I disturbi di pertinenza geriatrica

Renzo Rozzini (Brescia)

I disturbi psichiatrici di pertinenza geriatrica

- **Demenza, BPSD, Delirium**
- **Disturbi dell'umore (e ansietà)**
- **Disturbi del comportamento alimentare**
- **Disturbi del sonno**
- **Psicosi funzionali**
- **Abuso di sostanze**
- **Maltrattamento**
- **Senza fissa dimora**
- **Disturbi sessuali**

I disturbi psichiatrici di pertinenza geriatrica

- Demenza, BPSD, Delirium
  - Farmaci e delirium
  - Organi di senso e allucinazioni
- Disturbi dell'umore (e ansietà)
  - Malattie cardiovascolari
  - Cancro
- Disturbi del comportamento alimentare
  - Rifiuto dell'alimentazione
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Delirium From Transdermal Scopolamine in an Elderly Woman

To the Editor.—Perhaps too little attention is paid by practitioners to central anticholinergic effects of drugs in the elderly.

Report of a Case.—Recently, a 77-year-old woman was hospitalized for sudden global loss of memory, disorientation, and clouded sensorium after a journey to a holiday resort. Clinical and diagnostic evaluation did not indicate any abnormality. The patient had no history of drug intake. She was released after two days owing to spontaneous remission of the symptoms.

The woman remained well for the remaining 15 days of her vacation, after which she went back home. On reaching her home, she experienced the same global disturbance of cognition as previously and again had to be hospitalized. Results of diagnostic evaluation were normal.

After a more detailed drug history was taken, however, it was found that the elderly woman had used a scopolamine transdermal preparation (retroauricular) to prevent car sickness on her way to and back from the holiday resort.

Delirium is a common feature of anticholinergic drug intoxication in the aged; while potentially reversible, it may herald serious problems for the self-sufficiency of the elderly. The appearance of delirium requires a complete assessment of the patient to detect reversible conditions such as that reported here.

Delirium

Strategie di terapia farmacologica

La maggior parte degli studi disponibili hanno focalizzato l'attenzione prevalentemente sull'impiego di farmaci antipsicotici o sedativi del delirium. Sebbene questi farmaci siano efficaci nel ridurre l'agitazione e i disturbi comportamentali associati al delirium, che spesso disturbano l'organizzazione assistenziale, non esiste alcuna evidenza che la terapia antipsicotica o sedativa sia in grado di migliorare in modo significativo la prognosi dei pazienti.

Oggi si pratica una terapia finalizzata a convertire il delirium iperattivo in delirium ipoattivo (più facilmente gestibile). Un numero crescente di evidenze suggerisce però che il trattamento sedativo possa prolungare la durata del delirium e dei disturbi cognitivi ad esso associati e peggiorare gli outcome clinici. La terapia del delirium dovrebbe essere focalizzata al trattamento che facilità il recupero, migliora lo stato funzionale e gli outcome clinici.

Prevenzione farmacologica

Ad oggi non si raccomanda alcun approccio farmacologico preventivo del delirium.


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Is it heaven? Pleasant visual hallucinations in nonagenarians

Case 1

A male, 93-years-old, with a university education, is in general good health and suffers from a mild degenerative joint disease, predominantly affecting his left hip; there is no history of major diseases. The content of his hallucinations is the representation of flowers (cyclamens' fields, floods of wistarias and lilacs), Renaissance paintings, Chinese tapestries, and monumental squares. Hallucinatory symptoms have occurred with a frequency of once/twice a week during the last year. This patient is unimpaired in basic and instrumental activities of daily living. His mental status is good, with a MMSE score of 29/30. His Geriatric Depression Score is 7/30. There is no evidence of psychopathology either anamnestic or present. There is no family history of mental diseases. Neither epileptiform activity nor pathological slow activity was observed during basal registration or hyperventilation on EEG.

