Psychiatry Research Review™

Making Education Easy

Issue 39 – 2015

In this issue:

Abbreviations used in this issue

ADHD = attention-deficit/hyperactivity disorder
CBT = cognitive behavioural therapy
FEP = first-episode psychotic illness
HAM-D = Hamilton depression scale
HRQoL = health-related quality of life
SSRI = selective serotonin reuptake inhibitor

Welcome to issue 39 of Psychiatry Research Review.

An association exists between selective serotonin reuptake inhibitors (SSRIs) and violent crime, report researchers from the University of Oxford. In particular, subgroup analysis highlighted that this association was evident in people aged 15–24 years, but not significant for those aged ≥25 years. As the study authors note, the data do not prove causation, since possible confounding by one or more unidentified factors linked to both SSRI use and violent crime may explain the results. Nevertheless, the data have good credibility: this was a large study from Sweden, involving about 850,000 individuals (10.8% of the Swedish population) who were prescribed SSRIs over the 3-year study period; 1% of these individuals were convicted of a violent crime.

In another study, a research group from Wellington, New Zealand, linked national breast and colorectal cancer registrations (2006–2010) in order to explore cancer survival in the context of mental illness. Their data attest to poorer survival after diagnosis with breast or colorectal cancer among men and women with a history of recent psychiatric service use compared with those without such a history. The researchers call for further investigation of the cancer treatment journey amongst those with experience of mental illness, to help explain this survival difference.

We hope you find this issue useful for your daily practice and we welcome any comments or feedback.

Kind regards,

Associate Professor Wayne Miles
waynemiles@researchreview.co.nz

Associate Professor David Menkes
davidmenkes@researchreview.co.nz

Restoring Study 329: efficacy and harms of paroxetine and imipramine in treatment of major depression in adolescence

Authors: Le Noury J et al.

Summary: This reanalysis of data from SmithKline Beecham's Study 329 (Keller MB et al. J Am Acad Child Adolesc Psychiatry. 2001;40(7):762-72) reviewed original trial documents from this trial that was conducted between 20 April 1994 and 15 February 1998 involving 275 adolescents (aged 12–18 years) with unipolar major depression who were randomised to 8 weeks of double-blind twice-daily treatment with paroxetine (20–40mg; n=93), imipramine (200–300 mg; n=95), or placebo (n=87). The reanalysis was performed according to the restoring invisible and abandoned trials (RIAT) initiative (see Doshi P et al. BMJ. 2013;346:f2865). The prespecified primary efficacy variables were change from baseline to the end of the 8-week acute treatment phase in total Hamilton depression scale (HAM-D) score and the proportion of responders (HAM-D score ≤8 or ≥50% reduction in baseline HAM-D) at 8 weeks. Prespecified secondary outcomes were changes from baseline to endpoint in depression items in K-SADS-L, clinical global impression, autonomous functioning checklist, self-perception profile, and sickness impact scale; predictors of response; and number of patients who relapsed during the maintenance phase. Neither paroxetine nor imipramine was statistically or clinically significantly different from placebo for any of the prespecified efficacy outcomes. HAM-D scores decreased by 10.7, 9.0 and 9.1 points (least squares mean), respectively, for the paroxetine, imipramine and placebo groups (p=0.20). Both drugs were associated with clinically significant increases in harms, including suicidal ideation and behaviour and other serious adverse events in the paroxetine group and cardiovascular problems in the imipramine group.

Comment (DM): This reanalysis and republication of Study 329 marks a milestone in efforts to disentangle psychiatric research from distortion by vested interests. For years, the original 2001 publication had been challenged repeatedly by psychiatrists and others concerned with the famous study's shortcomings, in particular the disconnect between the numerical results and the conclusions. As documented in a website dedicated to the issue (http://study329.org/), these concerted efforts were essentially ignored by the study's authors, their home institutions, the sponsor, and the high-impact journal in which the original study appeared. Remarkably, even with the damning reanalysis and republication in the *BMJ*, the original study has not been retracted or corrected, and continues to be cited as evidence that paroxetine is "safe and effective" in adolescent depression. There are several 'take-home' lessons from this remarkable saga. One is that journal editors and reviewers, and indeed readers, need to redouble their vigilance regarding potential conflicts of interest in submitted manuscripts, as these can quite clearly affect analysis and interpretation of results. Another conclusion is that public access to primary data from clinical trials should be mandatory, irrespective of whether or not the given study is published. I encourage *Research Review* readers to support efforts, spearheaded by the Cochrane Collaboration, to ensure this becomes standard practice (see, for example, www.alltrials.net); NZ psychiatrists should be gratified that the RANZCP has, somewhat belatedly, joined the list of supporters.

