SF3PA

Société Francophone de Psychogériatrie et de Psychiatrie de la Personne Âgée

What's up/What's next en gériatrie, psychogériatrie et psychiatrie de la personne âgée ?

Dr Mathieu HERRMANN, psychiatre, BRON
Dr Alexis LEPETIT, psychiatre et gériatre, LYON
Dr Julien VERNAUDON, gériatre, VILLEFRANCHE-SUR-SAÔNE

LE VINATIER
PSYCHIATRIE UNIVERSITAIRE
LYON MÉTROPOLE

Hôpitaux
Nord-Ouest
Villefranche-sur-Saône

HCL
HOSPICES CIVILS DE LYON
L'INSTITUT DU VIEILLISSEMENT

ACPPA
Groupe

Conflits et lien d'intérêt

- Julien VERNAUDON : aucun
- Alexis LEPETIT
  - Laboratoires Lundbeck
    - Investigateur principal protocole Memory
    - Symposium satellite (congrès SF3PA 2019, 2023 et 2024)
    - Participation à un board d'expert (2023)
  - Acadia Pharmaceuticals
    - Investigateur associé protocole ACP-103-032
    - Investigateur associé protocole ACP-103-033
  - Laboratoire Delbert
- Mathieu HERRMANN
  - Aucun dans le cadre de cette présentation
  - Investigateur associé étude Lundbeck 17354N (2018-2020)

SF3PA

Vos orateurs

3 domaines

- Psychiatrie de la personne âgée
  - Dr Mathieu Herrmann

- Prise en charge des symptômes psychocomportementaux des troubles neurocognitifs majeurs
  - Dr Alexis Lepetit

- Gériatrie
  - Dr Julien Vernaudon

Antipsychotiques d’action prolongée et PA

Wei Y, Yan VKC, Huang C, Deng EK et al. Disease relapse, all-cause mortality, and adverse events associated with long-acting injectable antipsychotics versus oral antipsychotics in older people with schizophrenia in oral antipsychotics in older people with schizophrenia in Hong Kong: a population-based within-subject analysis. Lancet Psychiatry 2025; 18:830-40

Contexte

Clinical Interventions in Aging

Dovepress

open access to scientific and medical research

Open Access Full Text Article

REVIEW

Efficacy and safety of risperidone long-acting injection in elderly people with schizophrenia

This article was published in the following Dove Press journal:
Clinical Interventions in Aging
25 August 2009

Am J of Geriatric Psychiatry 28:1 (2020) 23–30

Regular Research Article

A Comparison of Long-Acting Injectable Antipsychotics With Oral Antipsychotics on Time to Rehospitalization Within 1 Year of Discharge in Elderly Patients With Schizophrenia

Ching-Hua Lin, M.D., Ph.D., Feng-Chua Chen, B.S., Hung-Yu Chan, M.D., Ph.D., Chun-Chi Hsu, M.D.

Am J of Geriatric Psychiatry 32:12 (2024) 1420–1430

Regular Research Article

Long-Acting Injectable Antipsychotics in the Geriatric Population: A longitudinal Study

Nafiz Mosharraf, M.D., Tanya Peguero Estevez, M.D.†, Lisa J. Cohen, Ph.D., Melinda Lantz, M.D.

Original Investigation | Psychiatry

July 28, 2022

Association of Long-Acting Injectable Antipsychotics and Oral Antipsychotics With Disease Relapse, Health Care Use, and Adverse Events Among People With Schizophrenia

Yue Wei, MPH[1]; Vincent K. C. Yan, BPharm[1]; Wei Kang, MSc[1]; et al

Oral Antipsychotic Versus Long-Acting Injections Antipsychotic in Schizophrenia Spectrum Disorder: a Mirror Analysis in a Real-World Clinical Setting

By Nicola Poloni, Marta Ielmini, Ivano Caselli, Giulia Lucca, Alessandra Gasparini, Giorgia Lorenzoli, Camilla Callegari

Disease relapse, all-cause mortality, and adverse events associated with long-acting injectable antipsychotics versus oral antipsychotics in older people with schizophrenia in Hong Kong: a population-based within-subject analysis

Yue Wei, Vincent K C Yan, David J Castle, Caige Huang, Eunice Kehui Deng, Shek-Ming Leung, Hei Hang Edmund Yiu, Kyung Jin Lee, Simon S Y Lui, Vanessa W S Ng, Joseph F Hayes, Francisco T T Lai, Huali Wang, Eric W C Yan, Esther W Chan

Lancet Psychiatry 2025; 12: 830–40

Etudes monocentriques, rétrospectives, faibles effectifs et durées de suivi
Pas d'étude du risque de mortalité et EI détaillé

Méthodes et résultats

Objectif principal

Taux de rechute (hospitalisation pour schizophrénie)

Objectifs secondaires

Mortalité toute cause

Effets secondaires

Admission pour cause CV
Sd EP
Atteinte hépatique aigue
Atteinte rénale aigue

n = 4696 65+ (24 985)
51,2% Femmes
2004-2023 avec suivi moyen 7,92ans (SD 5,31)

Multicentrique

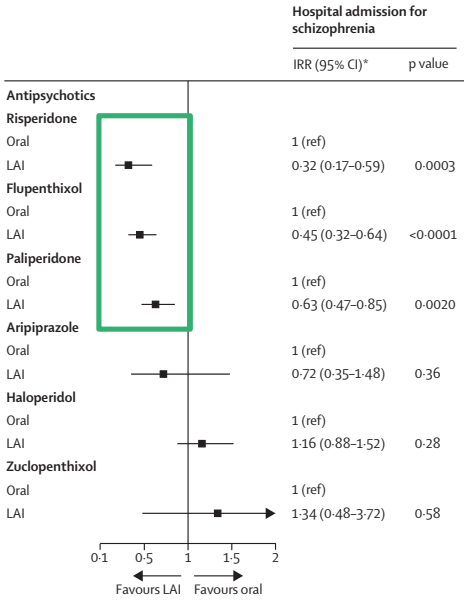
Analyse intra-individuelle sur données de population

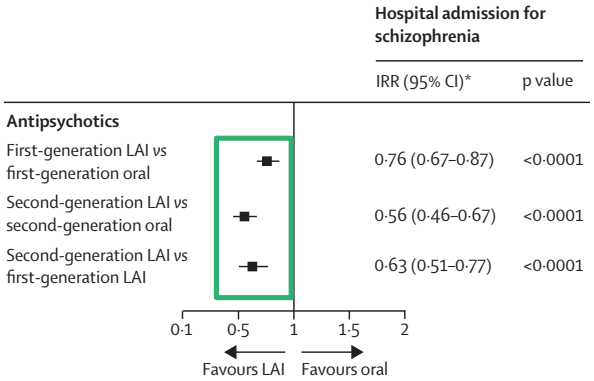
Registre du Hong Kong Hospital Authority

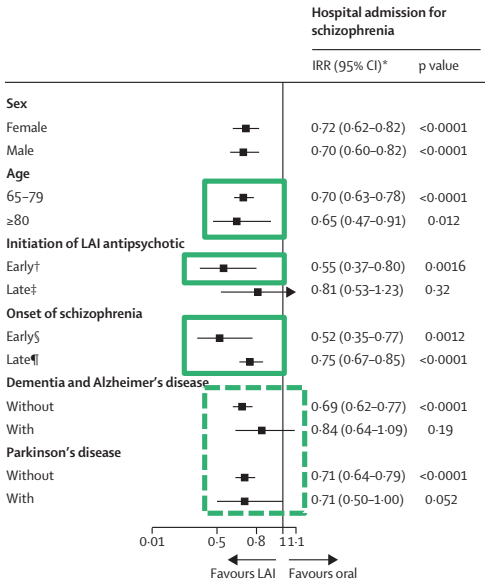
Résultats

Objectif principal

Taux de rechute (hospitalisation pour schizophrénie)







Résultats

Objectifs secondaires

Mortalité toute cause

Effets secondaires

Admission pour cause CV

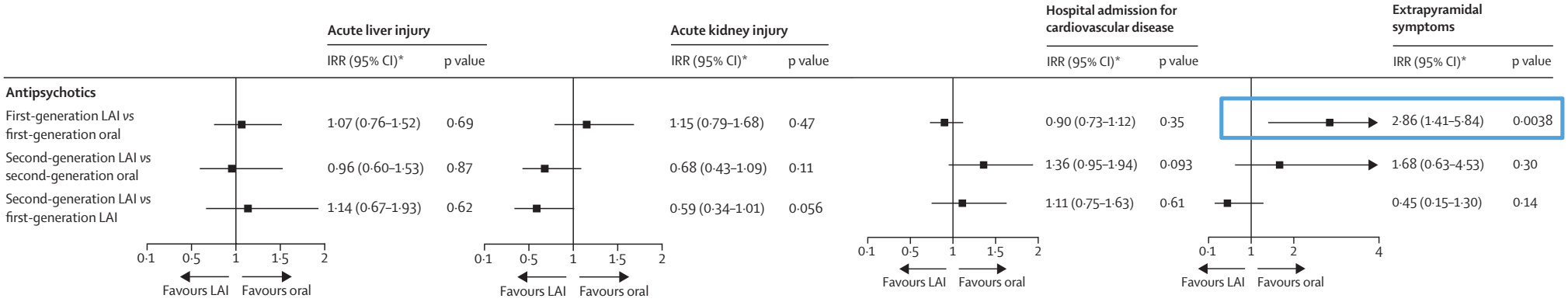
Sd EP

Atteinte hépatique aigue

Atteinte rénale aigue

↘ Mortalité toute cause

HR = 0,23 (p<0,0001)



APAP vs PO

Diminution des réhospitalisations

Diminution de la mortalité

Pas de majoration du risque d'EI

Sauf ↗ risque Sd EP avec 1G

Données limitées dans les TNC

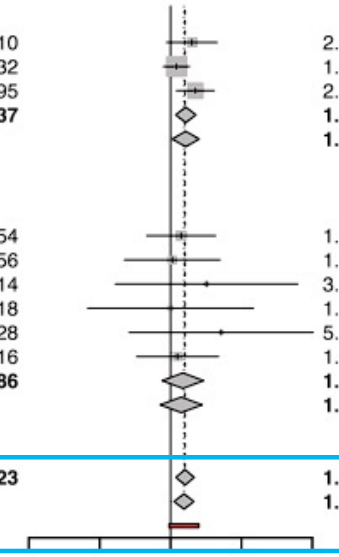
Arrêt des antipsychotiques dans les SPCD

Roche S, Naran N, Scholtz J, Liu KY, Reeves S, Howard R. Systematic review and meta-analysis of antipsychotic discontinuation in dementia. Alzheimer's Dement. 2025;11:e70188. doi.org/10.1002/trc2.70188

Arrêt des antipsychotiques dans les SPCD

Roche et al. 2025

Study	Experimental Events	Experimental Total	Control Events	Control Total	Risk Ratio	RR	95% CI	Weight (common)	Weight (random)
trial_type = RW									
Devanand 2010	8	10	4	10		2.00	[0.88, 4.54]	8.1%	13.9%
Devanand 2012	38	67	15	32		1.21	[0.79, 1.85]	41.2%	41.7%
Tariot 2021	28	99	12	95		2.24	[1.21, 4.14]	24.9%	23.1%
Common effect model		**176**		**137**		**1.64**	**[1.18, 2.28]**	**74.2%**	.
Random effects model						**1.64**	**[1.06, 2.54]**	.	**78.8%**
Heterogeneity: $I^2 = 34.6\%$, $p = 0.2170$									
trial_type = CS									
Ballard 2004	6	46	5	54		1.41	[0.46, 4.32]	9.3%	7.8%
Ballard 2008	3	53	3	56		1.06	[0.22, 5.01]	5.9%	4.1%
Bridges–Parlet 1997	2	22	0	14		3.22	[0.17, 62.42]	1.2%	1.2%
Findlay 1989	1	18	1	18		1.00	[0.07, 14.79]	2.0%	1.4%
Ruths 2008	2	27	0	28		5.18	[0.26, 103.13]	1.0%	1.1%
Van Reekum 2002	4	17	3	16		1.25	[0.33, 4.76]	6.3%	5.6%
Common effect model		**183**		**186**		**1.49**	**[0.76, 2.93]**	**25.8%**	.
Random effects model						**1.41**	**[0.71, 2.80]**	.	**21.2%**
Heterogeneity: $I^2 = 0\%$, $p = 0.9400$									
Common effect model		**359**		**323**		**1.60**	**[1.19, 2.16]**	**100.0%**	.
Random effects model						**1.55**	**[1.12, 2.13]**	.	**100.0%**
Prediction interval							**[0.95, 2.51]**		



Heterogeneity: $I^2 = 0.0\%$, $p = 0.8233$

Test for subgroup differences (common effect): $\chi^2_1 = 0.06$, df = 1 ($p = 0.8036$)

Test for subgroup differences (random effects): $\chi^2_1 = 0.12$, df = 1 ($p = 0.7244$)

FIGURE 3 Forest plot of relative risk difference following antipsychotic withdrawal. CS, cessation study; Events, relapse events per group; RR, risk ratio; RW, randomized withdrawal trial; Total, sample size; Weight, adjusted fixed-effects weight using Mantel–Haenszel method; 95% CI, associated 95% confidence interval.

DOI: 10.1002/trc2.70188

RESEARCH ARTICLE

Translational Research & Clinical Interventions

Systematic review and meta-analysis of antipsychotic discontinuation in dementia

Sophie Roche[1,2] | Nimesh Naran[1] | Janneke Scholtz[1] | Kathy Y. Liu[2] | Suzanne Reeves[2] | Rob Howard[2]

- 9 articles
- 682 patients
- **Risquede rechute à l'arrêt de l'AP d'environ 50%**

Arrêt des antipsychotiques dans les SPCD

Roche et al. 2025

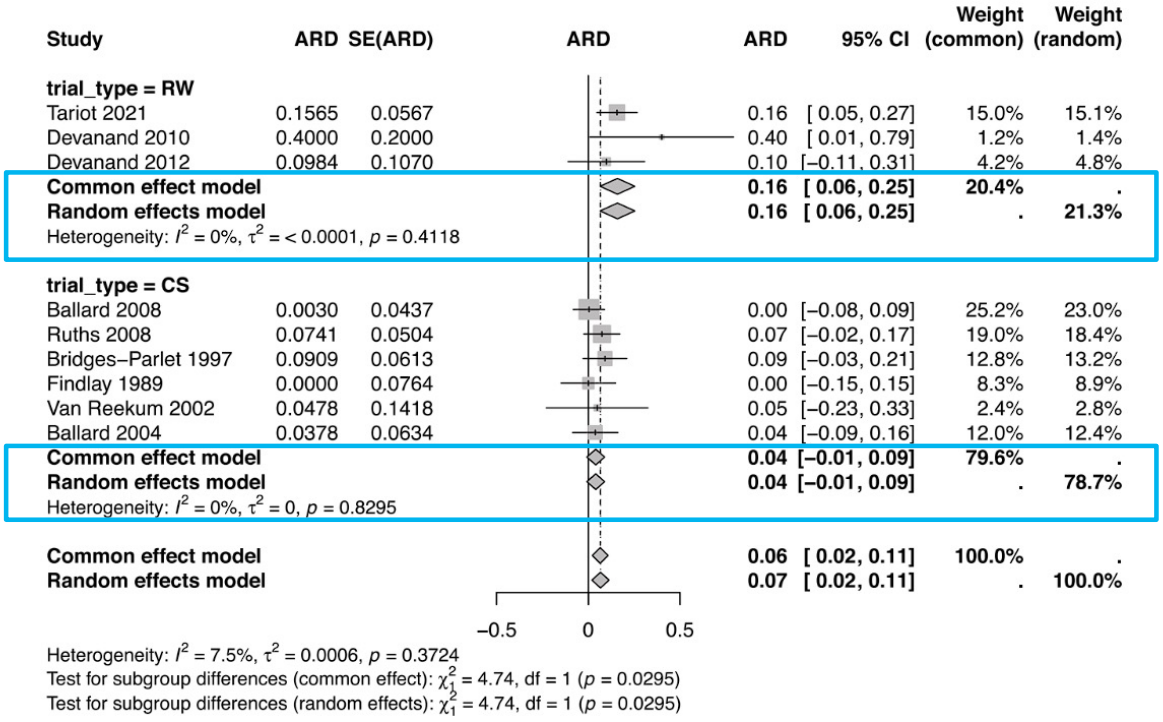
DOI: 10.1002/trc2.70188

RESEARCH ARTICLE

Alzheimer's & Dementia Translational Research & Clinical Interventions

Systematic review and meta-analysis of antipsychotic discontinuation in dementia

Sophie Roche[1,2] | Nimesh Naran[1] | Janneke Scholtz[1] | Kathy Y. Liu[2] | Suzanne Reeves[2] | Rob Howard[2]



Attention à la méthodologie des études incluses:

RW: essais randomisés d'interruption du traitement (population enrichie)
Risque absolu de rechute à l'arrêt: 54,9 %

VS

CS: essais de discontinuation
Risque absolu de rechute à l'arrêt :10,7%

Amyloid-beta-targeting monoclonal antibodies for people with mild cognitive impairment or mild dementia due to Alzheimer's disease

16 avril 2026

Cochrane Library

SF3PA

Anticorps anti-amyloïde

Contexte

- **Aducanumab**
  - FDA accord le 07/06/2021
  - EMA refus le 17/12/2021
  - Arrêt production et commercialisation 2024
- **Lecanemab**
  - FDA accord le 06/01/2023
  - EMA refus le 26/07/2024
  - EMA accord le 14/11/2024
  - AMM par Commission européenne le 15/04/2025
  - HAS refus accès précoce le 09/09/2025
  - HAS SMR insuffisant le 07/11/2025
- **Donanemab**
  - FDA accord le 02/07/2024
  - EMA refus le 28/03/2025
  - EMA accord le 24/07/2025
  - HAS refus accès précoce le 28/03/2026
  - HAS SMR insuffisant le 26/05/2026