Is it heaven? Pleasant visual hallucinations in nonagenarians

Case 2

A female, 92-years-old is a noblewoman with a secondary school education. She is only moderately hypertensive and is taking Enalapril 10 mg daily. She is in very good health and has no history of major somatic disease. The content of her visual hallucinations is characterized by flowers (chrysanthemums and orchids) and by tropical plants and trees, paintings (such as Botticelli's Spring), golden frames, and silk curtains floating in the wind. Hallucinatory symptoms have occurred three/four times a month during the last 3 months. Her MMSE score is 30/30. She does not suffer from depressive symptoms (GDS = 3/30). She is completely self-sufficient in both ADL and IADL functions. There is no evidence of psychopathology, either anamnestic or present. There is no family history of mental diseases. Neither epileptiform activity, nor pathological slow activity was observed during basal registration or hyperventilation on EEG.

Is it heaven? Pleasant visual hallucinations in nonagenarians

Case 3

This is an 87-year-old female with primary education background. She suffers from a recent hip fracture caused by an accidental fall. Her MMSE is 25/30, and her GDS score is 10/30, indicating a mild degree of depression. Before the fracture she was completely self-sufficient in both ADL and IADL functions.

The content of her hallucinations is poorer than the previous two cases, but equally pleasant: little geometrical and colorful flowers, floral tapestries, mountain brooks, clouds moving fast in the sky, and waves crushing on the shore. Hallucinatory symptoms occurred once/twice a week during the last 3 years. In this old lady, as well, there was no evidence of psychopathology, anamnestic or present, nor was there a family history of mental diseases. EEG showed a normal posterior alpha rhythm at 10 Hz, bilateral and synchronous, with short periods of theta rhythm (7 Hz), especially during hyperventilation. No epileptiform nor pathological slow activity was detected.

Is it heaven? Pleasant visual hallucinations in nonagenarians

In all three cases, the onset of the hallucinations was not associated with a detectable change of vision; hallucinations are stopped by focusing attention on a specific object. Results are consistent with earlier reports suggesting that these hallucinations are not due to psychopathology or compromised cognitive functioning. Our patients do not suffer from mental disorders, and their insight is good.

Because there are not symptoms of mental diseases, it could be proposed that complex visual hallucinations represent ongoing neural activity in the visual system following eye damage. Sensory deprivation might produce patterns of nerve impulses that give rise to visual experiences.[5] Complexity of hallucinations is probably attributable to the degree of schooling and culture of the patients: the richer the cultural background, the greater the complexity of psychic symptoms.

View and review
Arq Neuropsiquiatr 2011;69(2-B):395-400

Musical hallucination associated with hearing loss

Tanit Ganz Sanchez[1], Savya Cybelle Milhomem Rocha[2], Keila Alessandra Baraldi Knobel[3], Márcia Akemi Kii[4], Rosa Maria Rodrigues dos Santos[5], Cristiana Borges Pereira[6]

ABSTRACT

In spite of the fact that musical hallucination have a significant impact on patients' lives, they have received very little attention of experts. Some researchers agree on a combination of peripheral and central dysfunctions as the mechanism that causes hallucination. The most accepted physiopathology of musical hallucination associated to hearing loss (caused by cochlear lesion, cochlear nerve lesion or by interruption of mesencephalon or pontine auditory information) is the disinhibition of auditory memory circuits due to sensory deprivation. Concerning the cortical area involved in musical hallucination, there is evidence that the excitatory mechanism of the superior temporal gyrus, as in epilepsies, is responsible for musical hallucination. In musical release hallucination there is also activation of the auditory association cortex. Finally, considering the laterality, functional studies with musical perception and imagery in normal individuals showed that songs with words cause bilateral temporal activation and melodies activate only the right lobe. The effect of hearing aids on the improvement of musical hallucination as a result of the hearing loss improvement is well documented. It happens because auditory hallucination may be influenced by the external acoustical environment. Neuroleptics, antidepressants and anticonvulsants have been used in the treatment of musical hallucination. Cases of improvement with the administration of carbamazepine, meclobemide and donepezil were reported, but the results obtained were not consistent.
Key words: musical hallucination, auditory hallucination, hearning loss, deafness.

