CHALLENGING BEHAVIOUR IN DEMENTIA

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Content

- QUIZ
- 3 CASES
- FURTHER DISCUSSION

Q 1. Challenging behaviours in dementia are neuropsychiatric symptoms?

- TRUE

BPSD = Neuropsychiatric symptoms = Challenging behaviours

Behavioural

- Aggression,hitting,kicking
- Agitation,pacing
- Apathy
- Wandering / Restlessness
- Hoarding
- Screaming
- Disinhibition-sexual,urinating, defaecating
- Changes in sleep and appetite
- Calling out,repetitive questioning

Psychological

- Anxiety
- Depression
- Psychosis

Q2.CHALLENGING BEHAVIOURS IN DEMENTIA ARE NOT COMMON?

- FALSE

Prevalence estimates

More than 90% of PWD will experience BPSD

2/3 people with dementia in care homes have BPSD

Challenging behaviour is not a symptom of dementia as such but represents an unmet need in the patient who is disorientated often with communication problems, misperceptions and an altered experience of the world around them.

Q3. The dementia subtype has no influence on the symptoms experienced ?

- FALSE

Influence of the Dementia Subtype

Neuropsychiatric manifestations are embedded in some diagnostic criteria:

- **Frontotemporal dementia (FTD)**
  - gradual and insidious decline in social functioning and regulation of personal conduct; emotional blunting; stereotypic behaviours
- **Semantic Dementia (FTD)**
  - Compulsive behaviours
- **Lewy Body Dementia**
  - 76% experience visual hallucinations
- **Parkinson's disease dementia**
  - 54% experience visual hallucinations

Q4. Rapid onset of symptoms may indicate delirium ?

- True
- Also reduced attention, fluctuant symptoms,hallucinations
- Consider medical admission

‘PINCH ME’

- **P**ain
- **I**nfection
- **N**utrition
- **C**onstipation
- **H**ydration
- **M**edication
- **E**nvironment

Q5. Pain is not usually an important factor?

- FALSE

Pain is Common, Missed and Increases Suffering

- **40 – 83%** of residents in nursing homes are affected by pain.
- Pain is **under-reported** and **under-treated** in older people, even more so in people with dementia.
- Pain is the **highest** issue affecting **quality of life.**

Q6.A detailed history and analysis of behaviour is not usually necessary?

- FALSE

Assessment

Initial questions to ask:

- **Is it really a problem?**
- Who is it that finds the behaviour problematic?
- Are there external factors that are challenging to the person with dementia?
- Is the behaviour compromising the safety of the person or others?

What Information do you need

- What is the person's previous behaviour and personality
- What has changed – nature, degree and frequency?
- When did it change?
- What are the triggers?
- Understand the biopsychosocial context – i.e. **Rule out PAIN, DELIRIUM, ENVIRONNMENTAL and INTERPERSONAL FACTORS**

- What has been tried to date?

Which is considered the Gold Standard BPSD assessment tool?

