# DEMENTIA NEWSLETTER FOR PHYSICIANS

*A Publication of the Ontario Dementia Network*

**Vol. 2, No. 1** **Winter 2012**


## In This Issue ...





## Resources for Physicians

Visit www.champlaindementia.org and go to the "Physicians" tab.

## For more information


Alzheimer Society of Ottawa and Renfrew County
Tel: 613-523-4004
Fax: 613-523-8522
Email: info@asorc.org


# Strategic Use of Antipsychotics in Patients with Dementia


*Dr. Kiran Rabheru, MD, CCFP, FRCP, Geriatric Psychiatrist, The Ottawa Hospital and Elisabeth Bruyère Continuing Care*


### Key Points:

- Before using antipsychotics in behavioural symptoms of dementia, rule out medication side-effects, infection, metabolic derangement, and structural lesions. Also try non-pharmacological interventions first.
- If antipsychotics are required, use the lowest effective dosing, for the shortest period of time.

**Background:** Over 90% of dementia patients experience behavioral and psychological symptoms of dementia (BPSD), including physical or verbal aggression with psychosis[i]. These commonly pose risk of harm to the patient and those caring for them. Providing care safely for the patient becomes challenging requiring institutionalization or hospitalization resulting in poorer quality of life and increased cost to society.

**Goal:** To provide clinicians a strategic framework for decisions regarding safe use of antipsychotics in patients with dementia.

**Document Target Symptoms: Consider "Behavioral Vital Signs Tool"** (BVS Tool)[ii]**.** It is extremely useful to identify target symptom(s) or cluster(s) using a systematic team approach. Guidelines suggest that antipsychotic therapy may be considered for when significant risk of harm to patient or others is likely due to *aggressive symptoms* that are persistent, recurrent, or severe enough to cause significant suffering and distress, or significant interference with care.

Non-aggressive behaviors e.g. purposeless repetitive verbal or motor activity, wandering, or exit-seeking must not be targeted for treatment with antipsychotics.


*Cont'd on page 2*


## WEBINAR FOR FAMILY PHYSICIANS


**Topic:** Strategic Use of Antipsychotics in Patients with Dementia

**Presenter:** Dr. Kiran Rabheru, MD, CCFP, FRCP, Geriatric Psychiatrist, The Ottawa Hospital and Elisabeth Bruyere Continuing Care

**Date/Time:** Wednesday, April 4, 2012 from 12 to 1 p.m.

FULLY SUBSCRIBED

**Due to the high interest in this topic, a repeat webinar is being scheduled for family physicians and nurse practitioners. To receive notice when details available, email info@asorc.org**

# Strategic Use of Antipsychotics in Patients with Dementia (cont'd from page 1)

**Mandatory: "S.M.A.R.T." Approach[iii]**

1) **S**afety assessment is crucial: Is the patient / family / caregiver / co-patient / co-resident safe?
2) **M**edical workup: to treat reversible causes; reduce medication load
3) **A**ssess Competency re: personal care decisions, financial, driving; protect assets
4) **R**est, nutrition, hydration; pain, ambulation, vision, hearing, constipation
5) **T**rial of medication: cholinesterase inhibitor / antipsychotic / antidepressant/ mood stabilizer.

**Optimize Care[iv]:** Correct reversible factors. Problems related to other drugs, infection, metabolic derangement, or structural brain lesion. Also assess pain, vision, hearing, oral cavity, dentition, bowel, bladder, skin, and feet. Probe social stressors, loneliness, fear, boredom; environmental stressors e.g. noise, lighting, temperature. Implement caregiver-led non-pharmacological interventions in all cases.

**Pharmacotherapy for acute use:**

*Atypical antipsychotics: For emergency or non-emergency use.*

1) Risperidone 0.25–1 mg PO tablets, liquid, or M-tabs* q2–4h as needed and tolerated.
   Maximum of 2 mg/ 24 hours for many dementia patients. Lower for DLB/PDD**

2) Olanzapine 2.5–5 mg PO tablets (Zydis) q2–4h as needed and tolerated.
   Maximum of 10 mg/ 24 hours for many dementia patients. Lower for DLB/PDD**

3) Quetiapine 12.5–25 mg q2-4 hours as needed and tolerated.
   Maximum of 150mg/ 24 hours for many patients. Lower for DLB/PDD**.
   Consider first-line for patients with DLB/PDD**

*Typical antipsychotics: Usually for emergency use only.*

1) Haloperidol: 0.25–0.5 mg PO tablets, liquid, or IM q2–4h as needed and tolerated.
   Maximum dose: 2 mg/ 24 hours for many dementia patients. Lower for DLB/PDD**

2) Loxapine: 2.5–5 mg PO, liquid, or IM q2–4h as needed and tolerated.
   Maximum dose 10–25 mg / 24 hours. Lower for DLB/PDD.

*Benzodiazepines: Usually for emergency use only.*

1) Lorazepam 0.5–1 mg PO, liquid, sublingual, or IM q2–4 hours as needed and tolerated.
   Maximum of 2- 4 mg / 24 hours. Lorazepam can be combined with haloperidol or loxapine for greater efficacy and to reduce the dose for each medication individually.

*M-tabs are rapid-dissolving tablets. **DLB = dementia of Lewy body type; **PDD = Parkinson's disease dementia.

**Pharmacotherapy with atypical antipsychotics for longer-term management of severe symptoms beyond 6–12 Weeks:**

The guidelines for dosing of atypical antipsychotics beyond 6-12 weeks are essentially the same as for the acute phase. However, a strategic approach is required as follows:

Following treatment of the acute phase, a decision must be made as to whether to continue or stop the antipsychotic medication. It is important to review the need for ongoing antipsychotic therapy after 4–6 weeks of treatment as many people with BPSD experience a significant improvement or resolution of symptoms over that period. Atypical antipsychotics do confer modest benefits in treating aggression and psychosis over 6–12 weeks, with an NNT ranging from 5 to 14.

*Cont'd on page 3*

## 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


***Dr. Andrea Moser, MD, MSc, CCFP, FRCP,***
***Focus Practice in Care of the Elderly, OLTCP***


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.