MEDICAL PHARMACIES TABLET

Drug information and news for health care providers

May 2014

ANTIPSYCHOTIC USE IN LONG-TERM CARE

Antipsychotic use in elderly long-term care residents is once again in the media. An article in the April 21, 2014 issue of the *Toronto Star* entitled "Antipsychotic Drugs Prescribed to Seniors at Alarming Rates, Province Finds," references a new provincial Health Ministry report that claims thousands of seniors in Ontario nursing homes are taking combinations of antipsychotics and sedatives. The May 2, 2014 issue of the *Toronto Star* reveals a database that details the antipsychotic use in more than 600 long-term care homes across the province (available online at http://www.thestar.com/news/gta/nursing_homes.html).

In this issue of the *Tablet*, we will review indications for antipsychotic use and strategies for differentiating between dementia, depression, and delirium.

BACKGROUND AND ANTIPSYCHOTIC INDICATIONS

Second-generation (or atypical) antipsychotics that are most often used in Canada include risperidone, olanzapine, quetiapine, and more recently, aripiprazole, and clozapine. Risperidone, olanzapine, quetiapine, and aripiprazole are indicated for treatment of schizophrenia and bipolar disorder, while clozapine is indicated for the management of symptoms of treatment-resistant schizophrenia. Only aripiprazole tablets (not prolonged release injectable suspension) are indicated for adjunctive treatment for major depressive disorder. None is officially indicated for delirium. (Please refer to individual product monographs.)

Although antipsychotic drugs are often used off-label for the treatment of dementia, risperidone is the only antipsychotic of those mentioned that carries an official indication for treatment of the condition. The product monograph states the following:

"Risperidone may be useful in severe dementia for the short-term symptomatic management of inappropriate behaviour due to aggression and/or psychosis. Other behavioural disturbances seen in this patient population as well as disease stage remained unaffected by risperidone treatment."[1]

It is important to be aware that there is a black box warning (see below) on all of these medications. Residents and/or family members need to be made aware of the potential risks and expected benefits of these medications. Consent should always be obtained before any of these medications are started as part of a resident's therapy.

Increased Mortality in Elderly Patients with Dementia: Elderly patients with dementia treated with atypical antipsychotic drugs are at an increased risk of death compared to placebo. Analyses of thirteen placebo-controlled trials with various atypical antipsychotics (modal duration of 10 weeks) in these patients showed a mean 1.6-fold increase in the death rate in the drug-treated patients. Although the causes of death were varied, most of the deaths appeared to be either cardiovascular (e.g., heart failure, sudden death) or infectious (e.g., pneumonia) in nature.

DIFFERENTIATING BETWEEN DEMENTIA, DELIRIUM AND DEPRESSION

Differentiating between dementia, delirium, and depression can be quite difficult, because the elderly may have additional comorbidities that can contribute to cognitive and affective changes, and all involve memory impairment.[2,3]

It is important to distinguish between the three diagnoses, because treatments differ (see table on next page). A thorough patient history and physical assessment are necessary.[3] **MPT**

1. Risperdal Product Monograph. e-CPS 2014.
2. Gagliardi JP. Differentiating among Depression, Delirium, and Dementia in Elderly Persons. J Ethics 2008;10:383-388.
3. Inott T. Is it delirium, dementia, or depression? Nursing 2007, Nov. 2007, Vol. 37, Issue 11, p. 65. http://journals.lww.com/nursing/Fulltext/2007/11000/Is_it_delirium,_dementia,_or_depression_.49.aspx.
4. Abilify Maintena product monograph. 2014.

	Dementia	Delirium	Depression
Onset	Usually progressive and irreversible.	Reversible state of acute confusion, abrupt in onset.	Variable rate of onset.
Presentation	Memory loss that interferes with patient's ability to function independently. When asked a question, patient may try hard to find the best response but misses the correct answer. In early dementia, an individual may be quite distressed by the inability to answer correctly.	Patient's thinking is disorganized, and the patient can't answer specific mental status questions in a logical manner.	Often confused with dementia, as patient often answers questions with "I don't know" or "I can't remember." Thought process is slow but intact; when gently encouraged, patient may provide detailed and coherent information. Signs and symptoms are the same in any age group: sad mood; lack of pleasure in things that once were pleasurable; difficulty concentrating; changes in eating, sleeping, and elimination patterns. Use validated depression screening test.
Outcome	Further progression brings on loss of other cognitive abilities, which results in aphasia (inability to comprehend language), apraxia (inability to execute learned movements), and agnosia (inability to recognize familiar persons or objects).	Usually an underlying, treatable cause such as infection, adverse drug reaction, dehydration, hypoxia, metabolic disturbance or nutritional deficiency.	Treatable through counselling, therapy and antidepressant medication where appropriate.

Abilify Maintena® (aripiprazole for prolonged release injectable suspension)

A new dosage form of the atypical antipsychotic aripiprazole has been recently approved by Health Canada. Abilify Maintena® is indicated for the maintenance treatment of schizophrenia in stabilized adult patients.[4] Unlike the short-acting tablet form of aripiprazole, it is NOT indicated for treatment of any other psychiatric conditions.

Dose & Administration

Abilify Maintena® is available in 300 mg and 400 mg vials. The recommended starting and maintenance dose is 400 mg, administered by a healthcare professional once monthly by a single intramuscular injection. The safety and efficacy of Abilify Maintena® in patients 65 years of age or older has not been established. No dosage adjustment is recommended for elderly patients; however, owing to the greater sensitivity of this population, a lower starting dose should be considered when clinical factors warrant. Abilify Maintena® is not indicated in elderly patients with dementia.

Adverse Effects

Adverse events associated with discontinuation of treatment in clinical trials were experienced by 7.5% of patients. The most frequently observed adverse drug reactions in clinical trials included insomnia, weight gain, akathisia, headache, anxiety, loss of weight, nasopharyngitis, and injection site pain. Overall, the adverse events were mild to moderate in severity and similar to those in the placebo-treated patients. **DN**

Please refer to Abilify Maintena® product monograph for more comprehensive information.