Tayside Guidance - Antipsychotics in older people with dementia

People with dementia are more likely to experience delirium. Before treating new symptoms of stress or distress (also known as behavioural and psychological symptoms of dementia, BPSD) in a person with dementia, the possibility that the person has delirium should be excluded. For the management of delirium in adult and older people see the NHS Tayside clinical guidelines (intranet only) for further information.

Non-pharmacological interventions should always be first line. Ensure other possible therapies and causes have been investigated e.g. physical causes, psychological causes and environmental factors before initiating antipsychotic medication. Refer to the Quick Reference Guide for possible causes. It is not appropriate to initiate antipsychotic medication to manage symptoms which are unlikely to be modified by antipsychotic medication e.g. wandering, repetitive vocalisation, resistiveness, sleep disturbance, repetitive questioning.

Dementia is very common in patients with Parkinson’s Disease, and is most likely to be of dementia with Lewy bodies (DLB) pathology or may be of Alzheimer’s Disease pathology. Antipsychotic use in people with dementia with Lewy Bodies is associated with increased mortality. Alternative medication such as Cholinesterase Inhibitors may be useful for visual hallucinations in this group.

In older people with dementia, antipsychotic drugs (atypical and typical) are associated with a small increased risk of mortality and an increased risk of stroke or transient ischaemic attack. They may be prescribed with caution in the management of symptoms of stress and distress (psychosis, aggression, or severe agitation/anxiety) associated with some types of dementia only after adequate analysis of the potential risks and benefits. It is important to remember that such behaviour can be a temporary phenomenon and that drugs should be prescribed on a short-term basis. In older people, antipsychotics must be used with particular caution because of the side-effect profile, including extrapyramidal symptoms, sedation, anticholinergic effects, cardiovascular effects and tardive dyskinesia. See the BNF and MHRA website for further information.

Refer to the Good practice guides for rationalisation of antipsychotics in people with dementia – initiation of treatment and reduction and cessation of treatment before prescribing antipsychotics in people with dementia.

Clinicians are reminded of the need to involve patients and relevant others in decisions about medication - see Adults with incapacity (Scotland) Act 2000 Medical treatment flowchart and certificate.

Patients/caregivers should also be cautioned to immediately report signs and symptoms of potential cardiovascular adverse events such as sudden weakness or numbness in the face, arms or legs, and speech or vision problems. Fact sheets on the use of antipsychotic medication in people with dementia are available on the Alzheimer’s Scotland website www.alzscot.org . Information on the signs and symptoms of potential cardiovascular adverse events is included in the Patient Information Leaflet for each medication.

Haloperidol, Risperidone or quetiapine [unlicensed use ‘off-label’] may be used for symptoms of Stress and Distress in people with Alzheimer’s Disease; however haloperidol or risperidone should not be used in the presence of Parkinson’s Disease. Quetiapine [unlicensed use ‘off-label’] may also be used for symptoms of...
Stress and Distress in people with Dementia with Lewy bodies or in patients with Parkinson’s disease at lower doses than in younger patients. There is a link with increased mortality in people with Dementia with Lewy Bodies prescribed antipsychotic medication. Cholinesterase Inhibitors may be effective in visual hallucinations in people with Dementia with Lewy Bodies. There is little evidence base for the treatment of symptoms of Stress and Distress in vascular or stroke related dementia or other dementias. Antipsychotics may be used in combination with cholinesterase inhibitors under specialist supervision.

- Antipsychotics should only be used where other strategies (including non-drug treatments e.g. evidence-based psychological interventions) have been tried and failed.
- Other reasons for behavioural problems, including physical problems need investigated before prescribing antipsychotics.
- The target symptoms for which antipsychotics are prescribed must be identified and the effect of treatment on these symptoms monitored.
- Patients with dementia who are prescribed antipsychotics must have their prescription reviewed regularly.

**Reduction of antipsychotics in older people with dementia**

- As with initiation of medication, reduction should be carried out slowly with monitoring of effect.
- Start with a reduction of 25% of the total daily dose.
- If the current dose is low, e.g. at the suggested starting dose, the medication may be stopped without tapering the dose.
- **Review the effect** after one week. See the Good Practice Guide for reduction and cessation for further information.

**Symptoms of Stress and Distress in people with Alzheimer’s Disease**

**FIRST CHOICE: HALOPERIDOL**

**Haloperidol** tablets 500micrograms, 1.5mg, oral liquid 1mg/mL, 2mg/mL

Dose: Agitation and restlessness in the elderly [licensed indication], severe agitation/anxiety in Alzheimer’s Disease [unlicensed use ‘off-label’], by mouth, initially 500micrograms once or twice daily; max. dose 1.5mg twice daily. See rationalisation of antipsychotics in people with dementia – **Good Practice Guides** for initiation of treatment and for reduction and cessation of treatment.

**Risperidone** tablets 500micrograms, orodispersible tablets 500micrograms, liquid 1mg/mL

Dose: 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 [licensed indication], psychosis or severe agitation/anxiety in Alzheimer’s Disease [unlicensed use ‘off-label’], by mouth, initially 250micrograms twice daily, increased according to response in steps of 250micrograms twice daily on alternate days; usual dose 500micrograms twice daily (up to 1mg twice daily has been required). See rationalisation of antipsychotics in people with dementia – **Good Practice Guides** for initiation of treatment and for reduction and cessation of treatment.
Symptoms of Stress and Distress (in people with Dementia with Lewy Bodies)

**Quetiapine** tablets 25mg, 100mg, 150mg
Dose: Psychosis, aggression, or severe agitation/anxiety in Dementia with Lewy Bodies [unlicensed use ‘off-label’], by mouth, initially 12.5mg-25mg daily; up to 25mg-150mg daily. Effective dose is likely to be lower than in younger patients. See rationalisation of antipsychotics in people with dementia – **Good Practice Guides** for initiation of treatment and for reduction and cessation of treatment.

**Quetiapine** may also be considered as a second line choice for symptoms of stress and distress in Alzheimer’s Disease [unlicensed use ‘off-label’].

If antipsychotic medication is required for severe stress and distress in dementia, the intramuscular (IM) route of administration should only be used where patients are unable to take oral medication. In this case Haloperidol 0.5mg as required up to a maximum of 2mg in 24 hours can be used for emergency treatment [unlicensed [off-label] route for this indication]. If IM treatment is required for longer than 24 hours this must only take place following discussion with and approval of the relevant consultant. The Mental Health (Care and Treatment) Act (Scotland) legislation must be considered at this point to ensure patient safety and rights are protected. Vital signs (BP, pulse, temperature and respiratory rate) should be monitored and recorded at regular intervals, and close monitoring for dystonia or other extrapyramidal side effects is required.