THE BEST OF

Quoi de neuf en gériatrie ?

Geriatric Golden Globe Awards

Méta-analyse des facteurs de risque de la seconde fracture de hanche chez les patients âgés

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Review

Meta-analysis of risk factors for the second hip fracture (SHF) in elderly patients

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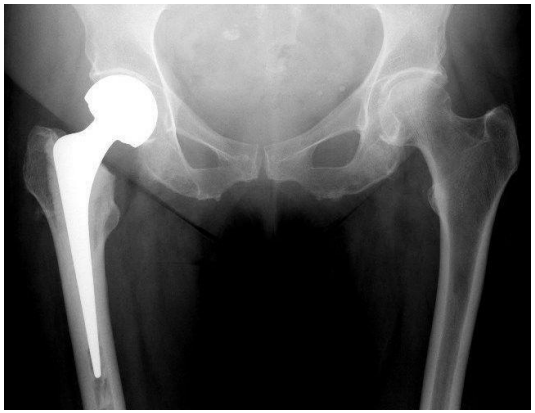
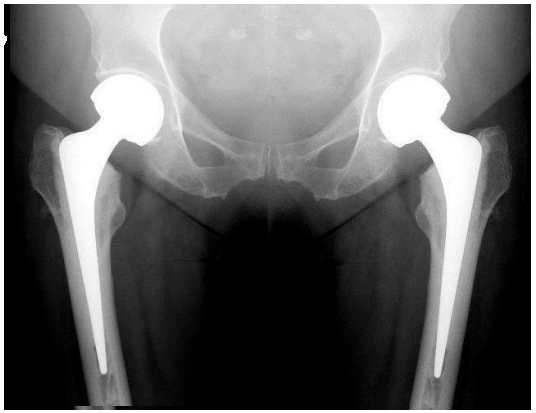
ABSTRACT

This study aims to quantitatively summarize the risk factors for the incidence of SHF. A meta-analysis was performed with the data obtained from 22 relevant papers published in Pubmed, Embase and Cochrane central database (all through January 2014) following strict selection. The pooled odds ratios (ORs) or standardized mean difference (SMD) with 95% confidence intervals (CIs) were calculated for potential risk factors associated with SHF. Our meta-analysis indicated the significant risk factors for SHF were female (OR, 1.46; 95%CI, 1.29–1.66), living in institutions (OR, 2.23; 95%CI, 1.29–3.83), osteoporosis (Singh index (SI) 1–3) (OR, 10.02; 95%CI, 5.41–18.57), low vision (OR, 2.09; 95%CI, 1.06–4.12), dementia (OR, 1.89; 95%CI, 1.47–2.43), Parkinson (OR, 2.90; 95%CI, 1.41–5.95), cardiac diseases (OR, 1.32; 95%CI, 1.02–1.70) and respiratory disease (OR, 1.97; 95%CI, 1.16–3.32). Related strategies must be implemented on those involved with above-mentioned medical conditions to effectively prevent a SHF.

La seconde fracture de hanche

Quels sont les facteurs favorisants ?





Méthodes

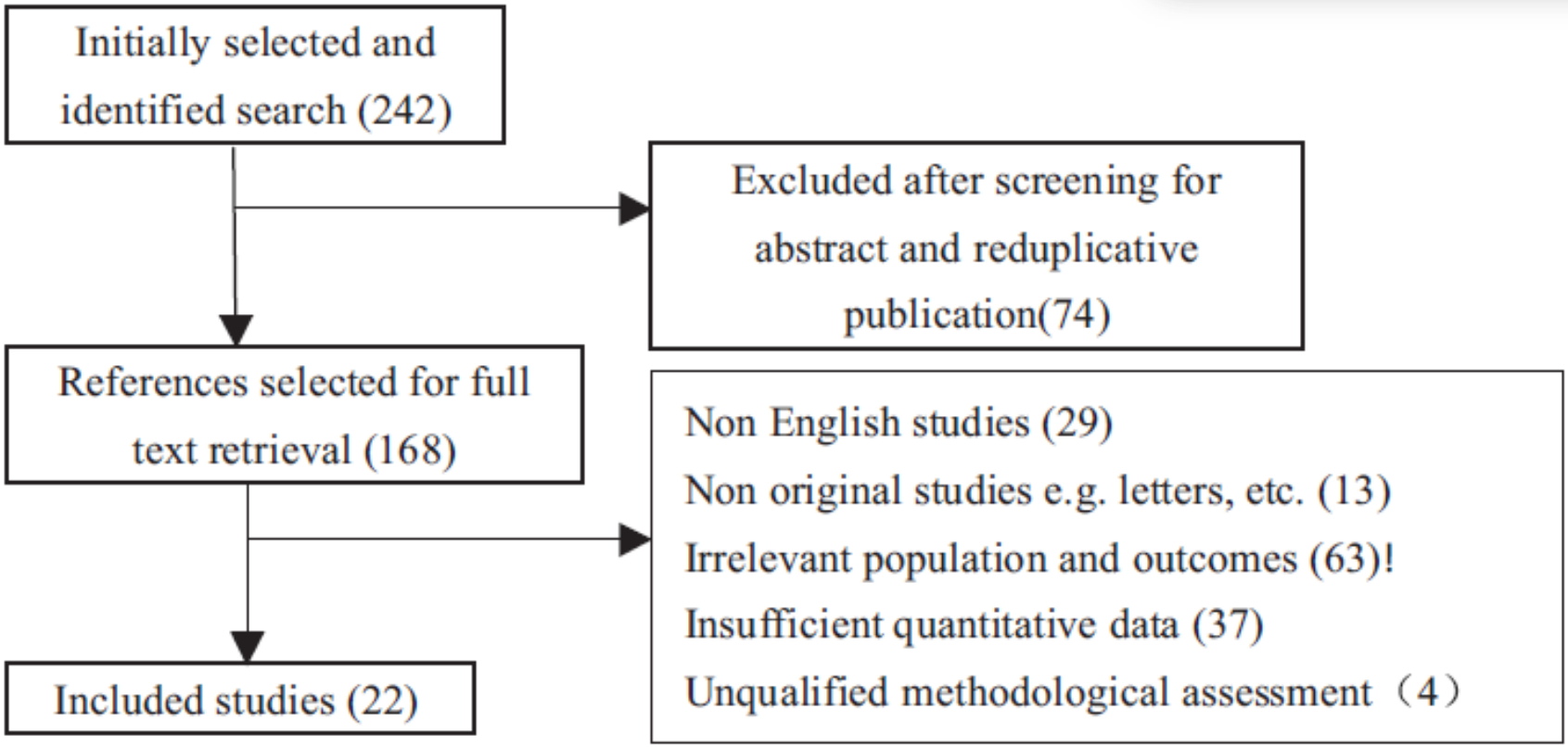
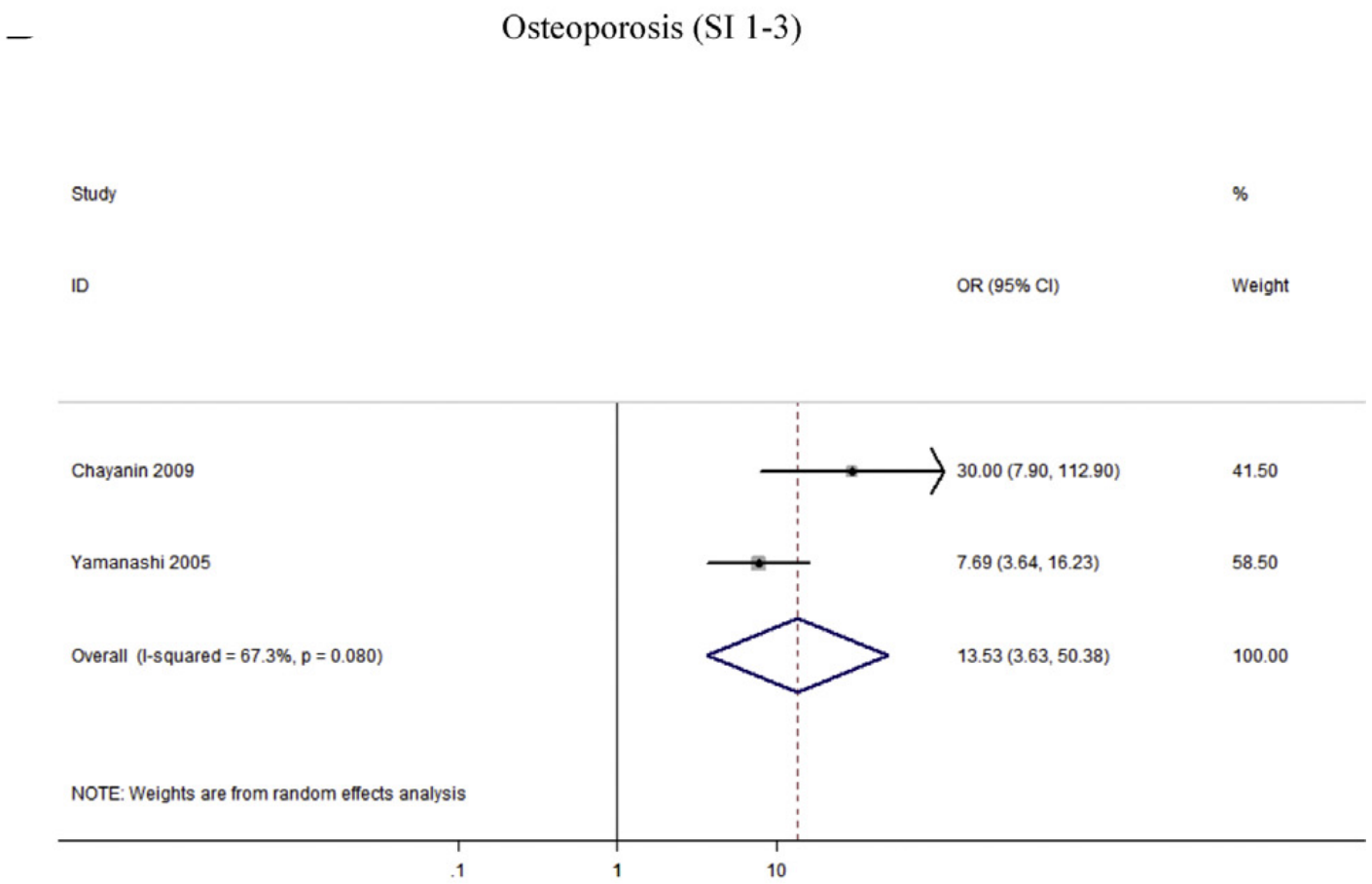


