Medication Treatment of Cognitive and Behavioral Symptoms in Dementia

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Environmental interventions directly decrease psychotropic use

- What do you (or your facility) do to increase quality of life, decrease behavioral symptoms, and minimize use of psychotropic medication?
- Does better communication improve outcomes?
- What important, seemingly small things may we be taking for granted, or overlooking?
## Changes in Key Domains as AD Progresses

<table>
<thead>
<tr>
<th>Stages of Alzheimer’s Disease</th>
<th>Mild</th>
<th>Moderate</th>
<th>Severe</th>
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</thead>
<tbody>
<tr>
<td><strong>Activities of daily living (ADLs)</strong></td>
<td>Problems with routine tasks</td>
<td>Needs help with basic ADLs (eg, feeding, dressing, bathing)</td>
<td>Progresses to total dependence on caregiver (eg, feeding, toileting)</td>
</tr>
<tr>
<td><strong>Behavior</strong></td>
<td>Changes in personality</td>
<td>Anxiety, suspicion, pacing, insomnia</td>
<td>Agitation, wandering</td>
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<tr>
<td><strong>Cognition</strong></td>
<td>Confusion and memory loss, ie:</td>
<td>Difficulty recognizing family and friends</td>
<td>Loss of speech</td>
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<td></td>
<td>– Misplacing objects</td>
<td>Chronic loss of recent memory</td>
<td>Misidentifies or is unable to recognize familiar people</td>
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<td>– Forgetting names</td>
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<td>– Disorientation</td>
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What are “Behavioral Sx?”

- IPA: 1996 BPSD
- Cohen-Mansfield: 2001 “Unmet need”
- DMS V
- ICD-10
Peak Frequency of Behavioral Symptoms as Alzheimer’s Disease Progresses
Marge and Don
Behavioral Sx—Depression/Anxiety

- Social withdrawal/Sadness
- Anergia
- Anhedonia
- Tearfulness
- Irritability/anxiety
- Obsessive thoughts/statements; compulsive/repetitive actions (scratching/picking)
- mania/hypomania (less common)
Behavioral Sx--Psychosis

- **Delusions**—false beliefs (9-63%)
  - Paranoia
  - Grandiosity
- **Hallucinations** (4-44%)
  - Visual
  - Auditory
### “Agitation”/Aggression (11-80%)

<table>
<thead>
<tr>
<th></th>
<th>Verbal</th>
<th>Physical</th>
<th>Sexual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Directed/Aggressive</td>
<td>Name calling/ Attacking</td>
<td>Hitting/slapping Intentionally wanting</td>
<td>Knowingly inappropriate behavior</td>
</tr>
<tr>
<td></td>
<td>Racial/sexual slurs</td>
<td>to cause harm</td>
<td></td>
</tr>
<tr>
<td>Non-Directed/Non-Aggressive</td>
<td>Chanting Moaning Non-specific</td>
<td>Restless Pacing Defending self</td>
<td>Loss of impulse control/ confuses targeted person with spouse</td>
</tr>
</tbody>
</table>
Rule out Delirium

- Temporary Confusional State
- Abrupt onset
- Often identifiable cause (such as...?)
- Patients with dementia at high risk
- Sx are temporary; treatment should be too!
- A thorough history and physical exam are needed.
Unmet Need

- Is the ‘behavior’ unexplainable, or is it due to an unmet need?
  - What are common unmet needs?
Causes of Behavioral Changes

- Physical
- Environmental
- Tasks
- Communication
- Problem solving
- Caregiver Burden
- All of the above are capable of being addressed!
Causes of Behavioral Changes

- Physical
  - Meds—side effects, interactions (be informed)
  - Health—infection, constipation/dehydration
  - Pain—hunger, skin breakdown, fracture (be aware)
  - Sensory/acuity—visual, auditory
  - Exacerbation of Chronic Illness—angina, DJD, ulcer
  - Sleep disturbance
Causes of Behavioral Changes

• Environmental
  – Changes—esp multiple moves: home/hosp/NH; change in familiar caregiver
  – Stimulation—hectic pace/unfamiliarity
  – Sensory—lighting, sounds, smells
  – Routine—lack of orientation-->fear. A highly structured routine is often very comforting.
Causes of Behavioral Changes

• Tasks
  – Complexity—as complex or straightforward as makes sense. Don’t frustrate, but also don’t infantilize. Allow CHOICES. (A or B, not open ended)
  – Hierarchy—person specific, gradual steps to complete with supportive comments
  – Familiarity—as casual or formal as appropriate.
Causes of Behavioral Changes

