Summary of Pharmacological Treatment Options for Behavioural and Psychological Symptoms of Dementia

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

To be used in conjunction with the Behaviours that Challenge CLiP**.** Complete an assessment of underlying causes and consider the use of psychosocial and environmental interventions before starting any non-pharmacological and pharmacological interventions.

Drug group	Target Symptoms	Licensed	Unlicensed	Recommendations
Drugs for dementia	Agitation		Donepezil Rivastigmine Galantamine Memantine	NICE recommends Acetylcholinesterase Inhibitors (AChEI)are considered for: - People with mild, moderate, or severe Alzheimer's disease who have non-cognitive symptoms and/or behaviour that challenges, causing significant distress or potential harm to the individual providing: (i) a non-pharmacological approach is inappropriate or has been ineffective and (ii) antipsychotic drugs are inappropriate or have been ineffective. - People with Lewy Body Dementia (LBD) who have non-cognitive symptoms causing significant distress to the individual, or leading to behaviour that challenges, should be offered an AChEI. - Memantine is recommended as an option for managing moderate Alzheimer's disease for people who cannot take AChEI, and as an option for managing severe Alzheimer's disease and can be used in combination with AChEI.
	Apathy		Donepezil	
	Psychosis		Donepezil Rivastigmine Galantamine Memantine	
Antipsychotics* ***Caution** - all antipsychotics considered to have increased risk for all-cause mortality and cerebrovascular events. Do not use antipsychotics for agitation in LBD or PDD without careful consideration and senior advice.	Aggression	Risperidone - Up to 6 weeks in severe aggression	Risperidone > 6 weeks treatment Olanzapine Alternatives: Quetiapine Amisulpride Aripiprazole	**Only offer antipsychotics for people living with dementia who are either: at risk of harming themselves or others, or experiencing agitation, hallucinations or delusions that are causing them severe distress. NICE recommends** the following points are considered and documented • Discuss benefits and risks of treatment with patient and/or family/carer (See Choice and Medication website for decision aid link) • Use lowest effective dose for the shortest possible time. • Assess response and whether antipsychotic still needed at least every 6 weeks Stop antipsychotic if person is not getting clear ongoing benefit AND after discussion with the patient and/or carer. See Trustwide monitoring recommendations for patients on antipsychotics link **In confirmed or possible LBD and Parkinson's Disease Dementia (PDD) antipsychotics can worsen disease and should only be used with appropriate caution –** severe EPSEs (especially rigidity) and autonomic instability can occur at low doses resulting in rapid deterioration and death if not discontinued quickly. Cautious use of e.g. low dose Quetiapine or Clozapine can be considered for treatment of severe or distressing symptoms of psychosis in LBD or PDD, where a trial of AChEI has been unsuccessful or is contraindicated, but evidence is limited and individual risk / benefit analysis should always be documented.
	Agitation	Haloperidol - agitation and restlessness in the elderly		
	Psychosis			
	Sexual disinhibition		Benperidol	
Antidepressants For Depression and Anxiety see Trust medication pathways	Agitation		Trazodone Sertraline Citalopram* Mirtazapine	The use of SSRIs may be justified in some cases. Effect is modest at best. Supporting evidence is weak. * ***Caution with citalopram****: Risk of dose dependant QT prolongation* Trazodone is widely used in BPSD although evidence is limited. It is found to reduce irritability and agitation, most probably by its sedative effect. In people living with mild to moderate dementia; do not routinely offer antidepressants for mild to moderate depression and/or anxiety unless they are indicated for a pre-existing severe mental health problem, consider psychological treatments.
	Sexual disinhibition		Fluoxetine	
	Diurnal rhythm / sleep disturbances		Trazodone Mirtazapine	
Anticonvulsant Mood stabilisers			Carbamazepine	Evidence for use of carbamazepine is conflicting and trials were short term. Use may be justified where other treatments are contra-indicated or ineffective. Do not offer valproate to manage agitation or aggression, unless it is indicated for another condition.
Analgesics	Agitation	Paracetamol		Ensure any underlying pain is treated. See TEWV Management of pain guidance. Even with people without overt pain trial of analgesics (paracetamol) worthwhile
Benzodiazepines	Anxiety	Lorazepam/diazepam		Benzodiazepines are widely used but poorly supported by evidence. Use should be avoided.
Anti-androgens	Sexual disinhibition	Cyproterone		Limited benefit in managing disinhibited sexual behaviour in elderly men with dementia.
Hypnotics	Diurnal rhythm disturbances / Sleep disturbances	Zopiclone		NICE recommends a personalised multicomponent sleep management approach including sleep hygiene, exposure to daylight, exercise and personalised activities. Short term treatment with hypnotics such as zopiclone can be helpful, but there is considerable uncertainty about the balance of benefits and risk. There is no evidence to support that the use of melatonin (up to 10mg) helped in sleep disorders in moderate to severe Alzheimer's Disease dementia and its use is not recommended by NICE.
Antihistamines	Agitation		Promethazine	Short term treatment can be helpful but poorly supported by evidence. **Caution:** sedating and antihistamines have an anticholinergic effect potentially worsening cognition. Refer to Rapid Tranquilisation policy for guidance and precautions on using IM.
No pharmacological treatments		Abnormal or disruptive vocalisations, Wandering, Resisting care, Poor appetite, Misidentification		

Approved by	Drug & Therapeutics Committee	Date of Approval	23 May 2019(amended v3.1 25 March 2021)
Protocol Number	PHARM-0051-v3.1	Date of Review	1st December 2022 (extended)