



National Prescribing Service Limited

29 August 2008



000001 000
Dr Sam Sample
123 Sample Street
Sampletown ABC 1234



Prescribing Practice Review

No. 43 Treating the symptoms of dementia

Dear Dr Sample,

This *Prescribing Practice Review* provides advice on treating some of the symptoms of dementia. Included are your prescribing data for the cholinesterase inhibitors, along with practice points for your review.

Use non-pharmacological strategies at all stages

Non-drug strategies can assist in managing dementia throughout the course of the condition.

Benefits of cholinesterase inhibitors and memantine are small, some patients will not respond, and adverse effects are common

Cholinesterase inhibitors and memantine may produce small improvements in cognition, but will often cause adverse effects. It is unclear if they improve quality of life or delay institutionalisation.

Monitor and objectively assess the effectiveness of cholinesterase inhibitors and memantine if they are to be used

Any beneficial effect usually occurs within 3 months of starting the highest tolerated dose.

Trial a withdrawal of antipsychotics if there are no clear beneficial effects

Use antipsychotics only if non-drug strategies do not control distressing agitation, aggression or psychoses. Reassess use within 3 months and, if symptoms are stable, trial a gradual cessation.

Plan to review medications regularly as well as opportunistically

Monitor response to cholinesterase inhibitors or memantine every 6 months, and antipsychotics 3-monthly. Identify drugs that can interact or exacerbate the symptoms of dementia.

Counsel patients and their carers on the limited benefits of drug therapy

Emphasise that cholinesterase inhibitors and memantine treat symptoms but do not cure dementia. Set aside sufficient time to manage patient and carer expectations.

Yours sincerely,

Dr Janette Randall
Chair, National Prescribing Service Limited

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NPS is an independent, non-profit organisation for Quality Use of Medicines, funded by the Australian Government Department of Health and Ageing.

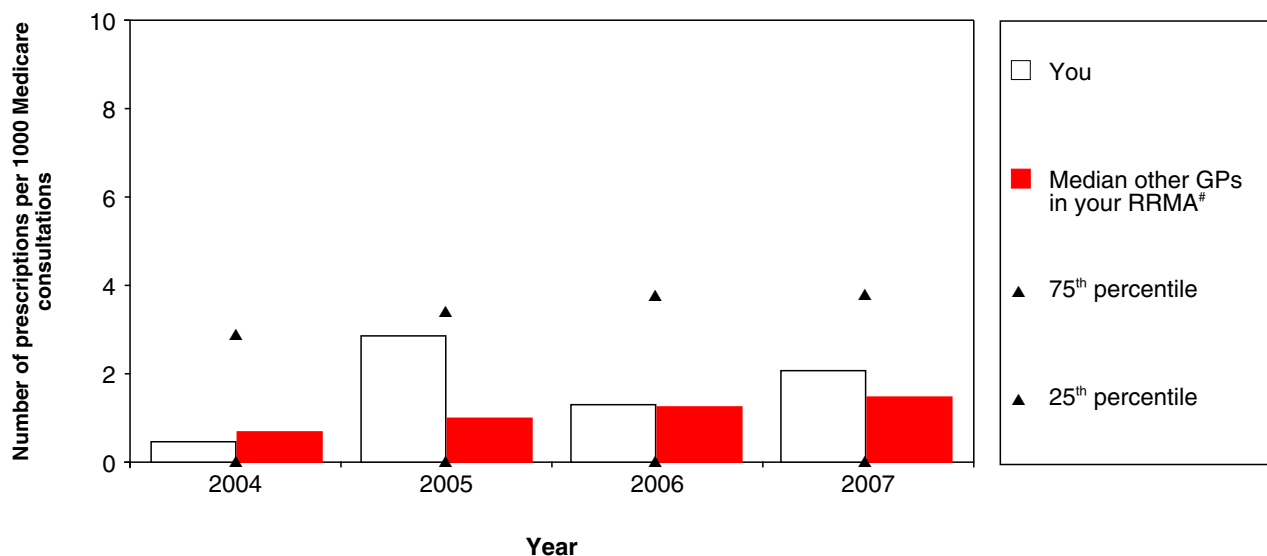
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Your confidential prescribing data

The data presented from Medicare Australia include all prescriptions dispensed for the cholinesterase inhibitors donepezil (Aricept), galantamine (Reminyl) and rivastigmine (Exelon). As all the items are above the general patient co-payment, data capture is complete. Galantamine 4mg, 8mg and 12mg tablets were discontinued and replaced with (8mg, 16mg and 24mg) controlled-release capsules in 2006.

Total cholinesterase inhibitor use in 2004 - 07



▲ 25% to 75% of all doctors in the comparator group fall in the range shown by the triangular symbols

Please note: the median above is low because a substantial proportion of other GPs in your RRMA[#] have not prescribed cholinesterase inhibitors in the time frame shown.

