

Atypical Review and Discussion



R Clinical
Concepts





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The HISTORY of Treatment of Mental Illness

The following treatments were considered the

Standard of Practice

during their time.

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Early man believed that mental illness was the result of **demonic possession**.

Evidence was discovered from about 5000 BC that crude stone instruments were used to chip holes into the skull to allow the Demons to escape!

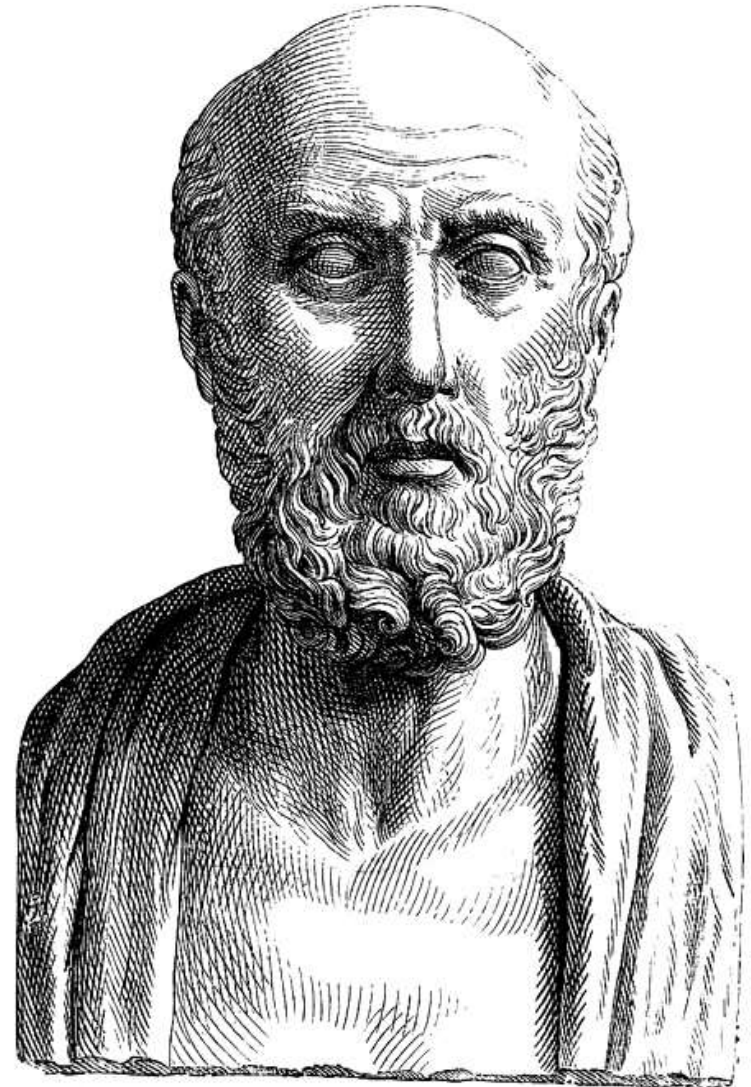


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He disputed that it was not caused by “Demons”

He along with the Romans believed that there was an imbalance of four essential fluids,

Blood, Phlegm, Bile and Black Bile



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To balance these fluids patients were given emetics, laxatives, and were bled using *leeches or cupping*



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1933 Insulin Shock treatment was introduced in Berlin.

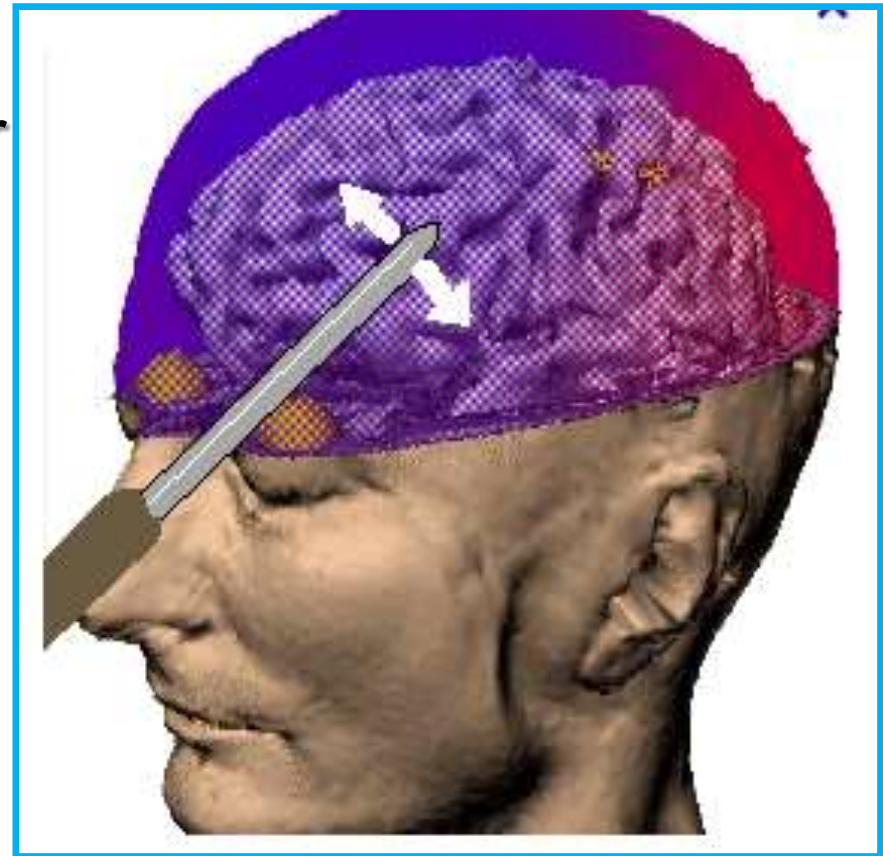
Use to correct chemical imbalance



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1935 up until 1950s
Lobotomy was popular
Also, produced a...

