A SYSTEMATIC REVIEW OF RISK FACTORS OF ADVERSE DRUG REACTIONS IN HOSPITALIZED PATIENTS

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ABSTRACT

Adverse drug reactions (ADRs) pose both financial and health encumbrances for patients. Although prevalence and risk factors associated with ADRs have been published in many studies, most of them lack the statistical evidence for predictors. The aim of this study was to review the published literature to determine the risk factors in the adult and elderly population for ADRs. An electronic search of articles published in English language in databases such as Cochrane Database of Systematic Reviews, MEDLINE, EMBASE, Scopus, and Google Scholar was conducted in between January 2001 and April 2018. The search terms used were: “ADR,” “drug-related problems,” “risk factors,” “general adult population,” “elderly patients,” and “hospital admission.” For inclusion in the review, studies had to include an explicit definition of what was considered an ADR and/or an explicit assessment of causality, as well as a clear description of the method used for ADR identification. Polyparmacy was the major risk factor of ADR followed by comorbidities and length of hospital stay.

Keywords: Adverse drug reactions, Risk factors, Elderly patients, Adult patients, Logistic regression.

INTRODUCTION

Patient safety is one of the most essential elements of modern-day health-care systems [1]. With the mounting reliance on medication therapy as the primary intervention for most illnesses, medications may also cause either non-preventable adverse effects or potentially preventable medications errors [1,2]. Adverse drug reactions (ADRs) are common causes of mortality and morbidity worldwide, and its occurrence in real-world medical practice cannot always be predicted by pre-marketing data given that a limited number of selected patients are enrolled in clinical trials for specific indications and monitored for a limited period of time [3]. Various studies in general adult populations have quantified that 5%-7% of all hospitalizations are attributable to ADRs, with over half of these arbitrated to be preventable, and that 3%-6% of ADRs are fatal or have serious health consequences [4-6]. Health-care costs attributable to ADRs have been estimated to be 5%-9% of total inpatient costs per annum [7]. Older people experience greater morbidity with a corresponding increase in medication utilization, resulting in a higher risk of ADRs. The relative physiological change that occurs with aging affects the pharmacokinetics and pharmacodynamics of medications, which may increase the potential for drug toxicity and ADRs [8]. Various definitions are being identified by researchers for ADR, for instance, the US FDA definition described it as “any adverse event for which there is a reasonable possibility that the drug caused the adverse event, reasonable possibility” suggesting a causal relationship between the drug and the adverse event”[9], the World Health Organization (WHO) defines it as “a response to a medicine which is noxious and unintended, and which occurs at doses normally used in man” [10], and as per Edwards and Aronson definition, “ADR is an appreciably harmful or unpleasant reaction, resulting from an intervention related to the use of a medicinal product, which predicts hazard from future administration and warrants prevention or specific treatment, or alteration of the dosage regimen, or withdrawal of the product”[11]. There are various factors that predispose patients to ADRs such as polypharmacy, age, intercurrent diseases, comorbidity, gender, history of ADRs, and length of hospital stays [12]. Although few authors have explored the relationship between the risk factors and ADRs [13-15], there exists a controversial corroboration due to differences in definitions, study settings, study designs, study population, statistical methods, race, and ethnicity [16]. Few studies explored that female gender is the major predictor of adverse reactions [17-20], while other findings documented that patients with age above 65 years had more than 50% of hospitalizations due to ADRs [5,21].

Even though a large number of studies have identified and assessed ADRs, little has been focused on the associated risk factors with appropriate statistical analysis in adult and elderly population. This review was conducted with the aim to determine potential significant risk factors of ADRs during hospitalization in the adult and elderly population.

This review was conducted and reported according to the Preferred Reporting Items for Systematic Reviews and Meta-Analyses guidelines. An electronic search of articles published in English language in databases such as Cochrane database of systematic reviews, MEDLINE, EMBASE, Scopus, and Google Scholar in between January 2001 and April 2018 was conducted. Medical subject heading terminology and other keywords were used for studies published in different databases. The search terms used were: ‘Adverse reactions,’ “ADRs,” “adverse effects,” “drug-related problems,” “risk factors,” “predictive factors,” “general adult population,” ”elderly patients,” and “hospital admission.” The auxiliary search terms used included: “Drug adverse effects,” “drug therapy,” “geriatric,” “hospitalization,” and “emergency admissions.” All the titles and abstracts of identified studies were examined critically for potential relevance. The reference lists of all eligible full-text articles were hand searched and reviewed to locate other relevant original studies. Two reviewers undertook searches independently and assessed and discussed study findings, and the final consensus was reached to ensure the search strategy was accurate and reproducible.

