JORNADA

SOBRE CONTROVERSIAS EN FARMACIA PSIQUIÁTRICA: MONOTERAPIA vs POLITERAPIA EN ESQUIZOFRENIA Y DEPRESIÓN

ORGANIZA:

sefh Sociedad Española de Farmacia Hospitalaria

fefh Fundación Española de Farmacia Hospitalaria

CRONOS

PATROCINA:

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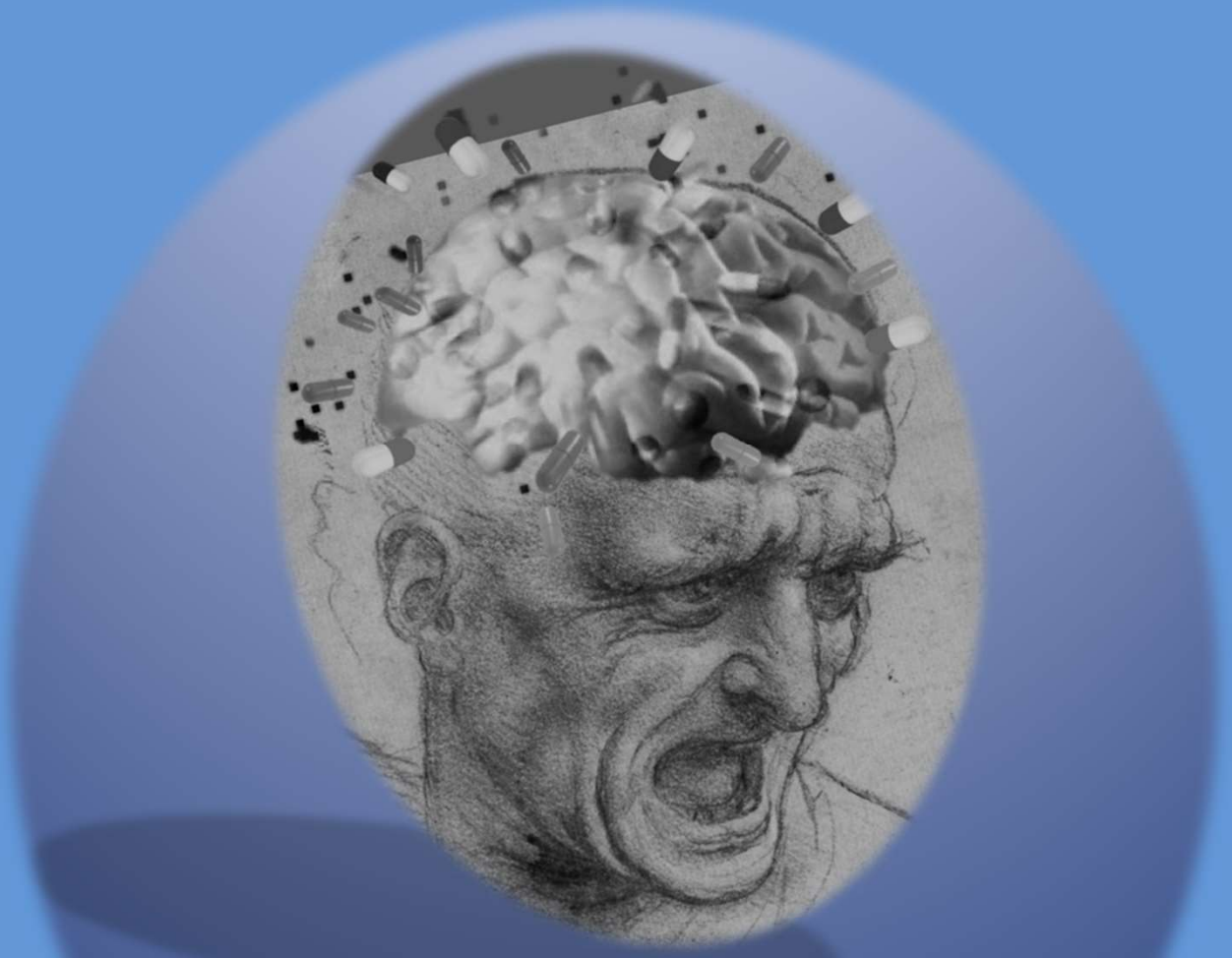

OPTIMIZACIÓN FARMACOTERAPÉUTICA DEL PACIENTE INGRESADO CON ENFERMEDAD DE PARKINSON

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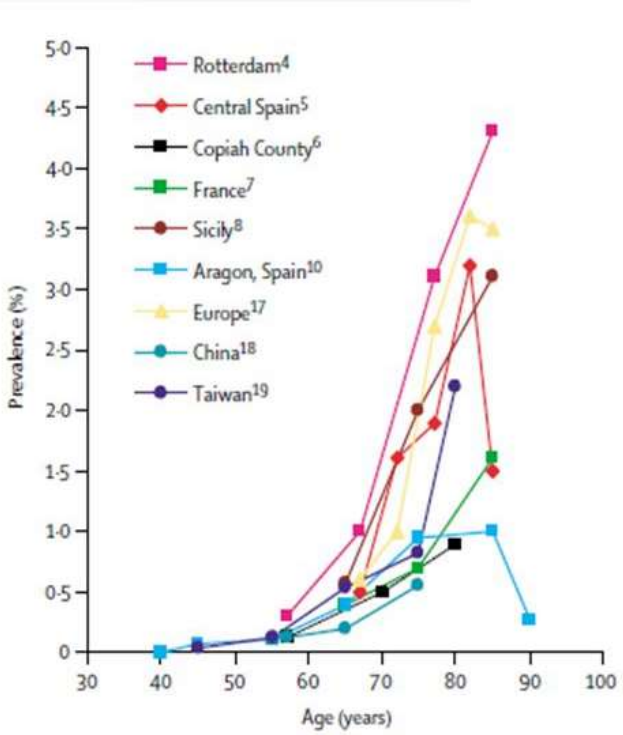
- Perdida de conciencia?
- Dolor hombro

ENFERMEDAD DE PARKINSON

- 2ª enfermedad neurodegenerativa más frecuente

- ↑ Edad → ↑ Prevalencia

≒ 1% en >60 años



De Lau LM, Breteler MM. Epidemiology of Parkinson's disease. Lancet Neurol 2006; 5:525-35.

