9. Deterioramento cognitivo nel paziente anziano

Deterioramento cognitivo e anomalie comportamentali

Question: Should risperidone vs placebo be used in elderly people with cognitive deterioration?

Bibliography: Ballard CG, Waite J, Birks J. Atypical antipsychotics for aggression and psychosis in Alzheimer's disease. Cochrane Database of Systematic Reviews 2006; Issue 1

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Risperidone	Placebo	Relative (95% CI)	Absolute		
Agitation (follow-up mean 13 weeks; measured with: CMAI; Better indicated by lower values)												
3	randomised trials	no serious risk of bias	very serious[1]	no serious indirectness	no serious imprecision	none	453	356	-	MD 1.17 lower (2.02 to 0.32 lower)	⊕⊕OO LOW	CRITICAL
Aggressiveness (follow-up mean 13 weeks; measured with: BEHAVE-AD; Better indicated by lower values)												
2	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	no serious imprecision	none	263	275	-	MD 0.84 lower (1.28 to 0.4 lower)	⊕⊕⊕⊕ HIGH	CRITICAL
Psychotic symptoms (follow-up mean 13 weeks; measured with: BEHAVE-AD or NPI PSYCHOSIS; Better indicated by lower values)												
4	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	serious[2]	none	688	616	-	MD 0.14 lower (0.25 to 0.03 lower)	⊕⊕⊕O MODERATE	CRITICAL
Adverse events (follow-up mean 13 weeks; assessed with: number of adverse events)												
3	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	serious[3]	none	453/550 (82.4%)	447/571 (78.3%)	OR 1.33 (0.98 to 1.8)	45 more per 1000 (from 3 fewer to 84 more)	⊕⊕⊕O MODERATE	IMPORTANT
Cerebrovascular adverse events (follow-up mean 13 weeks; assessed with: number of cerebrovascular adverse events)												
5	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	no serious imprecision	none	37/1175 (3.1%)	8/779 (1%)	OR 3.64 (1.72 to 7.69)	26 more per 1000 (from 7 more to 64 more)	⊕⊕⊕⊕ HIGH	IMPORTANT
Mortality (follow-up mean 13 weeks; assessed with: number of deaths before end of treatment)												
5	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	very serious[3]	none	43/1175 (3.7%)	22/779 (2.8%)	OR 1.25 (0.73 to 2.16)	7 more per 1000 (from 7 fewer to 31 more)	⊕⊕OO LOW	CRITICAL

Total dropouts (follow-up mean 13 weeks; assessed with: number of patients leaving the study before end of treatment)												
5	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	serious[3]	none	258/861 (30%)	218/778 (28%)	OR 1.11 (0.9 to 1.38)	22 more per 1000 (from 21 fewer to 69 more)	⊕⊕⊕O MODERATE	CRITICAL

[1] Heterogeneity I squared = 79%

[2] 95% CI ranges from substantial benefit with risperidone to no difference

[3] 95% CI ranges from no difference to substantial harm with risperidone

Question: Should olanzapine vs placebo be used in elderly people with cognitive deterioration?

Bibliography: Ballard CG, Waite J, Birks J. Atypical antipsychotics for aggression and psychosis in Alzheimer's disease. Cochrane Database of Systematic Reviews 2006; Issue 1

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Olanzapine	Placebo	Relative (95% CI)	Absolute		
Agitation (measured with: NPI-NH AGITATION/AGGRESSION; Better indicated by lower values)												
2	randomised trials	no serious risk of bias	serious[1]	no serious indirectness	no serious imprecision	none	355	174	-	MD 0.77 lower (1.44 to 0.1 lower)	⊕⊕⊕O MODERATE	CRITICAL
Aggressiveness (measured with: BEHAVE AD; Better indicated by lower values)												
1	randomised trials	no serious risk of bias	no serious inconsistency[2]	no serious indirectness	very serious[3]	none	100	105	-	MD 0.40 lower (2.74 lower to 1.94 higher)	⊕⊕OO LOW	CRITICAL
Psychotic symptoms (follow-up mean 10 weeks; measured with: NPI-NH PSYCHOSIS; Better indicated by lower values)												
3	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	serious[4]	none	548	265	-	MD 0.36 lower (1.22 lower to 0.5 higher)	⊕⊕⊕O MODERATE	CRITICAL
Adverse events												
0	No evidence available					none	-	-	-	-		IMPORTANT
Cerebrovascular adverse events (follow-up mean 10 weeks; assessed with: number of cerebrovascular adverse events)												
1	randomised trials	no serious risk of bias	no serious inconsistency[2]	no serious indirectness	very serious[3]	none	5/203 (2.5%)	0/94 (0%)	OR 5.94 (0.29 to 95.69)	-	⊕⊕OO LOW	IMPORTANT
Mortality (follow-up mean 10 weeks; assessed with: number of deaths before end of treatment)												
2	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	very serious[3]	none	14/460 (3%)	3/223 (1.3%)	OR 2.31 (0.66 to 8.13)	17 more per 1000 (from 5 fewer to 86 more)	⊕⊕OO	CRITICAL

