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From hospital to community: Use of antipsychotics in hospitalized elders, follow up study

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Background

Despite limited evidence of efficacy, antipsychotics (AP) are commonly used to treat delirium. APs are associated with increased mortality in elders, particularly those with dementia. The authors have reported that 48% of hospitalized elders who were newly started on antipsychotic (AP) medications had the drugs continued at discharge. This follow up study analyzes the duration of AP use in this population for 1 year after the index admissions.

Methods

We previously described a retrospective cohort of 300 elders (> 65 years) admitted to a tertiary care hospital between 10/1/2012 and 9/31/2013 who were newly prescribed APs while hospitalized. Of these, 148 patients were discharged on APs. We now report on patients from this cohort who were readmitted within 1 year. We examined the number of readmissions and whether the patients were still on APs at the time of readmission or receiving sedating medications such as anxiolytics, hypnotics and antihistamines. Two investigators extracted the charts independently to see if APs were resumed or discontinued and to examine the circumstances around the time of drug changes. We used descriptive statistics and performed cross-tabulations on the selected variables.

Results

Of the 148 elders discharged on APs, 60 (41%) were readmitted at least once (111 total readmissions). The mean age was 81.3, 60% were male and 45% were admitted from post-acute facilities. Median time to readmission was 43.5 days. Inpatient mortality was 8% (5/60). When readmitted, 39/60 (67%) of patients were still receiving the same APs on which they had been discharged. The APs were continued after readmission in 80% of patients (61% quetiapine, 19% olanzapine and 13% risperidone). One patient was started on quetiapine in the outpatient setting. No patients had new orders for benzodiazepines, non-benzodiazepine hypnotics or antihistamines on their admission medication lists.

Eighteen patients (9 on existing APs) received new APs during the readmission hospitalizations. These included haloperidol (89%) and quetiapine (39%). Delirium was the main reported indication for starting APs (77%), but in 17% of cases no indication was documented. An EKG was performed in 94% prior to APs administration and for 22% after APs administration. QTc prolongation >500msec was present in 17% and 11% respectively. Of patients who survived, 58% were discharged to post-acute facilities. Patients who were not on APs on readmission were more likely to receive new APs (9/20; 45% versus 9/39; 23%) during their hospital stays but were less likely to be discharged on new APs than those still receiving the drugs at the time of readmission. [6/11; 55% versus 27/37 (2 patients expired); 73%].

Conclusion

Many elders discharged on APs were readmitted within a year. APs were started in the hospital possibly due to lack of behavioral modification options, and patients were subsequently discharged on these medications with majority of them still receiving the same APs on subsequent admissions. Additionally, those whom APs had been discontinued had them resumed during subsequent hospital stays. These patients are likely to remain taking these medications for long-term, which put them at high risk for adverse effects and death.