ARCHIVES OF NEUROLOGY

Time Until Institutionalization and Death in Patients With Dementia: Role of Caregiver Training and Risk Factors

Objective: To determine which variables best predict prognosis—time to nursing home admission (NHA) and death—in patients with dementia.
Design: Survival analysis employing the Cox proportional hazards model with the use of risk variables pertaining to dementia severity and its rate of progression and caregiver functioning.
Setting: Patients and their caregivers participating in a controlled intervention study of training for caregivers in home management of dementia.
Participants: Patients with mild *Diagnostic and Statistical Manual of Mental Disorders, Third Edition*–defined dementia (N=91; 68 patients with Alzheimer-type dementia, 20 with vascular dementia, and three with other types) and their caregivers.
Follow-up: All subjects had repeated assessments in the first year to determine rates of change and thereafter annually to determine the date of NHA and/or death.
Risk Variables: (1) Caregiver training; (2) dementia severity at index assessment; (3) caregiver stress, neuroticism, and socialization; (4) changes in patients and caregivers during the first 12 months; and (5) patient characteristics.
Results: By 5 years' follow-up, 76% of patients had entered a nursing home and 42% had died. Dementia severity and rate of deterioration ("how far" and "how fast") and caregiver psychological morbidity significantly influenced rates of NHA and death. Training of caregivers was significantly associated with delayed NHA and reduced mortality. Greater patient age, non-Alzheimer's dementia, and, unexpectedly, greater caregiver psychological morbidity were associated with shorter survival to death.
Conclusions: Both severity ("how far") and rate of deterioration ("how fast") influence time to NHA and death. Caregiver training may have important ameliorating effects on the prognosis of dementia.

(1993;50:643-650) H. Brodaty, MD, et al, Academic Department of Psychogeriatrics, Prince Henry Hospital, Anzac Parade, Little Bay, New South Wales 2036, Australia.

ARCHIVES OF GENERAL PSYCHIATRY

Alprazolam in the Treatment of Premenstrual Syndrome: A Double-blind, Placebo-Controlled Trial

Objective: To evaluate the efficacy of alprazolam in the treatment of premenstrual syndrome.
Design: A randomized, double-blind, placebo-controlled, crossover trial of alprazolam during eight menstrual cycles.
Setting: Outpatient clinic at the National Institute of Mental Health, Bethesda, Md.
Participants: Twenty-two women with prospectively confirmed premenstrual syndrome entered this study. All subjects were either self-referred or were referred by their physicians. All reported having regular menstrual cycle lengths, were taking no medication, and were free of current or recent medical or psychiatric illness. Two subjects did not complete the trial.
Intervention: Participants were assigned to receive alprazolam or placebo as follows: cycle 1, 0.25 mg of alprazolam or placebo three times daily beginning on menstrual cycle day 16; cycle 2, 0.50 mg of alprazolam or placebo three times daily according to the regimen during the first cycle; cycles 3 and 4, 0.75 mg of alprazolam or placebo three times daily from menstrual cycle day 16 and continued throughout the fourth menstrual cycle to evaluate the efficacy of relatively long-term (approximately 6 weeks) treatment with alprazolam.
Main Outcome Measures: Daily self-report symptoms ratings were completed during the entire study period.
Results: We observed no significant differences in the severity of premenstrual symptom ratings during alprazolam administration compared with placebo on any scale except the Beck Depression Inventory Scale. The Beck Depression Inventory ratings demonstrated a statistically ($F_{1,19}=7.1$, $P<.05$), but not clinically, significant improvement in depressive symptoms during alprazolam administration compared with placebo.
Conclusion: Our findings do not support alprazolam as a uniformly effective treatment for the symptoms of premenstrual syndrome.

(1993;50:467-473) P. J. Schmidt, MD, et al, Bldg 10, Room 3N238, 9000 Rockville Pike, Bethesda, MD 20892.

