MANAGEMENT OF BEHAVIOURAL AND PSYCHOLOGICAL SYMPTOMS OF DEMENTIA (BPSD) IN THOSE AGED 65 YEARS AND OVER.

Guidelines

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MANAGEMENT OF BEHAVIOURAL AND PSYCHOLOGICAL SYMPTOMS OF DEMENTIA (BPSD) IN THOSE AGED 65 YEARS AND OVER.

Summary- Assessment & Treatment of BPSD

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Management of Behavioural & Psychological Symptoms of Dementia (BPSD) in patients aged 65 years and over - ASSESSMENT

- Obtain informed consent under the Mental Capacity Act before each treatment decision (including permission to discuss with carer).
- Review regularly depending on type of treatment (see BNF/SPC) and record in patient notes.
- Tailor individual care plan to help carers & staff. Record the care plan in the notes, Frequency of review to be agreed with carers & staff. Review staff competencies and train where required.

Patient presents with BPSD (non-cognitive symptoms including hallucinations, delusions, anxiety, agitation, aggression, sleep disturbance, mood symptoms such as depression, apathy & behavioural issues such as shouting, sexual disinhibition e.t.c. with steady decline in cognition over 6 months.)

<table>
<thead>
<tr>
<th>Rule out delirium (short history &lt; 1 week, confusion, hallucination, delusion with fluctuating cognition).</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes - Treat underlying cause e.g. UTI, chest infection e.t.c. <a href="http://www.nice.org.uk/nicemedia/live/13060/49910/49910.doc">http://www.nice.org.uk/nicemedia/live/13060/49910/49910.doc</a></td>
</tr>
<tr>
<td>No - Assess the risks to the patient and others</td>
</tr>
</tbody>
</table>

Immediate, SEVERE risk?

- Yes - Go to treatment

No - NONE or MILD- Risk manage in present setting with WATCHFUL WAITING CARE PLAN.

Try NON-PHARMACOLOGICAL INTERVENTIONS - manage or treat for an adequate period of time (GP review at 2 and 4 weeks)

| P | Physical problems e.g. infection, pain |
| --- |
| A | Activity-related e.g. dressing, washing |
| I | Iatrogenic e.g. side effects of drugs |
| N | Noise & other environmental factors e.g. lighting |

If behaviour unresolved consider other interventions

Other interventions:

- Watchful waiting (may be self-limiting)
- One to one physical presence with carer
- Recreational/social activities and therapies e.g. music therapy, complementary therapies.
- Behavioural interventions e.g. distraction, leave & return.
- Psychological & psychosocial interventions e.g. carer support may improve coping ability of carer
- Risk assess to see appropriateness of placement

Where SEVERE non-cognitive symptoms PERSIST despite non-pharmacological interventions OR there is an IMMEDIATE RISK OF HARM to the patient or others consider pharmacological treatment.

**Dementia type known?**

Continue on with treatment guidelines.

**Highlight Dementia with Lewy Bodies or Parkinson’s Disease**

Dementia on patient notes - key features: long term (6 months), history of vivid visual hallucinations or parkinsonism or fluctuating cognition.

**Unknown dementia type? - refer to specialist!**

The reasons for initiating/continuing/discontinuing treatment in secondary care MUST be notified to the GP. These must form part of the GP’s regular patient reviews & records.

Continue with non-pharmacological interventions and go to pharmacological treatment guidelines.

See [http://www.alzheimers.org.uk/antipsychotics](http://www.alzheimers.org.uk/antipsychotics) for patient/carer leaflet, review charts and care plans.
Management of Behavioural & Psychological Symptoms of Dementia BPSD in patients aged 65 years and over - Oral Pharmacological Treatment Guidelines (Does not cover rapid tranquilisation of acutely disturbed or depot injections)

**Identify the dominant target symptoms:** Psychosis; aggression; depression/ anxiety; agitation; sleep disturbance; other symptoms

Discuss treatment options with, explain risk/benefits to patients (if they have the capacity) &/or family and carer/family (as appropriate) under the Mental Capacity Act. Agree treatment (highlighting any “off-label” prescribing) and criteria for assessment. Document discussions. Don’t add antipsychotics, hypnotics or benzodiazepines to repeat medication to prompt regular review.

**Carry out risk benefit analysis** tailored to individual patient needs. Include baseline investigations when required or if specified in SPC.

### Depressi on/ anxiety and sleep disturbance
Follow existing guidelines for the management of these drugs in elderly patients without dementia. Treatment doses should follow BNF guidelines. Antidepressants may need to be used for at least 12 months and up to 2 years where there is a history of recurrence. See summary of antidepressants (table 1) and NHS Surrey Depression & Anxiety website.

http://www.surreyhealth.nhs.uk/services/Professionals/DP C/Pages/default.htm See SPC & BNF for discontinuation.

### Aggression
Risperidone (an antipsychotic) is the only licensed drug for short term treatment (up to 6 weeks) of persistent aggression in patients with moderate to severe Alzheimer’s dementia unresponsive to non-pharmacological approaches and when there is a risk of harm to self or others. See SPC and antipsychotics below for treatment and discontinuation.

### Agitation
Haloperidol (an antipsychotic) is licensed for restlessness and agitation in the elderly. See SPC and antipsychotics below for treatment and discontinuation. The SSRIs citalopram and sertraline plus anticonvulsant carbamazepine are unlicensed.

### Psychosis

**Treat with an antipsychotic.** Decide on which antipsychotic with patient/carer/family/specialist as appropriate.

See [http://www.mhra.gov.uk/Safetyinformation/Generalsafetyinformationandadvice/Product- specificinformationandadvice/Antipsychoticdrugs/index.htm](http://www.mhra.gov.uk/Safetyinformation/Generalsafetyinformationandadvice/Product-specificinformationandadvice/Antipsychoticdrugs/index.htm) for the increased risk of stroke (~3-fold) and mortality (~ 1-2%) when antipsychotics are prescribed in patients with dementia and Time for Action


- Consider extrapyramidal side effects (e.g. akathisia), metabolic side effects (e.g. weight gain) and other side effects (e.g. sedation, constipation & unpleasant subjective experiences).
- Consider cerebrovascular risks e.g. diabetes, hypertension, cardiac arrhythmias, smoking and existing evidence of vascular dementia (Check SPC for ECG requirement, undertake physical examination, review personal history).
- Follow this same guideline for “as required” (p.r.n.) antipsychotics and review weekly. Check dosage appropriate in BNF/SPC.
- Patients with Dementia with Lewy Bodies or Parkinson's Disease Dementia are vulnerable to neuroleptic sensitivity reactions and marked extrapyramidal side effects. Make choice of antipsychotic accordingly.

