

PSYCHIATRY UPDATE FOR GENERAL PRACTITIONERS:

PRESCRIBING IN OLDER ADULTS

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OVERVIEW

- INTRODUCTION
- PRINCIPLES OF PRESCRIBING
- MCI AND DEMENTIA
- ANTIDEPRESSANTS
- ANTIPSYCHOTICS
- HYPNOTICS
- MISCELLANEOUS
- SUMMARY



INTRODUCTION: SA DEMOGRAPHICS

- **JULY 2012:**
 - Population est. 48 810 427
 - >65 years: 5.7% (Males 1,125,709 & females 1, 660, 694)
 - Males < females (0.67)
 - Life expectancy: 49.41 years
 - HIV/AIDS 5.6 million
 - 2025: 10% > 65years
- **Dementia: 35 million worldwide, 2050 → 100 million**

INTRODUCTION

The years teach much which the days
never knew.

~Ralph Waldo Emerson

PRINCIPLES OF PRESCRIBING IN OLDER ADULTS (1)

- Elderly population:
 - Multiple co-morbid illnesses
 - Polypharmacy +/-25% (≥ 4 drugs)^{1,2}
 - More sensitive to side effects (Altered pharmacodynamics and kinetics)
 - Increased body fat, decreased water and albumin
 - Impaired renal function

“problem with polypharmacy...correlated with age, co-morbidity, disability... nursing home placement, impaired mobility, morbidity, hospitalization and death.”³

1. PAYNE RA ET AL. BR J GEN PRACT 2011; 61: 83–84.

2. JUNIUS-WALKER ET AL. FAM PRACT 2007; 24: 14–19.

3. GADSBY ET AL. DIABET. MED. 29, 136–139 (2012)

PRINCIPLES OF PRESCRIBING (2)

- Always exclude a GMC
- Examine your patient
- Good OTC/substance history
- Start low, go slow
- Anticipate adverse drug reactions
- Simplify regimens
- Longer anticipated response
- Get to know your drugs

MCI

- Normal aging ----- dementia
- Measured: neuropsychological testing
- Prevalence increases with age
- “Forgetfulness”
- Absence of sensory or motor deficits
- Broad differential diagnosis
- No established treatment
- Monitor
- Vascular risk factors, physical activity, mental activity

DEMENTIA

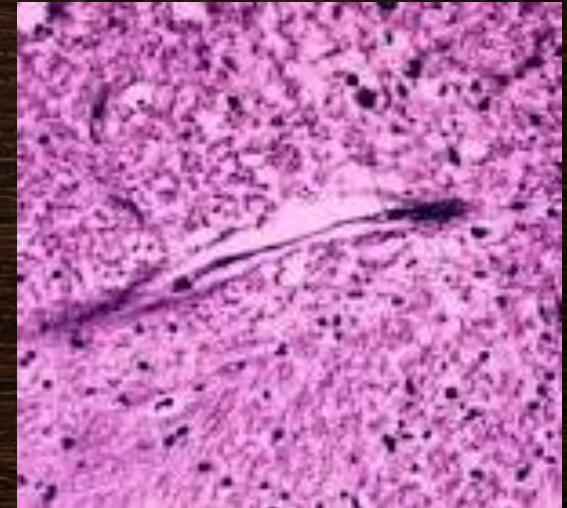
“ progressive, degenerative, neurological syndrome characterized by:

- Cognitive decline
 - Impaired memory and thinking
 - Gradual loss of skills required for ADLs
 - Other mental functions: mood, personality and social behaviour
- UK: AD > Vascular > DLB
 - SA: Kalula et al: 74% new referrals had dementia
 - 44% AD > 28% vascular > 15 % mixed > 13% other dementia
 - HAND in SA: 42.4% MND



ALZHEIMER'S DEMENTIA: COGNITIVE ENHANCERS

- Cholinergic hypothesis
- Acetyl cholinesterase inhibitors:
 - Donepezil (AChE)
 - Rivastigmine (AChE and BuChE)
 - Galantamine (AChE and nicotinic)
- Licensed: mild (19-25) – moderate AD (14-18)
- Cognition and BPSD
- Adverse effects: due to \uparrow cholinergic activity
- Efficacy similar



MONITORING AND RESPONSE

- Predicting response = difficult
 - Higher MMSE
 - Good initial response
 - Short duration between diagnosis and treatment
 - Higher mean doses
- Review tolerability within a month
- Efficacy 3-6 months: "rule of thirds"
- Cost
- 50% discontinue within 1 year