Psychotherapy and Bulimia Nervosa: Longer-term Effects of Interpersonal Psychotherapy, Behavior Therapy, and Cognitive Behavior Therapy

Objectives: To determine whether cognitive behavior therapy (CBT) for bulimia nervosa has a specific therapeutic effect and determine whether a simplified behavioral treatment (BT) of CBT is as effective as the full treatment.
Design: Randomized controlled trial involving three psychological treatments. Two planned comparisons, CBT with interpersonal psychotherapy (IPT), and CBT with BT. Closed 12-month follow-up period. Independent assessors.
Setting: Secondary referral center.
Patients: Seventy-five consecutively referred patients with bulimia nervosa. Patients with concurrent anorexia nervosa were excluded.
Interventions: Cognitive behavior therapy, IPT, BT conducted on an individual outpatient basis. There were nineteen sessions over 18 weeks. Six experienced therapists administered all three treatments. There was no concurrent treatment.
Main Outcome Measure: Frequency of binge eating and purging.
Results: High rate (48%) of attrition and withdrawal among the patients who received BT. Over follow-up, few patients undergoing BT met criteria for a good outcome (cessation of all forms of binge eating and purging). Patients in the CBT and IPT treatments made equivalent, substantial, and lasting changes across all areas of symptoms, although there were clear temporal differences in the pattern of response, with IPT taking longer to achieve its effects.
Conclusions: Bulimia nervosa may be treated successfully without focusing directly on the patient's eating habits and attitudes to shape and weight. Cognitive behavior therapy and IPT achieved equivalent effects through the operation of apparently different mediating mechanisms. A further comparison of CBT and IPT is warranted. The behavioral version of CBT was markedly less effective than the full treatment.

(1993:50:419-428) C. G. Fairburn, DM, FRCPsych, et al. Reprints not available.

ARCHIVES OF INTERNAL MEDICINE

Alcohol Consumption and Risk of Ischemic Heart Disease in Women

Background: Most studies suggest that alcohol use decreases the risk of coronary heart disease in men, however, this association has not been well established in women.
Method: This study investigates the relationship between alcohol use and ischemic heart disease (IHD) incidence among women aged 45 to 74 years in the Epidemiologic Followup Study of the First National Health and Nutrition Examination Survey. The cohort was free of heart disease at baseline. During the follow-up period (mean, 13 years), 884 IHD cases were identified through hospital records, reported hospital stays, or death certificates.
Results: Women reporting any amount of alcohol use had about a 20% decrease in risk of IHD incidence compared with abstainers. Using a Cox regression model to adjust for known cardiovascular risk factors, this relative risk of IHD remained essentially unchanged. The greatest reduction in the risk of IHD (36% to 39%) was among women who consumed about half to two drinks per day compared with abstainers.
Conclusions: This study of a nationally representative sample with a mean follow-up of 13 years and a substantial number of IHD cases suggests that moderate alcohol use decreases the risk of IHD. However, the risk and benefits of moderate alcohol consumption need to be viewed within a broader perspective especially since the potentially harmful effects of alcohol have been well documented.

(1993:153:1211-1216) R. Garg, MD, MS, et al, the Clinical Trials Branch, DECA, National Heart, Lung, and Blood Institute, National Institutes of Health, Bethesda, MD 20892.

Discussion of Preferences for Life-Sustaining Care by Persons With AIDS: Predictors of Failure in Patient-Physician Communication

Objectives: To assess the determinants of communication about resuscitation between persons with acquired immunodeficiency syndrome (AIDS) and their physician.
Design and Setting: Structured patient interview at a staff-model health maintenance organization (HMO), an internal medicine group practice at a private teaching hospital, and an AIDS clinic at a public hospital.
Patients: 289 persons with AIDS.
Main Results: Only 38% of patients had discussed their preferences for resuscitation with their physician. Using logistic regression, we found that patients were less likely to have discussed resuscitation with their physician if they were nonwhite (odds ratio [OR], 0.49; 95% confidence interval [CI], 0.24 to 0.99), had never been hospitalized (OR, 0.52; 95% CI, 0.27 to 0.99), or were cared for in the HMO (OR, 0.44 relative to the private teaching hospital; 95% CI, 0.23 to 0.82). Patients were more likely to have discussed their preferences if they were not currently taking zidovudine (OR, 1.76; 95% CI, 1.02 to 3.03) and if they had decided to defer life-sustaining therapy (OR, 2.30; 95% CI, 1.35 to 3.91). Among nonwhites, those with a nonwhite physician were more likely to have discussed

resuscitation (OR, 4.38; 95% CI, 1.13 to 16.93). Of patients who had not discussed their preferences for life-sustaining care, 72% wanted to do so. Patient desire for discussion of this issue did not vary by race, severity of illness, hospitalization status, use of zidovudine, or site of care.