Treatment with antipsychotics is an Individual therapeutic trial

- Record indications, expected benefits & risks (including “off-label” prescribing and symptoms of stroke), expected time for a change in symptoms and for side effects to occur.
- **START LOW AND GO SLOW** Start with the lowest dose (BNF or SPC) and titrate up slowly (increase every 2-4 days if no response) at the best time of day (e.g. lunch time for “sundowning”).
- Justify & record reasons for dosage outside range specified in BNF or SPC.
- Monitor and record efficacy, side effects, adherence & physical health regularly throughout treatment.
- Record the rationale for continuing, changing or stopping medication & the effects.
- **Carry out a trial of the medication at optimum dosage for 4-6 weeks.** Patients who respond to treatment should have the drug cautiously withdrawn after 6 weeks. Discontinuation after 12 weeks should be default except in extreme circumstances.
- **Where treatment is LESS THAN 12 WEEKS.** For LOW DOSES stop and monitor. Review at 2 weeks. For HIGHER DOSES reduce to half dose for 2 weeks, GP review at 2 weeks, discontinue immediately after a further 2 weeks. Review at 2 weeks. (DAA & RCGP).
- If symptoms represent then reintroduce the drug at the starting dose.
- Patients often have to try several different antipsychotics before the right one is found. Don’t start regular combined antipsychotics except for short periods e.g. when changing medication.
- Contact specialist for advice, particularly if patient had schizophrenia with psychosis prior to BPSD or prescribing beyond 12 weeks.

BPSD can persist and treatment with antipsychotics may be required for longer than the trial period. Review 6 weekly (max 3 monthly) so that ineffective drugs are not continued unnecessarily. Consider stopping drugs or reducing doses at every review. Document (including secondary care decisions which must be notified to GP) target symptoms & any adverse effects, reasons for continuing/discontinuing treatment after risk/benefit analysis, discussions with patient/family/carers, secondary care decisions in patient record.

**TREATMENT GREATER THAN 12 WEEKS** must be gradually discontinued per BNF/SPC or by slowly tapering down over at least 3 weeks whilst closely monitoring (Maudsley Guidelines).

For patients prescribed antipsychotics see BNF & SPC on monitoring of urea & electrolytes, full blood count, blood lipids, weight, plasma glucose, ECG, blood pressure, prolactin, liver function tests, creatinine phosphokinase & other tests.

**The use of acetylcholinesterase inhibitors or memantine in BPSD should be initiated and supervised only by a specialist. Treatment with acetylcholinesterase inhibitors and memantine can be continued in primary care when under a shared care agreement.**

FOR RELAPSE START ALGORITHM AGAIN AS SYMPTOMS AND RISKS MAY HAVE CHANGED.
MANAGEMENT OF BEHAVIOURAL AND PSYCHOLOGICAL SYMPTOMS OF DEMENTIA (BPSD) IN THOSE AGED 65 YEARS AND OVER.

This guideline is based on:

- NICE clinical guideline 42 Dementia: supporting people with dementia and their carers in health and social care
- NICE technology appraisal guidance 217 Donepezil, galantamine, rivastigmine and memantine for the treatment of Alzheimer's disease (review of NICE technology appraisal guidance 111)
- All-Party Parliamentary Group on Dementia (APPG)
- The use of antipsychotic medication for people with dementia: Time for action.
- Living well with dementia: A National Dementia Strategy
- Medicines and Healthcare Products Regulatory Agency (MHRA)
- South West London and St George’s Mental Health Trust “The use of antipsychotic medicines for non-cognitive symptoms in dementia”
- Surrey and Borders Partnership NHS Trust “Managing Behavioural Problems in People with Dementia”.
- BNF (2011)
- The Maudsley Prescribing Guidelines (10th edition)
- Proposal: Antipsychotic Drugs in Dementia - Dr Jill Rasmussen
- Alzheimer’s Society: “Reducing the use of antipsychotic drugs” and “Optimising treatment and care for people with BPSD: A best practice guide for health and social care professionals”

Prescribers should refer to the individual Summaries of Product Characteristics (www.emc.medicines.org.uk) for individual medicines.

1 Introduction

The behavioural and psychological symptoms of dementia (BPSD) are non-cognitive symptoms which may include aggression, wandering, anxiety, sleep disturbance, hallucinations, delusions, sexual disinhibition and other mood disorders. They are accompanied by a steady decline in cognition over six months.

The symptoms are recognised under three separate syndromes that can occur independently or together; these are:

- Agitation (which includes aggression or wandering)
- Psychosis
- Mood disorders

Each syndrome is thought to have a different biological basis. The different symptoms of each syndrome can result in a variety of medicines being prescribed to treat them such as antidepressants, hypnotics and anxiolytics, but also more controversially can include antipsychotics.

Dementia is a chronic, progressive mental disorder and the main sub-types of dementia are Alzheimer’s disease, vascular dementia, mixtures of these two pathologies (‘mixed dementia’) and rarer types such as Lewy body dementia, dementia in Parkinson’s disease and fronto-temporal dementia. Alzheimer’s disease is the most common form of dementia and it affects predominantly, but not exclusively, people over 65 years of age.

Some statistics for the UK from the National Dementia Strategy:

- There are approximately 700,000 people with dementia.
- In just 30 years, the number of people with dementia is expected to double to 1.4 million
- The national cost of dementia is about £17 billion per year.
- In the same 30 years, the cost will treble to over £50 billion per year.
Dementia is predominantly a disorder of later life, but there are at least 15,000 people (around 2%) under the age of 65 who have the illness (early onset dementia).

There is currently no cure for Alzheimer’s disease and the aims of treatment are to promote independence, maintain function and treat the symptoms. NICE noted that clinical specialists and patient

An independent report 11 “Time for action” looked at the prescribing of antipsychotics in people with dementia and highlighted an unacceptable level of people with dementia dying as a result of being prescribed an antipsychotic. It recommended that non-pharmacological approaches to dealing with anxiety and behavioural problems are available and should be used to reduce the prescribing of antipsychotics where possible. The use of low dose antipsychotics should be used in prescribing for those aged 65 years and over where this cannot be avoided.

