Pearls from Dr. Popeo 2018

1. *Dr. Popeo DOES NOT recommend the use of "zolpidem and its friends" for sleep due to worsening of cognition and increased risk for falls.*
2. The risk of death in the Black Box warning on typical and atypical antipsychotics might be overstated, but WILL NOT be removed. Use of these agents is sometimes necessary, but requires COMPLEX risk/rewards discussion with a patient's family. - Dr Popeo

In-Depth Show Notes

Sleep

The Basics

Ask your older adults patients and their family members about nocturia, and sleep wake reversal, which are common barriers to sleep. In fact, some big cities like New York have nocturnal adult daycare programs.

Make sure your patients are practicing basic sleep hygiene. These include the avoidance of liquids, cigarettes, and caffeine close to bedtime. Discourage patients from taking naps longer than 30 minutes. Dr. Popeo reminds us to *manage expectations*, "An 85 year old will not sleep for eight hours per night" (Review by Lavoie. BMC. 2017)

Check out this previous episode on Insomnia with Psychiatrist, Dr. Karl Doghramji from Thomas Jefferson University.

Z Drugs

Dr. Popeo does not recommend the use of zolpidem and friends in older adults. They might work, but their long-term use makes symptoms of dementia worse (Cheng. J Am Geriatr Soc. 2017 PMID: 28884784) and they increase fall risk (Kolla. J Hosp Med. 2013).

Trazodone

Trazodone is an "older antidepressant" that is non-habit forming. It has the beneficial side effect of sedation and doesn't affect blood pressure like some other sleep aids. It can be

helpful for sleep at doses of 25 to 50 mg at bedtime (Jaffer. Innov Clin Neurosci. 2017. PMC 5842888). Priapism is a rare complication. *-Dr Popeo's expert opinion*

Gabapentin

Gabapentin is sometimes used off-label and has some evidence for treatment of insomnia (Rosenberg. J Clin Sleep Med. 2014 PMID 25317090). Dr. Popeo suggests doses of 100 to 300 mg at bedtime might be helpful (expert opinion).

Mirtazapine

Mirtazapine has been helpful for sleep in geriatric patients with depression (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3907331/). It should be noted that lower doses of mirtazapine (15 mg or less) are more sedating than higher doses. This may be due to more noradrenergic activation at higher doses (Hirsch et al. Atypical antidepressants: Pharmacology, administration, and side effects. UpToDate.com).

Melatonin

Melatonin is not helpful as a sleep aid in Dr. Popeo's experience. Additionally, experts cannot seem to agree on dosing.

Diphenhydramine

Dr. Popeo reminds listeners that they SHOULD NOT use diphenhydramine! Recall our previous episode on dementia where Dr. Steven Dekosky noted that anticholinergic medications blunt cognition in patients with dementia.

Behavioral disturbances

Irritability (or agitation) is a common symptom in dementia and should be considered separately from psychotic features like paranoia.

Disclaimer

The mainstay of treatment for the neuropsychiatric symptoms remains nonpharmacologic strategies. Dr. Popeo advocates for cautious use of medical therapy when the potential

benefits outweigh the risks of harm. Please refer back to our GeriSiders episode #82 with Eric Widera MD for a more in-depth discussion of this clinical conundrum.

Benzodiazepines

Dr. Popeo notes that benzodiazepines are risky because they can be habit forming, even in older folks [Juergens. Mayo Clinic Proceedings 1993]. They increase the risk of falls, hip fractures and death [Donnelly. PLoS One. 2017]. They also may worsen cognition [Rochon. CMAJ. 2017], and there's observational studies that link use to Alzheimer's disease [Billioti de Gage. BMJ 2014], but there is not yet consensus about their long term effects on cognition. There is a low incidence of benzodiazepine induced respiratory depression because of low density of binding sites in the brainstem respiratory center [Kang. StatPearls. 2018 NBK 482238]. Respiratory depression is mostly a risk if mixed with alcohol or other substances (Dr. Popeo).

Paradoxical reactions

Dr. Popeo points out that, benzodiazepines are like alcohol. A small dose may cause disinhibition and the patient might act like a person at a party after a few glasses of wine. Therefore, it's important to give enough that the person goes to sleep from the dose.

Antipsychotics

Dr. Popeo notes that the **Black Box Warning** [Steinberg. Am J Psychiatry. 2012] for both *atypical and conventional antipsychotics* probably overstates the risk, but it will never be removed. These agents may be considered for patients with dementia who express severe agitation or irritability, but this requires a *complex risk/benefit analysis and discussion* with the patient's family members. That being said, the decision to use these agents is more straightforward if a patient has *psychosis and/or paranoia.* Patient's with this type of symptoms warrant referral to a geriatric psychiatrist (*Dr. Popeo's expert opinion).*

The CATIE-AD study, referenced by Dr. Popeo, tested the use of risperidone, olanzapine and quetiapine "on psychiatric and behavioral symptoms in patients with Alzheimer's disease (AD) and psychosis or agitated behavior" (Sultzer. Am J Psychiatry. 2008). Risperidone and olanzapine showed some benefit for various psychiatric or behavioral symptoms versus placebo, but did not improve functional skills.

Dr. Popeo notes that risperidone comes in a liquid that is odorless, colorless, and tasteless. It can easily be mixed into patient's food or drink for convenient dosing. He reminds us that the goal is to keep the patient in their home in a safe way, and uncontrolled behavioral symptoms are a barrier to this goal.

Alternative Agents

Citalopram at 30 mg per day significantly reduced caregiver stress and agitation in patients with Alzheimer's disease (Porsteinsson. JAMA. 2014), but it's use is limited by cognitive side effects and cardiac toxicity (prolonged QTc) at doses over 20 mg per day.

Gabapentin has been effective for nocturnal agitation in at least one case report (Buskova. Med Sci Monit. 2011).

Trazodone may help with agitation and psychosis in dementia, but further studies are needed [Seitz. Cochrane Database Syst Rev. 2011]

Nonpharmacologic Interventions

Caregiver stress is a major factor that leads to nursing home placement. Therefore, it must be addressed if you want to keep people in their homes. *-Dr Popeo*

Behavioral interventions work well in studies, but not as well for families in real world settings. For this reason, pharmacologic interventions are often pursued.

There is a **"Dementia Village"** set up at a nursing home in the small town of Weesp, in Holland (Gizmodo article by Campbell-Dollaghan). Unfortunately, this option is not widely available or practical at this time.

There is about one geriatric psychiatrist for every 8,000 to 9,000 people so primary care clinicians must be proficient in managing these issues. *–Dr Popeo*