DERBYSHIRE JOINT AREA PRESCRIBING COMMITTEE (JAPC)

Managing Behavioural Problems in Patients with Dementia

Behavioural and psychological symptoms in dementia (BPSD)
(delusions, hallucinations, depression, agitation, sleep problems associated with a steady decline in cognition)

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Review patient including physical, social and lifestyle history

P - Pain
I - Infection
N - Nutrition
C - Constipation
H - Hydration
M -Medication
E - Environment
S - Sleep

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Does the patient have delirium?

(Sudden onset with a short history (<1 week), confusion, hallucinations with fluctuating cognition)

Yes →

Treat underlying cause

e.g., infection, side effects from medication

No ↓

Treat with non-pharmacological approaches

e.g., distraction techniques, meaningful activities, leave and return, relaxation, music, aromatherapy, carers support

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Consider pharmacological treatments only if depression, psychosis, or behaviour is harmful or distressing to the patient or others

Ensure risks of prescribing are reviewed, discussed with the patient/carer, and documented

Summary of treatment options

Alzheimer's

Key Symptom	First Line	Second Line
Depressive	Citalopram	Sertraline, Mirtazapine
Psychotic	Risperidone	Aripiprazole, Olanzapine, Haloperidol, Memantine
Aggression	Risperidone	Aripiprazole, Olanzapine, Haloperidol, Carbamazepine, Memantine
Moderate Agitation/Anxiety	Citalopram	Sertraline Trazodone Memantine
Severe Agitation/ Anxiety	Risperidone	Olanzapine, Haloperidol, Memantine, Short term benzodiazepine as adjunct or alone
Poor Sleep	Zopiclone	Temazepam Trazodone

Dementia with Lewy Bodies or Parkinson's disease dementia

Key Symptom	First Line Parkinson's	First Line Lewy Body	Second line Parkinson's	Second Line Lewy Body
Depressive	Citalopram		Sertraline	
Psychotic	Rivastigmine[L] Donepezil, Memantine Galantamine	Rivastigmine, Donepezil, Galantamine	Quetiapine Aripiprazole Clozapine	Benzodiazepine short term adjunct to 1st line agent or alone
Aggression	Rivastigmine[L] Donepezil, Memantine Galantamine	Rivastigmine, Donepezil, Galantamine	Quetiapine Aripiprazole Memantine	Benzodiazepine short term adjunct to 1st line agent or alone
Moderate Agitation/ Anxiety	Rivastigmine[L] Donepezil, Memantine Galantamine	Citalopram	Citalopram	Rivastigmine, Donepezil, Memantine Galantamine
Severe Agitation/ Anxiety	Rivastigmine[L] Donepezil, Memantine Galantamine	Rivastigmine, Donepezil, Memantine Galantamine	Quetiapine Short term benzodiazepine as adjunct or alone	Benzodiazepine short term adjunct to 1st line agent or alone
Poor sleep	Zopiclone			
REM sleep behaviour disorder	Clonazepam Melatonin (Circadin MR) GREY following specialist recommendation.			

[L] – licensed for indication. All other medications unlicensed but recommended by NICE NG71

Vascular dementia or stroke related dementia
There is little evidence base for the pharmacological treatment of BPSD in these dementias. The cholinesterase inhibitors (Donepezil, Rivastigmine, Galantamine) and Memantine are not licensed in vascular dementia and should not be used. Prescribers are advised to follow the guidance for Alzheimer's Disease keeping mindful of the increased cerebrovascular risk associated with antipsychotics.

Other BPSD and other dementias (e.g., Fronto-temporal lobe dementia)
There is little evidence base for the treatment of other BPSD or for the treatment of common BPSD in other dementias. Seek Specialist advice.

Dose guidelines in dementia

	Starting dose	Maximum dose
Risperidone	**250 micrograms twice daily**	**1mg twice daily**
Haloperidol	**500 micrograms twice daily, check ECG**	**1.5mg twice daily**
Aripiprazole	**2.5mg once daily to 5mg once daily** Cross-titrate if switching antipsychotic Wait 2-3 weeks to assess response (long half-life)	**10mg once daily**
Olanzapine	**2.5mg once daily**	**10mg once daily**
Quetiapine	**12.5mg twice daily**	**100mg twice daily**
Clonazepam	**250 microgram nocte**	**2mg nocte**
Trazodone	**50mg per day**	**150mg nocte (sleep)** **300mg/day (anxiety)**

Behavioural and psychological symptoms in dementia (BPSD) are a spectrum of symptoms including delusions, hallucinations, depression, agitation, sleep problems associated with a steady decline in cognition that can be distressing to the patient and those around them. This guideline does not cover drug management of acutely disturbed patients with dementia requiring parenteral medication (rapid tranquilisation).