“Time for action” estimated that:
- The UK treats 180,000 people with dementia with antipsychotic medication.
- Of these, only up to 36,000 (20%) will derive some benefit from the treatment.
- Use at this level equates to an additional 1,620 cerebrovascular adverse events, around half of which may be severe.
- Antipsychotic treatment adds an additional 1,800 deaths per year on top of those that would be expected in this frail population.

2 Prescribing in those aged 65 years and over

The following principles will need to be considered for all prescribing:

- Concurrent illnesses and potential drug interactions.
- How drugs affect the ageing body (altered pharmacodynamics) due to poorer reflexes and increased sensitivity may lead to more serious side effects e.g. stroke with antipsychotics; bleeding with SSRIs. There may also be a longer therapeutic response time.
- Ageing affects drug therapy (altered pharmacokinetics) due to slower absorption, different distribution (more fat and less albumin), reduced liver size for hepatic metabolism and reduced renal function affecting excretion.
- Drug interactions, toxicity and therapeutic failure are more common due to the above factors, particularly in medicines with a narrow therapeutic index e.g. digoxin, warfarin, theophylline, phenytoin and lithium or those affecting metabolising enzymes e.g. SSRIs, erythromycin and carbamazepine.

To reduce drug related risk:

- Use drugs only when absolutely necessary.
- Avoid, if possible, drugs that block alpha1 adrenoceptors, have anticholinergic side effects, are very sedative, have a long half-life or are potent inhibitors of hepatic metabolising enzymes.
- Start with a low dose and increase slowly but do not under treat. Some drugs will require the full adult dose (see BNF/ SPC).
- Try not to treat the side effects of one drug with another. Switch to a better-tolerated alternative.

Prescribe at the best time of day. For example where patient experiences “sundowning”, dosing may be best at lunch time.

3 Assessment
Assess the patient to establish the likely factors that may generate, aggravate or improve non-cognitive behaviour that challenges.

The Alzheimer’s Society has some clinical checklists, care plans and review charts that can be used in their guidance for health and social care professionals.12

Record:

12 http://www.alzheimers.org.uk/antipsychotics
• Physical health; rule out delirium.
• Depression.
• Possible undetected pain or discomfort.
• Side effects of medication.
• Individual biography, including religious beliefs and spiritual and cultural identity.
• Psychosocial factors.
• Physical environmental factors.
• Behavioural and functional analysis conducted by professionals with specific skills, in conjunction with carers and care workers.
• Is behaviour a problem for patient or carer?

4 Non-pharmacological management

Consider these approaches first in BPSD and use a watchful waiting care plan with GP review after 2 and 4 weeks.

- Where possible put into effect solutions to the PAIN approach e.g.
  - Treat underlying health problems.
  - Environmental interventions such as design and layout of the physical environment, day and night routines.
  - Compensating for sensory impairments, improving diet and general health.

- Physical presence where carer spends more time with person such as one to one.
- Recreational or social activities and therapies such as music therapy or complimentary therapies can help to structure the day plus improve social interaction.
- Behavioural interventions by identifying the nature, causes and consequences of the behaviour (behaviour therapy). Consider distraction, leave and return.
- Psychological and psychosocial interventions tailored to the needs of the individual patients, family, carers and staff (need led therapy).
- After a risk assessment consider appropriateness of placement.
- Watchful waiting (up to half of all cases may be self-limiting and will resolve within 4 weeks\(^\text{13}\)) - use a watchful waiting care plan.

Carer support may improve coping ability of carer.

If the symptoms improve after 4 weeks stay with patient-centred care and if they have not resolved consider moving to specific treatments.

5 Hypnotics

Promote good sleep patterns and sleep hygiene by:

- Looking at PAIN in the algorithm above & reviewing the environment e.g. comfort, lighting, reducing noise to a minimum.
- Having a regular sleeping and waking time.
- Scheduling medication rounds to avoid disturbing sleep.
- Avoiding nursing or medical procedures during sleeping hours, if possible.

The use of hypnotics in those aged 65 years and over should be avoided where possible and reserved for short courses in the acutely distressed. If non-pharmacological interventions are unsuccessful, consider prescribing a short-acting hypnotic to reduce the associated risks of ataxia, confusion and falls. Tolerance develops after 3 to 14 days. Benzodiazepines should be used to treat insomnia only when it is severe, disabling, or causing the patient extreme distress; temazepam minimises the residual effect the following day.

Discontinuation

\(^\text{13}\) http://www.alzheimers.org.uk/antipsychotics
Discontinuation can cause rebound insomnia. Hypnotics should be discontinued as soon as possible. Warn patients & carers that sleep may be disturbed for a few days before normal rhythm is established. Broken sleep with vivid dreams may persist for several weeks. For benzodiazepines avoid abrupt withdrawal and titrate down in steps of one-eighth (range one-tenth to one-quarter) of the daily dose every fortnight (see also under anxiolytics for suggested protocol).

### 6 Antidepressants

Antidepressants may need to be used for at least 12 months in those aged 65 years and over and up to 2 years where there is a history of recurrent depression. See the NHS Surrey Depression and Anxiety website for in depth choice of drug.

http://www.surreyhealth.nhs.uk/SERVICES/PROFESSIONALS/dpc/Pages/default.htm

Antidepressants have largely equal efficacy so the choice should be determined by:

- The individual clinical circumstances of the patient.
- Individual antidepressant safety profile, particularly in overdose (TCAs and venlafaxine greater risk in overdose. Dosulepin should not be prescribed.)
- Co-morbidity.
- Other medication and interaction potential (higher risk with fluoxetine, fluvoxamine and paroxetine but see BNF/SPC).
- Previous experience of treatment.
- Side-effect profile.
- Patient preference.
- Propensity to cause discontinuation symptoms (increased risk with paroxetine and venlafaxine).
- Concomitant presence of generalised anxiety disorder.
- MAOIs have dangerous interactions with some foods and drugs. Initiation, maintenance and discontinuation should be via specialist only.

SSRIs have a favourable risk/benefit ratio in comparison to TCAs, but in those aged 65 years and over there is an increased risk of GI and other bleeds (consider patient history, NSAIDs, steroids, warfarin), hyponatraemia and postural hypotension leading to falls, see table 1 below. Sertraline has been found to be safe post MI, in unstable angina & heart failure.

SSRIs, in particular citalopram and sertraline, may benefit agitation in dementia as well as mood and anxiety, although this is an unlicensed indication.\(^\text{14}\)

**Discontinuation**

Discontinuation symptoms on stopping treatment are usually mild, but may be severe with shorter half-life drugs like paroxetine and venlafaxine, as these drugs (or their metabolites) inhibit and are metabolised by the cytochrome p450(CYP)2D6 isoenzyme system. Discontinuation of these drugs can therefore cause an abrupt drop in levels.

