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Combating Controversies in BPSD Care

Dr. Lisk:
Behavioral and psychological symptoms of dementia, or BPSD for short, refers to a group of noncognitive symptoms that commonly occur in patients with dementia. And while data shows efficacy for treatment modalities for these symptoms and behaviors, the use of psychotropic medications has been met with controversy due to their adverse effects. So how can we address those controversies while providing optimal care to our patients?

Welcome to *NeuroFrontiers* on ReachMD. I am Dr. Jerome Lisk. And joining me to talk about the management of BPSD is Dr. Raj Tampi, Professor and Chairman of the Department of Psychiatry at Creighton School of Medicine. He also presented data on the exact topic at the 2023 American Psychiatric Association Annual Meeting.

Dr. Tampi, welcome to the program.

Dr. Tampi:
Thank you for having me, Dr. Lisk.

Dr. Lisk:
So to start off with, let's get some background, Dr. Tampi. Can you explain the behaviors and psychological symptoms associated with dementia?

Dr. Tampi:
So as you explained in your introduction, behavioral and psychological symptoms are a group of noncognitive symptoms, so it is a constellation of different behaviors, different symptoms that can occur in patients with any neurocognitive disorder, dementia being the major neurocognitive part and it can happen even in the mild neurocognitive disorder, and it continues through the course of the dementing illness. The noncognitive symptoms, that is the behavioral and psychological symptoms, also known as neuropsychiatric symptoms, are very common. They are seen during the life course in over 90 percent of patients with dementia irrespective of etiology of the dementia.

Dr. Lisk:
And what are the outcomes associated with leaving these symptoms untreated, Dr. Tampi?

Dr. Tampi:
The BPSD or NPS, the neuropsychiatric symptoms, are like I pointed out, very common in individuals with dementia. We know that 1/3 of the overall cost of caring for individuals with dementia in the United States is actually taken up by the BPSD or neuropsychiatric symptoms, and it is over $70 billion a year, so it is a very expensive illness to tackle.

Second thing, this may be the first time the individual with a neurocognitive disorder is actually being diagnosed with dementia. So I

have had patients being seen in clinic who clearly are moderately demented when you do the assessments and you do the rating scales, but no one has ever talked to the family that their loved one is actually now having a dementia and has probably had it for over three to five years, so it may be the first time that the actual label or the diagnosis of dementia is actually being given.

Third is that it can happen at any time during the life history of the neurocognitive disorder when it starts to become more prominent and becomes more persistent as the neurocognitive disorder progresses.

And one of the questions that people ask is, is dementia just part of Alzheimer's disease? It really is not. So Alzheimer's disease has a life course. It goes from the preclinical Alzheimer's disease to the mild cognitive impairment of Alzheimer's disease and then the dementia of Alzheimer's disease, so it actually goes in the life course. The difference is in the preclinical stages we have biomarkers that are changing both in the cerebrospinal fluid and in the brain. Then we have the mild cognitive impairment of Alzheimer's disease, which is where people start to have symptoms—memory problems, other cognitive issues, but no functional decline—and the dementia part of Alzheimer's disease is where people actually have the functional change because of the cognitive decline. And so as the illness progresses, you will see more and more symptoms and more persistent symptoms; and during the moderate to severe phase is where you would see more severe symptoms like psychosis, aggression, inappropriate sexual behaviors. Apathy, which is the most common behavioral symptom, starts very early on in the list and continues throughout the course of the illness, so it is a good clinical biomarker we could use for the process of the dementing process.

Dr. Lisk:
Now your APA presentation focused on managing these symptoms in our patients, can you tell us about the available treatment options, which I'm sure that majority of physicians really want to know? How are we going to deal with this? How are we going to manage it and treat it short- and long-term?

Dr. Tampi:
Correct. So the most important thing to remember is that we have to first and foremost make sure that the symptoms are being observed by either the family members or loved one or caregivers or professionals—is it really behavioral and psychological symptoms of dementia? Many times the symptoms that are occurring may be either due to a primary medical condition or a primary psychiatric condition. If the patient is agitated because of severe pain, giving a psychotropic medication is really not going to fix that. It's actually going to make them worse. So first and foremost, you have to rule out a medical condition, so it is a medical workup that needs to happen.

We also want to rule out other psychiatric conditions, people with psychiatric disorders like major depressive disorder, bipolar disorder, generalized anxiety disorder, posttraumatic stress disorder. All these individuals also have greater risk of becoming demented when they age, so if it is the exacerbation of a previously existing condition, giving a psychotropic medication which is not appropriate for their symptom is not going to help. It actually may make matters worse. So ruling out medical conditions, ruling out comorbid or coexisting psychiatric conditions, then using rating scales to both qualify and quantify the symptoms and then deciding on a treatment plan is the way to go.

One size does not fit all. Nonpharmacological management is the cornerstone of treatment, and among the nonpharmacological management, we know that education to caregivers, education to staff, education to professionals, has the best outcome both in the short and the long run. And then psychotropic medications if needed for behaviors that are refractory to the nonpharmacological management as an adjunct and for short period of time and optimizing the dose not maximizing the psychotropic dose is the way to go.