- Communication
  - Largest part of caregiving process
  - APPROACH is the key. Friendly, + eye contact, smile, appropriate humor, touch. NON-VERBALS are highly important. Gestures. Allow time to respond. Brief silence is OK.
  - Listen to person’s tone and their non-verbal behavior.
Causes of Behavioral Changes

• Problem solving
  – Define the problem
  – Patterns
  – Expect the unexpected
Causes of Behavioral Changes

- Caregiver Burden
  - Problem for both spouse/family caregivers and professional/paid caregivers
  - Everybody needs a break!
Pharmacological Treatment

• Behavioral medications
  – **No medications are approved by the FDA for the treatment of Behavioral Symptoms of dementia. Most of the commonly prescribed medications have “Black Box” warnings.

• Cognitive medications
  – May have modest ‘behavioral’ effect (often not appreciated until after they have been discontinued)
“Behavioral Medications”

- Anti-depressants
- Anti-psychotics/neuroleptics
- Anti-anxiety/anxiolytics
- Anti-convulsants/mood stabilizers
- Cognitive enhancers
- Miscellaneous
Behavioral Medications

- **Antidepressants**: apathy/isolation, depression/anxiety, mild irritability
- **Mood Stabilizers/Anticonvulsants**: moderate to severe agitation/impulsivity
- **Atypical Antipsychotics**: psychosis, severe agitation

The type/severity of behavior guides the medication choice:
- Mild
- Moderate
- Severe
Maximize Medication Response

- Prescribe adequate dose/duration
- Promote compliance
- Treat underlying physical problems
- Monitor for adverse effects
- Continue environmental/behavioral interventions
No medications will help with:

- Appropriate irritability
- Entitled personality
- Urinating in inappropriate places
- Wandering into others’ rooms
- Racist/sexist comments
Antidepressants

- Depression
- Mild irritability
- Mild to moderate anxiety
- Chronic pain

- Will have no acute benefit (except placebo and side effects)
Atypical Antipsychotics

• Clozaril (Clozapine)\(^a\)
• Zyprexa (Olanzapine)\(^b\)
• Risperdal (Risperidone)\(^c\)
• Seroquel (Quetiapine)\(^#\)
• Geodon (Ziprasidone)\(^d\)
• Abilify (Aripiprazole)\(^#\)
• Invega (Paliperidone)\(^a\)

• Fanapt (Iloperidone)
• Saphris (Asenapine)
• Latuda (Lurasidone)
• Vraylar (Cariprazine)
• Rexulti (Brexpiprazole)
Atypical Antipsychotics

• All carry FDA black box warnings:
  – “cerebrovascular” AE risk
  – Metabolic risks

• Weigh out potential risks v. benefits

• Only when necessary, use the ‘best fit’ medication, at the lowest effective dosage, for the shortest time required
Antianxiety Medications

• Benzodiazepines
  – Lorazepam, oxazepam, temazepam

• Buspirone (Buspar)—slow titration, delayed efficacy

• Antihistamines—primarily avoid
Mood Stabilizers

• Lithium—bipolar indication; renal concerns

• Antiseizure medications
  – Depakote
    • Liver monitoring
Miscellaneous

- Neudexta (Dextromethorphan/Quinidine)
  - “pseudobulbar affect”
Clinical Trials—why participate?

• Access to:
  – The newest medications, before available by Rx
  – Extensive, in depth evaluations and follow-up
  – Evaluation and treatment at no cost

• Possible direct benefit to subject/caregiver

• Contributing to the better understanding of AD
• Treatment of Dementia and Agitation: A Guide for Families and Caregivers (Postgraduate Medicine, January 2005, p 101-108)

• CATIE-AD: Effectiveness of Antipsychotic drugs in patient’s with AD (NEJM, 2006, 355, 1525-1538.)

• ACNP White Paper: Update on Use of Antipsychotic Drugs in Elderly Persons with Dementia (Neuropsychopharmacology, 2008, 957-970)
Literature

• Cognitive Effects of Atypical Antipsychotic Medications in patients with AD: Outcomes from CATIE-AD (AJP 168:8, August 2011, p831-839)

• Antipsychotic Drugs and the risk of hyperglycemia in Older Adults without Diabetes (AJGP, 19:12, Dec 2011, p 1026-1033)

• Risk of Mortality among individual antipsychotics in patients with dementia (AJP 2012, 169, 71-79)
Literature

• The role of antipsychotic Drugs in the Treatment of Neuropsychiatric Symptoms of Dementia. FOCUS, winter 2013, vol XI, No 1.
Discussion

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