Reference: BMJ. 2015;351:h4320
Abstract

Selective serotonin reuptake inhibitors and violent crime: a cohort study

Authors: Molero Y et al.

Summary: These researchers compared the rate of violent crime while individuals were prescribed serotonin reuptake inhibitors (SSRIs) with the rate of violent crime in the same individuals while not receiving medication, using matched data from the Swedish Prescribed Drug Register and the Swedish national crime register. A total of 856,493 individuals aged ≥15 years residing in Sweden who were prescribed SSRIs in 2006 were followed-up to 31 December 2009. An overall association was found between SSRIs and violent crime convictions (hazard ratio [HR] 1.19; 95% CI, 1.08 to 1.32; p<0.001; absolute risk = 1.0%). Age-stratified analysis revealed a significant association between SSRIs and violent crime convictions for individuals aged 15–24 years (HR 1.43; 95% CI, 1.19 to 1.73; p<0.001, absolute risk = 3.0%), but not for those aged 25–34 years (HR 1.20; 95% CI, 0.95 to 1.52; p=0.125, absolute risk = 1.6%), 35–44 years (HR 1.06; 95% CI, 0.83 to 1.35; p=0.666, absolute risk = 1.2%), or ≥45 years (HR 1.07; 95% CI, 0.84 to 1.35; p=0.594, absolute risk = 0.3%). Increased risks were also found in those aged 15–24 years for violent crime arrests with preliminary investigations, non-violent crime convictions, non-violent crime arrests, non-fatal accidental injuries, and emergency inpatient or outpatient treatment for alcohol intoxication or misuse.

Comment (DM): For many years there has been concern that antidepressants may be associated with disinhibited and sometimes violent behaviour. For example, our study a decade ago in the same journal (http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1564177/) highlighted this possibility based on a case series, together with suggestive data regarding "hostility" in paroxetine drug trials. The current study is far more powerful, based on its use of Swedish national registers of prescriptions, forensic and hospital outcomes. The results are striking and indicate significant risk, particularly in younger patients. Of particular interest is the association with alcohol intoxication and misuse in the same demographic. These results are consistent with our recent report (http://www.ncbi.nlm.nih.gov/pubmed/25214162) of a significant interaction between antidepressants, particularly SSRIs, and alcohol. Implications for clinical practice are substantial; even though the absolute risk appears modest, of the order of 1–3%, the prevalence of antidepressant prescription in New Zealand (similar to many Western countries, including Sweden), coupled with uncommon but serious and sometimes catastrophic outcomes, means that these risks need to be considered by both prescribers, patients, and their families. Implications for the criminal justice system, in terms of diminished responsibility or outright exculpation, are evolving and also likely to be substantial.

Reference: PLoS Med. 2015;12(9):e1001875
Abstract

Time spent reading this publication has been approved for CME for Royal New Zealand College of General Practitioners (RNZCGP) General Practice Educational Programme Stage 2 (GPEP2) and the Maintenance of Professional Standards (MOPS) purposes, provided that a Learning Reflection Form is completed. Please **CLICK HERE** to download your CPD MOPS Learning Reflection Form. One form per review read would be required.

Time spent reading this publication has been approved for CNE by The College of Nurses Aotearoa (NZ) for RNs and NPs. For more information on how to claim CNE hours please **CLICK HERE**.

Cognitive behavioral therapy for insomnia comorbid with psychiatric and medical conditions: a meta-analysis

Authors: Wu JQ et al.

Summary: This meta-analysis included 37 randomised controlled trials that had at least one cognitive behavioural therapy (CBT) arm for insomnia and enrolled an adult population meeting diagnostic criteria for insomnia as well as a concomitant condition (n=2,189). At post-treatment evaluation, a significantly larger proportion of patients who received CBT for insomnia were in remission compared with those in the control or comparison conditions (36.0% vs 16.9%; pooled odds ratio [OR] 3.28; 95% CI, 2.30 to 4.68; p<0.001). Pretreatment and post-treatment controlled effect sizes were medium to large for most sleep parameters (self-reported sleep efficiency: Hedges $g=0.91$, 95% CI, 0.74 to 1.08; sleep onset latency: Hedges $g=0.80$, 95% CI, 0.60 to 1.00; wake after sleep onset: Hedges $g=0.68$; subjective sleep quality: Hedges $g=0.84$; all p<0.001), except total sleep time. Comorbid outcomes yielded a small effect size (Hedges $g=0.39$, 95% CI, 0.60 to 0.98; p<0.001); improvements were greater in psychiatric than in medical populations (Hedges $g=0.20$, 95% CI, 0.09 to 0.30; χ^2 test for interaction = 12.30; p<0.001).

