DEMENTIA-RELATED BEHAVIORAL PROBLEMS

AGS Geriatrics Evaluation and Management Tools (Geriatrics E&M Tools) support clinicians and systems that are caring for older adults with common geriatric conditions.

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Geriatrics Evaluation & Management Tools

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BACKGROUND

All patients with dementia should be screened for behavioral symptoms of dementia, because these symptoms may increase caregiver stress, patient injury, institutionalization, and morbidity

SCREENING

"Have there been any bothersome behavioral problems since the last visit?"

EXAMPLES OF DEMENTIA-RELATED BEHAVIORAL PROBLEMS

- Repetitive vocalizations:
  - Constant unwarranted requests for attention or help
  - Repetitive sentences or questioning
- Psychomotor hyperactivity:
  - Inappropriate dressing or disrobing
  - Repetitive non-purposeful movements
  - Picking at self
  - Opening and closing cupboards
- Physical aggression:
  - Pushing
  - Grabbing
  - Spitting
  - Scratching
  - Hitting
  - Biting
  - Kicking
  - Throwing items
  - Destroying property
- Self-neglect
- Resisting help with personal care
- Anger and irritability:
  - Complaining
  - Cursing
  - Screaming
- Manic-like behavior:
  - Emotional lability
  - Disinhibition
  - Irritability
  - Psychomotor hyperactivity
  - Hypersexuality
- Disturbance of sleep cycle:
  - Sleeping throughout the day; awake throughout the night
  - Insomnia
- Psychosis:
  - Hallucinations
  - Delusions
  - Paranoia
- Depression
- Inappropriate sexual behavior
- Pacing or wandering

HPI

- Rule out delirium (see AGS Geriatrics Evaluation and Management: Delirium)
- Document the following information:
  - Specific problem behavior
  - Triggers for the behavior, circumstances surrounding the behavior
  - Timing, onset, frequency, and duration of the behavior
  - Severity/impact of the behavior—is the patient or caregiver at risk of harm?
  - Attempted nonpharmacologic and pharmacologic interventions and their outcomes
  - Previous successful treatment strategies
- Rating scales such as the Cohen-Mansfield Agitation Inventory (CMAI), the Neuropsychiatric Inventory (NPI), and the Behavioral Pathology in Alzheimer Diesease Rating Scale (BEHAVE-AD) can be used by clinicians to quantify symptoms based on caregiver interview

PAST MEDICAL HX

Investigate underlying medical or psychological disorders that could be contributing to behavior

SOCIAL HX

- Document alcohol and drug use that could be contributing to behavioral problems
- Assess caregiver stress levels
- Assess patient's risk for elder mistreatment

MEDICATIONS

Thoroughly review all medications and determine if they contribute to behavior

PHYSICAL EXAM

Perform a comprehensive exam to identify physiologic triggers for behavioral problems

NONPHARMACOLOGIC MANAGEMENT

- **Nonpharmacologic interventions have been shown to be more effective than pharmacologic treatment for dementia-related behavioral problems and therefore should be attempted first**
- **Treat underlying physiologic, environmental, and caregiver communication triggers**
  - Free educational resources such as http://www.nia.gov/alzheimers

PHYSIOLOGIC TRIGGERS	ENVIRONMENTAL TRIGGERS	COMMUNICATION TRIGGERS
▪ Discontinue inappropriate medications ▪ Encourage patient to use their glasses and hearing aids ▪ Offer food and drink ▪ Provide appropriate physical exercise such as a walk	▪ Provide regular daily routine, activities and structure ▪ Provide a comfortable, familiar living environment ▪ Provide the same caregiver if possible ▪ Engage the patient in simple daily activites they are able to do	▪ Show a warm, kind, matter-of-fact manner ▪ Make eye contact ▪ Provide simple step-by-step instructions ▪ Ask questions with limited choices such as, "Would you like water or milk?" rather than "What would you like to drink?"

