



Alzheimer Scotland
Action on Dementia

Information Sheet



Drugs used during dementia -

sleeping tablets, tranquillisers and anti-depressants

Introduction

With the advent of the 'anti-dementia' drugs which help some people suffering from Alzheimer's and Lewy body types of dementia, we have entered a new world, with hopes that eventually there will be drugs that prevent the onset of dementia, or cure it once it has begun. These drugs are described in other information sheets available from Alzheimer Scotland - Action on Dementia.

At the moment, however, the commonest drugs prescribed for dementia are sleeping tablets, tranquillisers and anti-depressants, used to try to treat some of the symptoms or behaviour problems that arise during the long course of the illness. This information sheet briefly describes these drugs, the circumstances when they might be used, their possible benefits and the side effects they may have. All effective drugs have a wide variety of possible side effects, but only some of these will be at all common. We will only mention these commoner side effects.

Treating people with dementia

In all cases where drug treatments are used, the doctor will be more cautious in an older person, probably starting from a low dose and very gradually building up the dose, making sure that the person is tolerating each level before any increase. Side effects of all drugs are commoner in older people. Sometimes an older person will respond well to lower doses of the drug than is recommended for younger people.

Forgetfulness and disorientation make *compliance* with medication a problem in dementia. You may need to use special reminders or reminder-boxes (dosette boxes) to make sure that the person actually takes the drug and does not take too much. Ask the doctor to simplify the drug prescription as much as possible, cutting out unnecessary drugs and giving them only once or twice a day.

Consent

Consent to treatment is sometimes a problem. For example, the person with dementia may not recognise that he or she is behaving in a disturbed fashion, or may be unable to communicate his or her wishes. Doctors are expected to take account of the person's views and consult with all concerned before deciding whether there are any grounds for giving a drug without the person's express consent. The doctor may wish to consult a specialist or even consider use of the powers of the Mental Health (Scotland) Act if essential drug treatment cannot be given.

Reasons for treatment

There is no excuse for using a tranquilliser or other such drug just because someone is suffering from dementia. There must be a specific problem or problems that the doctor hopes will be improved by the drug.

Sometimes there is some doubt about the diagnosis in the very early stages of dementia. Older people who suffer depression may feel, or even act, mentally confused. It may therefore be reasonable to try a course of an anti-depressants if a person goes to the

doctor with memory problems but also shows some of the characteristic signs and symptoms of depression. If the anti-depressant does not improve the person's memory the diagnosis of dementia becomes more likely.

The doctor may consider drug treatment for someone with dementia if the person is:

- sleeping poorly
- depressed or subject to sudden mood swings
- restless, irritable or behaving in other ways which pose problems for him or herself or others
- experiencing hallucinations or mistaken beliefs.

Before deciding to prescribe a drug the doctor should always analyse the problem, for it may be due to some other physical illness (for example constipation causing restlessness, or pain causing sleeplessness). The person may be reacting to the dementia or to his or her current situation (for example depressed or anxious about disorientation and poor memory, or irritable about the way people are treating him or her).

There may be ways of helping the situation without recourse to drugs. For example stimulating activities, advice and education for carers, psychological approaches or management by a variety of other specialist professionals may help. Only if these approaches fail should drug treatments be considered, unless the drug is a very specific treatment for a particular symptom.

Hypnotics or sleeping tablets

Hypnotics or sleeping tablets should never be used for long periods, because they lose their effect and the person may become dependent on them. Withdrawal from a hypnotic after more than a few weeks use can be difficult and can even cause insomnia.

The principal use of sleeping tablets in dementia is when the person has got into the habit of going to sleep at unusual times, or has 'sleep reversal' – up at night and sleeping during the day. Most hypnotics are short-acting and are good at inducing sleep, but will not necessarily keep the person asleep throughout the night. Drugs which are commonly used include *zopiclone* (*Zimovane*), *zolpidem* (*Stillnoct*), *temazepam* and *chlormethiazole* (*Heminevrin*).

People with Lewy body dementia sometimes have particularly poor sleep, and the drug *clonazepam* (*Rivotril*) may be especially helpful. Poor sleep is also a symptom of depression, and some doctors prefer to use anti-depressants to treat the depression and sleep disturbance together, giving the whole daily dose at night.

Anti-depressants

Anti-depressants should be considered when the person has a significant degree of depression in addition to the changes of dementia. There is nothing different about treating depression in someone with dementia. There are many anti-depressants, which work on a number of different chemical systems in the brain. All anti-depressants can cause a degree of sedation (drowsiness) and shakiness, and occasionally they may cause restlessness or irritability instead of helping. The *tricyclic* drugs like *amitriptyline* (*Tryptizol*) and *dothiepin* (*Prothiaden*) are less used now than in the past, because they can cause constipation, slowing of the flow of urine, confusion, unsteadiness, low blood pressure, and effects on the heart, particularly in older people. *Lofepramine* (*Gamanil*) is one of the safer of these drugs.

