MANAGING PSYCHIATRIC SYMPTOMS IN NEUROLOGIC DISEASE

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DISCLOSURES

• No financial disclosures
• Off-label (non-FDA approved) use of medications will be discussed
MANAGING PSYCHIATRIC SYMPTOMS IN NEUROLOGIC DISEASE

- Evaluation
- Common neuropsychiatric conditions
  - Alpha-synucleinopathies:
    - Diffuse Lewy Body Dementia (DLB)
    - Parkinson's disease (PD)
  - Huntington's disease (HD)
  - Multiple sclerosis (MS)
- Considerations for care of patients with neuropsychiatric symptoms

EVALUATION (IN ADDITION TO A FULL PSYCHIATRIC EVAL)

- Confirm evidence of cognitive impairment:
  - History (patient, family/caregiver)
    - ADLs and IADLs, wandering, agitation, aggression
  - Neuropsychological testing
    - "Bedside": MoCA vs MMSE
    - Formal neuropsychological testing
- Rule out other conditions that affect cognition: depression, anxiety, delirium, intoxication, medications
- Neuro/PE exam: attention to motor exam, A fib, bruits
- Imaging
  - Can be useful on initial evaluation
  - Repeat only if suspecting onset of acute and/or reversible cause like NPH, new CVA
- Lab testing (Chemistry, CBC, TSH, B12/folate, RPR, HIV)
  - Typically low yield (but you don’t want to miss them!)
**BEDSIDE TESTING**

### Mini Mental Status Exam (MMSE)
- Proprietary
- Can complete under 10 min
- Score <24/30 suggests impairment
- Sensitivity of 87%, specificity of 82% in hospital-based sample
- Not sensitive for mild dementia
- Changes of 2 points or less not considered significant
- Weaker screen for visuospatial/constructional skills

### Montreal Cognitive Assessment (MoCA)
- At mocatest.org (free)
- Around 10 min to administer
- 3 versions as well as a blind version
- Threshold of scores <26: sensitivity 94%, specificity 60%
- Lower cut-offs in veterans seeking care at a VA

### Both
- Screening for baseline cognition cannot occur if patient is currently delirious
- Requires effort, ability to write
- Need to know educational background, including learning disabilities, total education
- Deficits in patients with high educational attainment may not be obvious on exams
- Sensory impairments can falsely lower score (but are important to function)
- Should be followed over time
- Repeat any dramatically changed results

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**ALPHA-SYNUCLEINOPATHIES**

- Diffuse Lewy Body Dementia
- Parkinson’s disease
- (Multiple System Atrophy)
ALPHA-SYNUCLEINOPATHIES

Lewy Bodies: Intraneuronal inclusion bodies containing alpha-synuclein
- Distribution varies in the different diseases:
  - Parkinson’s disease: substantia nigra, the basal nucleus of Meynert, locus ceruleus. Later in the cortex
  - Lewy body dementia: anterior frontal and temporal lobes, the cingulate gyrus, and the insula; also substantia nigra and locus ceruleus, nucleus basalis of Meynert, and brainstem nuclei

REM Sleep Behavior disorder
- Failure of paralysis during REM sleep leading to complex motor behaviors
- Found in > Half of all PD and Lewy body dementia cases
- Possible predictor for developing an alpha-synucleinopathy (Jung et al 2017)
- Patients with REM sleep behavior disorder and MCI (vs MCI alone) more non-amnestic features (89%) such as executive function deficits and depression (Szeto et al 2017)

Typical treatment for REM sleep behavior disorder is clonazepam
- Use benzos in the elderly should be weighed against risks
- Can also consider melatonin or pramipexole

DIFFUSE LEWY BODY DEMENTIA (DLB)
LEWY BODY DEMENTIA, DSM 5 CRITERIA

- Criteria met for major or mild neurocognitive disorder
- Insidious onset and gradual progression
- For probable major or mild neurocognitive disorder with Lewy bodies: two core features, or one suggestive feature with one or more core features. For possible major or mild neurocognitive disorder with Lewy bodies: only one core feature, or one or more suggestive features:
  - Core diagnostic features:
    - Fluctuating cognition with pronounced variations in attention and alertness (looks like delirium)
    - Recurrent visual hallucinations (VH) that are well-formed and detailed
    - Spontaneous features of parkinsonism, with onset subsequent to the development of cognitive decline
  - Suggestive diagnostic features:
    - Meets criteria for REM sleep behavior disorder
    - Severe neuroleptic sensitivity
- The disturbance is not better explained by cerebrovascular disease, another neurodegenerative disease, the effects of a substance, or another mental, neurological, or systemic disorder

DIFFUSE LEWY BODY DEMENTIA (DLB)