Journal of Parkinson's Disease 8 (2018) S3–S8
DOI 10.3233/JPD-181474
IOS Press

Review

The Emerging Evidence of the Parkinson Pandemic

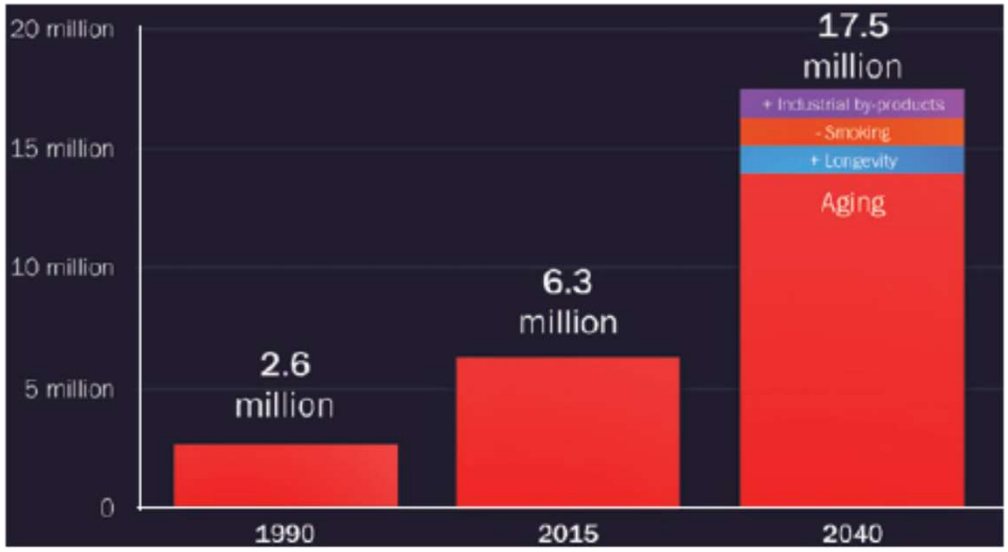
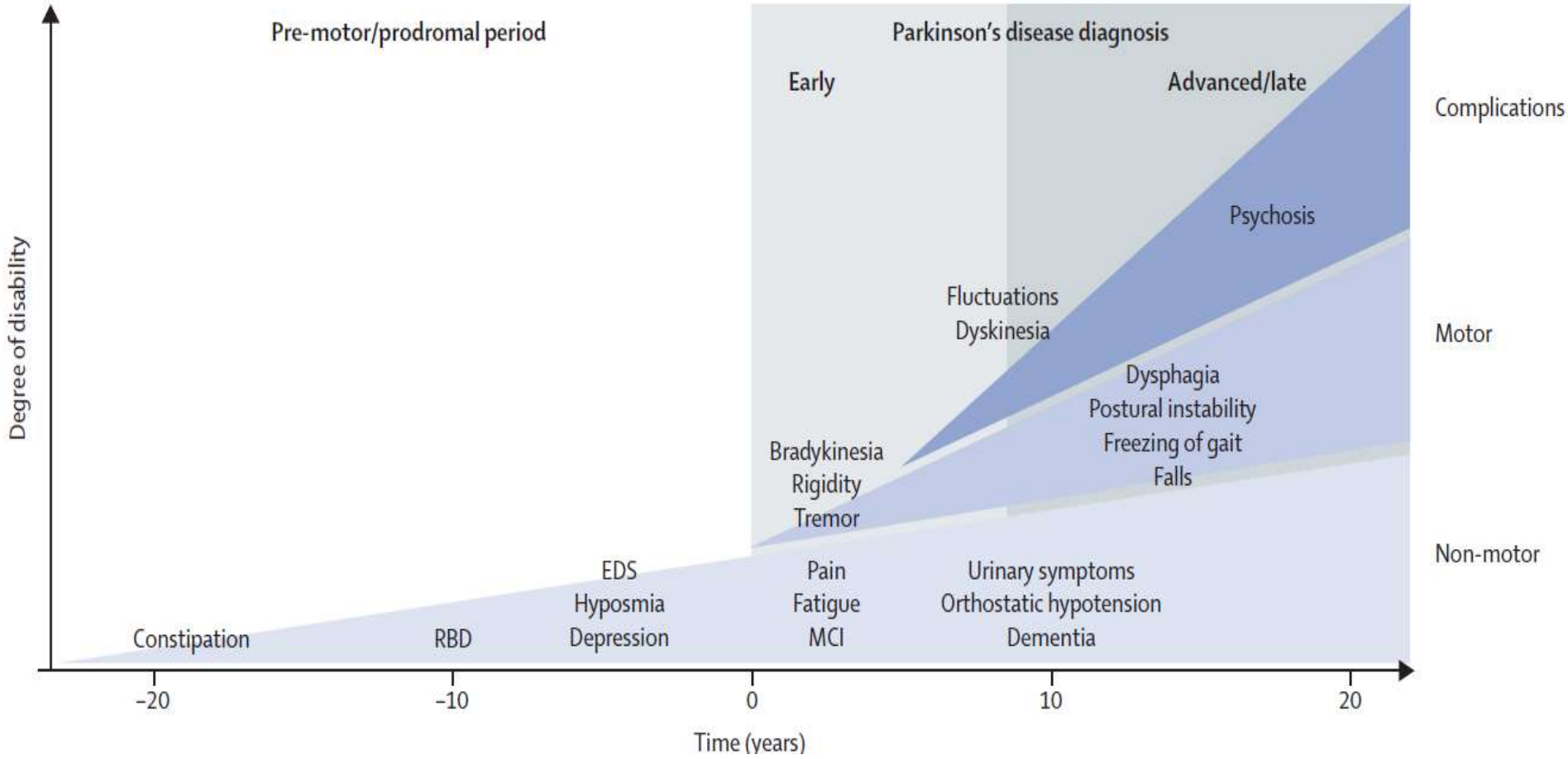


