Prescribing Support Document: Management of Dementia Drugs Process Summary

Following assessment under EMDASS, patient is diagnosed with mild to severe Alzheimer's disea

Drug for dementia is initiated by EMDASS/SMHTOP team.
Dose is titrated and patient is monitored and reviewed for 6-8 months

Good therapeutic response and patient is stable on treatment

Patient either does not have a good therapeutic response or cannot be stabilised on treatment

EMDASS to send clinic letter to the GP to include: -

- Clear diagnosis and care plan
- Details of drug treatment and dose
- Patient is confirmed to be stable on a maintenance dose and benefitting from treatment.
- 8 week prescription of on-going medication
- Specialist team contact details for back up advice/support
- Patient consent to treatment documented

Patient is retained by HPFT
Information continues to be passed onto GP about patient's care

Referral made to SPA:
Crisis referrals seen by Crisis Assessment and Treatment Team (CATT) within 4 hours
Urgent referrals contacted by SMHTOP Team within 72 hours
Standard referrals assessed within 4 weeks in E&NCCG and 6 weeks in HVCCG by SMHTOP

- GP accepts the responsibility for the on-going prescribing and monitoring of the dementia medication and assumes the responsibilities as detailed in the prescribing support document.
- GP monitors adverse effects and drug interactions and takes the appropriate actions with access to back up advice/support

There is a trigger for referral of patient to secondary care specialist service:

- Difference of opinion GP and carer about stopping medication
- Consideration of switch to memantine in severe dementia
- Uncertainty about side effects or benefits
- Behavioural issues requiring community team input (whether or not the patient is taking anti-dementia medication).

GP conducts an annual monitoring review in primary care including the cognitive, functional, behavioural and global assessment and takes appropriate actions

Worthwhile effect on cognitive, global, functional or behavioural symptoms?

Yes: continue dementia medication

No: Discontinue dementia medication

Prescribing Support Document: Drugs for the Management of Dementia (donepezil, galantamine, rivastigmine, memantine)

Change History

Version number	Change details	Date
V 1.0	Transfer of Care Guidelines	June 2016
V 2.0	Document updated to Prescribing support document. Transfer of care form removed. This is replaced by a clinic letter sent by Psychiatrist to the GP. GP fax back reply for refusal of transfer of care – removed. **Note:** New dementia guidelines are being developed to include NICE 2018 recommendations. Current document in place till new guidelines developed and approved.	November 2018

1. Introduction

The clinical management of patients with dementia in Hertfordshire, including the prescribing of dementia drugs, has been the responsibility of the Specialist Mental Health Teams for Older People (SMHTOP), Hertfordshire Partnership University NHS Foundation Trust (HPFT) since the implementation of NICE guidance (TA 217) in 2011.The Early Memory Diagnosis and Support Service (EMDASS) is responsible for the diagnosis and initiation of medication.

There is now agreement between both Herts Valleys Clinical Commissioning Group (HVCCG), and East and North Herts Clinical Commissioning Group (ENHCCG) and HPFT for appropriate patients who are maintained on a stable dose of dementia medication to be transferred to the General Practitioner (GP) for on-going prescribing and monitoring in primary care.

The aim of this guideline is to ensure that the transfer of care of the patient with dementia from EMDASS to the GP is safe and appropriate by providing the following information: -

- The roles and responsibilities of the secondary care specialist team, the GP, the CCG's and patient/carer.
- Criteria for the transfer of prescribing from secondary care to the GP.
- Clinical information on the drugs used in the management of dementia including the monitoring requirements of these medications in primary care.
- Cognitive, global, functional and behavioural assessment scales (where appropriate).
- Criteria for when medication should be stopped.
- When and how to refer back to specialist services.
- Secondary care contact details for support and back-up advice.

The GP will assume both the clinical and legal responsibility of prescribing the dementia drugs and the clinical management of the patient. Patients considered complex by the HPFT Old Age Psychiatrist will be excluded from the transfer of care arrangement.