All studies that were peer-reviewed, highly cited, available in English language, and full-text articles were included. Those studies that
reported ADRs either prospectively or retrospectively in hospitalized adult and elderly patients were included, irrespective of hospital department or specialty. For inclusion in the review, studies had to include an explicit definition of what was considered an ADR and/or an explicit assessment of causality, as well as a clear description of the method used for ADR identification. In particular, studies also had to explore factors associated with an increased risk of an ADR statistically through logistic regression (univariate and multivariate).

Studies that looked at ADR-related hospital readmissions were excluded from the review. Those studies with only abstracts were excluded if the full-text article could not be found, as it restricts meaningful evaluation and quality appraisal provided in abstracts. Studies and/or clinical trials that reported adverse reactions in special populations such as pediatric and pregnant women and lactating mothers were excluded. The exclusion of ADRs associated with off-label drug usage were also excluded from the study.

All the titles and abstracts that fulfilled inclusion criteria were assessed critically for relevance of title, year of publication, first author, country of origin, study sample size, study population, study design, and subject age groups. Data were extracted including explicit ADR definition, identification method, risk factors, statistical method and prevalence, and causality assessment using a custom-designed data extraction form. In those studies, where the prevalence was not directly reported, it was calculated by dividing the number of patients identified with an ADR of all included patients. Extracted data were entered into Microsoft Excel 365 for descriptive data analysis. Overall mean ± standard deviation of ADR prevalence was calculated at 95% confidence intervals (CIs).

**ADR ASSOCIATED RISK FACTORS - ADULT POPULATION**

The risk factors were categorized as patient-related and medication-related risk factors. Univariate analysis identified very few significant medication-related risk factors such as polypharmacy [1,15,22,23], non-adherence [1], anti-tuberculosis drugs [23], and ART drugs [23]. Whereas results of multivariate analysis concluded that polypharmacy [1,15,22,23] was the highly influential independent predictor of ADR. Patient-related risk factors such as comorbidities, female gender, body mass index, h/o ADR, length of hospital stay, impaired renal function, number of diagnoses, and dependent living situation were significant [1,15,22,23]. Among these, comorbidity was evidenced as independent predictor in four studies, followed by h/o ADR and length of hospital stay.

**ADR-ASSOCIATED RISK FACTORS - ELDERLY POPULATION**

In this assessment of the effect of predictors in the development of ADRs, under univariate analysis, patient-related determinants were age, female gender, comorbidities, length of hospital stay, renal failure, liver disease, dementia, HFD, heart failure, depression, hyperlipidemia, and increased serum concentration and the medication-related predictors were polypharmacy, number of doses, narrow therapeuticIndex, anticholinergic drugs, antiarrhythmics, and antihyperglycemic drugs, and inappropriate prescription was significant [25-30]. While in the multivariate analysis, age ≥85 years [27], female gender [26], and length of hospital stay [29] were patient-related independent predictors and polypharmacy was the only medication-related independent predictor identified in four studies, in which polypharmacy with 88 drugs was observed as the highly influential predictor in two studies [29,29] and ≥5 drugs was evidenced in a single study [26].

To the best of our knowledge, this is the first kind of systematic review that appraised univariate and multivariate logistic regression in the identification of significant risk factors for ADRs. This search found only 11 studies that met the inclusion criteria, and nearly half of the studies were done in adult population. Studies showed explaining the variations in prevalence rates and risk factors of ADRs.

An overall up to 13.7% of patients admitted to hospital experience an ADR during their hospitalization, while previously conducted systematic review [31] projected that up to 4% of all adult patients admitted to hospital experience an ADR either leading to or during their hospital admission. However, a meta-analysis conducted by Oscanoal et al. [32], in the year 2017, reported that the prevalence of ADR among elderly patients that led to hospital admissions accurately to be 8.7% (95% CI, 7.6-9.8%).

In our review, three unambiguous definitions were being utilized in the studies for ADR identification which might explain the differences in ADR prevalence rate reported. Previous literatures [33] have sufficiently elaborated on the contribution of different fundamental criteria adopted in various setting in the identification of ADR between reported studies with respect to prevalence. Although one study used USFDA definition, there was no significant change in prevalence rate reported owing to the slenderness difference compared to the WHO definition.

**RISK FACTORS OF ADRs**

In our review, overall 80 risk factors were studied among the total population of 20,974, wherein 30 significant risk factors were recognized as potential and 18 as independent predictors of ADRs based on univariate and multivariate logistic regression analysis (Table 1).

