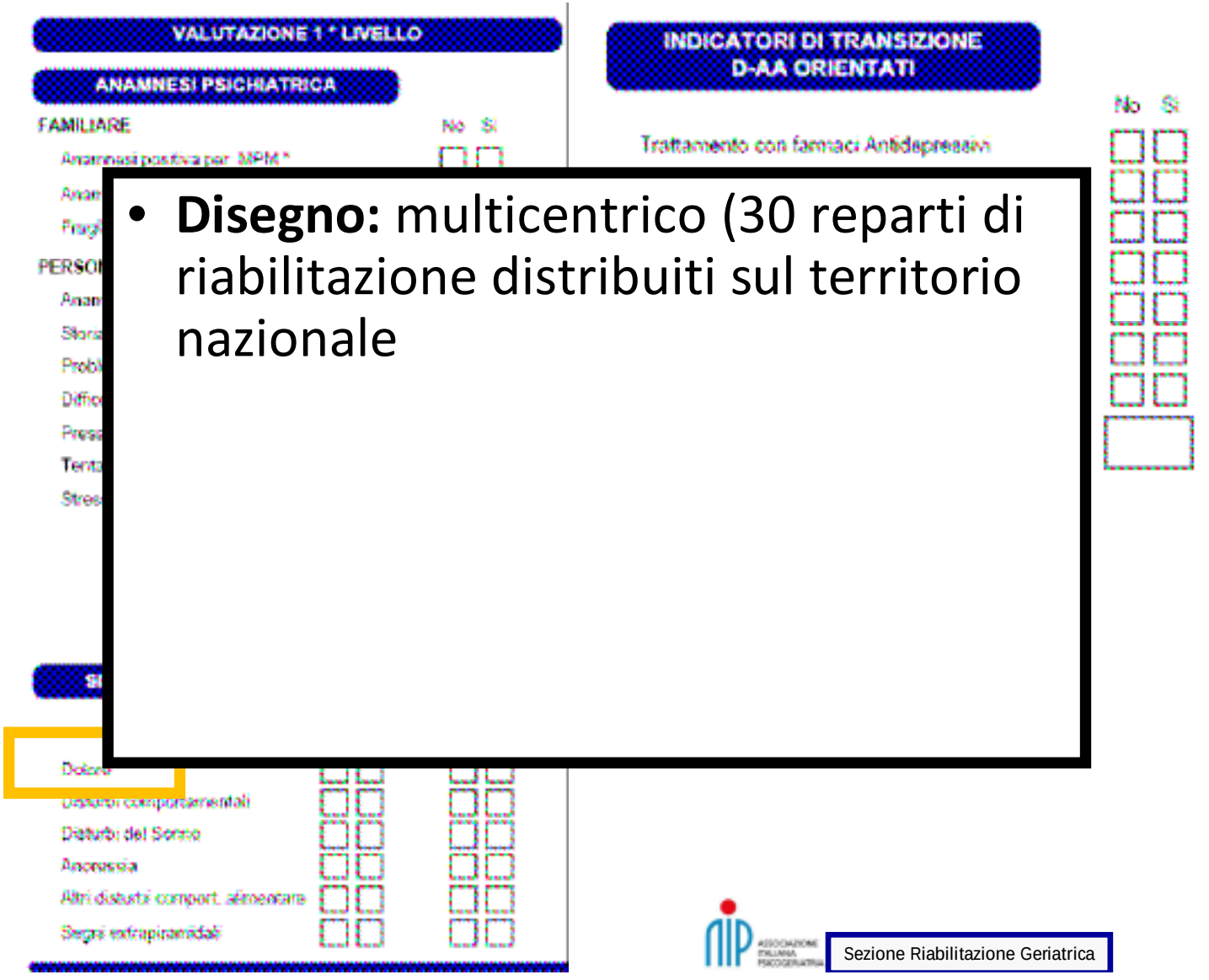
	No	Sì
Trattamento con farmaci Antidepressivi		
Trattamento con Benzodiazepine		
Trattamento con farmaci Tranquillanti Maggiori		
Trattamento Neuropsicologico		
Supporto Psicologico		
Terapia Occupazionale		
Altro		