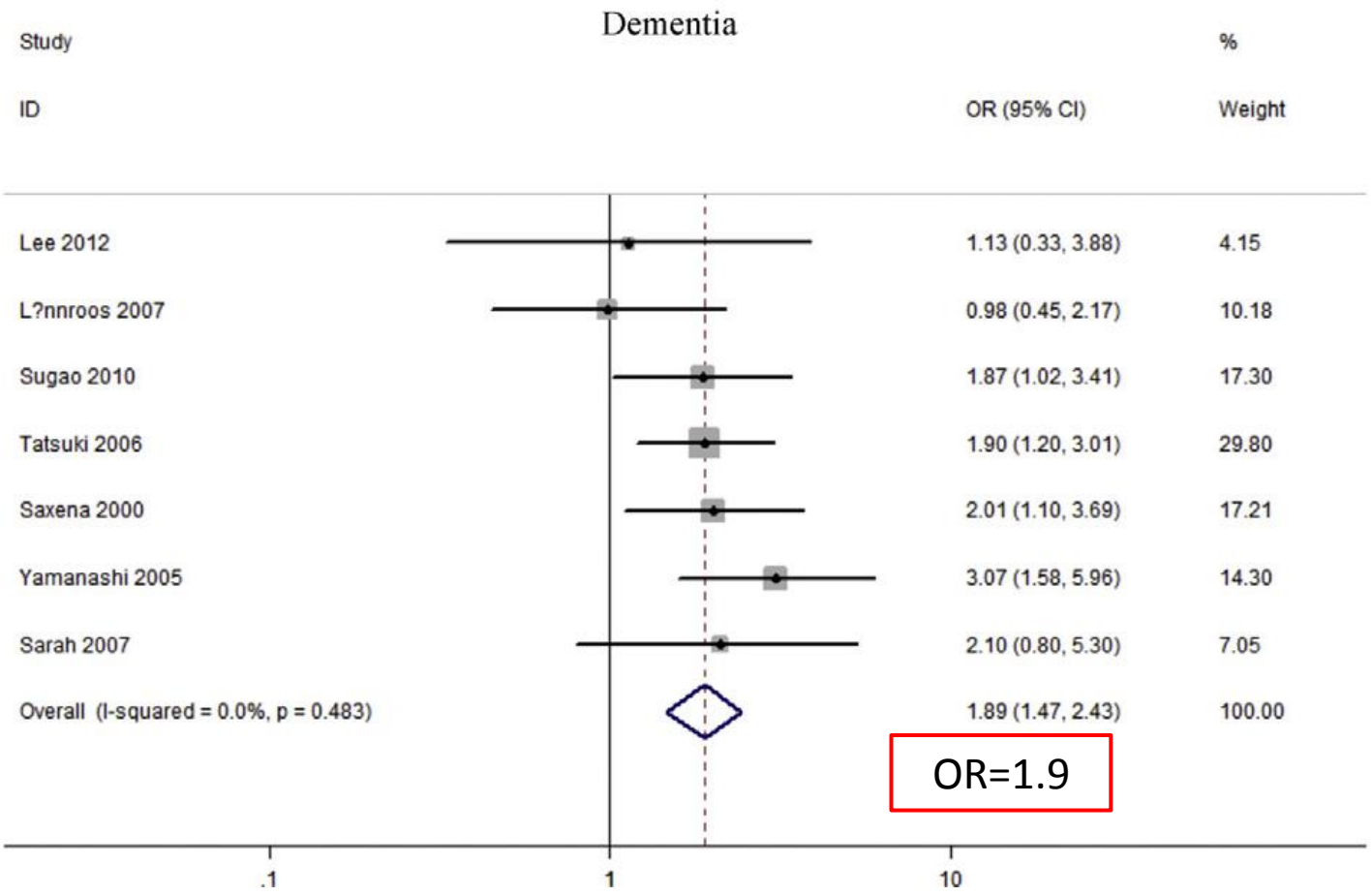
Fig. 1. Flow diagram of literature searching.

Ostéoporose

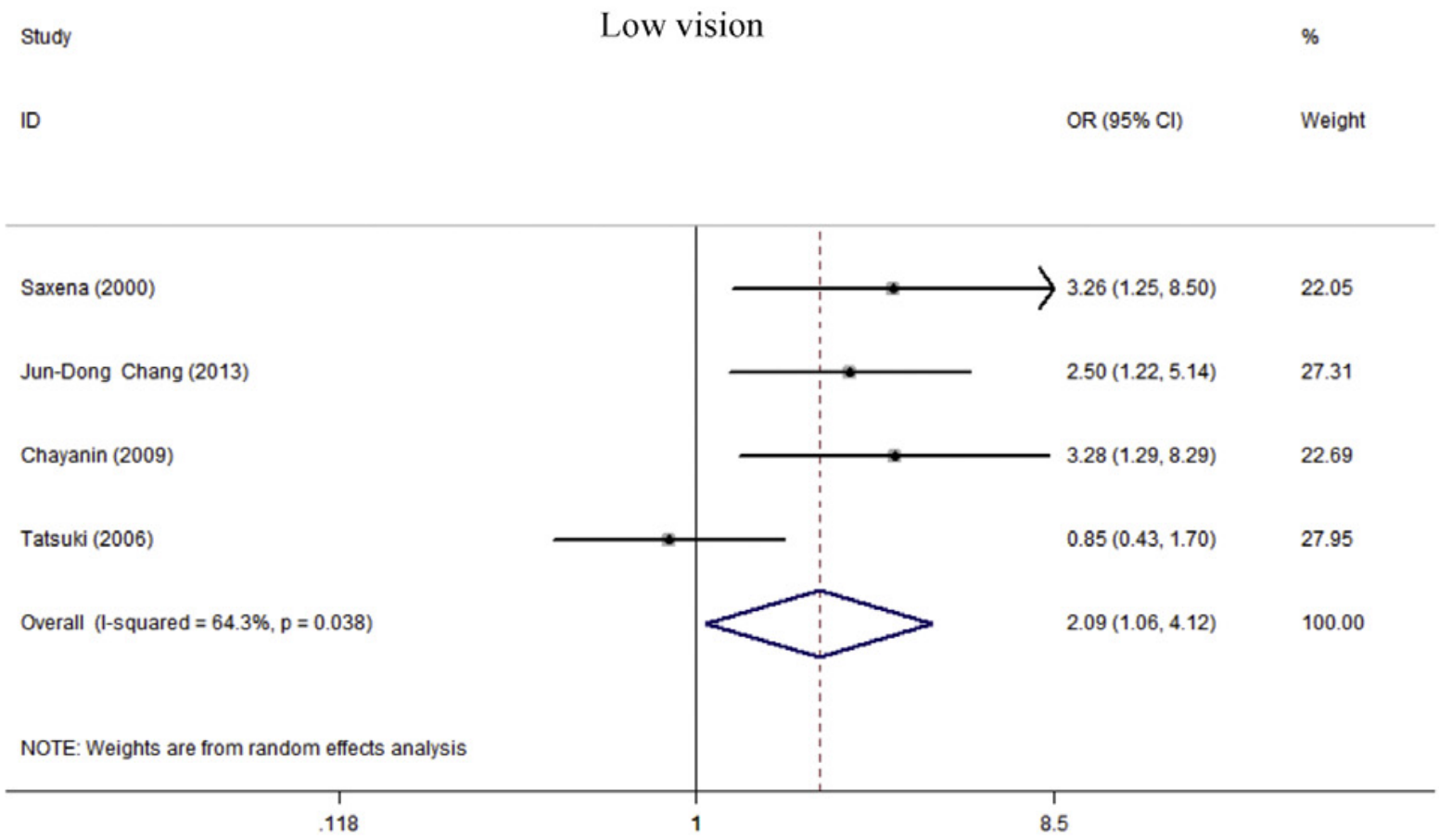


OR=13.5

Démence


Dementia
Study
ID
OR (95% CI)
%
Weight
Lee 2012
1.13 (0.33, 3.88)
4.15
L?nnroos 2007
0.98 (0.45, 2.17)
10.18
Sugao 2010
1.87 (1.02, 3.41)
17.30
Tatsuki 2006
1.90 (1.20, 3.01)
29.80
Saxena 2000
2.01 (1.10, 3.69)
17.21
Yamanashi 2005
3.07 (1.58, 5.96)
14.30
Sarah 2007
2.10 (0.80, 5.30)
7.05
Overall (I-squared = 0.0%, p = 0.483)
1.89 (1.47, 2.43)
100.00
OR=1.9
.1
1
10

Basse vision



Les facteurs de risque

Potential risk	No. of studies	Pooled OR or SMD	*P* value
Female	15	1.46	<0.001[a]
Age	9	0.08	0.415[b]
BMI	4	−0.10	0.144[a]
Institutionalized	4	2.23	0.004[b]
Dementia	7	1.89	<0.001[a]
Low vision	4	2.09	0.034[b]
Cardiac disease	7	1.32	0.032[a]
Diabetes mellitus	7	1.35	0.132[b]
Hypertension	5	0.97	0.806[a]
Parkinson	2	2.90	0.004
Respiratory disease	6	1.97	0.011[b]
Neurological diseases	8	1.17	0.244[b]
Fracture type (femoral neck)	9	1.06	0.672[b]
Surgical type (osteosynthesis)	3	0.75	0.311[b]
Cognitive impairment	3	2.01	0.077[b]
Osteoarthritis	3	1.47	0.483[b]
Osteoporosis (SI 1–3)	2	10.02	<0.001[a]
Alcoholism	2	1.93	0.266[a]
Cancer	2	0.71	0.400[a]

Research

Original Investigation

Effect of Citalopram on Agitation in Alzheimer Disease
The CitAD Randomized Clinical Trial

Anton P. Porsteinsson, MD; Lea T. Drye, PhD; Bruce G. Pollock, MD, PhD; D. P. Devanand, MD; Constantine Frangakis, PhD; Zahinoor Ismail, MD; Christopher Marano, MD; Curtis L. Meinert, PhD; Jacobo E. Mintzer, MD, MBA; Cynthia A. Munro, PhD; Gregory Pelton, MD; Peter V. Rabins, MD; Paul B. Rosenberg, MD; Lon S. Schneider, MD; David M. Shade, JD; Daniel Weintraub, MD; Jerome Yesavage, MD; Constantine G. Lyketsos, MD, MHS; for the CitAD Research Group

IMPORTANCE Agitation is common, persistent, and associated with adverse consequences for patients with Alzheimer disease. Pharmacological treatment options, including antipsychotics are not satisfactory.

OBJECTIVE The primary objective was to evaluate the efficacy of citalopram for agitation in patients with Alzheimer disease. Key secondary objectives examined effects of citalopram on function, caregiver distress, safety, cognitive safety, and tolerability.

DESIGN, SETTING, AND PARTICIPANTS The Citalopram for Agitation in Alzheimer Disease Study (CitAD) was a randomized, placebo-controlled, double-blind, parallel group trial that enrolled 186 patients with probable Alzheimer disease and clinically significant agitation from 8 academic centers in the United States and Canada from August 2009 to January 2013.