- Considered second most common type of dementia (10-20%)
- Some patients show mixed features of AD and DLB or DLB and PD with mixed neuropathology
- Cognitive impairment PRECEDES parkinsonism (in contrast to PD)
- Death up to 10-15 years after onset (typically faster than AD)
- Pathology (gold standard for diagnosis):
  - Lewy bodies in cortical neurons diffusely (anterior frontal and temporal lobe, the cingulate gyrus, and the insula; also substantia nigra and locus ceruleus, nucleus basalis of Meynert, and brainstem nuclei)
  - Loss of dopamine transporter (DaT) seen at autopsy in striatum
  - Clinical diagnosis (no blood test, imaging that is definitive)
    - DaTSCAN (single photon emission CT scan) may facilitate dx
    - Alpha-synuclein is found in peripheral nerve fibers in DLB patients but not control dementia pts (Donadio et al 2017) → possible test
DIFFERENTIATING DLB FROM AD

DLB
- More vivid hallucinations, apathy, and dysphoria
- Greater impairment of attention, executive and visuospatial functions
- Parkinsonism more common
- Periods of stupor not related to delirium
- Relative preservation of memory function
- Difference is attenuated with age
- Faster progression of illness
- Higher cost of care per month of survival

AD
- Less hallucinations
- More recent memory impairment

Bowman et al 2017
Mueller et al 2017
Bronnick 2016
Oliveira et al 2015
Nagahama et al 2017

PHARMACOLOGIC TREATMENT OF DLB: ANTICHOLINESTERASE INHIBITORS

- There is loss of cholinergic transmission in DLB
  - Lewy bodies found in the nucleus basalis and pontine nuclei
- Treatment with anticholinesterase inhibitors can reduce VH
- Resolution of VH correlated with reduction of PET activity in medial occipital cortex with donepezil treatment (Satoh 2010)
- Anticholinesterase inhibitors do not seem to worsen motor symptoms in RCT (Mori et al 2015)
ANTICHOLINESTERASE INHIBITORS IN DLB

- Donepezil improved symptoms in DLB as compared to placebo in a 12 week RCT (N=140):

![Graph A: MMSE](image1)

- Absence of deterioration in CGI: Improvement

![Graph B: Neuropsychiatric inventory](image2)

DONEPEZIL FOR DLB

![Graph C: Neuropsychiatric inventory improvements](image3)

- CGI: Improvement

Absence of deterioration

*FIGURE 3: Mean changes (95% confidence intervals) of individual Neuropsychiatric Inventory items.*
### MMSE

<table>
<thead>
<tr>
<th>Study or Subgroup</th>
<th>Mean</th>
<th>SD</th>
<th>Total</th>
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<th>Total</th>
<th>Mean Difference* (95% CI)</th>
<th>Mean Difference* (95% CI)</th>
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<td>75</td>
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<td>61</td>
<td>10.7%</td>
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### Neuropsychiatric inventory

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<td>0.60 (-15.75, -0.50)</td>
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<tr>
<td>Total (95% CI)</td>
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<td>644</td>
<td>100.0%</td>
<td>3.80 (0.00, 7.10)</td>
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<td>Test for subgroup difference: Z=1.37, k=3, p=0.27, F=45%</td>
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Stinton et al. 2015

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### Pharmacologic treatment of DLB

- **Anticholinesterase inhibitors, first line**
- **Antipsychotics can be used but may be sensitivity in terms of dosing, side effects (worsening confusion, movement symptoms)**
  - **Olanzapine:** post-hoc trial of AD patients that including DLB patients showed improvement in psychotic sx (Cummings 2002); however, side effects in 1/3. No RCT data
  - **Quetiapine:** does not worsen motor symptoms but has inconsistent data to support improvement in psychotic symptoms
  - **Risperidone:** worsened cognition (MMSE change -2.3) Culo et al. 2010
- **Antidepressants have not been studied systematically.**
  - **Citalopram** is not efficacious or well-tolerated, 70% discontinuing for adverse effects (Culo et al. 2010)
- **Memantine:** weak data, with low numbers, mixed with PDD patients
  - **May improve survival** (Subendorff et al. 2014)
- **ADR of hallucinations**
- **Medications in pipeline:** intepirdine a selective 5HT6 receptor antagonist that enhances ACh
PARKINSON’S DISEASE (PD)

- Chronic progressive neurodegenerative disorder characterized by:
  - Tremor
  - Bradykinesia
  - Rigidity
  - Postural instability

- Affects 1%, M>F

- Loss of pigmented dopaminergic neurons in the substantia nigra that project to the striatum

- Lewy bodies found in substantia nigra, the basal nucleus of Meynert, locus ceruleus, cerebral cortex, sympathetic ganglia, the dorsal vagal nucleus, myenteric plexus, cardiac sympathetic plexus

- “Parkinsonism” (features of PD) may be caused by medications, trauma, or stroke with different prognoses and response to treatment