When taken continuously for 6 weeks or more, antidepressants should not be stopped abruptly unless a serious adverse event has occurred.

- Reassure patients and advise them of the likely discontinuation symptoms (see SPC/BNF).
- Slow tapering may not reduce the incidence and severity of discontinuation symptoms so some patients may prefer abrupt cessation and a shorter discontinuation syndrome.

\(^{14}\) http://www2.cochrane.org/reviews/en/ab008191.html
Down-titrate the dose over at least 4 weeks (not required for fluoxetine which has a longer plasma half-life), and longer if discontinuation symptoms emerge. This is more important if the drug has a shorter half-life, refer to SPC.

The end of the taper may need to be slower when the reduction of total daily dosage of the antidepressant is proportionately substantial to the original daily dose and so discontinuation symptoms may then appear.

At risk patients may need a slower taper.

For patients on long-term maintenance treatment down-titrate over 6 months.

If discontinuation symptoms are mild on cessation then reassure the patient that these symptoms are common after discontinuing an antidepressant and that they will stop after a few days.

For severe discontinuation symptoms on cessation, reintroduce the original antidepressant (or another with a longer half-life from the same class) and taper again gradually whilst monitoring for symptoms.

There is some evidence for the use of anticholinergic agents in tricyclic withdrawal and fluoxetine for clomipramine or venlafaxine withdrawal.

If discontinuation symptoms continue then refer to a specialist.

Table 1: Summary of antidepressants and side effects in those aged 65 years and over (refer to BNF & SPC)

<table>
<thead>
<tr>
<th>Anticholinergic side effects</th>
<th>SSRIs</th>
<th>Older TCAs</th>
<th>Lofepramine</th>
<th>Others</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dry mouth with paroxetine.</td>
<td>Marked in most; moderate with nortriptyline, imipramine and dosulepin.</td>
<td>Constipation and sweating can be severe, otherwise moderate.</td>
<td>Few with mirtazepine, venlafaxine, reboxetine, duloxetine.</td>
<td></td>
</tr>
</tbody>
</table>

| Postural hypotension | Less of a problem than with TCAs, but some evidence of increased risk of falls. | Dosage titration is essential as all can cause postural hypotension. | Can be problematic, but not as severe as older TCAs. | Venlafaxine and duloxetine can cause hypotension at lower doses but conversely hypertension at higher doses. |

| Sedation | May occur with paroxetine and fluvoxamine. Unlikely with other SSRIs. | Variable. Severe with trimipramine. Minimal with imipramine. | Minimal. | Duloxetine is neutral. Mirtazapine, mianserin and trazodone are sedative. |

| Weight gain | Generally weight neutral apart from paroxetine and possibly citalopram. | All cause weight gain. | Little evidence. Lack of spontaneous reports may indicate less potential than older TCAs. | More problematic with mirtazapine, although not so severe with this age group. |

| Safety in overdose | Safe, apart from citalopram (minor metabolite can cause significant QTc prolongation). | Dosulepin and amitriptyline are the most toxic (seizures and cardiac arrhythmia). For this reason dosulepin should not be prescribed. | Relatively safe. | Venlafaxine is more toxic in overdose than SSRIs but safer than TCAs. Others are relatively safe. |

| Other side-effects | Hyponatraemia, GI effects, headaches; increased risks of bleeds; orofacial dyskinesia with seizures, anticholinergic induced cognitive impairment, increased risk of bleeds with Raised LFTs. | Reboxetine causes insomnia and hypokalaemia. Venlafaxine causes nausea. Duloxetine causes weight loss and... |
### Drug interactions

<table>
<thead>
<tr>
<th>Drug interactions</th>
<th>paroxetine.</th>
<th>serotonergic drugs.</th>
<th>nausea.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Citalopram and escitalopram are safest, followed by sertraline. Several hepatic cytochrome enzymes are severely inhibited by fluvoxamine, fluoxetine and paroxetine.</td>
<td>Mostly pharmacodynamic: more sedation with benzodiazepines, more hypotension with diuretics, increased constipation with anticholinergic drugs.</td>
<td>Mostly pharmacodynamic: more sedation with benzodiazepines, more hypotension with diuretics, increased constipation with anticholinergic drugs.</td>
<td>Check for potential interactions. Duloxetine inhibits CYP2D6 enzymes; moclobemide and venlafaxine inhibit CYP450; Reboxetine is safe.</td>
</tr>
</tbody>
</table>

### Cardiac effects

#### Summary (refer to SPC for each drug)


7 Anxiolytics

Intervention is only required when these symptoms are severe and there is a risk to the patient or others.

For generalised anxiety disorder (GAD), panic disorder and obsessive-compulsive disorder (OCD), psychological therapy is more effective than pharmacological therapy and should be used as first line under NICE. SSRIs should be used where indicated for first line pharmacological therapy if psychological therapy fails.\(^\text{15}\)

**SSRIs** should be used to treat GAD, panic disorder and OCD particularly in the medium to longer term. Refer to the BNF and SPC for individual drugs and the NHS Surrey Depression & Anxiety website.

http://www.surreyhealth.nhs.uk/services/Professionals/DPC/Pages/default.htm

**Discontinuation**

To discontinue SSRIs, the dose should be reduced as slowly as tolerated over several weeks to months. See antidepressants section 6.

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**Benzodiazepines** give rapid symptomatic relief from acute anxiety states in GAD, but should only be used at the lowest possible dose for the shortest possible time (preferable 2 weeks, maximum 4 weeks) whilst medium/longer term treatment is put into place. This is to reduce the risk of physical dependence, withdrawal symptoms, falls and confusion.

**Discontinuation**

**For withdrawal where dependence has occurred:**

Titrated down in steps of one-eighth (range one-tenth to one-quarter) of the daily dose every fortnight.

**Suggested protocol for patients who have difficulty:**

1. Transfer patient to equivalent daily dose of diazepam preferably taken at night (Approximate equivalent dose, diazepam 5mg=chlordiazepoxide 15mg; loprazolam 0.5mg-1mg; lorazepam 500 micrograms; lormetazepam 0.5mg-1mg; nitrazepam 5mg; oxazepam 15mg; temazepam 10mg).
2. Reduce diazepam dose every 2-3 weeks in steps of 2 or 2.5mg; if withdrawal symptoms occur, maintain this dose until symptoms improve.
3. Reduce dose further, in smaller doses if necessary (can range from 500 micrograms to 2.5mg depending on initial dose and duration of treatment).
4. Stop completely.