**Polypharmacy**

Polypharmacy was the most consistent and highly acknowledged predictor to be listed in almost all the literature to quantify the risk associated with ADR [1,15,24,26-29,34]. In continuation, few studies quoted that polypharmacy is chosen when a patient presents with multiple comorbidities in order to augment the initial therapy and advanced age of patients who may require drugs with varied mechanisms of action [35]. However, polypharmacy intensifies the possibility of ADRs due to drug-drug interactions from 2% to 5% [36-40] and may heighten it up to 9% with each additional prescribed drug thereafter [27]. And also, it can increase the risk of multiple ADRs than single ADR [41]. It is important for the prescribers to ponder on this risk factor, take imperative steps to reduce the risk through usage of combinational drugs, or discontinuation of unnecessary drugs through reevaluating the disease condition of the patients specifically in older adults. Reducing the number of drugs in the prescription is the simplest way of reducing the ADRs [42]. Furthermore, the total number of drugs along with the individual drug’s risk could be incorporated into an electronic algorithm and determining the benefit-to-risk ratio of individual drug therapy is essential to minimize polypharmacy.

**Comorbidities**

Comorbidity was the second most frequently reported significant risk factor for ADR in the adult and elderly patients [1,2,23,25,26,28,30]. However, three studies particularized through the application of multivariate logistic regression to identify it as an independent predictor of ADR but then only in adult patients [1,2,23]. Two authors expressed renal dysfunction and limited sample size as the possible cause of refuting comorbidity as a significant risk factor. Patients with polycomorbidity may have altered pharmacodynamic and pharmacokinetic mechanisms due to drug-disease interaction predisposing them to ADRs and other explanations that require further research in this area.

**Length of hospital stay**

ADRs are considered a serious health hazard in hospitalized patients. From the findings of the review, significant association was built up between the length of hospital stay and ADRs [24,29]. Findings clarified that the length of stay is the proxy measure of comorbidity and chronic illness with an increased number of prescribed drugs at higher doses, reflecting an increased risk of ADR. The probability of adverse reactions increases 6% for every additional day of hospitalization [43], and every 2.2 hospital bed-day of patient was due to ADRs [26]. Length of hospital stays ≥12 days was 2.3 times of the risk for ADR [33], and it has more importance than patient characteristics in the explanation of ADR [44]. To back up this, literature witnessed that about 5% of all hospital
estimation of creatinine clearance to identify the renal function, before altered drug clearance results that may ensue either drug toxicity or patients [1,23,27,30]. The patients with renal impairment display an independent predictor of ADR in both adult patients and elderly the Smith number of ADRs, and it was recognized first time in the year 1966 by It is widely accepted that renal impairment has a direct effect on a polymorbidity, polypharmacy, usage of over the counter drugs, and deteriorating organ function, reduced hepatic and renal clearance, compared to other age groups [22,34,49,50], owing to increased age, the incidence of ADRs was significantly higher in the elderly patients older age was reported as an independent predictor of ADR, evidenced 1.8-8.5 days per patient per ADR. [45-48].

Strengths and limitations Strength of the present review was strict inclusion criteria mandating assessment of risk factor with fitting statistical method and usage explicit definitions of ADR. The number of studies selected was low, as many studies did not mention true sample sizes had to be excluded. Many studies failed to give the appropriate explanation for their insignificance of risk factors. However, our quality assessment of each study was subjected to affirm the independent predictors of ADRs.

CONCLUSION
Review of literature found eleven papers that detailed the following measurable risk factors polypharmacy, comorbidities, length of stay, age, renal impairment, history of ADR, and gender linked with ADRs. Multiple drug regimen is the most frequently documented independent medication-related risk factor of ADR. Renal impairment had non-discrimination in both adult and elderly patients with respect to their risk. Gender is an independent predictor of ADR evidenced in a negligible amount of studies; further, more research is required to find its definite relationship with ADR. Aging increases the risk of ADR in association with multiple diseases and number of drugs. There is a great significance for reevaluation of pharmacotherapy in the elderly patients to reduce the risk of drug-related issues. Researchers and health-care professionals should consider all the factors of drug-related issues for the rationale of treatment.

AUTHOR’S CONTRIBUTION
Manoj Kumar Mudigubba: Conceptualized the article, compiled full literature search, and drafted the manuscript. Mamatha Krishna Murthy: Developed the standards of manuscript. Ann Mary Swaroop: Reviewed and edited the manuscript. Niyantara M: Compiled literature search and evaluated. Saumilb Dahlia: Supervisor of the research work, provided guidance in the preparation of a standard paper.

CONFLICTS OF INTEREST
Authors declared no conflict of interest.

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