SF3PA

Méthodes

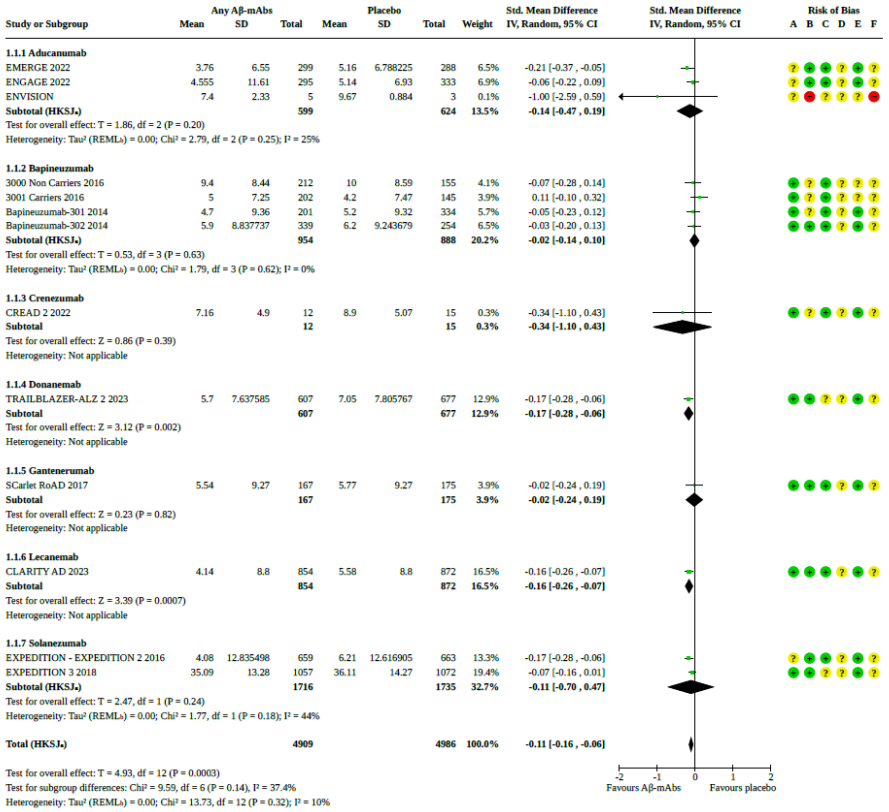
- Méta analyse
- 17 études vs placebo ≥ 18 mois
  - Aducanumab : 3
  - Bapineuzumab : 4
  - Crenezumab : 2
  - Donanemab : 1
  - Gantenerumab : 4
  - Lecanemab : 1
  - Solanezumab : 2
- 20.342 patients

- Résultats à 18 mois
  - Cognition (ADAS-Cog)
  - Sévérité du TNC (CDR-SB)
  - Statut fonctionnel (ADCS-ADL, ADSC-iADL, ADSC-ADL-MCI)
  - Effets indésirables : ARIA-E, ARIA-H, EI graves, mortalité

Résultats

Cognition : peu ou pas de différence vs placebo

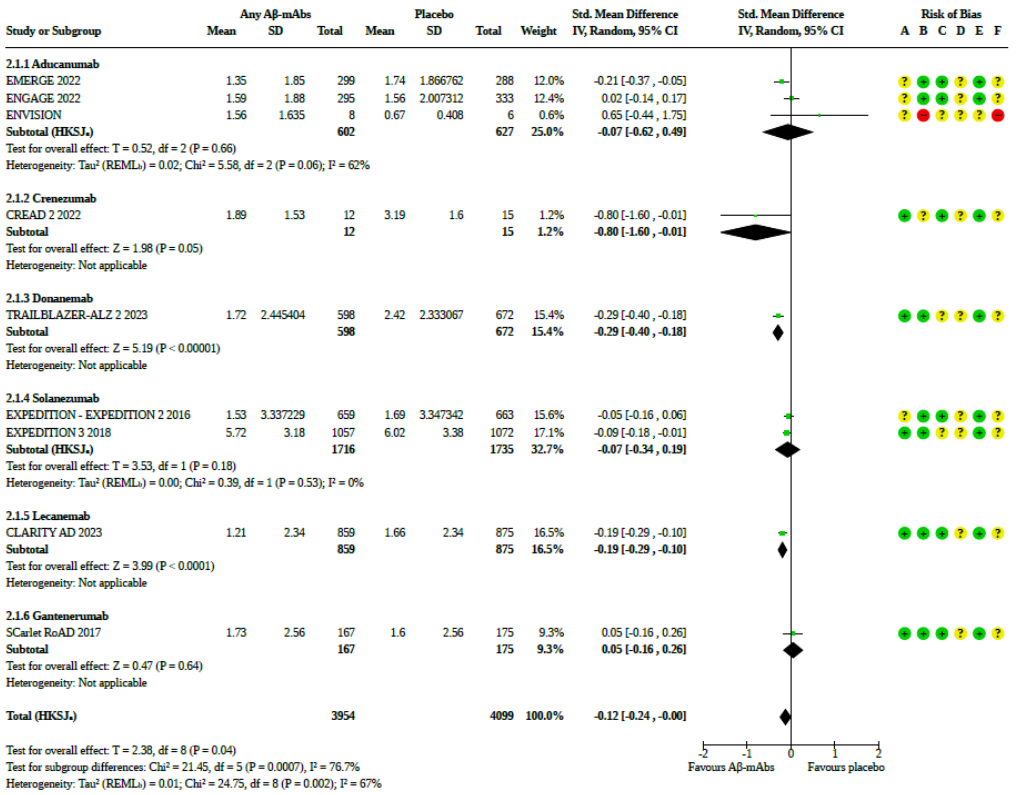
Figure 2. Forest plot showing the effect of Amyloidβ-targeting monoclonal antibodies versus placebo on cognitive function at 18 months



Résultats

Sévérité du TNC : peu ou pas de différence vs placebo

Figure 3. Forest plot showing the effect of Amyloidβ-targeting monoclonal antibodies versus placebo on dementia severity at 18 months



Résultats

Statut fonctionnel: peu ou pas de différence vs placebo ADL, faible effet IADL

Figure 5. Forest plot showing the effect of Amyloidβ-targeting monoclonal antibodies versus placebo on functional ability -measured with ADCS-ADL-MCI- at 18 months

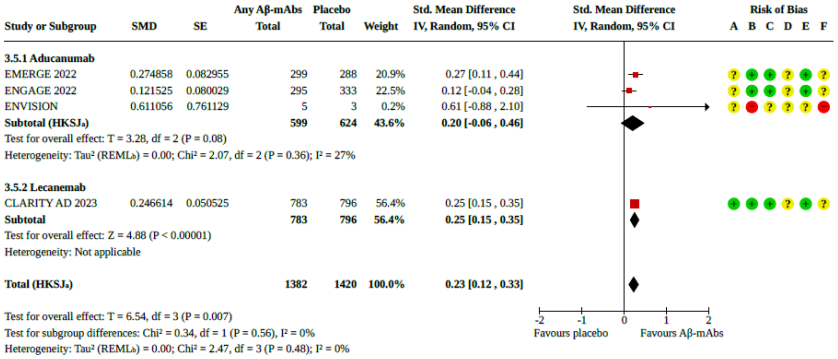


Figure 4. Forest plot showing the effect of Amyloidβ-targeting monoclonal antibodies versus placebo on functional ability at 18 months

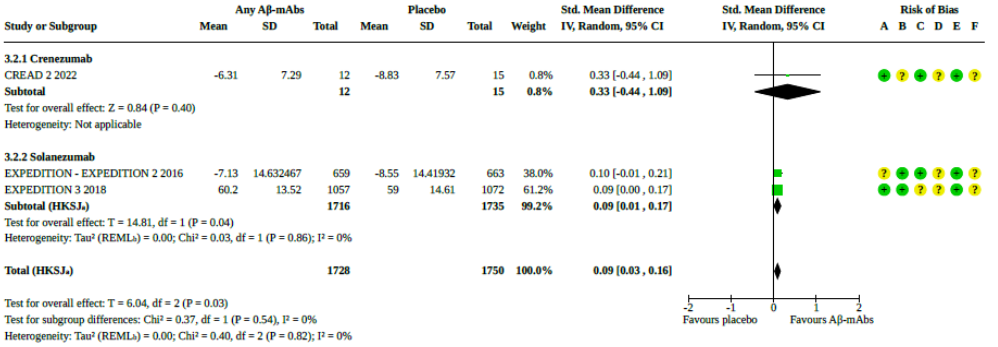
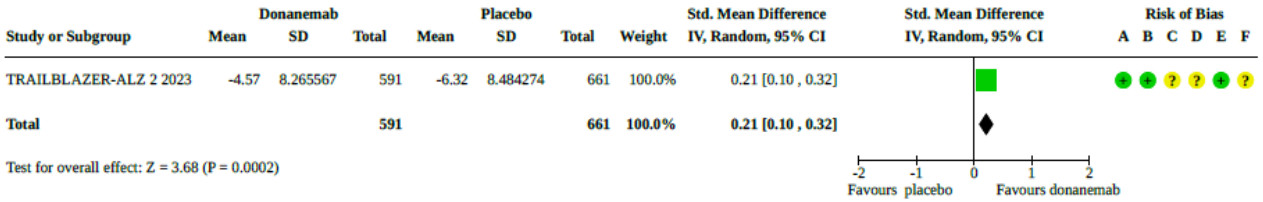


Figure 6. Forest plot showing the effect of Amyloidβ-targeting monoclonal antibodies versus placebo on functional ability - measured with ADCS-iADL- at 18 months



Résultats

Effets indésirables : petite augmentation risque ARIA-E, pas des EI graves ni mortalité

Figure 7. Forest plot showing the effect of Amyloidβ-targeting monoclonal antibodies versus placebo on any Amyloid-Related Imaging Abnormality edema (ARIA E) at 18 months

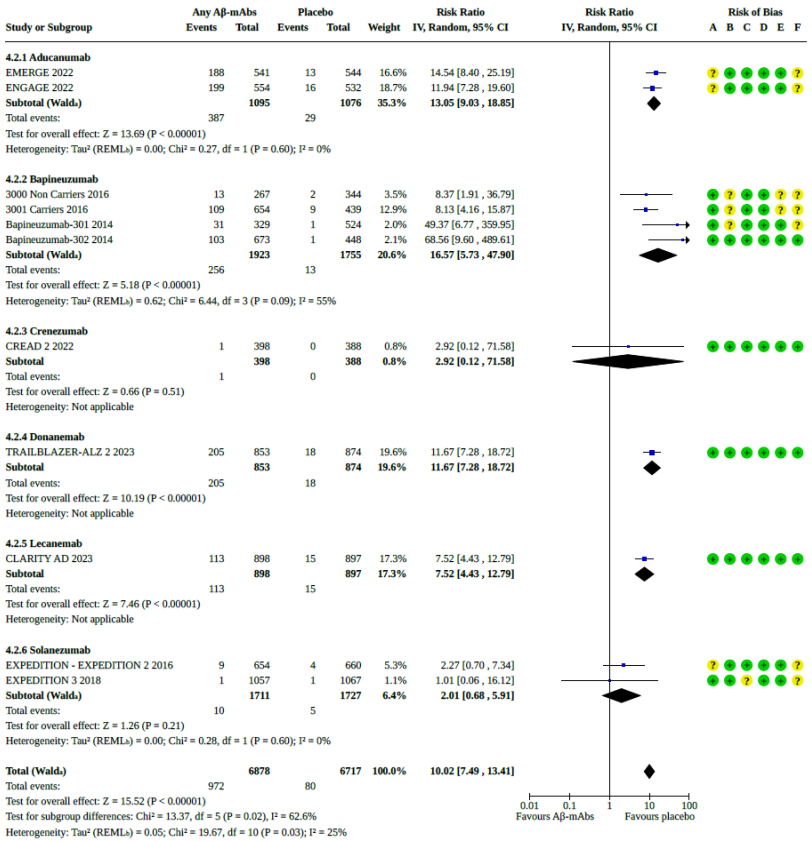
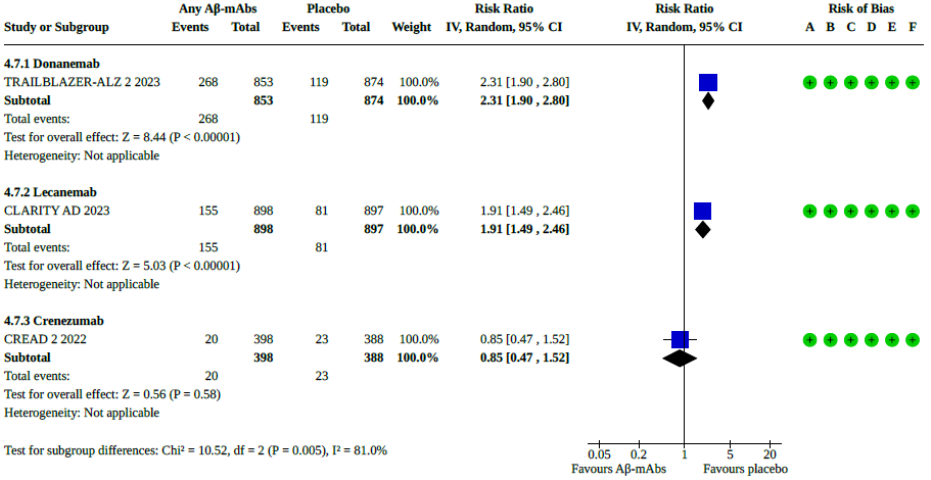


Figure 9. Forest plot showing the effect of Amyloidβ-targeting monoclonal antibodies versus placebo on any Amyloid-Related Imaging Abnormality haemorrhage (ARIA H) at 18 months



Conclusion

- Effet des Ac anti-amyloïde sur cognition, sévérité du TNC à 18 mois chez patients avec TNC L ou TNC M léger insignifiant
- Effet sur le statut fonctionnel au mieux faible
- Augmentation ARIA
- Peu d'EI graves
- La disparition des lésions amyloïde ne semble pas entraîner d'effets cliniques pertinents.
- Balance bénéfice/ risque non favorable

Réactions

- Fox NC, Kohlhaas S, Schott JM. Alzheimer's disease immunotherapy and the amyloid hypothesis: when aggregation obscures interpretation. Lancet. 2026 Apr 23
  - Ac avec cibles amyloïdes et propriétés pharmacologies différentes => dilution des effets cliniques et indésirables
  - Effet clinique pertinent
  - AMM dans plusieurs pays

Traitements du TSPT de la Personne Âgée : Revue systématique et méta-analyse

Gómez-Bautista D, Lye V, Zabihi S, Beenakker M et al. Effectiveness of treatments for post-traumatic stress disorder for older people: A systematic review and meta-analysis of randomized controlled trials. Journal of Affective Disorders. 2026; 394:120433

Contexte

Journal of Affective Disorders 394 (2026) 120433

Contents lists available at ScienceDirect

Journal of Affective Disorders

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

Effectiveness of treatments for post-traumatic stress disorder for older people: A systematic review and meta-analysis of randomized controlled trials

Denise Gómez-Bautista [a], Valerie Lye [a], Sedigheh Zabihi [b], Margreet Beenakker [c], Mia Maria Günak [d], Moïse Roche [a], Sjacko Sobczak [c,e,f], Joan M. Cook [g], Monica Cations [h], Miranda Olff [i,j], Vasiliki Orgeta [a,*], on behalf of the Global Collaboration on Trauma and Ageing group

Principes thérapeutiques extrapolés de l'adulte plus jeune pour

- Pharmacothérapie
- Traitements psychologiques

Peu de données efficacité/tolérance chez la PA

Journal of Anxiety Disorders 114 (2025) 103047

Contents lists available at ScienceDirect

Journal of Anxiety Disorders

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

Review

PTSD and cognition in older adults: A systematic literature review

Jasmijn E. van Rossum [a,*], Semmy Op den Camp [a,b], Renske Uiterwijk [b], Kay Deckers [c], Vasiliki Orgeta [d], Bernice J.A. Gulpers [b], Sjacko Sobczak [a,b,e]

Prévalence vie entière 4,5-7% pour les 60+

Sous-diagnostic et fréquence TSPT sub-syndromique

Déclin accéléré en cognition générale, mémoire et attention

Méthodes et résultats

Journal of Affective Disorders 394 (2026) 120433

Contents lists available at ScienceDirect

Journal of Affective Disorders

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

Effectiveness of treatments for post-traumatic stress disorder for older people: A systematic review and meta-analysis of randomized controlled trials

Denise Gómez-Bautista [a], Valerie Lye [a], Sedigheh Zabihi [b], Margreet Beenakker [c], Mia Maria Günak [d], Moïse Roche [a], Sjacko Sobczak [c,e,f], Joan M. Cook [g], Monica Cations [h], Miranda Olff [i,j], Vasiliki Orgeta [a,*], on behalf of the Global Collaboration on Trauma and Ageing group

Objectif principal

Taux de rémission et sévérité des symptômes de TSPT

Objectif secondaire clé

Symptômes dépressifs

10 RCT (analyse qualitative)
8 RCT (méta-analyse)

n = 682
~ 50% de vétérans ou trauma guerre
Majorité d'hommes
1 étude avec âge moyen > 80ans
ÉU/Israël (5)

Interventions psychologiques (6sem – 24mois)

- Thérapie exposition narrative (4)
- TCC centrée sur trauma (1)
- TCC par internet (1)
- Thérapie par réminiscence (1)
- Soins collaboratifs incluant case management et PST (1)
- Psychothérapie à orientation spirituelle (1)
- Accompagnement à l'activité physique (1)

Résultats

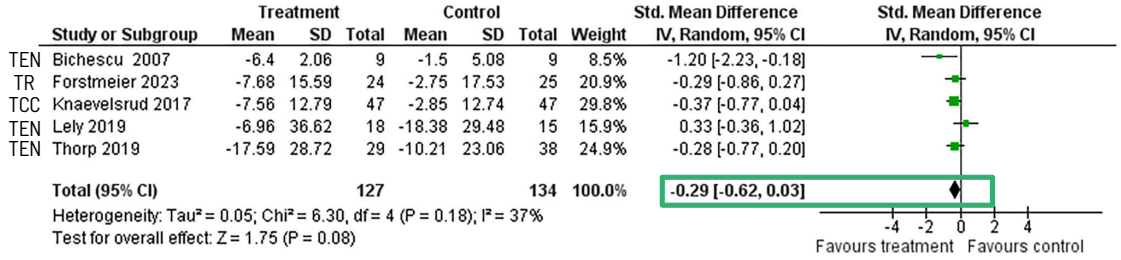


Fig. 2. Trauma-based treatments versus treatment as usual for PTSD symptoms post-treatment.

