Medication management of dementia-related behavior in primary care setting: when and how

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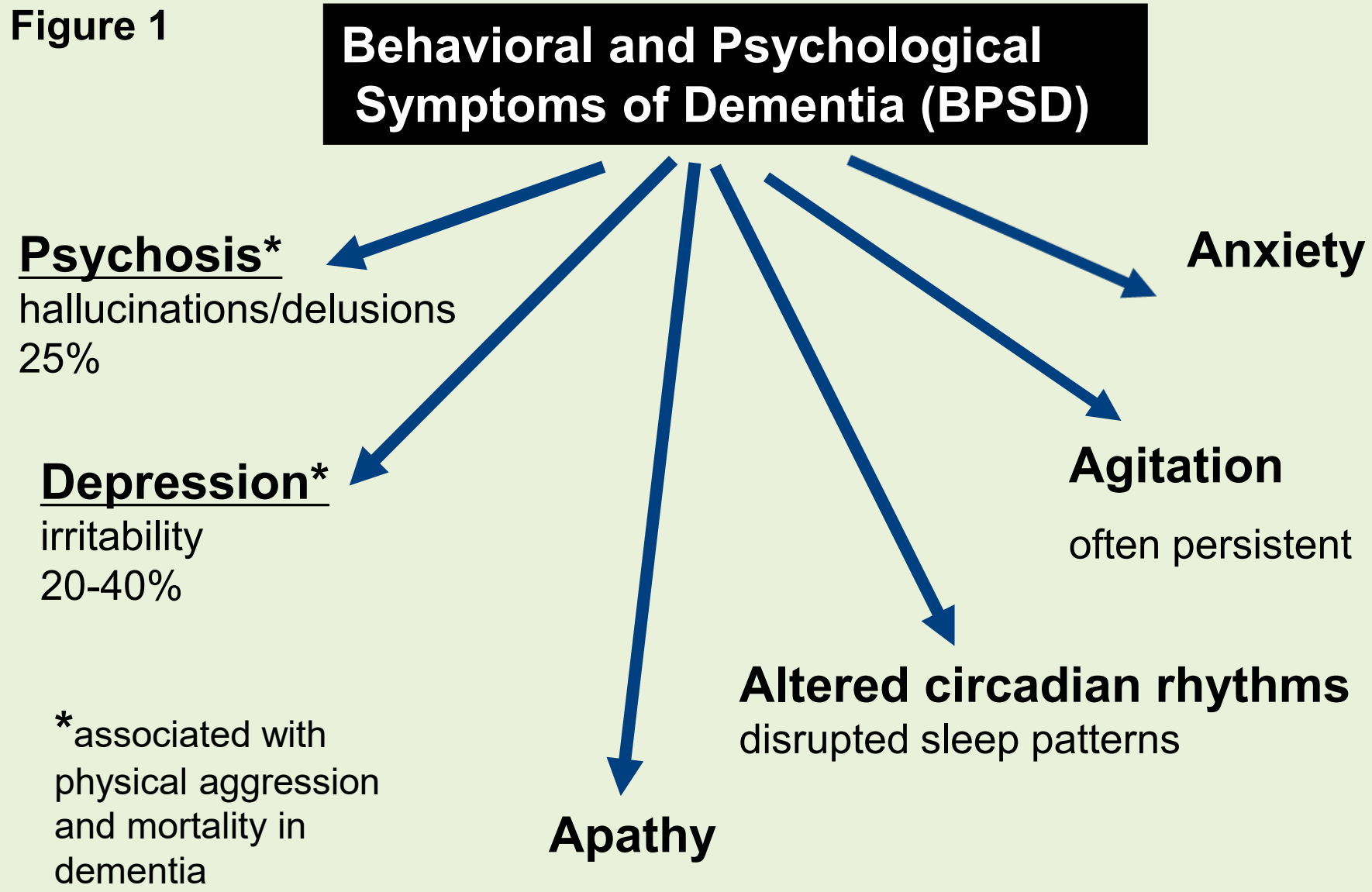
This handout is intended as a concise guide for practitioners in primary care setting on how to assess and address dementia-related behavior, including prescribing medications if needed.

Primary care providers (PCP) are increasingly tasked with managing challenging dementia-related behavior, especially with the growing aging population and lack of access to geriatric behavioral specialists in the US. Many are expecting such "crisis in geriatric mental health" to worsen. For example, in Honolulu, there has been a trend of more behavioral emergency resources being disproportionately allocated to elderly patients (ref. 1),

Dementia-related behaviors, often referred as behavioral and psychological symptoms of dementia (BPSD), are found in majority of patients with dementia. BPSD predicts higher mortality, increases risk of institutionalization, hastens institutionalization, and leads to high degree of depression and suffering for caregivers (ref. 2). BPSD can be broken down into definable symptom clusters as specific targets for treatment (Figure 1).

Figure 1



Clear description of symptom helps to facilitate specific and effective treatment

In a typical primary care setting, addressing BPSD-related complaints involves the following steps.

1st: Obtain clear description of behavior
Inquire caregivers regarding type of behavior, including duration, time of day, and triggers. Solicit patients' own narrative without confrontation. Determine what BPSD symptom clusters are present.

