Managing Behaviour and Psychological Problems in Patients with Diagnosed or Suspected Dementia in Primary and Secondary Care

Management guidelines for people with diagnosed or suspected dementia in Nottingham and Nottinghamshire

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Approved by Nottinghamshire Area Prescribing Committee (NAPC)

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Linked Guideline (July 2013)
Dementia Referral Guideline (short version)

Based on original work done by Hampshire Partnership NHS Foundation Trust, and NHS East Midlands

A reference list is available on request
MANAGING BEHAVIOUR AND PSYCHOLOGICAL PROBLEMS IN PATIENTS WITH DIAGNOSED OR SUSPECTED DEMENTIA

(Does not cover rapid tranquillisation of acutely disturbed patients)

This guideline covers Primary and Secondary care in Nottinghamshire

Quick points

1. Patient with dementia with Behavioural and Psychological Symptoms of Dementia (BPSD)
   – consider delirium
   – review all medication
   – identify and address provoking/exacerbating factors and physical health problems
   – if unresolved develop a person-centred care plan with family and/or carers
   – try watchful waiting, symptoms may resolve without intervention over a few months
   – if considering drug treatment, first identify dominant target symptom
   – initiate drug therapy appropriate to target symptoms
   – review at 6 weeks then every 3 months
   – actively try withdrawing/stoping the drug
   – some symptoms do not respond to drug treatment e.g. wandering, shouting or depression

2. Key messages for secondary care
   – always communicate drug changes to the GP
   – provide a reason for each prescription for BPSD
   – request a review of drugs prescribed for BPSD every 3 months and try withdrawing/stoping the drug

3. Key message for GPs and primary care
   – on-going antipsychotic prescriptions require a prescribing care plan
   – for patients in care homes, consider referral to the Dementia Outreach Teams (Nottinghamshire Healthcare Trust) if simple measures ineffective
   – review all drugs prescribed for BPSD every 3 months and try withdrawing/stoping the drug
   – pharmacists are in an ideal position to support GPs and request prescription review

4. This is a complex and contentious area. These are guidelines. They may not always apply in each individual clinical situation. Please use your professional judgment.

BPSD guideline NAPC September 2015
MANAGING BEHAVIOUR AND PSYCHOLOGICAL PROBLEMS IN PATIENTS WITH DIAGNOSED OR SUSPECTED DEMENTIA
(Does not cover rapid tranquilisation of acutely disturbed patients)

Patient has a Behavioural and Psychological Symptom in Dementia (BPSD): delusions, hallucinations, agitation, aggression, irritability, etc.

Yes

Does patient have delirium? (<1 week history increased confusion, fluctuation, inattention or drowsiness)

Yes

Seek and treat underlying medical problems (infections, brain, metabolic, or hypoxic disorders), & review medication.

No

Follow guidelines for delirium e.g. NICE

Identify, document and address provoking or exacerbating factors:
- Physical problems: pain, constipation, urinary symptoms, thirst or hunger
- Activity-related: boredom, misinterpretation of care tasks
- Treatment related: catheters, monitors, infusions, effects of medication
- Environment: noise, temperature, lighting, change of room, ward or bed space

Write a care plan. Consider person centred approaches. Involve family and/or carers for information and help with care. Collect information on biography, preferences and routines. Understand what the person with dementia experiences. Develop a relationship to relieve anxiety. Repeat explanation and reassurance frequently (up to every 30 mins). Don’t confront, punish or humiliate. If agitated try ‘leave & return’, distraction activity (matched to level of ability), or one-to-one care. Consider watchful waiting for 2 or 3 days. Patients may settle.

Identify the dominant target symptom group
- Psychosis: delusions or hallucinations (but care over ‘delusions’ due to forgetfulness)
- Depression
- Emotional lability; distress (e.g. crying, anger) disproportionate to emotional stimulus
- Apathy
- Aggression, agitation, anxiety
- Sleep disturbance
- Wandering
- Vocalisations, shouting, calling out

Behavioural problems unresolved

Consider pharmacological treatment if there is distressing psychosis, or behaviour that is harmful or severely distressing to the individual or puts others at risk. Continue person-centred approaches.

Could this be Dementia with Lewy Bodies or Parkinson’s Disease Dementia? Key features: Parkinsonism, visual hallucinations, delusions, fluctuation. If unsure get specialist

Follow treatment guidelines overleaf

General guidelines if antipsychotic treatment is indicated

Both typical and atypical antipsychotics worsen cognitive function, contribute to falls, increase risk of stroke (3x) and death (2x), and can significantly reduce quality of life. They should only be used after discussion with the patient (if s/he has capacity to understand) or family/carer about possible benefits and risks. Risk increases with age and vascular risk factors, and in established cerebrovascular disease. If antipsychotic treatment is necessary, start at low dose and increase slowly at weekly intervals if no response.

Always review for effects and side-effects. Patients with Dementia with Lewy Bodies or Parkinson’s Disease Dementia are particularly vulnerable to antipsychotic sensitivity reactions and extrapyramidal side effects. Extreme caution is required.

Patients who respond to treatment should be reviewed after 6 weeks. Consider withdrawal: halve the dose for one week and if no worse stop the drug. Review after 1 week. If the symptoms re-emerge reintroduce the drug at starting dose. Over half of BPSD resolve within 6 months. However, BPSD can persist and treatment with antipsychotics may be needed in the long term, but should be reviewed 3 monthly.

Secondary care prescribers: Communicate drug changes to the GP. Provide a reason for each prescription. Request a review every 3 months.

