**Title:** Prescribing and monitoring of antipsychotics for behavioural and psychological symptoms of dementia (BPSD)

**Scope:**
Pennine Care NHS Foundation Trust Commissioning CCG

**Version:**
Version 1

**Issue date:**
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**Replaces:**
Not applicable

**Author(s)/Originator(s):**
Pennine Care NHS Foundation Trust

**To be read in conjunction with the following documents:**
2. Summary of Product Characteristics (SPC) for individual antipsychotics [http://www.medicines.org.uk/emc](http://www.medicines.org.uk/emc)

**Authorised by:**
Drugs and Therapeutics Committee, Pennine Care NHS Foundation Trust

**Date authorised:**
24 January 2014

**Review Date**
24 January 2017
1. **Introduction**

‘Behavioural and psychological symptoms of dementia’ (BPSD) is the collective term used to describe a group of non-cognitive symptoms experienced in dementia. These can include psychosis, agitation and mood disorder, as well as challenging behaviour such as aggression and sexual disinhibition. BPSD can affect 50-80% of patients to varying degrees, [1]

NICE Clinical Guideline 42 (Dementia) [2] recommends that non-pharmacological interventions are used in the first instance for BPSD unless there is severe distress or an immediate risk of harm to the patient or to others. Medicines that may be used in BPSD include cholinesterase inhibitors, antidepressants and mood stabilisers as well as antipsychotics.

Antipsychotics should only be prescribed in BPSD in primary care under a shared care protocol with a relevant secondary or tertiary care service [2]. Their use in the elderly poses certain risks; in patients with dementia these include an additional increased risk of stroke, increased mortality, sedation, and postural hypotension [3]. Their use in this patient group therefore requires careful monitoring.

2. **Scope**

Pennine Care NHS Foundation Trust
Commissioning CCG

3. **Clinical condition to be treated**

- Severe behavioural and psychological symptoms associated with dementia.

- These may include hallucinations, delusions, anxiety, marked agitation and associated aggressive behaviour, wandering, hoarding, sexual disinhibition, apathy and disruptive vocal activity, repetitive questioning.

4. **Product information and treatment regimen to be used.**

4.1 **General Principles**

- Where all other specific interventions for severe BPSD have been unsuccessful, a trial of antipsychotic medication may be initiated.

- Treatment should be commenced at a minimum dose and titrated up to the lowest effective dose.

- Treatment should be time-limited, reviewed regularly and discontinued if ineffective or not tolerated.

- NICE guidelines recommend that reviews should take place no less frequently than every 12
weeks.

- Risperidone is the only antipsychotic licensed for use in (Alzheimer’s) dementia [3]
- First generation antipsychotics are not classified by GMMMG as amber. They are included in this Shared Care Guideline for the sake of completeness, and to promote uniform practice.

### 4.2 Prescribing information

#### 4.2.1 Licensed treatment - Risperidone

Risperidone is **licensed** for the short-term treatment (up to 6 weeks) of persistent aggression in Alzheimer’s dementia. [4]

<table>
<thead>
<tr>
<th>Drug</th>
<th>Dosage forms</th>
<th>Suggested dose range</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Starting</td>
</tr>
<tr>
<td>Risperidone</td>
<td>Tablets, Oro-dispersible tablets, Liquid</td>
<td>0.25mg twice daily</td>
</tr>
</tbody>
</table>

#### 4.2.2 Other second generation antipsychotics

All other second generation antipsychotics are unlicensed in this indication

<table>
<thead>
<tr>
<th>Drug</th>
<th>Dosage forms</th>
<th>Suggested dose range (see BNF and SPC)</th>
<th>Starting</th>
<th>Usual maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amisulpride</td>
<td>Tablets, Liquid</td>
<td>50mg daily [5]</td>
<td></td>
<td>400mg twice daily</td>
</tr>
<tr>
<td>Aripiprazole</td>
<td>Tablets, Oro-dispersible tablets, Liquid</td>
<td>5mg daily</td>
<td></td>
<td>30mg daily</td>
</tr>
<tr>
<td>Olanzapine</td>
<td>Tablets, Oro-dispersible tablets</td>
<td>2.5mg daily</td>
<td></td>
<td>20mg daily</td>
</tr>
<tr>
<td>Quetiapine</td>
<td>Tablets</td>
<td>12.5 mg daily</td>
<td></td>
<td>750mg daily in two divided doses</td>
</tr>
</tbody>
</table>
4.2.3 First generation antipsychotics

Some first generation antipsychotics are licensed for agitation, though not specifically in BPSD.

<table>
<thead>
<tr>
<th>Drug</th>
<th>Dosage forms</th>
<th>Suggested dose range (see BNF and SPC)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Starting</td>
</tr>
<tr>
<td>Chlorpromazine</td>
<td>Tablets Liquid</td>
<td>25mg daily</td>
</tr>
<tr>
<td>Haloperidol</td>
<td>Tablets Capsules Liquid</td>
<td>0.5mg daily</td>
</tr>
<tr>
<td>Promazine</td>
<td>Tablets Liquid</td>
<td>12.5mg twice daily</td>
</tr>
<tr>
<td>Trifluoperazine</td>
<td>Tablets Syrup</td>
<td>1mg twice daily</td>
</tr>
</tbody>
</table>

4.3 Cautions

(NB This list is not exhaustive. Please consult current BNF or SPC for full details)

- Patients with liver or kidney impairment – doses should be reduced by half.
- Patients with cardiovascular disease, cerebrovascular disease, history of epilepsy, diabetes, QT prolongation.
- Patients with Lewy Body dementia or Parkinson’s disease

4.4 Side effects

This list is not exhaustive. Please consult current BNF or SPC for full details

- Extrapyramidal side effects (tremor, dystonia, akathisia, tardive dyskinesia)
- Raised prolactin, sexual dysfunction
- Tachycardia, QT prolongation, hypotension
- Weight gain, hyperglycaemia, diabetes mellitus
- Sedation

4.5 Adverse drug reactions (ADRs)
Serious ADRs may be seen with long-term use, and may therefore present first to GPs. If they occur the patient should be referred back to the specialised team.

