

11 - Other dementias

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648 The Maudsley® Prescribing Guidelines in Psychiatry CHAPTER 6 Dementia with Lewy bodies (DLB) DLB may account for 15–25% of cases of dementia. Characteristic symptoms are dementia with fluctuation of cognitive ability, early and persistent visual hallucinations and spontaneous motor features of parkinsonism. Falls, syncope, transient disturbances of consciousness, neuroleptic sensitivity and hallucinations in other modalities are also common.¹²⁴ There are significant complexities in managing an individual with DLB. Presentation varies between patients and can vary over time within an individual. Treatments can address one symptom but worsen another, which makes disease management difficult. Symptoms are often managed in isolation and by different specialists, which makes high-quality care difficult to accomplish. Clinical trials and meta-analyses now provide an evidence base for the treatment of cognitive, neuropsychiatric and motor symptoms in patients with DLB.¹²⁵ In summary, robust evidence exists for the efficacy of rivastigmine and donepezil in the treatment of cognitive symptoms in patients with DLB, but high-quality RCTs of galantamine are needed. Memantine could have some benefits, but further studies with larger numbers of patients are also needed to determine whether there is an improvement and, if so, which specific symptoms are improved. Whether memantine should be used as a monotherapy or whether it should be combined with cholinesterase inhibitors is also unclear.^{125,126} For a helpful guide on the management of specific symptoms in DLB see the management of DLB summary sheets.¹²⁷ The 2018 update of the NICE guidelines¹ recommends the use of AChE-Is and memantine (if AChE-Is are not tolerated) in DLB and Parkinson's disease dementia (see Box 6.2). Mild cognitive impairment (MCI) Mild cognitive impairment is hypothesised to represent a pre-clinical stage of dementia but forms a heterogeneous group with variable prognosis. A Cochrane review assessing the safety and efficacy of AChE-Is in MCI found there was very little evidence that they affect progression to dementia or cognitive test scores. This weak evidence was countered by the increased risk of adverse effects, particularly gastrointestinal effects, meaning that AChE-Is could not be recommended in MCI.¹²⁸ A systematic review¹²⁹ found that there was no replicated evidence that any intervention was effective for MCI including AChE-Is and the NSAID rofecoxib. A further systematic review and meta-analysis found that although AChE-Is have a slight efficacy in the treatment of MCI, there are many safety issues, therefore they are difficult to recommend for MCI.¹³⁰ Experts from several different countries have reviewed the available evidence for the pharmacological and non-pharmacological treatment for MCI.^{131,132} Other dementias A systemic review of RCTs for frontotemporal dementias showed that certain drugs may be effective in reducing behavioural symptoms (e.g. SSRIs, trazodone) but none of these had an effect on cognition.¹³³ Due to new techniques in neuroimaging,

