Dementia Antipsychotic Prescribing Guide

General Guidelines:

1. **Rule out reversible causes** prior to using a drug.
2. **Try personalized care management strategies first.**
3. **Clearly document treatment targets** (symptoms) before and after a treatment strategy is tried.
   - **Justify use of an antipsychotic.** The treatment target symptom must present a **danger to the person or others** according to CMS guidelines for antipsychotic use in nursing homes and must also fail to respond to personalized care interventions. If symptoms are due to schizophrenia or related disorders, severe mood disorders or psychosis then antipsychotic use may be appropriate. In non-nursing home settings where these CMS regulations do not apply, many clinicians would consider antipsychotic use for persistent distressing symptoms related to hallucinations, delusions, or agitation, even if they do not clearly pose a danger to the patient or others. A key determinant is whether the antipsychotic appears to improve the patient's quality of life.
5. **See Guidance for Special Populations,** if the patient has fronto-temporal dementia, Parkinson's disease, Lewy body dementia, renal impairment, or hepatic impairment.
6. **Consider the impact of side effects on comorbidities** when choosing a drug, and **start with a low dose.**
7. **If the drug doesn't help, stop it** (use appropriate tapering).

Appropriate antipsychotic treatment targets:*

- Aggressive behavior (especially physical)
- Hallucinations (if distressing)
- Delusions (note: memory problems are often mistaken for delusions, e.g. thinks people are stealing lost items)
- Possibly other severely distressing agitation (see #4 above).

Inappropriate antipsychotic treatment targets:*

- Wandering
- Unsociability
- Poor self-care
- Restlessness
- Nervousness
- Fidgeting
- Mild anxiety
- Impaired memory
- Uncooperativeness without aggressive behavior
- Inattention or indifference to surroundings
- Sadness or crying alone that is not related to depression or another psychiatric disorder

Antipsychotic Efficacy

Evidence supports modest symptom improvements with **aripiprazole**, **haloperidol*, olanzapine, quetiapine, and risperidone**, but not with use of other antipsychotics in dementia. All antipsychotics appear to increase risk of death. The table below summarizes the strength of evidence supporting the efficacy of each **atypical antipsychotic** for different symptom domains.

	Aripiprazole	Olanzapine	Quetiapine	Risperidone
Dementia overall	+ +	+	+	+ +
Dementia psychosis	+	+ / -	+ / -	+ +
Dementia agitation	+	+ +	+ / -	+ +

+ + = moderate or high evidence of efficacy
+ = low or very low evidence of efficacy
+/ - = mixed results

*Haloperidol has shown efficacy for aggression in randomized trials

Adverse Effects Comparison Table

Drug *Brand Name* (daily dose range)	Aripiprazole *Abilify* (2-10 mg)	Haloperidol *Haldol* (0.25-2 mg)	Olanzapine *Zyprexa* (2.5-7.5 mg)	Quetiapine *Seroquel* (12.5-150 mg)	Risperidone *Risperdal* (0.25-2 mg)
***Movement Side Effects*[1]**	■■	■■■	■■	■	■■
Central Nervous System					
Sedation	■■	■■	■■■	■■■■	■■
Confusion, delirium, cognitive worsening	■	0	■■	■	■
Worsening psychotic symptoms	0	0	■	0	0
Cardiovascular/Metabolic					
Orthostatic hypotension	■?	■■	■	■?	■?
Edema	■?	0	■	0	■■
Weight gain/glucose ↑	0	■?	■■■	■	■■
Triglyceride ↑	0	0	■■■■	■■■	0
Urinary incontinence, UTI	■■■	■■	■■	■■	■■

■ = more boxes indicates greater risk. Colors are darker with increasing risk.
■? = evidence poor in dementia, but evidence in other conditions indicates some risk
0 = no clear evidence that the drug causes this side effect in a clinically important way, or very rarely
[1] Movement side effects = Parkinsonism, akathisia (restlessness), dystonia, tardive dyskinesia