Pittsburg Rehab. Partic. Scale

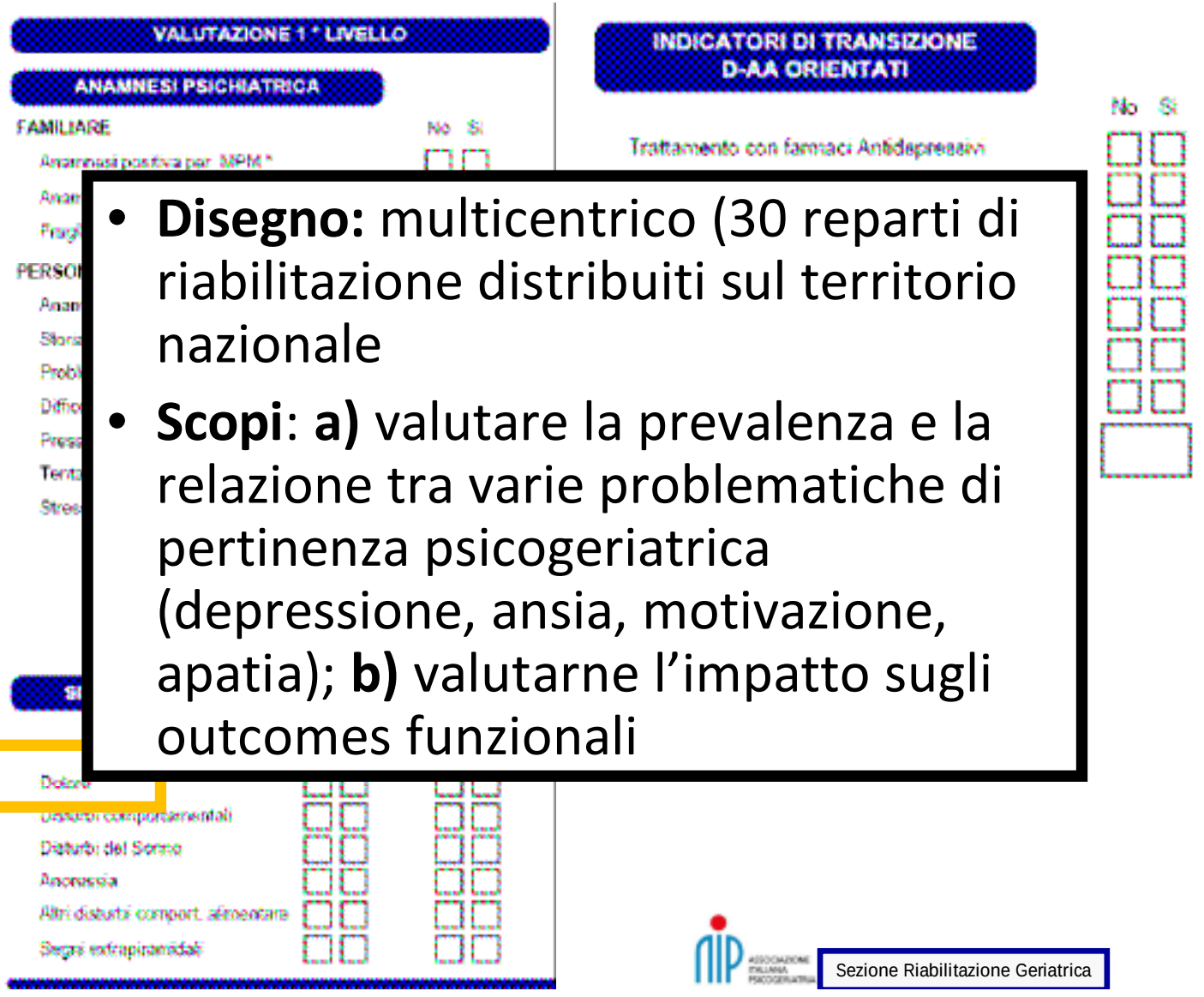
AIP ASSOCIAZIONE ITALIANA PSICOGERIATRIA

Sezione Riabilitazione Geriatrica


VALUTAZIONE 1° LIVELLO
ANAMNESI PSICHIATRICA
FAMILIARE
No Si
INDICATORI DI TRANSIZIONE
D-AA ORIENTATI
Trattamento con farmaci Antidepressivi
No Si
Disturbi del Sonno
Anoressia
Sezione Riabilitazione Geriatrica



- **Disegno:** multicentrico (30 reparti di riabilitazione distribuiti sul territorio nazionale



- **Disegno:** multicentrico (30 reparti di riabilitazione distribuiti sul territorio nazionale
- **Scopi**: **a)** valutare la prevalenza e la relazione tra varie problematiche di pertinenza psicogeriatrica (depressione, ansia, motivazione, apatia); **b)** valutarne l'impatto sugli outcomes funzionali

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