Dr. Lisk:
Yeah, excellent point. What I've noticed with managing dementia patients with psychiatric conditions also is that when documenting these, say, psychosis or delusions, are they threatening? If they're not threatening to the patient, does the patient have insight? If the patient has insight and knows they're not real and they're not disruptive to the family, many of these patients can really be kind of redirected by the family and not put on psychotropic medication or antipsychotics so that you kind of minimize medication too.

Dr. Tampi:
If you actually look at older adults in the United States, the National Comorbidity Survey showed that 16–23 percent of older adults do present with psychotic symptoms, usually paranoia and hallucinations. Unless they are impairing the functioning of those individuals,

unless they are impairing the individual's life, you don't have to necessarily give psychotropic medications because that may actually lead to worsening problems, including sedation, urinary retention, falls, confusion. You name it. So you only treat the symptoms that are causing distress.

Dr. Lisk:
Yeah. That's a pearl for those who are listening. That's really important in treatment.

For those of you just tuning in, you're listening to *NeuroFrontiers* on ReachMD. I'm Dr. Jerome Lisk, and I'm speaking to Dr. Raj Tampi about the management and behavioral and psychological symptoms of dementia.

Now, Dr. Tampi, these treatments we just spoke about have be met with some recent controversies. What do we need to know about these controversies?

Dr. Tampi:
The first medication for treating agitation and dementia due to Alzheimer's disease, which is brexpiprazole, was approved by the FDA for treating those symptoms, so I think this is a pertinent discussion. So if you look at the evidence for using psychotropic medications, until this medication was approved, there was no FDA-approved medication to treat behavioral and psychological symptoms of dementia for the simple reason it is a large constellation of symptoms and behaviors, so there is not one drug that is going to treat those symptoms. Rexulti has very specific indication. It is used for other conditions—for treating major depression, treating schizophrenia—but for agitation and dementia due to Alzheimer's disease, that's a very specific indication. The press release also says that brexpiprazole should not be used for treating psychosis unless there is agitation in Alzheimer's dementia, so that is very important. It's a very specific indication.

If you look at all psychotropic medications across the board—the atypical antipsychotic group, the anticonvulsant group, the antidepressant group, beta blockers, cannabinoids, ECT, TMS—they have modest efficacy. There are some randomized controlled trials that have showed benefit. Some others have not shown benefit. Tolerability then becomes the most important thing because older adults with or without dementia are a vulnerable group because of their pathophysiology and are at risk of developing more adverse effects than the younger population, so the caution is whatever you use you use after a risk-benefit analysis with clear discussions and documentation in the records with the patient, their family members or sort of their decision-makers so that there is no question that this was not discussed or there's no risk-benefit analysis. Then you start using psychotropic medications.

We have developed an algorithm for treating these symptoms. So our algorithm that my team has created, we divide these refractory symptoms into emergent behaviors which are psychiatric emergencies where the patient is trying to physically be aggressive to you or the caregiver, or the patient is having such agitation because of psychosis that you cannot manage the person in their home or in the nursing home or the assisted living facility. Those are psychiatric emergencies. That's less than 10 percent of the patients. The rest of the patients, it is the nonemergent behaviors where patients present with depressive symptoms, anxiety symptoms, bipolar symptoms, and psychotic symptoms. These symptoms fluctuate with psychomotor agitation being the most persistent and apathy being the most common.

For non-emergent agitation, we actually use donepezil or Aricept being the most prominent or the most common one. If the dementia progresses, in combination with Aricept and other drugs of that class we may use memantine. If that doesn't work, we use the antidepressants. If that doesn't work, we use trazodone, which is an antidepressant, but we don't use it as an antidepressant. We use it more for hypnotic now. Then we use atypical antipsychotics.

Again, the word of caution: if adverse effects occur, stop those treatments and go back to the drawing board and see which is the best medication for the patient. So that's the way to go. So caution and good risk-benefit analysis involving the family and the patient in the treatment is the way to go to treating BPSD.

Dr. Lisk:
It's a pleasure to have a geriatric psychiatrist as yourself on this program because as a neurologist, I'm just feeling just real good inside, that there is psychiatrists out there that are basically managing these patients in dementia, so that's excellent. This has been an insightful look at managing the strategies for BPSD. And I'd like to thank our guest, Dr. Raj Tampi, for joining me to talk about his presentation at the 2023 APA Annual Meeting.

Dr. Tampi, it was a pleasure speaking with you today, and I hope to have you on in the future.

Dr. Tampi:
Thank you very much, Dr. Lisk. It was a pleasure talking to you as well.

Dr. Lisk:
For ReachMD, I am Dr. Jerome Lisk. To access this and other episodes in our series, visit ReachMD.com/NeuroFrontiers where you can Be Part of the Knowledge. Thanks for listening.