Strategic Use of Antipsychotics in Patients with Dementia (cont'd from page 2)

However, they are associated with a number of major adverse outcomes e.g. sedation, parkinsonism, gait disturbance, dehydration, falls, chest infections, accelerated cognitive decline, stroke, and death. Patients and caregivers should be informed of these risks.

Antipsychotics should only be continued for persistent and severe symptoms that have a major impact on safety. The goal of longer-term management beyond 6-12 weeks is to continue treatment in order to maintain a patient's function and quality of life. This is to be done with the least effective dosage and for the shortest possible duration, while maintaining safety as well as optimal physical and mental health. Of the atypical antipsychotics, only risperidone has Health Canada approval for short-term use for aggression ± psychosis. Risperidone and olanzapine have a stronger evidence base than quetiapine, but quetiapine is often chosen preferentially in patients with DLB or PDD due to an increased risk of extrapyramidal side effects in these patients.

The benefit of long-term use beyond 12 weeks is not known. Longer term trials (up to 12 months) have not shown consistent benefit. Symptoms often fluctuate and are unstable over time, particularly in the case of Alzheimer's dementia, where hallucinations tend to resolve over a period of a few months, but delusions, aggression, and agitation may be more persistent. Therefore, long-term antipsychotic therapy beyond 6 months should only be undertaken with meticulous behavioral charting and documentation of the need for antipsychotic therapy. Careful consideration and documentation of the benefits and risks of long-term therapy are critical. Several national and international guidelines now recommend periodic attempts to taper the antipsychotic medication and monitoring for breakthrough symptoms.

References:

[i] Alzheimer Society of Canada. Rising Tide: The Impact of Dementia on Canadian Society. Toronto (ON): The Society; 2010.

[ii] Rabheru K. Behavioral Vital Signs Tool. Toronto (ON): Canadian Academy of Geriatric Psychiatry; http://www.cagp.ca/resources/Documents/Module%202%20-20BVS%20Tool.pdf.

[iii] Rabheru K. Take a 'S-M-A-R-T' approach: Unpredictable course of dementia can be managed. Can Family Physician March 2003; Vol 49: pg. 389

[iv] Rabheru K. Practical tips for recognition and management of Behavioral and Psychological Symptoms of Dementia. Canadian Geriatric Society Journal of CME. 2011; Vol 1, issue 1; pp 17-22

Case Report: Antipsychotic Medication Use from a Long-Term Care Physician Perspective

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Mr. Smith is an 85 year-old male who was admitted to a Long-Term Care Home (LTCH) on Jan 10, 2009. He had a diagnosis of moderate vascular dementia, depression, hypertension and osteoarthritis. On admission to the home, he exhibited exit-seeking behaviours and tearful episodes after his wife's visits, especially in the evening.

Current Medications:

Donepezil 10 mg daily, ASA 81 mg daily, ramipril 5 mg daily, citalopram 20 mg daily, and risperidone 0.5 mg bid.

On admission physical examination, the patient was cooperative, demonstrating a normal affect. There were no active psychoses, such as hallucinations or paranoia. He had symptoms of parkinsonism, with a stooped gait and cogwheel rigidity. There was no postural blood pressure drop, and cardio-respiratory exam was normal. He had a moderate dementia, requiring only some assistance with dressing and grooming, while being fully dependent for bathing and instrumental activities (i.e. phone use, medication-taking, finances). His driver's license was suspended some time ago. An MMSE on admission was 15/30.

Cont'd on page 3

Case Report: Antipsychotic Medication Use from a Long-Term Care Physician Perspective (cont'd from page 3)

Additional collateral history obtained from the patient's wife and prior family physician indicated that risperidone was added when the patient was hospitalized last year following a fall and a fractured humerus. At the time, he was reported to have hallucinations which were distressing, and he would strike out at the nursing staff. The behaviours improved on risperidone, and when he returned home, there had been no recurrence of these symptoms. Citalopram was added later due to tearful episodes and apathy, and this treatment was also helpful.

A baseline work-up was ordered, which included CBC, electrolytes, glucose, creatinine, albumin (to rule out significant liver or nutritional concerns), vitamin B12, TSH (due to depressive symptoms), and ECG (to rule out QT prolongation with use of citalopram). A urine culture was also ordered. These tests returned with normal results.

While some exit-seeking and tearfulness on admission to LTCH was noted, this did not represent psychosis or true agitation/ aggression. As well, there was concern of possible parkinsonism secondary to risperidone use (i.e. extrapyramidal symptoms, or EPS). Therefore, a possible decrease in risperidone was discussed with the patient's wife (Power of Attorney for Health). She was concerned that the patient would become as distressed as he had been in the hospital last year.

Outcome:

Consent was received to continue the patient's current medications, with a gradual reduction in risperidone. Health Canada's warning regarding increased risk of strokes and mortality on risperidone in dementia was reviewed with the patient's wife, and this conversation was documented in the medical record.

It was explained that there would be continued monitoring of behavioural symptoms and possible side effects (e.g. parkinsonism, hypotension, gait instability), and that these would be documented in the medical record.

If the patient's disturbing aggression or psychoses were to re-emerge, then risperidone would be reinstated. Another attempt at dose reduction of risperidone would then be considered after 3-6 months of improved behaviours.

Education was provided to the patient's wife regarding optimal dementia care, behavioural and psychological symptoms, risk of falls, medication management, and interdisciplinary behavioural strategies aimed at decreasing distress.

These strategies were quite effective in reducing the patient's behaviours, and over a period of 8 weeks his risperidone was successfully discontinued.

Other Resources for Family Physicians

- **A Guide to Scheduling and Billing for Family Physicians (in Ontario)**
  Ontario Dementia Newsletter for Physicians
  Dr. Bill Dalziel, Regional Geriatric Program of Eastern Ontario
  www.champlaindementianetwork.org/en-resources.asp#PHYSICIANS - click on Dementia Newsletter for Physicians Vol. 1, No. 1, Fall 2010, page 1-2

- **Driving and Dementia Video (15 minutes)**
  Dr. Frank Molnar, Chief, Regional Geriatric Program of Eastern Ontario
  www.akeresourcecentre.org - go to the right hand side and click on Driving and Dementia e-module.