Fig. 2. Projected global burden of Parkinson disease accounting for changes in aging, longevity, smoking rates, and industrialization, 1990–2040.



Kalia LV, Lang AE. Parkinson's disease. Lancet. 2015 29;386:896-912.

más ingresos

+

mayor duración

+

motivo de ingreso diferente de EP

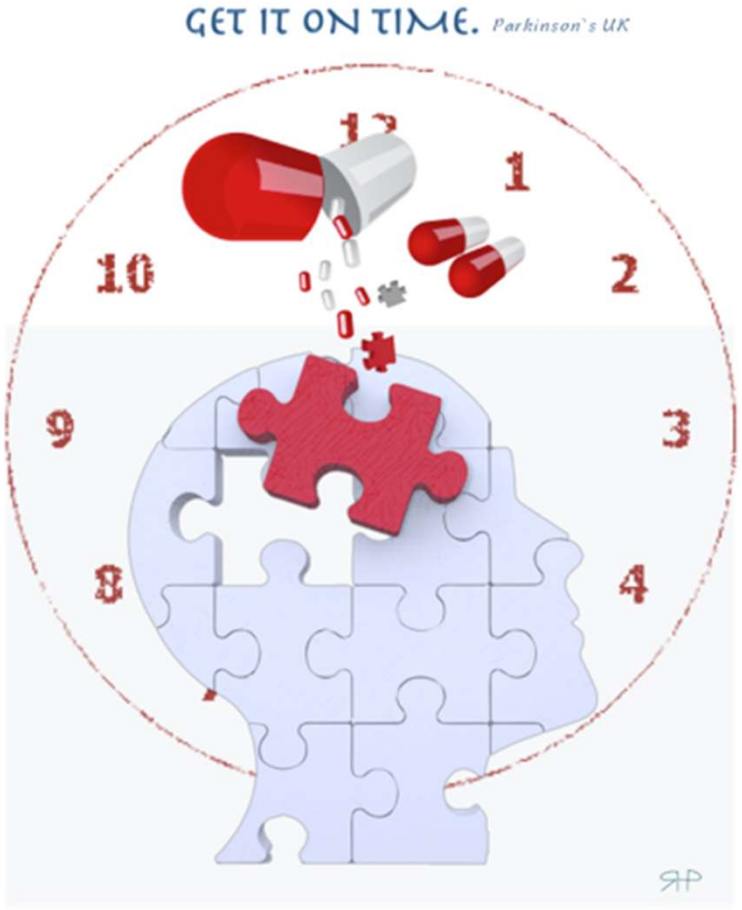
+

servicios con conocimiento pobre de EP

Complicaciones frecuentes

DÍA 0: Tratamiento habitual

- **Levodopa/carbidopa/entacapona 150/37,5/200 (Stalevo®): 1 a las 07:30 AM, 1 a las 10:00 PM, 1 a las 10 PM y 1 a las 18 PM.**
- Levodopa/Carbidopa retard: 1 comp 200/50 mg en DE.
- Paroxetina: 20 mg en DE.
- Olanzapina: 1 comp de 15 mg en CE.
- Oxibutinina: 1 comp de 5 mg en DE
- Cinitaprida: 1 comp de 1 mg en DE-CO-CE



"Se debería controlar el régimen posológico de levodopa de manera tan rigurosa como el de insulina"

Magdalinou KN, Martin A, Kessel B. Prescribing medications in Parkinson's disease (PD) patients during acute admissions to a District General Hospital. Parkinsonism Relat Disord 2007; 13: 539-40.

Pero…¿tan importante es?

NO consecuencias ——————— **Hiperpirexia-rigidez**

- Posología **compleja**, regímenes **individualizados**, **múltiples** administraciones diarias.

SINEMET PLUS 25/100 MG	Levodopa,	ORAL	100 MG	L: 1(9)-1(12)-1(15)-1(18)-1(21)

- Horarios administración hospital, rígidos.
- Se recomienda a los pacientes que no tomen la medicación que han traído de casa durante su ingreso por seguridad.