INTERVENTIONS Participants (n = 186) were randomized to receive a psychosocial intervention plus either citalopram (n = 94) or placebo (n = 92) for 9 weeks. Dosage began at 10 mg per day with planned titration to 30 mg per day over 3 weeks based on response and tolerability.

Editorial page 677

Author Video Interview at jama.com

Supplemental content at jama.com

JAMA. 2014;311(7):682-691.

Contexte

Symptôme fréquent chez les patients ayant la maladie d'Alzheimer

AGITATION

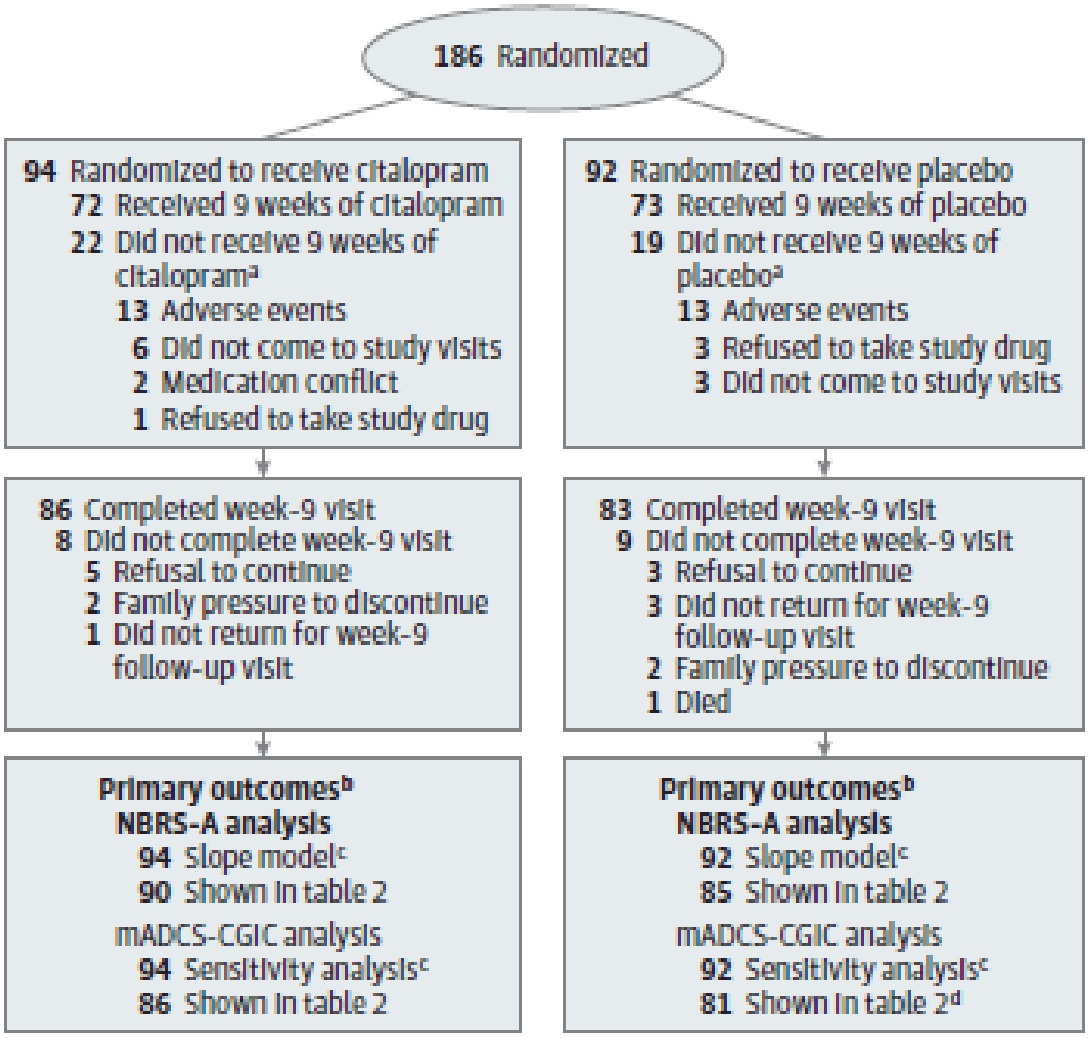
- Pas de traitement pharmacologique satisfaisant

Essai randomisé controllé en double aveugle : citalopram 30 mg/j VS placebo

Critères d'inclusion

- Maladie d'Alzheimer
- Avec agitation (NPI)
- Présence d'un aidant
- MMSE 5 à 28
- Tt IACE ou mémantine stable

Figure 1. Participant Flow in Randomization to Citalopram vs Placebo for Agitation in Alzheimer Disease



Caractéristiques des patients

Table 1. Patient Characteristics at Baseline

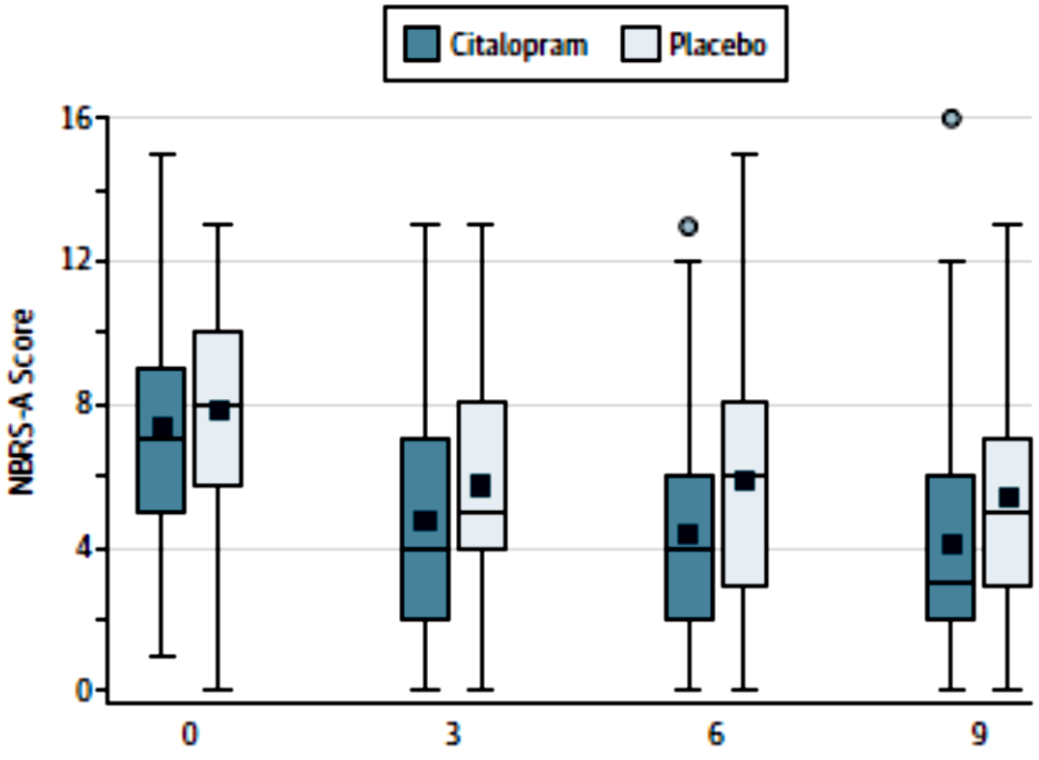
	Citalopram (n=94)	Placebo (n=92)
Age, mean (SD), y	78 (9)	79 (8)
Women, No. (%)	44 (47)	41 (45)
Highest education, No. (%)		
No high school diploma	25 (27)	27 (29)
High school diploma	20 (21)	23 (25)
Associates degree or some college	18 (19)	11 (12)
Bachelor's degree	21 (22)	16 (17)
Professional or graduate degree	10 (11)	15 (16)

Table 1. Patient Characteristics at Baseline

	Citalopram (n=94)	Placebo (n=92)
Duration of dementia, mean (SD), y	5 (4)	5 (4)
Concomitant medications, No. (%)		
Cholinesterase inhibitors	62 (66)	66 (72)
Memantine	41 (44)	37 (40)
Lorazepam	6 (6)	9 (10)
Trazodone	11 (12)	8 (9)
History of anxiety or mood disorder, No. (%)[a]	11 (12)	14 (15)
Assessment, mean (SD), score		
NBRS-A[b]	7.4 (3.3)	7.8 (3.0)
CMAI[c]	27.7 (6.7)	28.7 (6.7)
NPI[d]		
Total score	37.3 (17.5)	37.3 (17.7)
Agitation subscore	7.8 (2.2)	8.0 (2.4)
Depression subscore	2.2 (3.1)	1.9 (2.7)
Caregiver distress	16.8 (8.3)	16.8 (8.7)
MMSE[e]	17.0 (6.2)	14.4 (6.9)
ADCS-ADL[f]	44.6 (19.0)	41.1 (17.8)

Critère de jugement principal

Figure 2. Neurobehavioral Rating Scale (NBRS)-Agitation Subscale



No. of participants				
Citalopram	94	87	85	86
Placebo	92	84	84	81

Différence à 9 semaines
−0.93
(95%CI, −1.80 to −0.06),
***P* = .04.**

Autres effets

Item	Citalopram	Placebo	P
Clinical impression of change (amélioration)	40%	26%	0.007
Cohen-Mansfield (CMAI)	23.8	26.2	0.008
MMSE	-0.3	+0.9	0.03
ADL	40.1	41.1	NS
Allongement QT	12%	4%	
Perte de poids	1,2%	10,1%	0.02
Hyponatrémie	5%	8%	NS

Conclusion

- **Effet significatif** sur l'agitation dans la maladie d'Alzheimer (> placebo)
- Effet cliniquement pertinent (impression globale de changement)
- Effets secondaires à ceux attendus
- A confirmer par d'autres essais

CLINICAL INVESTIGATIONS

Effect of the Bathing Without a Battle Training Intervention on Bathing-Associated Physical and Verbal Outcomes in Nursing Home Residents with Dementia: A Randomized Crossover Diffusion Study

Pedro Gozalo, PhD, MSc,[*†] *Shivaani Prakash, MSc,*[†] *Danya M. Qato, PharmD, MPH, PhD,*[*†] *Philip D. Sloane, MD, MPH,*[‡§] *and Vincent Mor, PhD*[*¶¶]