Alucinações musicais associadas a perda auditiva

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Editor's Note

Reframing Depression Treatment in Heart Failure

Patrick G. O'Malley, MD, MPH

Congestive heart failure and depression are 2 common and disabling chronic conditions. When depression occurs in patients with heart failure, which is often, the illness burden and management complexity increase multifold. Freedland et al[1] tested the hypothesis that the effective treatment of comorbid depression with cognitive behavior therapy (CBT) would also lead to improvements in heart failure self-care and physical functioning and found it did not. The good news is that CBT did significantly improve emotional health and overall quality of life, and the improvement in depressive symptoms associated with CBT was larger than observed in pharmacotherapy trials for depression in patients with heart disease. This is supportive evidence for a shift in practice away from so much pharmacotherapy and more use of psychotherapy to achieve better mental health and overall quality-of-life outcomes in patients with heart failure. In reframing how we think about the management of depression in patients with heart failure, we should be talking more and prescribing less.

Related article page 1773

Conflict of Interest Disclosures: None reported.

1. Freedland KE, Carney RM, Rich MW, Steinmeyer BC, Rubin EH. Cognitive behavior therapy for depression and self-care in heart failure patients: a randomized clinical trial [published online September 28]. *JAMA Intern Med*. doi:10.1001/jamainternmed.2015.5220.

Il problema è chiarire se la depressione sia una comorbilità, 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.

Depression and Negative Outcomes in Patients With Heart Failure

Arch Int Med, 2003; 163:498-499

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Mayr and Schmid *BMC Cancer* 2010, **10**:569
http://www.biomedcentral.com/1471-2407/10/569

BMC Cancer

DEBATE Open Access

Pancreatic cancer and depression: myth and truth

Martina Mayr*, Roland M Schmid

Abstract

Background: Various studies reported remarkable high incidence rates of depression in cancer patients compared with the general population. Pancreatic cancer is still one of the malignancies with the worst prognosis and therefore it seems quite logical that it is one of the malignancies with the highest incidence rates of major depression.

However, what about the scientific background of this relationship? Is depression in patients suffering from pancreatic cancer just due to the confrontation with a life threatening disease and its somatic symptoms or is depression in this particular group of patients a feature of pancreatic cancer per se?

Discussion: Several studies provide evidence of depression to precede the diagnosis of pancreatic cancer and some studies even blame it for its detrimental influence on survival. The immense impact of emotional distress on quality of life of cancer patients enhances the need for its early diagnosis and adequate treatment. Knowledge about underlying pathophysiological mechanisms is required to provide the optimal therapy.

Summary: A review of the literature on this issue should reveal which are the facts and what is myth.

OPINION

Cytokines and their relationship to the symptoms and outcome of cancer

Bostjan Seruga, Haibo Zhang, Lori J. Bernstein and Ian F. Tannock

Abstract | Tumours contain immune cells and a network of pro- and anti-inflammatory cytokines, which collaborate in the development and progression of cancer. Cytokine profiles might prove to be prognostic. The systemic effects of pro-inflammatory cytokines are associated with fatigue, depression and cognitive impairment, and can affect quality of life before, during and after treatment. In people with advanced cancer, pro-inflammatory cytokines are additionally associated with anorexia and cachexia, pain, toxicity of treatment and resistance to treatment. However, physical activity might modify cytokine levels and decrease fatigue in patients with cancer, and might also improve their prognosis.

