Bradycardia due to cholinesterase inhibitors: identify adverse effects and take them into account

Abstract

- The cholinesterase inhibitors donepezil, rivastigmine and galantamine have a modest and transient benefit in Alzheimer’s disease. Their known adverse effects include bradycardia.

- A Canadian case-control study conducted between 2003 and 2008 showed a statistically significant increase in the risk of hospitalisation for bradycardia among patients who had been taking a cholinesterase inhibitor for less than 3 months, compared with patients who had stopped taking a cholinesterase inhibitor more than 6 months previously.

- After hospital discharge, more than half of these patients were again prescribed a cholinesterase inhibitor, and 4% of them were re-admitted for bradycardia.

- In practice, when an adverse effect has been identified and treated, this information must be shared and taken into account by all those involved in the patient’s subsequent management.

In practice: identify adverse effects and take them into account. Bradycardia is a predictable adverse effect associated with cholinesterase inhibitors and is therefore, to some extent, avoidable. Rechallenge entails a risk of recurrence.

When an adverse effect has been identified and treated, this information must be shared and taken into account by all those involved in the patient’s subsequent management (7).

A Canadian case-control study. A case-control study was conducted in the province of Ontario. It focused on patients at least 67 years of age who had been hospitalised for bradycardia between 1 January 2003 and 31 March 2008 after taking a cholinesterase inhibitor during the 9 months preceding hospitalisation (6). For each “case” (a patient hospitalised for bradycardia), the authors recruited 3 matched controls (patients hospitalised without bradycardia) (6).

Among the 161 patients hospitalised for bradycardia, 22 had stopped taking cholinesterase inhibitors at least 6 months previously and 139 had taken a cholinesterase inhibitor during the 3 months prior to admission. Among the 466 controls (patients hospitalised for another reason), 117 had stopped taking cholinesterase inhibitors at least 6 months previously and 349 had taken a cholinesterase inhibitor during the 3 months prior to admission.

Mean age was 83 years and 51% of the patients were women (6).

Hospitalisation for bradycardia twice as frequent in patients having recently started cholinesterase inhibitor therapy. A statistically significant increase in the risk of hospitalisation for bradycardia was found among patients who had taken a cholinesterase inhibitor less than 3 months prior to admission compared to patients who had stopped taking cholinesterase inhibitors at least 6 months preceding hospitalisation (adjusted odds ratio 2.13, 95% confidence interval (CI) 1.29-3.51, p=0.003) (a)(6).

A similar level of risk was found in the subgroups of patients with a history of heart disease (odds ratio 2.25; 95% CI 1.18-4.28; p=0.014) or patients treated with other heart-rate-lowering drugs (odds ratio 2.34; 95% CI 1.16-4.71; p=0.017) (b)(6).

Among the 161 patients hospitalised for bradycardia, 17 (11%) received a pacemaker and 6 (4%) died in hospital (6).

A known but neglected adverse effect. After hospital discharge, more than half of patients (78 out of the 138 patients, after excluding those who received a pacemaker or died) were again prescribed a cholinesterase inhibitor. Three of them (4%) were again hospitalised for bradycardia within the 3 months following hospital discharge (6).

In practice: identify adverse effects and take them into account. Bradycardia is a predictable adverse effect associated with cholinesterase inhibitors and is therefore, to some extent, avoidable. Rechallenge entails a risk of recurrence.

When an adverse effect has been identified and treated, this information must be shared and taken into account by all those involved in the patient’s subsequent management (7).

Selected references from Prescrire’s literature search.

4- Prescrire Rédaction “Syncopes et inhibiteurs de la cholinestérase” Rev Prescrire 2003; 23 (245): 836.