Agitation in Dementia: Start Tx Nonmedically

Confounding environmental, psychological factors, as well as medications, often cause the condition.

BY ROBERT FINN
San Francisco Bureau

San Francisco — At least 80% of patients with dementia will experience agitation, Dr. Josepha A. Cheong said at the annual meeting of the American Academy of Clinical Psychiatrists. The temptation, especially at in-patient facilities, is to go immediately to medical management for that agitation.

Before reaching for the prescription pad, however, one should rule out any medical causes for that agitation, and then try nonmedical management, which can be highly effective, said Dr. Cheong of the University of Florida, Gainesville.

In dealing with patients with dementia, Dr. Cheong asks herself how she would deal with this patient if he or she were a 3- to 5-year-old child. "Has there ever been a time when you were raising [toddlers] that you wanted to just pull out that syringe of Haldol?" Dr. Cheong asked. "It would be nice, but that's not what we do. One, it's not socially acceptable. And two, it's not appropriate.

'A lot of times, there's a tendency [with dementia] to go straight to the meds. And there's nothing wrong with that if what's least restrictive has failed.'

"I really feel much the same way in treating agitation in dementia. A lot of times, there's a tendency to go straight to the meds. And there's nothing wrong with that if what's least restrictive has failed."

Urinary tract infections constitute one of the most common medical causes of agitation. This has inspired a joke: Question: What's the first-line medication for agitation in an in-patient medical unit? Answer: Septra.

Dehydration is another common cause for agitation. "Even if they don't have a urinary tract infection, it's amazing how people will perk up if you just hydrate them a little bit," Dr. Cheong said.

Anticholinergics and over-the-counter medications can also result in agitation. Ditropan, which is used for urinary incontinence, is one of the biggest offenders, in Dr. Cheong's view. "I always tell patients and their families: 'Look, it's better to be in Depends than to be demented because of Ditropan.' This can make the difference between keeping someone at home and having them in a nursing home in restraints or in an in-patient unit," Dr. Cheong said.

Drug interactions can also cause agitation. The combination of an NSAID and lithium is a frequent culprit. A patient taking lithium might turn to a seemingly innocuous dose of over-the-counter Motrin after an especially vigorous golf game, and the next thing you know he's in the emergency room suffering from lithium toxicity.

Once medical causes have been excluded, consider whether the patient has experienced a recent change in environment, which can often result in agitation. Has a beloved pet died recently? Has the care facility's routine changed? Is there a new nurse on the ward?

Consider also whether the patient's agitation comes at a certain time of the day, or with certain activities. Shower time often precipitates agitation. One solution is simply not to insist that patients shower daily. Elderly patients often do fine showering or bathing just twice a week, and this has the extra benefit of preventing their skin from drying out.

Another tip is to enter the reality of the patient. People who work in geriatric units are used to seeing patients waiting every morning by the front door for the bus to take them to work. The patient is likely to become upset if he or she is told that he's been retired for 20 years. Instead, it might be better to say, "Why don't you come sit down and have some breakfast while you're waiting?"

Overstimulation and understimulation should both be avoided. The change-of-shift chaos in many in-patient units can be highly disturbing to patients. This might be a good time to have patients away from the chaos in a quiet day room with soothing music. On the other hand, lack of activities and boredom can lead to restless behavior and attempts to escape. Studies show that simply adding a recreational therapist to a nursing-home setting can decrease the amount of agitation that patients experience.

Keep the patient's choices simple. Three choices of salad dressing and four choices of entrées at mealtimes may be confusing to the demented patient; it's better to provide a single offering. And, just like toddlers, patients with dementia do best with finger foods.

Everyone has a basic need for attention, intimacy, and affection. The lack of that human connection can lead to agitation and impulsive sexual behavior. Soothing rituals such as massage or even hair brushing can go a long way to calming the agitated patient.

Psychiatrists may have difficulty getting paid for nonmedical treatment of agitated patients, because Medicare may regard it as psychotherapy, and psychotherapy is not indicated for patients with dementia. Dr. Cheong's tip is to code the treatment as being for behavioral and psychotic symptoms of dementia. ■

Atypicals Ameliorate Behavioral Problems Modestly in Dementia

BY KERRI WACHTER
Senior Writer

San Juan, P.R. — Atypical antipsychotics appear to have a modest effect on behavioral symptoms in elderly patients with dementia, but the effectiveness of nonpharmacologic treatments is less clear, according to a metaanalysis presented at the annual meeting of the American Association for Geriatric Psychiatry.