Nature-Cancer, 2008

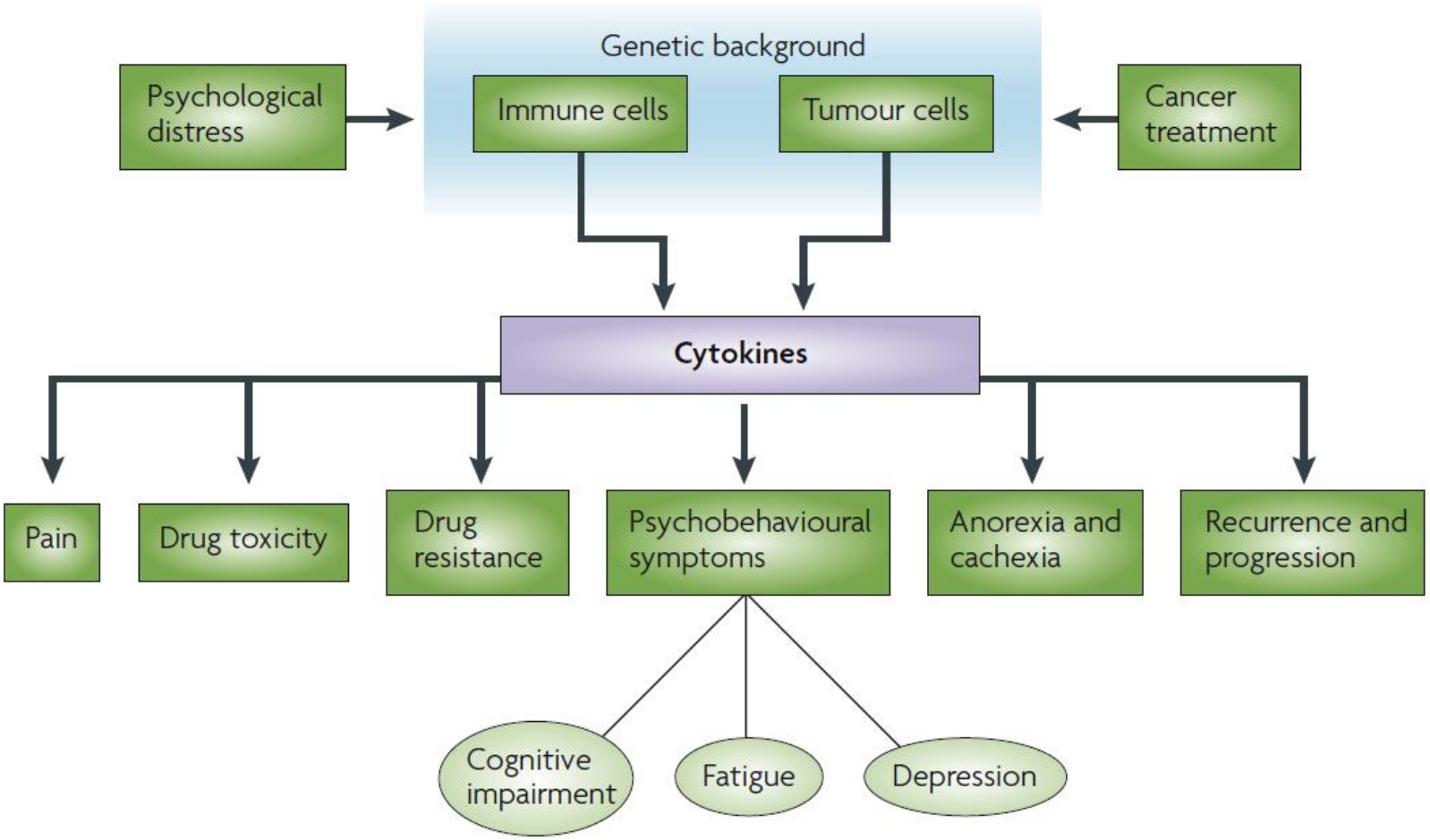

Figure 3 | **A conceptual model of cytokines in cancer.** Tumour and immune cells are sources of cytokines, which support the growth of cancer and lead to to psychobehavioural symptoms (fatigue, depression, and cognitive impairment), drug toxicity, drug resistance, anorexia and cachexia, pain, and cancer recurrence and progression. Genetic background, cancer treatment and psychological distress may corroborate the production of cytokines. In cancer survivors, hyperactive immune cells might be the major source of cytokines in psychobehavioural symptoms.

