GUIDE FOR THE USE OF

ANTIPSYCHOTICS

IN OLDER PEOPLE

This guide focusses on the role of antipsychotics in the management of behavioural and psychological symptoms of dementia (BPSD). Up to 70-80% of people with dementia will develop some behavioural disturbance as part of the course of their disease.

Behaviours may be "positive" or "negative" in terms of level of activity and agitation. Common positive behaviours are hallucinations, delusions, paranoia, calling out, wandering and aggression. Common negative behaviours are depression and apathy.

CAUSES OF BPSD

Behaviours may be "positive" or "negative" in terms of level of activity and agitation. Common positive behaviours are hallucinations, delusions, paranoia, calling out, wandering and aggression. Common negative behaviours are depression and apathy.

Behaviours can have intrinsic or external and environmental triggers and are recognised as being due to unmet needs. Many triggers are treatable or modifiable and hence a comprehensive review is essential.

Common causes of these behaviours are:

- Pain
- Fever/Infection
- Constipation
- Medication (anticholinergics, benzodiazepines, narcotics)
- Anxiety/fear
- Environmental Issues (personal interactions, change of accommodation or routine)

TREATMENT OF BPSD

A number of non-pharmacological treatments are equally or more effective than antipsychotics for BPSD. These include pet and doll therapy, music, exercise therapy and one-on-one interaction.

Knowing the person and their background is the key to understanding the behaviour. Treatment can then be tailored to each person's unique situation. When BPSD is sufficiently severe, despite non-pharmacological therapy, the addition of antipsychotic agents may be required if there is significant distress, or risk to the patient or care giver[i,ii,iii]. Many behaviours improve initially due to sedation effects, only some people maintain this initial improvement for more than a week or two. Some behaviours are less likely to improve with antipsychotics (see Table 1).[iv,v,vi,vii]

RESPONSE OF BEHAVIOURS TO ANTIPSYCHOTICS	
MAY RESPOND	**RESPOND POORLY**
Hallucinations	Apathy
Delusions	Wandering
Persistent angry states	Calling out
Persistent extreme anxiety	Inappropriate toileting
Persistent agression	Low mood
	Hypersexuality

TABLE 1 Response of Behaviours to Antipsychotics

Starting doses, increments and maximum doses of commonly used antipsychotics for BPSD are:

Risperidone **0.25mg** starting/incremental to a maximum of 2mg daily (PBS listed for this indication)

Olanzapine **2.5mg** starting/incremental to a maximum of 5mg daily (Not PBS listed for this indication)

Quetiapine **25mg** starting/incremental to a maximum of 100mg daily (Not PBS listed for this indication)

Haloperidol has the highest rate of adverse effects including mortality of the antipsychotic agents when used for this indication.

Response to antipsychotics is limited, with 9-20% of patients having a reduction in their symptoms. Patients with a higher frequency of symptoms are more likely to have a noticeable response.[v,vi,vii]

Antipsychotic agents are associated with increased risk of falls, fractures, extrapyramidal side-effects (EPS), weight gain and diabetes.[viii]

There is also significant risk of more serious adverse effects, including stroke and death associated with these agents and the risk/benefit should be made clear to the patient and/or carers (see Figure 1).[ix,x,xi,xii,xiii]

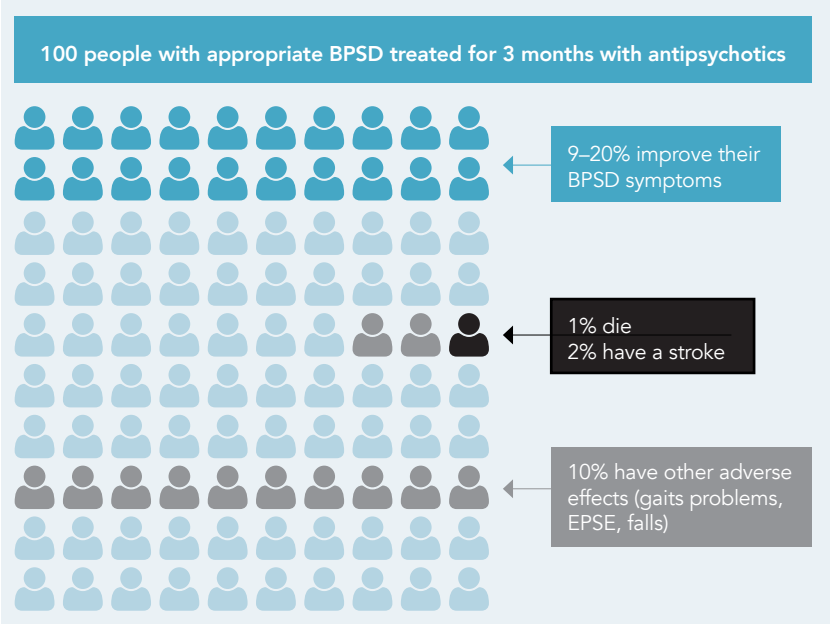

FIGURE 1 Risk/Benefits of Antipsychotics for BPSD

The risk of adverse effects increases with higher doses and also with longer duration of treatment. Mortality increases significantly with long term (2 years or more) treatment.[xiv]

The high stroke risk (particularly in patients with non-Alzheimer's dementia) has prompted the Therapeutic Goods Administration to modify the approved indications for risperidone to limit duration of use to 12 weeks for severe symptoms.[xvi]

	DEATHS IN 180 DAYS		
MEDICATION	USERS N (%)	NON-USERS N (%)	NNH N (95%CI)
Haloperidol	398 (20.7)	162 (8.4)	26 (15-99)
Risperidone	883 (13.9)	538 (8.5)	27 (19-46)
Olanzapine	265(13.9)	187 (9.8)	40 (21-312)
Quetiapine	545 (11.8)	378 (8.2)	50 (30-150)
Antidepressant	2472 (8.3)	2367 (8.0)	166 (107-362)
Valproic Acid	110 (12.2)	65 (7.2)	NS

TABLE 2 Mortality in 6 months after commencing Antipsychotics for Dementia[xv]

REGULAR REVIEW OF ANTIPSYCHOTICS

If improvement does not occur within 3 months, it is unlikely to occur and the antipsychotic can usually be tapered and ceased.

Most people who have stable BPSD can have their antipsychotics reduced and ceased without worsening of these be. Some people with very severe paranoid or psychotic symptoms are at higher risk of their behaviours recurring and so risk and benefit review is essential for long term treatment.

Tapering the dose of antipsychotic reduces the chance of recurrence of BPSD. Reducing by 25% of the dose every 2 weeks until the minimum dose is reached (for the last 2 weeks) is usually effective. An increase in dose can occur if the symptoms recur.[xvii]

Content for this Guide is based on information provided by Consultant Pharmacy Services (www.consultantpharmacyservices.com.au) and references can be accessed at: www.primaryhealthtas.com.au

CPS CONSULTANT PHARMACY SERVICES
Australian Government
phn TASMANIA An Australian Government Initiative