失智症行為心理症狀的照護與治療
Behavioral and Psychological Symptoms of Dementia (BPSD) and Treatment

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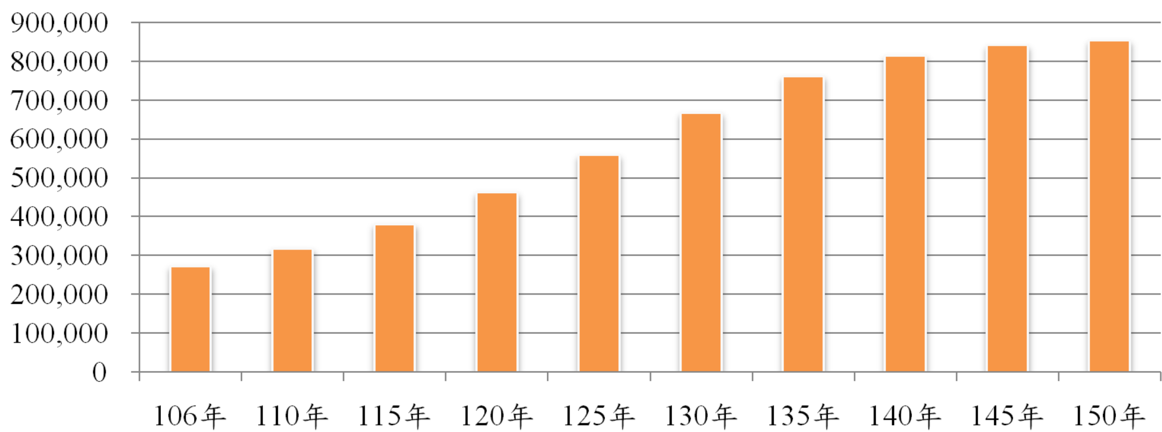
台灣失智症盛行率

- 內政部106年12月人口統計資料：
  - 65歲以上老人約326萬人，其中失智症人口有26萬人(約占8%)、MCI則有60萬人(約占18%)。
  - 30-64歲失智症盛行率為千分之一。
  - **推估民國106年12月台灣失智人口共271,642人，佔全國總人口1.15%，亦即在台灣每100人中即有1人是失智者。**

年齡	65-69	70-74	75-79	80-84	85-89	≥90
失智症盛行率	3.40	3.46	7.19	13.03	21.92	36.88



國家發展委員會「中華民國人口中推計（民國105-150年）」及失智症盛行率

失智症警訊—常見的早期症狀

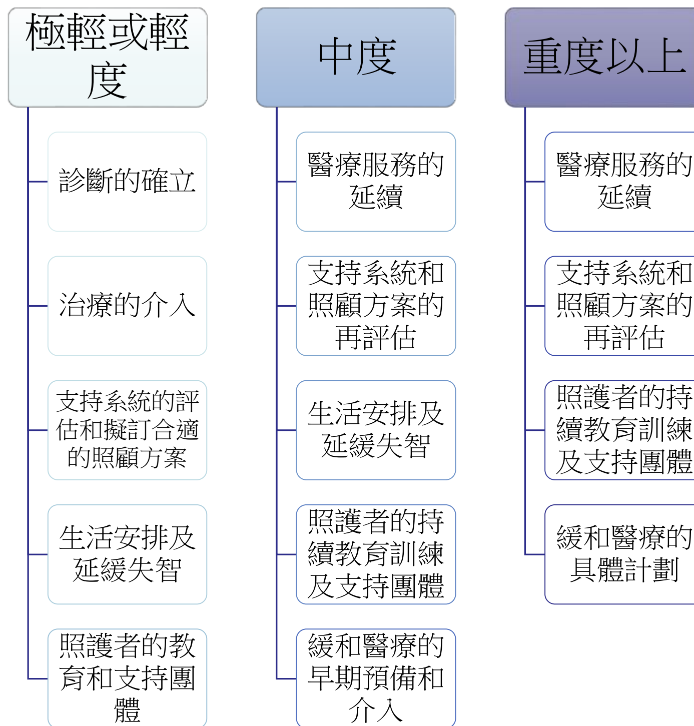
- 記憶減退影響到工作
- 無法勝任原本熟悉的事務
- 言語表達出現問題
- 喪失對時間的概念、錯過約會
- 判斷力變差、警覺性降低
- 抽象思考出現困難
- 東西擺放錯亂
- 行為與情緒出現改變；個性改變
- 活動及開創力喪失

