Dear Colleague

**Use of Antipsychotics in Dementia Care and Advice to Other Practitioners**

**Background:**
Historically antipsychotics have been a mainstay of managing behavioural and psychotic symptoms in dementia. However over the last few years there has been increased concern about their toxicity especially a doubled risk of CVA[1] and more recently that longer term use is associated with increased mortality (compared to patients not on antipsychotics)[2]. Simultaneously has come increased evidence that their effectiveness is only in physical aggression and possibly psychotic symptoms[3]. Originally Risperidone and Olanzapine were highlighted by the Committee of Safety of Medicines[1] but more recently this has been shown to be a class effect through newer and older antipsychotics[4]. This has come to the forefront of dementia care with the recent and much publicised report to the Minister of State for Care Services by Professor Sube Banerjee.[5]

Owing to harmonisation of European regulatory systems Risperidone does have a licence for short term use in behavioural problems in dementia but the CSM caution still needs to be borne in mind All other antipsychotics would be used off licence. The best evidence base is for Risperidone with Aripiprazole second (please note the manufacturers of Aripiprazole do not recommend to be used in dementia). Olanzapine and Quetiapine have a much poorer evidence base.

Antipsychotics have an evidence base for physical aggression and psychosis only. There is evidence they do not work for verbalisation- screaming or factors such as wandering, insomnia.

**Assessment**

Before prescribing consideration should be given to other causes such as pain, constipation and delirium. It behoves care staff to adjust their interaction as much as possible to minimise aggression. Antipsychotics prescription should never be a replacement for poor staffing levels.

**Treatment**

Antipsychotics should only be used for physical aggression where there is risk to self or others. If the patient does not have capacity if practical effort should be made to discuss the risks and benefits to the family, this may not always be possible especially in an emergency situation

If an antipsychotic is to be used we are recommending Risperidone first line. Risperidone has a license for "persistent aggression in moderate to severe dementia in Alzheimer's disease unresponsive to non-pharmacological therapy and where there is risk of harm to self or others for up to 6 weeks''. Dose may be starting as low as 0.25mg o.d. and titrating up. In usual circumstances we do not recommend doses above 1mg bd.

**Monitoring**

Any prescription must be time limited. It is strongly recommended that an automatic discontinuation date is given on initiation. Usually we would suggest 6 weeks with cessation and only re-instatement if the same problem occurs. At six months fifty per cent of behavioural problems do remit spontaneously. We would also recommend that any patients already on antipsychotics for behavioural problems in dementia (not schizophrenia or allied psychosis) have their medication stopped regularly and only re-instated if problems recur. The maximum time a patient should be on an antipsychotic before a trail cessation should be 6 months

Continued…

It is recommended the indication is specified and response to those target symptoms documented on review. A sample form is enclosed with this letter. Obviously care staff/ family need to be made aware of possible side effects such as sedation/Parkinsonian symptoms that need to bring for ward a review.

**Alternatives**

There are alternatives to consider. Lorazepam has a safer side effect profile, the dose will be dependent on the frailty of the patient, and will be around 0.5mg o.d. or b.d. We do not recommend Diazepam because of its longer half life. Antidepressants have a partial role in depressive symptoms in dementia – many verbal complaints such as "help me, I want to go home, I want my mother", may indicate underlying depression. Sodium Valporate has no evidence base for its use[6]. Carbamazepine has a limited evidence base though dose should be started low at 100mg o.d. and awareness for rashes or drowsiness.[6] All medications for behavioural problems in dementia must be recognised as temporary measures, especially benzodiazepines We do not recommend continued use of Zopiclone or Temazepam for night sedation although it may have a role as a pulse prescription.

Yours sincerely

References


1) Medical Health Regulation Agency March 2004, US Food and Drug Administration 2003
2) Schneider et al. Risk of death with atypical antipsychotic drug treatment for dementia: meta-analysis of randomised placebo-controlled trials. JAMA 2005, 294(15),192=34-43
3) Schneider et al .Efficacy and adverse effects of atypical antipsychotics for dementia: meta-analysis of randomised, placebo controlled trials. Am J of Geriatric Psychiatry , 2006,14,191-210
4) Pharmacovigilance Working Party Public Assessment Report on Antipsychotics and CVA Sept 2005. Medical Health Regulation Agency Sept 2005
5) S.Banerjee. The use of antipsychotic medication for people with dementia: A time for action. Dept of Health.
6) NICE-SCIE Guideline on supporting people with dementia and their carers in health and social care. National Clinical Practice Guideline Number 42 2007


Disclaimer

This letter is not meant as a guideline or protocol. All Doctors have their own responsibility for their prescriptions and have to bear in mind licensing issues as well as evidence base.


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