Overall period needed for withdrawal can vary from 4 weeks to a year or more.

**8 Antipsychotics**

The Alzheimer’s Society have produced a leaflet for patients and carer’s, called “Reducing the use of antipsychotic drugs: A guide to the treatment and care of behavioural and psychological symptoms of dementia”. They also have a toolkit “Optimising treatment and care for behavioural and psychological symptoms of dementia: A best practice guide” for health and social care professionals which contains a pathway for patients who do not have a current antipsychotic prescription and one for those who have already been prescribed antipsychotic drugs. There are also useful checklists, care plans, monitoring plans and a review chart. Prevention, watchful waiting, specific interventions and antipsychotic prescribing are all covered. Both documents can be accessed on their website.16

Where an antipsychotic is prescribed the following risk/benefits should be assessed for each individual (see BNF/SPC and table 2 below):

- Cerebrovascular risk (including risk factors for cerebrovascular disease).17
- Extrapyramidal side effects (EPS), including akathisia.
- Metabolic side effects (including weight gain)
- Other side effects (including unpleasant subjective experiences).

Before starting treatment with antipsychotics an electrocardiogram (ECG) should be offered if specified in the SPC. Also consider if an ECG would be beneficial after assessing the risks (including risk predictors for stroke) and benefits, for example where:

- A physical examination has identified a cardiovascular risk (e.g. hypertension)
- Patient has a history of cardiovascular disease.
- Patient is being admitted as an inpatient.

Patients/caregivers should be cautioned to immediately report signs and symptoms of potential cardiovascular events such as sudden weakness or numbness in the face, arms or legs, and speech or vision problems.

Newer or ‘atypical’ antipsychotics have a lower potential risk of EPS. However, these side effects are not the only ones that should be considered. Weight gain and gynaecomastia/galactorrhoea may also be important to patients and effects on blood lipids and glucose tolerance may also be clinically significant. For older patients the increased risk of movement disorders, stroke, anticholinergic effects and postural hypotension or sedation leading to falls may outweigh the increased risks of diabetes, dyslipidaemia and weight gain. The lowest effective dose should be prescribed.

16 http://www.alzheimers.org.uk/antipsychotics

Management of BPSD in those aged 65 years and over
Review. June 2013
The clinical trials CATIE\(^{18}\) and CuTLASS\(^{19}\) have demonstrated that, with the possible exception of clozapine, if differences in EPS can be minimised by careful dosing and anticholinergic use avoided there is little to choose between the effectiveness of older generation (so-called ‘typical’ or ‘conventional’) antipsychotics, such as haloperidol and perphenazine, and the newer (‘atypical’) antipsychotics such as risperidone\(^{\downarrow}\), olanzapine\(^{\downarrow}\) and quetiapine. All are associated with a high rate of discontinuation and patients will frequently need to try more than one drug to identify the one that is sufficiently effective and well tolerated to be acceptable to the individual patient.

**Risperidone\(^{\downarrow}\)** is the only antipsychotic indicated for a behavioural problem in people with dementia, for short-term treatment (up to six weeks) for persistent aggression in patients with moderate to severe Alzheimer’s dementia unresponsive to non-pharmacological approaches and when there is a risk of harm to self or others.

**Haloperidol is indicated for restlessness and agitation in the elderly.**\(^{20}\)

**Clozapine is a red drug.** It is only prescribed by Surrey & Borders Partnership consultants. Patient, prescriber & supplying pharmacist must be registered with the relevant manufacturer’s patient monitoring service. Clozapine should not be prescribed in primary care.

### Vascular dementia

Management options are currently very limited and concentrate on reducing the underlying risk factors for cerebrovascular disease.

### Dementia with Lewys Bodies (DLB)

See anticholinesterase inhibitors (section 10) below.

#### Initiation:

- Record discussions on off-licence prescribing and risk/benefits in patient notes.
- Patients/caregivers should be cautioned to immediately report signs and symptoms of potential cardiovascular events such as sudden weakness or numbness in the face, arms or legs, and speech or vision problems.
- A trial of the medication should be carried out at the optimum dosage for 4 to 6 weeks.
- Treatment should be reviewed at least once monthly.\(^{21}\)
- Initial doses should be reduced (usually to half the adult dose or less, but see BNF/SPC for each drug) after taking into account the patient’s weight, co-morbidity and concomitant medication.
- Consider taking specialist advice if necessary.

#### Discontinuation:

Unless there is severe risk or extreme distress the recommended default management is to discontinue the antipsychotic and monitor/assess using watchful waiting and specific interventions under PAIN or other interventions. If further treatment with antipsychotics is clinically necessary after 12 weeks then a referral to specialist services is advised.\(^{22}\)

Undertake a thorough risk/benefit analysis for each individual patient and document in the patient record.

- **Due to the increased cerebrovascular and mortality risks in patients aged 65 years and over,** antipsychotics **should not be prescribed for more than 3 months in BPSD without sound reasons,** which should be documented\(^{23}\).
- If patient had schizophrenia with psychosis prior to BPSD then this may be a good reason to continue prescribing beyond 3 months.
- Recurrence of BPSD may be more likely if previous discontinuation has caused symptoms to return or the person currently has severe symptoms.\(^{24}\)

Consider the following factors:

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19 Jones P, et al. Cost utility of the latest antipsychotic drugs in schizophrenia study (CuTLASS 1). Arch Gen Psych;63:1079-1087.
20 [http://www2.cochrane.org/reviews/en/ab002852.html](http://www2.cochrane.org/reviews/en/ab002852.html)
21 [http://www.nyrdtc.nhs.uk/docs/smu/rdtec_smu_09_antisychotics.pdf](http://www.nyrdtc.nhs.uk/docs/smu/rdtec_smu_09_antisychotics.pdf)
22 [http://www.alzheimers.org.uk/antipsychotics](http://www.alzheimers.org.uk/antipsychotics)
24 [http://www.alzheimers.org.uk/antipsychotics](http://www.alzheimers.org.uk/antipsychotics)
Are there any symptoms from the agreed criteria and if now symptom free, for how long?
Are there any adverse effects and how severe are they?
How severe were the symptoms, what was the speed of onset, duration and was there any danger to the patient or others from the symptoms?
Has dosage reduction been already been tried and what was the result?
What are the physical and social circumstances of the patient and are they likely to exacerbate a relapse?
What is the potential social cost of a relapse? e.g. carer unable to cope.
Is the patient/carer/family able to monitor symptoms and contact a healthcare professional if there is a relapse?

