

Behaviour Management in Dementia

Where Do Antipsychotics Fit?



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Guidelines/Reviews

Dementia

- ◆ CCCDTD₃ 2006:
<http://www.cccdt.ca/>
- ◆ Tx Mild-Mod 2008:
<http://www.cmaj.ca/content/179/10/1019.full.pdf+html>
- ◆ Tx Severe Alzheimer's 2008:
<http://www.cmaj.ca/content/179/12/1279.full.pdf+html>²
- ◆ NICE (UK) 2006:
<http://www.nice.org.uk/nicemedia/live/10998/30318/30318.pdf>

Other Reviews

Cognitive Impairment:

<http://www.rxfacts.org/professionals/CognitiveImpairment.php>

Pt/Caregiver Resources

First Link Program Alzheimer's
- <http://alzheimer.ca/saskatchewan/>
- <http://www.alzheimer.ca/english/society/FirstLink.htm>

RxFiles Related

Anticholinergic Drug List³
Antipsychotic Chart⁴
BPSD Tx Chart⁵
CATIE-AD Trial Summary⁶
Hypersexuality Tx Chart⁷
Psychotropics Newsletter⁸

Highlights

- 1) Assess for medical causes (eg. Infection^{UTI}, constipation, urinary retention, delirium).
- 2) Look for drug causes (esp. recent med Δ's, but also anticholinergic load)
- 3) Implement non-drug tx before initiating drugs if patient/caregiver in no immediate harm.
- 4) Unrecognized pain? Try oral acetaminophen (650mg q6h while awake, or 1300mg LA am & hs).
- 5) Only certain symptoms are likely to respond to antipsychotics:
 - severe agitation
 - aggression
 - psychosis
- 6) Reassess need for antipsychotics after ~ 3 months as behaviours stabilize (stopping ↓s risk of adverse events)
- 7) Caution with combo & PRN overuse of APs

Background Issues

Behavioural and psychological symptoms of dementia (**BPSD**) create a significant caregiver challenge. Key symptoms include aggression, agitation, psychosis and mood disorders.

Table 1: Common BPSD Neuropsychiatric symptoms

◆ agitation*	◆ resistive	◆ emotional lability
◆ apathy	◆ wandering	◆ paranoid behaviours
◆ aggression*, verbal/physical	◆ intrusiveness	◆ psychosis*, hallucinations / delusions
◆ calling out, screaming	◆ repetitive behaviours	
◆ hostility	◆ vocalizations	
◆ sexual disinhibition	◆ hoarding	
	◆ nocturnal restlessness	

*symptoms with some evidence for benefit of antipsychotics

Approach to Managing BPSD

- Document the target symptom (e.g. DOS form⁹)
- Assess for any triggering factors (See Table 2)
- Identify if symptom requires treatment (e.g. is family/caregiver disturbed or in danger?)
- Use non-pharmacological measures whenever possible (See Table 4, next page.)
- **Is pain a possible contributing factor?**
 - Try regular acetaminophen; reassess at 1 wk
- **If drug treatment required:**
 - Tailor to the target symptom(s)
 - Consider potential harms
 - Start low, go slow; **reassess in 3-7 days** for both beneficial and any adverse effects
 - Try tapering the dose or stopping drug every **3+ months** [taper by 25% every 1-2 weeks]. Some behaviours decline as disease worsens. {If treating acute delirium, stop upon resolution!}

Table 2: Common Triggering Factors in BPSD

Psychosocial		
Distress	Feeling abandoned	Loss of autonomy
Fear of danger		Paranoia
Misinterpretation		
Environmental		
"Bad company"	Excessive demands	Lighting - inadequate
Boredom	Change/lack of routine	Loneliness
Confusing surroundings		Noise
Medical		
B12 / folic acid deficiency	Hypo-thyroidism	Metabolic
Hunger/thirst	Infection (UTI, pneumonia)	Nocturia
Hypercalcemia		Pain
		Constipation
Medications (e.g. rule out drug induced delirium) ¹⁰		
Anticholinergics	Cholinesterase inhibitors	Opioids
Benzodiazepines	Digoxin	Substance abuse
		... & many others

What do we know about the benefits and risks of psychotropic meds in BPSD?

- Evidence for psychotropic use is limited and all classes have limited efficacy and serious adverse event (SAE) concerns. (See Table 3) For an overview see *BPSD chart* (Page 4).⁵

Where do Antipsychotics (APs) Fit?

- AP effectiveness** in BPSD is modest & their role is limited due to SAEs.^{11,12,13,14} See CATIE-AD Trial Summary.⁶
- APs, both typical (e.g. haloperidol) & atypical (risperidone *Risperdal*, olanzapine *Zyprexa* & quetiapine *Seroquel*), have been studied in BPSD.
 - Placebo response rates often ~40%, reflecting high rates of spontaneous resolution & the value of psychosocial input in such trials.¹⁵ [The *more severe* patients may *respond better* to APs.]
 - Of these atypical agents **risperidone** has the most evidence for efficacy (aggression ≤1mg/day & psychosis ≤2mg/day).^{13,16}

Serious Adverse Events (SAEs) for all APs.

- SAEs with APs include stroke^(OR: 1.3-3.1)^{13,17}, seizures, EPS effects, ↑ falls, drowsiness, cognitive decline, pneumonia & death.
- Death may be ↑ with atypical & conventional APs in dementia based on RCTs (OR: 1.2-1.6; AR ≥1% /12 wks; NNH=87/12wks).^{13,18,19,20,21} However observational data is equivocal; some suggest no increase in death for APs typical or atypical.^{22,23,24}

Stopping long-term antipsychotics reduced

- mortality by ~25% at 2 years in long-term follow-up to the **DART-AD RCT**.²⁵ (n=165, age ~85; Alzheimer's patients MMSE-11 on APs for ≥ 3months for BPSD; 2 arms: stop AP & switch to placebo vs AP use x12months; no significant difference in survival at 12 months; survival at 2yrs: 71% vs 46%; NNT=4/2yrs; survival over 2-4.5yrs: 54% vs 38%, NNT=8, CI: 5-42)
- BPSD outcomes: no statistical difference except verbal fluency better in patients who stopped at 6 mos.²⁶ There may have been individual differences (e.g. in the more severe).
 - Remember, if antipsychotic use is restricted, alternative drugs could be just as harmful!

Table 3: Risks of Various Psychotropic Meds

- ◆ Benzodiazepines: falls, fractures, confusion
- ◆ Carbamazepine: falls, many DIs & side effects
- ◆ Antidepressants: ↓sodium, falls, osteoporosis
- ◆ Opioids: delirium; constipation, fractures, ?CV²⁷

Avoid the use of psychotropic meds for BPSD if at all possible. When needed, assess for tolerability in ≤3-7 days & reassess for possible taper and/or discontinuation every 3 months.