A. Cohen Mansfield Inventory

B. Neuropsychiatric Inventory

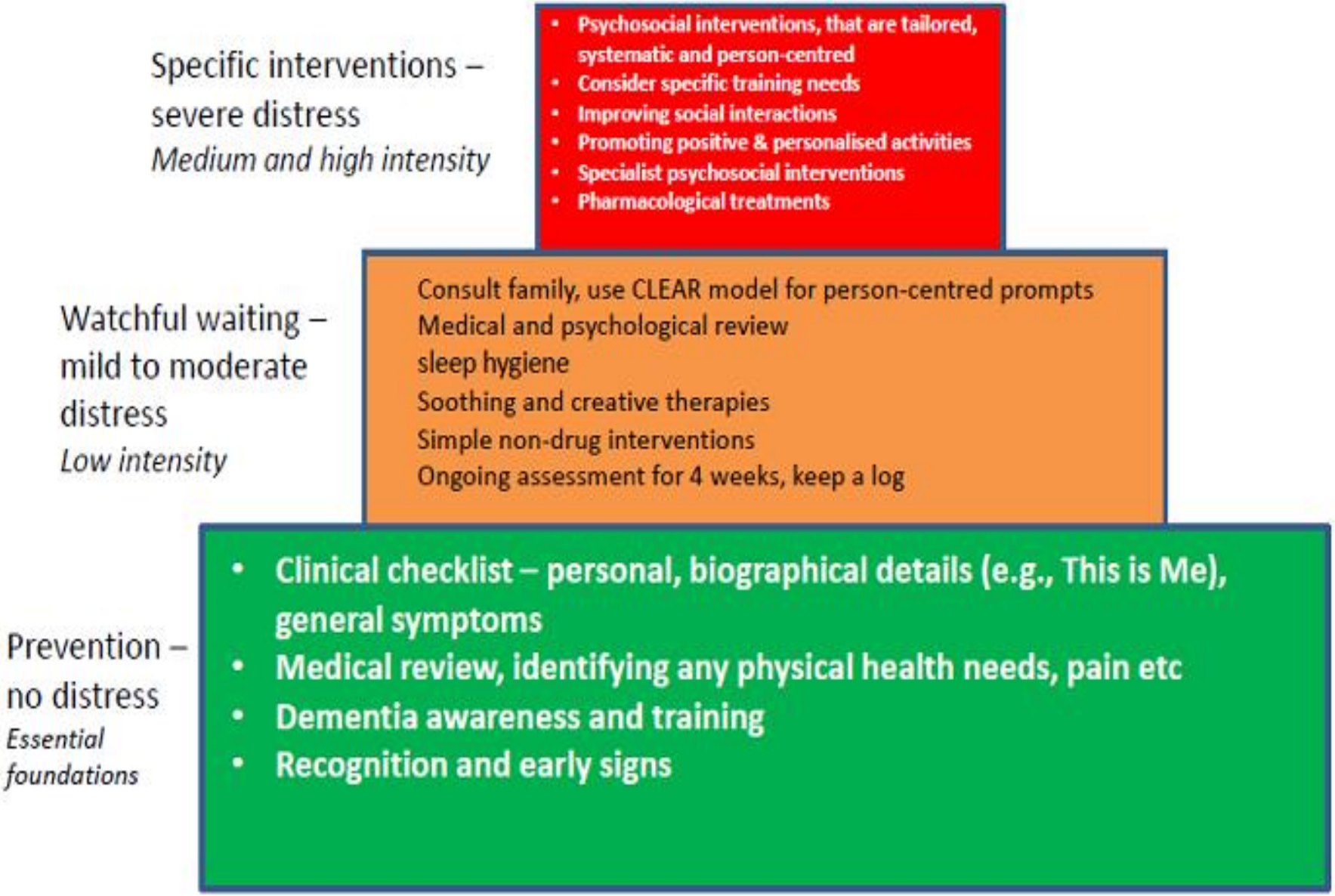
C. BEHAVE-AD

D. Cornell Scale for Depression in Dementia

E. Apathy Evaluation Scale

Q7. Pharmacological Rx is the first line ?

- FALSE
- The Alzheimer's Society toolkit (2011) proposes a three stage, stepped-care approach


Specific interventions – severe distress
Medium and high intensity
• Psychosocial interventions, that are tailored, systematic and person-centred
• Consider specific training needs
• Improving social interactions
• Promoting positive & personalised activities
• Specialist psychosocial interventions
• Pharmacological treatments
Watchful waiting – mild to moderate distress
Low intensity
Consult family, use CLEAR model for person-centred prompts
Medical and psychological review
sleep hygiene
Soothing and creative therapies
Simple non-drug interventions
Ongoing assessment for 4 weeks, keep a log
Prevention – no distress
Essential foundations
• Clinical checklist – personal, biographical details (e.g., This is Me), general symptoms
• Medical review, identifying any physical health needs, pain etc
• Dementia awareness and training
• Recognition and early signs

Q8.There are no adverse effects from the use of antipsychotics in dementia?

