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Research paper

Psychiatric symptoms and use of psychotropic medication in elderly fall and syncope patients

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ABSTRACT

Introduction: The prevalence of psychiatric symptoms has hardly been investigated in elderly syncope patients. The aim of this study was to investigate the prevalence of psychiatric symptoms in elderly syncope patients in comparison with elderly patients with falls.

Materials and methods: Observational cohort study including consecutive patients aged ≥ 65 with syncope and/or unexplained falls at an outpatient fall and syncope clinic. Main outcomes were the prevalence of depressive and anxiety symptoms. Secondary outcomes were the prevalence of fear of falling (FOF), 15-item Geriatric Depression Scale, 2-item Patient Health Questionnaire, use of psychotropic medication, and functional activity.

Results: We included 194 syncope patients and 184 fall patients (mean age of 79.7 ± 6.5 [SD] years). Depressive symptoms, including sadness, occurred frequently (33% in syncope group and 23% in fall group, $P = 0.05$). Symptoms of anxiety were present in 20% of both syncope and fall patients. The prevalence of FOF was 68% in the syncope group and 67% in the fall group. Compared with patients without FOF, patients with FOF more often had depressive symptoms ($P = 0.01$), used more antidepressants ($P = 0.03$) and benzodiazepines ($P = 0.00$), and scored worse on the handgrip strength test (19.3 ± 8.4 vs. 22.6 ± 10.2 , $P = 0.01$).

Conclusions: Psychiatric symptoms may be common in elderly patients with syncope or falls, occurring in one fifth to one third of these patients. Physicians taking care of older patients with syncope should be aware of the high prevalence of FOF with its associated functional decline, depressive symptoms, and high use of psychotropic medications.

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1. Introduction

The prevalence of anxiety and depression has hardly been investigated in elderly syncope patients. Syncope is defined as 'a transient loss of consciousness (T-LOC) due to transient global cerebral hypoperfusion characterized by rapid onset, short duration and spontaneous and complete recovery' [1]. Approximately 50% of syncope patients have fear of falling (FOF) [2]. FOF leads to a restriction of functional activity, resulting in muscle weakening and, subsequently, falls [3]. FOF is a serious threat to autonomy and may cause depressive symptoms [4]. FOF may be a symptom of an anxiety disorder (AnxDis), which often occurs at a young age and may recur in the elderly [5].

Psychiatric disorders as defined by the Diagnostic and Statistical Manual of Mental Disorders, fourth edition, text revision (DSM-IV-TR), might be more common in elderly syncope patients, especially when the exact mechanism of syncope is unknown [6]. Younger patients with reflex syncope are vulnerable to psychiatric disorders, especially AnxDis, as anxiety may induce reflex syncope [7], but data in older syncope patients are limited.

It is also possible that syncope is caused by psychotropic medication for the treatment of psychiatric symptoms [8–10]. Tricyclic antidepressants (TCAs) have been shown to increase the frequency of syncope recurrence [8]. However, when used to treat anxiety that induced reflex syncope in younger patients, the prevalence of syncope actually decreased [11].

Unlike the unclear relationship between psychiatric disorders and syncope, the link with falls has been thoroughly investigated in elderly subjects. The risk of falling increases in the presence of major depressive disorder (MDD) [12,13]. Vice versa, psychiatric

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symptoms seem to be more common in older fall patients; especially FOF, with a prevalence ranging from 20–85% [14,15].

Since there is a large overlap between syncope and falls [16], it is not unlikely that the same psychiatric symptoms/disorders exist in syncope patients as in fall patients. To our knowledge this has not yet been investigated. Our objectives were to investigate the prevalence of depressive and anxiety symptoms/disorders in patients aged ≥ 65 with syncope compared with falls.

2. Materials and methods

We conducted an observational cohort study at the Fall and Syncope Clinic (FSC) of the Northwest Clinics, Alkmaar, the Netherlands, including consecutive patients with unexplained fall and/or syncope aged ≥ 65 years between November 2011 and May 2016. Specific patient consent and ethical board approval were not requested, because this study used archive data of standard geriatric evaluations and had no implications for therapeutic decisions. No sensitive patient data were used and patient anonymity has been protected. This study had no specific exclusion criteria.

The FSC is a multidisciplinary diagnostic pathway for elderly patients with unexplained falls and/or syncope, involving geriatricians, cardiologists, neurologists, an old age psychiatrist (OAP), radiologists, physiotherapists, and nurses. Details of this 2-day program have been published earlier [16]. Patients underwent a comprehensive geriatric assessment, including medical history, medication review, physical examination, and, if available, eye witness account. A nurse and physiotherapist investigated mental, nutritional, and functional state. The Montreal Cognitive Assessment (MoCA), with a cut-off < 26 , was used to screen for mild cognitive impairment [17]. Laboratory tests, blood pressure measurements, and a 12-lead electrocardiogram were performed. A magnetic resonance imaging (MRI) scan of the brain was performed in all patients unless contraindicated, and evaluated by a radiologist who was unaware of the patient's cognitive function. The Fazekas score was used to determine white matter abnormalities [18]. The cardiologist examined all patients with suspected syncope. Patients with falls were referred to the neurologist. On indication, patients were referred to an OAP and/or dietician.