Prior to treating with non-pharmacological and pharmacological options, the patient should be reviewed, and other possible causes of the distress should be ruled out or treated where appropriate e.g., urinary tract infection, environmental causes, side effects to medication or withdrawal from drugs or alcohol. If a sudden onset with fluctuating cognition and psychotic symptoms this is likely to be delirium. See the NICE delirium guidance for more information and treat cause accordingly.

The PINCHMES mnemonic can be useful in identifying possible causes of the distress/delirium.
P - Pain
I - Infection
N - Nutrition
C - Constipation
H - Hydration
M - Medication
E - Environment
S - Sleep

Once a delirium has been treated or ruled out, the patient should be reviewed ensuring adequate knowledge of the patients social and lifestyle history. Non-pharmacological approaches should be considered first line e.g., distraction techniques, meaningful activities, leave and return, relaxation, music, aromatherapy and carers support.

If the symptoms are over 6 months in duration with a history of vivid visual hallucinations, Parkinson's Disease or fluctuating cognition, the patient maybe experiencing Lewy Bodies or Parkinson's Disease Dementia. If unsure specialist help should be sought.

Pharmacological treatment should only be considered if the symptoms are harmful or distressing to the patient or others. If symptoms are complex or prolonged, refer to local older adult community mental health team.

Prescribing considerations

- Using an antipsychotic to manage BPSD may worsen cognitive function and may also increase the risk of cerebrovascular events (~3x) and the mortality rate (~2x). For every 1,000 dementia patients treated with an antipsychotic for 12 weeks, it is estimated up to 200 may show improvement in BPSD but up to an additional 18 people may suffer a stroke (half of which may be severe) and an additional 10 may die. Antipsychotics should be reserved for severe symptoms unresponsive to non-pharmacological strategies (ref.1)
- Antipsychotics should only be used after a full and documented discussion with the patient (if has capacity to understand treatment) and/or family/carer about possible benefits and likely risks. Risk is likely to increase with increasing age **and** if other risk factors are present e.g., diabetes, hypertension, cardiac arrhythmias, smoking and existing evidence of stroke or transient ischaemic attack (TIA) or vascular dementia**.**
- There is evidence that mortality is greater with first generation antipsychotics e.g., Haloperidol than with second generation antipsychotics e.g., Risperidone (ref.2). Give preference to a second-generation agent. Use ultra-low dose (usually half the normal elderly dose) and increase every 2-4 days if no response (see specific dose suggestions on summary page)
- Patients who respond to treatment should have the drug cautiously withdrawn after 6 weeks. Halve the dose for one week and if no symptoms emerge stop the drug. Review after 1 week. If symptoms re-emerge reintroduce the drug at starting dose. BPSD can persist and treatment with an antipsychotic may be needed in the long term but should be reviewed every 3 months.
- Evidence from WHELD program (ref. 3) indicates antipsychotic reduction and discontinuation may only derive benefit when combined with person-centred non-pharmacological interventions of social interaction or exercise aiming for at least 1hour/ week
- Antipsychotics do not help with repetitive vocalisations, wandering, social withdrawal, distress and anxiety during personal care or disinhibition.
- Patients with Dementia with Lewy Bodies or Parkinson's Disease Dementia are particularly vulnerable to antipsychotic sensitivity reactions and may have marked extrapyramidal side effects
- The use of anti-depressants and hypnotics for BPSD has little evidence base and should follow existing guidelines for their use in elderly patients without dementia. **Both are associated with an increased risk of falling**; a personalised risk/benefit evaluation is essential, with appropriate follow up monitoring and review. Treatment doses should follow BNF guidelines
- Memantine may be started in patients already prescribed an acetylcholinesterase inhibitor

- **Risperidone** is licensed specifically for up to 6 weeks' treatment of aggression in Alzheimer's. **Haloperidol** is licensed for persistent aggression and psychotic symptoms in Alzheimer's and vascular dementia for up to 6 weeks. For other symptoms, drugs are used which either have been shown to improve BPS in non-dementia subjects or are licensed for cognitive enhancement in dementia.

If problems continue, or for further advice, contact local Older Adult Psychiatry Specialist in DHCFT:
Kingsway Hospital (Derbyshire South) Tel. 01332 623700 or Derbyshire North Tel. 01246 515964 or High Peak Tel. 01298 24149

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