

Prescribing...

Antipsychotics in dementia

- This month's bulletin revisits the extremely difficult question of how to safely and effectively manage the behavioural and psychological symptoms of dementia (BPSD).
- Advice from NICE in 2006 & in 2013 and from the MHRA in 2009 is that all antipsychotics should be reserved for the short term management of severe BPSD.
- NICE advises that patients with dementia on APs be reviewed to establish why they were prescribed.
- In consultation with carers, families and with expert colleagues such as Psychiatrists, doctors are recommended to establish if it is appropriate to continue or if it safe to discontinue.
- Much of the prescribing in this area is off-label. If so, GMC opinion is that prescribers take full responsibility for the decision and informed consent should be obtained and documented.

Dementia is a progressive and largely irreversible condition, characterised by widespread impairment of mental functioning. The most common cause is Alzheimer's disease and the symptoms include memory loss, language impairment, disorientation, personality changes, difficulties in carrying out daily activities, self neglect etc. Primarily a disease of old age, about two thirds of sufferers are aged over 80 years and two thirds of these live in private households. Many of the spouses or informal carers may be elderly and vulnerable themselves, making management of these issues particularly difficult.

On a population basis the acetylcholinesterase inhibitors or AChIs: donepezil, galantamine and rivastigmine, and memantine demonstrate a modest but statistically significant effect to improve or delay the deterioration in cognitive decline. They are widely prescribed on the islands, at a cost of over £200,000 in 2013.

What is the role of antipsychotics ?

Antipsychotics have been used in the past to manage severe non-cognitive symptoms such as psychosis and/or agitated behaviour, but have no disease modifying effect.

The only antipsychotic licensed for this indication is risperidone. It is restricted for use for up to six weeks for persistent aggression in people with moderate to severe Alzheimer's disease which is unresponsive to non-pharmacological methods and where there is a risk to either the patient or to others. Other drugs, such as low dose quetiapine and olanzapine are not licensed.

The advice of NICE is that their use should be part of a care plan and that

- A full discussion of the possible benefits and likely risks should take place,
- Target symptoms should be identified, quantified and documented,
- A low starting dose be used and then titrated upwards,
If prescribed off-label, GMC guidance is that informed consent must be obtained.
- They should be avoided entirely in dementia patients with Lewy bodies, as these people may be particularly sensitive to severe adverse reactions and
- Treatment should be time limited and reviewed regularly i.e. every three months.

What are the concerns ?

The side effect profile of APs is well known and includes weight gain, cardiovascular symptoms, sedation, parkinsonism, dehydration, falls, chest infection and accelerated cognitive decline. Elderly people are also particularly susceptible to postural hypotension and to hyper- and hypo-thermia in hot or cold weather. In 2009 the MHRA issued a warning that there was increased risk of stroke in patients with Alzheimer's disease who were given anti-psychotics. A subsequent independent clinical report commissioned by the UK government by Professor Bannerjee found that

- There was an unacceptable level of people with dementia dying as a result of being prescribed antipsychotics.
- There was clear evidence that they were being over prescribed.
- That non-pharmacological methods for dealing with anxiety and behavioural problems are available, are more effective and should be used.

For every 100 patients with dementia treated with antipsychotics, 20 will derive some benefit. However 1 patient will die and another 1 will suffer a CVA, who would not have done so if they had not been given an antipsychotic. The risks may outweigh the benefits in people with moderate symptoms.

It concluded that there was an unacceptable level of people with dementia who were dying as a result of being prescribed antipsychotics, as there were better alternatives available.

The UK government advises that this risk applies to all first and second generation antipsychotics, formerly known as typical and atypical.

Since 2009 the prescribing of olanzapine and risperidone had decreased marginally in the UK. However the prescribing of low dose quetiapine has increased proportionately. It is likely that many of these prescriptions are for the unlicensed treatment of people with dementia.

AChIs are also an option for people with Alzheimer's disease or dementia with Lewy bodies with non-cognitive symptoms causing severe distress, where non-drug treatments or antipsychotics are inappropriate or ineffective.

So what is the advice on how to manage these symptoms?

The advice of NICE is that, when patients with dementia first present with BPSD every effort should be made to establish the likely causative factors and to treat them. Depression, pain, physical discomfort, drug side effects etc. can all cause distress and upset in unwell elderly people.

Prescribers considering continuing APs in people with a current prescription are recommended to establish why they were initiated. In consultation with families, carers and colleagues such as psychiatrists, it is recommended that doctors consider if it is appropriate to continue and if not whether it is safe to begin discontinuing.

In summary:

APs should only be initiated when non-drug and other measures have been unsuccessful in relieving the patient's distress. Risperidone is licensed for short term use, but other treatments such as orally dispersible olanzapine or low dose quetiapine are not. All prescribing should be time-limited, regularly reviewed and the results of this review documented.

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References : NICE KTT no 7 , NICE CG 42, GMC Guidance on Prescribing Medicines, EPACKT, BNF no 68