The most commonly used anti-depressants nowadays are the *SSRIs* (*selective serotonin reuptake inhibitors*), such as *fluoxetine* (*Prozac*), *sertraline* (*Lustral*), *citalopram* (*Cipramil*) and



paroxetine (Seroxat). They are less likely to have the above side-effect, but can cause stomach upset at the start of treatment, and some can cause low sodium in the blood. Other drugs in common use include *moclobemide (Manerix)*, *venlafaxine (Efexor)*, *nefazodone (Dutonin)* and *trazodone (Molipaxin)*. *St John's Wort*, a herbal medicine, is increasingly being used for its anti-depressant effects.

Emotional lability is a common symptom particularly in vascular dementia and after strokes. The person suddenly finds him or herself overtaken by a fit of tears, or laughter or irritation, for very little reason, and just as suddenly comes out of it again. The SSRI drugs, particularly *fluoxetine* may be helpful in this condition.

Antidepressants, especially the SSRI's and *trazodone*, have also been used in attempts to treat repetitive behaviour, because they have been found to help patients troubled by rituals and obsessional thoughts. *Trazodone* has been used as a more general tranquilliser, but it is not always effective and can be quite sedating.

Anti-anxiety drugs or anxiolytics

Anti-anxiety drugs or anxiolytics, such as *diazepam*, *lorazepam* or *oxazepam* are occasionally needed, but they should not be used for longer than a few weeks, for the same reasons as apply to hypnotics. They will be most helpful when the person is severely anxious and this is interfering with his or her ability to carry out normal tasks or communicate clearly. They are sometimes used also as tranquillisers for agitation if the person cannot tolerate other tranquillisers, but their effects are likely to wear off over time. In Lewy body dementia they may be used to try to deal with the hallucinations.

Anti-psychotic drugs (neuroleptics or major tranquillisers)

Anti-psychotic drugs, also known as neuroleptics or major tranquillisers are very commonly used for a variety of behaviour problems in dementia, including restlessness, irritability and aggression, emotional instability, and loss of inhibitions. They should be the last resort, after non-drug methods have been tried and failed. But there are times when nothing else seems to be helping.

All of these drugs can cause sedation, and a variety of neurological side effects can occur, including shakiness like Parkinsonism, abnormal movements particularly around the mouth and tongue (called dyskinesia), muscle spasms (dystonia) and restlessness (akathisia). The restlessness can be particularly confusing, for it may seem as if the patient is getting worse rather than better, so the doctor is tempted to increase the drug further when he should be decreasing or stopping it. The drugs can also cause lowered blood pressure and falls are a danger.

In the past *thioridazine (Melleril)* was widely prescribed, but it can cause a paradoxical increase in confusion and other side effects. *Thioridazine* is no longer licensed for the treatment of behaviour disturbance in dementia. Anyone who is on this drug and has dementia should be reviewed by his/her doctor and/or a specialist. Other similar drugs are still in use, including *promazine (Sparine)* which is relatively mild in action, *haloperidol (Serenace or Haldol)* and *droperidol (Droleptan)*, which are sometimes used in more urgent situations, *pimozide*, which needs careful monitoring to avoid side effects on the heart and *sulpiride (Dolmatil)*.

In the past few years there has been much more use of 'atypical' anti-psychotics, especially *risperidone (Rispedal)* and *olanzapine (Zyprexa)*. These seem to be quite effective in some

patients in calming restlessness and have relatively fewer side effects than the 'typical' drugs, but this does not mean that side-effects do not ever occur. *Olanzapine* can make patients put on weight. *Risperidone* can cause sedation and unsteadiness. Both tend to be used effectively in relatively small doses, and there is usually little point increasing the dose if a small dose has not been effective.

We might expect that these drugs would be most useful when a person with dementia experiences hallucinations or delusions, the 'psychotic symptoms' of the illness, and sometimes this is the case. **However, they are not safe for patients who have Lewy body dementia.** Even small doses used to treat the visual hallucinations or behaviour problems which are common in this condition can produce serious side effects of over-sedation or neurological effects including stiffness and unsteadiness. It has been found that the anti-dementia drugs – the *anticholinesterases* such as *donepezil*, *rivastigmine* and *galantamine* can not only help the mental impairment of Lewy body dementia, but also the hallucinations. If these do not work other drugs will have to be used on a trial and error basis.

Other drugs

Other drugs are tried when anti-psychotic drugs are ineffective, particularly for patients who have very severe behaviour disturbances, such as

persistent restlessness by night and day, severe aggression to others or repetitive shouting. The use of the anti-depressant *trazodone* has already been mentioned. *Carbamazepine (Tegretol)* and *sodium valproate (Epilim)* are anti-epileptic drugs, but sometimes seem to have a calming effect, perhaps especially when loss of self control is a problem. Analgesics (pain-killers) have sometimes been quite effective in reducing restlessness and anxiety, even if the person is not giving any indication that he or she is in pain. Occasionally loss of control over sexual behaviour in men leads to the use of *cyproterone (Androcur)*.

But in these and in all cases of behaviour disturbance, drugs may not be effective and doctors and other professionals need to explore other management methods which will help the person be more at ease, and more able to live with other people.

Dr Alan Jacques

Grateful thanks to Dr Donald Lyons and Dr Alan Clubb for their comments on this information sheet.

Note: In this information sheet the 'proper' chemical name of the drug is given first. Proprietary names given by particular drug companies are put in brackets.



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