2. NICE guidance

NICE TA 217 (Mar 2011) recommends: -

- The three anticholinesterase (AChE) inhibitors donepezil, galantamine and rivastigmine as options for managing mild to moderate Alzheimer's disease

- The glutamate receptor antagonist, memantine, alone (monotherapy) as an option for managing Alzheimer's disease for people with:
    - Moderate Alzheimer's disease who are intolerant of or have a contraindication to AChE inhibitors
    - Severe Alzheimer's disease
- Treatment to be initiated only by specialists in the care of patients with dementia
- Treatment should be continued only when it is considered to be having a worthwhile effect on cognitive, global, functional or behavioural symptoms
- Patients who continue on treatment should be reviewed regularly using cognitive, global, functional and behavioural assessment. Carer's views on the patient's condition on follow-up should be sought*.
- AChE inhibitor treatment should normally be started with the drug with the lowest acquisition cost (taking into account required daily dose and the price per dose). However, an alternative AChE inhibitor could be prescribed if considered appropriate taking into account adverse event profile, expectations about adherence, medical comorbidity, possibility of drug interactions and dosing profiles.
- Except as part of properly constructed clinical studies, do **not** use:
    - acetylcholinesterase inhibitors or memantine for cognitive decline in vascular dementia
    - acetylcholinesterase inhibitors in mild cognitive impairment.

***Please see Section 9 (Monitoring Requirements in Primary Care) for further details**

3. Criteria for transfer of prescribing and monitoring to primary care

The following must apply before the GP is asked to accept on-going prescribing responsibility and monitoring of the patient in primary care: -

- The GP practice, if based in HVCCG, has signed up to the dementia component of the HVCCG Local Incentive Scheme (LIS).
- The patient must have undergone the appropriate assessments and shown a beneficial response to treatment.
- The patient is stable on a maintenance dose of dementia drug
- The patient's care plan is stable* or predictable

The ***inclusion*** criteria include:

- *The patient must have undergone the appropriate assessments and shown a beneficial response to treatment.*
- *The patient is❖stable on a maintenance dose of dementia drug*
- *The patient's care plan is stable or predictable*
- *Alzheimer's Disease*
- *Dementia in Parkinson's Disease*
- *Dementia with Lewy Bodies*
- *Mixed dementia (has to include one of the above types of dementias)*

The ***exclusion*** criteria include: -

- *Vascular dementia*
- *Fronto-temporal dementia*
- *Memantine for mild dementia (unlicensed)*
- *Patients on dual/combination therapy*

❖'Stable' for the purpose of the transfer of care arrangement is defined as when the patient is living at their usual address without requiring any additional psychiatric service other than the memory clinic (EMDASS).

The request for the transfer of care will usually be made when the patient has been on 6- 8 months of treatment.

4. Areas of responsibility

	CCG RESPONSIBILITIES
1	The CCG will confirm acceptance of the Local Incentive Scheme (LIS) with practices. In the event that a practice declines to sign the LIS, the CCG will notify HPFT.
2.	The CCG will monitor the LIS implementation and continue to work towards a comprehensive post-diagnostic support network.
3.	Both CCG's will review the transfer of care guideline annually.

	SPECIALIST RESPONSIBILITIES (HPFT Consultant and associated team)
1	The specialist team will be aware (having been notified by the CCG) of practices that are *not* LIS signatories and will ensure that transfers of prescribing care are not initiated to practices that are not LIS signatories.
2.	Initial assessment of patient to include tests of cognitive (MMSE or alternative score), global, functional and behavioural symptoms and activities of daily living.
3	Confirm the diagnosis of dementia. Ensure patient has access to an overall programme of care.
4	Counsel patients and carers on the implications of the diagnosis, the likelihood of potential benefits and side effects of treatment and treatment endpoints and include the consequence of poor compliance. Provide patient with comprehensive advice and information. HPFT's Choice and Medication website can be used: http://www.choiceandmedication.org/hertfordshire/class/13/ http://www.choiceandmedication.org/hertfordshire/medications/115/
5	Initiate and stabilise treatment with donepezil, galantamine, rivastagmine or memantine if clinically appropriate, and ensure compliance. • The preferred option is **generic donepezil standard tablets** for mild to moderate severity Alzheimer's disease. Generic rivastigmine tablets would normally be a 2nd line choice if donepezil cannot be tolerated. • Where there are specific patient reasons where these preferred choices cannot be used, the rationale for the choice of drug/formulation must be communicated to the GP and documented in the patient's notes. • Memantine monotherapy is reserved as an option in moderate Alzheimer's disease for people who are intolerant or have a contraindication to AChE inhibitors, or in severe Alzheimer's disease. • HPFT fully supports the use of equivalent cost-effective 'branded generics' in primary care i.e. galantamine XL.
6	During the first 6-8 months of treatment: - • Monitor patient regularly for compliance, side-effects and signs of deterioration. Report adverse events via the yellow card scheme, if appropriate. • Increase the dose at appropriate intervals or switch to alternative drug/formulation if there are signs of intolerance.
7	Assessment of patient for evidence of treatment efficacy at approximately 3 months (2 – 4 months depending on time spent at sub-therapeutic doses during titration). Medication should be continued only where there has been an improvement or no deterioration in MMSE (or alternative) score, together with evidence of global improvement on the basis of behavioural and/or functional assessment.
8	Discontinue treatment where there has not been benefit or where there has been deterioration of the condition.
9	If appropriate for patient to continue with medication, GP to be promptly informed to take on further prescribing and monitoring in primary care after 6-8 months. The following information (as a minimum) to be provided to the GP in order that the on-going prescribing and monitoring can be taken on in primary care - see checklist in Section 5 – Communication and Handover from secondary to primary care:- • Prescribing support document • Clear diagnosis and care plan • Confirmation that the patient is stable on a maintenance dose and there has been benefit from treatment. • Eight weeks prescription of on-going medication from last appointment • Specialist team contact details for GPs to obtain advice and support. • Patient has been fully informed with regards to their treatment and consent has been discussed and documented including the change in where their future prescriptions will be issued from (GP not HPFT). This includes informing patients that their medication (i.e. galantamine XL) may be switched to an equivalent