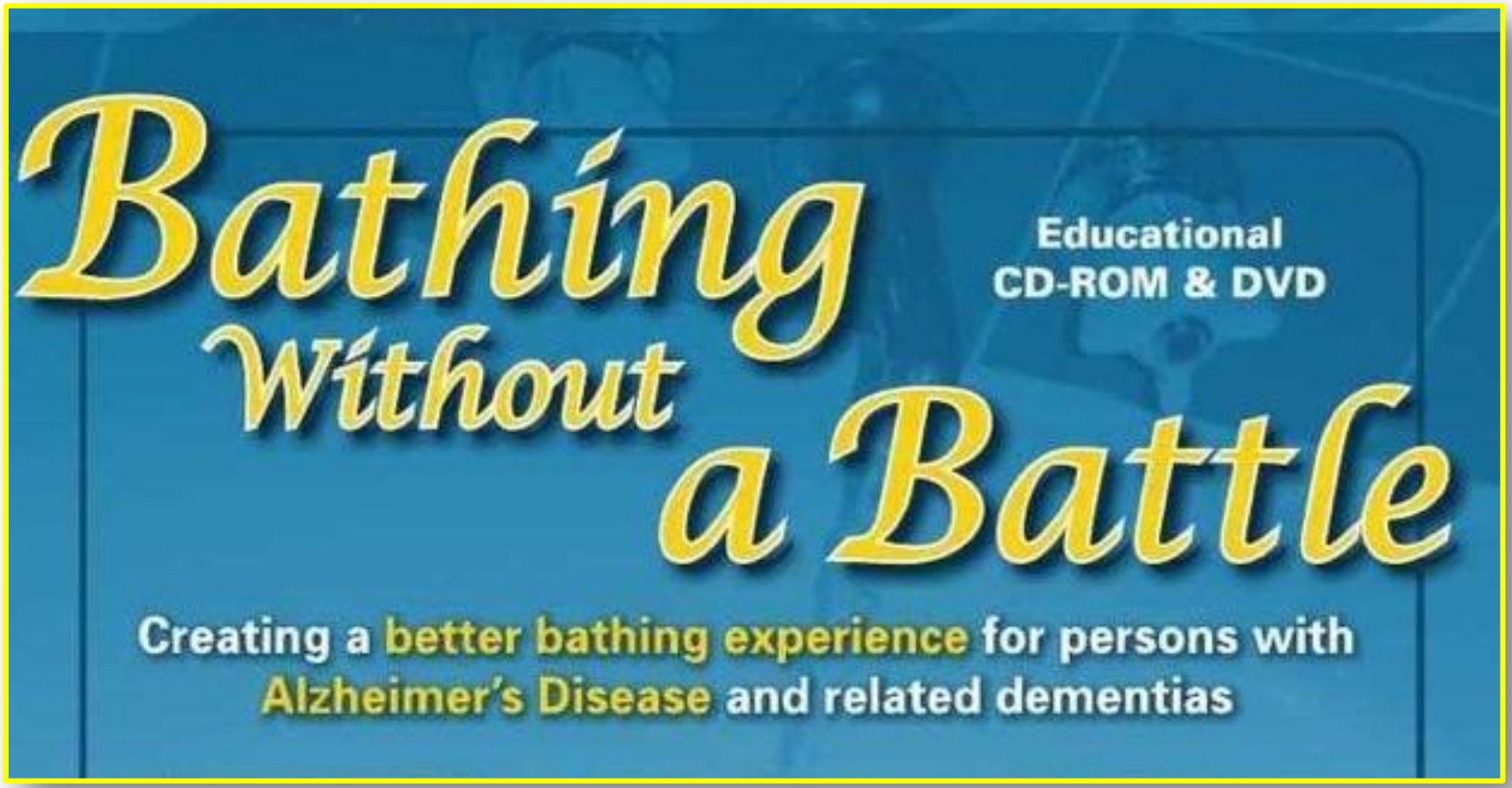
OBJECTIVES: To evaluate the effectiveness of the Bathing Without a Battle intervention in reducing physical and verbal aggressive behaviors for nursing home residents with dementia.

DESIGN: A randomized crossover diffusion study, with one group receiving the intervention after one round of baseline observations and a delayed intervention group receiving the intervention after two rounds of baseline

aggressive and agitated behaviors, particularly verbal, during residents' baths. The use of in-bed baths increased 17%, and average bath duration decreased significantly (average 1.5 minutes less) in the postintervention period, particularly for in-bed baths. Verbal behaviors declined 17.8% ($P = .008$), combined verbal and physical behaviors declined 18.6% ($P = .004$), and antipsychotic use declined 30% ($P = .002$) after the intervention.

CONCLUSION: The Bathing Without a Battle educa-

Gozalo P, J Am Geriatr Soc 2014;62:797-804.



CONTEXTE

Programme de recherche ➔ toilette centrée sur le patient pour malades déments en institution et s'opposant à la toilette

➔ Évaluation du comportement des résidents

➔ Mise au point d'un programme de formation

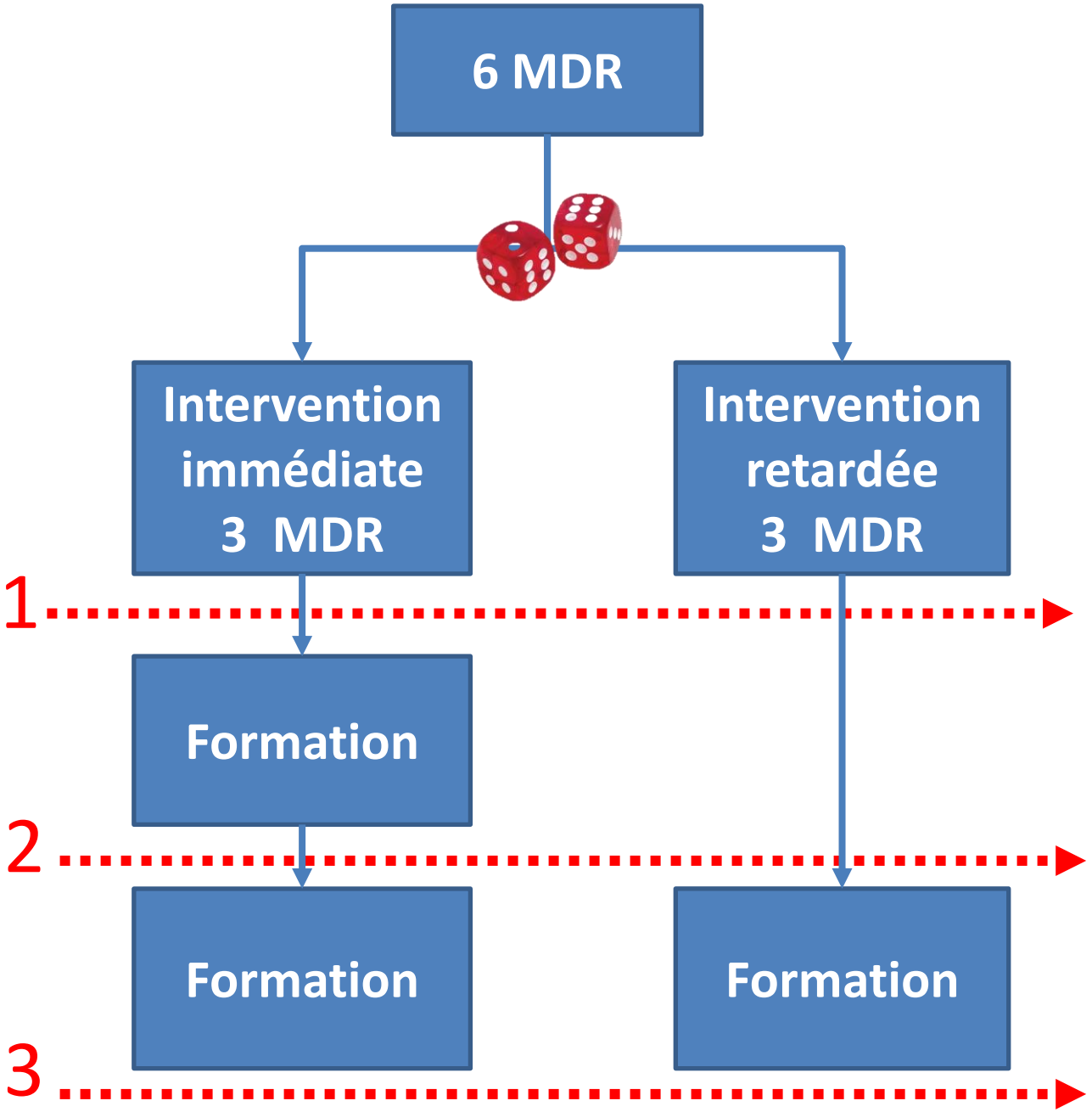
OBJECTIF DE l'ETUDE

➔ Etude de dissémination : Quel effet du programme en maison de retraite

Méthodes

- 6 maisons de retraite de la région de New-York
- Etude randomisée en cross-over
- Intervention = programme de formation pour les personnes chargées de la toilette des résidents

DESIGN de l'étude



Caractéristiques des 240 résidents

➔ **Pas de différence significative entre les résidents des 2 groupes**

Characteristic	Total, N = 240
Age, mean ± SD	84.7 ± 11.2
Female, %	65.8
Activity of daily living score,	
Bed mobility	2.0 ± 1.5
Transfer	2.2 ± 1.5
Locomotion	2.2 ± 1.6
Dressing	3.1 ± 0.9
Eating	1.8 ± 1.5
Toileting	2.9 ± 1.3
Hygiene	3.1 ± 1.0
Bathing	3.4 ± 0.8
Incontinent of bladder, %	63.3
Incontinent of bowel, %	57.5
Any incontinence, %	67.9
Cognitive Performance Scale score, mean ± SD[b]	4.1 ± 1.2

Evolution des toilettes après la formation (obs 1 vs obs 3)

	Avant	Après	P
Douches	68,8%	56,9%	0,001
Toilette au lit	11,3%	28,5%	<0,001
Toilette au lavabo	11,9%	5,7%	<0,001
Durée de la toilette	9,4 +/- 5,2	7,9 +/- 4,1	<0,001

Effets sur le comportement des résidents

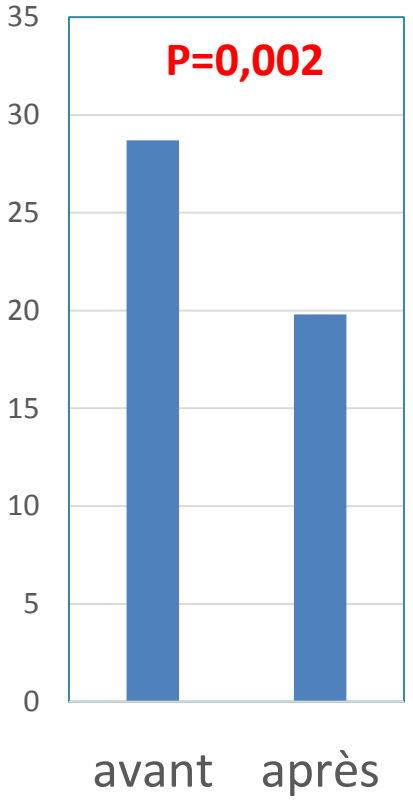
Table 4. Observed Behaviors for Group 1 and 2 Facilities According to Intervention Status: Percentage of Bath Time with Any Behavior