Dr. Mark B. Snowden of the department of psychiatry and behavioral sciences at the University of Washington in Seattle and his colleagues used metaanalysis techniques to compare the efficacy of nonpharmacologic treatments with that of pharmacologic therapies.

Articles from peer-reviewed, English language publications, including textbooks, from 1970 on were considered for the analysis. Nursing home residents had to make up at least half of the populations being studied. In addition to literature searches in several medical and nursing databases, the researchers submitted articles that they were aware of but that had not previously been identified. Articles were included only if they documented randomized, controlled trials.

The researchers identified five randomized, controlled trials of antipsychotic drugs and three randomized, controlled trials for nonpharmacologic interventions. The drug trials included four atypical drugs and one traditional antipsychotic drug.

The nonpharmacologic trials included 8 hours of nurses' aide training to communicate more effectively with patients with dementia, 8 hours of education/training with weekly follow-ups and hands-on activities of daily living care, 3 hours per day of psychosocial activities, and combined nonpharmacologic approaches.

The calculated effect size for nonpharmacologic interventions was – .088, which was not statistically significant. In comparison, the calculated effect size for pharmacologic interventions was – .23, which "would be considered small to modest at best," Dr. Snowden said. "In this instance, the finding was consistent enough across studies that it is statistically significant."

Only the pharmacologic studies provided data on the number of patients whose condition did or did not improve. giving a statistically significant mean odds ratio of 1.87; thus, patients had an 87% chance of improving with drug treatment.

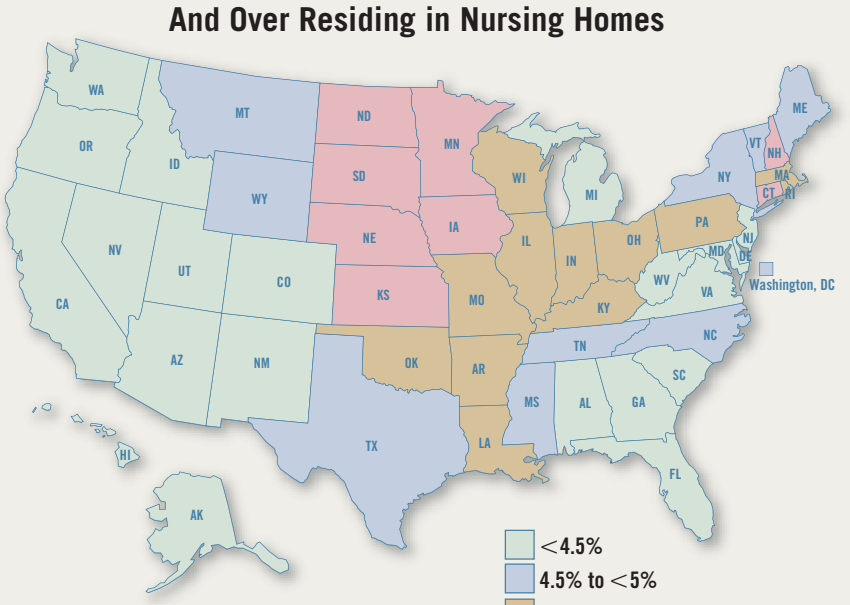
The researchers also calculated the benefit-to-harm ratio for antipsychotic treatment. "For every 14 people who got a drug and improved, you would expect one excess death," Dr. Snowden said. While Dr. Snowden pointed out that one excess death is not a trivial number, "when presented with this data, I have yet to have a nursing home family say that they don't want an antipsychotic drug given to their relative."

In 2003, the American Geriatrics Society and the American Association for Geriatric Psychiatry released a consensus statement on the management of behavioral symptoms associated with dementia. In the statement, the two groups recommended the use of nonpharmacologic interventions as the initial treatment, as long as patients did not display psychotic symptoms and there was no immediate danger to the resident or to others. The statement iterated that antipsychotic drugs should only be considered for first-line treatment in cases with severe behavioral symptoms with psychotic features. Since then, the Food and Drug Administration has issued a public health advisory about increased mortality associated with off-label use of atypical antipsychotics in elderly patients.

"Given the modesty of the effect size, I think we probably need to remove the requirement for psychosis or danger. . . . Danger is a very high standard," Dr. Snowden said. "If you say you can only use antipsychotics in someone who is dangerous, there are going to be a lot of people who are distressed that you're not going to treat." ■

DATA WATCH

Percentage of Population Aged 65 Years And Over Residing in Nursing Homes



Source: 2000 data, U.S. Census Bureau

Elsevier Global Medical News