After the full evaluation, the final diagnosis and advice for treatment were devised in the multidisciplinary team. Based on their final diagnosis, patients were divided into the syncope group (SG) and fall group (FG), which included patients who experienced a fall without T-LOC.

We compared the following baseline characteristics: age, comorbidities, medication use, cognitive state, functional state, and frailty. We developed a frailty score including 5 items:

- ADL dependency;
- MoCA < 26 [17];
- timed to get up and go ≥ 13.5 s [19];
- abnormal low handgrip strength test (HST) adjusted for age and gender [21];
- a Mini Nutritional Assessment short-form ≤ 11 [20];
- patients were considered frail with a score ≥ 3 .

Primary outcome was the prevalence of anxiety and depression. Data on anxiety and depressive symptoms were collected from the medical history. Anxiety symptoms were defined as anxiety about anything except FOF. Depressive symptoms included sadness and anhedonia. AnxDis and/or MDD were diagnosed by the OAP or geriatrician according to the DSM-IV-TR. We also investigated the overall prevalence of anxiety disorder/symptoms and of depressive disorder/symptoms, combining patients with a DSM-IV-TR

disorder and those with symptoms not meeting DSM-IV-TR criteria in a single group.

Secondary outcomes were the prevalence of a 15-item Geriatric Depression Scale (GDS-15) score ≥ 5 and 2-item Patient Health Questionnaire (PHQ-2) score ≥ 1 (presence of sadness and/or lack of interest) [22,23], the use of psychotropic medication, and referral to the OAP during or to a psychiatrist of the Mental Health Service Organization after the FSC evaluation.

Finally, we investigated the prevalence of FOF. FOF was not subsumed under the general anxiety symptoms that were mentioned previously. Information about FOF was gathered from the medical history and the Carefall Triage Instrument [24]. We investigated differences between patients with FOF and without FOF (non-FOF), using the same baseline characteristics and outcomes as mentioned above.

2.1. Statistical analysis

Statistical analyses were performed using SPSS for Windows[®], version 20 (IBM Corp., Armonk, NY, USA). Descriptive statistics were used, as well as Pearson's Chi-Square Test or Fisher's Exact test for dichotomous variables, and Mann-Whitney-U test for ordinal and abnormally distributed continuous variables. The Kolmogorov-Smirnoff test was used to test for normal distribution. Logistic regression was used for multivariate analysis. A two-tailed P -value < 0.05 was considered significant.

3. Results

We included 378 of 432 consecutive patients: 194 syncope patients (SG) and 184 fall patients without T-LOC (FG). Twelve patients were excluded because they were < 65 years, and 42 patients because they experienced no syncope or fall.

Table 1 shows baseline characteristics and medication use. We included a very elderly population with a mean age of almost 80 years and multiple comorbidities, predominantly female. No significant differences were found between the SG and FG, besides a history of ischemic heart disease and use of diuretics, which were more common in the SG ($P = 0.02$). Twenty-two percent of the SG and 16% of the FG used benzodiazepines ($P = 0.15$), and 17% vs. 15% used antidepressants ($P = 0.63$).

Table 2 shows outcomes of the FSC evaluation. We did not observe significant differences between the SG and FG in functional tests. Sixty-six percent of the SG and 57% of the FG had a MoCA < 26 ($P = 0.10$). Mean Fazekas score was 1.9 in both groups. A frailty score ≥ 3 was found in 32% of the SG vs. 30% of the FG ($P = 0.76$).

Depressive disorder/symptoms were more common in the SG than the FG (33% vs. 23%, $P = 0.05$), including symptoms of sadness reported by the patient (28% vs. 20%, $P = 0.05$). Likewise, there was a trend towards more MDDs in the SG (5% vs. 2%, $P = 0.13$). However, the difference in depressive symptoms disappeared, when patients with a history of psychiatric disorders were excluded (24% vs. 21%, $P = 0.46$). We found no significant difference between SG and FG in the symptom of sadness in the PHQ-2 (27% vs. 21%, $P = 0.22$). A high GDS-15 score was observed in 49% of the SG and 36% of the FG ($P = 0.10$). No significant differences were found in the presence of anxiety disorders/symptoms. Only 16 syncope patients and 7 fall patients were referred to an OAP during the FSC evaluation. The OAP diagnosed an AnxDis in eight patients; seven of whom belonged to the SG. An MDD was diagnosed in four syncope and three fall patients. Because these numbers were so small, we did not compare the SG and FG on these outcomes.

FOF was present in 68% of the SG and 67% of the FG ($P = 0.89$). FOF and non-FOF patients did not significantly differ in baseline

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