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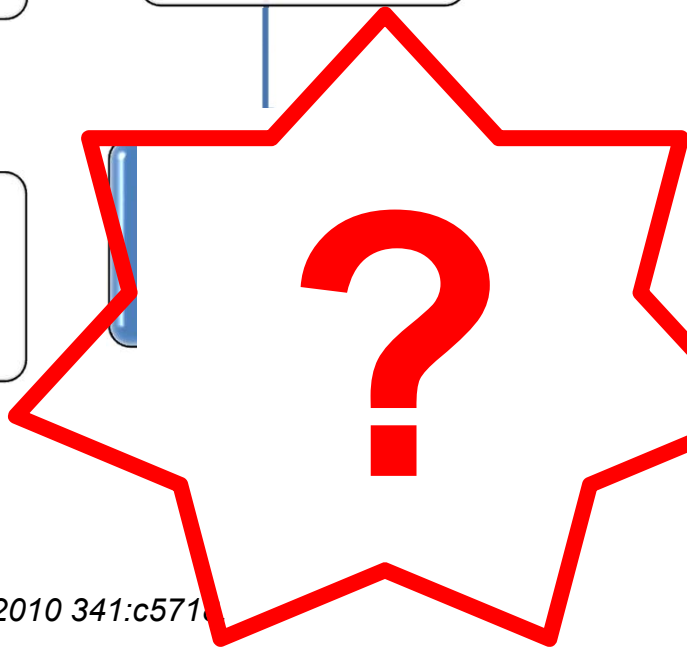
PROTOCOLO PARA EVITAR OMISIONES DE LEVODOPA EN PACIENTES INGRESADOS CON ENFERMEDAD DE PARKINSON

- VIA ORAL **NO** DISPONIBLE
  - **DOSIS EQUIVALENTE DE LEVODOPA**
    - ROTIGOTINA TD

    - APOMORFINA SC

- VIA ORAL DISPONIBLE
  - MEDICAMENTO DISPONIBLE
    - ADMINISTRAR

  - MEDICAMENTO **NO** DISPONIBLE



Brennan, KA; Genever, RW Managing Parkinson's disease during surgery. BMJ. 2010 341:c571

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EN FARMACIA PSIQUIÁTRICA:
MONOTERAPIA vs POLITERAPIA EN
ESQUIZOFRENIA Y DEPRESIÓN

THE NEUROHOSPITALIST
SAGE

A Proposal to Prevent Omissions and Delays of Antiparkinsonian Drug Administration in Hospitals

The Neurohospitalist
2015, Vol. 5(2) 53-54

DOI: 10.1177/1941874414566986
nhos.sagepub.com
SAGE

Unax Lertxundi, PharmD[1], Arantxazu Isla, PhD[2],
Mª Angeles Solinis, PharmD[2], Saioa Domingo-Echaburu, PharmD[3],
Rafael Hernandez, MD[4], and Juan Carlos García-Moncó, MD, PhD[5]


Medicina Interna





"Dosis equivalente de levodopa" (LED)

JUSTO A TIEMPO

Levodopa Equivalent Dose Calculator

This page is for people with Parkinson's (PwP). It calculates the contribution made by each of your Parkinson' dose (LED). The LED is the amount of levodopa (taken with carbidopa) that has a similar effect as the drug ta (LEDD).

To find your LEDD, enter your data in the green boxes. Where a drug contains levodopa and other active com

Drug	Dose(mg)	Conversion Factor	LED(mg)	Comments
Levodopa with Entacapone	150	1.33	200	
Calculate		Total, LEDD (mg) =	200	

Stalevo® 150/37,5/200

https://www.parkinsonsmeasurement.org/toolBox/levodopaEquivalentDose.htm

DÍAS 1,2

- El paciente grita durante la noche (llama a su madre, fallecida hace tiempo). Nauseas.
- Analítica y sedimento urinario normales.
- **Haloperidol “si agitación”**
- **Metoclopramida si vómitos**

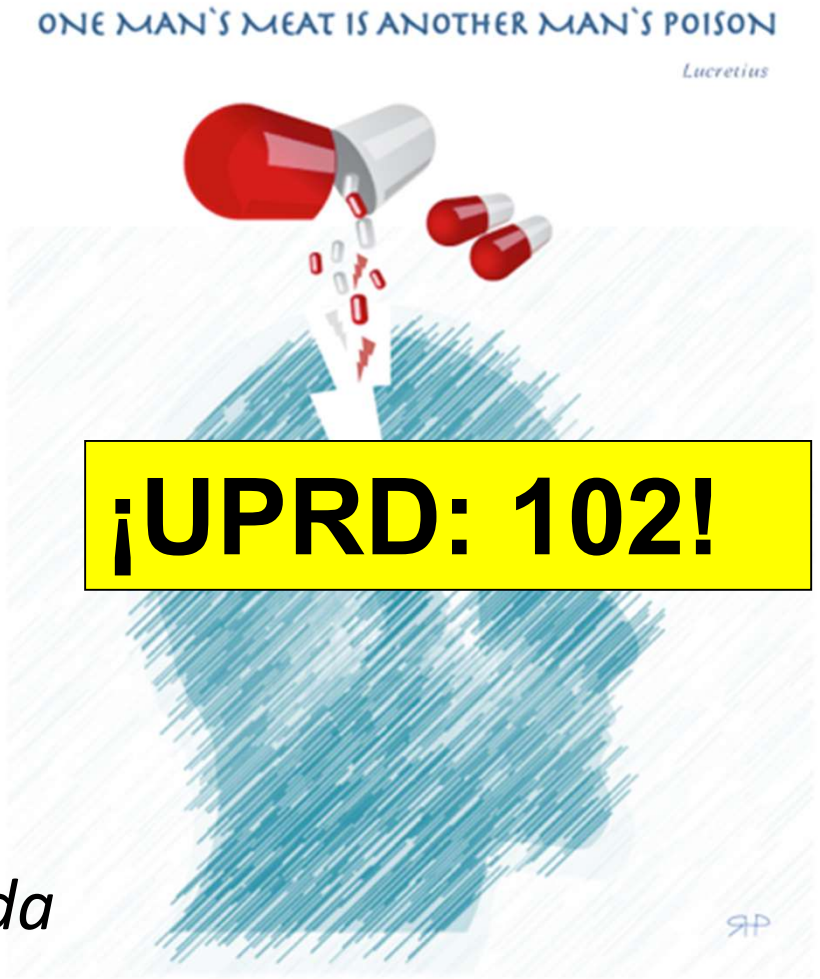
UTILIZACIÓN INAPROPIADA DE ANTIDOPAMINÉRGICOS

- Comorbilidades:
  náuseas/vómitos, psicosis…

↓

Antidopaminérgicos con actividad central

Cinitaprida, olanzapina, haloperidol, metoclopramida



Current Drug Safety, 2013, *8*, 63-68

Domperidone in Parkinson's Disease: A Perilous Arrhythmogenic or the Gold Standard?

