PSYCHIATRY OF OLD AGE - 2

Dementia - Behavioural problems

Behavioural problems include:

- Wandering
- Repeatedly asking questions
- Shouting/screaming
- Aggression
- Psychosis
- Depression
- Inappropriate sexual activity
- etc.

Non-pharmacological interventions should be considered the foundation of management for behavioral symptoms in dementia. Key aspects of this approach include:
(i) education and support of the family
(ii) maintaining a non-stressful, constant, and familiar environment
(iii) training programmes for carers to teach appropriate comminication skills and environmental interventions
(iv) aiming to balance safety with as much freedom as possible.

The efficacy of neuroleptics, the most widely used drugs for behavioral symptoms, is far from unequivocal. Neuroleptics also have the risk of significant side effects including anticholinergic effects, cardiovascular and cerebrovascular toxicity, and extrapyramidal syndromes. The placebo response is 37.5% and the neuroleptic non-response rate is 40.5%. This implies that 18% of agitated dementia patients benefit from a neuroleptic [beyond effect of placebo] There are limited placebo controlled data to support the efficacy of carbamazepine, trazodone, and the SSRI's for some symptoms.

'Paraphrenia' & late-onset schizophrenia

Patients who develop a non-organic, non-affective psychosis with onset after the age of 60 tend to have a female preponderance, abnormal premorbid personality, social isolation, and sensory impairment. Diagnosis in this group of patients is controversial with opposing opinions [as to whether it is a disorder distinct from schizophrenia in younger adults] possibly explained by differing definitions of 'late-onset'.

Treatment is with neuroleptics. Doses much lower than those used for schizophrenia in younger adults are usually effective. The newer 'atypical' neuroleptics [e.g. risperidone and olanzapine] are preferred as they are less likely to cause extrapyramidal side effects.

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