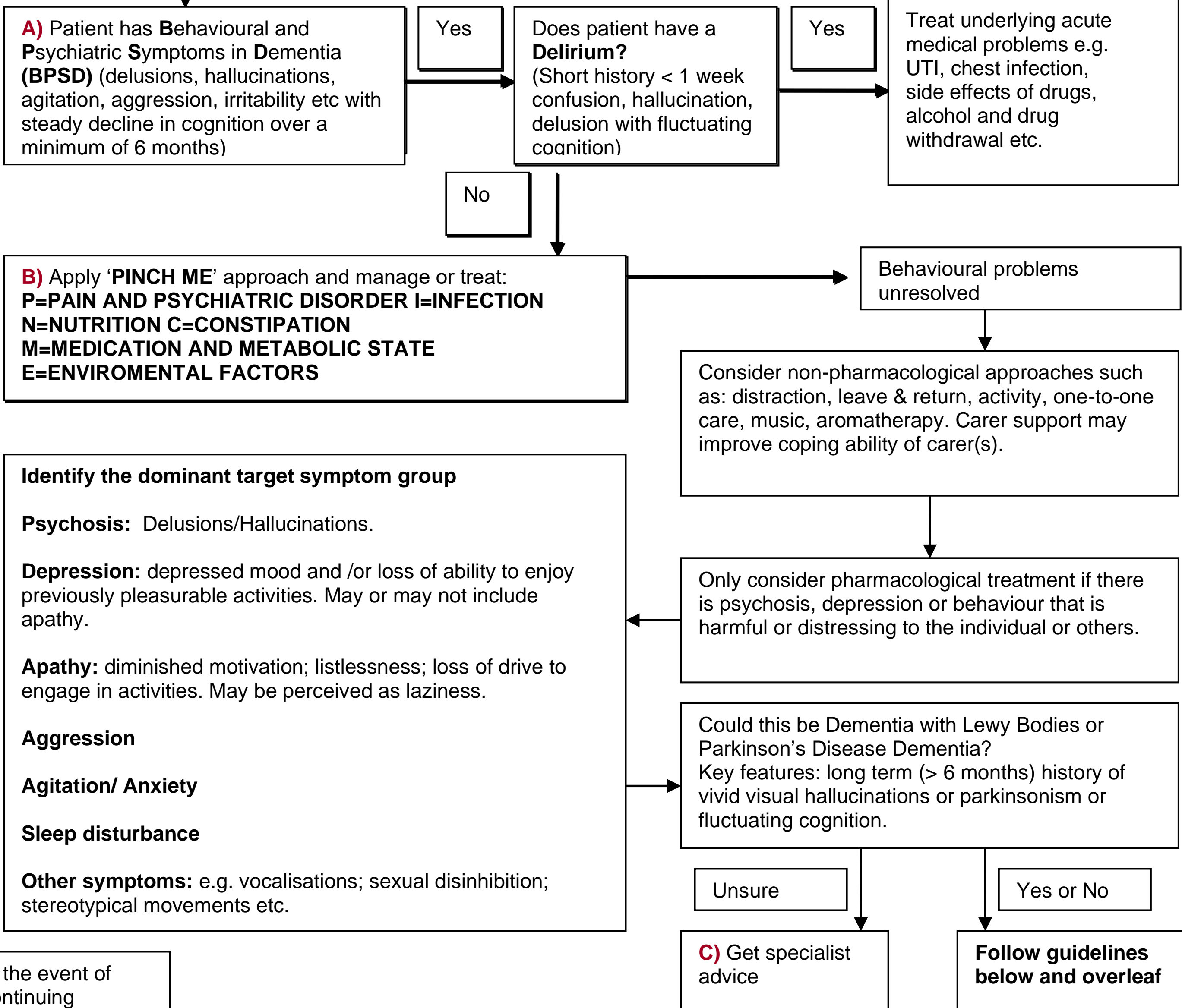
RDASH PROTOCOL FOR MANAGING BEHAVIOURAL AND PSYCHOLOGICAL SYMPTOMS IN PATIENTS WITH DEMENTIA (February 2015)
(Does not cover rapid tranquillisation of acutely disturbed)

A) Primary care responsibility B) Optional primary care responsibility with secondary care support if required or requested C) Secondary care responsibility



In the event of continuing problems, advice can be obtained from CMHT(OP)'s, liaison team or memory service, 01302 796708

*There is only one drug (**Risperidone**) licensed specifically for the treatment of BPSD. For other symptoms drugs are used which have either been shown to improve these symptoms in subjects without dementia or are licensed for cognitive enhancement in patients with dementia.*

General guidelines if pharmacological treatment is indicated.

<u>The use of either typical or atypical antipsychotics in patients with dementia</u> worsens cognitive function; increases the risk of cerebrovascular events (~ 3 xs) and increases mortality rate (~2x). They should only be used after full discussion with the patient (where the patient has capacity to understand) and carer about the possible benefits and likely risks. Risk is likely to increase with increasing age <u>and</u> if other risk factors for cerebrovascular events are present e.g. diabetes; hypertension, cardiac arrhythmias; smoking and existing evidence of **stroke or vascular dementia**.

If antipsychotic treatment is considered necessary avoid typical antipsychotics and start oral risperidone 0.5mg and increase every 2 -4 days if no response **(see specific doses suggestions overleaf).** Patients who respond to treatment should have the drug cautiously withdrawn after 6 weeks. Halve the dose for one week and if no re-emerging symptoms stop the drug. Review again after one week. If symptoms re-emerge reintroduce the drug at starting dose. BPSD can persist and treatment with atypical antipsychotics may be needed in the long term but should be reviewed on a 3 monthly basis. **Patients with Dementia with Lewy Bodies or Parkinson's Disease Dementia** are particularly vulnerable to antipsychotic sensitivity reactions and also have marked extrapyramidal side effects. Treatment doses should follow guidelines overleaf.

<u>The management of antidepressants and hypnotics in patients with dementia</u> has little evidence base and should follow existing guidelines for the management of these drugs in elderly patients without dementia. Treatment doses should follow BNF guidelines.

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.

Authors: Prof C Holmes and Dr S Muthalagu, - March 2009 (Hampshire), Dr S Wright, Ms Sue Wright, April 2011 (Rotherham)

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 type**	**Second line**	**Evidence 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 which is harmful to self or others	Risperidone L Haloperidol	1 2	Olanzapine, Aripiprazole; . Lorazepam Memantine S	2 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; RivastigmineS; 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; GalantamineS. Rivastigmine S Lorazepam	3-4
Agitation/ Anxiety	Citalopram.	3 + £	Rivastigmine S. DonepezilS 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:
L = Licensed indication S = Secondary care initiation

Evidence levels: 1 = Metanalysis; 2 = RPCT's; 3 = Other studies; 4 = Expert opinion; £ = 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**