	'branded generic' product by the GP. The 'branded generic' is a preferred CCG choice which is cost-effective in primary care.
10	Specialist to ensure that patient/carer is informed and made aware of their responsibilities (as detailed under patient/carer responsibilities in these guidelines) for when transfer of care to the GP occurs.

GP RESPONSIBILITIES	
1	Review the request from the specialist to take on the transfer of prescribing and monitoring of the patient. Acceptance is assumed (except in relation to practices that have not signed the Local Incentive Scheme (LIS)). Prompt communication to EMDASS if prescribing responsibility is not accepted for other reasons (within 2 weeks), including the clinical reason for not taking on the transfer of care. Responsibility cannot be declined on grounds of cost of medication.
2	Check sufficient information has been provided to take on the responsibility of continued prescribing and monitoring – see Section 5 'Communication and handover from secondary to primary care' checklist. Request any missing information to be provided from EMDASS consultant before taking on the prescribing in primary care. Transfer of care can be refused by GP if information is insufficient.
3	Prescribe donepezil, galantamine, rivastigmine or memantine at the maintenance dose recommended. Switch to the CCG preferred cost-effective 'branded generic' product where relevant i.e. galantamine XL.
4	Monitor treatment as stated in Section 7 'Monitoring in Primary Care' in the prescribing support document. Report adverse events via the yellow card scheme, if appropriate.

5	Seek advice from the specialist on any aspect of patient care of concern to the GP that may affect treatment. See Section 6 and 7 'Contact details for backup advice and support' in the prescribing support document..
6	Check for possible drug interactions when newly prescribing or stopping concurrent medication.
7	Discontinue treatment when there has not been benefit or where there has been deterioration of the condition – see Section 10 'Stopping Medication' in the prescribing support document..
8	Refer patient back to secondary care when appropriate , clearly highlighting that the referral relates to a patient under this transfer scheme– see Section 11 'Triggers for re-referral to secondary care' in the transfer of care guidelines.

PATIENT/CARER RESPONSIBILITIES	
1	Report to their GP if they do not have a clear understanding of or have any concerns with their treatment with donepezil, rivastigmine, galantamine or memantine.
2	Inform their GP of any over the counter products (the GP will know all the other medications that are being prescribed for the patient) and tell the pharmacist of their prescribed medication when buying over the counter medications
3	Report any adverse effects to the GP or whilst taking donepezil, galantamine, rivastigmine or memantine.
4	Report any changes in disease symptoms to the GP.
5	Following the transfer of prescribing, obtain further prescriptions for dementia medication from the GP and not HPFT.