Unax Lertxundi[*,1], Saioa Domingo-Echaburu[*,2], Amaia Soraluce[3], Montserrat García[4], Borja Ruiz-Osante[5] and Carmelo Aguirre[4,5]

[1]*Pharmacy Service, Red de Salud Mental de Araba, C/alava 43, 01006 Vitoria-Gasteiz, Alava, Spain*

[2]*Pharmacy Service, OSI Alto Deba, C/Zaldibar s/n, 20500, Arrasate-Mondragon, Gipuzkoa, Spain*

[3]*Pharmacy Service, Red de Salud Mental de Araba, Spain*

[4]*Basque Pharmacovigilance Unit, Hospital Galdakao-Usánsolo, Spain*

[5]*University of the Basque Country, Faculty of Medicine, Department of Pharmacology, Spain*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Sinemet® 25 mg/250 mg comprimidos
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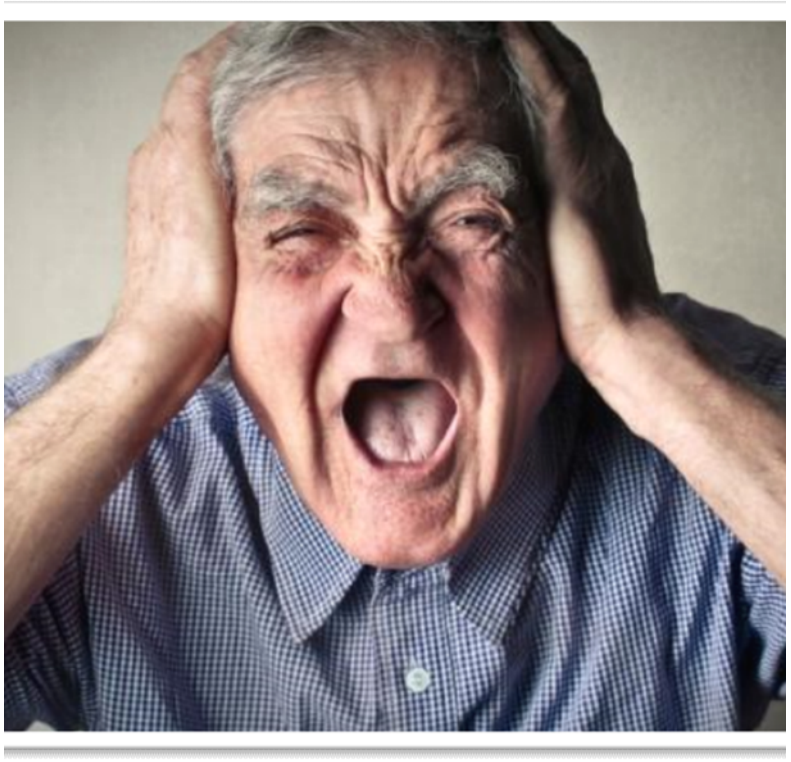
60 comprimidos
Vía oral.

“Sin- Emesis”

- **CLOZAPINA**
- QUETIAPINA
- PIMAVANSERINA



Journal of the
American Geriatrics Society

BEERS 20 CRITERIA ARIPIPRAZOLE IN
PARKINS

To the Ed latest version
of the Be teresting fea-
tures, suc t of delirium
with anti ve were sur-

Juan Medrano, MD
Psychiatry Service, Bizkaia Mental Health Network,
Portugalete, Bizkaia, Spain

Confussion Assesment Method

Tipo de valoración	Cambio agudo. Curso fluctuante	Inatención	Pensamiento desorganizado	Alteración del nivel de conciencia
Respuestas de los pacientes: Cualquier evidencia de síntoma, respuesta incorrecta, falta de respuesta o respuesta sin sentido indica presencia de la característica	Preguntar si ha presentado alguna de las siguientes situaciones el día anterior: - Estar confuso - Pensar que no está en el hospital - Ver cosas que no están ahí	Pida al paciente que haga lo siguiente: - Secuencia de dígitos (3 dígitos) hacia atrás - Secuencia de dígitos (4 dígitos) hacia atrás - Días de la semana hacia atrás - Meses del año hacia atrás	Pida al paciente que diga lo siguiente: - El año actual - El día de la semana - El tipo de lugar (hospital)	
Observaciones del entrevistador: Cualquier "sí" indica que la función está presente	- ¿Hubo fluctuaciones en el nivel de conciencia - ¿Fluctuaciones en la atención? - ¿Fluctuaciones en el habla o pensamiento?	- ¿El paciente tuvo problemas para seguir la entrevista - ¿El paciente se distraía fácilmente?	- ¿El flujo de ideas del paciente fue claro o ilógico? - ¿Conversación divagante o tangencial? - ¿Discurso inusualmente limitado o escaso?	- ¿Tenía sueño el paciente? ‡ - ¿Estuporoso o comatoso? - ¿Hipervigilante?

