DEMENTIA NEWSLETTER *for* PHYSICIANS

Vol. 5, No. 2 | OTTAWA | Summer 2005

A Publication of the Dementia Network of Ottawa

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Disponible en français

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Traduction gracieuseté de:

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Prescribing Atypical Antipsychotics With Caution

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Is it safe to prescribe atypical antipsychotic medication to treat behavioural symptoms in demented patients? Over the last few years the safety of atypical antipsychotics (AP) for the treatment of behavioural and psychological symptoms of dementia (BPSD) has come under increasing scrutiny. What is the evidence for or against the practice of prescribing AP for the treatment of BPSD?

Several published randomized placebo controlled studies (RCT), with over 1150 patients for risperidone (3 studies) and 850 patients for olanzapine (2 studies), and 2 placebo controlled trials with quetiapine published as abstract, have shown a modest efficacy in the treatment of BPSD. Approximately 60% of the patients on AP improved versus 40% of the placebo group (Number Needed to Treat =5). Clinically these medications have been found to be generally better tolerated than classical antipsychotics. There is less parkinsonism, akathesia, tardive dyskinesia, sedation, orthostatic hypotension and anticholinergics effects with the AP.

Metabolic syndromes (truncal obesity, insulin resistance, hypertriglyceridemia) have been associated with this class of

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medication. Recently there have been particular concerns of increased risk of adverse cerebrovascular events (CVAE), with an odds ratio of 3, in people treated with risperidone and olanzapine, and a twofold increase in all causes of mortality when compared to a placebo group. The number needed to harm (NNH) for every year of treatment is estimated to be between 4 and 14.

The European Agency for the Evaluation of Medicinal Products (EMEA) and the Committee for the Safety of Medicine (CSM) in the UK have advised against prescribing risperidone and olanzapine for the treatment of BPSD in people with dementia. We do not know the risk associated with other antipsychotics as such data is currently not available. Lack of data does not confer less risk. Dosage and duration of treatment were not associated with the risk of developing CVAE, nor was there a temporal relationship clearly evident. The mechanism by which these drugs could provoke a stroke is unclear. Pre-existing risk factors such as hypertension, diabetes, atrial fibrillation, smoking, age over 75 years, and a diagnosis of vascular or mixed dementia were identified risk factors for CVAE. Furthermore, risk factors for increased death included treatment-emergent sedation, concomitant use of benzodiazepines and pulmonary conditions such as pneumonia with or without aspiration.

Is the magnitude of the risks sufficient to outweigh the likely benefits in the treatment of BPSD? European drugs agencies believe it to be so. The FDA and Health Canada have sent out a warning and will require manufacturers to include description of safety information sheet for these drugs (black box warning).

What are clinicians to do as AP remain a helpful treatment choice when other alternatives have been exhausted such as ruling out a delirum or a contributing medical condition, environmental manipulations and other non pharmacological approaches have failed, or when the behaviours are severe with a threat to the person or others' safety? Atypical antipsychotics should only be used when it is absolutely necessary and its use should be closely monitored to use the lowest effective dosage for a minimum period of time. Medication use should be reviewed at regular intervals (every three months) and attempts be made to decrease and discontinue the use of AP. Cerebrovascular risks factors should be monitored and treated appropriately.

Suggested reading: D. Ames, C. Ballard, J. Cream, A. Shah, G.H. Suh, I. McKeith For debate: should novel antipsychotics ever be used to treat the behavioural and psychological symptoms of dementia? International Psychogeriatrics (2005) 17;1,3-29.

Innovative Physician Education For You!

We will come to your office and do a one to one session with you (20-30 minutes) or a 4-6 member breakfast or lunch and learn session (40-60 minutes). We will provide the food!

Physician educators will include:
Anna Byszewski, Bill Dalziel,
Tony Guzmàn, Barbara Power, Tilak Mendis,
Inge Loy-English, and Louise Carrier

To find out more information, please call: 523-4004

Driving and Dementia: How Do I Tell My Patients They Need to Stop Driving?

Although seniors are involved in fewer crashes than middle-aged drivers, when adjusted for kilometers driven, crash rates in this age group approach those in the high risk group of 16-20 year olds.

Alzheimer Society of Ottawa

Photo by Valberg Imaging Inc.

