HYPNOTIC USE IN PEOPLE WITH DEMENTIA
– ARE OUR EYES OPEN TO THE PROBLEM?

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Introduction: antipsychotics in dementia

The National Dementia and Antipsychotic Prescribing Audit (2012) showed that, in England, there was a substantial fall in the percentage of people with dementia prescribed anti-psychotic drugs. This steady trend commenced in 2006/7 i.e. before the publication of Time for Action (Banerjee, 2009). Caution is needed in interpreting these figures, because the absolute number of people with dementia on the Quality and Outcomes Framework register in England increased by 38% over the same period. The Audit also showed a substantial reduction in the proportion of people newly diagnosed with dementia who received an anti-psychotic within a year of diagnosis.¹ A key question remains; what change has there been in anti-psychotic use in the population most likely to receive these drugs i.e. people with moderate or severe dementia, particularly those who have received more than one prescription?

What about other psychotropics?

Anti-depressants

The Audit demonstrated a reduced percentage of people with dementia taking anti-depressants, though the magnitude of this reduction was less than the increase in people with a diagnosis.² Figures from Scotland (Guthrie et al., 2010) showed a steady increase in anti-depressant use from 2001 to 2010 with some reduction thereafter. The issue is complicated by the inclusion of Amitriptyline and Trazodone in this class of drugs, both of which are used for indications other than depression. But the figure for anti-depressant use (circa 40%) remains hard to justify, especially in light of the HTA-SADD study which suggested we need to reconsider how we use antidepressants as first-line treatment for people with dementia who are depressed (Banerjee et al., 2011). A recent nursing home study from the Netherlands (van Asch et al., 2013) acknowledged the increased use for depressive symptoms in people with dementia compared to those without dementia, and suggested that around 18% of people with dementia were treated with anti-depressants.

¹ chart 5
² chart 8
The use of hypnotics

Almost unnoticed in this mix is the use of hypnotics, and figures were not reported separately in the National Prescribing Audit (2012). The percentage of people with dementia receiving hypnotics in Scotland has varied little since 2002 (Guthrie et al., in press) but, as the number of people diagnosed with dementia has increased substantially over that period, the absolute number of people with dementia being treated with hypnotics has also increased considerably.

Rates of hypnotic usage are high internationally particularly in care homes, e.g. Slovenia – 47% (Ster, 2011); Tasmania – 27.5% (Westbury et al., 2010); Helsinki – 22.8% (Bell et al., 2010); Australia – 33% (Nishtala et al., 2009). The latter figure may be consistent over many years e.g. Sydney – 32% (Snowdon et al., 1995). Rates of use in long-term hospital settings seldom appear, but one survey (Connelly, 1992) noted a rate of 30% use in 104 long-stay patient with dementia. A more recent publication (Deslandes et al., 2010) from Cardiff described even higher use (68%) though the latter figure included the use of benzodiazepines as anxiolytics.

An excellent review (Lee and Thomas, 2011) described the typical variety of sleep problems in patients with dementia and carers. Sleep disturbance amongst carers was cited as a frequent reason for seeking admission of a patient to a care home. Hypnotic use is higher in care homes with higher staff levels than those with low levels (Zuidema et al., 2011). This paradoxical finding may be pejoratively interpreted as evidence that hypnotics are used for the benefit of staff rather than patients, but further interpretation of these data were not presented.

A review of the treatment of sleep disturbance in Alzheimer’s disease (Salami et al., 2011) once again identified the lack of clinical trials of hypnotics, but also pointed out the relative dearth of evidence to support non-pharmacological alternatives, although issues such as procedural intervention, environmental knowledge and disruption of circadian rhythm in under-stimulated care environments are all known to contribute to sleep disturbance and resolution of these problems may have a significant impact on sleep. Appropriate clinical trials in this area are long overdue.

The risk of falls associated with hypnotics is well described (Sterke et al., 2012; Woolcott et al., 2009) and includes “z-drugs” (Kolla et al., 2013). Increased hospitalisation of people with dementia and increased length of stay is likely to result, especially if delirium is precipitated by the fall.

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Evidence about increased mortality associated with hypnotic use is controversial (Gisev et al., 2011; Taipale et al., 2012). One keynote study linking benzodiazepine use with cancer (Kripke et al., 2012) failed to find a direct link between increased mortality and hypnotic usage, but increasing age was identified as a risk factor.

A number of studies describe interventions to reduce benzodiazepine use (Bell et al., 2011; Tsunoda et al., 2010). Although the interventions themselves have mixed results when reduction in prescribing is measured (Smith and Tett, 2010), none showed deterioration in behaviour as a consequence, though a well-designed placebo-substitution trial would be welcome.

The current evidence base would suggest that hypnotic use in people with dementia is widespread and at a high level internationally. There are no high quality clinical studies which support their use, either versus placebo or versus non-pharmacological interventions. Falls risk and possibly mortality is increased by their use, as is admission to hospital and length of stay. As a group, hypnotics are amongst the most frequently prescribed, potentially inappropriate, medications according to Beers criteria (Fick et al., 2012). Successful withdrawal programmes have been described.

The focus on the reduction of antipsychotic drugs in people with dementia has taken the spotlight away from a drug group whose use has potentially similar adverse consequences as antipsychotic medication, yet which appear to have less evidence to support their benefits. The message is that we may not be doing as well as we think when looking at psychotropic drug usage in people with dementia. When one considers the relative absence of evidence for efficacy and their association with adverse events we should ask whether it is now time for our action to generate a campaign to systematically reduce use of these drugs in people with dementia, particularly in care homes, as the next stage in improving the pharmacological management of aspects of dementia. The author, and the Old Age Faculty, would welcome your opinion.
REFERENCES


Kolla, B. P., Lovely, J. K., Mansukhani, M. P., Morgenthaler, T. I. 2013. Zolpidem is independently associated with increased risk of inpatient falls. Journal of Hospital Medicine, 8 (1), 1-6.