失智症常見症狀

- 輕度
  - 如忘記東西放在哪裡，卻怪別人亂放
  - 剛剛發生的事情過不久就忘了，因此同樣的問題老是要反覆詢問
  - 處理日常生活中比較複雜的事務時開始有些困難，譬如錢財管理出錯、烹調能力下降
  - 對之前喜歡從事的活動顯得興趣缺缺，變得不愛出門
- 中度
  - 對眼前剛發生過的事馬上忘記，經提醒仍無法想起或否認
  - 對於辨認環境和區分時間等更加困難，可能會誤以為目前所處的環境並非自己的家，因此吵著要「回家」，在熟悉的地方有時會迷路的
  - 煮飯、上街購物、打電話等活動難以獨自完成
  - 個人衛生開始需要他人協助，好幾天不刷牙洗臉，忘記如何洗澡，無法適當地穿衣或處理衣物。
  - 言語表達不連貫，缺乏邏輯性；閱讀及語言能力可能逐漸喪失

失智症行為心理症狀(BPSD)

- 超過9成的失智症患者，在病程中曾經有呈現過BPSD
- 在照護中心的失智症患者，任何時候都有將近3分之2的比例會呈現BPSD


失智症照護
極輕或輕度
診斷的確立
治療的介入
支持系統的評估和擬訂合適的照顧方案
生活安排及延緩失智
照護者的教育和支持團體
中度
醫療服務的延續
支持系統和照顧方案的再評估
生活安排及延緩失智
照護者的持續教育訓練及支持團體
緩和醫療的早期預備和介入
重度以上
醫療服務的延續
支持系統和照顧方案的再評估
照護者的持續教育訓練及支持團體
緩和醫療的具體計劃

失智症行為心理症狀(BPSD)

- 在失智症病程的不同階段有不同表現
- 增加照護者的負擔及減少生活品質
- 可能造成較早被安置到照護中心
- 增加經濟支出
- 可能導致老人虐待

常見的失智症行為心理症狀

- 情緒方面
  - 憂鬱/ 不悅
    - 傷心
    - 對愉悅的事沒有反應
    - 情緒日夜不同變化 (早晨特別低落)
  - 焦慮
    - 災難式反應
    - 畏懼 (害怕一人獨處)
  - 過度愉悅
  - 無情感 (Apathy)
  - 易怒/ 脆落敏感
  - 情緒失禁 (Emotional incontinence)

常見的失智症行為心理症狀

- 行為
  - 激動/ 侵略攻擊性
  - 失去抑制(Disinhibition)
  - 怪異(Aberrant)或不恰當行為
  - 重覆/刻板/強迫/儀式化行為
    - 囤積Hoarding, 吐口水spitting
  - 游走(Wandering)
  - 迷路(Lost)
  - 遲滯(Retardation)
  - 失去興趣(less involved in usual activities)

常見的失智症行為心理症狀

- 認知
  - 語言
    - 重覆相同的語句或問題
    - 答非所問, 思考及言談混亂
    - 語多或語
  - 妄想
    - 被偷、被害、錯認、嫉妒、虛談(confabulation)
  - 幻覺
    - 視、聽、嗅、觸幻覺
  - 多重身體抱怨或慮病
  - 負面思考 (Idea disturbance in depression)
    - 自殺意念
    - 低自尊、自責、失敗感
    - 悲觀想法