Behavior	Before Intervention		After Intervention		*P*-Value for Difference Between Before and After Intervention
	Group 1	Group 2	Group 1	Group 2	
Baths, n	263	403	329	115	
Outcome (percentage of bath time with any), mean ± SD					
Any physically or verbally aggressive or agitated behavior	22.6 ± 30.3	25.4 ± 32.9	19.6 ± 28.7	20.3 ± 32.1	.004
Any physically aggressive behavior	6.2 ± 17.1	4.8 ± 15.6	4.9 ± 13.9	3.8 ± 15.2	.39
Grabbing caregiver	4.7 ± 15.2	3.6 ± 12.8	3.3 ± 11.7	3.5 ± 14.9	.15
Hitting	3.2 ± 11.7	1.8 ± 10.4	2.2 ± 7.6	1.0 ± 6.6	.95
Kicking	0.3 ± 2.5	0.9 ± 8.1	0.3 ± 2.8	0.1 ± 1.2	.28
Biting	0.1 ± 1.5	0.7 ± 7.6	0.1 ± 1.0	0.5 ± 5.4	.39
Throwing objects	0.0 ± 0.0	0.6 ± 6.7	0.01 ± 1.3	0.0 ± 0.0	>.99
Spitting	0.7 ± 2.2	0.3 ± 6.2	0.4 ± 4.8	0.8 ± 5.0	.60
Any verbally aggressive or agitated behavior	20.9 ± 29.8	24.6 ± 32.8	18.8 ± 28.2	19.8 ± 31.6	.008
Aggressive language	2.2 ± 11.1	1.8 ± 9.3	1.7 ± 9.1	2.2 ± 16.0	.92
Call for help or protesting	19.5 ± 28.2	17.9 ± 28.1	17.4 ± 26.5	10.9 ± 22.1	.04
Yelling	6.7 ± 21.5	10.3 ± 24.8	7.4 ± 21.4	10.8 ± 25.7	.86

Effets sur le comportement des résidents

Behavior	*P*-Value for Difference Between Before and After Intervention
Baths, n	
Outcome (percentage of bath time with any), mean ± SD	
Any physically or verbally aggressive or agitated behavior	.004
Any verbally aggressive or agitated behavior	.008
Aggressive language	.92
Call for help or protesting	.04
Yelling	.86

% de résidents ayant des neuroleptiques



New Oral Anticoagulants in Elderly Adults: Evidence from a Meta-Analysis of Randomized Trials

Partha Sardar, MD, Saurav Chatterjee, MD,† Shobhana Chaudhari, MD,* and Gregory Y. H. Lip, MD‡*

OBJECTIVES: To evaluate the efficacy and safety of new oral anticoagulants (NOACs) in elderly adults.

DESIGN: Meta-analyses of randomized clinical trials (RCTs).

SETTING: PubMed, Cochrane Library, EMBASE, Web of Science, and CINAHL databases were searched from January 1, 2001, through March 30, 2013.

PARTICIPANTS: Elderly population (≥75) in RCTs comparing NOACs (rivaroxaban, apixaban, and dabigatran) with conventional therapy.

MEASUREMENTS: Two authors reviewed the trials, and odds ratios (ORs) were calculated using a random effects model.

RESULTS: Ten RCTs included 25,031 elderly participants. Risk of major or clinically relevant bleeding was not significantly different between NOACs and conventional therapy in elderly adults (OR = 1.02, 95% confidence interval = 0.73–1.43). Similar results were observed

Key words: new anticoagulants; elderly; meta-analysis

The prevalence of arterial and venous thromboembolic diseases increases with age.[1–3] For individuals aged 80 to 90, risk of atrial fibrillation (AF) related stroke also increases with age; in the Framingham Study, 23.5% of strokes in individuals aged 80 and older were attributable to AF.[4] Age 75 and older is considered a risk factor in stroke risk-stratification schemes and contributes 1 point toward a maximum risk score of 6 in the cardiac failure, hypertension, age, diabetes, stroke ($CHADS_2$) scheme.[5,6] In the CHA_2DS_2-VASc score, aged 75 and older contributes 2 points toward a maximum score of 9.[5,7] The prevalence of other risk factors, including hypertension, prior

Sardar P, J Am Geriatr Soc 2014;62:856-64.

Objectifs de la méta-analyse

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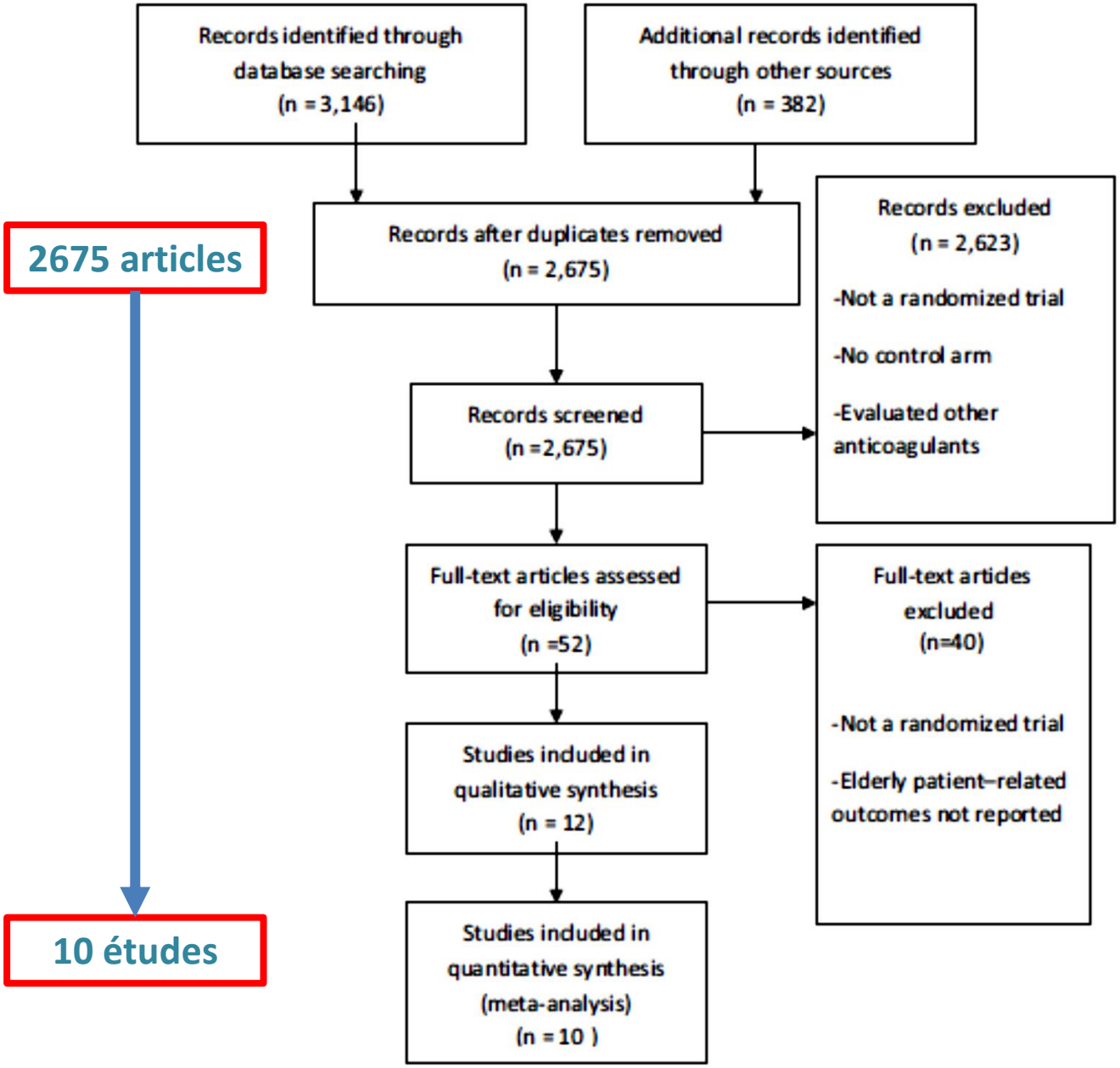

Records identified through database searching (n = 3,146)
Additional records identified through other sources (n = 382)
2675 articles
Records after duplicates removed (n = 2,675)
Records excluded (n = 2,623)
-Not a randomized trial
-No control arm
-Evaluated other anticoagulants
Records screened (n =2,675)
Full-text articles assessed for eligibility (n =52)
Full-text articles excluded (n=40)
-Not a randomized trial
-Elderly patient–related outcomes not reported
Studies included in qualitative synthesis (n = 12)
10 études
Studies included in quantitative synthesis (meta-analysis) (n = 10)