Marcantonio ER. Ann Intern Med. 2014 October 21; 161(8): 554–561. *N Engl J Med 2017;377:1456-66.*

The NEW ENGLAND JOURNAL of MEDICINE

CLINICAL PRACTICE

Caren G. Solomon, M.D., M.P.H., *Editor*

Delirium in Hospitalized Older Adults

Edward R. Marcantonio, M.D.

This Journal feature begins with a case vignette highlighting a common clinical problem. Evidence supporting various strategies is then presented, followed by a review of formal guidelines, when they exist. The article ends with the author's clinical recommendations.

From the Division of General Medicine and Primary Care, Department of Medicine, Beth Israel Deaconess Medical Center, and Harvard Medical School — both in Boston. Address reprint requests to Dr. Marcantonio at Beth Israel Deaconess Medical Center, 330 Brookline Ave., CO-216, Boston, MA 02215, or at emarcant@bidmc.harvard.edu.

N Engl J Med 2017;377:1456-66.
DOI: 10.1056/NEJMcp1605501

A 75-year-old man is admitted for scheduled major abdominal surgery. He is functionally independent, with mild forgetfulness. His intraoperative course is uneventful, but on postoperative day 2, severe confusion and agitation develop. What is going on? How would you manage this patient's care? Could his condition have been prevented?

THE CLINICAL PROBLEM

ALTHOUGH DELIRIUM HAS BEEN DESCRIBED IN THE MEDICAL LITERATURE for more than two millennia, the condition is still frequently not recognized, evaluated, or managed appropriately.[1,2] Delirium is also known as acute confusional state, altered mental status, and toxic metabolic encephalopathy, among more than 30 descriptive terms.[3] Delirium can be thought of as acute brain failure[4] and is the final common pathway of multiple mechanisms, similar to acute heart failure. The official definition of delirium in the *Diagnostic and Statistical Manual of Mental Disorders*, fifth edition (DSM-5),[5] requires a disturbance in attention and awareness that develops acutely and tends to fluctuate (Table 1). The pathophysiological mechanisms of delirium remain poorly understood; leading models include neurotransmitter imbalance and neuroinflammation.[1,2,7,8]

An audio version of this article is available at NEJM.org

Delirium is extremely common in hospitalized older adults. One third of general medical patients who are 70 years of age or older have delirium; the condition is present in half of these patients on admission and develops during hospitalization in the other half.[7] Delirium is the most common surgical complication among older adults, with an incidence of 15 to 25% after major elective surgery and 50% after procedures such as hip-fracture repair and cardiac surgery.[8] Among [illegible] in the intensive care unit (ICU), the [illegible] exceeds [illegible] active [illegible] nosis, potentially because it is less frequently [illegible] lirium range from mild to extremely severe, with greater severity associated worse outcomes.[1,2,7,8]

Clinical Review & Education

JAMA | Review

Delirium in Older Persons
Advances in Diagnosis and Treatment

Esther S. Oh, MD, PhD; Tamara G. Fong, MD, PhD; Tammy T. Hshieh, MD, MPH; Sharon K. Inouye, MD, MPH

IMPORTANCE Delirium is defined as an acute disorder of attention and cognition. It is a common, serious, and often fatal condition among older patients. Although often underrecognized, delirium has serious adverse effects on the individual's function and quality of life, as well as broad societal effects with substantial health care costs.

OBJECTIVE To summarize the current state of the art in diagnosis and treatment of delirium and to highlight critical areas for future research to advance the field.

EVIDENCE REVIEW Search of Ovid MEDLINE, Embase, and the Cochrane Library for the past 6 years, from January 1, 2011, until March 16, 2017, using a combination of controlled vocabulary and keyword terms. Since delirium is more prevalent in older adults, the focus was on studies in elderly populations; studies based solely in the intensive care unit (ICU) and non–English-language articles were excluded.

FINDINGS Of 127 articles included, 25 were clinical trials, 42 cohort studies, 5 systematic reviews and meta-analyses, and 55 were other categories. A total of 11 616 patients were represented in the treatment studies. Advances in diagnosis have included the development of brief screening tools with high sensitivity and specificity, such as the 3-Minute Diagnostic Assessment; 4 A's Test; and proxy-based measures such as the Family Confusion Assessment Method. Measures of severity, such as the Confusion Assessment Method–Severity Score, can aid in monitoring response to treatment, risk stratification, and assessing prognosis. Nonpharmacologic approaches focused on risk factors such as immobility, functional decline, visual or hearing impairment, dehydration, and sleep deprivation are effective for delirium prevention and also are recommended for delirium treatment. Current recommendations for pharmacologic treatment of delirium, based on recent reviews of the evidence, recommend reserving use of antipsychotics and other sedating medications for treatment of severe agitation that poses risk to patient or staff safety or threatens interruption of essential medical therapies.

CONCLUSIONS AND RELEVANCE Advances in diagnosis can improve recognition and risk stratification of delirium. Prevention of delirium using nonpharmacologic approaches is documented to be effective, while pharmacologic prevention and treatment of delirium remains controversial.

JAMA. 2017;318(12):1161-1174. doi:10.1001/jama.2017.12067

Author Audio Interview
Supplemental content
CME Quiz at jamanetwork.com/learning

Author Affiliations: Department of Medicine, Johns Hopkins University School of Medicine, Baltimore, Maryland (Oh); Department of Psychiatry and Behavioral Sciences, Johns Hopkins University School of Medicine, Baltimore, Maryland (Oh); Department of Pathology, Johns Hopkins University School of Medicine, Baltimore, Maryland (Oh); Department of Neurology, Beth Israel Deaconess Medical Center, Harvard Medical School, Boston, Massachusetts (Fong); Aging Brain Center, Hebrew SeniorLife, Boston, Massachusetts (Fong, Inouye); Division of Aging, Department of Medicine, Brigham and Women's Hospital, Harvard Medical School, Boston, Massachusetts (Hshieh); Department of Medicine, Beth Israel Deaconess Medical Center, Harvard Medical School, Boston, Massachusetts (Inouye).