This list is not exhaustive. Please consult current BNF or SPC for full details

- Stroke or transient ischaemic attack
- Severe extrapyramidal side effects
- Symptoms of hyperprolactinaemia eg galactorrhoea, gynaecomastia
- Tardive dyskinesia
- Priapism (rare)

4.6 Drug interactions

This list is not exhaustive. Please consult current BNF or SPC for full details

- Antifungal drugs: dose reduction may be necessary
- Sedative drugs: may increase sedative effects of antipsychotics
- Hypotensive drugs: may be potentiated by antipsychotics

5. Regimen Management

5.1 Aspects of care for which the consultant psychiatrist/specialist team is responsible

Assessment and patient liaison

- To make a diagnosis, and assess the suitability of the patient for antipsychotic treatment.
- To choose the appropriate antipsychotic for the patient’s needs.
- To discuss with the patient and/or carers full details of the target symptoms, proposed treatment, benefits and risks of treatment, including possible side effects, review arrangements and obtain their agreement to proceed
- To arrange for the following baseline tests to be carried out: LFT, FBC, U&E, ECG, weight, waist circumference BMI, blood pressure, blood lipids, plasma glucose and prolactin

Treatment initiation

- To establish the appropriate dose for the patient by up-titration
- To continue the care of the patient to ascertain that their initial response and progress has been satisfactory

GP liaison

- To ask the GP whether they are willing to participate in shared care
• To ensure that clear arrangements are in place for back-up advice and support from secondary care

• To provide the GP with advice on when and how to stop the antipsychotic treatment (See flowchart Appendix 1)

• To review the patient promptly if requested to do so by the GP

**Adverse reaction reporting**

• To report any adverse reactions to the medicines and Healthcare Regulatory Agency (MHRA) via the Yellow Card scheme [https://yellowcard.mhra.gov.uk](https://yellowcard.mhra.gov.uk)

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### 5.2 Aspects of care for which the GP is responsible

#### Secondary care liaison

• To reply to the request for shared care as soon as practicable

• To refer to the consultant psychiatrist/ specialist team in the event of
  - A severe deterioration in the patient’s mental state
  - A severe adverse reaction to the antipsychotic
  - A problem with the patient’s medication concordance

#### Patient care

• To prescribe the antipsychotic at appropriate intervals

• To review the patient no less frequently than every 12 weeks, to monitor the effectiveness and tolerability of the treatment

• To ensure there are no interacting medicines co-prescribed with the antipsychotic

• To continue monitoring, as agreed with specialist service: LFT, FBC, U&E, ECG, weight, waist circumference BMI, blood pressure, blood lipids, plasma glucose and prolactin, at a frequency determined by the patient’s clinical condition and/or by the guidelines in the BNF section 4.2.1.

• To stop the treatment, if and when considered necessary in collaboration with the consultant/specialist team (see section 5.1 above ‘GP liaison’ and flow chart Appendix 1)

#### Adverse reaction reporting

• To report any adverse reactions to the medicines and Healthcare Regulatory Agency (MHRA) via the Yellow Card scheme [https://yellowcard.mhra.gov.uk](https://yellowcard.mhra.gov.uk)

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### 6. Back-up care available to GP from Hospital, including emergency contact procedures and help line numbers.

Where the concern relates to a specific known patient, and arises within office hours (9am - 5pm),
then the sector consultant psychiatrist and GP should normally liaise with each other directly.

Out-of-hours, the on-call psychiatric service covering the local hospital can be contacted via the switchboard.

Bury: Fairfield General Hospital 0161 764 6081
Rochdale: Birch Hill Hospital 01706 377777
Oldham: Royal Oldham Hospital 0161 624 0420
Stockport: Stepping Hill Hospital 0161 483 1010
Tameside & Glossop: Tameside General Hospital 0161 331 5151

7. **Statement of Agreement between GP and Consultant.**

This document is a request by the Consultant to share the suggested care pathway of the patient.

If the GP is unable to agree to the sharing of care and prescribing the suggested medication and on-going monitoring of the patient, he/she is requested to please make this known to the Consultant within as soon as possible, ideally stating nature of his/her concern.

8. **Written information provided to patient**

Patient information leaflet [www.choiceandmedication.org/penninecare](http://www.choiceandmedication.org/penninecare)

9. **References**


   4. SPC Risperidone
[http://www.medicines.org.uk/emc/medicine/12818/SPC/Risperdal+Tablets%2c+Liquid+%26+Quicklet](http://www.medicines.org.uk/emc/medicine/12818/SPC/Risperdal+Tablets%2c+Liquid+%26+Quicklet)

Review clinical records

Review patient

Have the symptoms improved and the patient stable for 6-12 weeks?

Yes

Trial dose reduction. If on small dose*, discontinue over two weeks and review.

No

Refer to specialist services

Have the symptoms returned?

Yes

Use the smallest beneficial dose

Review the patient after 6-12 weeks

Attempt further reduction if appropriate

No

If on small dose stop the antipsychotic over 2 weeks

If on larger dose* reduce medication (up to 50% if appropriate)

(See dosage chart in text)

*FOR RANGE OF DOSES SEE SECTIONS 4.2.1, 4.2.2 AND 4.2.3