Behavioural symptoms of dementia

FMF 2019
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Models

- Unmet needs model
- Progressively lowered stress threshold model
- Learning model

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Unmet need?

Lowered threshold?

Learning?

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What to do: Assessment & Management

- What's happening?
- Is it a problem (and who's problem is it?)
- What's the risk?
- Get the details (and perspectives!)
- Generate hypotheses to explain the behaviour
- Collaboratively set a *realistic* treatment goal
- Non-pharmacologic interventions (unless serious imminent risk)
- Add pharmacologic therapy if non-pharm ineffective.

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Assessment

- Cornerstone of treatment
- Multiple sources of information
- Look for patterns, triggers
- Understand cognitive impairments

- Antecedent-Behaviour-Consequences (ABC)
- Dementia Observation Scale (DOS)*
- Cohen Mansfield Agitation Inventory (CMA-I)

*Behavioural Supports Ontario: brainxchange.ca/BSODOS.aspx#2

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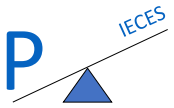
Use a structured approach to develop hypotheses: PIECES

Internal
- **P**hysical
- **I**ntellectual
- **E**motional

External
- **C**apabilities
- **E**nvironment
- **S**ocial

Each health discipline tends to be a bit "letter-centric"

e.g. Physicians tend to be "P"-centric



Engage carers to generate hypotheses

P.I.E.C.E.S.™ Learning & Development Model
Supporting Relationships for Changing Health and Health Care
http://pieceslearning.com/

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Non-pharmacologic interventions

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Importance of language and approach

- **Person centred language** – words matter!
- **Approach** – normalizing (stages of Alzheimer's disease, typical challenges, help that is available)
- **Hope!**
- Acknowledging transitions

EN: Alzheimer.ca/powerofwords; FR: Alzheimer.ca/pouvoirdesmots

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Common Issues

- Getting lost (wandering)
- Repetition, suspiciousness, accusations
- Sexual behaviour

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Common issues (con't)

- Apathy
- Physical and emotional outbursts

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PAIN

- Importance of full medical assessment
- Behaviours as a way to communicate pain and discomfort

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Treat pain

- Randomized parallel blinded in LTC (N= 352)
- Acetaminophen→morphine→fentanyl→pregabalin
- Included agitation, excluded physical aggression
- Significant reduction in behavioural symptoms

Husebo, Ballard et al., BMJ 2011; 343

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What about when families say: "No thanks".

- Referral to local community resources (e.g. local day program;
- Alzheimer Society services; in home supports, etc)

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Common non-pharmacologic intervention strategies

- Physical activity
- Sensory enhancement
- Social interaction
- Purposeful engagement
- Environmental design
- Differential reinforcement
- Staff/carer education

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Pharmacologic interventions

- Treat everything else! Pain, constipation, heart failure, etc.
- Are symptoms likely to respond?
- Are symptoms **disturbing, distressing or dangerous**?
- Have you weighed potential benefits and harms?
- Have you received and documented informed consent?

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Pharmacologic interventions: Alzheimer

- **Psychosis, physical aggression, severe agitation:** atypical antipsychotics (risperidone*, aripiprazole, quetiapine) NNT = 5-14, NNH = 100 (stroke, death)
- **Severe agitation:** SSRI (citalopram)
- **Anxiety:** SSRI, SNRI, buspirone
- **Depression:** RCTs question benefit of pharmacotherapy ? Trial of SSRI, SNRI
- **Apathy:** cholinesterase inhibitor, methylphenidate (limited role and careful trial)

https://cep.health/media/uploaded/UseofAntipsychotics_PrimaryCare2016-2.pdf

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Tools:

- Alzheimer Society of Canada – Information resources for family doctors and family caregivers:
  - www.alzheimer.ca/medications
  - www.alzheimer.ca/brainhealth
  - www.alzheimer.ca/intimacyandsexuality
  - www.alzheimer.ca/brochures (Search "Treatment Options", "Drug approval process", "For Family Doctors")
- Centre for Effective Practice (CEP) tool/App: https://cep.health/clinical-products/antipsychotics-and-dementia-primary-care-edition/
- PIECES Canada: https://cep.health/clinical-products/antipsychotics-and-dementia-primary-care-edition/
- Behavioural Supports Ontario: brainxchange.ca/BSODOS.aspx#2
- Dementia Advisor App (Reitman Centre, Sinai Health System): http://www.dementiaadvisor.com/

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Ms. Blake

Ms. Blake has moderately advanced Alzheimer type dementia. She requires assistance with dressing and toileting.

- **Each time she is taken to the bathroom, Ms. Blake helps lower her pants but refuses to sit on the toilet. She resists and grabs her personal carer with such force that they are getting injured.**

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References

- Wolf MU, Goldberg Y, Freedman M. *Aggression and agitation in dementia.* Continuum (Minneap Minn) 2018;24(3-Behavioural Neurology and Psychiatry):783-803
- Husebo BS, Ballard et al. *Efficacy of treating pain to reduce behavioural disturbances in residents of nursing homes with dementia: cluster randomised clinical trial* BMJ 2011;343:d4065
- Abraha I, et al. *Systematic review of systematic reviews of non-pharmacological interventions to treat behavioural disturbances in older patients with dementia. The SENATOR-OnTop series.* BMJ Open 2017;7:e012759. doi:10.1136/bmjopen-2016- 012759

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Objectives

By the end of this session, participants will be better able to:

1. Recognize key transition points in the dementia journey of patients and families from initial diagnosis to end of life care;
2. Produce practical, evidence-based advice to support patients and family members at these key transitions;
3. Integrate available tools and resources into family practice settings to optimally care for patients and families living with dementia.

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SECTION DES GROUPES D'INTÉRÊT DES MEMBRES (SGIM)

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Questions? Contact us at migs@cfpc.ca

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What is **one thing** you will consider doing differently to support your patients with dementia and their families?

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