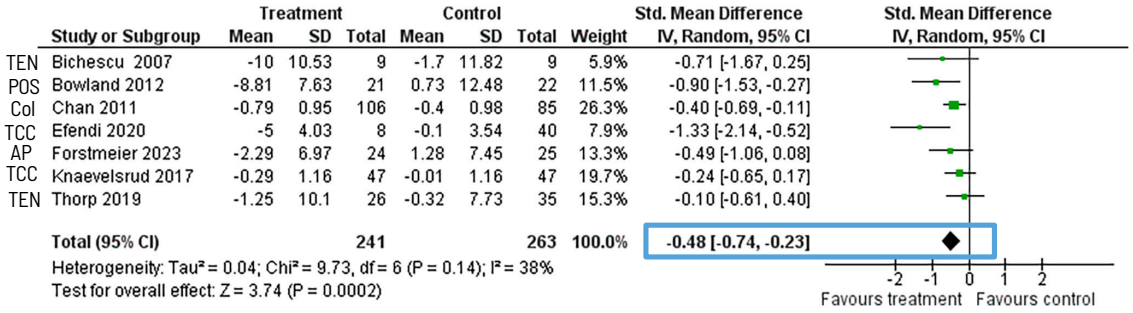


Fig. 3. Trauma-based treatments versus treatment as usual for depressive symptoms post-treatment.

Objectif principal

Taux de rémission et sévérité des symptômes de TSPT

Faible niveau de preuve

Objectif secondaire clé

Symptômes dépressifs

Niveau de preuve modéré
Effet de taille moyen

Pharmacothérapies ?

activity counselling (1 trial). Intervention duration varied from 6 weeks to 24 months, with sessions lasting from 60 to 120 min each. Control conditions included waiting lists, usual care, relaxation training, supportive group therapy, psychoeducation, and present-centred therapy. We did not identify any trials evaluating pharmacological treatments.

Nécessité d'études à plus large échelle, population plus diversifiée

Techniques possibles chez PA et bénéfiques

Adaptations à facteurs liés à l'âge (troubles sensoriels, cognitifs, comorbidités physiques…)

Anxiété et maladie de Parkinson

Berry, A.J., Costello, H., Jesús, S., Price, G. and Jha, A. (2025), Management of Anxiety in Parkinson's Disease. Mov Disord Clin Pract, 12: 1490-1501.
doi.org/10.1002/mdc3.70144

Anxiété et maladie de Parkinson

Berry et al. 2025

TABLE 1 *Summary of anxiety rating scales in Parkinson's disease.*

Scale	Description
Parkinson Anxiety Scale (PAS)[22]	Validated in PD, divided into sections screening for "persisting anxiety," "episodic anxiety" and "avoidance behavior," and rates the severity of symptoms. A score of >14 has been suggested as a "cut off" score for an anxiety disorder. There are both self-rated and observer-rated versions of the PAS, and they take 2–5 min to administer.
Geriatric Anxiety Inventory (GAI)[23]	A 20-item self-report measure of severity of anxiety symptoms. The scale excludes the inclusion of somatic symptoms of anxiety which overlap with PD motor features, making it a useful scale in PD
Non-Motor Symptoms of Parkinson's disease scale (NMSS)[24]	Clinician-based scale. Validated in PD and can screen for a multitude of other non-motor symptoms. Questions are weighted towards depression and apathy rather than anxiety specifically.
Neuropsychiatric Inventory (NPI)[25]	Clinician-based scale, which can be administered to careers, and may be helpful in identifying problems with caregiver burden. Is validated for use in dementia.
State–Trait Anxiety Inventory (STAI)[26]	Self-assessment Likert scale, where a cut off >40 has been proposed to detect clinically significant anxiety in the general population
Liebowitz Social Anxiety Scale[27]	Self-assessment tool using a Likert scale to rate fear and avoidance of several scenarios that may provoke anxiety. This scale has been used by some study groups to assess for presence of anxiety symptoms in PD.
Hospital Anxiety and Depression Rating Scale (HADS)[28]	Self-assessment symptom severity scale, which has the advantage of screening for depressive symptoms too. Scoring >11 is felt to represent the presence of clinically significant anxiety.
Hamilton Anxiety Rating Scale (HAM-A)[29]	Clinician-administered questionnaire. Focused towards detection of generalized anxiety symptoms (rather than panic attacks, or phobic anxiety brought on by particular scenarios)
Beck Anxiety Inventory (BAI)[30]	Self-assessment scale, focused towards the assessment of panic symptoms predominantly

Movement Disorders
CLINICAL PRACTICE
REVIEW
Check for updates

Management of Anxiety in Parkinson's Disease

Alex J. Berry, MRCPsych,[1] Harry Costello, MRCPsych, PhD,[1,2] Silvia Jesús, MD, PhD,[3] Gary Price, FRCPsych, PhD,[1] and Ashwani Jha, MRCP, PhD[4,*]

- Prévalence moyenne: **31%** (6-55%)
- Dépression + Anxiété: **19,3%**
- Facteurs de risque
  - Sexe féminin
  - Perte d'autonomie importante
  - Âge de début précoce de la MPI
  - Haute dose de L-DOPA quotidienne
  - Insomnie
  - Antécédent d'anxiété
  - Fluctuations motrices

SF3PA

Anxiété et maladie de Parkinson

Berry et al. 2025

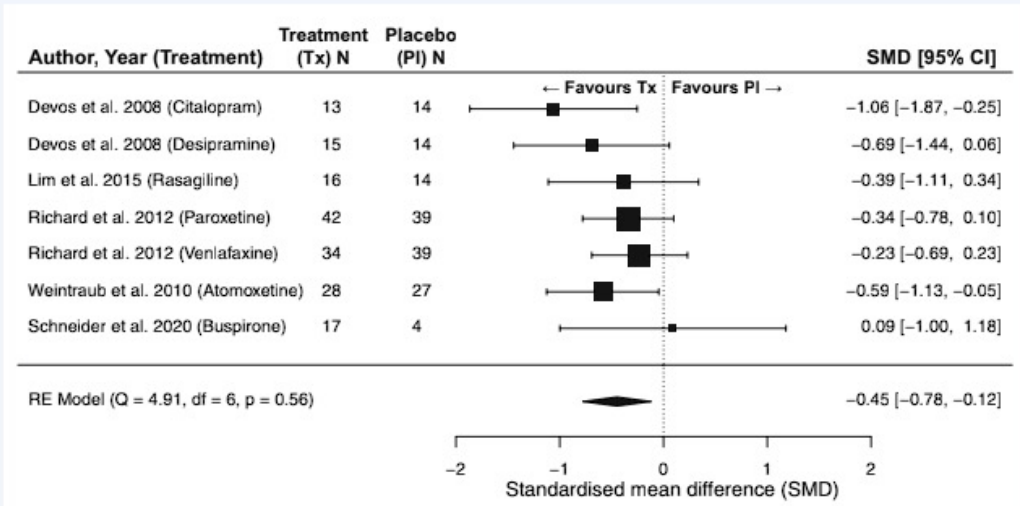


Figure 1. Forest plot of anxiety symptom change with treatment versus placebo in RCTs of pharmacological therapies in PD where anxiety is reported as a secondary outcome measure. The included RCTs were identified from three published systematic reviews of treatments for depression in PD, rather than through an independent systematic review of anxiety treatments. A multilevel meta-analysis was performed, clustering by study as a random effect to account for multiple treatment arms from two included studies.

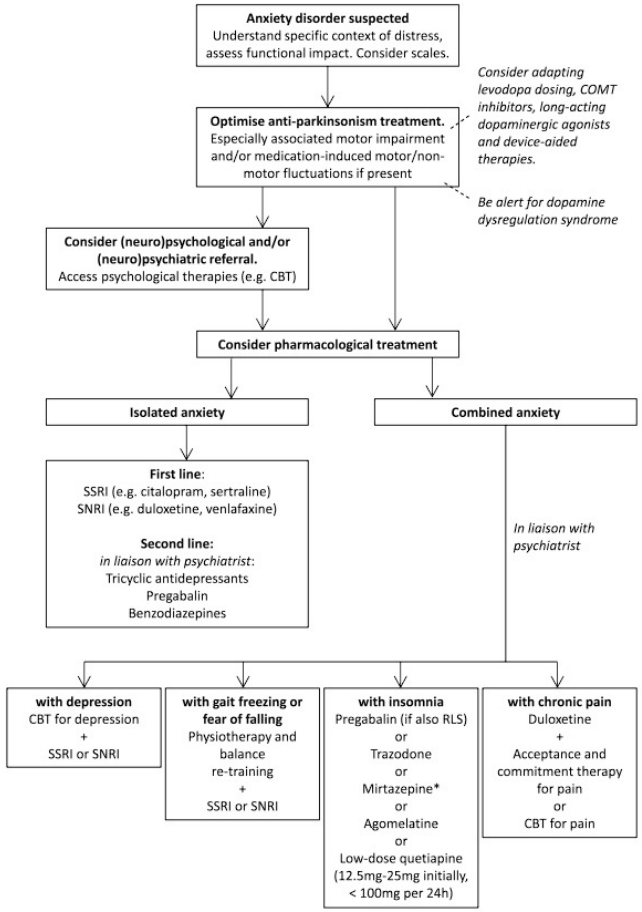
Movement Disorders
CLINICAL PRACTICE
Check for updates
REVIEW

Management of Anxiety in Parkinson's Disease

Alex J. Berry, MRCPsych,[1] Harry Costello, MRCPsych, PhD,[1,2] Silvia Jesús, MD, PhD,[3] Gary Price, FRCPsych, PhD,[1] and Ashwani Jha, MRCP, PhD[4,]*

Anxiété et maladie de Parkinson

Berry et al. 2025



Movement Disorders
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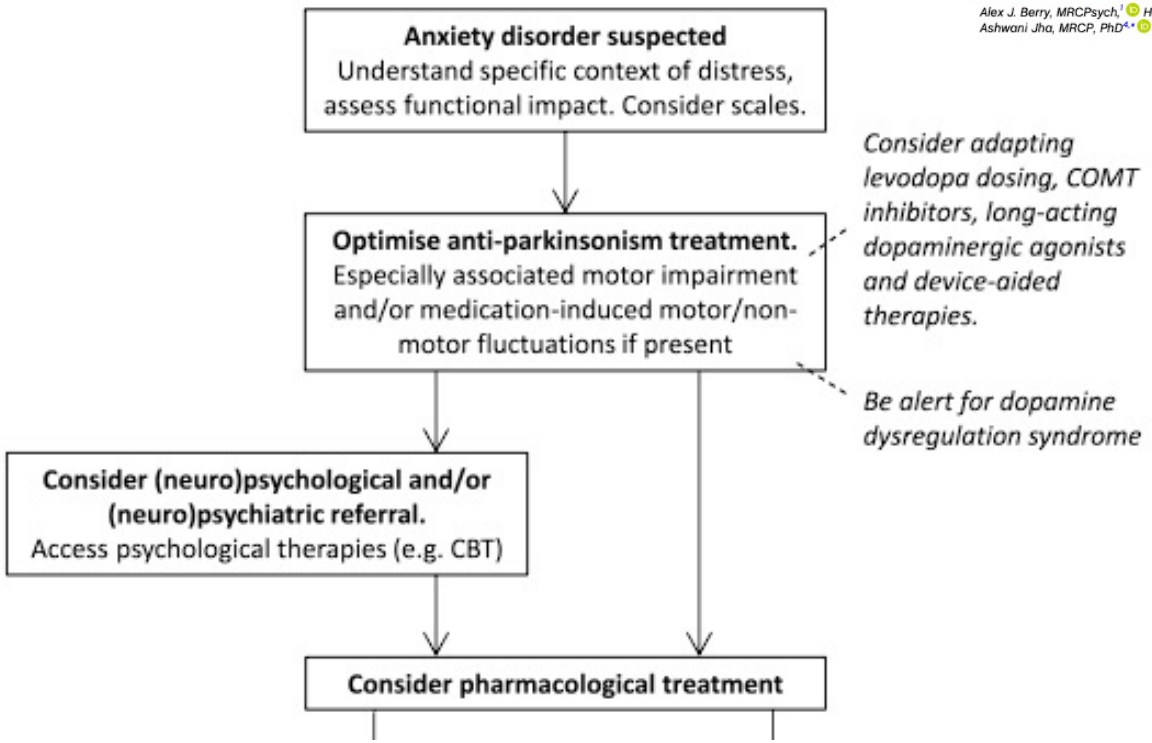
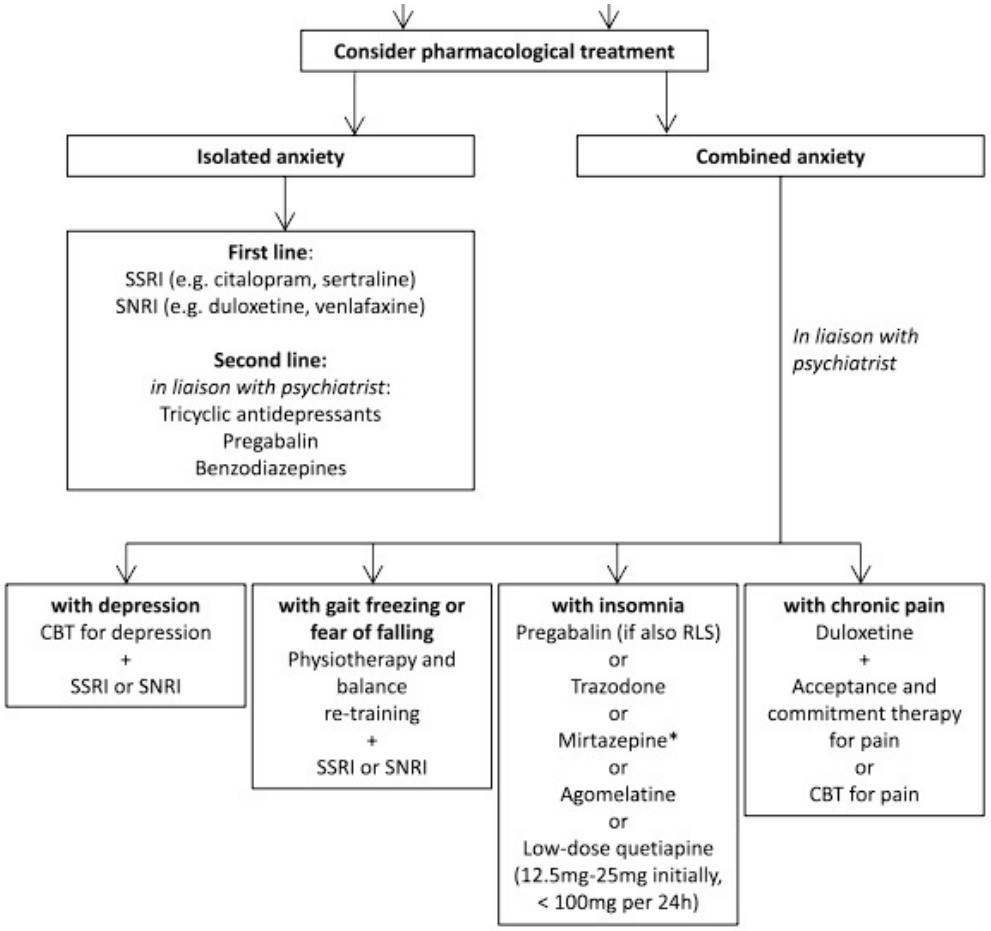


Anxiété et maladie de Parkinson

Berry et al. 2025



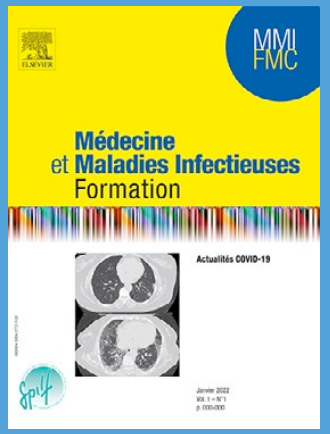
Movement Disorders
CLINICAL PRACTICE
REVIEW

Management of Anxiety in Parkinson's Disease

Alex J. Berry, MRCPsych,[1] Harry Costello, MRCPsych, PhD,[1,2] Silvia Jesús, MD, PhD,[3] Gary Price, FRCPsych, PhD,[1] and Ashwani Jha, MRCP, PhD[4,*]

Antibiothérapie sous-cutanée: recommandations pour la pratique clinique - Société de Pathologie Infectieuse de Langue Française/Société Française de Gériatrie et de Gérontologie

11 décembre 2025



Emmanuel Forestier; Gaëtan Gavazzi; Sylvain Diamantis; Sylvain Goutelle; Claire Roubaud-Baudron. Antibiothérapie sous-cutanée: recommandations pour la pratique clinique - Société de Pathologie Infectieuse de Langue Française/Société Française de Gériatrie et de Gérontologie. Médecine et Maladies Infectieuses Formation, Mars 01, 2026, Volume 5, Numéro 1, Pages 64-77

Contexte et méthodes

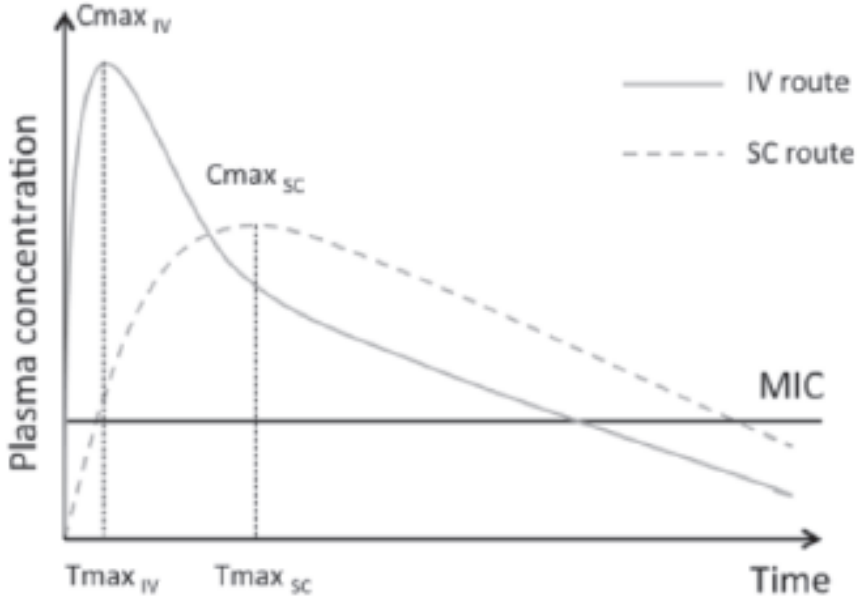
- Situations complexes pour ATB IV ou PO
- ceftriaxone SC
  - Hors AMM en 2014 suite avis EMA
  - ANSM 22/10/2019 : « dans certaines situations, le clinicien peut juger indispensable l'administration de la ceftriaxone par voie sous-cutanée au regard du rapport bénéfice/risque pour son patient et sous réserve d'en informer ce dernier ou sa famille
- Pas d'autre ATB SC
- Recommandations de bonnes pratiques cliniques

Grade A : Preuve scientifique établie.
Grade B : Présomption scientifique.
Grade C : Faible niveau de preuve scientifique.
AE : Avis d'Expert.