Abrupt withdrawal when on high doses may lead to discontinuation symptoms in some patients and should be avoided unless there is a severe adverse reaction. For low doses discontinuation symptoms are unlikely and so they can be stopped with carefull monitoring. Withdrawal after long-term therapy on higher doses should be gradual and closely monitored.

For relapse start the patient treatment algorithm again as symptoms and risks may have changed.

There is currently little evidence available on the numbers of patients that need to restart antipsychotics after discontinuation in dementia. One study reported that 20% of residents whose antipsychotic was stopped or their dose lowered had the agent restarted or the dose increased and that 33% of those residents had axis I psychiatric disorders other than dementia.25 DART-AD, another long term study noted that only 7 patients of 64 on placebo were restarted on antipsychotics (11%) but this finding was not a primary objective of the study.26 “Time for Action” found that only up to 20% of patients will derive some benefit from treatment with antipsychotics.27 The Alzheimer’s Society advises that at least 30% of antipsychotic prescriptions could be reduced or stopped without any ill effects and that 70% of people have no worsening of symptoms when antipsychotics are discontinued.28

Discontinuing antipsychotic use of up to 12 weeks duration:

**For patients receiving a low dose antipsychotic (Dementia Action Alliance(DAA)&RCGP)**:
Proceed directly with discontinuation and monitoring. Review at 2 weeks.
The suggested low doses are:
- Risperidone low dose=0.5mg
- Olanzapine low dose=2.5mg
- Quetiapine low dose = 50mg
- Aripiprazole low dose=5mg
These are the suggested doses but it is recommended to check the BNF/SPC.

**For patients receiving a higher dose antipsychotic (DAA&RCGP)**:
Taper the dose over one month.
- Reduce to half dose for two weeks.
- GP review at two weeks.
- Discontinue immediately after a further two weeks.
- Review at 2 weeks

For patients under review by secondary care then, provided patient is stable, a trial discontinuation of antipsychotic should be recommended alongside management of recurrence of BPSD by the care home (consider non-pharmacological approaches and staff training where necessary). Review is to be agreed between primary and secondary care for the patient until it has been determined that they are stable.

Discontinuation for antipsychotic treatment over 12 weeks duration:
- Establish reason for initiation of antipsychotic and consider whether this is a “sound reason” for continuing with treatment. Record in notes.
- See SPC for discontinuation or gradually withdraw treatment by slowly tapering down over at least 3 weeks (see below for examples) for oral antipsychotics (Maudsley Guidelines).
- Closely monitor.

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26 http://www.thelancet.com/journals/laneur/article/PIIS1474-4422(08)70295-3/abstract
28 http://www.alzheimers.org.uk/antipsychotics
29 http://www.alzheimers.org.uk/antipsychotics
30 http://www.alzheimers.org.uk/antipsychotics
For patients under review by secondary care, then the same recommendations for a trial discontinuation should apply, but where the patient still requires antipsychotics, the review and responsibility for continued prescribing is to be agreed between primary and secondary care on an individual basis.

Refer to specialist for depot OR if there are concerns.

Tapering of antipsychotic medication:
Prior to tapering medication ensure that the patient has no physical health problems associated with BPSD, non-pharmacological approaches of treatment are available and that Care Home staff/carers have had training in management of BPSD.

With carer support:
- Implement small decreases in dose (ensure dose possible with strengths), one step down at a time.
- Where the antipsychotic is given more than once daily, decrease only one dose to start with, choosing the dose where the patient is likely to be least affected.
- Allow sufficient time for the patient to adapt to the new dose (usually one to two weeks) before considering the next small reduction in dose.
- When the lowest dose has been achieved on a daily basis then administer on alternate days before stopping completely.

Examples:

<table>
<thead>
<tr>
<th>Drug</th>
<th>AM Dose</th>
<th>PM Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Haldol</td>
<td>1mg</td>
<td>1mg</td>
</tr>
<tr>
<td>Change to</td>
<td>1mg</td>
<td>0.5mg</td>
</tr>
<tr>
<td>2 weeks later</td>
<td>0.5mg</td>
<td></td>
</tr>
<tr>
<td>Aripiprazole</td>
<td>10mg</td>
<td>n/a</td>
</tr>
<tr>
<td>Change to</td>
<td>5mg</td>
<td>n/a</td>
</tr>
<tr>
<td>2 weeks later</td>
<td>2mg</td>
<td></td>
</tr>
</tbody>
</table>

Table 2: A guide to the relative adverse effects of antipsychotics

<table>
<thead>
<tr>
<th>Drug</th>
<th>EPS</th>
<th>Prolactin elevation</th>
<th>Weight gain</th>
<th>QTc prolongation</th>
<th>Sedation</th>
<th>Hypotension</th>
<th>Anticholinergic effects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amisulpride</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+/-</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Aripiprazole</td>
<td>+/-</td>
<td>-</td>
<td>+/-</td>
<td>+/-</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Chlorpromazine</td>
<td>++</td>
<td>++/++++</td>
<td>++/++++</td>
<td>+++</td>
<td>+++</td>
<td>+++</td>
<td>++++/++++</td>
</tr>
<tr>
<td>Clozapine</td>
<td>-</td>
<td>-</td>
<td>+++</td>
<td>+</td>
<td>+++</td>
<td>+++</td>
<td>+++</td>
</tr>
<tr>
<td>Haloperidol</td>
<td>+++</td>
<td>+++</td>
<td>+++</td>
<td>+</td>
<td>+++</td>
<td>+++</td>
<td>+++</td>
</tr>
<tr>
<td>Olanzapine</td>
<td>+/-</td>
<td>+</td>
<td>+++</td>
<td>+</td>
<td>+++</td>
<td>+</td>
<td></td>
</tr>
<tr>
<td>Paliperidone▼</td>
<td>+</td>
<td>+++</td>
<td>+/++</td>
<td>+</td>
<td>+/+</td>
<td>+/++</td>
<td>+/-</td>
</tr>
<tr>
<td>Perphenazine</td>
<td>+++</td>
<td>+++</td>
<td>+/+</td>
<td>+/-</td>
<td>+++</td>
<td>+</td>
<td></td>
</tr>
<tr>
<td>Quetiapine</td>
<td>-</td>
<td>-</td>
<td>++</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td></td>
</tr>
<tr>
<td>Risperidone▼</td>
<td>+/-</td>
<td>+++</td>
<td>+++</td>
<td>+</td>
<td>+/+</td>
<td>+/++</td>
<td>+/-</td>
</tr>
<tr>
<td>Sulpiride</td>
<td>+</td>
<td>+</td>
<td>++</td>
<td>+</td>
<td>+</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Trifluoperazine</td>
<td>+++</td>
<td>+++</td>
<td>+/++</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>/+</td>
</tr>
<tr>
<td>Zotepine</td>
<td>+</td>
<td>+++</td>
<td>+/+++</td>
<td>+/+</td>
<td>+/+</td>
<td>+</td>
<td></td>
</tr>
</tbody>
</table>

