RDASH PROTOCOL FOR MANAGING BEHAVIOURAL AND PSYCHOLOGICAL SYMPTOMS IN **PATIENTS WITH DEMENTIA (February 2015)** (Does not cover rapid tranquillisation of acutely disturbed) A) Primary care responsibility B) Optional primary care responsibility with secondary care support if required or requested C) Secondary care responsibility Treat underlying acute A) Patient has Behavioural and Yes Does patient have a Yes medical problems e.g. Psychiatric Symptoms in Dementia Delirium? UTI, chest infection, (BPSD) (delusions, hallucinations, (Short history < 1 week side effects of drugs, confusion, hallucination. agitation, aggression, irritability etc with alcohol and drug steady decline in cognition over a delusion with fluctuating withdrawal etc. minimum of 6 months) coanition) No Behavioural problems B) Apply 'PINCH ME' approach and manage or treat: unresolved P-PAIN AND PSYCHIATRIC DISORDER I-INFECTION **N=NUTRITION C=CONSTIPATION M=MEDICATION AND METABOLIC STATE E=ENVIROMENTAL FACTORS** Consider non-pharmacological approaches such as: distraction, leave & return, activity, one-to-one care, music, aromatherapy. Carer support may improve coping ability of carer(s). Identify the dominant target symptom group Psychosis: Delusions/Hallucinations. **Depression:** depressed mood and /or loss of ability to enjoy Only consider pharmacological treatment if there previously pleasurable activities. May or may not include is psychosis, depression or behaviour that is apathy. harmful or distressing to the individual or others. Apathy: diminished motivation; listlessness; loss of drive to engage in activities. May be perceived as laziness. Could this be Dementia with Lewy Bodies or Aggression Parkinson's Disease Dementia? Key features: long term (> 6 months) history of **Agitation/ Anxiety** vivid visual hallucinations or parkinsonism or fluctuating cognition. Sleep disturbance Other symptoms: e.g. vocalisations; sexual disinhibition; Unsure Yes or No stereotypical movements etc. C) Get specialist Follow guidelines In the event of advice below and overleaf continuing problems, advice General guidelines if pharmacological treatment is indicated. can be obtained The use of either typical or atypical antipsychotics in patients with dementia worsens from CMHT(OP)'s. cognitive function; increases the risk of cerebrovascular events (~ 3 xs) and increases mortality rate liaison team or (~2x). They should only be used after full discussion with the patient (where the patient has memory service, capacity to understand) and carer about the possible benefits and likely risks. Risk is likely to 01302 796708 increase with increasing age and if other risk factors for cerebrovascular events are present e.g. There is only one drug diabetes; hypertension, cardiac arrhythmias; smoking and existing evidence of stroke or vascular (Risperidone) licensed specifically for the If antipsychotic treatment is considered necessary avoid typical antipsychotics and start oral treatment of BPSD. For risperidone 0.5mg and increase every 2 -4 days if no response (see specific doses suggestions other symptoms drugs overleaf). Patients who respond to treatment should have the drug cautiously withdrawn after 6 are used which have weeks. Halve the dose for one week and if no re-emerging symptoms stop the drug. Review again either been shown to after one week. If symptoms re-emerge reintroduce the drug at starting dose. BPSD can persist improve these symptoms and treatment with atypical antipsychotics may be needed in the long term but should be reviewed in subjects without on a 3 monthly basis. Patients with Dementia with Lewy Bodies or Parkinson's Disease

Based on 1.CSM CEM/CMO/2004/1(MHRA); 2.BNF (2008); 3.Faculty of Old Age Psychiatry (2008); 4. Maudsley Guidelines; 5.NICE-SCIE guidelines; 6. SIGN 2006: 6. Ballard C, Current Opinions in Psychiatry 2009: Cochrane review of antipsychotics in dementia 2001/2010.

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Dementia are particularly vulnerable to antipsychotic sensitivity reactions and also have marked

evidence base and should follow existing guidelines for the management of these drugs in elderly

The management of antidepressants and hypnotics in patients with dementia has little

extrapyramidal side effects. Treatment doses should follow guidelines overleaf.

patients without dementia. Treatment doses should follow BNF guidelines.

dementia or are licensed

enhancement in patients

for cognitive

with dementia.