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Il rifiuto dell'alimentazione

Un disturbo comportamentale non infrequente nelle fasi terminali della vita è rappresentato dalla profonda anoressia, che può manifestarsi in assenza di altri aspetti neurovegetativi ed in presenza di apparente eutimia.

Si riscontra prevalentemente nei pazienti molto vecchi e si associa a patologia cronica multipla, spesso nella fase terminale delle malattie.

Il quadro tipico è rappresentato dall'aspetto senescente del paziente, che appare visibilmente deteriorato, che ha rinunciato alla vita e che -rifiutando di mangiare- sembra stia commettendo un suicidio passivo.

La gestione di questi pazienti in ospedale non infrequentemente è complicata dal disaccordo da parte dei curanti con i familiari relativamente al problema del "diritto di morire" addotto dai familiari stessi; l'ambivalenza non è insolita anche fra lo staff medico, che si interroga circa l'appropriatezza dell'ospedalizzazione, la scarsa qualità della vita legata ad un trattamento aggressivo (dibattuta l'opportunità di intraprendere un alimentazione per vie artificiali).

Una significativa percentuale di pazienti in questa categoria risponde in modo sorprendente al trattamento antipsicotico e antidepressivo con ripristino dell'appetito, incremento di peso e ricomparsa di un nuovo desiderio di vivere.