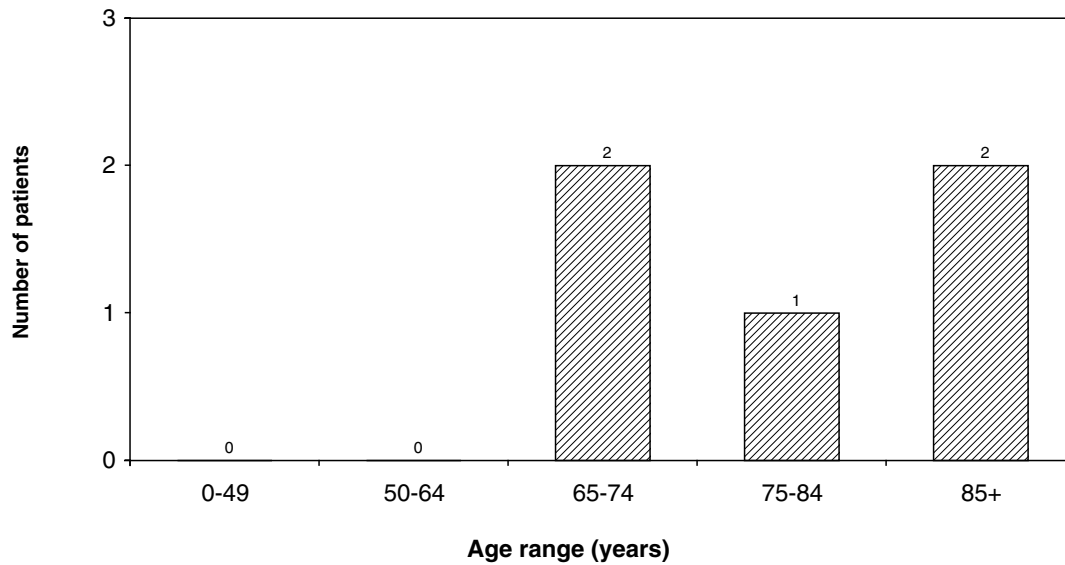
Practice points

- The benefits of cholinesterase inhibitors used for symptomatic treatment of dementia are marginal. Many of the improvements shown in trials were statistically significant, but were not clinically significant or were of unknown clinical significance.^{1,2}
- Cholinesterase inhibitors trialled in Alzheimer's Disease show differences from placebo of 1.4 to 3.9 points on the 70 point ADAS-Cog measure.³ A change of 4 points is generally considered clinically significant in mild to moderate dementia.⁴
- Initiate treatment with clearly defined treatment goals and an objective measure of effectiveness.⁵
- Set aside time regularly to manage expectations of the patient, family and carers regarding medication and clinical improvement.

® Data shown are an aggregate for all your provider locations

The comparator group "other GPs in your RRMA" includes all prescribers who are currently located in a similar geographical region i.e. 1. capital cities, 2. other metropolitan centres, 3. large rural centres, 4. small rural centres, 5. other rural centres, 6. remote centres and 7. other remote centres

Your cholinesterase inhibitor prescribing by patient age in 2007

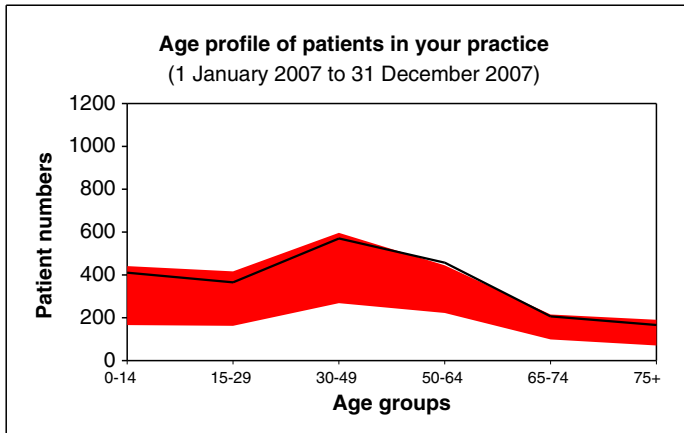


Practice points

- As there are no reliable predictors of response to cholinesterase inhibitors, carefully assess benefit after 3 months of treatment at full or highest tolerated dose.⁶
- Reassess patients on long-term treatment at least every 6 months.⁵
- Stop treatment if there are significant adverse effects, poor compliance, lack of stabilisation or no improvement of symptoms.⁶
- Review medications used for co-morbid conditions. Could they be contributing to cognitive decline?

Practice profile

Some data shown earlier are presented as prescribing rates (per 1000 Medicare consultations) to adjust for volume of service. Age profile and concession card holding status of patients in your practice are provided to assist you in interpreting your prescribing data.