5. Communication and Handover from Secondary to Primary care

The following information should be provided/action undertaken when requesting the transfer of prescribing of the patient with dementia to primary care

- Clear diagnosis and care plan including information that has been discussed with patient and carer.
- Details of drug treatment and dose.
- Confirmation that the patient is ❖stable on a maintenance dose and there has been benefit from treatment.
- Eight weeks prescription of on-going medication from last appointment.
- Specialist team contact details for GPs to obtain advice and support.
- Confirmation that patient has been fully informed with regards to their treatment and consent has been discussed and documented including the change in where their future prescriptions will be issued from (GP not EMDASS) . This includes informing patients that their medication i.e. galantamine XL may be switched to an

equivalent 'branded generic' product by the GP. The 'branded generic' is a preferred CCG choice which is cost-effective in primary care.

- The post-diagnostic support service will work in parallel with the secondary care titration clinic. The post-diagnostic support service will provide the following information to the GP (if consent from the patient is obtained):
  - Confirmation of the standard information handed to the patient.
  - Details of whether advanced care plan has been agreed or discussed.
  - Any patient or carer specific information (at discretion of professional).
  - Any useful telephone numbers.
  - Report at discharge.
  - Specialist team contact details for back-up advice and support.

6. The Principles of Access to Back-Up Advice:

- GPs are expected to use the usual crisis pathway for crisis support (as with other patients).
- The EMDASS/SMHTOP team will respond to GP requests for back-up advice by telephone ***within 24 hours*** and will provide access to consultant clinics ***within 2 weeks*** (when needed).
- The GP will be able to contact the post-diagnostic support service (Inc. the dementia carers support nurse) to enable targeted support when patients/carers may be approaching crisis. The GP will be able to refer to the Alzheimer's Society, or other community based organisations (as usual) for signposting and support.

7. EARLY MEMORY DIAGNOSIS & SUPPORT SERVICE (EMDASS)

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8. Supporting Information

(For full details, please refer to the current individual drug Summary of Product Characteristics, SPC, and BNF)

Dosage and administration Treatment should be started at the lowest dose and built up to a tolerable dose within the effective range	
Donepezil	5mg once daily in the evening, just before bed, increased if necessary after 1 month to 10mg once daily. Orodispersible tablet available (significantly more expensive)
Rivastigmine	Capsule and liquid Starting dose 1.5mg twice daily with meals. Increase dose to maximum tolerated up to 6mg twice daily. Minimum of 2 weeks between dose increases. Patch *(only if capsule/liquid cannot be administered)* 4.6mg/24hours increasing to 9.5mg/24hours after a minimum of 4 weeks.
Galantamine	Standard release tablet and liquid Start at 4mg twice daily preferably with meals. Increase to maximum tolerated up to 12mg twice daily. Minimum of 4 weeks between dose increases. Modified release tablet 8mg once daily increasing to maximum tolerated up to 24mg once daily. Minimum of 4 weeks between doses.
Memantine	Tablet and oral solution 5mg once daily, increased in steps of 5mg at weekly intervals, until reaching the recommended maintenance dose of 20mg once daily. Oral solution should be dosed onto a spoon or into a glass of water.

Absolute Contraindications	
All drugs	Where there is hypersensitivity to the active substance or any of the excipients.
Donepezil	Known sensitivity to piperidine derivatives
Galantamine	Severe hepatic/renal impairment or those who have both significant renal and hepatic dysfunction. Urinary retention or history of prostatic condition
Donepezil & galantamine	Patients with rare hereditary problems of galactose intolerance, the Lapp lactase deficiency or glucose-galactose malabsorption
Rivastigmine	Known hypersensitivity to carbamate derivatives or severe liver impairment
Memantine	Patients with rare hereditary problems of fructose intolerance should not take oral solution (contains sorbitol).

Cautions – to be used with caution in the following			
AChE inhibitors (donepezil, galantamine, rivastigmine)	*May exacerbate/induce extrapyramidal symptoms* • AV node block • Severe asthma • Concomitant digoxin or beta-blocker therapy • Urinary symptoms (avoid use of galantamine)	• People at increased risk of peptic ulcers (those with history of ulcer disease or on concomitant NSAIDs	• Obstructive pulmonary disease or active pulmonary infections • Epilepsy • CVD

Memantine	• History of convulsions • Patients with recent MI, uncontrolled hypertension or uncompensated congestive heart failure were excluded from the clinical trials and there is limited data for the use in these patients. These patients should be closely supervised. • Patients who have had drastic diet changes e.g. carnivore to vegetarian or a massive ingestion of alkalising gastric buffers since this causes alkalisation of urine which reduces elimination of memantine.

