



Telephone: 866-970-7500 ext. 82203

Website: www.seniorscript.com

Fax: 800-887-4113

Telephone: 614-763-0036

Website: www.midwestcarealliance.org

Email: info@midwestcarealliance.org

“Lunch & Learn” Seminar — Independent-Study Program

Provided by SeniorScript and the

Midwest Center for Home, Hospice & Palliative Care Education

Managing Agitation in Patients with Dementia (March/2011) • 03/31/13

SeniorScript and the Midwest Center for Home, Hospice & Palliative Care Education are pleased to announce that our very popular “Lunch & Learn” seminars are now available online as self study programs offering continuing educational (CE) credit. These learning modules are accessible to SeniorScript clients via www.seniorscript.com and to Midwest Care Alliance members via www.midwestcarealliance.org.

This recorded series has been available for quite some time, but did not offer the option of receiving continuing educational credit. We are delighted that in addition to offering excellent education in a format to be accessed at your convenience, we are now offering you and your staff members another source to assist you in meeting your CE requirements.

Each seminar (*beginning with 2009*) is available as an independent-study program and includes the documents needed to apply for CE credit within this handout. After listening to the seminar online, simply complete the CE Request Form which includes both an evaluation and post test. Once completed, submit it along with the processing fee of \$10 to request credit. In order to qualify for credit, a minimum score of 70% must be achieved on the post test.

Please be advised that credit for CE purposes may only be awarded to each person once per seminar. It is the responsibility of the student to keep his or her personal records to avoid repeating a module. Periodical audit reviews will also be conducted to determine any violations.

We hope you will find this convenient new format helpful and effective!

Disclosure Information:

John Shuster, MD Nothing to Disclose Disclosure

Discussion of off-label use of drugs. Research grant support from Eli Lilly and Co.

No commercial support was received for this educational activity.

**Online Independent-Study Program • CE Request Form
 Managing Agitation in Patients with Dementia (March 2011)**

Requesting CE Credit For: Nursing CE

**Upon submittal of the proper forms, this program offers 1 CE credit for nursing valid nationally (not valid for Iowa licenses).*

Criteria for Successful Completion: Listening to the audio seminar, submitting completed CE Request Form with processing fee, and achieving a minimum score of 70% on the post test.

Expiration: This program expires on March 31, 2013.

Part I - Participant Information (please print legibly)

Date Completed:	
Name:	
Employer:	
Occupation/Credentials: (RN, LPN, SW/C)	
Complete Mailing Address: (Street, City, State, Zip)	
Phone:	
Email Certificate To:	

Part II - Evaluation

Were the following objectives met?

- Identify the causes and precipitants of dementia-related agitation. YES NO
- Describe a systematic treatment approach to dementia-related agitation. YES NO
- Outline a range of pharmacologic approaches for the management of dementia-related agitation. YES NO

This speaker demonstrated effective teaching on a scale of 5 (excellent) to 1 (poor):

John Shuster, MD: 5 4 3 2 1

Comments:	
Questions for Speaker:	

Part III - Post Test

- Which of the following drug classes has the the strongest published evidence base supporting its effectiveness in the treatment of dementia-related agitiaton?
 - Serotonin Reuptake-Inhibitor Antidepressants
 - Beta Blockers
 - Atypical Antipsychotics
 - Benzodiazepines
- The first treatment step in the management of dementia-related agitiaton is initiation of appropriate pharmacologic therapy. TRUE FALSE
- When pharmacologic treatment for dementia-related agitiaton is initiated, it is important to start with high medication doses in order to get behaviors under control rapidly. TRUE FALSE
- Patients with dementia may demonstrate agitation or restlessness as a consequence of :
 - Pain
 - Urinary retention
 - Depression
 - All of the above
- The FDA has issued a series of warnings that antipsychotics (both conventional and atypical types) are associated with an increased risk of mortality in elderly patients treated for dementia-related psychosis. TRUE FALSE
- Length of time (IN MINUTES) to complete this self study: _____

Send this original completed form and \$10 processing fee to:
 SeniorScript, Attn: Mary Anne McDowell, 1460 Ann St., Montgomery, AL 36107

Managing Agitation in Patients with Dementia

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Overview

- Background
- Approach to Assessment and Diagnosis
 - Differential diagnosis
- Systematic Treatment Approach
 - Serial trials
- Pharmacologic Approaches to Agitation in Dementia

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Terminology

- Agitation
- Delirium
- Psychosis

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Agitation

- A state of restlessness and increased psychomotor activity generally observed as an expression of emotional tension and characterized by purposeless, restless activity.

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- A cognitive disorder, characterized by:
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- Surveys of nursing home residents have found that moderate to severe behavior problems are present in up to 64% of the nursing home population.