Les essais cliniques inclus

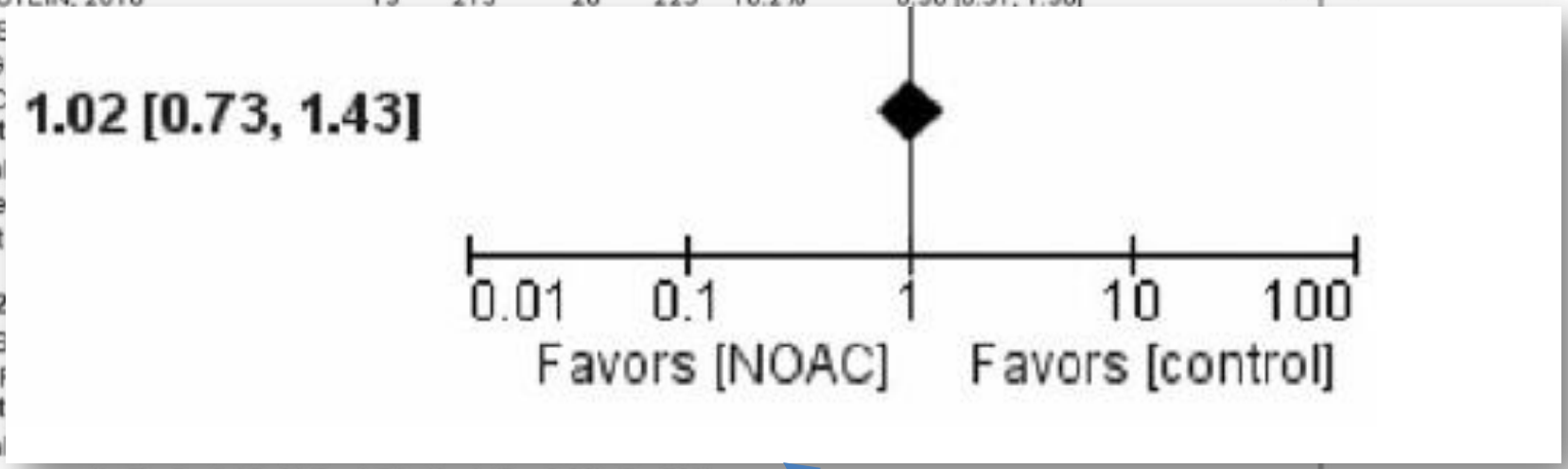
Trial (Reference)	Intervention	Control	NOAC Group According to Age, n	Control Group According to Age, n
Atrial fibrillation				
ROCKET-AF (2011)[25]	Rivaroxaban 20 mg once daily	Warfarin	>75 = 3,082[b]	>75 = 3,082[b]
ARISTOTLE (2011)[27]	Apixaban 5 mg twice daily	Warfarin	>75 = 2,743 65–75 = 3,504	>75 = 2,752 65–75 = 3,660
AVERROES (2011)[28]	Apixaban 5 mg twice daily	Aspirin 81–324 mg/d	>75 = 909 65–75 = 1,090	>75 = 983 65–75 = 942
RE-LY (2009)[30]	Dabigatran 150 mg twice daily	Warfarin	>75 = 4,828 [b]	>75 = 2,360 [b]
Acute VTE or pulmonary embolism				
EINSTEIN (2010)[22]	Rivaroxaban 15 mg twice daily for 3 weeks, followed by 20 mg once daily	Enoxaparin/ VKA	>75 = 215 65–75 = 371	>75 = 225 65–75 = 382
EINSTEIN PE (2012)[23]	Rivaroxaban 15 mg twice daily for 3 weeks, followed by 20 mg once daily	Enoxaparin/ VKA	>75 = 441 65–75 = 517	>75 = 402 65–75 = 532
Extended treatment of VTE				
EINSTEIN-Extension (2012)[22]	Rivaroxaban 20 mg daily	Placebo	>75 = 89 65–75 = 153	>75 = 99 65–75 = 121
AMPLIFY-EXT (2013)[26]	Apixaban 5 and 2.5 mg twice daily	Placebo	>75 = 220 65–75 = 318	>75 = 109 65–75 = 172
RE-MEDY (2013)[29]	Dabigatran 150 mg twice daily (N = 1,430)	Warfarin	>75 = 140 65–75 = 303	>75 = 119 65–75 = 288
Medically ill participants				
MAGELLAN (2013)[24]	Rivaroxaban 10 mg once daily	Enoxaparin 40 mg/d for 10 ± 4 days and oral placebo for 35 ± 4 days	>75 = 1,084 65–75 = 862	>75 = 1,149 65–75 = 842

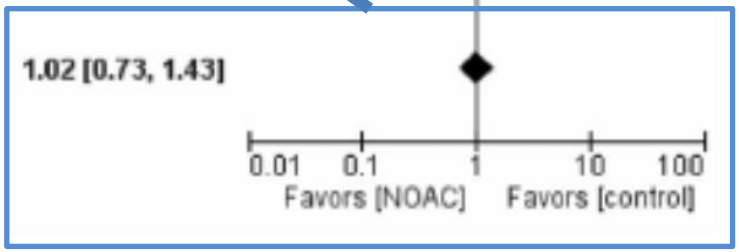
Les hémorragies

Patients aged more than 75 years: Major or clinically relevant bleeding

Study or Subgroup	NOAC Events	NOAC Total	Control Events	Control Total	Weight	Odds Ratio M-H, Random, 95% CI
1.1 Rivaroxaban						
EINSTEIN PE, 2012	58	440	67	401	13.9%	0.76 [0.52, 1.11]
EINSTEIN, 2010	19	215	20	223	10.2%	0.98 [0.51, 1.90]
EINS						
MAG						
ROC						
Subt						**1.02 [0.73, 1.43]**
Total						
Hete						
Test						
1.2						
ARIS						
AVEI						
Subt						
Total						
Heterogeneity: Tau² = 0.17; Chi² = 4.54, df = 1 (P = 0.03); I² = 78%						
Test for overall effect: Z = 0.68 (P = 0.50)						
1.3 Dabigatran						
RE-LY, 2009	450	4,828	206	2,360	16.1%	1.07 [0.90, 1.28]
Subtotal (95% CI)		**4,828**		**2,360**	**16.1%**	**1.07 [0.90, 1.28]**
Total events	450		206			
Heterogeneity: Not applicable						
Test for overall effect: Z = 0.82 (P = 0.41)						
Total (95% CI)		**13,625**		**11,083**	**100.0%**	**1.02 [0.73, 1.43]**
Total events	868		697			
Heterogeneity: Tau² = 0.17; Chi² = 50.25, df = 7 (P < 0.00001); I² = 86%						
Test for overall effect: Z = 0.13 (P = 0.89)						
Test for subgroup differences: Chi² = 0.87, df = 2 (P = 0.65), I² = 0%						

Odds Ratio M-H, Random, 95% CI

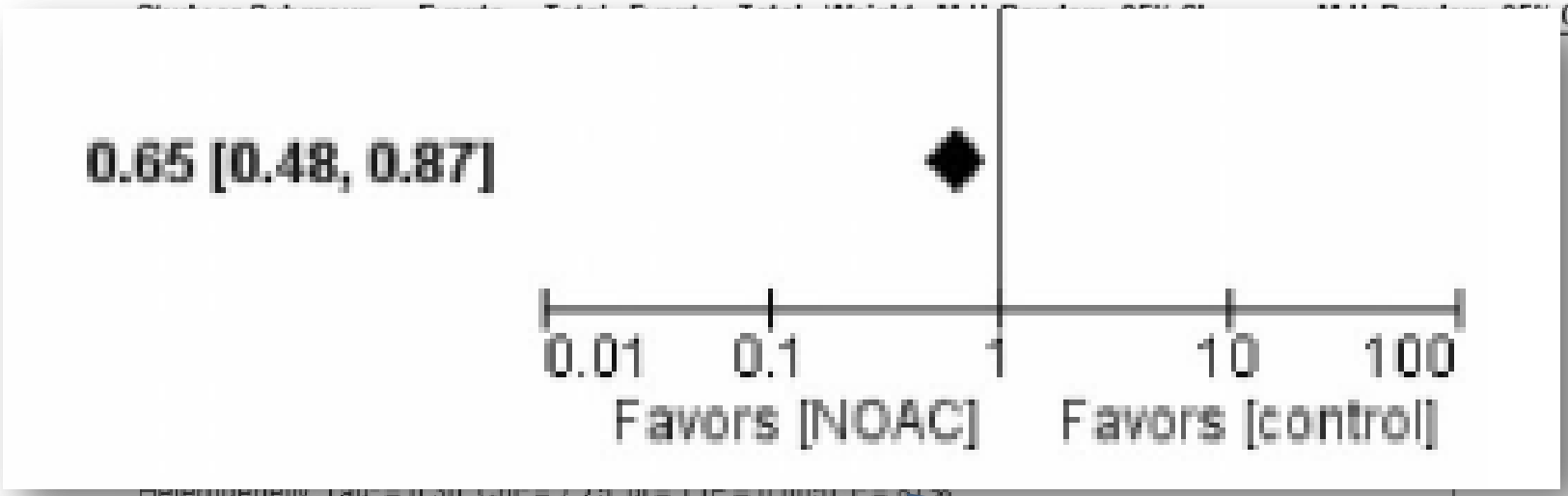


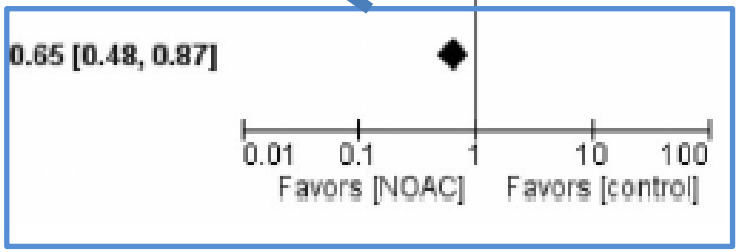


Les accidents emboliques

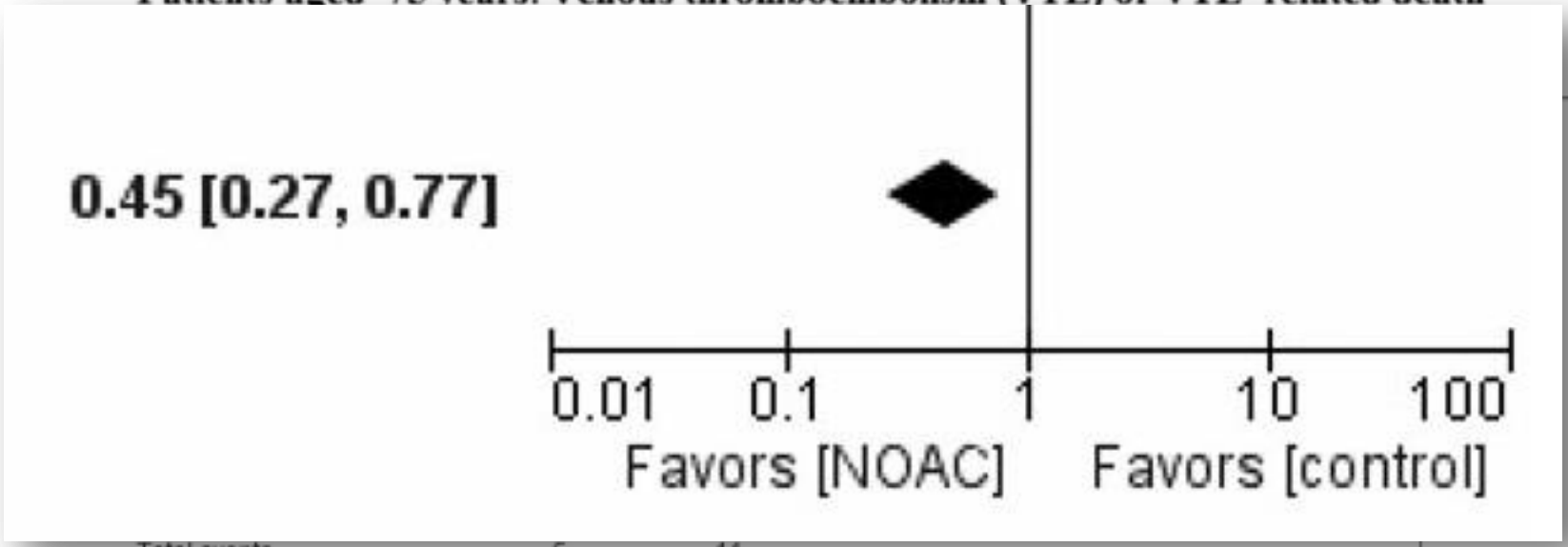
Patients aged more than 75 years: Stroke or systemic embolism

