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Summary

Prescribing in older people CHAPTER 6 Pimavanserin (inverse agonist and antagonist at 5HT2A receptors) is approved by the FDA for the treatment of hallucinations and delusions associated with Parkinson’s disease psychosis. One RCT evaluated its use for the treatment of psychosis in AD and showed improved psychotic symptoms when compared with placebo and a lower risk of relapse with continuation. Headache, constipation, urinary tract infection and asymptomatic QT prolongation occurred with pimavanserin.99 It has also shown improvement of depressive symptoms in patients with Parkinson’s disease.100 A recent phase III, randomised double-blind placebo-controlled multicentre study investigating the efficacy of lumateperone (a potent antagonist at 5HT2A receptors, and a serotonin reuptake inhibitor) in reducing dementia-related agitation failed to show any benefit.101 Other agents being investigated for BPSD include dextromethorphan/quinidine (one RCT found it decreased agitation and was well tolerated),102 bupropion/dextromethorphan103 and methylphenidate (one RCT found it to be effective for apathy in AD in individuals who were not anxious or agitated).103,104 Prazosin (a centrally acting α1 adrenoceptor antagonist) appears to benefit individuals with dementia and agitation and aggression. When compared with other treatments for BPSD, the data for its use in BPSD are limited to just one good-quality RCT. Given these limitations, its routine use for the management of BPSD cannot be recommended at this time; however, it may be used when other medications (e.g. acetylcholinesterase inhibitors, memantine, antidepressants and/or atypical antipsychotics) have been ineffective or not tolerated.47,105 A Cochrane review (4 small studies, 110 participants) found low-certainty evidence suggesting there may be little or no clinically important effect of cannabinoids on overall BPSD assessed with the Neuropsychiatric Inventory.106 Electroconvulsive therapy (ECT) Electroconvulsive therapy may have a place in the treatment of severe and refractory BPSD. A review (20 published reports, 172 individuals with dementia; 40% AD) found that over 90% of the individuals responded to ECT treatment. Adverse effects were infrequent, mild and transient. The most common adverse event noted was postictal confusion/ memory impairment that was seen in approximately 15% of the individuals.47 However, ECT would not be recommended as a common intervention given limited evidence, and the considerable practical aspects of transporting patients to the ECT clinic and difficulty with obtaining consent. Summary The evidence base available to guide treatment in this area is insufficient to allow specific recommendations on appropriate management and drug choice. The basic approach is to exclude physical illness and try non-drug measures before resorting to the use of psychotropics. When using pharmacological treatments, there should be clearly documented treatment aims and prescribing should cease if these aims are not met within a specified timeframe. Recommendation: There is insufficient evidence to recommend ECT use in BPSD. Caution: It can cause significant cognitive adverse effects.

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