Comment (DM): Most psychiatrists and other mental health clinicians recognise the importance of sleep, and often include descriptions of sleep disturbance in patient assessments, irrespective of diagnosis. Unfortunately, management of insomnia is inconsistent and commonly relies on prescription of hypnosedatives, even though these are generally contraindicated for continued use beyond two weeks. The principles of sleep hygiene are, unfortunately, often honoured in the breach. The current study provides strong evidence that CBT can effectively treat insomnia that presents in the context of either medical or psychiatric illnesses. Given the substantial effect sizes, together with evidence of collateral benefit to comorbid illnesses, ensuring that CBT is available for this indication should be a priority for adult mental health services in New Zealand.

Reference: JAMA Intern Med. 2015;175(9):1461-72
Abstract

Is adult ADHD a childhood-onset neurodevelopmental disorder? Evidence from a four-decade longitudinal cohort study

Authors: Moffitt TE et al.

Summary: The 1,037 participants in this analysis were born in Dunedin, New Zealand, in 1972 or 1973. They were assessed every 2 to 3 years until age 21 and then at ages 26, 32 and 38 years, for symptoms of attention-deficit/hyperactivity disorder (ADHD), associated clinical features, comorbid disorders, neuropsychological deficits, genome-wide association study-derived polygenic risk, and life impairment indicators. Data were sourced from participants, parents, teachers, informants, neuropsychological test results, and administrative records. Study retention was high (95%). Sixty-one children (6%) (79% of cases were male) satisfied DSM-III childhood ADHD criteria (diagnoses were made up to age 15 years and required symptom onset before age 7). Diagnosis was associated with childhood comorbid disorders, neurocognitive deficits, polygenic risk, and residual adult life impairment. The prevalence of adult ADHD was 3% (gender balanced) and was associated with adult substance dependence, adult life impairment, and treatment contact. There was virtually no overlapping between the childhood ADHD and adult ADHD groups; 90% of adult ADHD cases lacked a history of childhood ADHD. Moreover, the adult ADHD group did not show tested neuropsychological deficits in childhood or adulthood, nor did they show polygenic risk for childhood ADHD.

Comment (DM): The results of this New Zealand birth cohort study fundamentally challenge our usual conception of ADHD across the lifespan. If replicated, the implications for clinical practice are substantial, as adult ADHD would then need to be considered as a distinct disorder with its own aetiology. It remains an open question as to what extent these results will have implications for psychostimulant and other treatments for adult-onset ADHD. As *Research Review* readers will recall, psychostimulant prescription in adults is controversial with regard to both efficacy and risk of abuse and/or diversion. As a consequence, many psychiatrists are reluctant to prescribe methylphenidate and dexamphetamine, and tend to leave treatment decisions and follow-up to colleagues with a special interest in the area.

Reference: Am J Psychiatry. 2015;172(10):967-77
Abstract

Cancer survival in the context of mental illness: a national cohort study

Authors: Cunningham R et al.

Summary: This investigation linked New Zealand breast and colorectal cancer registrations (2006–2010) to psychiatric hospitalisation records for adults (18–64 years) and compared cancer-specific survival between recent psychiatric service users and nonusers. The researchers identified 8762 women with breast cancer, of whom 440 had had contact with psychiatric services in the 5 years prior to cancer diagnosis. There were 4022 people identified with colorectal cancer diagnosed before age 65, of whom 190 had contact with psychiatric services in the 5 years prior. People with schizophrenia or bipolar affective disorder comprised Group A; others using mental health services comprised Group B. In analyses adjusted for confounding variables, risk of death from breast cancer was increased for Group A (HR 2.55; 95% CI, 1.49 to 4.35) and Group B (HR 1.62; 95% CI, 1.09 to 2.39), and from colorectal cancer for Group A (HR 2.92; 95% CI, 1.75 to 4.87). Later stage at diagnosis contributed to survival differences for Group A, while comorbidity contributed for both groups. Fully adjusted HR estimates were breast: Group A 1.65 (95% CI, 0.96 to 2.84), Group B 1.41 (95% CI, 0.95 to 2.09); colorectal: Group A 1.89 (95% CI, 1.12 to 3.17), Group B 1.25 (95% CI, 0.89 to 1.75).