Conclusions: A majority of persons with AIDS in this study had not discussed their preferences for life-sustaining care with their physician, despite the desire to do so. Interventions to improve patient-physician communication about resuscitation for nonwhites and other groups at risk of inadequate discussion might lead to clinical decisions that are more consistent with patient preferences.

(1993;153:1241-1248) J. S. Haas, MD, MS, et al. Reprint requests to A. M. Epstein, MD, MA, Department of Health Care Policy, Harvard Medical School, Parcel B, First Floor, 25 Shattuck St, Boston, MA 02115.

Hormone Replacement Therapy and the Risk of Stroke: Follow-up of a Population-Based Cohort in Sweden

Background: The protective effect of postmenopausal estrogen replacement therapy on coronary heart disease has been shown in several studies. However, the effect on stroke is more controversial, and data on estrogen-progestin combinations are sparse.

Methods: A total of 23 088 women living in the Uppsala (Sweden) Health Care Region were identified from pharmacy records as having been prescribed noncontraceptive estrogens during 1977 through 1980. They were followed up from 1977 to 1983 for admissions to the hospital because of a first stroke (*International Classification of Diseases, Eighth Revision,* codes 430 through 438 and 344). The mean observation time was 5.8 years. The expected number was based on person-years in the cohort and incidence rates in the population of the region.

Results: Overall, 361 cases of first stroke were observed in the cohort, as compared with 403.2 expected (relative risk [RR], 0.90; 95% confidence limits, 0.81, 0.99). The RR for acute stroke (*International Classification of Diseases, Eighth Revision,* codes 431 through 436) was 0.85 (0.75, 0.97). In women younger than 60 years at entry who were prescribed estradiol compounds (1 to 2 mg) or conjugated equine estrogens (0.625 to 1.25 mg), the risk of any stroke was reduced by almost 30% (RR, 0.72; 0.58, 0.88) and the risk of acute stroke was reduced by 40% (RR, 0.61; 0.46, 0.79). Women prescribed a combined estradiol-levonorgestrel brand also had a lowered risk of stroke (RR, 0.61; 0.40, 0.88). Weak compounds (mainly estriol) showed no stroke-protective effect, nor was there any relationship between hormone replacement and risk of subarachnoid hemorrhage.

Conclusion: Hormone replacement therapy with potent estrogens alone or cyclically combined with progestins can, particularly when started shortly after menopause, reduce the risk of stroke.

(1993:153:1201-1209) M. Falkeborn, MD, et al. Reprints not available.

AMERICAN JOURNAL OF DISEASES OF CHILDREN

A 2- to 3-Year Outcome After Bronchiolitis

Objective: To determine the risk factors and short-term outcome until 3 years of age for subsequent wheezing in children with early childhood bronchiolitis or pneumonia.

Design: Prospective follow-up of a patient group.

Setting: University hospital providing primary care for all pediatric patients of a defined area.

Patients: One hundred twenty-seven children under 2 years of age hospitalized owing to wheezing (n=83) or pneumonia (n=44) during 12 months in 1981 to 1982. One hundred eight children completed the prospective follow-up until 3 years of age.

Interventions: None.

Main Results: The wheezing and pneumonia groups had equal viral and bacterial etiologic findings. History of wheezing, atopic eczema, and elevated serum IgE levels were more common in patients with wheezing than with pneumonia. Subsequent wheezing was seen after bronchiolitis in 76% (61 of 80) of the children at 1 to 2 years of age and in 58% (44 of 76) at 2 to 3 years of age. The respective figures were significantly lower, 9% (three of 33) and 16% (five of 32), in patients with pneumonia. An analysis of risk factors did not reveal any with a significant effect on subsequent wheezing.

Conclusions: Subsequent wheezing is common after bronchiolitis, but rare after early childhood pneumonia, although caused by the same viruses or bacteria. Atopic diathesis is the host factor associated with initial wheezing. No genetic or environmental risk factor had significant association with later wheezing.

(1993;147:628-631) M. Korppi, MD, et al. Reprints not available.