常見的失智症行為心理症狀

- 驅力
  - 夢魘 (Nightmare disturbance)
    - 難以入眠
    - 中斷睡眠
    - 晨間早醒
  - 胃口/飲食改變
  - 性慾增高/ 不恰當的性行為
  - 無意志(Avolition)
  - 缺乏活力(Lack of energy)
    - 容易疲累，無法維持活動

失智症行為心理症狀的治療考量

- 多數醫療指引和專家團體都建議“非藥物的治療介入”為較佳的第一線治療方式
- 藥物比“非藥物的治療介入”為佳的幾個考量理由:
  - 缺乏非藥物的治療提供者訓練
  - 需要時間而且缺少給付
  - 缺乏清楚的治療指引，包括劑量和時間
  - 覺得比藥物效果差
  - 病患和照護者的安全考量

失智症行為心理症狀的評估

- 大部分的歸責因子是可調整的
  - 和失智症病患相關的因子
    - 急性病症 acute medical illness (infection, dehydration)
    - 感覺缺失 sensory deficits
    - 需求未被滿足 unmet needs (疼痛、解尿、排便、營養不良)
  - 和照護者相關的因子
    - 溝通不良poor communication
    - 情緒煩躁emotional upset
  - 和環境相關的因子
    - 擁擠、照護場所不斷更換
    - 過度刺激 (fatigue)、過少刺激 (boring)

失智症行為心理症狀的非藥物治療方式

NO “One size fits all” solution

BPSD的藥物治療原則

- 針對照顧者感到困擾的症狀
- 低劑量的抗精神病藥物 Start low, Go slow
  - Risperidone 0.5~2mg
  - Olanzapine 2.5~15mg
  - Quetiapine 12.5~150mg (400mg)
  - Aripiprazole 2.5~15mg
  - 略增加腦血管疾病的風險
- 最小有效劑量/考量利弊/重覆考量是否持續給藥
- 其他種類失智症的特殊治療議題
- 乙醯膽鹼酶抑制劑(AChEI)

Antipsychotics for BPSD

Tan et al. Alzheimer's Research & Therapy (2015) 7:20
DOI 10.1186/s13195-015-0102-9

RESEARCH Open Access

Efficacy and safety of atypical antipsychotic drug treatment for dementia: a systematic review and meta-analysis

Lin Tan[1], Lan Tan[1,2,3*], Hui-Fu Wang[3], Jun Wang[2], Chen-Chen Tan[2], Meng-Shan Tan[1], Xiang-Fei Meng[2], Chong Wang[2] and Jin-Tai Yu[1,2,3*]

Overall, 23 relevant RCTs with 5,819 participants were identified with three aripiprazole articles, five olanzapine articles, seven quetiapine articles and eight risperidone articles met all review criteria

Results

- Obvious benefits were observed for symptomatic efficacy on psychiatric symptoms and cognitive functions of **aripiprazole and risperidone** after statistically combining the trials

Antipsychotics for BPSD

Atypical antipsychotics for aggression and psychosis in Alzheimer's disease (Review)

Ballard CG, Waite J, Birks J

16 studies included , 5 for risperidone, 3 for olanzapine, 3 for quetiapine, 3 for aripiprazole, one study with risperidone and olanzapine arms and one study with risperidone, quetiapine and olanzapine arms

Results

- **Risperidone (1~2mg)** had a significant beneficial effect upon psychotic symptoms and aggression
- The data also indicate a significant benefit of **Olanzapine (5~10 mg)** for the treatment of aggression
- There are insufficient data to undertake a meaningful evaluation of the efficacy of any of the other atypical antipsychotics

Efficacy and Comparative Effectiveness of Atypical Antipsychotic Medications for Off-Label Uses in Adults

A Systematic Review and Meta-analysis

Marika Suttorp, MS
Jian-Hui Hu, MPP
Brett Ewing, MS
Zhen Wang, MS
Martha Timmer, MS
David Sultzer, MD
Paul G. Shekelle, MD, PhD