								0%		-	LOW	
Total dropouts (follow-up mean 10 weeks; assessed with: number of patients leaving the study before end of treatment)												
3	randomised trials	no serious risk of bias	serious[5]	no serious indirectness	serious[6]	none	171/567 (30.2%)	68/270 (25.2%)	OR 1.28 (0.92 to 1.78)	49 more per 1000 (from 15 fewer to 123 more)	⊕⊕OO LOW	CRITICAL

[1] Heterogeneity I squared = 61%
[2] heterogeneity not applicable, only one study included
[3] 95% CI ranges from substantial benefit with olanzapine to substantial benefit with placebo
[4] 95% CI ranges from substantial benefit with olanzapine to no difference
[5] Heterogeneity I squared = 73%
[6] 95% CI ranges from no difference to substantial harm with olanzapine

Question: Should aripiprazole vs placebo be used in elderly people with cognitive deterioration?

Bibliography: Schneider LS, Dagerman K, Insel PS. Efficacy and adverse effects of atypical antipsychotics for dementia: meta-analysis of randomized, placebo-controlled trials. American Journal of Geriatric Psychiatry 2006; 14: 191-210; Ballard CG, Waite J, Birks J. Atypical antipsychotics for aggression and psychosis in Alzheimer's disease. Cochrane Database of Systematic Reviews 2006; Issue 1

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Aripiprazole	Placebo	Relative (95% CI)	Absolute		
Agitation (follow-up mean 10 weeks; measured with: CMAI Total; Better indicated by lower values)												
2[1]	randomised trials	serious[2]	no serious inconsistency	no serious indirectness	no serious imprecision	none	475	236	-	SMD 4.05 lower (6.58 to 1.52 lower)	⊕⊕⊕O MODERATE	CRITICAL
Aggressiveness												
0	No evidence available					none	-	-	-	-		CRITICAL
Psychotic symptoms (follow-up mean 10 weeks; measured with: BEHAVE-AD PSYCHOSIS[3]; Better indicated by lower values)												
1[4]	randomised trials	no serious risk of bias	no serious inconsistency[5]	no serious indirectness	serious[6]	none	106	102	-	MD 1.03 lower (2.5 lower to 0.44 higher)	⊕⊕⊕O MODERATE	CRITICAL
Adverse events												
0	No evidence available					none	-	-	-	-		IMPORTANT
Cerebrovascular adverse events												
0	No evidence available					none	-	-	-	-		IMPORTANT
Mortality (assessed with: number of deaths before end of treatment)												
1[4]	randomised	no serious	no serious	no serious	very serious[6]	none	4/106	0/102	OR 9 (0.48 to	-	⊕⊕OO	CRITICAL

	trials	risk of bias	inconsistency[5]	indirectness			(3.8%)	(0%)	169.32)		LOW	
Total dropouts (assessed with: number of patients leaving the study before end of treatment)												
1[4]	randomised trials	no serious risk of bias	no serious inconsistency[5]	no serious indirectness	very serious[6]	none	18/106 (17%)	18/102 (17.6%)	OR 0.95 (0.47 to 1.96)	7 fewer per 1000 (from 85 fewer to 119 more)	⊕⊕OO LOW	CRITICAL

[1] Data from Schneider 2006
[2] Allocation concealment is unclear
[3] The same outcome is also assessed with BPRS-PSYCHOSIS SUBSCALE with a CI of [-1.27, -0.05]
[4] Data from Ballard 2008
[5] Heterogeneity not applicable: only one study included
[6] 95% CI ranges from substantial benefit with aripiprazole to substantial benefit with placebo

Question: Should quetiapine vs placebo be used in elderly people with cognitive deterioration?

