Dementia & Antipsychotic Medications

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OVERVIEW

- Behavioural and Psychological Symptoms of Dementia
- Management of BPSD
- Medications prone to cause BPSD
- Management of BPSD
  - First line: non-pharmacological
  - Second line: Antipsychotics
- Evidence for antipsychotics
- Side effects
- Treatment plan
- Doses
- Discontinuing therapy
- Dementia with Lewy bodies
- Identifying problems in your facilities
- Drug Usage Evaluations in practice
- Key messages
BEHAVIOURAL DISTURBANCES IN DEMENTIA

- Commonly referred to as “BPSD”

- Other common terms
  - Behavioural disturbances of dementia
  - Non-cognitive symptoms of dementia
  - Neuropsychiatric symptoms of dementia
BEHAVIOURAL DISTURBANCES IN DEMENTIA

Definition:

“symptoms of disturbed perception, thought content, mood, or behaviour frequently occurring in patients with dementia”¹

BEHAVIOURAL DISTURBANCES IN DEMENTIA

- Includes:
  - Calling out, shouting,
  - Wandering, pacing
  - Inappropriate touching, sexual behaviours
  - Delusions, hallucinations, anxiety
  - “Sundowning”
  - Depression
  - Restlessness
BEHAVIOURAL DISTURBANCES IN DEMENTIA

- Affect up to 61% of patients with dementia\(^1\)
- In a recent Australian study\(^2\) reviewing more than 10000 residents of hostels and nursing homes staff rated:
  - 32% of residents as having mild behavioural disturbance,
  - 22% as moderate,
  - 14% as severe.

MANAGEMENT OF BPSD

- Review possible causes of the distress:
  - Pain
  - Hyponatraemia (side effect of lot’s of common medicines in the elderly)
  - Constipation
  - Infection
  - Environmental factors (noise, lights, conflicts with others)
  - MEDICATIONS
MEDICATIONS PRONE TO CAUSE BPSD

- Anticholinergic medications
  - Tricyclic antidepressants (amitriptyline, nortriptyline, doxepin, dothiepin)
  - Oxybutynin
  - Tiotropium, ipratropium
  - Prochlorperazine, promethazine
MEDICATIONS PRONE TO CAUSE BPSD

- Anti-Parkinson's medications
  - Levodopa/carbidopa
  - Levodopa/benserazide
  - benztropine
MEDICATIONS PRONE TO CAUSE BPSD

- Benzodiazepines
  - Diazepam, Temazepam, Oxazepam
  - Clonazepam, Nitrazepam, Flunitrazepam

- Others
  - Tramadol
MANAGEMENT OF BPSD

- **First line:**
  - Non-pharmacological management
    - Music therapy
    - Pets therapy
    - Exercise
    - Regular social activities
MANAGEMENT OF BPSD

- Second line:
  - Antipsychotics
    - Risperidone, Haloperidol, Olanzapine
  - Should be used only if the behaviours pose a serious risk or causes severe distress
ANTIPSYCHOTICS - EVIDENCE

- Limited efficacy to support use of antipsychotics in management of BPSDs
- Symptoms with evidence
  - Aggression, agitation, hallucinations, delusions
- Placebo response rates in trials were 20% or higher, indicating that BPSD often resolves spontaneously within 12 weeks

Placebo response rates in trials were 20% or higher, indicating that BPSD often resolves spontaneously within 12 weeks\(^1\)

\(^1\) National Prescribing Service 2007, PPR 37: Role of antipsychotics in managing behavioural and psychological symptoms of dementia.
Troublesome symptoms are less likely to respond
- Wandering
- Shouting
- Incontinence
- Touching
- Withdrawal
ANTIPSYCHOTICS – SIDE EFFECTS

- Side effects are significant
  - Increased risk of death\(^1\)
    - Cardiovascular
    - Cerebrovascular
    - Infections
    - Sudden death

1. Rossi S (ed) 2010 Australian Medicine Handbook AMH Ltd Pty South Australia
ANTIPSYCHOTICS – SIDE EFFECTS

- A meta-analysis of 15 placebo-controlled trials found a small but statistically significant increase in risk of death compared with placebo.¹
  - One death was associated with antipsychotic therapy for every 100 patients treated over 10–12 weeks.¹
  - Risk greatest with olanzapine, risperidone

