Managing Behavioural Problems in Patients with Dementia

The potential dangers of using antipsychotic drugs in patients with dementia are well known.

Sedation
Increased risk of falls
Increased risk of cerebrovascular events and death
Accelerate cognitive decline

The following is advised when considering treatment with antipsychotic drugs.

• Agitated behaviour can be a sign of acute physical illness, pain, constipation, other physical discomfort, or depression. Screen for and address these factors before doing anything else.

• Non-pharmacological alternatives for management (such as environmental or behavioural strategies) should always be considered first.

• Particular care should be taken to avoid using anti-psychotic drugs in people with Parkinson’s Disease/Lewy Body Dementia.

• Antipsychotic drugs should only be considered if there is risk of harm to self or to others.

• Decide and record what symptom/behaviour you are treating, set up a system for monitoring it (e.g. using simple charts completed by nursing staff or carer), and monitor and record side effects closely (sedation, stiffness, tremor, mobility problems).

• Wherever possible, when prescribing an antipsychotic drug for someone with dementia, the risks and benefits should be discussed with relatives and/or care staff as there is a high level of public concern about the use of these drugs and the decision-making needs to include carers and relatives. Also it is good practice to inform relatives and carers if the antipsychotic drug being prescribed is not licensed for the treatment of behavioural and psychiatric disorders in dementia. If you do decide to prescribe “off licence” ensure you clearly record your reasons for doing so in the clinical notes.

• Once an antipsychotic drug has been started set a review date at which time the use of the drug should be reviewed. Very often behavioural disturbances in dementia are relatively short lived and a short course (e.g. one or two weeks) of an antipsychotic drug is all that is necessary. Don’t continue the drug if it is ineffective after a week’s trial.

• Start with extremely low doses. Low dose risperidone, up to 2mg per day, is licensed for the treatment of behavioural disorders in dementia/older people (although that does not mean it is any safer than any other antipsychotic).
• Patients requiring anti-psychotic medication on a regular basis for more than a week to manage behavioural disorder should in general be assessed by a psychiatric team.

• Avoid phenothiazine drugs such as Chlorpromazine because of their sedative and anti-cholinergic action.

• Patients should be reviewed regularly (at least monthly). Document the therapeutic response and signs of possible adverse events including mobility, falls, sedation, low blood pressure, chest infection, and anticholinergic side-effects.

• Consider reducing or stopping medication if appropriate after 3 months, at the latest.

• If the original reason for prescribing the antipsychotics returns then go through the above points. If initiated in secondary care then specialists should give clear instructions of when to review and stop medication.

Symptom management

<table>
<thead>
<tr>
<th>Key Symptom</th>
<th>First Line</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td>Citalopram, Sertraline, Mirtazapine</td>
</tr>
<tr>
<td>Apathy</td>
<td>Citalopram, Sertraline</td>
</tr>
<tr>
<td>Psychosis</td>
<td>Risperidone, Haloperidol</td>
</tr>
<tr>
<td>Aggression</td>
<td>Risperidone, Haloperidol</td>
</tr>
<tr>
<td>Moderate agitation/ anxiety</td>
<td>Citalopram, Mirtazapine</td>
</tr>
<tr>
<td>Severe agitation/ anxiety (after antidepressant trial)</td>
<td>Risperidone, Haloperidol</td>
</tr>
<tr>
<td>Sleep disturbance</td>
<td>Temazepam, Zopiclone</td>
</tr>
</tbody>
</table>

* Please note - max recommended citalopram dose is 20 mg daily for patient’s ≥ 65 years and 40 mg daily for patients < 65 years

Dosage Guidelines for Antipsychotics in Dementia

<table>
<thead>
<tr>
<th>Antipsychotic</th>
<th>Starting Dose</th>
<th>Optimal Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risperidone</td>
<td>250 microgram bd</td>
<td>500 microgram bd</td>
</tr>
<tr>
<td>Haloperidol</td>
<td>500 microgram bd</td>
<td>500 mcg bd</td>
</tr>
<tr>
<td>Quetiapine (not licensed)</td>
<td>25mg od</td>
<td>25 - 150mg daily</td>
</tr>
<tr>
<td>Olanzapine (not licensed)</td>
<td>2.5mg od</td>
<td>2.5-5 mg daily</td>
</tr>
</tbody>
</table>
MANAGING BEHAVIOUR PROBLEMS IN PATIENTS WITH DEMENTIA

Patient has Behavioural and Psychiatric Symptoms in Dementia (BPSD) (delusions, hallucinations, agitation, aggression, irritability with steady decline in cognition over 6/12)

Does patient have a delirium? (short history < 1 week, confusion, hallucination, delusion with fluctuating cognition)

Treat underlying acute medical problems, e.g. UTI, chest infection, side effect of drugs, alcohol, drug withdrawal etc

Anticholinergic drugs impair cognitive function - if possible STOP or REDUCE
- Tricyclic antidepressants – SSRI (citalopram) safer choice
- Antipsychotics – see below - especially Chlorpromazine
- Antihistamines – especially chlorpheniramine
- Antiparkinsonian drugs – especially Orphenadrine, procyclidine and trihexyphenidyl
- Antispasmodics – Oxybutinin, Hyoscine
- Bronchodilators – Theophylline
- Digoxin
- Furosemide

Behavioural problems unresolved

Consider non-pharmacological approaches such as distraction, activity, leave and return, one to one care, music, aromatherapy. Carer support may improve coping ability of carers

Only consider pharmacological treatment if there is psychosis, depression or behaviour that is harmful or distressing to the individual or others. Referral to CMHT may be appropriate before prescribing antipsychotics

Apply PAIN approach and manage or treat:
- P = Physical problems e.g. infection, pain
- A = Activity related e.g. dressing, washing
- I = Iatrogenic e.g. side effects of drugs e.g. anticholinergics
- N = Noise and other environmental factors e.g. lighting

General guidelines for the prescription of antipsychotic drugs in dementia

These Guidelines aim to reduce antipsychotic prescribing in line with recommendation one in the Department of Health Time for Action report

If the patient you are seeing is not known to the Dementia Service consider a referral. This will enable prompt assessment for appropriate non-pharmacological treatment and for cholinesterase Inhibitor therapy

Remember that depression and anxiety are common in dementia and it is often safer to use an antidepressant as a first line treatment before considering antipsychotic medication.

Care should be taken to avoid using antipsychotic drugs in people with Parkinson’s Disease/ Lewy Body dementia

When possible, before prescribing an antipsychotic drug for someone with dementia, the risks and benefits should be discussed with relatives and/or care staff. It is important to inform relatives and carers if the antipsychotic drug being prescribed is not licensed for the treatment of behavioural problems in dementia. If you do decide to prescribe “off licence” ensure you clearly record your reasons for doing so in the clinical notes.

There are several risks associated with the use of antipsychotic drugs in dementia. They can cause sedation, increase the risk of falls, increase the risk of cerebrovascular events and sudden death. The long term use of such drugs can accelerate cognitive decline.

The only product licensed for the treatment of behavioural problems in dementia is Risperidone. It is licensed for short term treatment of up to 6 weeks in patients unresponsive to non pharmacological approaches and when there is a risk of harm to self or others. Both Risperidone and Olanzapine have been linked to an increased risk of cerebrovascular events. It is likely that all antipsychotic drugs are associated with an increased risk of stroke.

Approved by Peterborough Prescribing Forum November 2011