Notes
This is not a comprehensive list of side effects. Please see the individual Summaries of Product Characteristics (www.emc.medicines.org.uk) for more details and other side effects that may occur. The ranking scores are approximate and refer to relative rather than absolute risks of adverse events occurring, and are based largely on the opinions provided from six sources [1–6]. They should be used as a rough guide only. Be aware that side effects are commonly dose related. Two ranking scores are provided (e.g. ++/+++) to indicate a range of opinion where views are divided. Not all sources provided an opinion for all side effects.

Key
+++ Frequently causes side effects at therapeutic dose
++ Sometimes causes side effect at doses
+ Mild or occasionally causes side effects at therapeutic doses
- Little risk or minimal side effects at usual therapeutic doses

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31 Proposal: Antipsychotic Drugs in Dementia- Dr Jill Rasmussen
Under intensive surveillance by MHRA; report all suspected adverse reactions; EPS: Extrapyramidal symptoms: these include parkinsonism, akathisia, acute dystonia, and tardive dyskinesia; QTc: QT interval corrected for heart rate

‡ These ratings are based largely on data from registration trials, few comparative studies exist and they should be interpreted with caution


Table 3: Antipsychotics- A guide to monitoring
The following is a comprehensive guide to monitoring and not all tests are mandatory (see SPC/BNF for each drug), however they may be helpful in allowing better management of some patient groups. The MHRA recommends that GPs who have patients on atypical antipsychotics should monitor and manage weight, glucose, and lipid levels.32

<table>
<thead>
<tr>
<th>Test</th>
<th>Frequency of testing</th>
<th>Action for results outside expected parameters</th>
<th>Special precaution drugs</th>
<th>Drugs not requiring monitoring</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urea, electrolytes (including creatinine or estimated GFR)</td>
<td>Baseline &amp; yearly</td>
<td>Investigate all abnormalities.</td>
<td>Amisulpride &amp; sulpiride are renally excreted. Consider dose reduction if GFR reduced.</td>
<td>None</td>
</tr>
<tr>
<td>Full blood count (FBC)</td>
<td>Baseline &amp; yearly.</td>
<td>If neutrophils fall below 1.5x10^9/l stop suspect drug. If neutrophils fall below 0.5x10^9/l refer to specialist. High frequency of benign ethnic neutropenia occurs in some ethnic groups.</td>
<td>Clozapine- FBC weekly for 18 weeks, then fortnightly up to one year, then monthly.</td>
<td>None</td>
</tr>
<tr>
<td>Blood lipids (cholesterol; triglycerides)</td>
<td>Baseline, at 3 months, then yearly.</td>
<td>Lifestyle advice. Consider changing antipsychotic &amp; starting statin therapy.</td>
<td>Clozapine, olanzapine, quetiapine, phenothiazines- 3 monthly in first year, then yearly.</td>
<td>Note- some antipsychotics not clearly associated with dyslipidaemia but prevalence is high in patient group, so monitor all patients.</td>
</tr>
<tr>
<td>Weight (include waist size &amp; BMI where possible)</td>
<td>Baseline, frequently for 3 months and then yearly.</td>
<td>Lifestyle advice. Consider changing antipsychotic &amp; dietary/ pharmacological intervention.</td>
<td>Clozapine, olanzapine- 3monthly for first year, then yearly.</td>
<td>Monitoring recommended although aripiprazole &amp; ziprasidone not clearly associated with weight gain. Obesity prevalence high in this patient group.</td>
</tr>
<tr>
<td>Plasma glucose (fasting sample)</td>
<td>Baseline, 4-6 months and then</td>
<td>Lifestyle advice. Fasting sample or Clozapine &amp; olanzapine- test</td>
<td>Monitor all patients.</td>
<td></td>
</tr>
</tbody>
</table>

32 http://www.mhra.gov.uk/Safetyinformation/DrugSafetyUpdate/CON111764
<table>
<thead>
<tr>
<th>Test</th>
<th>Frequency</th>
<th>Preferred intervention or test details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HbA1c and non-fasting</strong></td>
<td>yearly.</td>
<td>Consider referring to specialist.</td>
</tr>
<tr>
<td><strong>ECG</strong></td>
<td>Baseline &amp; after dose increases (ECG changes rare in practice). Should also be measured on admission to hospital &amp; before discharge if drug regimen changed.</td>
<td>If abnormality detected refer to cardiologist. ECG mandatory- Haloperidol, pimozide, sertindole. ECG mandatory in some situations-ziprasidone, zotepine. Risk of sudden cardiac death increased with most antipsychotics. All patients should be offered an ECG at least yearly where possible.</td>
</tr>
<tr>
<td><strong>Blood pressure</strong></td>
<td>Baseline and frequently during dose titration.</td>
<td>If severe hypotension or hypertension (clozapine) observed, slow rate of titration. Postural hypotension most likely to be associated with clozapine, chlorpromazine and quetiapine.</td>
</tr>
<tr>
<td><strong>Prolactin</strong></td>
<td>Baseline, 6 months and then yearly.</td>
<td>Change drugs if hyperprolactinaemia confirmed &amp; symptomatic. N/a Aripiprazole, clozapine, quetiapine, olanzapine (&lt;20mg), ziprasidone usually do not elevate prolactin but measure if symptoms arise.</td>
</tr>
<tr>
<td><strong>Liver function tests (LFTs)</strong></td>
<td>Baseline, then yearly.</td>
<td>Stop suspect drug if LFTs indicate hepatitis (transaminases x 3 normal) or functional damage (PT/albumin change) Clozapine &amp; chlorpromazine associated with hepatic failure. Amisulpride, sulpiride.</td>
</tr>
<tr>
<td><strong>Creatinine phosphokinase (CPK)</strong></td>
<td>Baseline, then if NMS suspected.</td>
<td>Rare but potentially serious or even fatal. Obtain specialist advice and stop antipsychotic or refer to A&amp;E as appropriate. First generation antipsychotics more likely to cause NMS. None</td>
</tr>
</tbody>
</table>

**Other tests:**
- Clozapine – patients may benefit from an EEG to determine the need for valproate (specialist).
- Quetiapine: Yearly thyroid function tests although the risk of abnormality is very small.

