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DEMENTIA - Behavioural and Psychological Symptoms (BPSD) Use of Antipsychotics

AMBER

The Pan Mersey Area Prescribing Committee recommends that antipsychotics prescribed for BPSD should be initiated by a dementia specialist* and reviewed in accordance with NICE/SCIE [1] guidelines

FOLLOWING SPECIALIST INITIATION *

NB: THIS DOCUMENT DOES NOT COVER THE MANAGEMENT OF DELIRIUM

Background

The core feature of dementia is cognitive decline, but BPSD is common and significant. Antipsychotics are sometimes prescribed for BPSD such as agitation, aggression, extreme anxiety, shouting, delusions and hallucinations.[1] Use of antipsychotics in people with dementia may produce only limited benefits and is associated with increased risk of stroke/TIAs, cardiac arrhythmias, chest infections, falls and mortality.[2, 3]

Managing BPSD

Involve the person/carers/care staff in developing an on-going person-centred care plan.[1, 3, 4]
Identify factors that generate or aggravate BPSD. These can include physical health problems, particularly pain, but also infection, discomfort, alcohol, constipation, depression, sleep disturbance, medication side effects, psychosocial factors and environment.[1, 3, 4]
Identify factors that improve BPSD e.g. music, dance, aromatherapy, cognitive stimulation, massage, multisensory stimulation, exercise, creative therapies, animal assisted therapies and well-lit environment.[3]
For non-severe BPSD the goal should be nil prescribing of antipsychotics[4]; use non-pharmacological interventions as listed above or watchful waiting.[3] Monitor response and adapt the care plan as needed.

Managing BPSD when patient is severely distressed or there is immediate 'risk of harm'

- Reversible causes of BPSD should be ruled out before initiating antipsychotic treatment.
- Use of antipsychotics should only be considered if other interventions have been unsuccessful[5]
- Antipsychotics should only be initiated by dementia specialists*; *however, in an emergency a non-specialist, e.g. a GP or general hospital doctor, may start treatment but MUST refer to a dementia specialist* as soon as is practical.*
- Only risperidone is licensed for the short term treatment (up to 6 weeks) of persistent aggression in moderate to severe Alzheimer's dementia unresponsive to non-pharmacological approaches and when there is a risk of harm to self or others. Initially 250 micrograms twice daily is recommended; adjusted by increments of 250 micrograms twice daily, (usual effective dose 500 mcg) up to a maximum of 1 mg twice daily.
- In Lewy Body Dementia or Parkinson's disease dementia, extreme care is required. Low dose quetiapine appears to be better tolerated if considering an antipsychotic.[6] If an antipsychotic is prescribed, prescriptions should be time limited and reviewed every 3 months or according to clinical need for benefits and side effects.[1]

All involved in the patient's care should always question continued use in a settled patient.

- Antipsychotics must be gradually discontinued, in discussion with relevant colleagues and ideally, the initial prescriber, unless benefits of continued treatment outweigh the known risks.

***Dementia Specialists: Consultant Psychiatrists, Neurologists, Psycho-geriatricians, Geriatricians and their Specialist Registrars, Non-Medical Prescribers and GPs with a special interest in dementia**

Note: Patients who are not eligible for treatment under this statement may be considered on an individual basis where their GP or consultant believes exceptional circumstances exist that warrant deviation from the rule of this policy. In this situation, follow locally defined processes.

DEMENTIA - Behavioural and Psychological Symptoms (BPSD) Use of Antipsychotics

EFFECTIVENESS[7]	SAFETY[7]
Antipsychotic drugs show minimal efficacy for BPSD.[1, 2] Treating 1000 people with BPSD with an atypical antipsychotic for around 12 weeks results in clinical improvement in 91 to 200 of these people (in addition to those who improve without antipsychotics).[2]	Antipsychotics are associated with a number of major adverse outcomes and side effects including sedation, extrapyramidal side effects, dehydration, falls, chest infection, accelerated cognitive decline, stroke and death.[5, 9, 10] One meta-analysis reported mortality with antipsychotic drugs of 3.5% versus 2.3% for placebo.[11] Treating 1000 people with BPSD with an atypical antipsychotic for around 12 weeks results in:[2] - 10 deaths - 18 cerebrovascular events - 58 to 94 people with gait disturbances (in addition to those who experience these without antipsychotics) Extreme care is needed if prescribing antipsychotics in patients with Lewy Body or Parkinson's disease dementia.
COST[7]	**PATIENT FACTORS[7]**
The greater cost of using behavioural interventions, rather than antipsychotics, is more than compensated by health care savings due to the reduced incidence of stroke and falls.[8] Taking into account quality of life improvements, the net benefit of using behavioural interventions rather than antipsychotics in England has been estimated as £54.9 million per year.[8]	Patient specific factors may generate, aggravate or improve BPSD, e.g. environment, physical health, pain, depression.[1,4] Challenging behaviours in dementia may be a way of communicating an unmet need.[1] The decision to prescribe antipsychotics should be taken on an individual basis after full consideration and discussion with the patient and/or carer about the risks and benefits.[1] The use of patient decision aids can be helpful.

PRESCRIBING INFORMATION - involve carers

Define and document target symptoms and severity.
If an antipsychotic is necessary, use low initial dose and titrate gradually; monitor for side-effects.
Treatment should be time limited and regularly reviewed.
Carefully review and if appropriate, consider discontinuing antipsychotic unless the person is severely distressed or there is an immediate risk of harm to the person or others
Settled patients on high doses of antipsychotics should have their doses halved initially.
Settled patients on low doses of antipsychotics should have their medication stopped.
Patients should be closely monitored for two weeks following reduction or discontinuation.
Previous doses should only be reinstated if the patient severely deteriorates resulting in extreme anxiety or risk of harm to self or others.
Document all discussions and decisions.

IMPLEMENTATION NOTES

Do not prescribe antipsychotics for BPSD unless initiated by a dementia specialist or in an emergency (see previous page)*.
Regularly review use of antipsychotics in BPSD and question need for continued use in 'settled' patients.

REFERENCES

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