Primary care prescribers: Antipsychotic prescriptions require a prescribing care plan. Try withdrawing and stopping the drug after 3 months. For patients who have been taking antipsychotics long-term a more cautious reduction over 4-6 weeks or longer, depending on the individual, is recommended. If problems are ongoing, refer to Community Mental Health, or the care home Dementia Outreach Teams (via Single Point of Access).
### Alzheimer’s Disease

<table>
<thead>
<tr>
<th>Key Symptom</th>
<th>First Line</th>
<th>Second Line</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression (1)</td>
<td>Watchful waiting, refer CMHT</td>
<td>Citalopram (2), Mirtazapine (1)</td>
</tr>
<tr>
<td>Emotional lability</td>
<td>Citalopram (2)</td>
<td>Mirtazapine (1)</td>
</tr>
<tr>
<td>Psychosis (3)</td>
<td>Risperidone (6)</td>
<td>Olanzapine (6), Haloperidol</td>
</tr>
<tr>
<td>Aggression</td>
<td>Risperidone (6)</td>
<td>Olanzapine (6), Quetiapine (5), Haloperidol, Memantine (6)</td>
</tr>
<tr>
<td>Severe Anxiety</td>
<td>Mirtazapine</td>
<td>Trazodone (7)</td>
</tr>
<tr>
<td>Severe Agitation</td>
<td>Risperidone (6)</td>
<td>Olanzapine (6), or Memantine (6) ± short term Lorazepam</td>
</tr>
<tr>
<td>Poor Sleep (4)</td>
<td>Zopiclone</td>
<td>Temazepam</td>
</tr>
<tr>
<td>Vocalisation/shouting</td>
<td>Identify underlying symptoms or problems. No specific drug treatment.</td>
<td></td>
</tr>
<tr>
<td>Wandering</td>
<td>No specific drug treatment.</td>
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</tbody>
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### Dementia with Lewy Bodies (LBD) or Parkinsons Disease Dementia (PDD)

<table>
<thead>
<tr>
<th>Key Symptom</th>
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<th>Second line</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression (1.5)</td>
<td>Citalopram (2)</td>
<td>Mirtazapine</td>
</tr>
<tr>
<td>Psychosis (3)</td>
<td>Stop dopamine agonists, consider reducing L-DOPA</td>
<td>Rivastigmine (6), Quetiapine (5,6)</td>
</tr>
<tr>
<td>Aggression (1.5)</td>
<td>Quetiapine (5,6)</td>
<td>Rivastigmine (6), Memantine (6)</td>
</tr>
<tr>
<td>Severe Anxiety (5)</td>
<td>Citalopram (2)</td>
<td>Rivastigmine (6), Donepezil (6)</td>
</tr>
<tr>
<td>Severe Agitation</td>
<td>Citalopram (2)</td>
<td>Rivastigmine (6) or Memantine (6) ± short term use of Lorazepam</td>
</tr>
<tr>
<td>Poor Sleep (4)</td>
<td>Zopiclone</td>
<td>Temazepam</td>
</tr>
<tr>
<td>REM sleep behaviour (nightmares, hyperactivity)</td>
<td>Clonazepam</td>
<td></td>
</tr>
<tr>
<td>Vocalisation/shouting</td>
<td>Identify underlying symptoms or problems. No specific drug treatment.</td>
<td></td>
</tr>
<tr>
<td>Wandering</td>
<td>No specific drug treatment.</td>
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</tr>
</tbody>
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**NOTES** (1) The largest trial to date showed sertraline and mirtazapine to be ineffective for treating depression in Alzheimers disease. (2) The dose of citalopram should start at 10mg/day and not exceed 20mg/day due to dose-related prolongation of QTc interval. (3) The evidence base for treating psychosis is poor. Antipsychotics will not work for ‘understandable delusions’ caused by forgetfulness, such as ‘living in the past’. (4) Sleep disturbance or sleep reversal is very common. Maximise daytime activity. A trial of hypnotics may be justified but may need longer than recommended treatment duration if symptoms persist. (5) Quetiapine and SSRIs may worsen motor symptoms of PDD. (6) Refer to NAPC Amber 2 Prescribing Information Sheets. Risperidone is the only oral atypical antipsychotic licensed for the short-term treatment (up to 6 weeks) of persistent aggression in patients with moderate-to-severe Alzheimer’s Dementia. (7) Trazodone - start at 25mg/day and increase cautiously at weekly intervals up to 100-150mg/day. Trazodone can increase falls risk.

### Vascular dementia or stroke-related dementia and other dementias

There is little evidence for the treatment of BPSD in vascular and other dementias and prescribers are advised to follow the guidance for Alzheimer’s Disease. Specialist advice may be required, especially for rare dementias such as fronto-temporal dementias.

### Drug dose guidelines for use of psychotropics in dementia

This needs to be judged according to the situation, including severity of symptoms, previous responses to drugs, age and weight, and general physical fitness or frailty. Small doses for small people.

<table>
<thead>
<tr>
<th>Antipsychotic</th>
<th>Starting dose</th>
<th>Usual dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risperidone</td>
<td>250microgram twice daily</td>
<td>500microgram-1mg twice daily</td>
</tr>
<tr>
<td>Olanzapine</td>
<td>2.5mg once daily</td>
<td>2.5-5mg once daily</td>
</tr>
<tr>
<td>Quetiapine</td>
<td>25mg once daily</td>
<td>25-150mg once daily or in divided doses</td>
</tr>
<tr>
<td>Haloperidol</td>
<td>500microgram twice daily</td>
<td>500microgram-1mg twice daily</td>
</tr>
<tr>
<td>Lorazepam</td>
<td>0.5mg once daily</td>
<td>0.5mg-1mg twice daily</td>
</tr>
<tr>
<td>Trazodone</td>
<td>25mg once daily</td>
<td>100-150mg daily in divided doses</td>
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