1: Accord fort.
2: Accord modéré.
3: Accord faible.

Rationnel utilisation voie SC

- Voie SC contre-indiquée pour les ATB concentration dépendants (Grade B-1)



Indications et contre-indications ATB SC

- Voie SC contre-indiquée en cas d'infection grave, notamment sepsis et choc septique (Grade C-1)
- Décision de la voie SC basée sur éléments cliniques (Grade C-1)
  - En faveur :
    - Capital veineux de mauvaise qualité
    - Troubles du comportement et risque d'arrachage du KT IV
    - Troubles de la vigilance et de la déglutition
    - Absence ou indisponibilité d'un ATB approprié PO
    - Anticoagulation CI injection IM
    - Nécessité de mobilisation
    - Situations de fin de vie
    - Thérapie prolongée
  - En défaveur : nécessité d'une voie IV pour un autre ttt, dermatose extensive, lymphoedème majeur

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Quels antibiotiques ?

- Ceftriaxone (Grade A-1)
- Céfazoline, ertapénem, méropénem, pipéracilline-tazobactam, témocilline, benzathine benzylpenicilline (Grade B-1)
- Téicoplamine (Grade C-1)
- Certaines beta-lactamines (amoxicilline +/- a. clavulanique, céfépime, céfazidime), daptomycine après avis spécialisé (Grade C-1)

Administration

- Sites : cuisse, abdomen, scapula (Grade C-1)
- Mêmes posologies et dilutions que voie IV (Grade C-1)
- Vitesse 30-60 minutes par gravité avec KT souple (Grade C-1)
- SC directe non recommandée (Grade C-1)
- Initiation SC directe pour ceftriaxone, ertapénem, méropenem, pipéracilline-tazobactam, témocilline, céfazoline (Grade B-1)
- Téicoplamine dose de charge IV 48h avant relais SC (Grade B-1)
- Benzathine benzylpenicilline : injection SC directe après anesthésie locale à la lidocaïne (Grade B-3)

Surveillance

- Point de ponction à chaque perfusion et au minimum 1 fois/ jour (Grade C-1)
- Vigilance renforcée si antiagrégant plaquettaire ou anticoagulant (Grade C-2)
- Arrêt perfusion si EI local important, retrait KT et réévaluation (Grade C-1)
- Déclaration pharmacovigilance si EI grave (avis d'expert)
- Traçabilité pose KT SC et ablation à 5 jours maximum (Grade C-1)
- Dosage plasmatique téicoplamine et adaptation de dose (Grade B-1)
- Surveillance plasmatique (Grade C-1) :
  - Infection complexe
  - Posologies fortes
  - Insuffisance rénale
  - Poids extrêmes

Aspects réglementaires

- ATB voie SC si absence d'alternative PO et balance bénéfice/ risque favorable comparée à voie IV ou IM (Grade B-1)
- Information du patient ou de son représentant légal sur le caractère hors AMM et traçabilité du consentement (avis d'expert)
- En établissement de santé : protocoles institutionnels validés par le référent ATB et le pharmacien (avis d'expert)
- En ambulatoire : mention à faire figurer en toutes lettres sur ordonnance (avis d'expert)

« *Modalité d'administration hors AMM, validée après information et accord du patient de la balance bénéfice/ risque favorable, en accord avec les recommandations de bonnes pratiques cliniques SPILF/ SFGG 2025 de l'antibiothérapie sous-cutanée, et avec la lettre aux professionnels de santé de l'ANSM de novembre 2019* »

Troubles du spectre bipolaire chez la Personne Âgée

Eyler LT, Klaus F, Van Dyne A, Xin Ng H, Dols A et Sajatovic M. The spectrum of bipolar disorder in older adults. Neuropsychopharmacology. Jan 2026

SF3PA

Méthodes et résultats

Données (principalement) issues de 2 initiatives de recherche et collaboration internationale

GAGE-BD – Global Aging and Geriatric Experiments in BD
5000 participants depuis 2019
ENIGMA-BD : Enhancing NeuroImaging Genetics through Meta-Analysis BD, depuis 2012

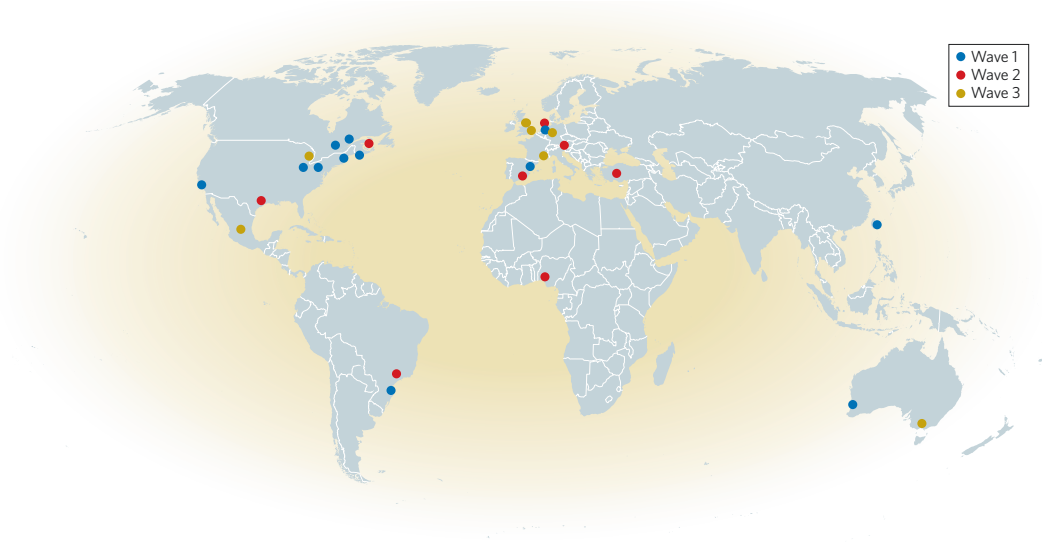
Développement d'une cohorte américaine multisite (10) avec suivi longitudinal BD[2]

American College of Neuropsychopharmacology

REVIEW ARTICLE OPEN

The spectrum of bipolar disorder in older adults

Lisa T. Eyler[1]✉, Federica Klaus[1], Angelina Van Dyne[2], Hui Xin Ng[3], Annemiek Dols[4] and Martha Sajatovic[5]



0,5 à 0,9% des 50+
LOBD = 5-10%

Particularités cliniques et comorbidités

Fréquence des états mixtes (70%)
Irritabilité / Troubles du langage et pensée
Troubles attentionnels, tristesse, anxiété

Charge somatique ↗
↗ avec âge
Femmes > Hommes
2,42 en moyenne
Pas d'impact direct sur fonctionnement

Comorbidités psy
Addiction 20%
Troubles Anxieux 22%
Troubles de la Personnalité 14,6%

Moindre sévérité des symptômes maniaques (+/- dépressifs)

Pas de différences d'intensité entre OABD (50+) et OOADB (70+)

LOBD
Comorbidités neurologiques 71%
Neurovasculaires, TNC...

Type 1 vs type 2
Comorbidités psychiatriques et somatiques ns

Implications pratiques
Rechercher ++ caractéristiques mixte et risque suicidaire
Prise en charge globale ++
Bilan cognitif et surveillance LOBD

Troubles cognitifs et évolution

Troubles cognitifs
Fréquents
Persistants
Hétérogènes

Fort impact sur les capacités fonctionnelles

Type 1 vs type 2
Fonctionnement général ns
Performance cognitive ns

Hétérogénéité d'évolution

Augmentation du risque de troubles neuro-évolutifs (2-6x)
Difficultés diagnostic différentiel (DFTvc, DCL)

Implications pratiques
Evaluation initiale et suivi
Pas de généralisation individuelle sur pronostic évolutif
Limiter BZD, (antipsychotiques ?), épisodes maniaques
Avis spécialisé consultation mémoire

Table 1. Summary of Cognitive Deficits in OABD.

•**Lower** episodic memory, attention, information processing speed, verbal fluency and executive functioning *compared to the general population.*
•**Mixed** findings on global cognition: lower and comparable results
•Correlates of cognitive performance
○**Better**: *more years of education, higher IQ, younger age, fewer manic episodes,*
○**Worse**: *benzodiazepine, antipsychotics, history of psychosis*
•**Lower psychosocial functioning** associated with *global and specific* (e.g., memory, attention, executive functioning) *cognitive deficits.*
•**Mixed findings** for cognitive trajectories in OABD.
○Both *accelerated cognitive decline* and *similar cognitive trajectories* to non-affected individuals noted.
○Could be explained by **high interindividual heterogeneity in OABD**.
•**2-6x prevalence of dementias** (Alzheimer's disease, bvFTD, DLB), as well as Parkinson's disease
•High **symptomatic overlap** between *bvFTD, DLB* and *OABD*, with bedside tools available for differentiation.

OABD older-age bipolar disorder, *bvFTD* behavioral variant of frontotemporal dementia, *DLB* dementia with Lewy bodies.

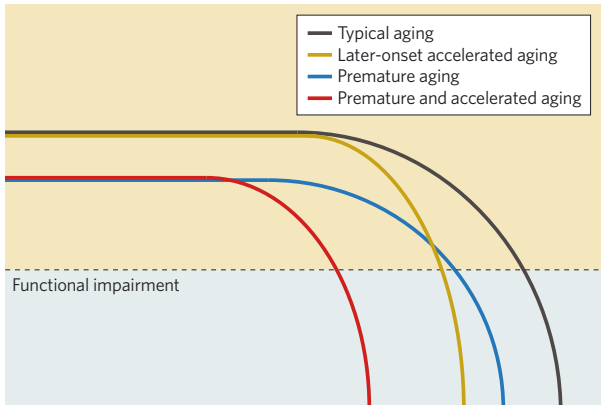


Fig. 2 Theoretical trajectories of change in cognitive performance over time in bipolar disorder. Colored lines show potential course

Neurobiologie et neuroimagerie OABD

Génétiques
Variants associés à OABD
Régulation sérotonine
Angiogenèse

Neurodégénérescence
↗ NfL DFT vs BD
Pas de hausse des marqueurs classiques

Vieillissement cérébral
Accéléré
Précoce
↗ « Âge cérébral » sous antiépileptique (+ AP) vs Li

Epigénétique
Vieillissement biologique accéléré
↗ âge épigénétique
Accéléré par le tabagisme
Ralenti par thymorégulateurs

Inflammation
↗ IL-6, CRP, TNFα
↗ CRP dans LOBD
↘ **Vit B9 et B12**
Impact sur fonctionnement cognitif

Diminution volume SG
CPF et hippocampe
↗ **Leucopathie**

Implications pratiques
Chercher et corriger déficit B9 et B12
NfL pour DFT vs OABD
Prévention/sevrage tabagique
Lithium si possible
Vigilance sur association antiE + AP

Journal of Affective Disorders
Volume 403, 15 June 2026, 121234

Research paper

Brain aging in bipolar disorder using a neuroimaging and machine learning-derived metric: Findings from the ENIGMA BD Working Group

Hui Xin Ng [a], Christoph Abé [b bj], Martin Alda [c], Silvia Alonso-Lana [d e], Gerard Anmella [i j k],

n=2919, 18-75ans
+2 à +5ans
Type 1 > Type 2

Thérapeutique

Table 2. Therapeutic approaches in OABD.

Category	Treatment	Key Findings/Notes
Pharmacological	**Lithium**	• Most effective for acute mania and mood stabilization. • Possibly neuroprotective (may reduce dementia risk). • Requires lower dosing, close monitoring due to renal clearance, toxicity risks. • Recommended serum levels: 0.4–0.8 mmol/L (age 60–79), 0.4–0.7 mmol/L (age 80+).
	Valproic Acid (VPA)	• Less effective than lithium in RCTs for acute mania. • Often used despite limited OABD-specific evidence.
	Lamotrigine	• Effective in delaying depressive/mood episodes. • Better cognitive side effect profile.
	Second-generation Antipsychotics (SGAs)	• Effective and generally well-tolerated: quetiapine, risperidone, aripiprazole, asenapine, lurasidone, cariprazine. • Watch for increased risk of metabolic, neurologic side effects; FDA black box warning in dementia.
	Antidepressants	• Controversial due to mania risk: should be used cautiously, ideally with mood stabilizers. • Limited OABD-specific data. • Safer options include mirtazapine, bupropion.
Neuromodulation	**ECT**	• Highly effective for TRBD, mania, catatonia. • Older adults respond well; fewer cognitive side effects than younger adults. • Often underused due to stigma. • Should not be reserved only for last-resort.
	rTMS	• Inconclusive evidence; small sample sizes. • Requires further research specific to OABD.
Novel Treatments	**Ketamine/Esketamine**	• Promising for BD depression; mostly studied in unipolar depression. • No data in OABD. • Higher risk of cognitive/cardiovascular side effects in older adults.
	Psilocybin/Psychedelics	• Early evidence shows antidepressant effects. • Limited and cautious use in BD/OABD. • Safety not yet established: needs more rigorous study.
Behavioral	**CBT**	• Moderately effective in reducing mania symptoms. • No OABD-specific adaptations in studies. Remote delivery is promising.
	Psychoeducation	• Some benefit, though less than CBT. • Could be combined with other interventions.

ECT Electroconvulsive therapy, *TRBD* treatment-resistant BD depression, *rTMS* repetitive transcranial magnetic stimulation, *CBT* cognitive behavioral therapy.

Sevrage en benzodiazépines

Brunner E, Chen CA, Klein T, Maust D, Mazer-Amirshahi M, Mecca M, Najera D, Ogbonna C, Rajneesh KF, Roll E, Sanders AE, Snodgrass B, VandenBerg A, Wright T, Boyle M, Devoto A, Framnes-DeBoer S, Kleykamp B, Norrington J, Lindsay D; Clinical Guideline Committee (CGC) Members; ASAM Staff and Contractors. Joint Clinical Practice Guideline on Benzodiazepine Tapering: Considerations When Risks Outweigh Benefits. J Gen Intern Med. 2025 Sep;40(12):2814-2859. doi: 10.1007/s11606-025-09499-2.

SF3PA

Recommandations ASAM 2025

Brunner et al. 2025

This clinical practice guideline has been endorsed by:
American Academy of Neurology (AAN)
American Academy of Physician Associates (AAPA)
American Academy of Sleep Medicine (AASM)
American Association of Nurse Practitioners (AANP)
American Association of Psychiatric Pharmacists (AAPP)
American College of Medical Toxicology (ACMT)
American College of Obstetricians and Gynecology (ACOG)
American Geriatrics Society (AGS)
American Society of Addiction Medicine (ASAM)

The JOINT
CLINICAL PRACTICE GUIDELINE ON

Benzodiazepine Tapering:

Considerations when Benzodiazepine Risks Outweigh Benefits

Recommandations ASAM 2025

Brunner et al. 2025

- Cas général

The JOINT
CLINICAL PRACTICE GUIDELINE ON

Benzodiazepine Tapering:

Considerations when Benzodiazepine Risks Outweigh Benefits

Benzodiazepine Tapering Strategies

The Tapering Process

Recommendations for the Tapering Process

6. Clinicians should generally consider dose reductions of 5% to 10% when determining the initial pace of the BZD taper. The pace of the taper should typically not exceed 25% every 2 weeks (*Clinical Consensus*, Strong Recommendation).

7. Clinicians can consider transitioning patients without contraindications to a comparable dose of a longer-acting BZD medication for the taper (*Clinical Consensus*, Conditional Recommendation).

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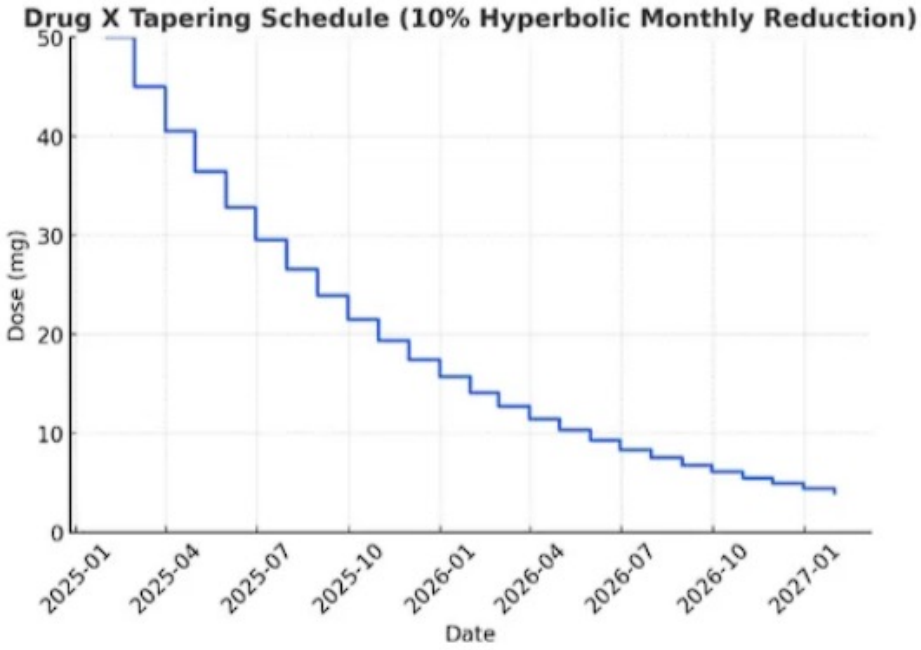
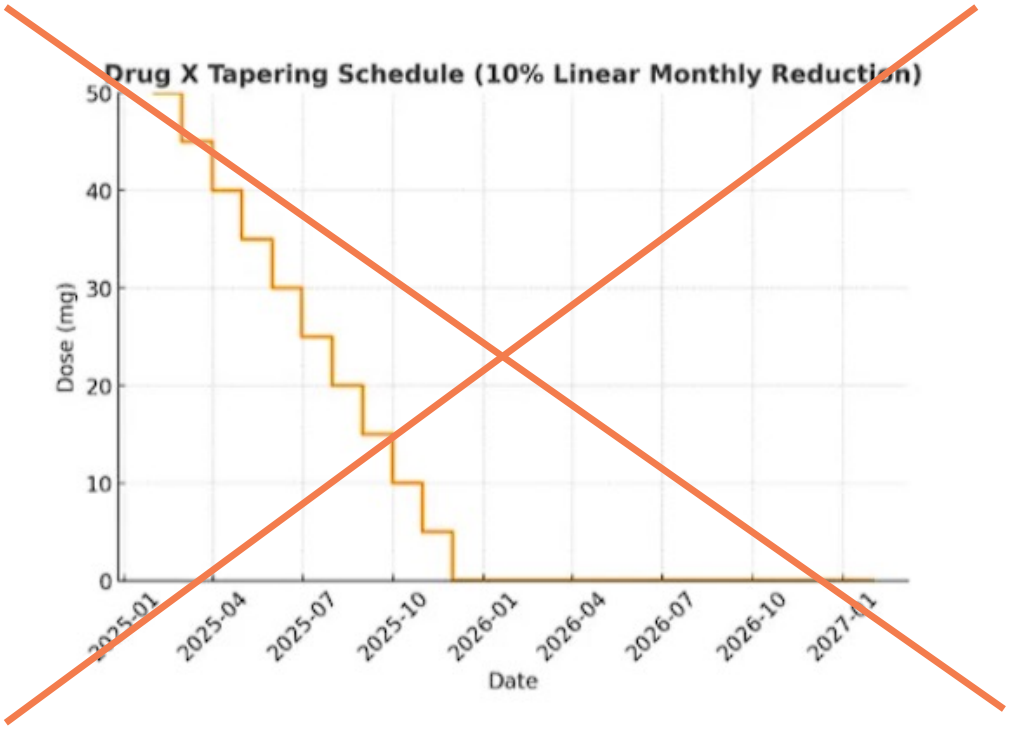
Recommandations ASAM 2025

Brunner et al. 2025





Recommandations ASAM 2025

Brunner et al. 2025

The JOINT
CLINICAL PRACTICE GUIDELINE ON

Benzodiazepine Tapering:

Considerations when Benzodiazepine Risks Outweigh Benefits

- Section Personnes Âgées

The patient panel noted that in older adults, even lower BZD doses might be associated with significant withdrawal risk due to metabolism changes. They emphasized the importance of starting with smaller dose reductions and proceeding more slowly with tapering in this population. As with all patients, clinicians should prioritize developing individualized tapering plans through shared decision-making.