Corresponding Author: Esther S. Oh, MD, PhD, Division of Geriatric Medicine and Gerontology, Johns Hopkins University School of Medicine, 5200 Eastern Ave, Seventh Floor, Baltimore, MD 21224 (eoh9@jhmi.edu).

Section Editors: [illegible]

DELIRIUM= "INSUFICIENCIA CEREBRAL AGUDA"

adults 65 years and older each year develop delirium and account for an estimated more than $164 billion in annual health care expenditures.[1] Given its adverse effect on function and quality of life, delirium holds significant societal implications for the individual, family, community, and the entire health care system.

lenging condition, and a synthesis of current evidence should optimize clinical care. The goals of this review were (1) to summarize the current approaches to diagnosis and treatment of delirium, (2) to highlight recent advances, and (3) to underscore critical gaps in knowledge where future research is needed to advance the field.

N Engl J Med 2017;377:1456-66. DOI: 10.1056/NEJMcp1605501

JAMA. 2017;318(12):1161-1174. doi:10.1001/jama.2017.12067

D **Drugs (fármacos)**

E Electrolite disturbance **(alteraciones metabólicas)**

L Lack of drugs **(deprivación)**

I Infection **(infección)**

R Reduced sensory input **(déficit sensoriales)**

I Intracranial disorder **(trastornos neurológicos)**

U Urinary and fecal disorder **(alteraciones urinarias y fecales)**

M Myocardial and pulmonary diseases **(patologías cardiopulmonares)**

Anticholinergic burden in Parkinson's disease inpatients

Unax Lertxundi, Arantxazu Isla, Maria Angeles Solinis, Saioa Domingo-Echaburu, Rafael Hernandez, Javier Peral-Aguirregoitia, et al.

European Journal of Clinical Pharmacology

ISSN 0031-6970
Volume 71
Number 10

Eur J Clin Pharmacol (2015)
71:1271-1277
DOI 10.1007/s00228-015-1919-7

Springer

- ~~Paroxetina~~ → Sertralina
- ~~Olanzapina~~ → Clozapina
- ~~Oxibutinina~~ → Ineficaz

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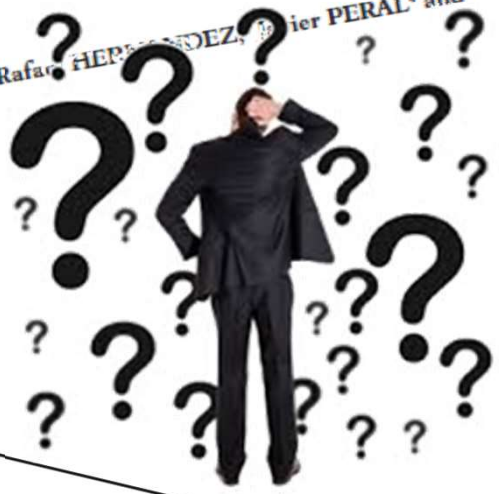
PSYCHOGERIATRICS
The Official Journal of the Japanese Psychogeriatric Society
PSYCHOGERIATRICS 2013; 13: 17–24
doi:10.1111/j.1479-8301.2012.00418.x

ORIGINAL ARTICLE

Expert-based drug lists to measure anticholinergic burden: similar names, different results

Unax LERTXUNDI,[1] Saioa DOMINGO-ECHABURU,[2] Rafael HERNÁNDEZ,[3] Javier PERAL[4] and Juan MEDRANO[5]



Eur J Clin Pharmacol
DOI 10.1007/s00228-013-1535-3

LETTER TO THE EDITORS

Comments on Duran et al.'s systematic review of anticholinergic risk scales (EJCP 2DOI 10.1007/s00228-013-1499-3)

Unax Lertxundi · Saioa Domingo-Echaburu · Borja Ruiz-Osante · Rafael Hernandez Palacios · Javier Peral Aguirregoitia · Juan Medrano Albeniz

Journal of the American Geriatrics Society

CONFUSION REGARDING ANTICHOLINERGIC BURDEN MEASUREMENT

To the Editor: In a recent work by Kalisch Ellett et al.,[1] in which high anticholinergic burden was associated with hospital admissions for confusion or dementia, the method used to measure anticholinergic burden raises some questions.

Many drug lists to measure anticholinergic burden exist,[2] but differences in drugs included and rating of anticholinergic effect have given rise to poor agreement among them when applied in a medium- and long-stay psychiatric hospital.[3]