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Crash rates have been reported to be 2-5 times increased in dementia. Research shows that within two years of diagnosis, the crash risk increases by 50%. The diagnosis of dementia should not by itself indicate an immediate license suspension. It is felt that impairments in divided attention, visual spatial skills and judgment place individuals with dementia at increased risk of motor vehicle crashes. In Canada most provincial jurisdictions (including Ontario) hold medical practitioners responsible to evaluate if their patients are safe to drive. Discussion of driving cessation is often a very challenging task and may impact on the patient-physician relationship.

How to break the bad news about driving and dementia:

Preliminary results of a study conducted by the Geriatric Program of The Ottawa Hospital, consisting of interviews with patients with dementia who were instructed to cease driving and their caregivers, has given us some directions. Some patients accepted the physicians' instructions to stop driving, but others rejected the evaluation. Most caregivers were supportive of the professional evaluations and recommendations. Suggestions included:

1. Need to prepare the patient for the inevitable fact that sooner or later they will lose their license. "…they hit you with that, bang, you should be warned".
2. It is expected that normal reactions may include anger, bargaining, depression, a sense of demoralization. Health care workers need to be prepared for dealing with emotions that arise.
3. Be prepared to offer alternatives regarding transportation; discuss Para Transpo, volunteer drivers, taxis (these can be much more economical than upkeep of a car if driven < 4000 miles per year).
4. Involve family and caregivers in the discussion, solicit their support and advice regarding how to help the patient accept this difficult recommendation.
5. Recognize your own discomfort in having to discuss this with your patients. Solicit support and evidence from as many sources as possible.
6. Patients and caregivers say they want more information why they can't drive and they want more detailed explanation of test results.
7. Focusing on a physical problem, such as vision loss or medications, may make the reason to cease more acceptable to the

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Driving and Dementia: How Do I Tell My Patients They Need to Stop Driving?
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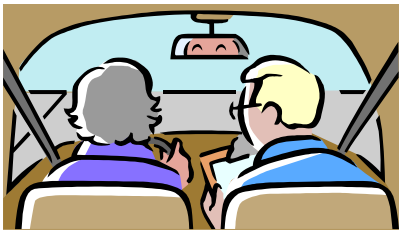
patient. Be firm yet empathic and avoid getting into argumentative discussions. Emphasize your ethical and legal responsibility and the fact that dementia is progressive and irreversible.

8. In some cases, referral to another physician such as a neurologist or geriatrician for a second opinion may help preserve the patient-family physician relationship.
9. A letter from the physician to the patient explaining the reasons for driving cessation can help the patient and family refer to a written account of what was discussed.
10. If necessary, explore ways to deter the person from driving with caregivers. This may include removing the keys, disabling or physically removing the car.

Driving risk of patients with dementia needs to be addressed when the diagnosis is made. Strategies outlined above may facilitate this process and ensure safety of both the patient and the public at large. The national CanDRIVE project is looking at issues of the older driver.



Educational Conference in Dementia

October 27 - 29, 2005
The Westin Hotel,
Ottawa

An outstanding Dementia Conference will be held in Ottawa in October, 2005; the 3rd Canadian Colloquium on Dementia. There will be 4 international speakers: (1. MCI – R. Peterson, 2. vascular dementia – G. Roman, 3. extrapyramidal dementias – C. Ballard, and 4. behavioural problems – J. Cohen / Mansfield) and a host of Canadian leaders in the field of dementia: 1. genetics – P. St. George Hyslop, 2. therapeutics – S. Gauthier & K. Rockwood, 3. capacity assessment – M. Tremblay, 4. driving assessment – M. Man-Son Hing, 5. depression in dementia – Lillian Thorpe, and 6. neuroimaging – S. Black.

The Conference runs from **5:00 pm Thursday, October 27, 2005 to 5:30 pm Saturday October 29, 2005.** It is accredited for 15.5 hours of Main Pro credits by the College of Family Physicians of Canada and the registration fees are $385 until September 12, 2005.

For further information and to register, please go to the website www.ccd2005.ca

THANK YOU

The Dementia Network of Ottawa would like to thank Janssen-Ortho, Pfizer and Lundbeck for sponsoring this edition of the Dementia Newsletter for Physicians.