Managing Behavioral and Psychological Symptoms of Dementia

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Disclosures

No Financial Conflicts of Interest

Non-approved FDA uses

• All medications that will be discussed to manage BPSD are off-label use.
Objectives

• Be able to develop systematic approach to evaluate and manage BPSD

• Be able to discuss both non-pharmacological and pharmacological management for BPSD
Dementia

Cognition

Function

Behavior: “BPSD”
Epidemiology of NPS -2-

- Most common sxs in DEMENTIA
  - Apathy (27-36%)
  - Depression (24-32%)
  - Agitation/aggression (24-30%)

- Most common sxs in MCI
  - Depression (20%)
  - Apathy (15%)
  - Irritability (15%)

Lyketsos et al. JAMA 2002
BPSD Natural History

Okura et al. JAGS 2010
Public Health Significance

- Dep sxs associated with increased risk of conversion from MCI to AD.

- BPSD associated with 25-35% of total care costs in community-residing patients with AD.

- BPSD confer increased risk for institutional placement & hospitalization.

- CG depression and distress

Case

- 87 yo male with hx of moderate AD, MMSE 17 with diffuse cognitive impairment across several domains including significant amnestic memory impairment and executive dysfunction. He is on donepezil 10 mg/day for a few years and tolerating fine.

- His primary care provider has recommended he no longer drive. Patient becomes irate when this is brought up: “I’ve never had an accident – what do you mean I can’t drive. That’s baloney!”
Case -2-

- He has been referred to an aging services care manager to help his wife, 83 yo, plan for future care needs.
- She reports severe angry outbursts at home and is at a loss what to do
BPSD Evaluation

- Describe – CG describes problem behavior
- Investigate – Provider investigates potential causes of problem behavior
- Create – Provider, CG/team work together to create/implement Tx Plan
- Evaluate – Provider evaluates whether Tx safe and effective

Describe Behaviors: ABC’s

- **Antecedents**: Triggers? Context?
  - Who, what, when and where?

- **Behaviors**: What is observed? Be specific
  - Patient distress?

- **Consequences**: How does the CG/Environment respond?
  - CG distress?

- Consider quantitative measure (e.g., NPI-Q)

http://download.lww.com/wolterskluwer_vitalstream_com/PermaLink/CONT/A/CONT_21_3_2015_02_26_KAUFER_2015-10_SDC2.pdf
Investigate Behavior: Pt Factors

- Dementia stage
- Establish/Revisit medical diagnoses
  - Consider delirium w/u
- Establish/Revisit psychiatric diagnoses
- Offending or change in medications
  - Anticholinergic, Sedative/hypnotics, Drug withdrawal/interactions
- Behavior = unmet need
  - Consider pain, sensory impairments, sleep hygiene, fear, loss of control, boredom
Investigate Behaviors: CG/Environment Factors

- Caregiver effects/expectations
  - CG depression & burn out, elder mistreatment (both ways)
- Social and physical environment
- Cultural factors
Create Tx Plan

- Respond to physical problems – treat delirium, medical/psychiatric conditions
- Behavioral log to better capture/understand behaviors
- CG interventions
  - Education and training
    - Behavioral approaches – remove triggers, change CG/environment response to problem behavior
    - You won’t win an argument!
    - Reassurance, redirection and distraction
  - Respite
  - Supports
Create Tx Plan -2-

- Strategize behavioral/environmental interventions
  - Enhance communication with pt
  - Increase/decrease stimulation in environment
  - Creating meaningful activities for pt
  - Simplifying tasks
  - Ensuring safe environment
  - Positive reinforcement for positive behaviors, not problem behaviors
Create Tx Plan -3-

- 2\textsuperscript{nd} line - consideration of psychotropic use
  - Acuity?
  - Safety - aggression?
  - Risks?
  - Are benefits >> risks given pt’s comorbidities?
  - Are symptoms responsive to Rx?
Evaluate Intervention

- At f/u:
  - Has plan been implemented by CG/team?
  - How is it working? Behavioral logs?
  - Consider modifications, address barriers
  - Safety concerns?
  - 2nd line - Consideration of psychotropic use (acuity/safety/risks)
Pharmacological Approaches

- No FDA-indicated pharmacological treatment of BPSD

- Strategies for choice of off-label med:
  - Diagnosable syndrome?
  - Target sx?
  - Severity sx?
  - Duration sx?
  - Distress?
  - Safety concerns? Including weigh potential risks vs. benefits of Rx
Pharmacological Interventions

- Atypical or typical antipsychotics (Risperidone, Olanzapine, Aripiprazole)
- Antidepressants (Citalopram, Sertraline)
- AChEI
- Memantine
- Antianxiety agents (Caution with BZD)
- Mood stabilizers (VPA, CBZ)
- Others (Trazodone, Prazosin)

Antipsychotics for Agitation/Psychosis

- FDA BLACK BOX WARNING for both atypicals and typicals (includes pimavanserin)

- Increase % mortality; NNH:
  - Haloperidol 3.8%; 26
  - Risperidone 3.7%; 27
  - Olanzapine 2.5%; 40
  - Quetiapine 2.0%; 50
  - Higher than c/w antidepressants
  - Higher dose, higher risks

Scheider et al. JAMA 2005; Maust et al. JAMA Psychiatry 2015
Antipsychotics

- Atypical antipsychotics
  - EPS (Risp>Arip>Olz>Quet>Cloz), sedation, falls, QT prolongation, cog decline, metabolic syndrome (ADA et. al., Diabetes Care, 2004)

- Typical antipsychotics (e.g., haldol)
  - Also increased risk of adverse outcomes (hosp, death)
  - Higher mortality than atypicals
  - EPS, falls, TD, QT prolongation
  - Anticholinergic effects, falls for lower potency agents

APA 15 Guidelines for Agitation/Psychosis of Dementia

- **Assessment guidelines**

  - “APA recommends that nonemergency antipsychotic medication should only be used for the treatment of agitation or psychosis in patients with dementia when symptoms are severe, are dangerous, and/or cause significant distress to the patient. (1B)”

- **Risks/benefits assessment**

- **Start low then titrate to min effective dose as tolerated; taper if no response after 4 wk; consider taper after 4 mo**
Case: Describe

- **Antecedant:** angry episodes preceded by being reminded by his wife not to drive whenever he tried to take the keys, “remember the doctor said you can’t drive?”
  - Pt did not remember, and the more his wife tried to educate him, the angrier he became.

- **Behavior:** him screaming, clenching his fist, making threatening statements, throwing/kicking things

- **Consequences:** his wife would try to grab the keys from him and continue to try to reason with him
Case: Investigate-Create-Evaluate

- **Investigate:**
  - No acute medical or psychiatric issues or meds
  - No change in home environment.
  - Hypothesis: lack of insight → not able to reason with him about recommendation to not drive

- **Create:**
  - CM worked with spouse to redirect/distract by changing her response

- **Evaluate:**
  - Significant improvement in number and severity of outbursts