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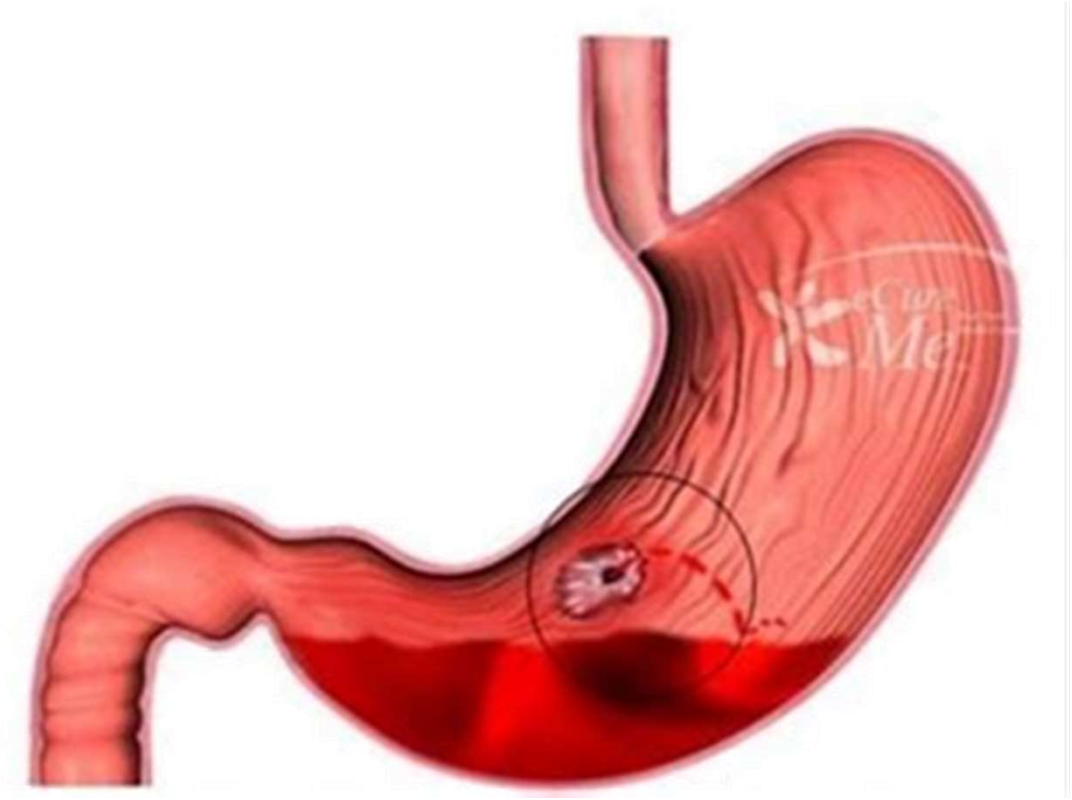
Juan Medrano, MD
Psychiatry Service, Bizkaia's Mental Health Network, Portugalete, Bizkaia, Spain

DÍA: 2

- Dolor en el hombro
- **Dexketoprofeno**

Paroxetina + AINE (dexketoprofeno)



¿Impacto clínico real ?

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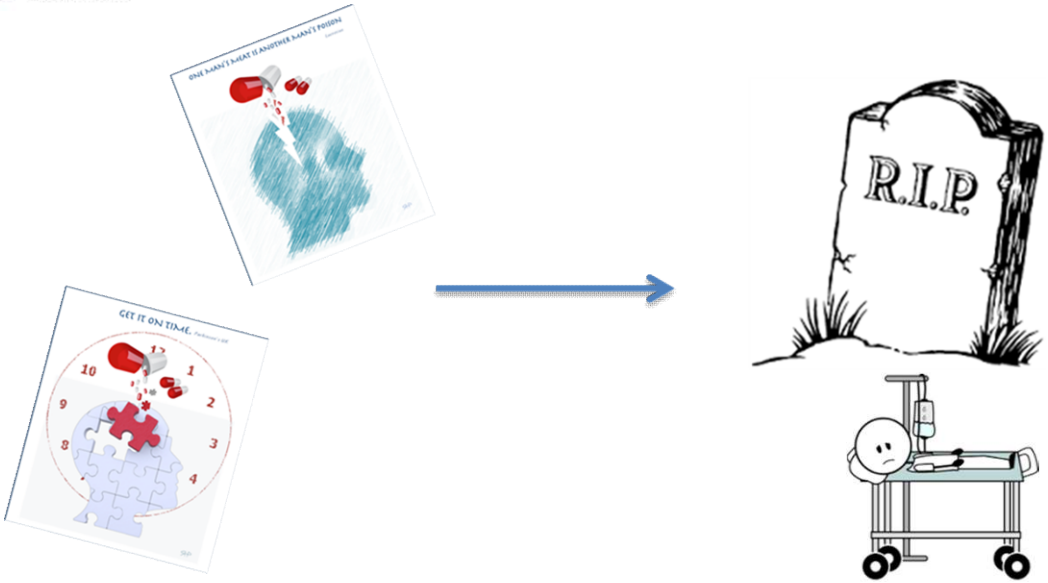
Contents lists available at ScienceDirect

Parkinsonism and Related Disorders

journal homepage: www.elsevier.com/locate/parkreldis

Medication errors in Parkinson's disease inpatients in the Basque Country

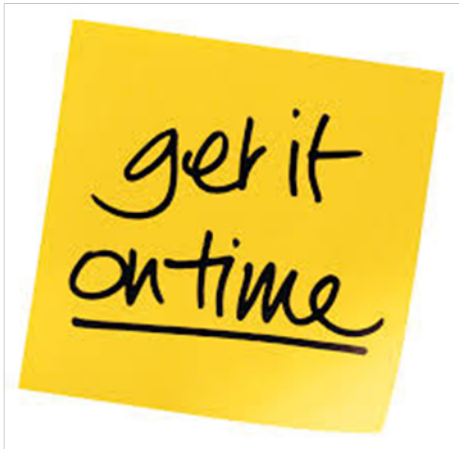
Unax Lertxundi [a, *], Arantxa Isla [b], María Ángeles Solinís [b], Saioa Domingo- Echaburu [c], Rafael Hernandez [d], Javier Peral-Aguirregoitia [e], Juan Medrano [f], Juan Carlos García-Moncó [g]



MSA! ARTICLES

Delayed Administration and Contraindicated Drugs Place Hospitalized Parkinson's Disease Patients at Risk

¡CONCIENCIACIÓN!



https://parkinson.org/

https://www.parkinsons.org.uk/