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L’alcoolismo

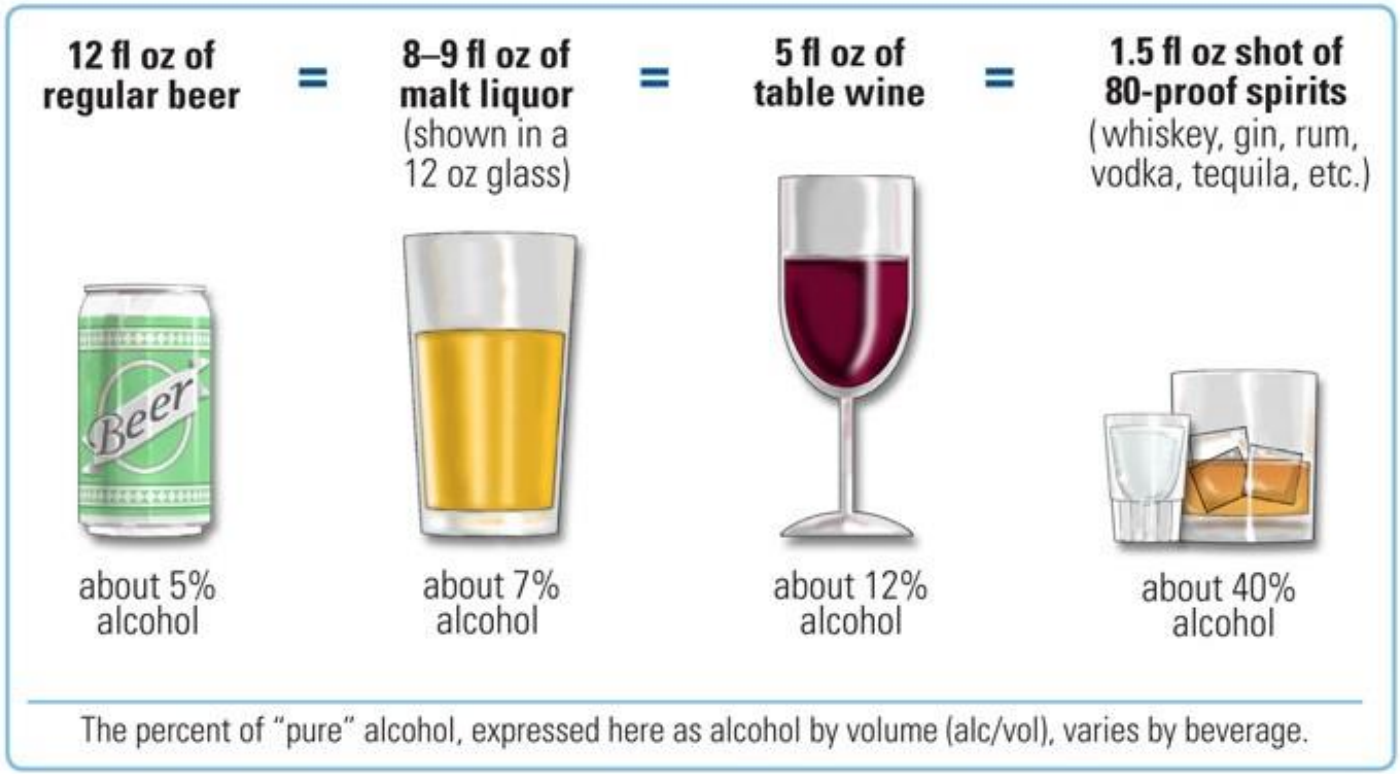

Table 1. Characteristics of 1201 Elderly Community-Dwelling Participants (Aged 70–75 Years) According to Alcohol Consumption

	Abstainers $N = 307$ Mean ± *SD* (%)	Moderate Alcohol Intake $N = 697$ Mean ± *SD* (%)	Heavy Alcohol Intake $N = 197$ Mean ± *SD* (%)
Age	72.6 ± 1.4	72.5 ± 1.5	72.5 ± 1.4
Gender (female), *n* (%)	241 (78.8)	515 (73.9)	56 (28.4)
Education (primary)	102 (33.2)	192 (27.6)	52 (26.4)
Unmarried, *n* (%)	196 (63.8)	448 (64.3)	87 (44.1)
Living alone, *n* (%)	117 (38.1)	275 (39.5)	58 (29.4)
Being poor	112 (37.0)	229 (33.0)	81 (41.5)
MSQ total	9.1 ± 1.2	9.4 ± 0.9	9.3 ± 0.9
aBDI (depression)	21.1 ± 14.6	17.9 ± 12.1	14.3 ± 11.8
IADL (number of functions lost)	0.5 ± 0.9	0.3 ± 0.7	0.3 ± 0.7
BADL	0.3 ± 0.8	0.1 ± 0.6	0.0 ± 0.4
Disabled (1 or more BADL functions lost)	46 (15.0)	61 (8.8)	14 (7.1)
Number of drugs	2.9 ± 2.0	2.5 ± 1.8	2.2 ± 1.7
Number of diseases	2.7 ± 1.5	2.4 ± 1.4	2.4 ± 1.4
Higher health care utilizers	120 (39.2)	229 (32.9)	51 (26.4)

16.4%

Journal of Gerontology: MEDICAL SCIENCES
2007, Vol. 62, No. 11, 1313–1314

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The NEW ENGLAND JOURNAL of MEDICINE

REVIEW ARTICLE

Edward W. Campion, M.D., *Editor*

Elder Abuse

Mark S. Lachs, M.D., M.P.H., and Karl A. Pillemer, Ph.D.

Table 1. Forms of Elder Abuse and Clinical Procedures for Assessment by the Physician.*

Type of Abuse	Manifestations	Assessment and Notable Findings
Physical abuse	Abrasions Lacerations Bruises Fractures Use of restraints Burns Pain Depression Delirium with or without worsening of dementia or dementia-related behavioral problems	Ask directly how injuries were sustained; note findings that are discordant with the mechanism of injury reported. Color of bruises does not reliably indicate their age; bruising can occur spontaneously in older adults in the absence of documented or recollected trauma.[14] Older adults may bruise spontaneously or without apparent awareness of injury. Injuries to the head, neck, and upper arms occur in victims of physical elder abuse, but they must be distinguished from accidental injuries caused by falls and other trauma. Jaw and zygomatic fractures are more likely to be sustained in a punch to the face than in a fall (falls typically result in fractures to orbital and nasal bones).