Transitioning Older Adults to a Longer-Acting Benzodiazepine for Tapering

As discussed in *The Tapering Process*, clinicians can consider transitioning patients without contraindications (eg, liver dysfunction) to a comparable dose of a longer-acting BZD for the taper. However, metabolic changes associated with aging—namely, reduced hepatic clearance—may increase risk of adverse events and toxicity.[171] As a result, the CGC cautioned against transitioning older adults to longer-acting BZDs prior to tapering.

Reduction of Antihypertensive Treatment in Nursing Home Residents

29 août 2025

The NEW ENGLAND JOURNAL of MEDICINE

Benetos A, Gautier S, Freminet A, Metz A, Labat C, Georgiopoulos I, Bertin-Hugault F, Beuscart JB, Hanon O, Karcher P, Manckoundia P, Novella JL, Diallo A, Vicaut E, Rossignol P; RETREAT-FRAIL Study Group. Reduction of Antihypertensive Treatment in Nursing Home Residents. N Engl J Med. 2025 Nov 20;393(20):1990-2000.

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Design

- Essai pragmatique, interventionnel et randomisé
- Evaluant l'effet d'une stratégie protocolisée de réduction progressive des traitements antihypertenseurs par rapport aux soins habituels
- Sur la mortalité toutes causes confondues
- Chez les résidents d'EHPAD > 80 ans, fragiles
- Présentant une TAS < 130 mmHg et recevant au moins 2 antiHTA

SF3PA

Design

- Randomisation 1:1
  - Stratégie de réduction progressive des antiHTA
  - Soins habituels
- Suivi 4 ans
- Evaluation
  - Autonomie : IADL
  - Cognition : MMSE
  - Force musculaire : hand-grip
  - Motricité : SPPB
  - Qualité de vie : EQ-5D-3L
  - Fragilité : Clinical Frailty Scale

Design

- Diminution des traitements M3, M6 et chaque M6 si TAS<130 mmHg
- Critère de jugement principal : décès toutes causes
- Critères de jugement secondaires :
  - Évènements cardiovasculaires majeurs
  - Décès de cause non cardiovasculaire
  - Évolution de TAS et TAD
  - Évolution capacité fonctionnelle
  - Evolution cognitive
  - Nombre de chutes
  - Nombre de fractures
  - Nombre de ttt
  - Nombre de ttt antiHTA
  - Score EQ-5D-3L
  - Décès liés au Covid-19

Résultats

- 1048 résidents de 108 EHPAD inclus
  - 528 stratégie de diminution
  - 520 soins courants

Table 1. Characteristics of the Patients at Baseline (Intention-to-Treat Population).*

Characteristic	Step-Down Strategy (N=528)	Usual Care (N=520)	Total (N=1048)
Age — yr	90.0±4.8	90.1±5.3	90.1±5.0
Female sex — no. (%)	423 (80.1)	423 (81.3)	846 (80.7)
Weight — kg†	64.9±14.8	65.2±15.0	65.1±14.9
Height — m‡	1.59±0.09	1.58±0.09	1.59±0.09
Body-mass index§	25.9±5.6	26.3±5.8	26.1±5.7
Systolic blood pressure — mm Hg¶	113±11	114±11	114±11
Diastolic blood pressure — mm Hg¶	65±10	65±10	65±10
Heart rate — beats/min¶	72±12	71±12	71±12
MMSE score‖	13.5±10.0	13.3±10.1	13.4±10.0
ADL score**	3.1±2.0	3.2±2.0	3.1±2.0
SPPB score††	1.2 ±1.9	1.2 ±2.0	1.2 ±1.9
EQ-5D-3L questionnaire score ‡‡	0.431±0.407	0.468±0.398	0.449±0.403
Peak muscular force — kg§§	11.7±6.4	12.0±6.8	12.0±6.8
Clinical Frailty Scale score — no./total no. (%)¶¶			
1, 2, or 3	47/525 (9.0)	52/514 (10.1)	99/1039 (9.5)
4 or 5	147/525 (28.0)	164/514 (31.9)	311/1039 (29.9)
6	118/525 (22.5)	111/514 (21.6)	229/1039 (22.0)
7 or 8	213/525 (40.6)	187/514 (36.4)	400/1039 (38.5)
Medications‖‖			
No. of list 1 and list 2 antihypertensive medications	2.6±0.7	2.5±0.7	2.5±0.7
No. of concomitant medications	6.7±3.2	6.7±2.8	6.7±3.0

SF3PA

Résultats

Table 2. Medications at Baseline and at the Last Follow-up Visit.*

Medications	Step-Down Strategy (N = 528)	Usual Care (N = 520)	Total (N = 1048)
At baseline — no.			
List 1 antihypertensive medications	1.8±0.8	1.8±0.7	1.8±0.8
List 2 antihypertensive medications	0.7±0.7	0.7±0.7	0.7±0.7
List 1 and list 2 antihypertensive medications	2.6±0.7	2.5±0.7	2.5±0.7
Concomitant medications	6.7±3.2	6.7±2.8	6.7±3.0
All medications	9.3±3.4	9.3±2.9	9.3±3.2
At last follow-up visit — no.			
List 1 antihypertensive medications	0.5±0.7	1.2±0.9	0.8±0.9
List 2 antihypertensive medications	1.1±1.0	0.8±0.9	0.9±0.9
List 1 and list 2 antihypertensive medications	1.5±1.1	2.0±1.1	1.8±1.1
Concomitant medications	6.8±3.7	6.6±3.5	6.7±3.6
All medications	8.3±4.1	8.6±3.8	8.5±3.9

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Résultats

Table 3. Primary and Secondary End Points.*

End Points	Step-Down Strategy (N=528)	Usual Care (N=520)	Adjusted Effect Measure (95% CI)	P Value†
Primary end point: death from any cause				
Intention-to-treat analysis — no. (%)	326 (61.7)	313 (60.2)	1.02 (0.86–1.21)‡	0.78
Per-protocol analysis — no./total no. (%)§	311/499 (62.3)	305/497 (61.4)	1.04 (0.87–1.23)‡	
Secondary end points				
Death from noncardiovascular causes — no. (%)	284 (53.8)	278 (53.5)	1.00 (0.83–1.19)¶	
Acute heart failure — no. (%)	67 (12.7)	57 (11.0)	1.19 (0.80–1.78)‖	
Falls				
Overall — no. (%)	264 (50.0)	260 (50.0)	—	
No. of falls per year	0.81±2.08	0.71±1.91	1.14 (0.84–1.51)**	
Fractures				
Overall — no. (%)	41 (7.8)	48 (9.2)	—	
No. of fractures per year	0.03±0.17	0.04±0.17	0.80 (0.51–1.26)††	
Death from Covid-19 — no. (%)	6 (1.1)	16 (3.1)	0.38 (0.10–1.00)‡‡	
Composite of major adverse cardiovascular events — no. (%)§§	102 (19.3)	90 (17.3)	1.15 (0.84–1.56)¶¶	

SF3PA

Résultats

Subgroup	Step-Down Strategy	Usual Care	Hazard Ratio for Death from Any Cause (95% CI)
	no. of patients with event/total no. of patients (%)		
All patients	326/528 (61.7)	313/520 (60.2)	1.02 (0.86–1.21)
Age			
>90 yr	185/267 (69.3)	176/253 (69.6)	0.97 (0.79–1.20)
≤90 yr	141/261 (54.0)	137/267 (51.3)	1.09 (0.86–1.38)
Systolic blood pressure			
<105 mm Hg	76/104 (73.1)	71/104 (68.3)	1.18 (0.85–1.63)
105–115 mm Hg	97/168 (57.7)	88/154 (57.1)	0.95 (0.71–1.27)
>115 mm Hg	153/256 (59.8)	154/262 (58.8)	1.06 (0.84–1.32)
Chronic heart failure			
Yes	87/128 (68.0)	74/118 (62.7)	1.15 (0.84–1.57)
No	239/400 (59.8)	239/402 (59.5)	1.00 (0.84–1.20)
Clinical Frailty Scale score			
1, 2, or 3	21/47 (44.7)	19/52 (36.5)	1.42 (0.76–2.64)
4 or 5	78/147 (53.1)	80/164 (48.8)	1.16 (0.84–1.58)
6	79/118 (66.9)	76/111 (68.5)	0.95 (0.69–1.31)
7 or 8	146/213 (68.5)	134/187 (71.7)	0.89 (0.70–1.12)

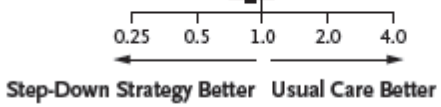

Figure 2. Subgroup Analyses of Death from Any Cause.

All the analyses except those of systolic blood pressure (measured while the patient was seated) were adjusted for baseline systolic blood pressure. The level of frailty was assessed with an algorithm that calculated a composite score. The algorithm included data on functional capacities (autonomy, mobility, and cognitive status) measured in the trial to classify frailty levels according to scores on the validated Clinical Frailty Scale. Scores range from 1 to 9, with a score of 1 indicating fit, 2 well, 3 managing well, 4 vulnerable, 5 mild frailty, 6 moderate frailty, 7 severe frailty, 8 very severe frailty, and 9 terminally ill. Clinical Frailty Scale scores were missing for three patients in the step-down group and six patients in the usual-care group.

SF3PA

Discussion

- Baisse de TAS 4.1 mmHg et TAD 1.8 mmHg
- Pas de différence entre les groupes sur critères de jugement
- Patients plus fragiles que dans les autres études
- Effet croisé non anticipé
- Biais de surestimation des EI par médecins traitants

Kétamine et psychédéliques dans la dépression de la Personne Âgée

Sukhdeo R, Tamura JK, Dri CE et McIntyre RS. Ketamine and Esketamine for Late-Life Depression: A systematic Review of Efficacy, Safety and Tolerability. Am J of Geriatric Psychiatry 34:1 (2026) 84-102

Kétamine et dépression de la PA

Am J of Geriatric Psychiatry 34:1 (2026) 84–102

Available online at www.sciencedirect.com

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journal homepage: www.ajgponline.org

Clinical Review Article

Ketamine and Esketamine for Late-Life Depression: A Systematic Review of Efficacy, Safety, and Tolerability

Ronesh Sukhdeo, H.B.Sc.[#], Jocelyn K. Tamura, M.D.[#], Christine E. Dri, B.H.Sc., Roger S. McIntyre, M.D.[3]

13 études
7 RCT, 4 en ouvert,
2 analyses post-hoc

60+
n=757
Sous-groupes (10/13)
Dépression résistante

Kétamine intranasale (5)	2 RCT 2 en ouvert 1 analyse post-hoc n=438 *65+* et 2 *60+*
Kétamine IV (4)	1 RCT 2 en ouvert 1 analyse post-hoc n=29 *60+*
Kétamine SC (1) Kétamine orale (1)	SC : RCT, n=16 *65+* PO : RCT, n=12 *65+*
Association induction par kétamine et ECT (2)	2 RCT n=160 *60+*

Kétamine et dépression de la PA

Kétamine IN

Signal positif mais résultats mixtes
Tendance positive mais ns (TRANSFORM-3)

Meilleure efficacité 65-74 vs 75+

Réponse maintenue à long terme (160sem)

Kétamine IV

Efficacité sur études en ouvert

Kétamine SC, po et kétamine + ECT

Effet dose pour SC (significatif à partir 0,2mg/kg)
Absence d'effets significatifs (po, k+ECT)

Tolérance

Légers et transitoires : vertiges, nausées, HTA, dissociation

Intérêt clonidine prophylactique sur HTA et dissociation ?

Bonne tolérance cognitive (voire amélioration)

Amélioration de la tolérance cognitive ECT avec ketofol vs propofol

GRADE Très faible à faible

Agents psychédéliques

REVIEW ARTICLE OPEN

Psychedelic therapeutics in psychiatric conditions

Philip D. Harvey[1,2]✉ and Charles B. Nemeroff[3]

Neuropsychopharmacology

Drugs & Aging
https://doi.org/10.1007/s40266-025-01221-5

CURRENT OPINION

Use of Psychedelic Agents in Older Adults with Treatment-Resistant Major Depressive Disorder: What the Evidence Shows

Lou Vinarcsik[1] · Charles Smoller[1] · George Grossberg[1]

Accepted: 10 June 2025

<1,4%

des participants ont 65+

Psilocybine

Effet agoniste 5HT2A (et autres)
↗ neuroplasticité, ↘ inflammation
Augmentation de l'empathie, créativité, réduction des affects négatifs...

Profil de sécurité ? Cardio-vasculaire, confusion, sd sérotoninergique, polymédication...

Aucun essai spécifiques dépression résistante PA

Essai de faisabilité dans deuil prolongé

Essais en cours dans MCI/MA + dépression et MPI + dépression

LSD microdosage

Tolérance satisfaisante chez volontaires âgés sains (55-75ans)

Ayahuasca, MDMA...

Données quasi-inexistantes

Psilocybine et vieillissement cellulaire

npj | aging

Brief communication

Published in partnership with the Japanese Society of Anti-Aging Medicine

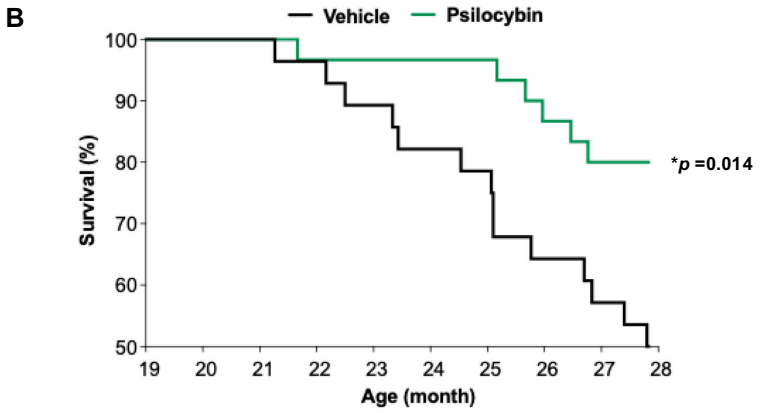
https://doi.org/10.1038/s41514-025-00244-x

Psilocybin treatment extends cellular lifespan and improves survival of aged mice

Check for updates

Kosuke Kato[1,2], Jennifer M. Kleinhenz[1,3], Yoon-Joo Shin[1], Cristian Coarfa[4], Ali J. Zarrabi[5] & Louise Hecker[1,3,6]

npj Aging | (2025)11:55



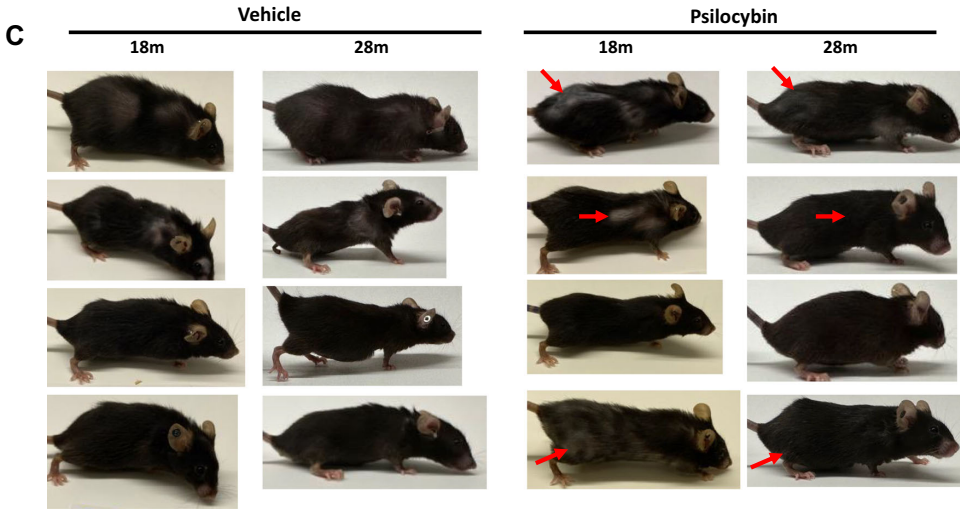


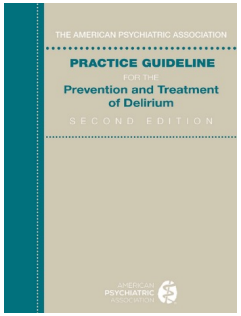
Fig. 2 | Psilocybin treatment in aged mice extends lifespan. C57BL/6J aged (19 month) female mice were treated with vehicle ($n = 28$) or psilocybin ($n = 30$) by oral gavage. Mice were given a lower dose (5 mg/kg) of psilocybin in month 1, followed by monthly dosing with high dose (15 mg/kg). At 10 months post-initial treatment, when the first group of mice reached median survival, all were euthanized. **A** Schematic diagram of treatment protocol. **B** Kaplan–Meier survival curve over the 10-month treatment duration, showing vehicle-treated ($n = 14$ out of 28) vs. psilocybin-treated ($n = 24$ out of 30) mice; $^*p = 0.014$ using the Log-rank Mantel–Cox test. **C** Representative images of mice prior to treatment (19 month) and after the final treatment (28 month) with vehicle or psilocybin. Red arrows indicate regions where hair growth and/or hair color changes were observed.