- FALSE

Medications in the treatment of BPSD – Worth the risk?

2 Recent Systematic Reviews

Other reviews include:

- Gauthier et al 2002
- Gauthier et al 2005
- Gauthier et al 2008
- Schneider et al 2006
- Ballard and Waite 2006

BUT:

- Not many studies
- Not many well-designed studies
- Evidence-base remains slim

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REVIEW

Pharmacological treatments for neuropsychiatric symptoms of dementia in long-term care: a systematic review

Dallas P. Seitz,[1] Sudeep S. Gill,[2] Nathan Herrmann,[3,4] Sarah Brisbin,[1] Mark J. Rapoport,[3,4] Jenna Rines,[1] Kimberley Wilson,[5] Ken Le Clair[1] and David K. Conn[3,6]

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Neuropsychiatry

RESEARCH PAPER

Pharmacological treatment of neuropsychiatric symptoms in Alzheimer's disease: a systematic review and meta-analysis

Jun Wang,[1] Jin-Tai Yu,[1,2] Hui-Fu Wang,[2] Xiang-Fei Meng,[1] Chong Wang,[1] Chen-Chen Tan,[1] Lan Tan[1,2]

Pharmacological Rx of BPSD

Medication	Evidence
Cholinesterase inhibitors	• Modest benefit on NPI • Especially apathy, depression and anxiety but NOT agitation • ?Especially galantamine (Wang et al, 2014)
Memantine	• Modest benefit for agitation/aggression, delusions and disinhibition (Gauthier et al 2005 and 2008) • Wang et al – favours but not statistically significant
Antipsychotics	• Most studied medications for BPSD Rx • Risperidone 1-2mg daily: modest benefit on aggression, more limited benefit for psychosis. No benefit from quetiapine (Schneider et al, 2006) • Small benefits for risperidone, olanzapine and aripiprazole (Seitz et al, 2013) • Small benefits of olanzapine and aripiprazole (Wang et al, 2014)

Pharmacological Rx of BPSD

Medication	Evidence
Antidepressants	• Modest benefit of citalopram 30mg but QTc prolongation - CitAD (Porsteinsson et al, 2014) • No benefit of antidepressants (Seitz and Wang)
Anticonvulsants	• Small single study support for carbamazepine (Seitz et al, 2013) • No benefit of valproate (Seitz) *and clinical worsening* (Wang et al, 2014)
Others	Single small study support for: • Oestrogen • Cyproterone acetate • Propranolol • Prazosin
Pain relief	• Improvements in agitation after stepped treatment with analgesics (Husebo et al 2011; Corbett et al 2012)

Antipsychotic in Dementia – Considerable Risk of Adverse Events

- Antipsychotics increase the risk of **death** (1% attributable risk over 12 weeks of Rx)
- And risk of **cerebrovascular events** increased 3 fold
- And **somnolence**, **falls**, and fall-related injuries including **hip fractures**
- They also accelerate **cognitive and functional decline**
- Other problems: EPSE, peripheral oedema, DVT/PE, prolonged QTc, chest infections

Antipsychotics in Dementia

Licensed use

- **Risperidone only** for use in dementia for up to **6 weeks** in patients with **severe aggression** (causing risk or severe distress, which has not responded to other treatments)

Guidelines

- **NICE** and American Psychiatric Association (**APA**) recommend:
  - **Atypical antipsychotic** treatment for maximum of **12 weeks**, except in exceptional circumstances

Q9. There is a poor prognosis for BPSD?

- FALSE

Prognosis

- BPSD in early stages of dementia predict a worse outcome
- Most BPSD will stop after 4 weeks without any pharmacological treatment.
- Long term prescriptions of antipsychotics can be discontinued without a detrimental effect on Neuropsychiatric symptoms (Declercq et al 2013)

CASE 1

- 84 year old widow Problems -
- 1. On going confusion following fractured neck of femur 6 weeks prior to assessment. She has had fluctuating cognitive function since then with poor short term memory and fluctuating orientation to place. She is unsettled and restless at night but this may be related to a disturbance in the bay from another patient.
- 2. Daughter gave a history of 1 year cognitive decline with memory problems since her TIA in 2014 and 2016. She had needed increased help with shopping, bathing, and has increasingly poor mobility.
- 3. Her daughter is concerned she may be depressed as her mood is labile and she is sometimes tearful. She lives alone in her own home.

