DERBYSHIRE JOINT AREA PRESCRIBING COMMITTEE (JAPC)

Managing Behavioural Problems in Patients with Dementia

Managing Behavioural Problems in Patients with Dementia

(Does **not** cover rapid tranquillisation of acutely disturbed patients with dementia)

Patient has a Behavioural and Psychological Symptom in Dementia (BPSD)
(delusions, hallucinations, agitation, aggression, irritability, etc.) with steady decline in cognition over six months

Yes

Does patient have delirium?
(short history <1 week confusion, hallucinations, delusions with fluctuating cognition)

Yes

Treat any underlying acute medical problem
e.g. UTI, chest infection, side effects of drugs, alcohol or drug withdrawal

Follow guidelines for managing delirium
e.g NICE

No

Look at complete social and lifestyle history **(life story)** and apply **PAIN** approach, then manage or treat:
P = Physical problems? e.g. infection, pain
A = Activity – related? e.g. when dressing, washing
I = Iatrogenic? e.g. side effects of drugs esp. anticholinergics
N = Noise and other environmental factors? e.g. lighting

Behavioural problems unresolved

Consider non-pharmacological approaches
e.g. distraction, leave & return, meaningful activity, one-to-one care, music, aromatherapy, exercise, social interaction. Carer support may improve coping ability of carer(s).

Identify the dominant target symptom group
Psychotic: Delusions/Hallucinations
Depressive +/or apathy: Depressed mood and/or loss of ability to enjoy previously pleasurable activities. May or may not include apathy (listlessness, loss of drive to engage in activities, may be perceived as laziness)
Aggression
Agitation/Anxiety
Sleep Disturbance: Altered sleep pattern. Parasomnias such as REM sleep behaviour disorder (acting out behaviour during REM sleep) may manifest early in some forms of dementia
Other symptoms: e.g. vocalisations, sexual disinhibition, stereotypical movements etc**.**

Could this be Dementia with Lewy Bodies (DLB) or Parkinson's Disease Dementia (PDD)?
Key features: long term (> 6 months) history of vivid visual hallucinations or parkinsonism or fluctuating cognition.
If unsure seek Specialist advice

Only consider pharmacological treatment if psychosis, depression or behaviour is harmful or distressing to the individual or others

Pharmacological treatment - general guidelines and see overleaf

- Using an antipsychotic to manage BPSD may worsen cognitive function and may also increase the risk of cerebrovascular events (~3x) and the mortality rate (~2x). For every 1,000 dementia patients treated with an antipsychotic for 12 weeks, it is estimated up to 200 may show improvement in BPSD but up to an additional 18 people may suffer a stroke (half of which may be severe) and an additional 10 may die. Antipsychotics should be reserved for severe symptoms unresponsive to non-pharmacological strategies (ref.1)
- Antipsychotics should only be used after a full and documented discussion with the patient (if has capacity to understand treatment) and/or family/carer about possible benefits and likely risks. Risk is likely to increase with increasing age **and** if other risk factors are present e.g. diabetes, hypertension, cardiac arrhythmias, smoking and existing evidence of stroke or transient ischaemic attack (TIA) or vascular dementia**.**
- There is evidence that mortality is greater with first generation antipsychotics e.g. Haloperidol than with second generation antipsychotics e.g. Risperidone (ref.2). Give preference to a second generation agent. Use ultra-low dose (usually half the normal elderly dose) and increase every 2-4 days if no response (see specific dose suggestions overleaf)
- Patients who respond to treatment should have the drug cautiously withdrawn after 6 weeks. Halve the dose for one week and if no symptoms emerge stop the drug. Review after 1 week. If symptoms re-emerge reintroduce the drug at starting dose. BPSD can persist and treatment with an antipsychotic may be needed in the long term but should be reviewed every 3 months.
- Evidence from WHELD program (ref. 3) indicates antipsychotic reduction and discontinuation may only derive benefit when combined with person-centred non-pharmacological interventions of social interaction or exercise aiming for at least 1hour/ week
- Patients with Dementia with Lewy Bodies or Parkinson's Disease Dementia are particularly vulnerable to antipsychotic sensitivity reactions and also may have marked extrapyramidal side effects
- The use of **anti-depressants and hypnotics** for BPSD has little evidence base and should follow existing guidelines for their use in elderly patients without dementia. **Both are associated with an increased risk of falling**, a personalised risk/benefit evaluation is prudent. Treatment doses should follow BNF guidelines

Only **Risperidone** is licensed specifically for up to 6 weeks' treatment of aggression in Alzheimer's
For other symptoms, drugs are used which either have been shown to improve BPS in non-dementia subjects or are licensed for cognitive enhancement in dementia

Prescribing Guidelines

Options listed are not licensed for managing BPSD except where indicated by [L]
Evidence levels: 1 = Meta-analysis 2 = RCTs 3 = Other studies 4 = Expert opinion
Always consider individual risk/benefit in the context of falls and cardio/cerebro vascular events