Bibliography: Ballard CG, Waite J, Birks J. Atypical antipsychotics for aggression and psychosis in Alzheimer's disease. Cochrane Database of Systematic Reviews 2006; Issue 1; Schneider LS, Dagerman KS, Insel P. Risk of death with atypical antipsychotic drug treatment for dementia: meta-analysis of randomized placebo-controlled trials. JAMA 2005; 19: 1934-43

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Quetiapine	Placebo	Relative (95% CI)	Absolute		
Agitation (measured with: CMAI TOTAL; Better indicated by lower values)												
1	randomised trials	no serious risk of bias	no serious inconsistency[1]	no serious indirectness	very serious[2]	none	27	30	-	MD 0.90 higher (6.7 lower to 8.5 higher)	⊕⊕OO LOW	CRITICAL
Aggressiveness												
0	No evidence available					none	-	-	-	-		CRITICAL
Psychotic symptoms (measured with: BPRS; Better indicated by lower values)												
1	randomised trials	no serious risk of bias	no serious inconsistency[1]	no serious indirectness	serious[3]	none	124	125	-	SMD 2.32 lower (4.93 lower to 0.29 higher)	⊕⊕⊕O MODERATE	CRITICAL
Adverse events												
0	No evidence available					none	-	-	-	-		IMPORTANT
Cerebrovascular adverse events												
0	No evidence available					none	-	-	-	-		IMPORTANT
Mortality (assessed with: number of deaths)												
3	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	very serious[4]	none	21/391 (5.4%)	7/246 (2.8%)	OR 1.67 (0.7 to 4.03)	18 more per 1000 (from 8 fewer to 77 more)	⊕⊕OO LOW	CRITICAL

Total dropouts (assessed with: number of patients leaving the study before end of treatment)												
1	randomised trials	no serious risk of bias	no serious inconsistency[1]	no serious indirectness	very serious[5]	none	5/26 (19.2%)	2/29 (6.9%)	OR 3.21 (0.57 to 18.24)	123 more per 1000 (from 28 fewer to 506 more)	⊕⊕OO LOW	CRITICAL

[1] heterogeneity not applicable: only one study included
[2] 95% CI ranges from substantial benefit with quetiapine to substantial benefit with placebo; number of patients = 57
[3] 95% CI ranges from substantial benefit with quetiapine to no effect
[4] 95% CI ranges from substantial benefit with quetiapine to substantial benefit with placebo
[5] 95% CI ranges from substantial benefit with quetiapine to substantial benefit with placebo; number of patients = 55

Question: Should haloperidol vs placebo be used in elderly people with cognitive deterioration?

Bibliography: Lonergan E, Luxenberg J, Colford J. Haloperidol for agitation in dementia. Cochrane Database of Systematic Reviews 2002; Issue 2

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Haloperidol	Placebo	Relative (95% CI)	Absolute		
Agitation (measured with: CMAI ; Better indicated by lower values)												
4	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	serious[1]	none	194	175	-	SMD 0.12 lower (0.33 lower to 0.08 higher)	⊕⊕⊕O MODERATE	CRITICAL
Aggressiveness (measured with: MOSES aggressiveness subscore, BEHAVE AD aggressiveness subscore; Better indicated by lower values)												
3	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	no serious imprecision	none	254	235	-	SMD 0.31 lower (0.49 to 0.13 lower)	⊕⊕⊕⊕ HIGH	CRITICAL
Psychotic symptoms												
0	No evidence available					none	-	-	-	-		CRITICAL
Adverse events (assessed with: number suffering at least one adverse events by endpoint)												
2	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	serious[2]	none	169/216 (78.2%)	152/217 (70%)	OR 1.53 (1 to 2.35)	81 more per 1000 (from 0 more to 146 more)	⊕⊕⊕O MODERATE	IMPORTANT
Cerebrovascular adverse events												
0	No evidence available					none	-	-	-	-		IMPORTANT
Mortality												
0	No evidence available					none	-	-	-	-		CRITICAL

Total dropouts (assessed with: dropouts by endpoint)												
5	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	serious[3]	none	73/295 (24.7%)	72/278 (25.9%)	OR 1.00 (0.68 to 1.46)	0 fewer per 1000 (from 67 fewer to 79 more)	⊕⊕⊕O MODERATE	CRITICAL

[1] 95% CI ranges from substantial benefit with haloperidol to no difference
[2] 95% CI ranges from substantial harm with haloperidol to no difference
[3] 95% CI ranges from substantial benefit with haloperidol to substantial benefit with placebo

Question: Should SSRI vs placebo be used in elderly people with cognitive deterioration?

