Top Tips: Patients with Dementia

- What are the common or significant health and symptom burdens for patients with dementia in the last years, months and days of life?
  - memory loss
  - increasing problems understanding what is being said to them and what is going on around them
  - progressive loss of speech
  - reduced mobility with risk of falls, sometimes becoming bed-bound
  - weight loss
  - poor initiation of eating/drinking requiring prompting or progressive difficulty with chewing/swallowing risking aspiration or choking
  - incontinence
  - psycho-behavioural problems; agitation, hallucinations
  - pressure sores
  - infections; chest, bladder
  - seizures

- Types of medications commonly used in dementia disease
  Non pharmacological approaches to managing dementia must be considered. There is emerging evidence highlighting the potential harms of medications such as anti-psychotics. Please see the NICE guidance to dementia revised in 2011:

<table>
<thead>
<tr>
<th>Medication group</th>
<th>Indications</th>
<th>Benefits</th>
<th>Risks and Burdens</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anti-psychotics (e.g. risperidone)</td>
<td>dementia-related behaviour disturbances – (up to 6 weeks)</td>
<td>treatment of persistent aggression in moderate to severe Alzheimer’s dementia unresponsive to non-pharmacological approaches</td>
<td>increased risk of falls, stroke and a small increased risk of death Can cause neuroleptic crisis in Lewy body dementia Can be sedating</td>
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<tr>
<td>Aspirin/anti-coagulation</td>
<td>Vascular dementia</td>
<td>Minimise risk of vascular events</td>
<td>Bleeding/gastric irritation Monitoring INR if on warfarin</td>
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<tr>
<td>ACE Inhibitors or Angiotensin receptor blockers</td>
<td>Vascular dementia</td>
<td>Minimise risk of vascular events Manage cardiac failure or hypertension</td>
<td>Symptomatic hypotension, electrolyte disturbance requiring monitoring – may need to consider dose reduction</td>
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<tr>
<td>Statins</td>
<td>Vascular dementia</td>
<td>Minimise risk of future vascular events</td>
<td>Tablet burden</td>
</tr>
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<tr>
<td>Donepezil/memantine*/</td>
<td>Alzheimer’s dementia</td>
<td>some evidence of slower decline in function and</td>
<td>Minimal tablet burden-most preparations only 1 tablet od</td>
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<tr>
<td>Rivastigmine/ galantamine</td>
<td>MMSE &gt; 10 (*particularly useful for psycho-behavioural symptoms)</td>
<td>cognition</td>
<td></td>
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<tr>
<td>Hypoglycaemic agents</td>
<td>diabetes</td>
<td>Avoid symptomatic hyperglycaemia</td>
<td>Hypoglycaemia particularly with reduced oral intake</td>
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<tr>
<td>Anti-epileptic</td>
<td>Seizure control/mood lability</td>
<td>Prevent seizure</td>
<td>Interactions with other medication and tablet burden</td>
</tr>
<tr>
<td>Anti-depressant e.g. SSRI</td>
<td>Low mood</td>
<td>Improve mood and quality of life</td>
<td>Interactions, postural instability and falls</td>
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<td></td>
<td>Risk of sedation- SSRIs less so than TCAs</td>
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<td>Risk of nausea and vomiting</td>
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<td>Anti-muscarinic effects of TCAs- dry mouth, blurred vision, arrhythmias and urinary retention</td>
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<td>Withdrawal syndrome if SSRIs stopped abruptly</td>
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</tbody>
</table>

- **Medications that may need stopping as illness progresses**
  - **Anti-hypertensives** – consider tablet burden and if patient has enough time to benefit from modifying long term risk of further vascular events
  - **Anti-coagulants** – monitoring levels burdensome and invasive, balance risk of bleeding with prevention of stroke, venous emboli etc.
  - **Lipid lowering agents** – consider tablet burden and if patient has enough time to benefit from modifying long term risk of further vascular events
  - **Diuretics** – renal impairment common in frail, older patients with reduced oral intake – risk of toxicity/increased toxicity from other medication
  - **Hypo-glycaemic agents** – aim should be keeping patient asymptomatic rather than trying to prevent microvascular complications. Poor appetite and limited oral intake risks hypoglycaemia. Avoid oral sulphonylureas if food intake is poor or variable.

- **Medications that may need continuing as illness progresses**
  Main consideration will be route of administration if oral route inconsistent-consider other routes such as transdermal or rectal:
  - **Analgesics**
  - **Anti-epileptics**
  - **Laxatives/PR bowel intervention**
  - **Memantine** if psycho-behavioural symptoms

- **Medications that may need introducing as illness progresses**
  Main consideration will be route of administration if the oral route is inconsistent - consider other routes such as transdermal or rectal
### Pain
- Buprenorphine patches, PR paracetamol/ diclofenac, if opioid naïve and opioids required for acute pain – start low and go slow e.g. diamorphine 1.25mg subcut PRN.

### Breathlessness or anxiety
- Lorazepam 0.5mg sublingual PRN (max 4mg in 24 hours), midazolam 1.25mg subcut PRN

### Restlessness/ Agitation
- Risperidone 0.25-1 mg per day (only licensed anti-psychotic for this indication, risks of stroke) Olanzapine 2.5-5mg per day (both have lower risk of extra-pyramidal side effects)

### Respiratory secretions
- Glycopyrronium 0.2-0.4mg subcut PRN, max 2.4mg in 24 hours

### Nausea and vomiting
- (depends on aetiology) metoclopramide 10mg subcut PRN (avoid in Parkinsonism/ Parkinson’s disease/ concomitant bowel obstruction), cyclizine 25-50mg subcut PRN, Domperidone suppositories 10mg PRN.

### Seizure management
- Buccal midazolam 10mg/1ml PRN

- **Refer to end of life section for anticipatory prescribing**

- **Key references**

- **Useful resources**
  - [http://www.rcpsych.ac.uk/pdf/Dementia%20Compromised_swallowing_guide_July_2010.pdf](http://www.rcpsych.ac.uk/pdf/Dementia%20Compromised_swallowing_guide_July_2010.pdf)