[Image of Parkinson's disease symptoms and medical context]
NON-MOTOR SYMPTOMS OF PD

- Increasing recognition of symptoms not improved with DA replacement
- Alterations of other pathways: 5HT, NE, ACh
- Non-motor symptoms (psychosis and dementia) predict mortality
- Non-motor symptoms predict nursing home placement
- Non-motor symptoms are more common in patients who were older at age of disease onset

Mood symptoms (depression)
- Dementia
- Psychosis
- Sleep changes
- Dopaminergic therapy complications
  - Psychotic symptoms
  - Impulse control disorders
- Autonomic dysfunction
- Pain
- Gastrointestinal changes (constipation)
- Impaired olfaction

Increasing recognition of symptoms not improved with DA replacement
Alterations of other pathways: 5HT, NE, ACh
Non-motor symptoms (psychosis and dementia) predict mortality
Non-motor symptoms predict nursing home placement
Non-motor symptoms are more common in patients who were older at age of disease onset

Forsaa et al 2010
Zhou et al 2013
https://i.ytimg.com/vi/OdhhsPyt0OY/maxresdefault.jpg

DEPRESSION DUE TO PARKINSON’S DISEASE

- Up to 50% of patients with PD have depressive symptoms
- Depression is associated with worsened functional impairment and reduced quality of life
- Depression is associated with a more rapid cognitive decline in PD
- Features of the disease (masked face/blunted affect), avolition/apathy, poor concentration, insomnia may be part of the degenerative process
- Worsening debility, self-consciousness about tremor, and increasing dependency can contribute to poor mood

Reidel et al 2010
DEPRESSION DUE TO PARKINSON’S DISEASE (SAD-PD)

- Multi-center RCT of antidepressants for depression in PD; N=115 randomized to paroxetine, venlafaxine or placebo
- Primary outcome was change in HAM-D
  - Paroxetine 10-40mg
    - Improved insomnia
  - Venlafaxine XR 37.5mg – 225mg
    - More likely to increase BP
- Movement symptoms were relatively mild
- Higher pre-treatment depression and lower anxiety scores predicted greater improvement (Moonen et al 2014)
- Affective, then somatic, followed by cognitive improvements (Broen et al 2016)

Richards et al 2012

DEPRESSION DUE TO PARKINSON’S DISEASE

- Sertraline and amitriptyline were beneficial in open label trials (Antonini 2006; Marino et al 2008)
- Nortriptyline (25-75mg) was more efficacious than paroxetine CR (12.5-37.5mg) in 8 wk RCT (N=52) using HAM-D (Menza et al 2009)
  - 6/11 patients in paroxetine group dropped out due to side effects vs 4/12 in nortriptyline group
- MAO inhibition with antidepressant may enhance response: ADAGIO study, N= 192 patients on an antidepressant (citalopram 20mg, amitriptyline 50mg, trazodone 100mg, sertraline 100mg, paroxetine 30mg, escitalopram 10mg) with added rasagiline 1-2mg (MAO-B inhibitor) vs. placebo (Smith et al, 2014)
  - 72 week, double-blind to rasagiline status
  - No restriction of tyramine in diet
  - No events of serotonin syndrome or tyramine hypertensive crisis
  - Rasagiline group had less decline in mood as compared to placebo group
- ECT can be effective in treating mood symptoms in PD and can improve motor symptoms (Anderson et al 1987)
PARKINSON’S DISEASE DEMENTIA, DSM 5 CRITERIA

- Criteria met for major or mild neurocognitive disorder
- Disturbance occurs in the setting of established Parkinson’s disease
- Insidious onset and gradual progression of impairment
- Neurocognitive disorder is not attributable to another medical condition and is not better explained by another mental disorder

**Major or mild neurocognitive disorder probably due to Parkinson’s disease** should be diagnosed if 1 and 2 are both met. **Major or mild neurocognitive disorder possibly due to Parkinson’s disease** should be diagnosed if 1 or 2 is met:

  1. No evidence of mixed etiology (i.e., absence of other neurodegenerative or cerebrovascular disease or another neurological, mental, or systemic disease or condition likely contributing to cognitive decline).
  2. Parkinson’s disease clearly precedes the onset of the neurocognitive disorder

PARKINSON’S DEMENTIA (PDD)

- Subcortical dementia with slower processing, difficulties with construction, and memory concerns
- Dementia is typically a late feature of PD and up to 80% of patients will have it at 20 years
- As compared to age-matched controls, 4-6x greater risk of dementia in PD (Aarsland et al 2001)
- In contrast to Lewy Body Dementia, the movement disorder precedes the change in cognition
- Dementia in PD is associated with increased apathy, delusions, hallucinations as compared to PD patients without dementia (Leroi et al 2012)
- Rivastigmine is FDA approved for mild to moderate PD dementia
EFFICACY OF RIVASTIGMINE AND DONEPEZIL FOR PDD
CGI IMPROVEMENT