JAMA, September 28, 2011—Vol 306, No. 12

Eighteen placebo-controlled trials reported outcomes between 6 and 12 weeks of follow-up and were included in the pooled analyses

Results

- For **aripiprazole, olanzapine, and risperidone**, the pooled estimate of the effect size was small but statistically significant (range, 0.12-0.20).
- The pooled estimate of effect for quetiapine was similar (0.11) but was not statistically different than zero

AChEI for BPSD

[Intervention Review]

Cholinesterase inhibitors for Alzheimer's disease

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Editorial group: Cochrane Dementia and Cognitive Improvement Group.
Publication status and date: Edited (no change to conclusions), published in Issue 5, 2012.
Review content assessed as up-to-date: 14 September 2005.

THE COCHRANE COLLABORATION®

Memantine for BPSD

[Intervention Review]

Memantine for dementia

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Editorial group: Cochrane Dementia and Cognitive Improvement Group.
Publication status and date: Edited (no change to conclusions), published in Issue 1, 2009.
Review content assessed as up-to-date: 21 February 2006.

THE COCHRANE COLLABORATION®

Results

- AChEI improved NPI in mild to moderate AD, but not statistically significant in moderate to severe AD
- Memantine improved NPI and behavioral disturbances in moderate to severe AD, but not in mild to moderate AD

Mood stabilizer for BPSD

- Few RCTs
- Some studies showed worsened NPI scores and MMSE scores in AD patients treated with mood stabilizers compared with placebo

Antidepressants for agitation/psychosis in dementia

- Few RCTs and small sample size
- A couple of studies showed favorable outcome of citalopram and sertraline than placebo in NPS of dementia

Antidepressants for depression in dementia

- SSRI, SNRI, TCAs
  - No significant change in effectiveness compared with placebo
  - But placebo effect was observable
    - SSRI : placebo=53% : 39%
  - RCT but small sample sizes
- Suggested

Benzodiazepam

- Consideration of psychopathology
- For anxious mood
- Avoid and use cautiously
- Paradoxical effect
- Dose: as low as possible

Prescribing Guidelines for BPSD in Dementia

For all cases of agitation and aggression in dementia, pain relief i.e. Paracetamol 1g tds should be seriously considered as an alternative to the medications below.
Husebo et al published a recent Norwegian study in the BMJ which showed analgesia significantly reduced agitation/aggression compared to controls- ***BMJ*** **2011;343:d 4065-** http://www.bmj.com/content/343/bmj.d4065

Alzheimer's Disease.

Key symptom	First line	Evidence type	Second line	Evidence type
Depression	Sertraline, Citalopram#	2 – 3 + £	Mirtazapine	3
Apathy	Sertraline, Citalopram#	2 – 3 + £	Donepezil [S]; Rivastigmine [S]; Galantamine [S]	2
Psychosis	Risperidone	1	Olanzapine; Aripiprazole; Memantine [S]	2
Aggression	Risperidone [L] Haloperidol	1 2	Olanzapine, Aripiprazole; Carbamazepine, Lorazepam Memantine [S]	2 2
Moderate Agitation/ Anxiety	Citalopram. #	3	Trazadone; Lorazepam; Mirtazapine; Memantine	2-4
Severe Agitation/ Anxiety	Risperidone,	1	Aripiprazole, Olanzapine, Memantine [S] Lorazepam.	2 - 4
Poor sleep	Temazepam; Zopiclone.	3 + £	Zolpidem	3

[L] = Licensed indication [S] = Secondary care initiation or recommendation under shared care
# If considering Citalopram, note MHRA guidance (contra-indication with antipsychotic and max dose in elderly 20mg) (link on p 3)

Evidence levels: 1 = Meta-analysis; 2 = RPCT's; 3 = Other studies; 4 = Expert opinion; £=cost

Cumbria Partnership NHS
NHS Foundation Trust