Alzheimer's disease (SDAT)

Key Symptom	First Line	Evidence Type	Second Line	Evidence Type
Depressive	Citalopram	2	Sertraline, Mirtazapine	3
Psychotic	Risperidone	1	Aripiprazole, Olanzapine, [#] Haloperidol, Memantine [L]	2 3 4
Aggression	Risperidone [L]	1	Aripiprazole, Olanzapine, [#] Haloperidol, Carbamazepine [E], Memantine [L]	2 2 3 3
Moderate Agitation/Anxiety	Citalopram	3	Sertraline Trazodone Mirtazapine	3 3 4
Severe Agitation/Anxiety	Risperidone	1	Olanzapine, [#] Haloperidol, Memantine, [L] Short term benzodiazepine as adjunct or alone	2 3 4
Poor Sleep	Zopiclone	3	Temazepam Trazodone	3 2

Dementia with Lewy Bodies (DLB) or Parkinson's disease dementia (PDD) Reviews – refs 4, 5

Key Symptom	First Line Parkinson's	First Line Lewy Body	Evidence Type	Second line Parkinson's	Second Line Lewy Body	Evidence Type
Depressive	* Citalopram		4	* Sertraline		4
Psychotic	* Rivastigmine [L]	Rivastigmine, Donepezil, Galantamine	3	** Quetiapine Aripiprazole ** Clozapine [L]	Benzodiazepine short term adjunct to 1st line agent or alone	3, 4, 2 / 4
Aggression	* Rivastigmine [L]	Rivastigmine, Donepezil, Galantamine	3	Quetiapine Aripiprazole Memantine	Benzodiazepine short term adjunct to 1st line agent or alone	3, 4 / 4
Moderate Agitation/Anxiety	* Rivastigmine [L]	Citalopram	2 / 3	* Citalopram	Rivastigmine, Donepezil, Galantamine Memantine	3 / 3
Severe Agitation/Anxiety	* Rivastigmine [L]	Rivastigmine, Donepezil , Galantamine Memantine	3	Quetiapine Short term benzodiazepine as adjunct or alone	Benzodiazepine short term adjunct to 1st line agent or alone	3 / 4
Poor Sleep	Zopiclone		3			
REM sleep Behaviour Disorder (RBD) See Review – ref 6	Clonazepam					3

***** may worsen motor symptoms of Parkinson's Disease (specialists consider negligible effect of SSRIs in practice)
****** consider reducing levodopa or dopamine agonist dose first
# overall mortality may be greater with 1st generation e.g. Haloperidol than with 2nd generation e.g. Risperidone in dementia. Haloperidol - check ECG
L = Licensed indication. **E** = Enzyme inducer (liver) so care as clinically significant drug interactions possible

Vascular dementia or stroke related dementia

There is little evidence base for the pharmacological treatment of BPSD in these dementias. The cholinesterase inhibitors (Donepezil, Rivastigmine, Galantamine) and Memantine are not licensed in vascular dementia and should not be used. Prescribers are advised to follow the guidance for Alzheimer's Disease keeping mindful of the increased cerebrovascular risk associated with antipsychotics

Other BPSD and other dementias (e.g. Fronto-temporal lobe dementia)

There is little evidence base for the treatment of other BPSD or for the treatment of common BPSD in other dementias. Seek Specialist advice

Dose guidelines in dementia

	Starting dose	Swallowing difficulties	Maximum dose
Risperidone	**250 microgram twice daily**	Liquid 1mg/1ml; Orodisp tab 500mcg, 1mg	**1mg twice daily**
Aripiprazole	**2.5mg once daily (PDD) to 5mg once daily** Cross-titrate if switching antipsychotic Wait 2-3 weeks to assess response (long $t_{1/2}$)	→ Use liquid for 2.5mg dose (or for 7.5mg dose) Liquid 1mg/1ml Orodisp tab 10mg	**10mg once daily**
Olanzapine	**2.5mg once daily**	Orodisp tabs 5mg, 10mg. Use aliquot if 2.5mg or 7.5mg dose	**10mg once daily**
Quetiapine	**12.5mg twice daily**	Crush & give in yoghurt (unlicensed, bitter taste)	**100mg twice daily**
Haloperidol	**500 microgram twice daily, check ECG**	Liquid available in 2 strengths	**1.5mg twice daily**
Clonazepam	**250 microgram nocte**	Disperse tab in water; give immediately (unlicensed)	**2mg nocte**
Trazodone	**50mg per day**	A Licensed liquid formulation available (50mg/5ml), but is expensive, only recommended with true dysphagia	**150mg nocte (sleep)** **300mg/day (anxiety)**

If problems continue, or for further advice, contact local Older Adult Psychiatry Specialist in DHCFT:
Kingsway Hospital (Derbyshire South) Tel. 01332 623700 or Derbyshire North Tel. 01246 515964 or High Peak Tel. 01298 24149

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