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WHAT YOU NEED
TO KNOW

BEHAVIOURAL AND PSYCHOLOGICAL SYMPTOMS OF DEMENTIA

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EDUCATIONAL CAMPAIGN

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**MOST PATIENTS
WITH DEMENTIA WILL
EXPERIENCE AT LEAST
ONE BEHAVIORAL OR
PSYCHOLOGICAL
SYMPTOM DURING ITS
COURSE.**



WHAT YOU NEED TO KNOW

BEHAVIOURAL AND PSYCHOLOGICAL SYMPTOMS OF DEMENTIA

Behavioral and psychological symptoms of dementia (BPSD) define the assortment of symptoms and signs of “disturbed perception, thought content, mood or behaviour”⁴ related to dementia. Most patients with dementia will experience at least one BPSD during its course. Contributing factors may include biological (such as brain changes, genetic makeup, comorbidities), psychological (such as life history, personality), and environmental (support network, living arrangements).

PRESENTATION

Symptoms, ranging from mild to very severe, are common in long-term care (LTC) facilities and may include aggression, agitation, depression, anxiety, delusions and hallucinations, pacing, screaming, sexual or social disinhibition, wandering and apathy. Agitation may worsen in the evening (“sundowning”). As per Seitz et al. (2010), approximately 60% of residents in LTC facilities have dementia and the

prevalence of BPSD amongst this group has been shown to be as high as 90% in some studies. These symptoms can be very distressful to the resident, as well as family members and caregivers.

MANAGEMENT

When a resident presents with symptoms suggestive of BPSD, a comprehensive assessment should be performed initially to rule out other possible explanations. These may include delirium, pain, constipation, infection, paranoia, substance abuse or withdrawal, hearing/vision problems, boredom, change of routine, and adverse drug reactions. Pre-existing personality characteristics should be considered as well, as these traits may affect how BPSD are displayed. Assessment tools are available, such as P.I.E.C.E.S., which can help to determine the causes for BPSD.

The nature of the symptoms must be measured, along with frequency, timing, and triggers, to establish an effective management plan for the BPSD.

BPSD may not require treatment if the symptoms are not problematic and the risks of treatment outweigh the benefits. However, both pharmacologic and non-pharmacologic treatment are often required to manage the resident with BPSD.

Non-pharmacological treatment should be trialed before pharmacological treatment whenever possible. Each treatment implemented should be assessed for efficacy and evaluated to determine when no longer needed.

NON-PHARMACOLOGICAL TREATMENT

Several approaches that do not involve the use of medication include:

- **Assessment and care plans that have been individualized for each resident (e.g. schedule for bathing, meals, and medication pass times may need to be more flexible)**
- **Reassure and redirect – allow behaviours that are not problematic**
- **Psychosocial activities (regular participation in meaningful experiences) – provide regular exercise**
Sensory stimulation, such as aromatherapy or music
- **Eliminate unnecessary medications**
- **Non-pharmacological treatment should be continued even if pharmacological treatment is necessary.**

PHARMACOLOGICAL TREATMENT

Atypical Antipsychotics

Controlled trials have shown the effectiveness of atypical antipsychotics, such as risperidone (most evidence for efficacy), olanzapine, and aripiprazole, in reducing BPSD in LTC facilities, especially when there is a possibility of harm to the resident or others. Haloperidol, a typical antipsychotic, is an option for treatment of delirium only, but risks for side effects are high. Quetiapine, although widely used due to fewer side effects, has mixed reviews but may be helpful in Parkinson's dementia (fewer extrapyramidal side effects). Clinical, lab, and ECG evaluations should precede use of antipsychotics. Monitoring is required for anticholinergic effects, sedation, orthostatic hypotension/falls, increased weight, extrapyramidal symptoms, infection, and QT-prolongation. Use of these agents requires careful consideration of potential benefits versus potential harm due to increased risk of cerebrovascular events and death. The risk of stroke continues for approximately 20 months after treatment start. The risk of death is approximately 1.2 to 1.6 times higher than without antipsychotics and is dose-dependent – therefore, start low and go slow⁷. The DART-AD trial finds a 25% reduction in mortality with treatment cessation after 2 years. To limit antipsychotic use, regular review of these medications should occur for possible tapering when BPSD are stable, clinical response is poor, or adverse reactions occur.

Antidepressants

As anxiety and depression are common BPSD, the use of an antidepressant may be very effective in improving cognition, agitation, and some behaviours, such as disinhibition. A Selective Serotonin Reuptake Inhibitor (SSRI), such as citalopram, escitalopram, or sertraline, or a Selective Serotonin and Norepinephrine Reuptake Inhibitor (SNRI), such as Venlafaxine XR, can be trialed, with monitoring for QT-prolongation and sodium depletion. A six-week trial should be allowed at an adequate dose to assess efficacy. Paroxetine and tricyclic agents are not recommended due to the high potential for anticholinergic side effects.

Cognitive Enhancers

Cholinesterase inhibitors (donepezil, galantamine, rivastigmine) may be effective in the management of the negative symptoms (e.g. apathy, depression, tension, irritability) in mild to moderate dementia. The N-methyl-D-aspartate receptor antagonist, memantine, may be more effective on the positive symptoms (e.g. agitation, delusions, hallucinations, aggression). Evidence does not strongly support the use of these agents as first line therapy in treating BPSD in LTC, possibly because symptoms may be more severe.

OTHER MEDICATION CHOICES

Anticonvulsants

Overall, mood stabilizers are not recommended for routine use in reducing BPSD due to the potential for serious side effects and limited evidence of efficacy.

Benzodiazepines

Evidence is lacking for BPSD treatment and use of benzodiazepines may result in unwanted effects such as dizziness, sedation, worsening cognition, disinhibition (e.g. sexual) and falls. Use should be limited to short durations in treatment of acute anxiety/agitation.

Antiandrogen

When other methods have failed, either cyproterone or medroxyprogesterone, in conjunction with an SSRI, has been found useful in reducing symptoms of disinhibition, such as sexual behaviours. Cyproterone has also been found to be useful in single studies in reducing general aggression. Use

may be limited by risk of weight gain, depression, hepatic dysfunction, cardiovascular toxicity (e.g. fluid retention, thromboembolism), and blood glucose fluctuation.

DEPRESCRIBING

The primary purpose of deprescribing a medication (reducing the dose or discontinuing a medication that is no longer effective or could be harmful) is to decrease pill burden, reduce the risk of harm, and maintain or improve quality of life.

Discontinuation of antipsychotics that are being used for BPSD is a good choice by the clinician, as excessive usage and risk for harm has been identified. Studies demonstrate that there may be no beneficial effect with antipsychotics for many BPSD such as hoarding, repetitive movements, wandering, and vocal disruption and, therefore, deprescribing is an option.

When symptoms are stabilized for at least 3 months after initiating an antipsychotic or the response to antipsychotic therapy is poor after a sufficient trial of 8 weeks, current recommendations are to deprescribe, since resident symptoms do not typically worsen with gradual withdrawal as compared to those who continue the antipsychotic. A tapering plan should be implemented (e.g. reduce dose 25-50% every 1 or 2 weeks) and the antipsychotic discontinued in conjunction with the patient and caregivers. Monitoring should occur every 1-2 weeks – if BPSD should reoccur, consideration can be given at that time to additional non-drug approaches or the antipsychotic can be restarted at the lowest possible dosage.

Deprescribing can be attempted in 3 months again, with a maximum of 2 attempts. Alternatively, another antipsychotic can be chosen. As always, other possible triggers of BPSD must be addressed, such as pain or infections.

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