Prescribing Guidelines - NB Antipsychotic medication should only to be used to treat psychosis or severe physical aggression which is harmful to self or others

Alzheimer's Disease.

Key symptom	First line	Evidence	Second line	Evidence
		type		type
Depression	Sertraline, Citalopram Mirtazapine (with sleep and appetite disturbance)	2-3+£		
Apathy	Sertraline, Citalopram	2-3+£	Donepezil ^S ; Rivastigmine ^S ; Galantamine ^S	2
Psychosis	Risperidone	1	Olanzapine; Aripiprazole; Memantine ^S	2
Severe physical Aggression	Risperidone L	1	Olanzapine, Aripiprazole; .	2
which is harmful to self or others	Haloperidol	2	Lorazepam Memantine S	2
Agitation/ Anxiety	Citalopram.	3	Lorazepam; Mirtazapine;	2-4
Poor sleep	Temazepam; Zopiclone.	3 + £	Zolpidem	3

Dementia with Lewy Bodies or Parkinson's disease dementia.

Key symptom	First line	Evidence type	Second line	Evidence type
Depression	Citalopram	4 + £	Sertraline	4
Apathy	Sertraline, Citalopram	4 + £	Donepezil ^S ; Rivastigmine ^S ; Galantamine ^S	2
Psychosis*	Rivastigmine ^S	2 - 3	Quetiapine ^S . Donepezil ^S ; Galantamine ^S .	3
Severe physical Aggression which is harmful to self or others	Quetiapine. Aripiprazole	3	Donepezil ^S ; Galantamine ^S . Rivastigmine ^S Lorazepam	3-4
Agitation/ Anxiety	Citalopram.	3 + £	Rivastigmine ^S . Donepezil ^S Galantamine ^S Lorazepam	2 - 4
Poor sleep	Temazepam; Zopiclone.	3 + £	Zolpidem	3
REM sleep behaviour (nightmares; hyperactivity)	Clonazepam**	3		

^{*} consider reducing antiparkinsonian medication first: ** 500-1000 microgram nocte:

Evidence levels: 1 = Metanalysis; 2 = RPCT's; 3 = Other studies; 4 = Expert opinion; \pounds = cost

Vascular dementia or stroke related dementia.

There is little evidence base for the treatment of BPSD in Vascular dementia or stroke related dementia. The cholinesterase inhibitors (Donepezil; Rivastigmine; Galantamine) and Memantine are not licensed for the treatment of vascular dementia and should not be used. Prescribers are advised to follow the guidance for Alzheimer's disease but to use with extreme caution drugs with an established increased cerebrovascular risk (i.e. antipsychotics)

Other BPSD and other dementias (e.g. Fronto-temporal lobe dementia).

There is little evidence base for the treatment of other BPSD or for the treatment of common BPSD in other dementias. **Specialist advice should be sought.**

Drug dose guidelines for antipsychotics and anxiolyitcs in dementia. Start at minimum recommended dose and titrate according to response (usually every 2-4 days) to maximum tolerated dose. Cautious withdrawal may be initiated at 6 weeks. See instructions page 1 of this guidance.

Drug	Starting dose	Maximum dose
Risperidone**	500 microgram o.d.	1mg b.d.
Olanzepine	2.5mg o.d.	10mg o.d.
Quetiapine	25mg o.d.	25-300mg daily
Aripiprazole	5mg o.d.	10mg o.d.
Haloperidol**	0.5mg bd-tds oral/IM	1mg tds oral/IM-IM secondary care only
Lorazepam	0.5 mg – 1mg bd oral/IM	1mg qdsoral/IM-IM secondary care only

^{**} Do not use haloperidol or risperidone in established or suspected Parkinson's disease or Lewy Body Dementia Edited Dr S Wright February 2013. Risperidone is the only drug licensed for aggression in patients with dementia

L = Licensed indication S = Secondary care initiation