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Optimizing Care for Older Adults With Dementia-Associated Psychosis

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ABSTRACT

Dementia continues to escalate as the aging population increases, and there are no medications available to reverse this disease. Dementia-associated psychosis/behavioral disturbances can be attributed to frontal lobe, vascular, Alzheimer, Parkinson, and Lewy body dementia, but patients must be assessed for other etiologies. Care for these patients can be challenging. Some studies find certain medications to be effective, but they are not without risk. Medications can lead to falls and even demonstrate paradoxical effects, causing significant distress in patients as well as their families. Nonpharmacologic interventions may prove helpful and should be used first if possible.

Keywords: Alzheimer, antipsychotics, dementia, dementia-associated psychosis, frontal lobe dementia, Lewy body dementia, Parkinson dementia, potentially inappropriate medications, vascular dementia

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Sarah, a 78-year-old retired schoolteacher with vascular dementia, was newly admitted to a local skilled nursing facility memory support unit. Upon admission, her medications consisted of 24 medications associated with hypertension, diabetes, heart disease, and dementia. Over time, her dementia worsened, and despite stable blood pressures and blood sugars, she showed the following signs of psychosis: constant agitation, confusion, and combative behaviors. Despite increases in antipsychotic medications and dementia medications, she unfortunately progressed and ultimately died of a fat embolus sustained after falling and fracturing her hip. Although the family was glad their loved one was no longer suffering, they stated that "this was difficult to observe, for our Mother would never have wanted to behave this way." A review of the literature was subsequently conducted to determine additional interventions available for those caring with patients with dementia-related psychosis.

PREVALENCE OF DEMENTIA-ASSOCIATED PSYCHOSIS

Dementia is prevalent in 40% of the world's population, with predictions for an even higher percentage by 2022.[1] Subtypes include Alzheimer dementia, which is the most common, vascular dementia, Lewy body dementia, frontal lobe dementia, and Parkinson dementia.[2] Dementia typically presents with cognitive decline and short-term memory loss. Unfortunately, cognitive impairment labeled as dementia can arise from many medications, such as antipsychotics, benzodiazepines, selective serotonin reuptake inhibitors, and anticonvulsants,[3] leading to a misdiagnosis and inappropriate care. One study found that 24% of patients given a diagnosis of dementia who exhibited psychosis were found to not have dementia.[4] Dementia symptoms can also be present in patients with thyroid disease, normal pressure hydrocephalus, brain tumors, subdural hematomas, and other etiologies.[2]

Dementia-associated psychosis can often occur at later stages of dementia, but this can vary.[2] Psychotic behaviors include delusions, hallucinations, aggression, paranoia, and depression. One study showed a 40% prevalence of psychotic behaviors in Alzheimer patients, the most common type of dementia.[5] This group demonstrated significantly more agitation than patients with mild cognitive impairment,[5] reinforcing that psychosis is more prevalent as the disease progresses. Among patients

with Parkinson disease, 50% have psychosis.[6] Frontotemporal dementia has consistently resulted in psychosis[7] because this part of the brain affects the filter of patient's thoughts and speech. Lewy body dementia and vascular dementia can also exacerbate into psychosis as the disease progresses.[2]

RISKS ASSOCIATED WITH PSYCHOSIS IN DEMENTIA PATIENTS

Agitation, aggressive, and combative behaviors associated with psychosis can create a domino effect within a memory support unit, contributing to a tense atmosphere for other patients. Patients with less severe conditions may become fearful that they too "may act that way some day." Dementia-associated psychosis can be variable throughout the day, so patients can feel *trapped* in a dementia unit during fleeting moments of clarity. Those with dementia and psychosis have a higher rate of depression than dementia patients without psychosis,[5] so it is not surprising that quality of life screening test scores were lower in patients with dementia and neuropsychiatric symptoms.[8]

Dementia-associated psychosis impairs judgment, which can lead to falls and associated injuries. When psychosis is present, it is challenging to meet the nutritional needs of patients, making them more prone to wounds and weight loss. When patients lose weight, a reduction in both diabetic and hypertension medications may be needed. Person-centered care can be difficult if patients are unable to express advanced directive wishes or share preferences regarding lifestyle choices or activities. Caregivers have a low to moderate agreement with patient choices for end-of-life care according to 1 study, reinforcing the need for early discussion of end-of-life choices before dementia ensues.[9]

CAREFUL DIAGNOSIS OF PSYCHOSIS ETIOLOGY IS ESSENTIAL

Psychosis is multifactorial and may be present in patients without dementia who have delirium, pain, uncontrolled diabetes or hypertension, neurologic impairment, or side effects from medications.[10] A study examined case notes of 660 patients with psychotic behaviors and found that health care providers missed various associated diagnoses, leading to the unnecessary use of antipsychotic medication. Sixty-eight percent of the sample had delirium, 27% had pain, 93% had depression or anxiety, and 71% had just started new medications before psychotic behaviors.[11]

According to 1 systematic review,[11] poor control of pain can alter cognitive function and lead to psychosis behaviors. Inversely, patients with an actual diagnosis of dementia may not be able to verbalize that they have pain, so a careful assessment is necessary.[12] A retrospective analysis with a large sample showed that the use of bladder antimuscarinics has been associated with cognitive decline.[13] Anticholinergics should be avoided whenever possible in older patients with psychosis.[2] There are conflicting reports about an association between urinary tract infections and psychosis, and, unfortunately, many older adults with colonized bacteria in their urine are actually treated unnecessarily for this presumed condition.[14]

PHARMACOLOGIC INTERVENTIONS FOR PSYCHOSIS IN DEMENTIA PATIENTS

Benefits of Medications

Cholinesterase inhibitors may slow the progression of dementia but are not associated with the prevention of psychosis.[15] In 1 study, 14 mg/d galantamine showed reduced agitation and was better tolerated than other medications in this class.[16] Pimavanserin was approved by the Food and Drug Administration for Parkinson disease—associated psychosis.[17] A study of 181 patients receiving 34 mg pimavanserin daily showed a significant reduction in psychosis. However, this medication is currently considered off-label for use in patients with psychosis who do not have Parkinson disease. A randomized double-blind trial of risperidone (dosing not specified) versus placebo use in patients with dementia psychosis found that risperidone had a favorable risk versus benefit ratio.[18] This study did state that this medication should only be used in cases with prominent psychotic and behavioral symptoms associated with distress, functional impairment, or danger to the patient. A retrospective study of 179 patients with dementia and behavioral disturbance showed buspirone to be effective in reducing agitation/aggressive behaviors in 68.6% of the sample.[19]

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