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ANTIPSYCHOTICS IN DEMENTIA – MORE HARM THAN GOOD?

WHAT IS THE PROBLEM?

- Antipsychotic drugs such as haloperidol and newer agents such as risperidone and quetiapine are commonly used to treat symptoms of dementia.
- In a report for the Department of Health in 2009, it was estimated that each year around 180,000 people with dementia in the UK are given antipsychotics for behavioural problems. The report found that on the basis of published evidence around a fifth of such patients (36,000) would derive some benefit from these drugs, but that at the same time over 1600 of them would be expected to have a stroke (half of these with severe consequences), and over 1800 are likely to die each year as a result of the medication.

WHAT IS THE EVIDENCE?

- There are currently around 700,000 people with dementia in the UK according to the Alzheimers Society. Over the next 30 years this number is expected to double.
- Antipsychotics were first introduced for the treatment of schizophrenia in the 1950s. Use of these agents to help with symptoms of dementia such as agitation, aggression, sleep disturbance and psychosis has grown, so that a report in 2009 found that they appeared to be the first line treatment for behavioural symptoms in many cases. Anecdotally much of this use did not appear to benefit patients.
  A large majority of prescriptions appeared to have been initiated by GPs and use of antipsychotics was particularly frequent in nursing homes, with up to a third of residents being treated with them. The report observed that there was generally a lack of plans to reduce or discontinue medication once started.
- The report analysed published trial data on the effects of antipsychotic drugs in dementia. In terms of their beneficial effect on behavioural symptoms, it was concluded that the effect size was small and clinically insignificant, though risperidone was moderately effective for aggression (but not for non-aggressive agitation). Aripiprazole was the only drug with evidence of benefit for psychosis in dementia, with an NNT of 13 (but this is an unlicenced use).

WHAT ARE THE RISKS?

- The risk of adverse effects of antipsychotics in dementia has been quantified by pooling studies. The pooled relative risk for mortality is 1.41 (a 41% increased risk of dying over the first 3 months of treatment). Put another way, the numbers needed to harm (NNH) for death from antipsychotics in dementia is 100 over the first 6 to 12 week period of treatment. This increased risk of mortality persists for at least 6 months from the initial prescription, based on observational studies.
- Meta-analysis of 15 trials of newer atypical antipsychotic drugs compared with placebo found robust evidence for an increase in cerebrovascular side effects of antipsychotics. The pooled relative risk was 2.57 (ie, taking an antipsychotic makes someone with dementia two and a half times more likely to have a stroke as someone not on antipsychotic). Put another way, if 59 people with dementia were treated with antipsychotics for 6-12 weeks, one of those would have a stroke, with a 50% chance this would be severe.

KEY MESSAGES

- **Only 1 in 5 patients with dementia symptoms can be helped with antipsychotic drugs, any effect is likely to be weak.**
- **Serious harms, particularly stroke and increased mortality are associated with antipsychotic use in dementia.**
- **NICE and social care guidance recommends use of antipsychotics in dementia for non-cognitive symptoms only if the person is severely distressed or there is an immediate risk of harm to themself or others.**
- **Treatment should be short term (maximum 12 weeks). A plan for dose reduction or discontinuation should be made when treatment is started and documented in the care plan.**
- **Patients with mild to moderate non-cognitive symptoms should ideally receive behavioural management without antipsychotics. Benzodiazepines or other psychotropics should not be substituted.**

Reference: http://www.npc.nhs.uk/qipp/resources/antipsychotics_in_dementia_qipp_notes.doc.
East Midlands guidance at http://www.lmsg.nhs.uk/LMSGDocs/Guidelines/BPSD%20Prescribing%20Guidelines.pdf

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