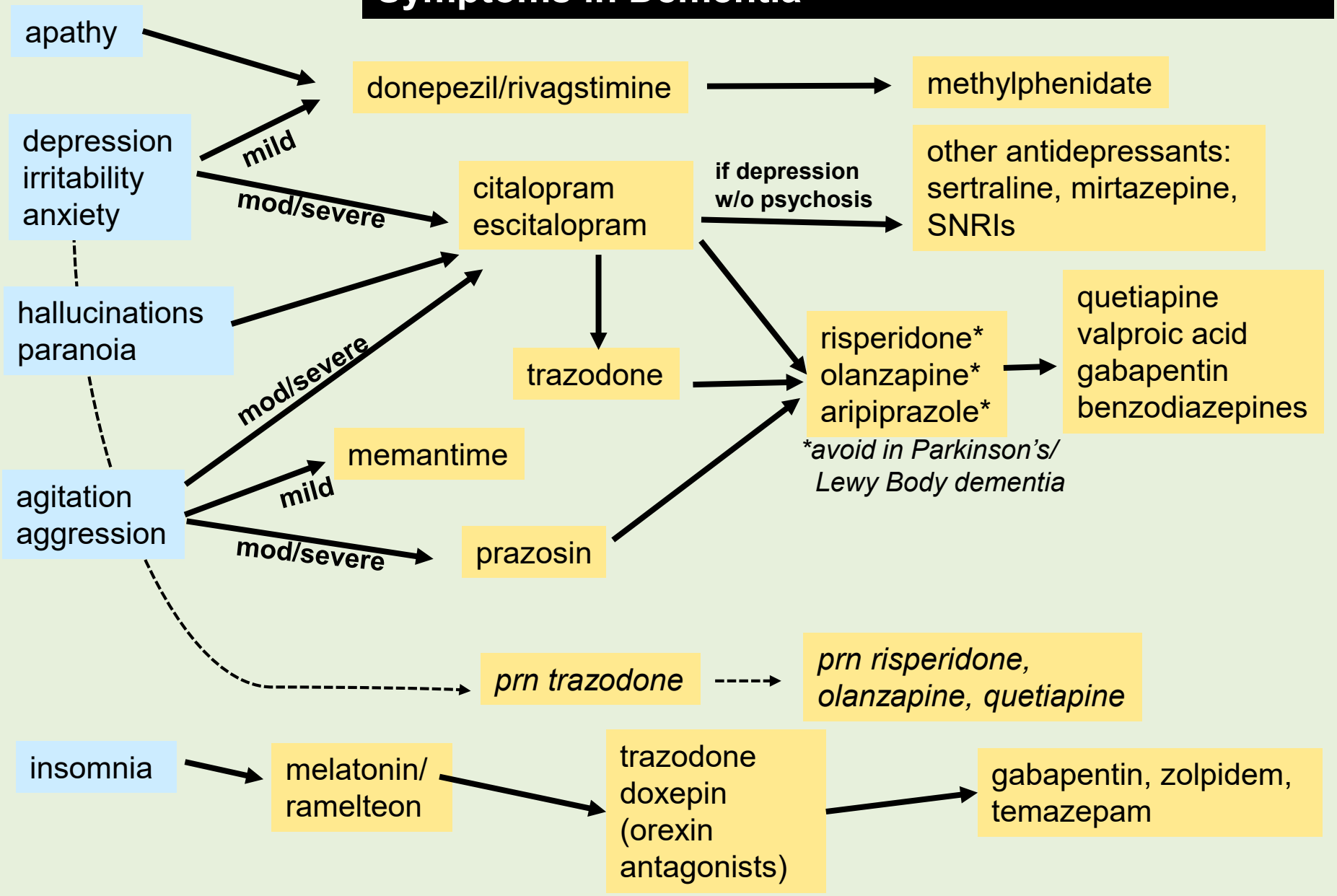
2nd: Address reversible/treatable medical causes
Screen or delirium, often presenting with acute behavioral symptoms, and treat promptly underlying medical etiology, such as UTI. Minimize pain, constipation, and neuropsychiatric side effects of medications, such as those from anticholinergics.

3rd: Optimize behavioral, or non-pharmacological, intervention (ref. 3)
Reinforce simple/calm speech, approaching patient from front, and gentle touch during care. Ensure sufficient sensory stimulation such as music. Explore outside resources/day programs to help lessen caregiver burnout.

4th: Consider medications for poor quality of life
Distressing, dangerous symptoms such as physical aggression and suicidal thoughts warrant medication consideration (ref. 4). Select meds based on benefit/risk ratio (Figure 2) with surrogate's informed consent.

Figure 2

Honolulu Medication Algorithm for Behavioral Symptoms in Dementia



updated (2022) per evidenced-based benefit to risk ratio, Lu 2016

General medication guidelines for BPSD

No “FDA-approved” medication for BPSD

Start with low dose to ensure tolerability and increase in small increments

May need up to 2-6 weeks for sustained improvement.

During this time, if target behavior persists, may not necessarily be “medication side effects” or “medication not working.”

Side effects usually present as clear and persistent change from baseline, such as sedation, confusion, motor symptoms, or gastrointestinal effects.

Consult geriatric medicine or geriatric psychiatrist if patient difficult to treat.

Some medication considerations:

-SSRIs often first line for BPSD but beware of hyponatremia

-prazosin, a BPH med crossing blood brain barrier, often effective for aggression

-dementia medications can confer small improvement in depression/anxiety

-antipsychotics can be highly effective in severe cases, as long as lowest effective dose used and side effects carefully monitored

-still limited evidence for benzodiazepines and valproate in BPSD, watch for sedation and disinhibition

Notes

References
(1) Lu et al, Am J Geriatr Psychiatry 25:6, 2017, (2) Finkel, Int J Geriatr Psychiatry 15:S2-S4, 2000, (3) Dyer et al, Int Psychogeriatr 30:295-309, 2018, (4) Davies et al, J. Psychopharmacol 32:509-523. 2018

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