The black line represents the age profile of patients in your practice. 25% to 75% of other GPs in your RRMA[#] fall within the shaded area.

Medicare patients and concession card holders in your practice
(1 April 2007 to 30 June 2007)

Patients	You	Median other GPs in your RRMA [#]
Total Medicare	982	678
Concession card holders^{##}	453	256

Data from a three month period (1 April 2007 to 30 June 2007) that best represent your patient mix have been provided.

Confidentiality

NPS has a contract with Medicare Australia to provide your prescribing feedback data directly to you. NPS does not have access to these data. The data contained in this feedback are not used for any regulatory purposes.

Discrepancies may occur between the data provided and your own prescribing practice. This may be due to either inaccurate recording of your prescriber number in the pharmacy or your prescription pad having been used by another doctor.

For any enquiries about your data, please contact NPS on 02 8217 8700 or by email at info@nps.org.au

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6. Australian Medicines Handbook. Adelaide, 2008.

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Your RRMA peer group is **3**

Includes those reaching Safety Net

Treating the symptoms of dementia

Key Messages

- Use non-pharmacological strategies at all stages
- Benefits of cholinesterase inhibitors and memantine are small, some patients will not respond, and adverse effects are common
- Monitor and objectively assess the effectiveness of cholinesterase inhibitors and memantine if they are to be used
- Trial a withdrawal of antipsychotics if there are no clear beneficial effects
- Plan to review medications regularly as well as opportunistically
- Counsel patients and their carers on the limited benefits of drug therapy

Use non-pharmacological strategies at all stages

Non-drug strategies are vital in managing dementia

Non-drug strategies can help promote and maintain independence, cognitive function and manage behavioural and psychological symptoms of dementia. Individualise management and involve the patient, their family and carers wherever possible.¹ Choose a combination of strategies according to the patient's needs, abilities and available resources.

Encourage patients to maintain social, physical and recreational activities

People with dementia may withdraw from social activities and stop physical or complex activities. This can hasten loss of independence.² Encourage patients to maintain activities that are appropriate to their interests and ability.

Is the patient in pain or discomfort?

Rule out disorders that may be causing pain or discomfort (e.g. constipation, reflux, arthritis or infection). Treating the underlying cause may alleviate behavioural and psychological symptoms of dementia without further intervention.

Identify and modify triggers of challenging behaviours

Observe the circumstances of behavioural and psychological symptoms of dementia to identify possible triggers. Such symptoms may arise from:

- visual or hearing impairment
- boredom or lack of stimulation
- use of certain medications (anticholinergics, anticonvulsants)
- loud noise or excessive, or poor, heating
- unfamiliar surroundings or routines
- carer behaviour.

Changes to these factors may help alleviate behavioural and psychological symptoms.

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Refer patients and carers to information and support services

Alzheimer's Australia (1800 100 500) offers information and support for people with Alzheimer's disease and their carers and families. The Commonwealth's *Dementia website* (www.health.gov.au/dementia) and its *Dementia Resource Guide* offers information to help people with dementia and their carers.

Benefits of cholinesterase inhibitors and memantine are small, some patients will not respond, and adverse effects are common

Drugs modify symptoms not disease progression

The cholinesterase inhibitors (donepezil [Aricept], rivastigmine [Exelon] and galantamine [Reminyl]) and memantine (Ebixa) do not alter the pathology of Alzheimer's disease.³ These drugs are used to improve symptoms only.

The cholinesterase inhibitors are only PBS listed for mild to moderate Alzheimer's disease. Memantine is only PBS listed for moderately severe Alzheimer's disease.

Expect modest improvements only

Taking a cholinesterase inhibitor for 6 months produces an average difference in cognition scores of 2 to 3 points on the 70-point ADAS-cog*⁴ compared with placebo.⁵ Using memantine for 6 months produces an average difference in cognition scores of 3 points on the 100-point Severe Impairment Battery (SIB)⁶ compared with placebo.⁷ The clinical importance of these improvements is unclear.⁸

Not everyone responds to treatment

Not every patient with dementia benefits from drug therapy. Some patients will have clinically important improvements, but there is no way of predicting who will benefit.¹

Adverse effects are common

In some clinical trials, half of the patients taking cholinesterase inhibitors withdrew because of adverse effects.⁸ Gastrointestinal adverse effects — such as nausea, vomiting and diarrhoea — are common initially and after dose escalation. People may also experience insomnia, dizziness, cramps, vivid dreams, asthma, slow heart beat and incontinence.^{3,9}

Up to 12% of patients in clinical trials stopped taking memantine because of adverse effects.⁹ Common adverse effects with memantine include confusion, dizziness, drowsiness, headache, insomnia, agitation and hallucinations.⁹

* Alzheimer's Disease Assessment Scale—cognitive subscale.