Comment (DM): Mental health clinicians are generally very aware of the premature mortality seen among patients with severe mental illness. While suicide and cardiovascular disease (notably in association with second-generation antipsychotic treatment) are well recognised in this regard, another important source of health disparity is now becoming clear. As elegantly analysed and presented by this Wellington epidemiology team, cancer mortality is also substantially higher in New Zealand patients with psychosis. There are probably multiple reasons for this, in addition to late diagnosis highlighted by the authors. As has been well described in presentations of myocardial infarction, people with schizophrenia often experience and communicate physical symptoms, notably pain, rather differently, complicating clinical investigation and management. Nevertheless, the 'Equally Well' (http://www.tepou.co.nz/initiatives/equally-well-physical-health/37) campaign emphasises our clinical and ethical obligation to provide best care and to take all practicable steps to close this group's lamentable morbidity and mortality gaps.

Reference: Gen Hosp Psychiatry. 2015;37(6):501-6
Abstract

Independent commentary by Associate Professor David Menkes, Waikato Clinical Campus, University of Auckland.
For full bio CLICK HERE.

Independent commentary by Associate Professor Wayne Miles, psychiatrist with Waitemata DHB, Clinical Director of Awhina Research and Knowledge, and Clinical Associate Professor with Auckland University School of Medicine.
For full bio CLICK HERE.

Smoking and schizophrenia in population cohorts of Swedish women and men: A prospective co-relative control study

Authors: Kendler KS et al.

Summary: These researchers predicted future risk for a diagnosis of schizophrenia or nonaffective psychosis from the smoking status of two Swedish cohorts: 1,413,849 women initially studied during prenatal care (mean initial age, 27 years; mean follow-up, 18 years); and 233,879 men from the Swedish conscript registries (mean initial age, 18; mean follow-up, 8 years). The mean age at end of follow-up was 46 for women and 26 for men. The risk of first-onset schizophrenia was higher among heavy smokers (≥10 cigarettes/day: HR 3.45; 95% CI, 2.95 to 4.03 for women and 3.80; 1.19 to 6.60 for men) than light smokers (HR 2.21; 95% CI, 1.90 to 2.56 for women and 2.15; 1.25 to 3.44 for men). These associations remained unchanged after censoring for schizophrenia onsets 3–5 years after smoking assessment. Hazard ratios declined only modestly in analyses adjusted for age, socioeconomic status, and drug abuse. Women who smoked into late pregnancy had a much higher risk for schizophrenia than those who quit early. Hazard ratios predicting nonaffective psychosis in the general population, in cousins, in half siblings, and in full siblings discordant for heavy smoking were, respectively, 2.67, 2.71, 2.54, and 2.18. In a model utilising all relative pairs, the risk for nonaffective psychosis was increased nearly 2-fold in the heavy-smoking member of discordant monozygotic twin pairs (HR 1.69; 95% CI, 1.17 to 2.44).

Comment (WM): This study bases itself on the high association between smoking and schizophrenia. It attempts to review whether smoking might be a predictor of subsequent development of schizophrenia and asks if there is a dose-response relationship. It examines the possible role of socioeconomic factors as a confounder of the association, then explores possible familial/genetic risk. The researchers utilised Swedish National data using the country's unique identifier. There is a good description of the sampling rules used and the analyses undertaken, which do not reveal reasons to discredit the findings.

The study found clear evidence between smoking and subsequent development of schizophrenia. A time period analysis does not support a view that the smoking may indicate a prodrome for schizophrenia. A dose-response relationship was also suggested with substantially increased rates in heavy compared to light smokers. Socioeconomic status and other drug abuse provided only a modest contribution to risk. The question of familial/genetic contribution was unable to be examined for schizophrenia due to limitations of cohort size. There was a demonstrable association between familial/genetic factors and non-affective psychosis.

These findings suggest that the link between smoking and schizophrenia is complex but do not explain whether the association is a causal one (i.e. smoking in some way predisposes to or causes schizophrenia) or reflects the presence of some shared pathways in the development.

Whatever the final link, it is another good reason to suggest your kids don't smoke.