Recommandation APA sur la prévention et le traitement du syndrome confusionnel

The American Psychiatric Association Practice Guideline for the Prevention and Treatment of Delirium
Second Edition . 2025

Practice Guideline for the Prevention and Treatment of Delirium - Second Edition

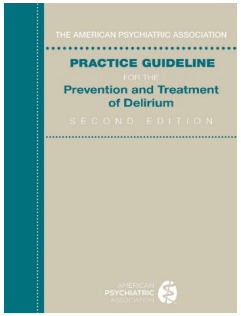
American Psychiatric Association, September 2nd, 2025



- Prise en charge médicamenteuse
  - **Contre-indication des BZD** sauf dans 7 situations précises
    - Sevrage alcoolique/BZD
    - Intoxication aiguë (anticholinergique, psychostimulant, psychédélique, substances multiples/inconnues)
    - Catatonie
    - Syndrome malin des neuroleptiques
    - Syndrome sérotoninergique
    - Encéphalite auto-immune
    - Poursuite d'un traitement chronique par BZD pendant la confusion pour éviter le sevrage.

Practice Guideline for the Prevention and Treatment of Delirium - Second Edition

American Psychiatric Association, September 2nd, 2025



- Les autres psychotropes et notamment les antipsychotiques ne doivent être utilisés que si
  - Echec des mesures de désescalade verbale/non verbale
  - Causes de la confusion évaluées et si possible traitées
  - Détresse majeure du patient ou risque pour son intégrité physique / celle des tiers

- Dexmedetomidine
  - Prévention du delirium chez les patients nécessitant sédation/anesthésie lors d'une chirurgie lourde, ventilation mécanique en réanimation
  - Sédation des patients confus nécessitant une ventilation mécanique

SF3PA

Practice Guideline for the Prevention and Treatment of Delirium - Second Edition

American Psychiatric Association, September 2nd, 2025

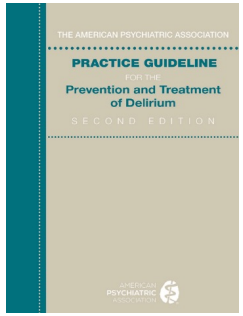


TABLE 7 **Antipsychotic medications that may be used in the treatment of severe neuropsychiatric disturbances of delirium**

	Aripiprazole	Haloperidol	Olanzapine	Quetiapine	Risperidone	Ziprasidone
Pharmacological properties[a]						
Route	Oral (tablet, disintegrating tablet,[b] solution)	Oral (tablet, concentrate), parenteral (short-acting lactate IM or IV injection)[c]	Oral (tablet, disintegrating tablet[b]), parenteral (short-acting solution for IM injection)[d]	Oral (immediate-release tablet, extended-release tablet)	Oral (tablet, disintegrating tablet,[b] solution)	Oral (capsule), parenteral (short-acting solution for IM injection)
Usual adult starting dose in delirium[e]	2 mg oral	0.5–2 mg oral/IM/IV	2.5 mg oral/IM	12.5–25 mg immediate-release oral[f]	0.25–0.5 mg oral	20 mg oral; 10–20 mg IM
Typical maximum daily dose in delirium	5–10 mg oral	20 mg oral/IM/IV	5–10 mg oral; 20–30 mg IM	100–200 mg immediate-release oral[f]	1–2 mg oral	40–80 mg oral; 20–40 mg IM
Oral bioavailability (%)	87	86	57	100	70	60 (with food)
Time to peak level[g]	3–5 hours oral	2–6 hours oral; 20 minutes IM; 2–10 minutes IV	6 hours oral; 15–45 minutes IM	1.5 hours immediate-release oral; 6 hours extended-release oral	1 hour oral	6–8 hours oral; 15–60 minutes IM

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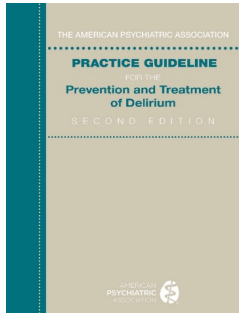
Practice Guideline for the Prevention and Treatment of Delirium - Second Edition

American Psychiatric Association, September 2nd, 2025



If the clinician decides to begin an antipsychotic to reduce neuropsychiatric disturbances of delirium, antipsychotic medications are usually begun on an as-needed (i.e., prn) basis and should be started at a low dose, typically half or less than that of a usual adult starting dose (Table 7).

medication order can help avoid excess sedation or other side effects of treatment. In addition, orders for antipsychotic medication should be limited in duration (e.g., 3–5 days), and potential benefits and risks of use should be reviewed before continuing treatment. Before discharge, the need for continued treatment should be reassessed (see Statement 15).

Recombinant zoster vaccine is associated with a reduced risk of dementia

9 février 2026

Rayens E, Sy LS, Qian L, Ackerson BK, Tubert J, Luo Y, Modha PP, Calderon RO, Chmielewski-Yee E, Oraichi D, Yun H, Koro C, Tseng HF. Recombinant zoster vaccine is associated with a reduced risk of dementia. Nat Commun. 2026 Feb 9;17(1):2056.

SF3PA

Contexte

- Réactivation VZV > 50 ans : augmentation risque TNC M
  - Dépôts amyloïdes
  - Réactivation HSV-1 quiescent
  - Anomalies vasculaires et évènements cérébro-vasculaires

Polisky V. et al. Nat Med. 2025

Gao J. et al. Neurol Sci. 2024

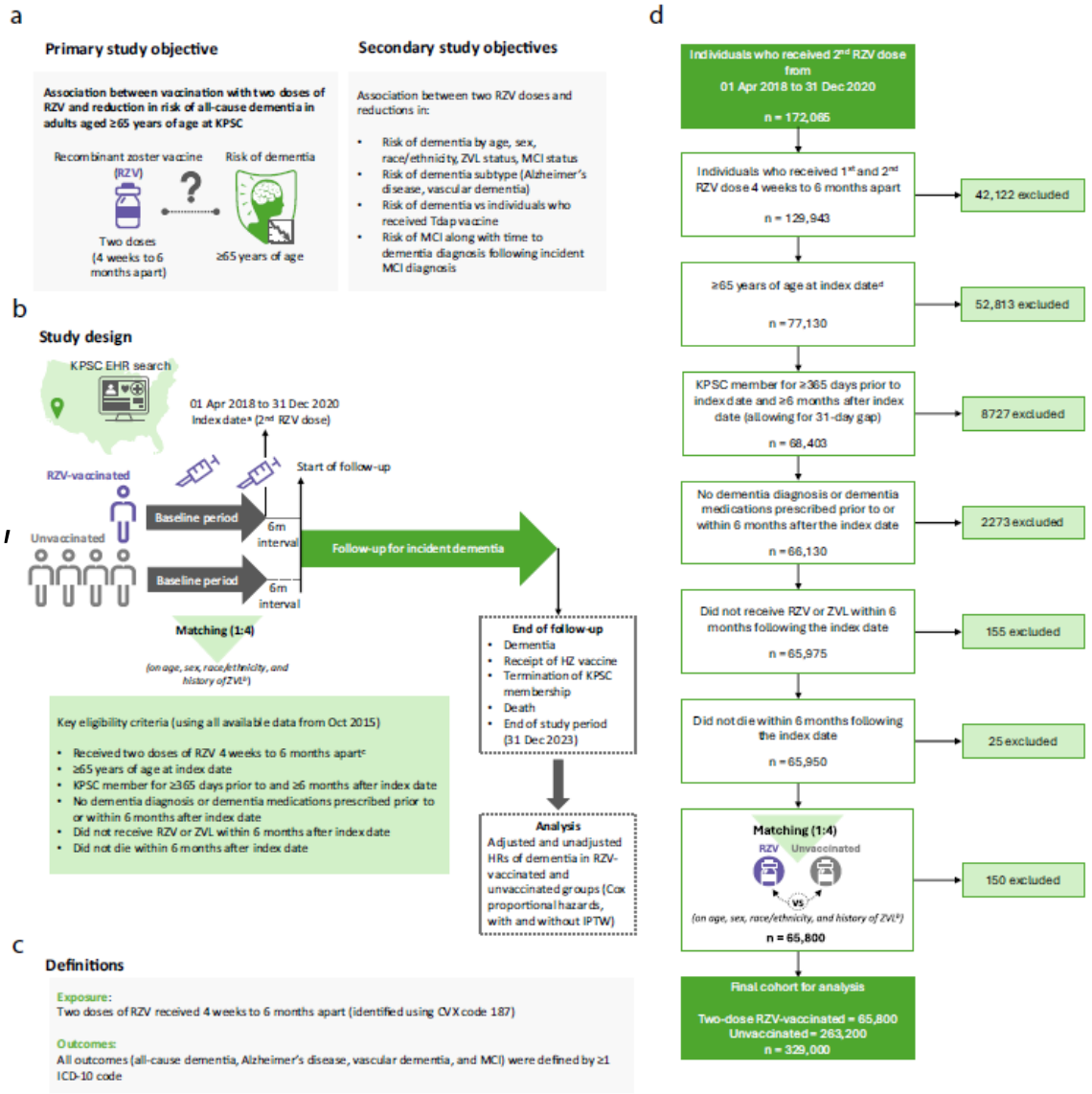
- Effets du vaccin VZV sur risque TNC M

Eyting M. et al. Nature. 2025

SF3PA

Objectifs :

- 1 : réduction TNC M
- 2 :
  - Réduction TNC M par âge, sexe, éthnie, statut VZV, statut TNC L
  - Type de TNC M
  - Vs vaccin DTPCa
  - Risque TNC L

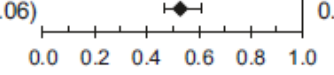


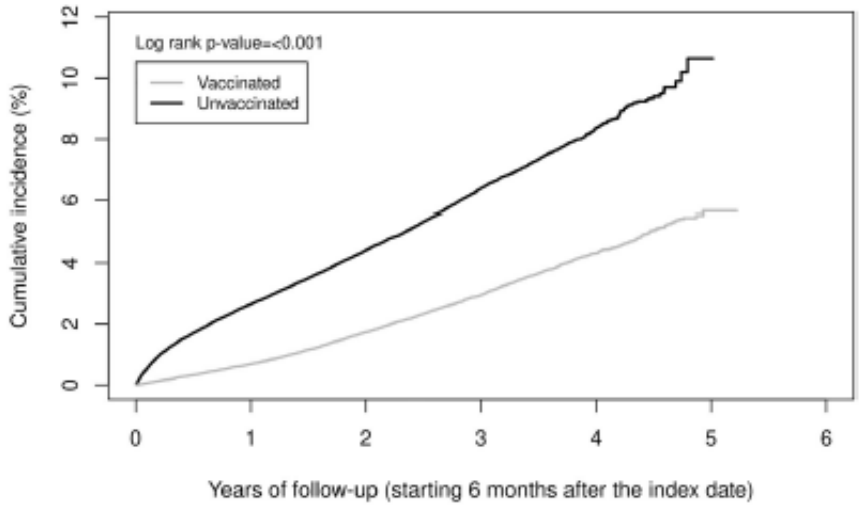
Réduction risque TNC M

Suivi :

- 3,4 ans RZV
- 1,8 an non RZV

	Incidence per 1000 person-years (95% CI)		aHR (95% CI)[a]
Dementia	**Vaccinated**	**Unvaccinated**	
Overall	10.74 (10.32–11.18)	23.04 (22.61–23.48)	0.49 (0.46–0.51)
Dementia subtype			
Alzheimer's disease	3.17 (2.95–3.42)	5.74 (5.53–5.95)	0.48 (0.44–0.53)
Vascular dementia	1.04 (0.91–1.18)	2.33 (2.20–2.47)	0.45 (0.39–0.53)
Age at index date, years			
65–69[b]	2.59 (2.25–2.99)	4.42 (4.10–4.76)	0.53 (0.44–0.64)
70–79	8.85 (8.33–9.40)	17.90 (17.38–18.43)	0.49 (0.45–0.53)
≥80[c]	34.33 (32.44–36.34)	83.35 (81.21–85.56)	0.48 (0.45–0.52)
Sex			
Female	10.07 (9.54–10.62)	23.82 (23.25–24.40)	0.45 (0.42–0.48)
Male	11.68 (11.01–12.39)	21.98 (21.33–22.64)	0.55 (0.51–0.59)
Race/Ethnicity, n (%)			
Non-Hispanic White	11.08 (10.54–11.64)	25.10 (24.52–25.69)	0.46 (0.43–0.48)
Non-Hispanic Black[d]	14.58 (12.38–17.16)	28.96 (26.87–31.21)	0.49 (0.40–0.60)
Hispanic[e]	10.53 (9.50–11.66)	20.63 (19.66–21.65)	0.55 (0.48–0.63)
Non-Hispanic Asian[f]	9.04 (8.11–10.07)	17.98 (17.03–18.97)	0.51 (0.44–0.58)
ZVL status			
No[g]	9.94 (9.25–10.70)	19.80 (19.17–20.45)	0.51 (0.47–0.56)
Yes	11.12 (10.60–11.66)	25.15 (24.57–25.73)	0.46 (0.43–0.49)
MCI status			
No	9.53 (9.14–9.95)	20.16 (19.76–20.57)	0.48 (0.46–0.51)
Yes[h]	99.00 (88.39–110.87)	219.86 (208.31–232.06)	0.53 (0.47–0.61)



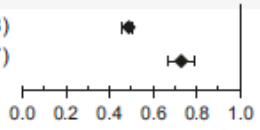


Vaccinated							
Number at risk	65,800	62,688	59,888	47,928	17,053	151	0
Cumulative events	0	449	1,096	1,784	2,294	2,401	2,401
Cumulative incidence	0	0.7	1.74	2.95	4.32	5.67	5.67
Unvaccinated							
Number at risk	263,200	176,826	125,601	53,513	7,928	1	0
Cumulative events	0	5,729	8,505	10,304	10,930	10,983	10,983
Cumulative incidence	0	2.65	4.42	6.38	8.36	10.64	10.64

Fig. 3 | Cumulative incidence of dementia among two-dose RZV-vaccinated versus unvaccinated individuals. RZV recombinant zoster vaccine.

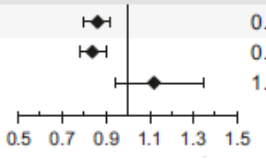
Biais vaccination

Dementia	Incidence per 1000 person-years (95% CI) RZV-Vaccinated	Comparison Group	aHR (95% CI)[a]
RZV Comparison Group			
Unvaccinated	10.74 (10.32–11.18)	23.04 (22.61–23.48)	0.49 (0.46–0.51)
Tdap		18.09 (17.44–18.77)	0.73 (0.67–0.79)



Réduction risque TNC L

MCI	Incidence per 1000 person-years (95% CI) Vaccinated	Unvaccinated	aHR (95% CI)[a]
Overall	7.05 (6.71–7.41)	7.47 (7.23–7.72)	0.86 (0.80–0.92)
<3.5 years of follow-up	6.81 (6.46–7.18)	7.51 (7.26–7.76)	0.84 (0.78–0.90)
≥3.5 years of follow-up	9.42 (8.18–10.85)	6.15 (4.88–7.74)	1.12 (0.94–1.35)



Discussion

- Résultats : diminution de 51 %du risque de TNC M
- Limites
  - Système de santé
  - Probables facteurs confondants résiduels
  - Courte période de suivi
  - Vaccinations VZV en cours de suivi
  - Problèmes de classifications des évènements et TNC
  - Sous diagnostic TNC L
- Perspectives : autres effets « désirables » de la vaccination VZV ?

ECT et *Oldest Old*

Arnison T, Eriksson A, Nordenskjöld A et al. Electroconvulsive Therapy in the Oldest-Old Patients with depression: Response and Remission Rates, Prognostic factors, Adverse Events and Mortality. Am J of Geriatric Psychiatry 33:10 (2025) 1065-1076

ECT en population très âgée

Am J of Geriatric Psychiatry 33:10 (2025) 1065–1076

Available online at www.sciencedirect.com

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journal homepage: www.ajgponline.org

Regular Research Article

Electroconvulsive Therapy in the Oldest-Old Patients With Depression: Response and Remission Rates, Prognostic Factors, Adverse Events and Mortality

Tor Arnison, Psy.D., Ph.D., Alina Eriksson, M.D., Axel Nordenskjöld, M.D., Ph.D.