Table 1. Forms of Elder Abuse and Clinical Procedures for Assessment by the Physician.*

Type of Abuse	Manifestations	Assessment and Notable Findings
Verbal or psychological abuse	Direct observation of verbal abuse Subtle signs of intimidation, such as deferring questions to a caregiver or potential abuser Evidence of isolation of victim from both previously trusted friends and family members Depression, anxiety, or both in the patient	Ask specifically about verbal or psychological abuse with questions such as "Does your son or daughter ever yell or curse at you?" "Have you been threatened with being sent to a nursing home?" "Are you ever prevented from seeing friends and family members whom you wish to see?" Assess the size and quality of the patient's social network (beyond the suspected abuser) with questions such as "How many people do you see each day?" "How many do you speak to on the telephone?" "Is there anyone to assist you in the event of accident or emergency?" "Who would that be?" Conduct standardized assessments of depression, anxiety, and cognition, directly or through referral. Other types of abuse are often concurrent with verbal abuse. Office staff (clinical and front desk) should be encouraged to report verbally abusive behavior to the physician if they observe it.

Table 1. Forms of Elder Abuse and Clinical Procedures for Assessment by the Physician.*

Type of Abuse	Manifestations	Assessment and Notable Findings
Sexual abuse	Bruising, abrasions, lacerations in the anogenital area or abdomen Newly acquired sexually transmitted diseases, especially in nursing home residents (and especially in cluster outbreaks) Urinary tract infection	Inquire directly about sexual assault or coercion in any sexual activity. Conduct a pelvic examination with collection of appropriate specimens or refer to emergency department for comprehensive assessment for sexual assault and collection of specimens. Ideally, forensic evidence should be collected by experienced professionals, such as nurses who have undergone Sexual Assault Nurse Examiners (SANE) training. A common form of geriatric sexual assault involves a hypersexual resident with dementia in a long-term care facility assaulting other residents who may or may not also have cognitive impairment.[15] This situation raises fundamental issues about the capacity of older persons with dementia to consent to sexual activity. For outpatients with dementia, direct queries to caregivers about hypersexual behavior as part of a larger history regarding dementia-related behaviors. Signs of sexual abuse are similar to manifestations of sexual violence in younger adults.

Table 1. Forms of Elder Abuse and Clinical Procedures for Assessment by the Physician.*

Type of Abuse	Manifestations	Assessment and Notable Findings
Financial abuse	Inability to pay for medicine, medical care, food, rent, or other necessities Failure to renew prescriptions or keep medical appointments Unexplained worsening of chronic medical problems that were previously controlled Nonadherence to medication regimen or other treatment Malnutrition, weight loss, or both, without an obvious medical cause Depression, anxiety Evidence of poor financial decision making provided by the patient, patient history, or others persons Firing of home care or other service providers by abuser Unpaid utility bills leading to loss of service Initiation of eviction proceedings	Ask about financial exploitation with questions such as "Has money or property been taken from you without your consent?" "Have your credit cards or automated-teller-machine card been used without your consent?" "Have people called your home to try and get you to send or wire money to them?" "At the end of the month, do you have enough money left over for food, rent, utilities, or other necessities?" Direct similar questions to caregivers who are not suspected of being the financial abuser. Conduct a formal assessment of cognition and mood. Be aware that victims may be unwilling to disclose exploitation out of embarrassment. Abrupt changes in the financial circumstances of the caregiver in either direction (e.g., sudden unemployment or extravagant purchases) may also herald an increased risk of financial exploitation or exploitation already under way. Abuse of the power of attorney is the situation in which an older person is inaccurately designated as lacking financial capacity or being unable to perform necessary financial tasks, or in which a lack of capacity is accurately designated but the person with the power of attorney is abusing the role (e.g., using the money improperly). If misrepresentation of the lack of capacity is suspected, the patient should be interviewed to determine

Table 1. Forms of Elder Abuse and Clinical Procedures for Assessment by the Physician.*