Cognitive - She is aware that she is in hospital, does not know why or how long she has been in. She is disorientated in time with poor attention. She says that she is a little forgetful but it's not a major problem. She has no insight into her ability to cope at home and says that she will be fine.

She has had a MOCA on which she scored 3/22
and a CT Head shows small vessel disease.
She probably has vascular dementia

What are the likely causes of her night time restlessness?

How should it be managed?

What are the risks?

- CASE 2
- 83 Year old widower was admitted to South Bristol Community Hospital on the 12th of May, 2017 for rehabilitation following an ischaemic left lacunar stroke on the 18th April.
- Post stroke problems -
- 1. Dysphagia,NG tube in situ,2. Mild dysarthria this was present prior to his stroke.3. Fatigued 4. Parkinson's disease diagnosed during his admission. His tremor and bradykinesia were present before his stroke and these symptoms have improved with Co-Careldopa.5. Deteriorated short-term memory again this is a problem prior to his stroke but has become much worse.6. Sexual disinhibition he makes inappropriate sexual comments to staff and occasionally he grabs inappropriately. He is insightful into this behaviour and apologetic.

- He was seen by a movement disorder consultant, and diagnosed with Parkinson's plus syndrome and progressive supranuclear palsy. He occasionally has visual hallucinations but he is not worried by these. He describes auditory hallucinations he hears the radio playing when it is not on and describes ideas of reference. He believes the people on the TV and radio talk about him saying that he is a nice man. He is not worried by these experiences. His best friend died three months ago. He says he misses him but again there is a lack of emotional affect when he describes this.
- BACKGROUND
- Past Psychiatric history- He has a long history of anxiety and depression following the death of his wife 14 years ago mental health recovery service. He was seen in November 2016 and March 2017. No evidence of low mood but MRI scan which showed significant fronto temporal atrophy suggesting fronto temporal dementia.

BACKGROUND

Past Psychiatric history- He has a long history of anxiety and depression following the death of his wife 14 years ago mental health recovery service. He was seen in November 2016 and March 2017. No evidence of low mood but MRI scan which showed significant fronto temporal atrophy suggesting fronto temporal dementia.

What are the symptoms here that may be perceived as challenging?

How are these symptoms best managed?

Case 3

73 year old widower was admitted on the 1st of March following a fall in the street and a fractured left wrist.

Problems:

1. Longstanding alcohol dependence Syndrome. He was drinking at least 4 pints of Cider daily prior to his last admission in August 2016 when he fell and fractured his scapula. He he says he has not drunk alcohol for 8 years but he was intoxicated on admission this time and was found with alcohol in his possession. Barry is in complete denial about his alcohol intake. This is a change from his previous admission last year when he admitted his drinking, but was ambivalent about giving up.

2. Alzheimer's/Dementia - His family give a two year history of cognitive decline with short term memory problems and reduced functional ability. His CT Head showed Hippocampal atrophy and Alzheimer's disease was diagnosed during his last admission to hospital. He appears to have declined cognitively since November 2016. He is more vague and repetitive with receptive and expressive aphasia .He is vague about the circumstances of his admission and frequently changes his story. He is much more apathetic and lacking in motivation. He's much more vague about his finances.

3. Poor mobility
4. Challenging behaviours
He is vague and apathetic when we discuss his living arrangements.
He is repetitive He says he hit a staff member today because the staff member grabbed his wrist and he wasn't able to accept that this was not the actual scenario and that the nurse was just trying to help him to get up.
He sometimes wanders around the ward naked.
He sometimes shouts at staff and throws things and can be very irritable.

What are the likely causes of the challenging behaviours he is exhibiting

How can they best be managed?