NONPHARMACOLOGIC MANAGEMENT (CONT'D)

PHYSIOLOGIC TRIGGERS	ENVIRONMENTAL TRIGGERS	COMMUNICATION TRIGGERS
▪ Treat symptons such as pain, constipation, urine retention, nausea, dyspnea, if present ▪ Evaluate and treat endocrine and metabolic disorders (blood sugar, thyroid, etc.) ▪ Evaluate and treat infections according to goals of care (pneumonia, UTI, dental caries) ▪ Evaluate and treat cardiovascular disorders according to goals of care	▪ Avoid overstimulation (noise, TV, crowds) ▪ Avoid social isolation ▪ Refer patient to adult day care programs if needed ▪ Consider music therapy	▪ Allow the patient to make decisions whenever possible and avoid domineering communication styles ▪ Reassure or redirect patient ▪ Avoid frequent corrections; "Please do this," instead of "Don't do this" ▪ Stay calm and patient when speaking and avoid tense body language ▪ Don't argue with the patient ▪ Don't talk about the person as if he or she isn't there

PHARMACOLOGIC MANAGEMENT

- **Pharmacologic treatment of behavioral disturbances in dementia is of limited efficacy and should be used only after nonpharmacologic interventions have been implemented**
- Treat targeted behavior with recommended pharmacotherapy (outlined in table below) if behavior is unresponsive to documented attempts at nonpharmacologic management or if there are documented concerns for patient or caregiver safety
- Many medications for dementia-related behavioral problems are used off-label with serious side effects; therefore, document a risk-benefit discussion before beginning treatment
- For detailed information on medication dosages, benefits, adverse reactions, and monitoring, please refer to *Geriatric Review Syllabus* chapter on Behavioral Problems in Dementia

TARGET BEHAVIOR	MEDICATION CLASS/DAILY DOSE	COMMENTS
▪ Depression	Antidepressants	▪ See AGS Geriatrics Evaluation and Management: Depression
▪ Psychosis ▪ Anger ▪ Physical aggression	Antipsychotics: ▪ Aripiprazole: 2–20 mg ▪ Asenapine: 5–10 mg ▪ Clozapine: 12.5–200mg (poorly tolerated) ▪ Haloperidol: 0.5–3mg ▪ Iloperidone: 1–12 mg ▪ Lurasidone: 40–80 mg ▪ Olanzepine: 2.5–15 mg ▪ Paliperidone: 1.5–12 mg ▪ Perphenazine: 2–2 mg ▪ Quetiapine: 25–200 mg ▪ Risperidone: 0.5–2 mg ▪ Ziprasidone: 40–160 mg	▪ Carry a Food and Drug Administration (FDA) black box warning of increased risk of mortality in patients with dementia (the rate of death was about 4.5% in drug-treated patients and about 2.6% in the placebo group). The FDA has indicated that risks/benefits of treatment should be reviewed and documented carefully with caregivers before starting therapy.

▪ Manic-like behavior	Mood Stabilizers
	▪ Depakote 250-2000 mg/d
	  ▪ Starting dose 125 mg q12h
	  ▪ Slowly titrate upward while monitoring for adverse effects
	  ▪ Serum levels of 50–100 mcg/mL have been shown to be effective
	▪ Lamotrigene 25–200 mg/d
		Depakote:
		▪ Better tolerated than other mood stabilizers in older adults
		▪ May cause nausea, GI upset, ataxia, sedation, hyponatremia
		▪ Monitor CBC, platelets, liver function tests at baseline and every 6 months
		Lamotrigene:
		▪ May cause skin rash, rare cases of Stevens-Johnson syndrome, dizziness, sedation, neutropenia, anemia
		▪ Increased adverse events and interactions when used with divalproex
		▪ Slow-dose titration required
		Carbamazepine and lithium:
		▪ Poor tolerability in older adults

▪ Disturbance of sleep cycle	Sleep Medications ▪ Mirtazapine 7.5 mg starting dose (7.5–30 mg usual dose) ▪ Trazodone 25–50 mg starting dose (25–150 mg usual dose)	▪ Refer to "*Nonpharmacologic Management*" section of AGS Geriatrics Evaluation and Management: Insomnia ▪ Avoid use of benzodiazepines and antihistamines for sleep, due to risk of falls, fractures, disinhibition, and cognitive disturbance ▪ There have been no controlled trials of zolpidem or zaleplon in sleep disturbances secondary to dementia
▪ Dangerous inappropriate sexual behavior or physical aggression	Antiandrogens ▪ Oral progesterone 5 mg/d starting dose (adjusted to suppress serum testosterone below normal) ▪ Depot progesterone 10 mg IM weekly (if behaviors are suppressed by oral progesterone) ▪ Leuprolide acetate (5–10 mg IM every month)	