Type of Abuse	Manifestations	Assessment and Notable Findings
Neglect	Decubitus ulcers Malnutrition Dehydration Poor hygiene Nonadherence to medication regimen Delirium with or without worsening of dementia or dementia-related behavioral problems	Examine the skin for bedsores and infestations. Assess hygiene and cleanliness. Assess appropriateness of dress. Measure drug levels in serum to assess adherence and accuracy of administration of medicines. Measure body-mass index and albumin. Conduct clinical examination to assess nutrition. Measure blood urea nitrogen and creatinine to assess hydration. Conduct a directed physical examination to assess the status of chronic illnesses under treatment. Interview primary caregiver about his or her understanding of the nature of the patient's care needs and how well care is being rendered. Neglect may be intentional or may be unintentional, stemming from an inability to provide care owing to the caregiver's frailty, cognitive impairment, mental illness, or limited health literacy.

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Sexuality and aging

Sexuality is an essential part of a person's make-up or psyche and expressing it is a basic human right. A sexual and a false assumption exists that physical attractiveness depends on youth and beauty. Many young people have difficulty believing that older people are sexual beings, possibly because this would mean accepting their parents as having sexual interests. There is a paucity of information on sexuality in elderly people. Booth studied groups of nurses and found that many of them did not believe that people in their seventies had sexual needs.

Many birthday cards which deal with sexuality in later life as a humorous topic (sexuality is funny): comical cards and ones on old age had messages about physical weakness and failures in sexual performance.

Other beliefs are that an elderly person who deviates from the stereotype and wants an active sexual life may be derided as foolish (a `dirty old man'). Elderly themselves are reluctant to verbalize their sexual feelings, for fear of being seen as depraved, or lecherous, so that myths about their sexuality are internalized.

Rozzini&Trabucchi in "The Oxford Handbook of Geriatric Medicine", in press

L’amore coniugale, la domanda d’aiuto del caregiver

La figlia ha tempestato di telefonate la segretaria chiedendo di potermi parlare prima della visita. Deve dirmi alcune cose che davanti al papà non riuscirebbe. Molti figli di pazienti hanno questo desiderio. Ma la segretaria ha la possibilità rifiutare queste richieste. Dovrei allungare il tempo di visita. E queste “indicibili” questioni riguardano molto più spesso i figli che i genitori.

Nonostante le barriere adottate al momento della visita riesce a entrare nello studio prima del padre, chiudendo con decisione la porta dietro di sé. Con imbarazzo dice che il problema riguarda entrambe i genitori, che lei accudisce. Il padre ha 85 anni, è cognitivamente integro e parzialmente limitato nei movimenti per un’artrosi delle ginocchia; la madre ha 80 anni e soffre di malattia di Alzheimer grave con disturbi del comportamento. Il padre quasi tutte le notti cerca una relazione intima con la moglie, che per questo interrompe il sonno diventando inquieta e ingestibile fino al mattino seguente. Mi implora di aiutarla, perché la situazione è diventata anche per lei insostenibile. Provo un attimo di tenerezza mentre cerca una giustificazione, perché “dopo tutto sono marito e moglie, si sono sempre voluti bene”. Ma ora non ce la fa più.

Faccio entrare e accomodare il paziente e raccolgo le informazioni. Lo visito accuratamente, lo faccio camminare e poi dopo un’occhiata d’intesa alla figlia dico ad alta voce mentre proditoriamente scrivo sul ricettario: “per il dolore delle sue ginocchia le prescrivo delle goccine; ne prenda 20 ogni sera e vedrà che il dolore passerà e dormirà anche molto bene”.

Conclusioni

Di tanta (a volte mi sembra enorme) fatica, che cosa mi resta, nella più triste epoca della vita? Quel che dice una bellissima parola neoellenica, in un verso di Giorgio Seferis: monaxià (solitudine).

Monaxià è tremendamente attuale, è urbano, disperato, assoluto, non c' è rimedio:

… Monaxià, monaxià… Solitudine, solitudine di solitudini, tutto è Solitudine…

Tragico tascabile, **GUIDO CERONETTI. ADELPHI, 2015**