Population peu étudiée
Peu de preuves
Polymédication
Comorbidités
Crainte de risque d'EI ↗ vs jeune

Registres
Q-ECT
Swedish NPR
Swedish CDR

n=522
85+
ECT

n=522
18-35
ECT

n=522
85+
nonECT

TABLE 1. Characteristics of Patients Aged ≥ 85 Treated With ECT, Patients Aged 18–35 Treated With ECT, and Patients Aged ≥ 85 Receiving Treatments Other Than ECT, for Depression

	Oldest-Old ECT Group	Young ECT Group	Oldest-Old Non-ECT Group
Group size (n)	*522*	*522*	*522*
Age, M (SD/Range)	87.2 (2.4/85–99)	28.0 (4.6/18–35)	87.1(2.3/85–96)
Sex, n (%)			
Female	377 (72.2)	366 (70.1)	375 (71.8)
Male	145 (27.8)	156 (29.9)	147 (28.2)
Diagnosis, n (%)			
MDD, moderate F32.1/F33.1	171 (32.8)	171 (32.8)	180 (34.5)
MDD, severe without psychotic features F32.2/F33.2	263 (50.4)	263 (50.4)	259 (49.6)
MDD, severe with psychotic features F32.3/F33.3	88 (16.9)	88 (16.9)	83 (15.9)
ECT treatment prior to index ECT, n (%)			
Yes	395 (75.7)	394 (75.5)	[a]
No	127 (24.3)	128 (24.5)	[a]
Co-morbidity, n (%)			
Rheumatic arthritis	64 (12.3)	9 (1.7)	62 (11.9)
Peripheral vascular disease	14 (2.7)	1 (0.2)	18 (3.5)
Metastatic cancer	4 (0.8)	0 (0.0)	6 (1.2)
COPD	6 (1.2)	3 (0.6)	6 (1.2)
Congestive heart failure	24 (4.6)	0 (0.0)	22 (4.2)
Peptic ulcer disease	14 (2.7)	2 (0.4)	11 (2.1)
Myocardial infarction	41 (7.9)	0 (0.0)	35 (6.7)
Severe liver disease	2 (0.4)	1 (0.2)	0 (0.0)
Severe kidney disease	12 (2.3)	2 (0.4)	7 (1.3)
Hemiplegia	3 (0.6)	1 (0.2)	4 (0.8)
Diabetes	22 (4.2)	11 (2.1)	19 (3.6)
Dementia	16 (3.1)	0 (0.0)	14 (2.7)
Cerebrovascular disease	64 (12.3)	3 (0.6)	68 (13.0)

Efficacité

Réponse
Oldest-old ECT (82%) >
Young ECT (67,4%)

Rémission
Oldest-old ECT (53,3%) >
Young ECT (27,4%)

Moins de séances/séries mais des paramètres plus élevés

TABLE 2. ECT-related parameters in the Oldest-old and Young ECT groups

	Oldest-old ECT group	Young ECT group	χ^2(df)/t(df)	P
Response, yes (%)	428 (82.0)	352 (67.4)	29.18 (1)*	<.001
Remission, yes (%)	130 (53.3)	79 (27.4)	21.88 (1)*	<.001
Electrode placement			2.02 (3)**	.568
Unilateral, n (%)	473 (91.1)	464 (89.2)		
Bilateral, n (%)	42 (8.1)	48 (9.2)		
Other, n (%)	4 (0.8)	8 (1.5)		
ECT sessions per series, Med. (IQR)	6.0 (2.0)	8.0 (3.0)	3.92 (1042)***	< .001
Seizure time, s, Med. (IQR)	49.0 (30.0)	47.0 (30.0)	2.97 (815)***	.003
Pulse width, ms, Med. (IQR)	0.50 (0.05)	0.50 (0)	6.44 (842)***	< .001
Frequency, Hz, Med. (IQR)	70.0 (20.0)	50.0 (30.0)	17.22 (839)***	< .001
Duration, s, Med. (IQR)	6.9 (2.0)	6.0 (2.4)	4.12 (841)***	< .001
Current, mA, Med. (IQR)	800.0 (100.0)	800.0 (100.0)	1.20 (841)***	.232
Charging dose, mC, Med. (IQR)	427.5 (194.0)	251.0 (143.0)	19.35 (841)***	< .001

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Facteurs pronostiques

Caractéristiques psychotiques
seul facteur pronostic de réponse et rémission

Comorbidités somatiques
Absence d'impact

TABLE 3. Results for the Firth's Logistic Regression Analysis of Factors Prognostic of Response and Remission After ECT for Depression in 522 Patients Aged ≥ 85 Years

Predictor	Outcome											
	Response						Remission					
	Univariate			Multivariate			Univariate			Multivariate		
	OR (95% CI)	Wald χ^2 (df)	p	OR (95% CI)	Wald χ^2 (df)	p	OR (95% CI)	Wald χ^2 (df)	p	OR (95% CI)	Wald χ^2 (df)	p
Age	1.01 (0.92–1.10)	0.01 (1)	0.918	1.00 (0.90–1.11)	0.01 (1)	0.977	1.07 (0.96–1.19)	1.35 (1)	0.246	1.07 (0.95–1.20)	1.10 (1)	0.294
Sex (male)	0.78 (0.48– 1.26)	1.03 (1)	0.310	0.70 (0.40–1.20)	1.71 (1)	0.191	1.24 (0.71–2.17)	0.57 (1)	0.451	1.24 (0.67–2.28)	0.47 (1)	0.491
CCI (0 reference)												
1	1.01 (0.60–1.70)	0.99 (1)	0.321	0.89 (0.50–1.57)	0.07 (1)	0.793	1.05 (0.60–1.85)	0.04 (1)	0.834	1.12 (0.60–2.07)	0.44 (1)	0.505
2+	0.60 (0.33–1.10)	2.97 (1)	0.090	0.67 (0.32–1.39)	0.89 (1)	0.345	1.26 (0.57–2.76)	0.274 (1)	0.601	1.97 (0.80–4.89)	1.90 (1)	0.168
Electrode placement (unilateral reference)												
Bilateral	1.54 (0.61–3.93)	1.60 (1)	0.450	1.17 (0.459–3.06)	0.10	0.757	0.99 (0.35–2.81)	0.23 (1)	0.631	0.63 (0.20–1.97)	0.62	0.430
Other	0.50 (0.10–2.51)	1.16 (1)	0.282	2.50 (0.09–71.54)	0.24 (1)	0.627	0.29 (<0.01–27.02)	0.28	0.594	[a]	[a]	[a]
Charging dose	1.00 (1.00–1.00)	1.99 (1)	0.159	1.00 (1.00–1.00)	2.62 (1)	0.106	1.0 (1.00–1.00)	1.08 (1)	0.298	1.00 (1.00–1.00)	0.38 (1)	0.535
Severity of depression (moderate reference)												
Severe no psychotic features	1.12 (0.63–2.00)	1.77 (1)	0.183	1.07 (0.54–2.11)	2.21 (1)	0.137	0.97 (0.48–1.95)	2.54 (1)	0.111	0.99 (0.46–2.13)	3.26 (1)	0.071
Severe with psychotic features	2.34 (1.18–4.65)	7.84 (1)	0.005	2.52 (1.13–5.66)	7.38 (1)	0.007	2.17 (1.01–4.68)	7.05 (1)	0.008	2.83 (1.22–6.57)	9.89 (1)	0.002

Tolérance : effets secondaires

Effets secondaires ns
mais patterns différents

OO-ECT
Plaintes mnésiques
Confusion
Complications CV

Y-ECT
Plaintes mnésiques
Céphalées

Hospitalisations à 1sem
OO-nonECT>OO-ECT
OR 2,68, p<0,01

Pas plus de mortalité
Tendance pour OO-nonECT
OR 4,56, p=0,06

TABLE 4. Prevalence of the Most Common Clinician-Reported Adverse Events During Treatment With ECT in Patients Aged ≥ 85 (Oldest-Old ECT Group) or 18–35 Years (Young ECT Group)

	Oldest-Old ECT Group, n (% of Age Group)	*Young ECT Group, n (% of Age Group)*	Odds Ratio (95% CI)	Wald χ^2 (df), p
Adverse events, total n (%)	103 (19.7)	121 (23.2)	0.82 (0.61–1.10)	1.79 (1), 0.180
Specific adverse events				
Memory impairment	39 (7.5 %)	69 (13.2 %)		
Confusion	23 (4.4 %)	8 (1.5 %)		
Cardiovascular complications	23 (4.4 %)	4 (0.8 %)		
Headache	8 (1.5 %)	39 (7.5 %)		
Nausea/Vomiting	6 (1.1 %)	8 (1.5 %)		
Muscle pain	3 (0.6 %)	7 (1.3 %)		
Suicide attempt	0 (0.0 %)	6 (1.1 %)		

TABLE 5. Causes of Hospitalization or Death (Within 1 Week From Discharge) in Oldest-Old Patients Treated for Depression Either With or Without ECT, as Well as in Young Patients (Aged 18–35) Who Received ECT

	Young ECT Group, n (%)	Oldest-Old ECT Group, n (%)	Oldest-Old Non-ECT Group, n (%)
Total number of hospitalizations, n (%)	23 (4.4)	30 (5.7)	72 (13.8)
Cause of hospitalization			
Infectious diseases	0 (0)	1 (0.2)	2 (0.4)
Cancer	0 (0)	0 (0.0)	2 (0.4)
Organic mental disorders[a]	0 (0)	1 (0.2)	7 (1.3)
Depression relapse	10 (2.2)	7 (1.3)	14 (2.7)
Other psychiatric condition	7 (1.3)	0 (0)	0 (0)
Dissociative stupor	0 (0)	1 (0.2)	0 (0.0)
Cardiovascular disease	0 (0)	5 (1.0)	8 (1.5)
Cerebrovascular disease	0 (0)	1 (0.2)	2 (0.4)
Influenza or pneumonia	0 (0)	4 (0.8)	6 (1.1)
Urinary disease	0 (0)	2 (0.4)	1 (0.2)
Syncope and collapse	0 (0)	1 (0.2)	0 (0.0)
Intestinal diseases	0 (0)	0 (0.0)	5 (1.0)
Musculoskeletal diseases	0 (0)	0 (0.0)	5 (1.0)
Traumatic injury	1 (0.2)	4 (0.8)	6 (1.1)
Pregnancy-related	2 (0.4)	0 (0)	0 (0)
Poisoning	5 (1.0)	0 (0)	0 (0)
Other	0 (0)	3 (0.6)	6 (1.1)
Total number of deaths, n(%)	0 (0)	2 (0.4)	9 (1.7)
Cause of death			
Heart failure	0 (0)	1 (0.2)	2 (0.4)
Infection	0 (0)	0 (0.0)	3 (0.6)
Asphyxiation	0 (0)	0 (0.0)	1 (0.2)
Unspecified	0 (0)	1 (0.2)	3 (0.6)

[a] Including dementia, delirium, disorientation and mild cognitive disorder.

Conclusion

Meilleure réponse et rémission

Bonne tolérance
Moindre risque d'hospitalisation précoce que pour traitement non-ECT

Pas d'impact des comorbidités sur la réponse/rémission (mais prévalence plutôt faible dans l'étude)

Autorisation de mise sur le marché dextrometorphane-buproprion (AUVELTY®) dans l'agitation liée à la maladie d'Alzheimer

FDA Approves First Non-Antipsychotic Drug to Treat Agitation Associated with Dementia. FDA
April 30th, 2026

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Dextrometorphane-buproprion (AUVELTY®)

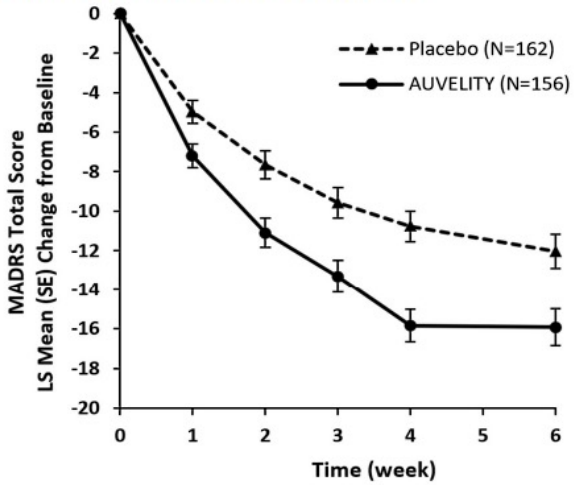
Dépression

Auvelity™
(dextromethorphan HBr and bupropion HCl)
extended-release tablets 45mg/105mg

FDA APPROVED

19 août 2022

Figure 3: Change from Baseline in MADRS Total Score by Week (Study 1)



Placebo (N)	161	162	159	159	157	150
AUVELITY (N)	156	155	142	132	128	124

SE = Standard Error

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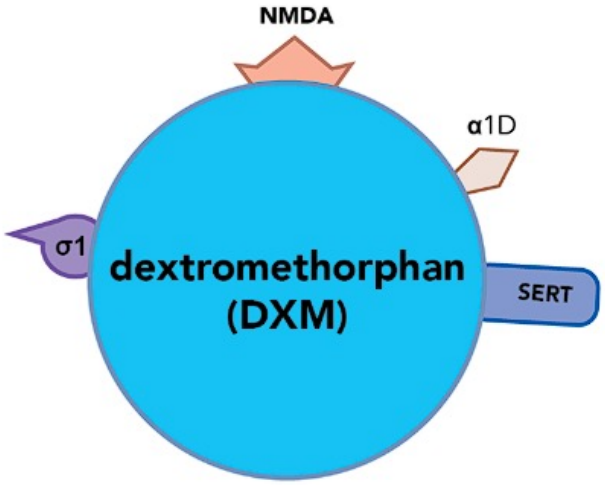
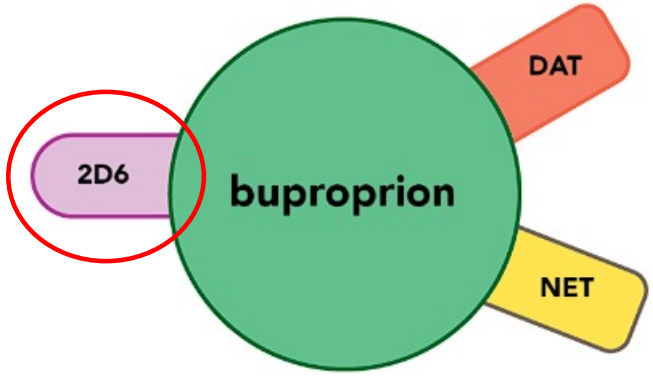
Pharmacodynamie

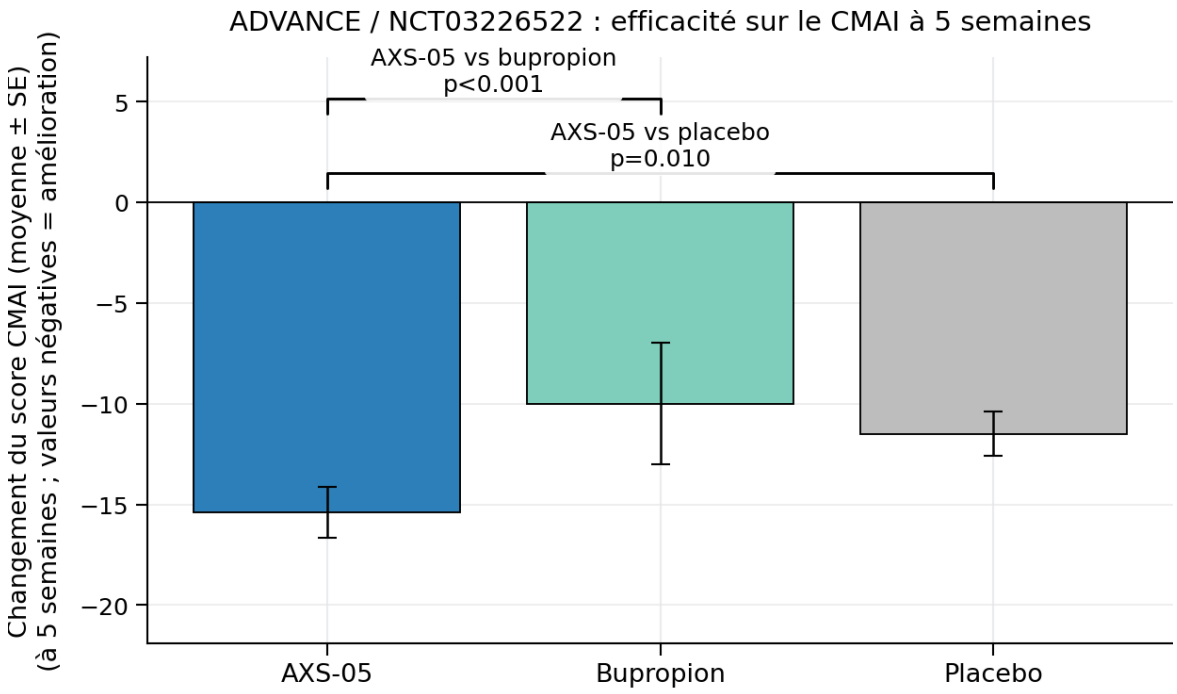
Neuroscience Education Institute, April 30th 2026





Dextrometorphane-buproprion (AUVELTY®)

ADVANCE-1 - O'Gorman et al. 2020



Source : ClinicalTrials.gov NCT03226522 (population mITT).

DOI: 10.1002/alz.047684
DRUG DEVELOPMENT
PODIUM PRESENTATIONS
Alzheimer's & Dementia®
THE JOURNAL OF THE ALZHEIMER'S ASSOCIATION
Developments in clinical trials and cognitive assessment

Efficacy and safety of AXS-05, a novel, oral, NMDA-receptor antagonist with multimodal activity, in agitation associated with Alzheimer's disease: Results from ADVANCE-1, a phase 2/3, double-blind, active and placebo-controlled trial

Cedric O'Gorman[1] | Amanda Jones[1] | Jeffrey L. Cummings[2] | Herriot Tabuteau[1]

Durée: **5 semaines**

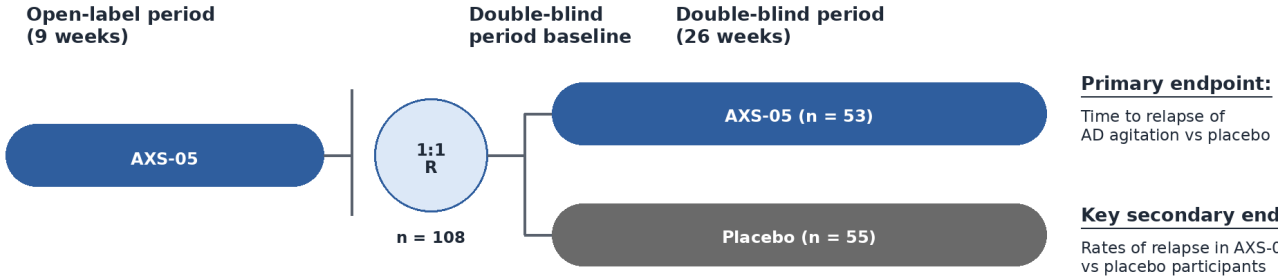
366 sujets inclus

- AXS-05: 159
- Buproprion: 49
- Placebo: 158

Dextrometorphane-buproprion (AUVELTY®)

ACCORD – AAN Annual Meeting - Cummings et al. 2024, April 2024

Study design (schematic)



Primary endpoint only

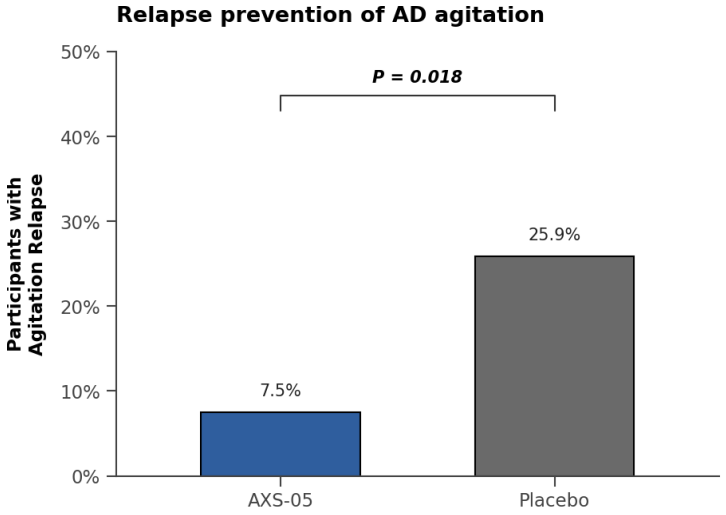
Relapse prevention of AD agitation

HR
0.276

Time to relapse of AD agitation vs placebo

P = 0.014

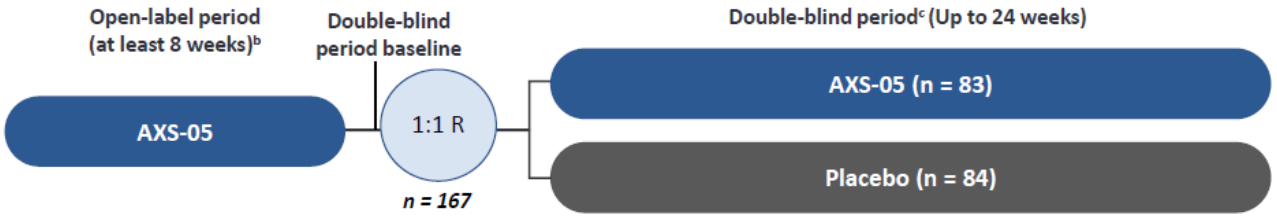
Source abstract DOI: 10.1212/WNL.0000000000205634



