BPSD – Behavioural and Psychological Symptoms of Dementia
Medical Management

Dr Shân Williams
BPSD in dementia

Wide range of symptoms

- Mood changes
  - emotional lability, depression (both common)
- Psychotic symptoms
  - hallucinations in all modalities, delusional beliefs
- Behavioural disturbance
  - agitation, wandering, sleep disturbance, feeding problems

All contribute to carer burden and increase likelihood of move to institutional care
PROBLEM BEHAVIOURS

3 main groups

- Lack of behaviour eg reduced function
- Exaggeration of normal behaviours eg wandering
- Abnormal and undesirable behaviour eg sexual disinhibition
Examples

- Restlessness and agitation, including pacing, wandering
- Irritability, including verbal/physical aggression
- Lack of cooperation with care
- Urinary incontinence, including inappropriate locations
- Sleep disturbance, including change to sleep/wake cycle
- Dietary change – loss of appetite, bingeing
- Sexual disinhibition
MULTIFACETED PROBLEMS

Eg Urinary incontinence, may be because:
- Loss of bladder control
- Infection
- Poor mobility – can’t reach toilet in time
- Disorientation – can’t find the toilet
- Agnosia – doesn’t recognise the toilet for what it is
- Embarrassment – female carers assisting with toileting
- Inadequate signs on toilet doors
BASIC PRINCIPLES

1. Exclude intercurrent illness
   - Infection, pain, constipation, metabolic, drug effects

2. Try non-pharmacological approach first
   - Improve the environment, behavioural assessment and therapy, music, reminiscence therapy, reality orientation, complementary therapy, aromatherapy (lemon balm)
   - Person centred care
   - Systemic perspective – inreach, carer support, staff training

3. Pharmacological interventions
NO EASY ANSWERS I’M AFRAID
CASE STUDIES

- Small groups
- Discuss the scenario – what are the issues?
- Decide how you would:
  - Assess the situation
  - Investigations you might consider
  - Manage the situation
- Get ready to feedback
CASE STUDY 1

- Mr R – 78 year old retired magician with a history of mixed Fronto-Temporal and Lewy Body Dementia, recently discharged from hospital to a nursing home. Staff report that since his move to the nursing home, his behaviour has been ‘relentless’. He has been frequently aggressive, usually when staff are attending to personal care. They report he has punched and scratched staff and managed to break the metal window latches in his bedroom.

- Of note, he has also displayed behaviour of a sexual nature, at one time pinning one of the nurses against a wall to touch her breasts. He has inappropriately touched several of the nurses but there is one in particular he focuses on. The staff are concerned by his behaviour; they themselves do not feel threatened as he will stop when they ask him to, but express concern regarding the vulnerable female residents at the home.

- He has an ongoing variable history of aggressive episodes, sometimes associated with visual hallucinations, with more lucid intervals in between. He was admitted to hospital after his wife could no longer manage him at home. He was reasonably settled on the ward and was prescribed memantine.

- The CPN who knows him well feels that his aggressive behaviour since discharge does fit into his previous pattern, but that he has not displayed any of the sexualised behaviour before.

- What do you do?
You are asked to see a 78 year old lady with severe Alzheimer’s Disease, who is cared for at home by her family.

They report that over the last few weeks, she has become increasingly distressed at times, often crying inconsolably and asking to go home to her mother.

She is not eating as much as she was, and does not sleep well at night. She appears to be more confused. She has prolonged QTc syndrome, but is otherwise well.

What do you do?
You are asked to see a 78 year old man who has a diagnosis of vascular dementia and who suffered a stroke 6 months ago, from which he has recovered well. He is reasonably self caring in the nursing home, his mobility is good, he is eating and drinking well.

Over the last few months, there have been some episodes of sexual behaviour which is out of character for him. He has touched one of the other female residents on the breast on one occasion, has unzipped his trousers in a public area on another, and has touched another lady on the thigh.