Monitor and objectively assess the effectiveness of cholinesterase inhibitors and memantine if they are to be used

Measure and record cognition at baseline and within 6 months of starting drug therapy

Use the MMSE (or SMMSE)¹ to measure baseline cognition and determine if the patient is eligible to try a cholinesterase inhibitor or memantine on the PBS.^{10,11} If the MMSE is ≥ 25 , a baseline ADAS-cog must be specified. Further information about these measures can be found in *NPS News 59*.

Any beneficial effect usually occurs within 3 months of starting the highest tolerated dose.⁸ To continue either class of drug under the PBS, the baseline MMSE must improve by 2 points within 6 months of beginning therapy.¹¹

It may be worth trying another drug if the patient does not respond to the first drug but there is no clear evidence to show that switching will produce a response.³

If slowing decline in cognition is no longer a goal (e.g. severe dementia), treatment with a cholinesterase inhibitor or memantine is no longer appropriate.⁸

In trials, many patients on placebo responded to treatment

Up to a third of people taking placebo in trials of the cholinesterase inhibitors showed a clinically significant improvement.⁸ Up to a quarter of people taking placebo showed a clinically significant improvement in trials of memantine.^{12,13}

† Mini-Mental State Examination or Standardised Mini-Mental State Examination.

Trial a withdrawal of antipsychotics if there are no clear beneficial effects

Reserve antipsychotics for patients who have not responded to non-drug strategies

Behavioural and psychological symptoms of dementia become more common as dementia progresses. Use antipsychotics only when non-drug strategies do not benefit patients who have distressing agitation, aggression or psychoses.

Antipsychotics increase the risk of mortality, stroke and extrapyramidal symptoms in patients with dementia.^{14–16} Prescribe only after an individual assessment of the benefits and harms, and as an adjunct to non-drug strategies.

Any response will be seen in the first few weeks

Response to antipsychotics usually occurs after 1–2 weeks and clinical improvement should be expected within 12 weeks.^{9,17} Discontinue if there is no improvement, and reassess the patient.

Stopping antipsychotics does not usually worsen behaviour

Many patients do not show worsening behaviour after antipsychotics are withdrawn.^{14,18} Review antipsychotic use within 3 months and, if symptoms are stable, gradually withdraw as part of a trial cessation.

Avoid stopping antipsychotics abruptly when withdrawing treatment — taper the dose by 50% every 2 weeks and stop after 2 weeks on the minimum dose.¹⁹

Plan to review medications regularly as well as opportunistically

Before starting cholinesterase inhibitors or memantine review current medications to identify drugs (e.g. antidepressants, anticholinergics) that may exacerbate the symptoms of dementia.¹

Review cholinesterase inhibitor or memantine use every 6 months

Review the response to the cholinesterase inhibitors or memantine by MMSE score and global, functional and behavioural assessment.^{1,20} Stop treatment if there are significant side effects, poor adherence, failure to meet the chosen treatment outcomes, or a significant deterioration in the patient's condition! Ensure that the deterioration is not due to an untreated concomitant illness before discontinuing.

Review antipsychotic use every 3 months

Review the patient for their target behaviour, changes in function and treatment-related adverse effects every 3 months, or according to clinical need.²⁰

Avoid anticholinergic drugs

Anticholinergic drugs impair cognition and directly oppose the action of cholinesterase inhibitors.^{9,21} Commonly used anticholinergic drugs include drugs for urinary incontinence, antihistamines and some antidepressants and antipsychotics. Examples of anticholinergic drugs to avoid are provided in *NPS News 59*.

Counsel patients and their carers on the limited benefits of drug therapy

Regularly discuss management with patients and carers

Set aside time with the patient, their family and carers to discuss their expectations of non-drug management of dementia, medications and clinical improvement.

Reinforce the importance of non-drug strategies in promoting and maintaining independence, maintaining cognitive function and managing behavioural and psychological symptoms of dementia.

Discuss the limitations of the cholinesterase inhibitors and memantine

When initiating drug therapy discuss the following with the patient, their family and carers:

- cholinesterase inhibitors and memantine treat the symptoms of dementia and cannot cure the underlying condition
- cholinesterase inhibitors and memantine do not work for everyone and the response to the drug cannot be predicted
- drug therapy will be trialled for up to 6 months
- continuing the drug after this time requires demonstrated improvement in cognitive function
- even if the patient initially responds to the drug, it usually needs to be ceased in those with severe dementia.

Expert reviewers

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Citations available online at www.nps.org.au/healthpro

The information contained in this material is derived from a critical analysis of a wide range of authoritative evidence. Any treatment decisions based on this information should be made in the context of the clinical circumstances of each patient.



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