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- Urinary retention
- Constipation
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- Intoxications
- Withdrawal states
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- Novel environment
- Over- or under-stimulation
- Sensory deprivation
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14

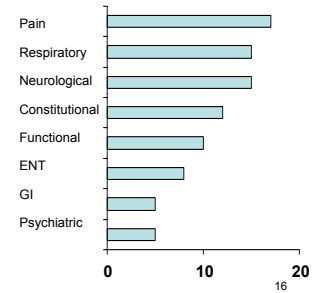
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- Common things are common.
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- Non-pharmacological comfort measures.
- Analgesic trial.
- (Consultation) and psychopharmacologic trials.

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First Steps

- Physical and psychological needs assessment - see Differential diagnosis

31

Non-pharmacologic Interventions

- Music/"white noise"
- Moderate exercise, physical activity
- Support and education for caregivers
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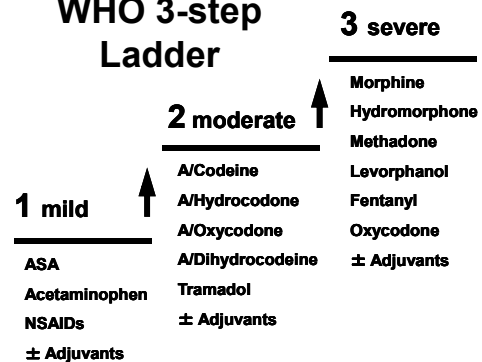
32

Analgesic Trials

- Acetaminophen alone may have limited effectiveness (Buffum, et al, 2004)
- NSAIDs poorly tolerated (GI bleeding, renal impairment)
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WHO 3-step Ladder



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- American Geriatrics Society Guideline (2002):
 - WHO Ladder may be only generally applicable
 - Daily opiate use for chronic pain may be preferable (safer) than daily NSAID use
 - Caution with specific opiates (e.g., meperidine, propoxyphene, pentazocine, methadone)

35

Analgesic Trials

- Adjuvants:
 - Older agents (e.g., TCAs) carry more risk in older patients
 - Newer agents not always well studied in older patients
- Effective analgesia improves secondary outcomes (e.g., depression, cognition, mobility, anxiety, sleep, appetite, agitation, participation in activities)

36

Psychotropics for Agitation

- Antipsychotics (Atypicals)
- Alternatives:
 - Antidepressants
 - Anticonvulsants
 - Anticholinergics and Memantine?
 - Benzodiazepines?

37

Antidepressants

- Best evidence for SSRIs (e.g., citalopram, sertraline) and trazodone (Seitz, et al, 2011)
- Especially if depression is present or suspected
- Lag time to effect
- Typical antidepressant doses

38

Anticonvulsants

- Best evidence for:
 - Carbamazepine
 - Valproate
- Cautious dosing, monitor for side effects, lab studies (liver function, blood counts)

39

Anticholinergics and Memantine

- Evidence is unclear for anticholinergics
- Some risk of exacerbating behavioral problems with Rx withdrawal
- Data are slightly more favorable for memantine, at least when added to an anticholinergic medication.

40

Benzodiazepines

- Some evidence for benefit
- But also potential for risk:
 - Falls
 - Sedation
 - Worsening cognition
 - Tolerance/withdrawal
 - Paradoxical agitation

41

The Antipsychotic Bind

- Best evidence of efficacy...
- ...but risk of death associated with treatment
 - Controversial
- Best evidence for atypical antipsychotics:
 - Risperidone about 1mg/day
 - Olanzapine 5-10mg/day
- Short-term use
 - Periodic trial tapers

42

Terminal Agitation

- Analysis of prospective data on 32 NH residents with dementia who died matched with 32 who did not die during a six-month period of observation.
- No differences in severity of comorbid illnesses, functional status, observed pain, number of painful diagnoses, or analgesic use.
- Residents who died displayed:
 - More verbal agitation
 - Less verbal interaction with staff
 - More time spent restrained
- Surviving residents were *more* likely to receive antipsychotic medications

– Allen, et al, *Gerontologist*, 2005 43

Antipsychotics for Agitation

- Consensus recommendations:
 - Assess risks/benefits
 - Severe agitation, aggression, delirium, psychosis - if untreated, places patient and those in environment at risk
 - Informed consent (caregiver)
 - Use for shortest time needed - test need with serial trail tapers
 - Use non-Rx interventions and other Rx concurrently

