Behaviour Management in Dementia
Where Do Antipsychotics Fit?

October 2011
Reprinted February 2012

Guidelines/Reviews

Dementia
- CCCDTD$_3$ [2006]: http://www.cccdtd.ca/
- Tx Mild-Mod [2008]: http://www.cmaj.ca/content/179/10/1019.full.pdf+html [1]
- 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 List[3]
Antipsychotic Chart[4]
BPSD Tx Chart[5]
CATIE-AD Trial Summary[6]
Hypersexuality Tx Chart[7]
Psychotropics Newsletter[8]

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 dis-inhibition	hoarding	
	nocturnal restlessness	

*symptoms with some evidence for benefit of antipsychotics

Approach to Managing BPSD

- Document the target symptom (e.g. DOS [form 9])
- 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)		
Anticholinergics [10]	Cholinesterase inhibitors	Opioids
Benzodiazepines		Substance abuse
	Digoxin	*...& 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, ?CV [27]

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.