Reference: Am J Psychiatry. 2015;172(11):1092-100
Abstract

Performance of the Maze Navigation Test in a sample of older New Zealanders

Authors: Ma'u E, Cheung G

Summary: In this study, driving performance was evaluated among 42 cognitively intact older people (age ≥65) with the Maze Navigation Test (MNT) and three commonly used bedside cognitive screening tools: Mini-Mental State Examination, the revised Addenbrooke's Cognitive Examination and the Trail Making Tests. The mean MNT completion time was 307.6 and 444.5 for the 65–74-year and 75–84-year age groups, respectively. Pearson's product-moment correlations were strongest with the Trail Making Test Part B (r=0.602).

Comment (WM): As the population ages, the demands on doctors to be able to make fair and reliable judgements about a person's driving capacity will increase. The authors of this paper review the use of a number of neuropsychological tests as a predictor, and summarise the rather modest contribution that these currently have to the decision. They describe a particular test (the Maze Navigation Test [MNT]) that was devised from the Porteous Maze, and which has been shown in an American sample to be predictive of driving ability.

It appears though that there has been no replication of that work and the hope that the MNT could become a useful test for clinicians is still just that. The paper describes a New Zealand study that confirms the MNT has correlated with other neuropsychological tests such that it might be a useful predictor of ability to drive. The authors propose on the basis of that testing that the MNT is worthy of more detailed study to examine how it performs as a test of ability to drive. Let us hope that such a definitive trial is conducted. Clearly this is a space for psychiatrists who have a role in helping determine driving capacity to keep an eye on.

Reference: Australas Psychiatry. 2015;23(5):503-6
Abstract

Positive Emotions Program for Schizophrenia (PEPS): a pilot intervention to reduce anhedonia and apathy

Authors: Favrod J et al.

Summary: Outcomes are reported from a pilot study that evaluated a programme designed to reduce anhedonia and apathy in schizophrenia – the Positive Emotions Program for Schizophrenia (PEPS). This intervention teaches participants skills to help overcome defeatist thinking and to increase the anticipation and maintenance of positive emotions. Its impact was assessed in a cohort of 37 participants meeting the ICD-10 criteria for schizophrenia or schizoaffective disorders. They participated in 8 PEPS sessions and were assessed prior to and after the intervention by the Scale for the Assessment of Negative Symptoms (SANS) and the Calgary Depression Scale for Schizophrenia (CDSS). Thirty-one people completed the programme; those who dropped out did not differ from completers. Participation in PEPS was associated with statistically significant reductions in the total scores for Avolition-Apathy and Anhedonia-Asociality on the SANS, with moderate effect sizes. There was also a statistically significant reduction of depression on the CDSS, with a large effect size. No changes were observed in emotional blunting or alogia during the intervention.

Comment (WM): There have been recent discussions about components of the negative syndrome of schizophrenia, with some authors giving cogent argument for the separation of those aspects that are mostly about a decreased capacity to experience (avolition, anhedonia, asociality) from those that are more about a limitation of the capacity for expression (alogia and emotional blunting). Some work suggests that the diminished experience group have a poorer prognosis than the group whose limitations are more in capacity to express. Both groups are poorly amenable to pharmacotherapy.

This is a preliminary presentation of the feasibility testing of a new treatment programme designed to address the problems of apathy and anhedonia, PEPS (Positive Emotions Program for Schizophrenia). PEPS arises from Swiss-based researchers. The article gives a very good outline of PEPS. It describes the open application of the programme to a group of people suffering schizophrenia or shizoaffective disorder. The programme was well received and able to be completed by most participants. It showed, using the SANS as primary measure, capacity to reduce avolition/apathy and anhedonia/asociality scores. There was a suggestion that depressed subjects showed more improvement.

These results are encouraging and would suggest that the programme is worthy of further testing, especially in a randomised trial. Any researchers looking for a good area for study might want to look at this.

Reference: BMC Psychiatry. 2015;15:231
Abstract

Clinical effectiveness and cost-effectiveness of tailored intensive liaison between primary and secondary care to identify individuals at risk of a first psychotic illness (the LEGs study): a cluster-randomised controlled trial

Authors: Perez J et al.