	NOAC		Control			Odds Ratio	Odds Ratio
Test for overall effect: Z = 1.73 (P = 0.08)							
1.3 Dabigatran							
RE-LY, 2009	156	4,828	101	2,360	28.0%	0.75 [0.58, 0.96]	
Subtotal (95% CI)		**4,828**		**2,360**	**28.0%**	**0.75 [0.58, 0.96]**	
Total events	156		101				
Heterogeneity: Not applicable							
Test for overall effect: Z = 2.24 (P = 0.03)							
Total (95% CI)		**11,562**		**9,177**	**100.0%**	**0.65 [0.48, 0.87]**	
Total events	380		430				
Heterogeneity: Tau² = 0.06; Chi² = 11.19, df = 3 (P = 0.01); I² = 73%							
Test for overall effect: Z = 2.87 (P = 0.004)							
Test for subgroup differences: Chi² = 1.37, df = 2 (P = 0.51), I² = 0%							





Maladie veineuse thromboembolique

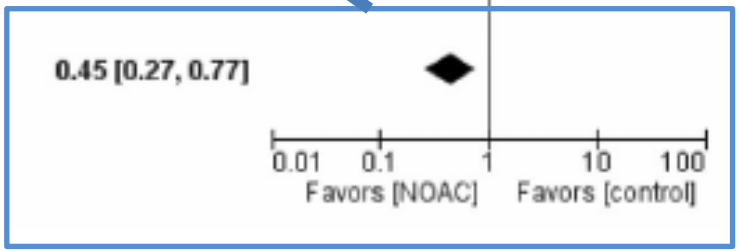


Total events 5 11
Heterogeneity: Not applicable
Test for overall effect: Z = 2.85 (P = 0.004)

1.3 Dabigatran

RE-MEDY, 2013 0 140 0 119 Not estimable
Subtotal (95% CI) **140** **119** **Not estimable**
Total events 0 0
Heterogeneity: Not applicable
Test for overall effect: Not applicable

Total (95% CI) **2,189** **2,103** **100.0%** **0.45 [0.27, 0.77]**
Total events 81 147
Heterogeneity: Tau² = 0.15; Chi² = 7.23, df = 4 (P = 0.12); I² = 45%
Test for overall effect: Z = 2.91 (P = 0.004)
Test for subgroup differences: Chi² = 2.70, df = 1 (P = 0.10), I² = 63.0%



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A Spanish Pillbox App for Elderly Patients Taking Multiple Medications: Randomized Controlled Trial

Monitoring Editor: Gunther Eysenbach

Reviewed by Gonzalo Bacigalupe and Luis Fernandez-Luque

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ALICE

- Application pour tablette tactile iOS et Android
- Traitements personnalisés avec des photos du médicament
- Alertes et rappels pour prendre les médicaments
- Mesure de l’adhérence : le patient valide chaque prise ; transmission au centre investigateur

Essai randomisé

- 99 pts > 65 ans
- Polymédiqués
- Vivant au domicile
- Assez autonomes

« Soin usuel » VS **ALICE**
pdt 3 mois
➔ Évaluation :
- adhérence ;
- erreurs ;
- doses oubliées

Avec ALICE : personnalisation de l'application ; installation dur une tablette tactile ; formation de 2 heures pour expliquer le fonctionnement de l'application

Résultats

Effets significatifs avec ALICE

- Augmentation du score d'adhérence
- Diminution du nombre d'erreurs
- Diminution des doses manquées

Une tablette au secours des gélules !

Fréquence des chutes dans un service de réhabilitation après une intervention mixte : éducation du patient et formation du personnel

Articles

Fall rates in hospital rehabilitation units after individualised patient and staff education programmes: a pragmatic, stepped-wedge, cluster-randomised controlled trial

Anne-Marie Hill, Steven M McPhail, Nicholas Waldron, Christopher Etherton-Beer, Katharine Ingram, Leon Flicker, Max Bulsara, Terry P Haines

Summary

Background Falls are the most frequent adverse events that are reported in hospitals. We examined the effectiveness of individualised falls-prevention education for patients, supported by training and feedback for staff, delivered as a ward-level programme.

Published Online
April 10, 2015
http://dx.doi.org/10.1016/S0140-6736(14)61945-0

Méthodes

- 8 services de réhabilitation
- Critères d ’inclusion :
  - Admission en service de réhabilitation
  - MMSE > 23/30
- Mise en œuvre d’une intervention structurée :
  - Éducation individuelle du patient : visionner un DVD et 2 à 4 séances de 30 mn avec un éducateur
  - Formation du personnel : visant à expliquer les actions envers les patients et à renforcer leur effet

Caractéristiques des patients

	Intervention period (n=1623 admissions)	Control period (n=1983 admissions)
Age, years	81·4 (9·3)	82·1 (8·3)
Women	999 (62%)	1211 (61%)
Men	624 (38%)	772 (39%)
Length of stay in rehabilitation unit (days)	12 (7–21)	11 (6–20)
Diagnosis on admission to rehabilitation ward		
Medical disorders*	461 (28%)	654 (33%)
Orthopaedic, musculoskeletal†	369 (23%)	395 (20%)
Hip fracture	168 (10%)	182 (9%)
Stroke	192 (12%)	175 (9%)
Other neurological disease‡	101 (6%)	162 (8%)
Cardiac	141 (9%)	198 (10%)
Respiratory	105 (7%)	120 (6%)
Other surgerys§	86 (5%)	97 (5%)

Résultats

	Intervention period (n=1623 admissions)	Control period (n=1983 admissions)	Adjusted ratio (robust 95% CI), p value*
Falls/injurious falls/fallers/fractures	196/66/136/4	380/131/248/6	
Falls, rate per 1000 patient-days	7·80	13·78	IRR 0·60 (0·42–0·94), 0·003
Injurious falls, rate per 1000 patient-days	2·63	4·75	IRR 0·65 (0·42–0·88), 0·006
Fallers, % group having one or more falls	8%	13%	OR 0·55 (0·38–0·81), 0·003

Résultats

	Intervention period (n=1623 admissions)	Control period (n=1983 admissions)	Adjusted ratio (robust 95% CI), p value*
Higher cognition score†	914 (56%)	1016 (51%)	
Falls /injurious falls /fallers	61/23/52	137/34/92	
Falls, rate per 1000 patient-days	4·87	10·68	IRR 0·53 (0·36–0·77), 0·001
Lower cognition score	709 (44%)	967 (49%)	
Falls /injurious falls /fallers	135/43/84	243/97/156	
Falls, rate per 1000 patient-days	10·70	16·46	IRR 0·65 (0·40–1·05), 0·08

Conclusion

- 1ère étude à montrer l'efficacité d'un intervention pour réduire l'incidence des chutes chez les sujets âgés hospitalisés en réhabilitation
- Effets meilleurs lorsque les fonctions cognitives sont meilleures

Imagerie Aβ florbetapir et évolution dans le Mild cognitive impairment (MCI)

Journal of
Neurology, Neurosurgery
& Psychiatry

Neurodegeneration

RESEARCH PAPER

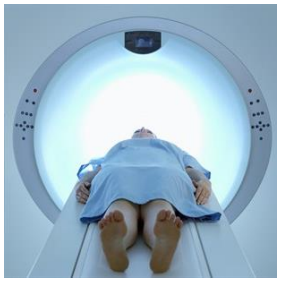
Aβ imaging with 18F-florbetaben in prodromal Alzheimer's disease: a prospective outcome study

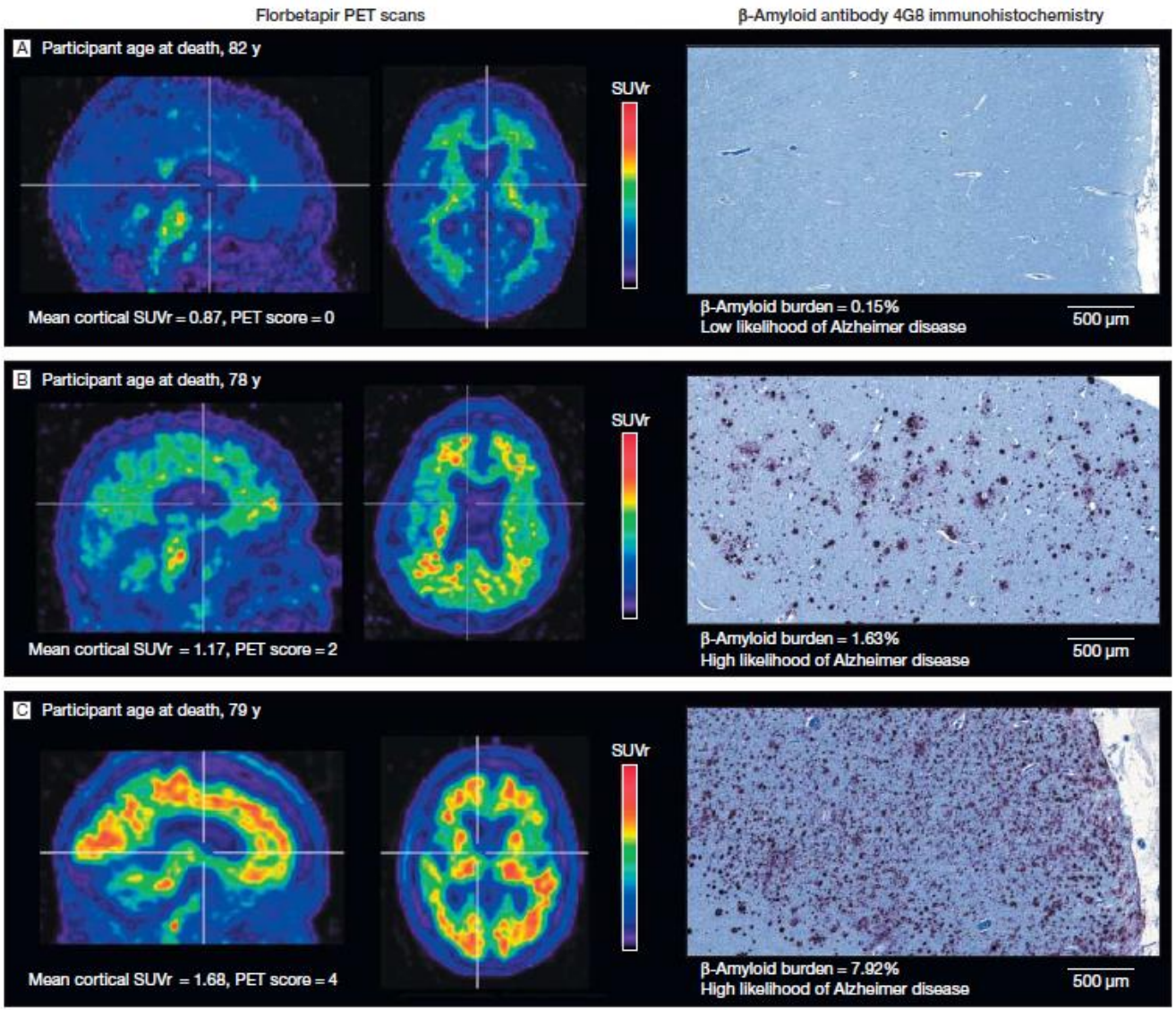
Kevin T Ong,[1] Victor L Villemagne,[1,2] Alex Bahar-Fuchs,[1,3] Fiona Lamb,[1] Narelle Langdon,[1] Ana M Catafau,[4] Andrew W Stephens,[4] John Seibyl,[5] Ludger M Dinkelborg,[4] Cornelia B Reininger,[6] Barbara Putz,[6] Beate Rohde,[6] Colin L Masters,[2] Christopher C Rowe[1]

