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Editor's view—mental and physical wellbeing

What's new in chronic subdural haematoma

In our recently introduced *Best Practice* category, Rickard *et al*. provide the latest insights into chronic subdural haematoma (cSDH) [1], which is projected to become the most common cranial neurosurgical condition by 2030. The authors outline the clinical presentation of cSDH and discuss current treatment options. Whilst burr-hole trephination remains the standard approach for symptomatic cases, Middle Meningeal Artery Embolisation (MMAE) has emerged as a promising minimally invasive alternative. Matching these findings, Raj *et al*. analysed data from the FINISH trial (N = 589) and found that one in five patients failed to regain functional improvement 6 months after cSDH surgery (burr-hole drainage) [2]. Key predictors of poor outcomes included pre-existing dementia, use of a walker, smaller hematoma width and lesser midline shift. Despite this, most patients maintained or improved their residential status and mobility, with nearly all those living independently before surgery remaining so, and over half of those requiring care preoperatively regaining independence. Dementia emerged as a major predictor of poor functional recovery, emphasising the need for improved patient selection and personalised treatment strategies.

MoNoPol or DREAM-START: Dementia and sleep

People with dementia often experience sleep disturbances, negatively impacting mental and physical functioning. Two recent RCTs, MoNoPol-Sleep and DREAMS-START, evaluated multimodal, nonpharmacological intervention to improve sleep in different care settings, with process evaluations conducted to assess implementation.

For MoNoPol-Sleep Wilfling *et al*. examined intervention fidelity, adoption, barriers and facilitators in nursing homes [3]. Whilst implementation was largely successful, fidelity varied across clusters. Daytime activities were the most frequently applied component. Key facilitators included managerial support, motivated staff and collaboration with researchers, whilst barriers included financial and time constraints and low staff motivation.

Amador *et al*. showed that in DREAMS-START, designed for community-dwelling people with dementia and their carers, attendance was high and fidelity strong [4]. Engagement was influenced by competing demands, time constraints and family dynamics.

Both trials demonstrated that structured, multicomponent interventions can be successfully implemented in different care settings, though challenges varied. MoNoPol-Sleep highlighted systemic barriers in institutional care, whilst DREAMS-START emphasised the importance of carer engagement and personalisation.

Mirtazepine to treat insomnia?

Cognitive behavioural therapy for insomnia is the gold standard for treatment of insomnia in young as well as older patients. Both clinicians and patients often prefer the simplicity of medication, but risks associated with hypnotics increase with age. As a potential alternative, Nguyen *et al*. assessed effectiveness and safety of low-dose mirtazapine (7.5 mg) in older adults with chronic insomnia in the MIRAGE study, a double-blind, placebo-controlled trial (N = 60) [5]. Mirtazapine significantly improved sleep parameters (Insomnia Severity Index). However, adherence was a challenge, due to mild but relevant adverse effects. No severe adverse events occurred. Despite the trial's short duration, results support mirtazapine's potential as a therapeutic option for chronic insomnia in older adults. However, limitations include high dropout rates, the short follow-up period and the need for long-term safety data.

Falls, gait, dizziness and blood pressure

Many falls in later life are preventable; however, this requires timely risk stratification and identification and treatment of the underlying cause or causes. In 2022, the first World Falls Guidelines provided a framework and expert recommendations to healthcare and other professionals working with older adults on how to identify and assess the risk of falls [6]. In a prospective cohort study of high-functioning community-dwelling adults (N = 403) Montero-Odasso *et al*. confirmed one of its the key messages, namely 'low risk is not no risk', as 41% of those deemed not-at-risk experienced at least one fall [7]. Notably, older adults with slow gait speed (<1 m/s) in the not-at-risk category had twice the rate of injurious falls compared to those without slow gait. The study highlights the value of routinely assessing gait speed to identify those who may benefit from preventive interventions, even if classified as not-at-risk.

Another observational study (N = 118) by Madden *et al*. aimed at identifying older adults at risk for falls, investigated the association between ambulatory 24-h blood pressure monitoring (ABPM) biomarkers and future falls in older adults with a history of falls [8]. Hypotensive episodes (systolic BP <100 mmHg) were associated with a more

than four-fold increased risk of further falls, whilst lower minimum systolic BP and greater morning BP surge also increased fall risk. Their findings suggest that BP instability, particularly hypotensive episodes and morning BP surges, may be modifiable fall risk factors. Integrating ABPM into falls assessments can potentially enhance fall prevention strategies in older adults.

Finally, although Benign Paroxysmal Positional Vertigo (BPPV) is common in older persons with lived falls experience and routine screening for BPPV as part of a comprehensive falls assessment is recommended [6], implementation in clinical practice is lagging behind. In a mixed-methods study (N = 447) Dale Bignel *et al*. aimed to assess the feasibility of routine BPPV physiotherapy management for older subacute inpatients with a fall history [9]. Two thirds successfully underwent BPPV assessment. Physiotherapists considered BPPV management acceptable (88%), appropriate (90%) and feasible (76%), but noted barriers such as patient factors, time constraints and environmental issues. BPPV was diagnosed in 6% of those assessed.

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