25% death rate



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In the **1950's**

Thorazine
(Chlorpromazine)
was introduced.

A Major Tranquilizer!

Allowing many to
come out of the
locked rooms.



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1980s – Atypical Antipsychotics were introduced. *Risperdal, Seroquel, Geodon, Loxitane, Zyprexa, Abilify*

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What are the **ONLY** indications for today's antipsychotics?

1. Schizophrenia
2. Bipolar 1 Disorder
3. Adjunct therapy in Major Depression
4. Autistic disorder in Children



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Indications from F-Tag 329 that were removed:

Psychosis NOS

Atypical psychosis

Brief psychotic disorder

Dementing illness with associated behaviors

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INAPPROPRIATE INDICATIONS

- wandering
- poor self-care
- restlessness
- impaired memory
- **mild anxiety**
- **insomnia**
- inattention or indifference to surroundings
- sadness or crying alone that is not related to depression or other psychiatric disorders
- fidgeting
- nervousness
- **uncooperativeness** (e.g. refusal of or difficulty receiving care).



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Are we really treating
Delusions and Psychosis?

Could it be that the patient is
being;

**Hostile, Aggressive or
Uncooperative?**



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Why does a person strike out?

In most cases it is due not having the ability to communicate their needs and wants

OR

Could it be **PAIN?**



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No Antipsychotic

is indicated for

Dementia or

Dementia with Psychosis

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BLACK BOXED WARNING !

Black Box - A black box warning is the most serious medication warning required by the FDA often because there are serious side effects including risks **of death.**

ALL Atypical Antipsychotics are **BLACK BOXED**

“Increased mortality in elderly patients with dementia related psychosis.”

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Data shows that the use of antipsychotic medications in older patients with Dementia increases the relative risk of death by 70%*.

It has been estimated that for every **100 dementia** patients treated with an antipsychotic medication, only about **15** patients will benefit and

1 will die*.

Antipsychotics are associated with an increased risk of **CVA(stroke), diabetes and mortality** in persons with dementia.

*Independent Drug Information Service
Antipsychotic medications in primary care
www.rxfacts.org

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Antipsychotic medications

may be considered

for the elderly resident with dementia

BUT

only after

**medical, physical, functional,
psychological, emotional psychiatric,
social and environmental causes have
been identified and addressed.**

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Risk vs Benefit Example;

This patient's behaviors are aggressive (**explicitly what are they and how often do they or did they occur**) in nature and do not allow for assisted self-care (**which care is affected**) essential for this resident's well-being.

Resident has had recurrent behaviors with previous dose reduction (**when - date**).

Resident is without side-effects of therapy and these continue to be monitored per facility protocol.



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Did you KNOW?

Statistics show that individual interactions produce better results than antipsychotics

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Possible Alternatives **Anxiety/Aggression**

Antidepressants

Paxil (paroxetine)* – 10mg + 10mg wkly, Target 40mg

Zoloft (sertraline)** – 25mg + 50mg wkly, Max 200mg

Celexa (citalopram) – 10mg daily, Max of 20mg >60yr

Effexor XR (venlafaxine)* – 37.5mg daily, up to
75mg 1 wk. w/ food. GAD Max 225mg

Lexapro (escitalopram)* – 10-20mg daily

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Possible Alternatives **Anxiety/Aggression**

Antidepressants

Cymbalta (duloxetine) – 20-60mg daily

Indications

Depression,
Gen Anxiety Disorder
Neuropathy,
Fibromyalgia,
Musculoskeletal Pain,
OA, and UI*

* Off Label



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Possible Alternatives **Anxiety/Aggression**

Anxiolytics

Ativan (lorazepam) – 0.5mg PRN up to 2mg/day

Xanax (alprazolam) – 0.25mg PRN up to 0.75mg/day

Buspar (buspirone) - 5mg 2-3X a day, 30mg Max/day
NOT A BENZO

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Possible Alternatives **Anxiety/Aggression**

Anticonvulsants

Neurontin (gabapentin) – 300mg daily, up to 900mg
Divided doses

Depakote (divalproex)* – 250mg TID, 60mg/kg/day,
>2000mg

Tegretol (carbamazepine)* – 200mg BID, may inc
200mg/3-4 days

Trileptal (oxcarbazepine) – 300mg BID, may inc by
600mg/wk up to 1800-2100mg

Lamictal (lamotrigine)* – 25, 50, 100mg QD-2wk,
Max 200mg QD

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Possible Alternatives Anxiety/Aggression

Nuedexta

Dextromethorphan with quinidine is for the treatment of pseudobulbar affect, PBA sometimes seen in stroke, brain injury and Alzheimer's.

In Phase II trials *



* The mfg attempts to treat sudden, intense emotional episodes, and reduced agitation in Alzheimer's patients more than a placebo

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Possible Alternatives for an Antipsychotic Medication.

Assess Pain, when we hurt we strike out! Consider a **routine Acetaminophen**.

General anxiety, **Escitalopram (Lexapro) 10mg daily**.
May increase to 20mg, **OR Cymbalta (duloxetine) 30 mg QD up to 60mg** during the initial dosing you may consider using a **“PRN”** lorazepam with a defined **STOP ORDER** in 10-14 days until Escitalopram is titrated.

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- ❑ What is the patient trying to **communicate**? Do They **HURT**?
- ❑ Remember antipsychotics are **15 %** effective and can cause **strokes, diabetes and death...**
- ❑ Remember, over time medical therapy do change practices.



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Thank you