44

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46

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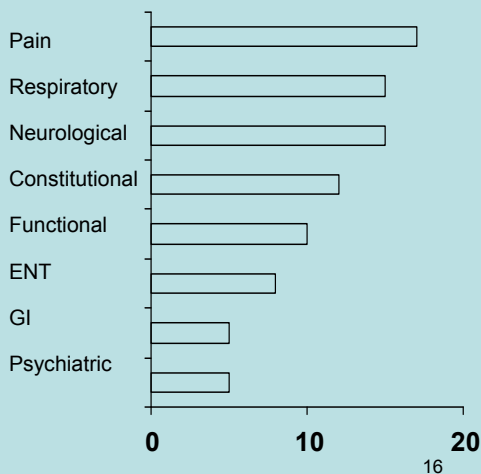
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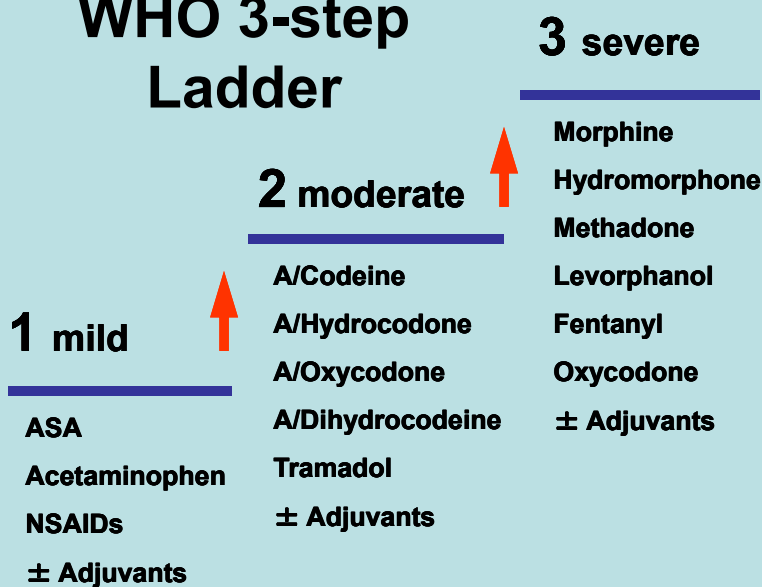
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 - Caution with specific opiates (e.g., meperidine, propoxyphene, pentazocine, methadone)

35

Analgesic Trials

- Adjuvants:
 - Older agents (e.g., TCAs) carry more risk in older patients
 - Newer agents not always well studied in older patients
- Effective analgesia improves secondary outcomes (e.g., depression, cognition, mobility, anxiety, sleep, appetite, agitation, participation in activities)

36

Psychotropics for Agitation

- Antipsychotics (Atypicals)
- Alternatives:
 - Antidepressants
 - Anticonvulsants
 - Anticholinergics and Memantine?
 - Benzodiazepines?

37

Antidepressants

- Best evidence for SSRIs (e.g., citalopram, sertraline) and trazodone (Seitz, et al, 2011)
- Especially if depression is present or suspected
- Lag time to effect
- Typical antidepressant doses

38

Anticonvulsants

- Best evidence for:
 - Carbamazepine
 - Valproate
- Cautious dosing, monitor for side effects, lab studies (liver function, blood counts)

39

Anticholinergics and Memantine

- Evidence is unclear for anticholinergics
- Some risk of exacerbating behavioral problems with Rx withdrawal
- Data are slightly more favorable for memantine, at least when added to an anticholinergic medication.

40

Benzodiazepines

- Some evidence for benefit
- But also potential for risk:
 - Falls
 - Sedation
 - Worsening cognition
 - Tolerance/withdrawal
 - Paradoxical agitation

41

The Antipsychotic Bind

- Best evidence of efficacy...
- ...but risk of death associated with treatment
 - Controversial
- Best evidence for atypical antipsychotics:
 - Risperidone about 1mg/day
 - Olanzapine 5-10mg/day
- Short-term use
 - Periodic trial tapers

42

Terminal Agitation

- Analysis of prospective data on 32 NH residents with dementia who died matched with 32 who did not die during a six-month period of observation.
- No differences in severity of comorbid illnesses, functional status, observed pain, number of painful diagnoses, or analgesic use.
- Residents who died displayed:
 - More verbal agitation
 - Less verbal interaction with staff
 - More time spent restrained
- Surviving residents were *more* likely to receive antipsychotic medications

- Allen, et al, *Gerontologist*, 2005 43

Antipsychotics for Agitation

- Consensus recommendations:
 - Assess risks/benefits
 - Severe agitation, aggression, delirium, psychosis - if untreated, places patient and those in environment at risk
 - Informed consent (caregiver)
 - Use for shortest time needed - test need with serial trail tapers
 - Use non-Rx interventions and other Rx concurrently

44

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45

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46