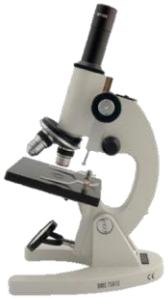
ABSTRACT

Background We assessed the clinical utility of β-amyloid (Aβ) imaging with ^{18}F-florbetaben (FBB) in positive individuals with mild cognitive impairment (MCI) due to AD reflecting differences in sample size, recruitment source, duration of follow-up and

Imagerie des plaques amyloides







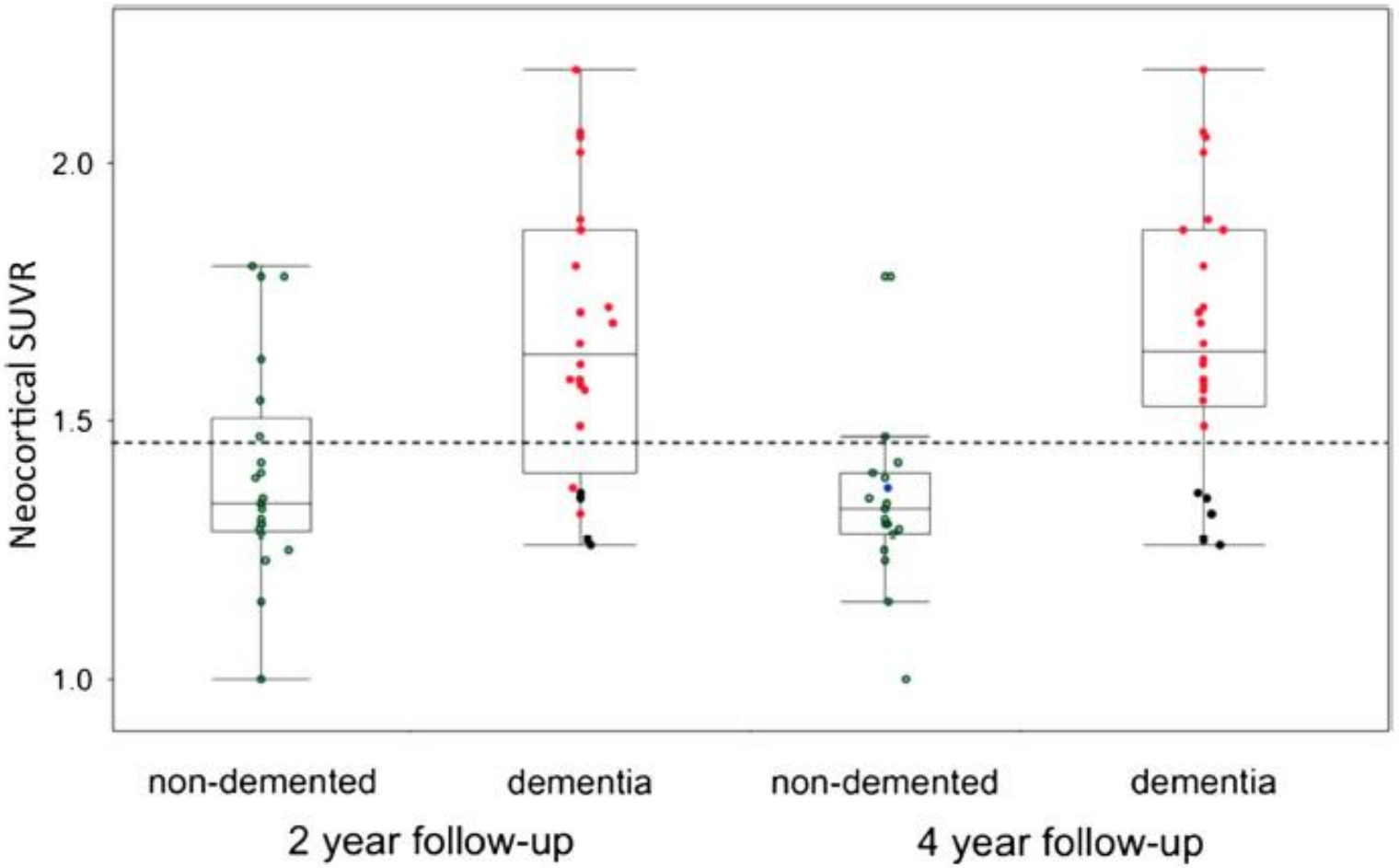
Clark CM,
JAMA 2011

Caractéristiques des 45 patients ayant un MCI

	FBB retention	
	Negative (FBB−)	Positive (FBB+)
N (% of total)	21 (47)	24 (53)
Age	71.8±6.1	73.5±6.9
Years of education	13.5±3.0	13.8±4.2
MMSE	27.9±1.4	26.7±1.9*
EM	−1.4±0.8	−2.8±1.0*
CDR SOB	1.3±0.9	1.6±1.0
Neocortical SUVR	1.30±0.09	1.75±0.19*
Hippocampal volume/cm^3	7.4±1.1	6.9±0.8

*$p<0.05$ compared with re

Captation corticale du traceur et évolution vers une démence de type Alzheimer



	Progressed to AD	
At baseline	Yes	No
FBB+ (by SUVR)**	18	6
FBB– (by SUVR)	2	19

PPV (%) (95% CI)	NPV (%) (95% CI)	Accuracy (95% CI)
75.0% (60% to 82%)	90.5% (74% to 98%)	82.8% (61% to 94%)

Equilibre postural et chutes chez les résidents de maison de retraite enrôlés dans un programme de danse de salon

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Postural balance and falls in elderly nursing home residents enrolled in a ballroom dancing program

Eliane Gomes da Silva Borges [a,*], Rodrigo Gomes de Souza Vale [a], Samária Ali Cader [a,b], Silvania Leal [a,b,c], Francisco Miguel [a], Carlos Soares Pernambuco [a,c], Estélio H.M. Dantas [a,c]

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ARTICLE INFO

Article history:
Received 8 November 2013

ABSTRACT

The aim of this study was to investigate the influence of a ballroom dancing program on the postural balance of institutionalized elderly residents. The sample consisted of 59 sedentary elderly residents of

RATIONNEL

DANSE DE SALON =

- Activité physique +
- Relations sociales

➔ BON POUR LA SANTE !

62 sujets âgés vivant en institution de soins de longue durée de Rio de Janeiro
Sans perte d'autonomie ni troubles cognitifs
Age 68 +/- 8 ans

Groupe Contrôle
Mode de vie habituel de l'institution

Groupe Intervention
50 mn de danse de salon
3 fois par semaine
pendant 12 semaines

Déroulement de la classe de danse

Echauffement 10 mn : Foxtrot, Waltz, Rumba, Swing, Samba, Bolero
Partie principale 30 mn : Forro, Pagode, Baia˜o, Cirandas, Salsa, Merengue, Square dancing
Relaxation 20 mn : Bolero, Samba, Waltz, Foxtrot

Evaluati

Nb de

E rie

Résultats

Équilibre postural

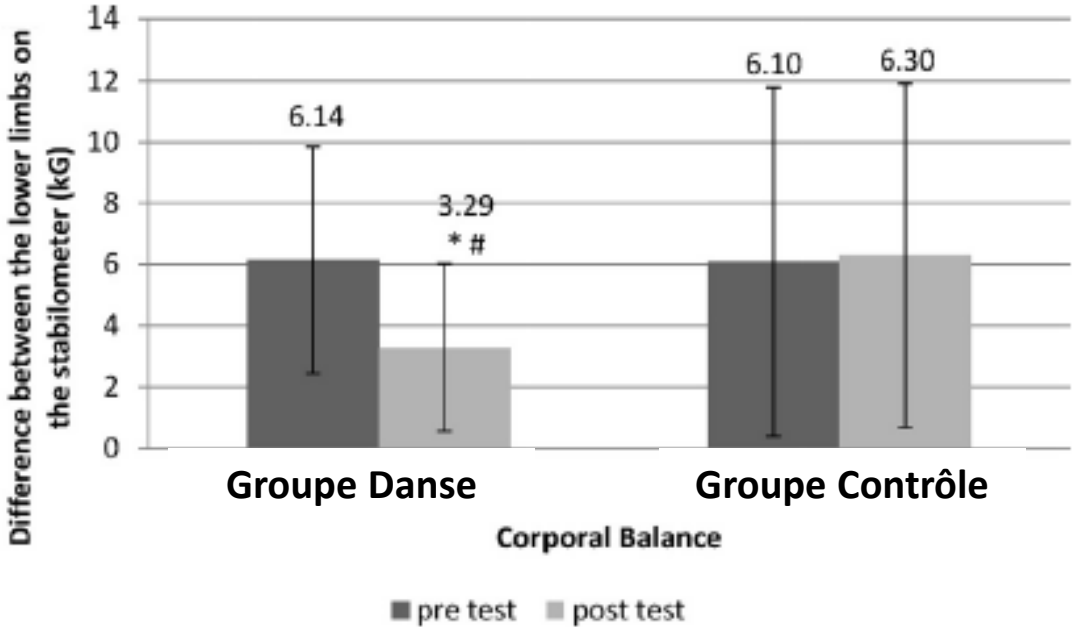

Fig. 1. Intra-and intergroup comparisons of the lower limb weight distribution. EG: experimental group; CG: control group. $^{*}p < 0.05$, pre- vs. post-test; $^{\#}p < 0.05$: EG vs. CG in the post-test.

Chutes :

Diminution significative dans le groupe Danse
p<0.0001

Quels mécanismes impliqués dans la danse-thérapie ?

Bien-être émotionnel
Bien-être physique
Bien-être mental

Equilibre
Force musculaire
Coordination
Latéralité
Rythme et réactivité du corps

Prévention des chutes

Faut-il prescrire la danse-thérapie dans les institutions françaises ?

➔ **Pas sans un large essai randomisé en EHPAD**