Adverse effects of AChE inhibitors (donepezil, galantamine, rivastigmine) and suggested actions

There are two practically important groups of adverse effects:

1. GI – common S/Es include abdominal pain, nausea, vomiting, diarrhoea, anorexia, weight loss
2. Cardiac
   - heart block (sino-atrial block, AV block) – this is rare but potentially serious and easily missed
   - bradycardia – if this occurs, carry out an ECG. If symptoms of collapse or dizzy spells and PR interval >200ms, then stop AChE inhibitor

Adverse effects	***Symptoms/signs***	***Frequency***	***Suggested actions***
GI symptoms	Anorexia, nausea, vomiting and diarrhoea	Very common	Generally mild and transient. Can be minimised by taking drug after food. If symptoms persist, reduce dose. If unsuccessful, consider switch to alternative AChE inhibitor.
	May enhance predisposition to gastric or duodenal ulceration	Uncommon/rare	Discontinue treatment if ulcer develops. Care with those at risk of or with active gastric or duodenal ulcer. Patient should be monitored regularly for symptoms.
Cardiovascular symptoms	Bradycardia	Uncommon/rare	**Seek urgent review.** Carry out an ECG. If symptoms of collapse or dizzy spells and PR interval >200ms then stop AChE inhibitor. Increased risk with 'sick sinus syndrome', sinoatrial or atrioventricular block or those receiving concomitant treatment with **digoxin or beta-blockers.** In such cases, stop treatment and undertake urgent review.
Neurological symptoms	Dizziness, headache, insomnia, somnolence	Very common/ common	Generally mild and transient. If symptoms persist, reduce dose. If unsuccessful, consider switch to alternative AChE inhibitor.
	Syncope	Common/ uncommon	Reduce dose. If symptoms persist, consider switch to alternative AChE inhibitor.
	Extrapyramidal symptoms (including worsening of Parkinson's disease)	Rare	Reduce dose. If symptoms persist, consider switch to alternative AChE inhibitor
	Decreased seizure threshold	Rare	Extreme caution in epilepsy
Skin	Galantamine *has been associated with **serious skin reactions** including Stevens Johnson Syndrome (SJS), acute generalised exanthematous pustulosis (AGEP) and erythema multiforme.*	Rare	*It is recommended that patients and carers are advised to **monitor** for skin reactions. In the advent of an apparent skin reaction patients should be advised to **stop treatment and seek medical advice***
General disorders	Asthenia, fatigue	Common	Generally mild and transient. If symptoms persist, reduce dose. If unsuccessful, consider switch to alternative AChE inhibitor.

Respiratory symptoms	May cause bronchoconstriction	No data available	Caution in patients with history of asthma or COPD or those with an active pulmonary infection (pneumonia).
Psychiatric symptoms	Agitation, confusion and insomnia	Common	Reduce dose. If symptoms persist, consider switch to alternative AChE inhibitor.

Adverse effects of memantine and suggested actions			
Appears to be well tolerated in practice but it is important to note that it might be easy to miss distressing side effects when it is used exclusively in a population with severe dementia.			
Adverse effects	***Symptoms/signs***	***Frequency***	***Suggested actions***
GI symptoms	Constipation	Common	PRN or regular laxative
Cardiovascular symptoms	Hypertension	Common	Reduce dose and review BP. Consider discontinuation
Neurological symptoms	Dizziness, headache, drowsiness	Common	Reduce dose and review symptoms. Consider discontinuation
Respiratory symptoms	Dyspnoea	Common	Reduce dose and review symptoms. Consider discontinuation

Drug Interactions	
All AChE inhibitors	• May interact (antagonism of effects) with medicines that have anticholinergic activity e.g. oxybutynin, antipsychotics and tricyclics. • Potential for synergistic activity with medicines such as succinylcholine (suxamethonium) and other neuromuscular blocking agents, cholinergic agonists or beta-blocking agents that have effects on cardiac conduction. • Potential for additive effects with other drugs that share the same side effects e.g. beta blockers and bradycardia, SSRIs and anorexia)
Donepezil and galantamine	Metabolised via CYP3A4 and CYP2D6 pathways in the liver. Inhibitors of these pathways (e.g. erythromycin, clarithromycin, ketoconazole, fluvoxamine, fluoxetine, paroxetine) may increase drug levels and patients may experience increased side effects. A dose reduction may be required. Enzyme inducers (e.g. rifampicin, phenytoin, carbamazepine and alcohol) may reduce levels so care should be taken with concurrent prescribing.