Taken from Maudsley Prescribing Guidelines 10th Edition. The summary is not exhaustive and each drug should be checked in the BNF and SPC. Key: BMI=body mass index, ECG=electrocardiograph, EEG=electroencephalogram, GFR=glomerular filtration rate, IFG=impaired fasting glucose, NMS=Neuroleptic Malignant Syndrome.

The Alzheimer’s Society have produced a leaflet for patients and carer’s, called “Reducing the use of antipsychotic drugs: A guide to the treatment and care of behavioural and psychological symptoms of dementia”. They also have a guide “Optimising treatment and care for behavioural and psychological symptoms of dementia: A best practice guide” for healthcare professionals which contains useful information on management of BPSD in those aged 65 years and over Review: June 2013

Management of BPSD in those aged 65 years and over
Review: June 2013

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checklists, care and monitoring plans. Both documents can be accessed on their website or see the appendices.  

9 Anticonvulsants

Various reviews have been undertaken on the use of anticonvulsants for agitation and aggression, as an unlicensed indication.\textsuperscript{34,35} The mood stabiliser carbamazepine has been found to be more effective than placebo in patients suffering with BPSD, particularly for agitation.\textsuperscript{36} The side effects, drug interactions, and narrow therapeutic window may limit the use of carbamazepine in BPSD.\textsuperscript{37} Studies suggest that therapy should be for a short period of time and initiated only where there is a serious risk.\textsuperscript{38} Specialist advice may be necessary.

10 Acetylcholinesterase Inhibitors

Alzheimer’s disease

Donepezil, galantamine and rivastigmine are recommended as treatment options for managing mild as well as moderate Alzheimer’s disease.\textsuperscript{39} NICE concluded that these drugs may offer some benefit in behavioural outcomes, although the nature and extent of the benefits are uncertain.

Traffic Light System: These are currently amber drugs for mild to moderate dementia in Alzheimer’s Disease (check for other indications) and treatment should be initiated by a specialist in the care of patients with dementia but can be continued by GPs under a shared-care protocol. Treatment should normally be started with the drug with the lowest acquisition cost (taking into account required daily dose, the price per dose once shared care has started and any adverse events etc).

- Treatment should be reviewed regularly using cognitive, global, functional and behavioural assessment under the shared care agreement.
- Take into account any physical, sensory or learning disabilities, or communication difficulties such as language when deciding on the appropriate method of assessment. Clinical judgement may be necessary rather than just MMSE alone.
- Continue treatment only whilst there is a worthwhile effect on cognitive, global, functional or behavioural symptoms.

When reviewing the patient using the Mini Mental State Examination (MMSE) score, severity in Alzheimer’s disease is defined as:

<table>
<thead>
<tr>
<th>Level</th>
<th>MMSE Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mild</td>
<td>21-26</td>
</tr>
<tr>
<td>Moderate</td>
<td>10-20</td>
</tr>
<tr>
<td>Moderately severe</td>
<td>10-14</td>
</tr>
<tr>
<td>Severe</td>
<td>&lt;10</td>
</tr>
</tbody>
</table>

Carers’ views on the patient’s condition at baseline and follow-up should be sought.

For people with vascular dementia, acetylcholinesterase inhibitors and memantine should not be prescribed for the treatment of cognitive decline, except as part of properly constructed clinical studies.

11 N-methyl-D-aspartate (NMDA)-Receptor Antagonist

The therapeutic indication for memantine, the N-methyl-D-aspartate (NMDA)-receptor antagonist, is for the treatment of patients with moderate to severe Alzheimer’s disease. NICE TA 217 recommends memantine as an option for managing moderate Alzheimer’s disease for people who cannot take acetylcholinesterase inhibitors, and as an option for managing severe Alzheimer’s disease. NICE

\textsuperscript{33} http://www.alzheimers.org.uk/antipsychotics
\textsuperscript{34} http://jama.ama-assn.org/content/293/5/596.short
\textsuperscript{35} http://www.crd.york.ac.uk/CRDWeb/ShowRecord.asp?ID=12002001577
\textsuperscript{36} http://ajp.psychiatryonline.org/cgi/content/full/155/1/54
\textsuperscript{37} http://www.aup.org/aup/2006/0215/p647.html
\textsuperscript{38} http://www.nature.com/nn/journal/v7/n6/abs/nn1926.html
\textsuperscript{39} http://www.nice.org.uk/nicemedia/live/13419/53619/53619.pdf
concluded that there was symptomatic benefit for *behavioural outcomes* with memantine, but the size of the benefit was uncertain.

Memantine is currently either a red or non-formulary drug under the NHS Surrey traffic light system (see each acute hospital and indication). NICE recommends that memantine should only be initiated by a specialist and that there must be a shared care agreement for transfer of patients into primary care. Treatment should normally be started with the drug with the lowest acquisition cost.

In addition to the evidence included in the NICE review\(^\text{40}\), there is additional evidence for the use of memantine in treating agitation and aggression in dementia.\(^\text{41, 42}\) Memantine may be a safe and effective treatment in Alzheimer's disease patients with agitation/aggression or psychosis, who are otherwise prone to rapid progression.\(^\text{43}\) However, the benefit may be minimal.\(^\text{44}\)

For people with vascular dementia, acetylcholinesterase inhibitors and memantine should not be prescribed for the treatment of cognitive decline, except as part of properly constructed clinical studies.

### 12 How and when to stop

Consider stopping drugs or reducing doses at every review. Refer to relevant sections above for discontinuation.

- Document discussions with patient and family/carers
- Undertake a thorough risk/benefit analysis
- Antipsychotics should not be prescribed for more than 3 months in the elderly (increased cerebrovascular risk). *If patient had schizophrenia with psychosis prior to BPSD then this may be a good reason to continue prescribing beyond 3 months.*
- Discontinuation symptoms may occur in abrupt withdrawals
- The patient must be closely monitored.
- Consider specialist advice where there are concerns

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\(^\text{42}\) [http://www.bentham.org/cmp/samples/cmp2-1/009CMP.pdf](http://www.bentham.org/cmp/samples/cmp2-1/009CMP.pdf)