Bibliography: Seitz DP, Adunuri N, Gill SS, Gruneir A, Herrmann N, Rochon P. Antidepressants for agitation and psychosis in dementia. Cochrane Database of Systematic Reviews 2011; Issue 2

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	SSRI	Placebo	Relative (95% CI)	Absolute		
Agitation (measured with: CMAI Total Score; Better indicated by lower values)												
2	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	serious[1]	none	126	124	-	MD 0.89 lower (1.22 to 0.57 lower)	⊕⊕⊕O MODERATE	CRITICAL
Aggressiveness (measured with: BEHAVE AD; Better indicated by lower values)												
1	randomised trials	no serious risk of bias	no serious inconsistency[2]	no serious indirectness	serious[3]	none	124	120	-	MD 0.7 lower (1.95 lower to 0.55 higher)	⊕⊕⊕O MODERATE	CRITICAL
Psychotic symptoms (measured with: NPI total scores; Better indicated by lower values)												
1	randomised trials	no serious risk of bias	no serious inconsistency[2]	no serious indirectness	serious[4]	none	124	120	-	MD 1.80 higher (2.01 lower to 5.61 higher)	⊕⊕⊕O MODERATE	CRITICAL
Adverse events												
0	No evidence available					none	-	-	-	-		IMPORTANT
Cerebrovascular adverse events												
0	No evidence available					none	-	-	-	-		IMPORTANT
Mortality												
0	No evidence available					none	-	-	-	-		CRITICAL

Total dropouts (assessed with: number of patients leaving the study before end of treatment)												
3	randomised trials	no serious risk of bias	no serious inconsistency[5]	no serious indirectness	serious[4]	none	45/177 (25.4%)	44/166 (26.5%)	RR 0.91 (0.65 to 1.26)	24 fewer per 1000 (from 93 fewer to 69 more)	⊕⊕⊕O MODERATE	CRITICAL

[1] Although the estimate is statistically significant, the 95% CI ranges from substantial benefit with SSRI to almost no difference
[2] Heterogeneity not applicable: only one study included
[3] 95% CI ranges from substantial benefit with SSRI to no difference
[4] 95% CI ranges from substantial benefit with SSRI to substantial benefit with placebo
[5] Missing

Question: Should trazodone vs placebo be used in elderly people with cognitive deterioration?

Bibliography: Seitz DP, Adunuri N, Gill SS, Gruneir A, Herrmann N, Rochon P. Antidepressants for agitation and psychosis in dementia. Cochrane Database of Systematic Reviews 2011; Issue 2; Martinon-Torres G, Fioravanti M, Grimley EJ. Trazodone for agitation in dementia. Cochrane Database of Systematic Reviews 2004; Issue 3

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Trazodone	Placebo	Relative (95% CI)	Absolute		
Agitation (measured with: CMAI Total Score[1]; Better indicated by lower values)												
1	randomised trials	no serious risk of bias	no serious inconsistency[2]	no serious indirectness	very serious[3]	none	37	36	-	MD 5.18 higher (2.86 lower to 13.22 higher)	⊕⊕OO LOW	CRITICAL
Aggressiveness												
0	No evidence available					none	-	-	-	-		CRITICAL
Psychotic symptoms (measured with: NPI[4]; Better indicated by lower values)												
1	randomised trials	no serious risk of bias	no serious inconsistency[2]	no serious indirectness	very serious[3]	none	15	16	-	MD 0.80 lower (13.35 lower to 11.75 higher)	⊕⊕OO LOW	CRITICAL
Adverse events												
0	No evidence available					none	-	-	-	-		IMPORTANT
Cerebrovascular adverse events												
0	No evidence available					none	-	-	-	-		IMPORTANT
Mortality												
0	No evidence available					none	-	-	-	-		CRITICAL

Total dropouts (assessed with: trial withdrawal)											
1	randomised trials[4]	no serious risk of bias	no serious inconsistency[2]	no serious indirectness	very serious[3]	none	12/37 (32.4%)	11/36 (30.6%)	RR 1.09 (0.41 to 2.93)	28 more per 1000 (from 180 fewer to 590 more)	⊕⊕OO LOW	CRITICAL

[1] Data from Seitz 2011

[2] Heterogeneity not applicable, only one study included

[3] 95% CI ranges from substantial benefit with trazodone to substantial benefit with placebo; number of patients less than 100

[4] Data from Martinon-Torres 2008

Question: Should SSRI vs atypical antipsychotic be used in elderly people with cognitive deterioration?