Costs (Source: Drug Tariff and Dictionary of Drugs & Medical Devices July 2016)

All costs below are quoted for maximum doses. Treatment is often at maximum dose although practice varies. In the case of oral rivastigmine, the maximum is often not reached.

Drug	**Formulation**	**Dose**	**28 days cost**	**Annual Cost**
Donepezil	Tablets	10mg od	£1.35	£18
	Orodispersible tablets	10mg od	£8.61	£112
Rivastigmine	capsules	6mg bd	£31.16	£406
	Oral solution 2mg/ml (120ml bottle)	6mg bd (6ml)	£193.64 (120ml = £96.82)	£2524
	Patches	13.3/24	£77.97	£1016
		9.5/24	£24.96	£325
		4.6/24	£77.97	£1016
Galantamine	Standard release tablets	8mg bd	£61.13	£797
		12mg bd	£74.10	£966
	Modified release capsules (prescribed generically)	16mg od	£64.90	£846
		24mg od	£79.80	£1040

	Modified release capsules (branded generic Gatalin XL®)	16mg od	£32.45	£423
		24mg od	£39.90	£520
	Oral solution 4mg/ml (100ml bottle)	8mg bd (4ml)	£240 (100ml = £120)	£1800
		12mg bd (6ml)	£240	£2640
Memantine	Tablets	20mg od	£1.68	£22

9. Monitoring requirements in primary care.

Monitor for adverse effects and drug interactions (see section 6 for details and suggested actions). The most relevant are:

- Exacerbation of asthma and COPD
- Anorexia and weight loss
- GI ulcer or bleed
- AV node block as a possible cause of collapse
- Potential additive effects with other drugs that share the same side effects (e.g. beta-blockers and bradycardia; SSRIs and anorexia)

Annual Monitoring Review in Primary Care

The following is a summary of the components to be included in the annual monitoring review of the patient:-

1. Compliance - is the medication being taken properly?		
2. Physical Health Monitoring		
Weight	If weight loss has started or accelerated after starting AChE inhibitor medication, this may be the cause	
Pulse	If <60, carry out an ECG. If PR interval > 200ms, stop drug or discuss with mental health specialist	
U+Es and LFTs	Renal or hepatic impairment may reduce an individual's tolerability to rivastigmine and/or donepezil	
Overall tolerance to medication	GI symptoms - anorexia, nausea, vomiting and diarrhoea Neurological symptoms – headaches, dizziness, drowsiness, syncope See section 6 for full details and suggested actions	
3. Impact on global functioning		
Functional and behavioural assessment is best made via a discussion with the patient and carer (it might be important to see the carer alone to elicit behavioural problems). [Rating scales do exist for functional, behavioural and global assessment but most were designed for research purposes and none has become widely established for practical clinical use. See Appendix 1 for available assessment scales.]		
Functional assessment	Impact on daily living. Is there declining function?	Review whether referral to Social Services (HCS) is required for declining function
Carer Impact	Does the carer value the effect of the medication?	It is important to take into account the impact of the medication to the carer.
Behavioural assessment	New behavioural problems? Is the patient displaying behavioural and psychological symptoms of dementia (BPSD)?	Review whether standard or urgent referral to SMHTOP via SPA is needed for new behavioural problems
4. Cognitive Assessment		
• Some patients are distressed by repeated use of formal cognitive scoring tests. Therefore it is not always necessary to repeatedly use a formal scale to measure cognition as this can also be assessed via patient and carer interview. Use of formal cognitive scales is not mandatory. • It is also important to consider the global functioning of the patient by discussion with the carer/relatives. It is often the case that no management change is likely whatever the result of the test (i.e. the global functional,		

behavioural and global assessments are positive and the dementia is not severe).