ANTIPSYCHOTICS – SIDE EFFECTS

- Increased risk of stroke (fatal and non-fatal) and TIAs
  - Risk greatest with risperidone and olanzapine but haloperidol may carry similar risks

- Increased falls risk

ANTIPSYCHOTICS – SIDE EFFECTS

- Parkinsonian symptoms (abnormal gait, shuffling)
- Type 2 diabetes
- Sedation
- Confusion
- Urinary incontinence
- Hostility
- Weight gain

Before commencing antipsychotics

- Determine specific behaviours to be targeted
- Review past medical history to assess risk versus benefit
- Measure baseline weight, BGLs, cholesterol levels
- Document BP
ANTIPSYCHOTICS – TREATMENT PLAN

- After commencing therapy:
  - Frequently review targeted behaviour
    - Response expected within 1-2 weeks
    - Clinical improvement within 12 weeks\(^1,2\)
  - Monitor to ensure side effects are tolerated

Australian Therapeutic Guidelines\(^1\) recommend this following:

<table>
<thead>
<tr>
<th>Antipsychotic</th>
<th>Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risperidone</td>
<td>0.5-2mg/day (in one or two divided doses)</td>
</tr>
<tr>
<td>Olanzapine</td>
<td>2.5-10mg /day in one or two divided doses</td>
</tr>
<tr>
<td>Haloperidol</td>
<td>0.5mg at night up to 2mg twice daily</td>
</tr>
</tbody>
</table>

ANTIPSYCHOTICS - COST

- Risperidone requires authority prescription
- Olanzapine not TGA listed for use for BPSD
  - Approved for bipolar and schizophrenia only
  - In the top 20 drugs for PBS expenditure for last 2 years!¹

ANTIPSYCHOTICS – TREATMENT PLAN

- Start with lowest dose
- Preferable at night to reduce sedation during the day
- Slowly titrate dose every 2-3 days until symptoms controlled or maximum dose of range reached

ANTIPSYCHOTICS – TREATMENT PLAN

- Use minimum effective dose
- Although common, minimal evidence to support PRN dosing

ANTIPSYCHOTICS – TREATMENT PLAN

- Review use of antipsychotics every three months:
  - Discontinue antipsychotic if:
    - If no change to targeted behaviour
    - BPSD stable (often temporary symptoms)
      - Many studies show that patients discontinued on therapy show no worsening in BPSD

DISCONTINUING THERAPY

- Discontinuing therapy
  - Do not cease abruptly
  - Reduce dose by 50% every two weeks
  - Stop after two weeks on minimum dose

DEMENTIA WITH LEWY BODIES

- Accounts for approximately 10% of all dementias
- Increased risk of extrapyramidal side effects and neuroleptic malignant syndrome with typical antipsychotics haloperidol

IDENTIFYING PROBLEMS IN YOUR FACILITIES

- Regular Psychotropic use audits
  - Commonly completed by RMMR service provider
- Drug Usage Evaluation
  - National Prescribing Service published a DUE for antipsychotic use for the management of behavioural and psychological symptoms of dementia
Putting DUE into practice

- We recently completed the DUE at one of the local 70 bed RACF
  - 40 patients were included
  - 30% patients were prescribed an antipsychotic for BPSD, other indications were excluded
  - High levels of prescribing of medications known to cause/exacerbate BPSD were found
  - Nil documentation of targeted behaviours
  - Minimal documentation of alternative non-drug therapies
After identifying the problem,
- The findings were presented to the Medication Action Committee
- Individual education sessions were completed with nursing and medical staff utilising the NPS facilitator
DRUG USAGE EVALUATION IN PRACTICE

Results

- 50% reduction in the prescribing of antipsychotics
- Documentation of targeted behaviour increased to 75%
- Increased uptake of non-pharmacological options and documentation
KEY MESSAGES

- BPSD is common in dementia
- Review any causes
  - Ask for a medication review
- First line treatment is non-drug options
- Second line treatment: antipsychotics
- Low doses are used
- Significant side effect profiles for all antipsychotics
KEY MESSAGES

- Benefit: Risk ratio must be assessed for each patient
- Limited evidence to support efficacy
- Regular review of BPSD and therapy is required
  - BPSD often temporary
  - Discontinue therapy if no response after 12 weeks
  - Taper by 50% every two weeks