Bibliography: Seitz DP, Adunuri N, Gill SS, Gruneir A, Herrmann N, Rochon P. Antidepressants for agitation and psychosis in dementia. Cochrane Database of Systematic Reviews 2011; Issue 2

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	SSRI	Atypical antipsychotic	Relative (95% CI)	Absolute		
Agitation												
0	No evidence available					none	-	-	-	-		CRITICAL
Aggressiveness												
0	No evidence available					none	-	-	-	-		CRITICAL
Psychotic symptoms (measured with: NBRS Psychosis Subscale; Better indicated by lower values)												
1	randomised trials	no serious risk of bias	no serious inconsistency[1]	no serious indirectness	very serious[2]	none	53	50	-	MD 0.26 higher (1.51 lower to 2.03 higher)	⊕⊕OO LOW	CRITICAL
Adverse events (measured with: UKU side effects scale; Better indicated by lower values)												
1	randomised trials	no serious risk of bias	no serious inconsistency[1]	no serious indirectness	very serious[3]	none	53	50	-	MD 2.82 lower (4.94 to 0.7 lower)	⊕⊕OO LOW	IMPORTANT
Cerebrovascular adverse events												
0	No evidence available					none	-	-	-	-		IMPORTANT
Mortality												
0	No evidence available					none	-	-	-	-		CRITICAL

Total dropouts (assessed with: number of patients leaving the study before end of treatment)												
1	randomised trials	no serious risk of bias	no serious inconsistency[1]	no serious indirectness	very serious[2]	none	28/53 (52.8%)	30/50 (60%)	RR 0.88 (0.63 to 1.24)	72 fewer per 1000 (from 222 fewer to 144 more)	⊕⊕OO LOW	CRITICAL

[1] Heterogeneity not applicable: only one study included

[2] 95% CI ranges from substantial benefit with SSRI to substantial benefit with antipsychotics; number of patients = 103

[3] 95% CI ranges from substantial benefit with SSRI to almost no difference; number of patients = 103

Question: Should SSRI vs typical antipsychotics be used in elderly people with cognitive deterioration?

Bibliography: Seitz DP, Adunuri N, Gill SS, Gruneir A, Herrmann N, Rochon P. Antidepressants for agitation and psychosis in dementia. Cochrane Database of Systematic Reviews 2011; Issue 2

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	SSRI	Typical antipsychotics	Relative (95% CI)	Absolute		
Agitation (measured with: CMAI Total Scores; Better indicated by lower values)												
2	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	very serious[1]	none	18[2]	15	-	MD 4.66 higher (3.58 lower to 12.9 higher)	⊕⊕OO LOW	CRITICAL
Aggressiveness												
0	No evidence available					none	-	-	-	-		CRITICAL
Psychotic symptoms												
0	No evidence available					none	-	-	-	-		CRITICAL
Adverse events												
0	No evidence available					none	-	-	-	-		IMPORTANT
Cerebrovascular adverse events												
0	No evidence available					none	-	-	-	-		IMPORTANT
Mortality												
0	No evidence available					none	-	-	-	-		CRITICAL

Total dropouts (assessed with: number of patients leaving the study before end of treatment)												
1	randomised trials	no serious risk of bias	no serious inconsistency[3]	no serious indirectness	very serious[4]	none	16/31 (51.6%)	16/31 (51.6%)	RR 0.95 (0.6 to 1.5)	26 fewer per 1000 (from 206 fewer to 258 more)	⊕⊕OO LOW	CRITICAL

[1] 95% CI ranges from substantial benefit with SSRI to substantial benefit with antipsychotics; number of patients = 33

[2] SSRI= fluoxetine + sertraline;

[3] Heterogeneity not applicable; only one study included

[4] 95% CI ranges from substantial benefit with SSRI to substantial benefit with antipsychotics; number of patients less than 100

Question: Should trazodone vs haloperidol be used in elderly people with cognitive deterioration?