When challenged by the staff, he appears to know that what he is doing is wrong, and is able to discriminate between appropriate and inappropriate touching.

What do you do?
CASE STUDY 4

- You are asked to see a 84 year old lady who has recently moved from her home into a dementia nursing home. She has a diagnosis of mixed Alzheimer’s and vascular dementia and is currently prescribed donepezil 10mg daily. She has been taking this for some time without problems according to her husband.

- The home are struggling as she is constantly “on the go”, walking around the unit day and night – her husband says that she used to take the dogs for a 10 mile walk each day and has always been fit!

- She does not really stop for anything, even meals and does not spend much time in bed at night. She has lost 5kg in the month since her admission, and she has been falling frequently.

- What do you do?
You are called to a nursing home to see an 86 year old lady whose food and fluid intake has been declining over the last few months, and who is now eating and drinking very little. She is not engaging with the staff at all, and is spending all her time in bed.

She was given a diagnosis of vascular dementia during a recent admission to Weston General Hospital (she had a UTI at the time).

Her friends say she has never really recovered from the death of her husband 3 years earlier and has often said she wanted to die to be with him.

When you see her she tells you that the food and her clothes are being tampered with by one of the nursing staff, and that she is only prepared to eat food that her friends bring in. She tells you she wants to die.

What do you do?
MOOD DISORDERS IN DEMENTIA

- Common – up to 50%

- Various presentations – anxiety, irritability, low mood, emotional lability but remember apathy does not necessarily mean depression

- Assessment of mood change – observed behaviour may be agitation, irritability, tearfulness, slowed speech or movement, sleep or appetite disturbance, lack of enjoyment

- Why important? – less likely to maintain ADLs, increased need for support
TREATMENT 1

- Consider non-pharmacological treatments first
  - Exclude other illness
  - Treatment of chronic and painful physical illness
  - Enhance patients own psychological resources and coping skills – information, memory cafes, voluntary organisations
  - Enhance support network and aim to reduce social isolation – day care, intensive support
  - Consider environment – increase practical support at home, train care staff appropriately, enhance the environment in care settings, increase activities
  - Support the carer – information, time out, respite, treat their depression
TREATMENT 2

- Pharmacological
  - Antidepressants
    - start low and go slow but may need normal doses
    - avoid TCAs
    - SSRIs – antidepressants of choice (sertraline)
    - Mirtazapine
PSYCHOSIS IN DEMENTIA

• Symptoms
  • Hallucinations – common in all types of dementia: 20-30% AD, 70-80% LBD, frequent in VaD
  • Delusions – common and varied in presentation – food being poisoned, intruders breaking in – always check out that beliefs are not founded in reality.

• Causes

• Risk Factors

• Prognostic significance
Management of psychosis

- Exclude physical illness

- Non-pharmacological approaches – don’t forget the wallpaper and soft furnishings!

- Pharmacological treatment
  - Shouldn’t be first line ideally
  - Risk – benefit analysis
  - Best evidence for RSP and aripiprazole for aggression and psychosis – (but problems with CVA, VTE, death and caution DLB, PD) other atypicals less effective
Pharmacological Treatment

- If hallucinating – consider CEI
- If aggressive and agitated – consider lorazepam, CEI, (memantine)
- If PD/LBD ruled out – consider risperidone, aripiprazole, amisulpride, olanzapine (but watch side effects and CVA risk),
- PD/LBD possible – try lorazepam, if no alternative try small doses of quetiapine 12.5mg/day or aripiprazole - but try to avoid neuroleptics generally if at all possible, clozapine also has some evidence
- Mood stabilisers – carbamazepine – some evidence but more difficult to tolerate
LONG TERM MONITORING of ANTIPSYCHOTICS

- Weight
- Lipid profile
- Blood glucose
- QTc interval – 440msec men, 470msec female
- Regular review and consider cautious withdrawal when behaviour settled – aim for withdrawal at 6 weeks
SLEEP DISTURBANCE

- Sleep/wake cycle often disturbed – early rising, sleep for long periods during day

