Pharmacological management of people with dementia

- Remove ‘toxic’ agents
- Risk reduction – vascular mainly
- Treat anxiety/depression
- Psychosis
- Cholinesterase Inhibitors

Remove what?

- Anticholinergic
- Analgesics
- Anti-hypertensives
- Benzodiazepines
- Antipsychotics
- Others – such as lithium

Risk reduction

- Reduce vascular risk in people with vascular dementia
- Alcohol
- Smoking

Anxiety and Depression

- Anxiety often result of cognition
- But improving anxiety can result in improved cognition
- Depression common – early in illness
- Often responds surprisingly well (to interventions)

Psychosis

- Commonly occurs at some point in the illness
- Sometimes cause of ‘BPSD’
- May be associated with aggression
- Often responds surprisingly well to treatment

Challenging Behaviours

- “BPSD”
- Non-medical approaches
- Medical management
- Evidence base for both is weak

(Likely to be covered in case reviews later)

Antipsychotics

- Increased risk of death and vascular events
- Evidence for effectiveness in some BPSD symptoms
- Risperidone, quetiapine
- ‘Palliative care’?
- Lowest dose, review, stop if minimal benefit
- Trial of stopping even if they are effective

My experience……

- They do work….sometimes

Dementia Drugs

- Donepezil
- Rivastigmine
- Galantamine
- Memantine

- When to use?

Young Onset Dementia

- “Onset under age of 65”
- Fall between services
- Different needs
- Do not fit well into ‘geriatric services’
- Often seen initially by neurology

And now what?

- Ongoing monitoring
- Challenging behaviours
- Carer burnout
- Delirium
- Physical deterioration

Supported Living

- Which is best?
- ‘Apartments’
- ‘Villas’

- Sometimes better not to move….

Residential Care

- ‘Stage 2’
- ‘Stage 3’
- ‘Hospital’
- ‘Psychogeriatric Hospital’

End of life decisions

- Advanced Directives – do not leave too late

- When does ‘Palliative Care’ start?

(need to talk about it)

The end

- The next generation worries about getting this…..
- Questions