Bibliography: Seitz DP, Adunuri N, Gill SS, Gruneir A, Herrmann N, Rochon P. Antidepressants for agitation and psychosis in dementia. Cochrane Database of Systematic Reviews 2011; Issue 2

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Trazodone	Haloperidol	Relative (95% CI)	Absolute		
Agitation (measured with: CMAI Total Score; Better indicated by lower values)												
2	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	very serious[1]	none	51	48	-	MD 3.28 higher (3.28 lower to 9.85 higher)	⊕⊕OO LOW	CRITICAL
Aggressiveness												
0	No evidence available					none	-	-	-	-		CRITICAL
Psychotic symptoms												
0	No evidence available					none	-	-	-	-		CRITICAL
Adverse events												
0	No evidence available					none	-	-	-	-		IMPORTANT
Cerebrovascular adverse events												
0	No evidence available					none	-	-	-	-		IMPORTANT
Mortality												
0	No evidence available					none	-	-	-	-		CRITICAL

Total dropouts (assessed with: number of patients leaving the study before end of treatment)											
1	randomised trials	no serious risk of bias	no serious inconsistency[2]	no serious indirectness	very serious[3]	none	12/37 (32.4%)	14/34 (41.2%)	RR 0.79 (0.43 to 1.46)	86 fewer per 1000 (from 235 fewer to 189 more)	⊕⊕OO LOW	CRITICAL

[1] 95% CI ranges from substantial benefit with trazodone to substantial benefit with haloperidol; number of patients less than 100
[2] Heterogeneity not applicable: only one study included
[3] CI includes no effect; number of patients = 71

Bibliografia

Ballard CG, Waite J, Birks J. Atypical antipsychotics for aggression and psychosis in Alzheimer's disease. Cochrane Database of Systematic Reviews 2006; Issue 1

Lonergan E, Luxenberg J, Colford J. Haloperidol for agitation in dementia. Cochrane Database of Systematic Reviews 2002; Issue 2

Martinon-Torres G, Fioravanti M, Grimley EJ. Trazodone for agitation in dementia. Cochrane Database of Systematic Reviews 2004; Issue 3

Schneider LS, Dagerman K, Insel PS. Efficacy and adverse effects of atypical antipsychotics for dementia: meta-analysis of randomized, placebo-controlled trials. American Journal of Geriatric Psychiatry 2006; 14: 191-210

Seitz DP, Adunuri N, Gill SS, Gruneir A, Herrmann N, Rochon P. Antidepressants for agitation and psychosis in dementia. Cochrane Database of Systematic Reviews 2011; Issue 2

Deterioramento cognitivo e sintomi depressivi

Question: Should antidepressants vs placebo be used in elderly people with cognitive deterioration?

Bibliography: Bains J, Birks J, Dening T. Antidepressants for treating depression in dementia. Cochrane Database of Systematic Reviews, 2002; Issue 4

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Antidepressants	Placebo	Relative (95% CI)	Absolute		
Depressive symptoms (measured with: Ham-D; Better indicated by lower values)												
4	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	very serious[1]	none	63	65	-	MD 0.93 lower (3.27 lower to 1.41 higher)	⊕⊕OO LOW	CRITICAL
Adverse events (assessed with: number of adverse events)												
3	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	no serious imprecision	none	196/397 (49.4%)	159/394 (40.4%)	OR 1.42 (1.07 to 1.89)	86 more per 1000 (from 16 more to 158 more)	⊕⊕⊕⊕ HIGH	IMPORTANT
Total dropout (assessed with: number of dropouts)												
5	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	serious[2]	none	28/130 (21.5%)	27/134 (20.1%)	OR 1.07 (0.59 to 1.94)	11 more per 1000 (from 72 fewer to 127 more)	⊕⊕⊕O MODERATE	CRITICAL

[1] 95% CI ranges from substantial benefit with antidepressant to substantial benefit with placebo; number of patients = 128
[2] 95% CI ranges from substantial benefit with antidepressant to substantial benefit with placebo

Bibliografia

Bains J, Birks J, Dening T. Antidepressants for treating depression in dementia. Cochrane Database of Systematic Reviews, 2002; Issue 4