- Phases of wakefulness during day and night common – often associated with wandering or pacing

- Prominent feature of DLB, PDD – REM behaviour sleep disorder

- When associated with depression – EMW, initial insomnia
Any reason for wakefulness? – nocturia, pain, caffeine – treat appropriately, sleep hygiene

Environment? – bedroom, low light, orientation

Increase activity - day centres

Bright light therapy – some evidence

Treat depression if present – consider what and when

Treat agitation if present

If no other cause – consider hypnotic – ideally short term, short half life eg zopiclone 3.75mg – 7.5mg – prepare to be flexible about dose time and review regularly; think about temazepam or melatonin

REM behaviour sleep disorder – clonazepam, avoid drugs which affect REM
APPETITE DISTURBANCE

- Diminished appetite common as people get older
- May be stage or type of dementia
- May be in response to psychotic beliefs eg poison
- May lose ability to feed themselves
- May have difficulty swallowing
- May have change in taste – esp Frontal lobe damage (not just dementia)
MANAGEMENT

- Try and be flexible and imaginative
- Consider depression – treat – mirtazapine appears to stimulate appetite in some
- Consider referral to dietician
- Go with personal tastes
- Consider food supplements
- Monitor weight/blood sugars if diabetic
- PEG feeding doesn’t improve outcomes
- Discuss with family
AGITATION

- Poorly defined – inappropriate motor, verbal or vocal activity - sundowning
- Common in dementia (20-60%)
- Causes:
  - Delirium
  - Repetitive semipurposeful activity
  - Pain, discomfort
  - Boredom
  - Depression
  - Profound disorientation
  - Medication – diuretics, neuroleptics
  - Environmental factors – isolation, overstimulation
  - Frustration
  - Communication difficulties
MANAGEMENT

- Exclude other cause – investigate and treat medical conditions
- Consider non-pharmacological methods – distraction, activity, is the environment too busy?
- Consider CEI (can occasionally make agitation worse), if on a CEI – consider reducing dose and see if things improve
- Consider antidepressant – trazodone, mirtazapine, SSRI for impulsive activity including vocalisation
- Try and establish good sleep-wake pattern
- Perhaps a benzodiazepine (but watch out for paradoxical increase in agitation)
- What about sodium valproate, gabapentin – some case reports
- Think about memantine
- If all else fails – consider neuroleptic but cautiously
SEXUAL DISINHIBITION

- Check out what’s happening – change in libido on part of patient or carer? Disinhibition as a result of frontal lobe damage? Misidentification?

- Prevalence of hypersexuality – 2-17%

- Significant positive association with severity of dementia

- Degree of value judgement in what is abnormal

- Ethical questions – patient’s competence is central: if noncompetent consider:
  - Staff have duty of care towards patient to ensure no harm results
  - Is it ethical to allow sexual contact? – difficult decision which should be considered in light of background, previous choices, nature of contact – discuss the situation with the family
ASSESSMENT

- Is it a problem?
- Understanding of what behaviours and contexts
- Consider functional assessment ABC
- How often?
- Where they occur?
- With whom?
- Balance risk of treatment against those presented by the behaviour
- Competence of participants
MANAGEMENT (1)

- Define target behaviours
- Rule out delirium
- Consider mood disorder or psychosis
- Review environmental factors
- Review cognitive and sensory factors
- Educate and support caregivers
- Consider specific behavioural methods
- Consider drug treatment
- Review progress
MANAGEMENT (2)

- Drug treatment – NONE ARE LICENSED IN PEOPLE WITH DEMENTIA
- Classes used:
  - Neuroleptics – olanzapine, risperidone, quetiapine
  - Anti-androgens – cyproterone
  - Oestrogens
  - LHRH analogues
  - Serotonergics - citalopram
  - Gabapentin
  - Finasteride – nonhormonal antiandrogen
  - Memantine (anecdotal), carbamazepine, propranolol, trazodone, benzodiazepines