Summary: This article notes that few studies have attempted to educate general practitioners to recognise individuals at high risk of developing psychosis or those with first-episode psychotic illness (FEP) to improve patient access to secondary mental health services. These researchers therefore sought to determine whether increasing the resources aimed at managing the interface from primary care to secondary care increased detection of young people at high risk of developing psychosis and early referral to a specialist early intervention team. The Liaison and Education in General Practices (LEGs) study randomised 54 primary care practices in Cambridgeshire and Peterborough, UK, to a 2-year low-intensity intervention (a postal campaign, consisting of biannual guidelines to help identify and refer individuals with early signs of psychosis; n=28) or a high-intensity intervention, which additionally included a specialist mental health professional who liaised with every practice and a theory-based educational package (n=26). An additional 50 practices that did not consent to randomisation comprised a practice-as-usual (PAU) group. During the intervention, more FEP cases were referred by high-intensity practices versus low-intensity practices (mean 1.25 vs 0.7; incidence rate ratio [IRR] 1.9; 95% CI, 1.05 to 3.4; p=0.04), although the difference was not statistically significant for individuals at high risk of psychosis (mean 0.9 vs 0.5; IRR 2.2; 95% CI, 0.9 to 5.1; p=0.08). For high risk and FEP combined, high-intensity practices referred both more true-positive (mean 2.2 vs 1.1; IRR 2.0; 95% CI, 1.1 to 3.6; p=0.02) and false-positive (mean 2.3 vs 0.9; IRR 2.6; 95% CI, 1.3 to 5.0; p=0.005) cases. Referral patterns did not differ between low-intensity and PAU practices. Over a 2-year follow-up, total cost per true-positive referral was £26,785 in high-intensity practices, £27,840 in low-intensity practices, and £30,007 in PAU practices.

Comment (WM): I approached this article anticipating some findings that would helpfully inform the process by which we can have more successful recognition of and even intervention for those at risk of first-episode psychosis who present in primary care. As health service systems shift to having a less siloed approach with a primary care focus ways to enhance recognition and treatment will be crucial.

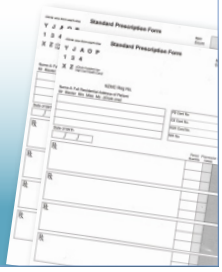
Considerable thought had been put in to the intervention (the liaison approach between secondary mental health and primary care) and the article describes this well. They had dealt as well as is possible to randomise practices (but of course it would never be possible to truly blind). Their approach seems to me to have been curtailed by an Ethics Committee decision that required full informed consent from practices involved (this further reduced any effect of randomisation and had only 50% of potential practices involved). The upshot of that was the numbers that did participate were too few to actually answer the questions.

What did emerge was that those practices that had a high intensity of educative input referred more patients but they were no more discriminating than those practices with minimal or no input (i.e. the rate of false positives to true positives did not differ).

The study was not designed to increase intervention possibility in primary care. It did have a costing model that purported to suggest the high-intensity input was cost-effective, but my limited economic capacity was not convinced by the method or the outcome of the analysis.

I am therefore still looking for good work that suggests how we successfully shape mental health care systems that detect and treat those at risk for psychosis.

Reference: Lancet Psychiatry. 2015;2(11):984-93
Abstract



Anticholinergic drugs and health-related quality of life in older adults with dementia

Authors: Sura SD et al.

Summary: These researchers used data from the Medical Expenditure Panel Survey to investigate the effects of anticholinergic drugs on health-related quality of life (HRQoL) in a cohort of 112 community-dwelling older adults (≥65 years) with dementia. Of the 15% of study participants who used anticholinergics, the majority were aged between 65 and 79 years (53%), female (57%), and with low family income (65%). In analyses controlling for other factors and baseline HRQoL, use of anticholinergics was associated with 7.48 unit reductions in the Physical Component Score (p<0.01), whereas no association was found between anticholinergic use and Mental Component Score.

Comment (WM): This American-based review set out to explore the relationship between quality of life in people living in the community with dementia and the exposure to drugs of anticholinergic type. The study took advantage of the regular sampling of people to analyse health care uses, expenditure and insurance coverage, using the Medical Expenditure Panel Survey. The survey includes health-related quality of life data as assessed by the SF-12. The definition of the study cohort and the protocol for data gathering and aggregation is reasonably well described. Data was analysed to determine the association of anticholinergic drug use with both the physical and mental health components.

Despite the potentially large population base the end sample had a disappointing number of subjects meeting criteria. There was a significant association of anticholinergic use and Physical Component score and no association between such medication use and Mental Health score. This study contributes to the evidence that suggests considerable care needs to be taken if considering prescribing drugs with anticholinergic effects to people with dementia.

Reference: J Am Pharm Assoc (2003). 2015;55(3):282-7
Abstract