MEMANTINE

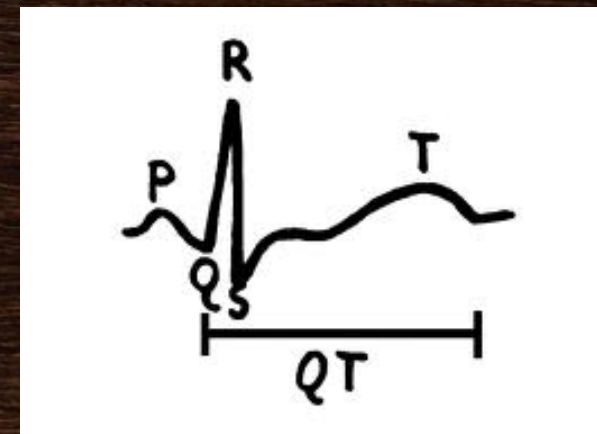
- **NMDA receptor antagonist**
 - Moderate to severe AD (MMSE<14)
 - Off-label in mild AD
 - Improves BPSD
- **US:** add memantine to donepezil often in mild stages (✓ FDA)
- **DOMINO TRIAL: @ 1 year**
 - Donepezil alone: better cognitive scores and ADLs
 - Adding memantine at time of discontinuation: better than not
 - Memantine + donepezil, not superior to donepezil alone

ANTIDEPRESSANTS: INTRO

- Depression is common: 10-15% (community), \approx 40%(OAH)
- Older people: excluded from trials, \uparrow co-morbidity
- Differential risk of antidepressants unclear in older populations
- State sector: SSRIs as first line > Mianserin > Venlafaxine
- Private sector: Mirtazapine, SSRIs
- Recommendation: at least 2 years of maintenance therapy to prevent relapse
- Cost vs risk vs benefit

ANTIDEPRESSANTS: SAFETY CONCERNS

- Citalopram: QT prolongation >40mg/day
- ↑ risk of ventricular arrhythmias
- Risk factors:
 - Cardiac: IHD, MI, brady.
 - Metabolic: K^+ , Mg^{2+} , Ca^{2+}
 - Drugs: erythromycin, clarithromycin, ampicillin, tamoxifen, methadone, cyclosporin
 - Extremes of age, females, anorexia
- Sertraline as alternative
- All classes associated with some risk



TAKE HOME: ANTIDEPRESSANTS

INDIVIDUAL RISK VS BENEFIT ANALYSIS

ANTIPSYCHOTICS: INTRODUCTION

- 1/3 nursing home residents
- Multiple indications, often inappropriate
- ?Underlying cause of behavioural disturbance
- US: OBRA Act 1990
 - Excessive in dose
 - Excessive duration
 - Inadequate monitoring or indication
 - Adverse effects
 - Duplicative
- Recently, safety issues

ANTIPSYCHOTIC SAFETY (1)

- FDA 2005: Atypicals ↑CVA 60-70% in dementia
- FDA 2008: extended to conventional antipsychotics
- Ongoing use and on the rise

“How does one choose the safest drug?”

ANTIPSYCHOTIC SAFETY (2)

- Cohort study: US 2001-2005, N=75 445
- Excluded: Schizophrenia; BPMD; Cancer
- Risperidone most frequently prescribed (reference drug)
- Haloperidol: ↑CVS disease & medical illness
- Reflect our prescribing habits
- Confounders and statistical considerations

ANTIPSYCHOTIC SAFETY (3): RESULTS

- 6598 deaths:
 - Circulatory 49%
 - CVA 10%
 - Respiratory 15%
- Haloperidol: double the risk of all cause mortality
- < 40days highest risk
- Quetiapine: safer than risperidone
- Not affected by presence of dementia

ANTIPSYCHOTICS: TAKE HOME

- DON'T PANIC!
- Thoughtful prescribing
- Alternative treatment strategies e.g. cognitive enhancers, antidepressants
- Risk vs. benefit analysis
- Inform patient and family of associated risk
- ECG at baseline, 3/12 and annually
- Monotherapy and review regularly
- Manage vascular risk

HYPNOTICS

- Never a good idea
- Associated with 4-6x risk of death
- ↑falls/fracture (incoordination; ataxia)
- ↑Cognitive impairment
- Tolerance and withdrawal (delirium)
- Excessive sedation
- Risk present in minimal use and dose-related ↑risk
- All sedatives confer risk

MANAGING SLEEP DISTURBANCE

- Exclude GMC/medications/psychiatric illness/substance
- No napping
- Psychoeducation: ↓need for sleep associated with age
- Sleep hygiene
- ↑Physical activity during the day
- Sedating antidepressants if depressed
- Promethazine

MISCELLANEOUS

- Gingko Biloba
- Ginseng
- Vit. E
- Omegas
- Folic acid
- Statins

**1st International
Association of
Gerontology and
Geriatrics Africa
Region Conference**



President Hotel, Bantry Bay

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THANK-YOU!

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QUESTIONS