- However in some cases a formal test can help find severe dementia and highlight that ongoing benefit of treatment is unlikely. An unexpectedly large change in a test score might prompt a conversation about other problems that need management – e.g. increased care package.
- When the use of a formal cognitive scoring test is appropriate (e.g. when there has been a significant deterioration in the global functioning), consider using either of the following open access primary care validated scales – 6CIT (six item cognitive impairment test) or GPCOG (the General Practitioner assessment of Cognition). See Appendix 1

5. Is the medication still of overall benefit?

10. Stopping Medication

Medication should be stopped if:

1. **There is no cognitive, behavioural, functional or global benefit.**
   For GP management it is anticipated that if there is still an ***overall*** benefit and providing the patient is tolerating the treatment and there are no contraindications, the treatment will be maintained until such a time as it becomes inappropriate such as in extreme frailty

2. **Consideration should be given to stopping AChEI medication when Alzheimer's disease has become severe.** Severe dementia is not a licensed indication for this class of medication. However, if there is still a beneficial impact on global functioning assessed by the carer/relative then the AChEI could be continued, even when dementia enters the more severe stages, providing the drug is well tolerated. GPs should be aware that this would be off-label use and would be accepting the responsibility for the off-label prescribing.

3. **If the patient cannot tolerate side effects** (see section 8 – adverse effects)

It is advisable to give reducing doses – e.g. donepezil 5 mg od for a month if the patient has been taking 10mg. Similar gradual reduction with other drugs may be used. Research evidence suggests there might not be a withdrawal reaction from AChEI medication (AD 2000 trial) but anecdotally these have been reported and therefore appears to be a reasonable precaution.

11. Triggers to refer to secondary care

- Difference of opinion between primary care team and carer about stopping medication
- Consideration of switch to memantine in severe dementia
- Uncertainty about side effects or benefits
- Behavioural problems that would require the community team whether or not the patient is taking anti-dementia medication

Appendix 1

References and Assessment Scales

- **NICE TA 217** - Donepezil, galantamine, rivastigmine and memantine for the treatment of Alzheimer's disease. NICE March 2011

- **Mini-mental state examination** – (Folstein and Folstein 1974) – the publishers do not allow free use for health professionals

- **6CIT** – This is free to use for health professionals and easy to find online – (Brooke P, Bullock R; Validation of a 6 item cognitive impairment test with a view to primary care usage. Int J Geriatr Psychiatry. 1999 Nov; 14(11):936-40)
  http://www.patient.co.uk/doctor/six-item-cognitive-impairment-test-6cit

- **GPCOG** - This is free to use for health professionals and easy to find online (Brodaty et al, JAGS 2002; 50:530-534)
  http://www.patient.co.uk/doctor/general-practitioner-assessment-of-cognition-gpcog-score

- **Abbreviated Mental Test Score** (**AMTS**) – This is quick and popular in general hospitals. It is not validated in primary care, though compares well against MMSE in some research. (Hodgkinson HM (1972) Evaluation of a mental test score for assessment of mental impairment in the elderly. Age and Ageing 1, 233-8)
  http://www.patient.co.uk/doctor/abbreviated-mental-test-amt

- **Bristol Activity of Daily Living Scale** (**BADLS**) – This assesses function. It is not recommended as a routine primary care assessment but can be a useful guide to assessing function less formally (Assessment of Activities of Daily Living in Dementia: Development of the Bristol Activities of Daily Living Scale R. S. Bucks et al - Age and Ageing 1996:25:113-120) copyright status unknown
  http://www.health.fgov.be/internet2Prd/groups/public/%40public/%40dg1/%40acutecare/documents/ie2divers/19073273_nl.pdf

- **Assessment of Motor and Process Skills (AMPS):** a standardised observation-based evaluation of a person's quality of performance of relevant and chosen personal or domestic activities of daily living.

- **Model of Human Occupation Screening Tool (MoHOST):** The MOHOST addresses client's motivation for occupation, pattern of occupation, communication/interaction, process, and motor skills, and environment. The MOHOST was designed to be used to document progress towards occupational therapy intervention goals as well as to screen for occupational therapy services.

- **Pool Activity Level (PAL) © 2015 Jackie Pool Associates:** The PAL Instrument contains a valid and reliable tool for assessing level of ability which is recommended in the National Clinical Practice Guideline for Dementia (NICE, 2006), for activities of daily living and for leisure activity. The instrument also contains profiling tools for interpreting the assessment in order to plan and deliver effective, enabling care and support.

- **Just checking (**http://www.justchecking.co.uk/) an activity monitoring system which can be used to establish routines and patterns of movement within the home. The information gained from this assessment can help inform decision making about future interventions and/or support needed, provide reassurance or as a baseline to compare against in the future if behaviours change.