Source abstract DOI: 10.1212/WNL.0000000000205634

Dextrometorphane-buproprion (AUVELTY®)

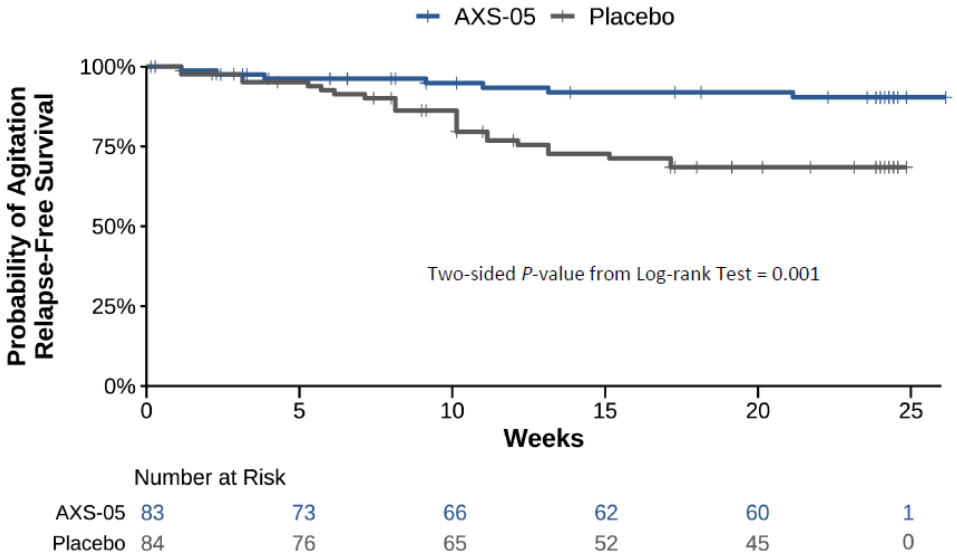
ACCORD-2 – Psych Congress Elevate Poster - Cummings et al., May 2025



Primary Endpoint: Time to relapse of AD agitation vs placebo

Key Secondary Endpoint: Rates of relapse in AXS-05 vs placebo participants

Figure 1. Kaplan-Meier Plot of Time from Randomization to Relapse of Agitation Symptoms



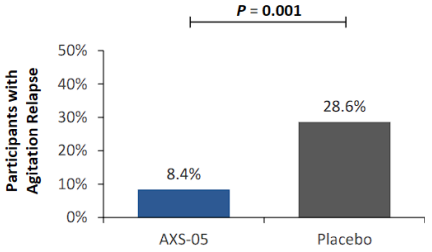
Agitation relapse defined as:

- ≥10-point increase (worsening) from randomization in the CMAI total score for 2 consecutive weeks *or* CMAI total score at assessment ≥ baseline[a] CMAI total score for 2 consecutive weeks
- Hospitalization for worsening AD agitation

- ACCORD-2 met its primary endpoint by significantly delaying the time to relapse of AD agitation with AXS-05 versus placebo (hazard ratio, 0.276)
- Risk of relapse was 3.6-fold less with AXS-05 compared to placebo

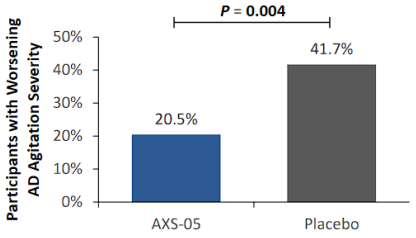
Hazard Ratio for Time to Relapse	
Hazard Ratio (95% CI)	0.276 (0.119-0.641)

Figure 2. Relapse Prevention of AD Agitation



- AXS-05 met the key secondary endpoint by significantly preventing relapse of AD agitation compared to placebo (8.4% vs 28.6%; P = 0.001)

Figure 3. Prevention of Worsening of AD Agitation



- AXS-05 significantly reduced worsening of AD agitation compared to placebo as assessed by CGI-S agitation (20.5% vs 41.7%; P = 0.004)

[a]Baseline values are from the ADVANCE-2 trial from which participants in the ACCORD-2 trial were carried over.
AD, Alzheimer's disease; CMAI, Cohen-Mansfield Agitation Inventory.

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Schéma posologique dans l'agitation de la MA

Axsome Therapeutics, press release April 30th 2026

- **J1**: 1 comprimé de 30 mg/105 mg 1 prise/jour le matin pendant 7 jours
- **J8**: 1 comprimé de 30 mg/105 mg 2 prises/jour, séparées d'au moins 8 heures
- **J15**: 1 comprimé de 45 mg/105 mg 2 prises/jour, séparées d'au moins 8 heures

Climate change and the health of older adults in Europe: a call for a geriatric climate medicine framework

22 octobre 2025

Lozano-Montoya I, Ruiz-Huerta C, Gómez-Pavón FJ. Climate change and the health of older adults in Europe: a call for a geriatric climate medicine framework. Eur Geriatr Med. 2026 Feb;17(1):1-9.

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Contexte

- Réchauffement du climat européen x2 > global
- Menace pour la santé publique
  - Augmentation de la température
  - Evènements climatiques extrêmes
  - Altération de la qualité de l'air
  - Perturbation écologique
- Personnes âgées = population très vulnérable
- Pas de recommandations cliniques gériatriques

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Effets sur la santé des personnes âgées

Vagues de chaleur

- Mortalité (Sud de l'Europe +++)
  - Femmes
  - > 80 ans
  - Fragilité
  - Pathologies sous-jacentes : cardiovasculaires, rénales, métaboliques
- Evènements cardiovasculaires
- Hospitalisations

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Effets sur la santé des personnes âgées

Pollution de l'air

- Inhalation chronique de particules fines PM2.5
  - Mortalité cardiovasculaire et respiratoire
  - Fragilité
  - Déclin cognitif
  - Hospitalisations

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Effets sur la santé des personnes âgées

Incendies de forêt

- Exposition à la chaleur, fumée, pollution de l'air (PM 2.5)
- Hospitalisations pour maladies cardiovasculaires ou respiratoires
- Excerbations de BPCO
- Pathologies liées à la chaleur
- Déclin cognitif et fonctionnel (déplacements, isolement, rupture de parcours de soins)

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Effets sur la santé des personnes âgées

Pathologies infectieuses

- Pathogènes par vecteur ou eau
  - Virus du Nil occidental
  - Dengue
  - Leishmaniose
  - Vibrions
  - Tique

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Effets sur la santé des personnes âgées

Autres

- Inondations
  - Infections
  - Déclin cognitif et fonctionnel (déplacements, isolement, rupture de parcours de soins)
- Insécurité alimentaire et hydrique
- « Stress climatique » : AVC, confusion, SPCD

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France

FRANCE

LANCET COUNTDOWN ON HEALTH AND CLIMATE CHANGE
DATA SHEET 2025

LANCET COUNTDOWN: HEALTH AND CLIMATE CHANGE IN EUROPE

Escalating heat exposure and unsafe conditions for physical activity

France continues to experience sharp increases in heat exposure, particularly among older adults, infants, and people engaging in outdoor activities. The data highlight that heat is becoming a consistent and widespread threat to population health and productivity, with little sign of adaptation keeping pace. According to Santé publique France, the summer of 2024 ranked as the eighth hottest since 1900, with heatwaves affecting 43 départements and around 40% of the population for nearly five days on average. More than 17 000 emergency visits and an estimated 3 700 deaths were attributed to heat exposure.**

RECORD-BREAKING SUMMERS TEST RESILIENCE ACROSS FRANCE

Heatwaves have repeatedly challenged public-health systems, with multiple départements under prolonged heat alerts in recent years. The 2024 summer brought concurrent agricultural, health, and energy impacts. National surveillance during this period also showed that older adults accounted for more than half of heat-related emergency visits and three-quarters of heat-attributable deaths.** This prompts renewed calls for urban greening, expanded early-warning systems, and occupational-safety adaptation plans. Sustained behavioural and infrastructural adaptation will be essential to reduce vulnerability as temperatures continue to rise.

In 2024, people in France were exposed to 12 heatwave days each, on average. Of these, 9 (75%) would not have been expected to occur without climate change. (Indicator 1.1.1)

In 2024, individuals in France were exposed to 149.9 hours per person of at least moderate heat stress risk during exercise, 127% higher than the 1990–1999 average. This can compromises safe outdoor activity and occupational performance. (Indicator 1.1.2)

90M

In 2024, heat exposure resulted in a loss of 90 million potential labour hour, 111% more than in 1990-1999. The construction sector accounted for 47% of the losses in 2024. (Indicator 1.1.3)

France lost 86,280 hectares of tree cover in 2023, reducing natural cooling and shade, amplifying heat stress during extreme temperature events and increasing risks to health and ecosystems. (Indicator 3.4)

Wildfire smoke and drought pressures on health

Climate-related hazards in France increasingly converge, with prolonged droughts amplifying wildfire risk and worsening air quality. While 2024 saw fewer wildfire exposure days, the long-term increase in smoke-related mortality and particulate concentrations reflects growing health threats under a warmer, drier climate. This points to greater health risks across large parts of France, especially in southern regions affected by recurrent summer fires.

From 2020–2024, an average of 44.6% of French land experienced at least one month of extreme drought per year, 148% higher than 1951-1960. (Indicator 1.2.2.) This illustrates a shift towards more severe and recurrent dry periods that degrade soil, ecosystems, and water security.

Wildfire-related fine particulate matter ($PM_{2.5}$) caused an estimated 700 deaths per year on average between 2020–2024, which is a 55% increase from 2003–2012 levels. In 2024, 656 deaths were attributed to wildfire smoke, still 45% higher than the baseline, highlighting persistent health risks even in years with fewer fire events. (Indicator 1.2.1)

Coastal warming and climate-sensitive infectious disease risk

Rising sea-surface temperatures and expanding pathogen habitats are heightening infectious-disease risks along France's extensive coastline. The warming trend in the Atlantic and Mediterranean waters supports the spread of Vibrio bacteria, posing growing public-health challenges for coastal residents and visitors.

Average sea-surface temperatures around France reached 16.0 °C in 2022–2024, representing a 7.6% increase from the 1981–2010 baseline. In 2024, the seas were 1.0°C warmer than the historical average, intensifying risks of harmful algal blooms and bacterial proliferation. (Indicator 1.4)

In 2024, France saw an estimated 2,700 Vibrio cases, a 78% rise compared with 1990–1999. France also had a 384% increase in the coastal length exposed to Vibrio risk. These infections, often associated with warmer waters and shellfish consumption, underscore the growing intersection between ocean warming and health outcomes in France. (Indicator 1.3.6) In addition, France has seen a sharp rise in autochthonous arboviral infections transmitted by Aedes albopictus, including 729 chikungunya cases across 78 clusters in 2025.***

Rôle de la gériatrie

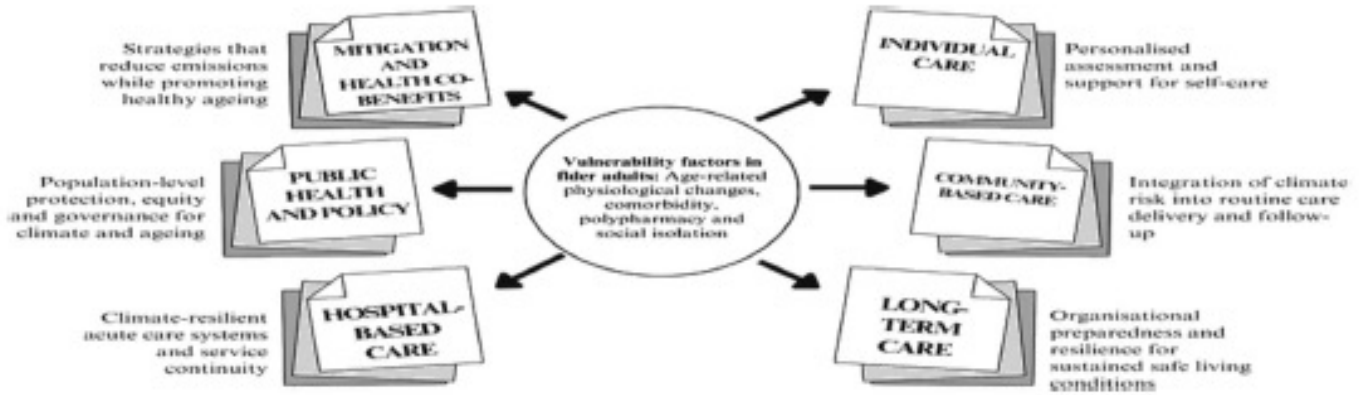

Fig. 1 European geriatric climate medicine framework outlining seven strategic domains for integrating climate resilience into geriatric health systems, with a central focus on vulnerability factors in older adults

Rôle de la gériatrie

Table 1 Recommendations to mitigate climate change impacts in older adults

Level of Care	Recommendation	Implementation Example	
Community-based care	Incorporate climate-related risk into the clinical history	Include standardized questions in the electronic health record regarding housing conditions, access to air conditioning, social isolation and evacuation capacity	Promote "green" lifestyles, including locally sourced and seasonal nutrition, adapted physical activity and social interactions
	Identify older adults at risk of dehydration (e.g., those without air conditioning or on diuretics) during routine home assessments	Measure indoor temperature. Use electronic health records to identify high-risk individuals for proactive follow-up	
	Provide education to patients and caregivers on how to stay safe during periods of extreme heat	Distribute printed or digital materials outlining hydration strategies, cooling options and early signs of heat-related illness	
	Maintain adequate hydration and review the use of medications that may increase vulnerability to dehydration	Conduct seasonal medication reviews, provide tailored advice on fluid intake during hot months	
	Address climate-related mental health symptoms	Assess for sleep disturbances, anxiety, or cognitive decline potentially exacerbated by extreme heat and provide mental health support	
Hospital-based care	Incorporate climate-sensitive screening into clinical protocols	Screen for signs of dehydration, orthostatic hypotension or confusion during triage (especially in patients with cognitive impairment)	
	Review and adjust medications that may increase the risk of heat-related illness	Temporarily modify or suspend diuretics, anticholinergics or other high-risk drugs during heatwaves	
	Adjust healthcare delivery practices to minimise exposure during extreme events	Prioritize telemedicine and home visits for frail patients	
	Prioritize reusable medical equipment and sustainable service contracts	Select suppliers that meet energy efficiency criteria in cleaning, laundry and waste management	
Long-term care	Establish protocols for managing heat emergencies	Develop institutional action plans, including temperature monitoring, hydration rounds and adjusted activity schedules	
	Train staff in recognizing heat-related illness	Include mandatory training modules on heat stress in annual education plans	
	Promote awareness of the need for heat-resilient housing	Recommend funding applications for passive cooling interventions (e.g., external shading and improved ventilation)	
	Include environmental risk factors in routine geriatric assessments	Add specific questions on thermal comfort and structural housing quality	

Un sujet brûlant !

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Electronic supplementary material:
The online version of this article contains supplementa

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Synthèse

Geriatr Psychol Neuropsychiatr Vieil 2026 ; 24 (1) : 15-29.

Impact du changement climatique et de la pollution sur la santé globale de nos aînés

Impact of climate change and pollution on the global health of older adults

Bastien Genet[1]
Rebecca Bonnetain[1]

Résumé. *Introduction.* Le changement climatique et la pollution représentent des enjeux majeurs de santé publique, particulièrement pour nos aînés vulnérables par leur polymorbidité, isolement et précarité. Dans une perspective de santé globale où la santé

Climate change assessment of t hazards on olde

Wood et al. Environmental Health (2024) 23:35
https://doi.org/10.1186/s12940-024-01075-1

RESEARCH

Exposure to ambient air pollution and cognitive funct English Longitudina

Dylan Wood[1,2,3*], Dimitris Evangelopoulos[1,2,3] Panayotes Demakakos[4] and Klea Katsouyann

Contents lists available at ScienceDirect

Environment International

vier.com/locate/envint

l neurological conditions in alysis

urt[a], Yimeng Song[a], Ji-Young Son[a], ok Kim[c], Hayon Michelle Choi[d], [e,h], Nicole C. Deziel[b],

| CLIMATE CHANGE AND HEALTH

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nature medicine

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Bethan Davies[1], Mahmood F. Bhutta[2]

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Giacomo Falchetta[1,2,3], Enrica De Cian[1,2,4], Ian Sue Wing[5] & Deborah Carr[6]

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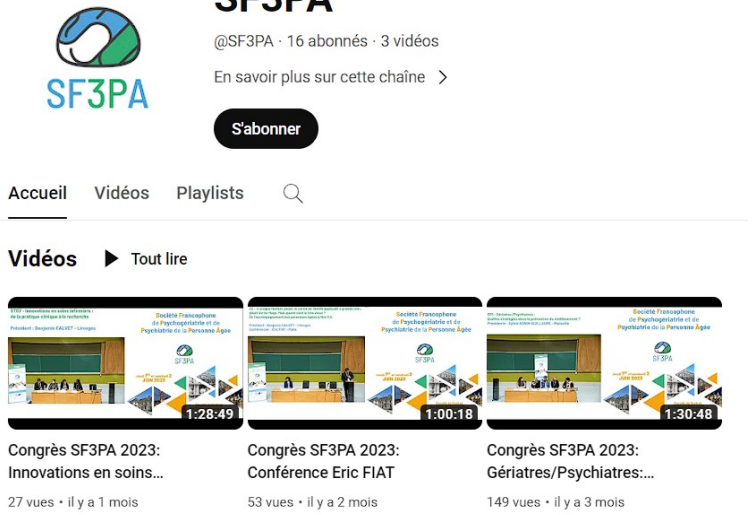

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