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EFFICACY OF RIVASTIGMINE AND DONEPEZIL FOR PDD
(MMSE)

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<td>Subtotal (95% CI)</td>
<td>213</td>
<td></td>
<td>208</td>
<td>38.8%</td>
</tr>
<tr>
<td>Heterogeneity: ( \tau^2 = 1.83, \chi^2 = 8.94, df = 3, p = 0.03 ), corrected for multiple comparisons: ( \hat{p} = 0.03 )</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Test for overall effect: ( Z = 0.63 ), ( p = 0.53 )</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PDD, rivastigmine</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Errne et al. (22)</td>
<td>0.8</td>
<td>3.8</td>
<td>335</td>
<td>-0.2</td>
</tr>
<tr>
<td>Subtotal (95% CI)</td>
<td>335</td>
<td></td>
<td>166</td>
<td>24.3%</td>
</tr>
<tr>
<td>Heterogeneity: not applicable</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Test for overall effect: ( Z = 2.92 ), ( p = 0.003 )</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total (95% CI)</td>
<td>692</td>
<td></td>
<td>510</td>
<td>100.0%</td>
</tr>
<tr>
<td>Heterogeneity: ( \tau^2 = 0.27, \chi^2 = 12.20, df = 7, p = 0.09 ), corrected for multiple comparisons: ( \hat{p} = 0.03 )</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Test for overall effect: ( Z = 4.10 ), ( p = 0.0001 )</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Test for subgroup differences: ( \chi^2 = 3.19, df = 3, p = 0.36 ), corrected for multiple comparisons: ( \hat{p} = 0.36 )</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
EFFICACY OF MEMANTINE IN PDD

CGI IMPROVEMENT

- Studies complicated by not separating PDD from DLB patients
- Data for memantine are weak in 2 meta-analyses and show no difference in cognition
- Movement Disorder Society recommends rivastigmine, and considers both donepezil and memantine with “insufficient evidence; acceptable risk”

<table>
<thead>
<tr>
<th>Study or Subgroup</th>
<th>Experimental Group</th>
<th>Control Group</th>
<th>Risk Ratio (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ennis et al. (2007)</td>
<td>31</td>
<td>60</td>
<td>28</td>
</tr>
<tr>
<td>Lleo et al. (2008)</td>
<td>6</td>
<td>10</td>
<td>6</td>
</tr>
<tr>
<td>Subtotal (95% CI)</td>
<td>37</td>
<td>34</td>
<td>70</td>
</tr>
</tbody>
</table>

Heterogeneity: $\chi^2 = 0.47, df = 1, p = 0.49, I^2 = 0\%$
Test for overall effect: $Z = 0.50, p = 0.61$
Test for subgroup differences: $Z = 1.64, df = 2, p = 0.44, I^2 = 0\%$

PARKINSON’S DISEASE PSYCHOSIS (PDP)

- Consensus definition: psychotic symptoms > 1 month, not due to another cause, with subtypes:
  - Presence or absence of dementia
  - Presence of insight
  - Concurrent use of dopaminergic medications
- PDP typically arises later in the disease (~10 years after initial diagnosis)
  - Initially, insight is retained, with symptoms progressing and insight lost
- Risk factors for PDP:
  - Exposure to dopaminergic medications
  - Advancing age
  - Increasing impairment in executive dysfunction/dementia
  - PD severity
  - Comorbid psychiatric symptoms (depression, anxiety)
  - Fatigue
  - Sleep disorders
  - Visual impairment
  - Polypharmacy
PARKINSON’S DISEASE PSYCHOSIS (PDP)

- Psychotic symptoms can include:
  - Hallucinations, Illusions
  - Paranoia
  - Delusions: typically younger age of onset than hallucinations
  - Minor hallucinations: “false sense of presence”

- Psychotic symptoms are associated with:
  - Poorer quality of life
  - Caregiver distress
  - Worse outcomes:
    - Nursing home placement
    - Mortality
  - Prevalence varies in the literature, but may be as high as 60%

<table>
<thead>
<tr>
<th>Primary psychotic disorder</th>
<th>PDP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hallucinations</td>
<td></td>
</tr>
<tr>
<td>Most often auditory, occasionally somatic persecutory in nature</td>
<td>Primarily visual with persistent images superimposed on a normal environment, false sense of presence and illusions also common</td>
</tr>
<tr>
<td>Typically no insight</td>
<td></td>
</tr>
<tr>
<td>Delusions</td>
<td></td>
</tr>
<tr>
<td>Paranoid, bizarre (being followed, mistreated, poisoned, mind-reading, ideas of reference, thought broadcasting, thought insertion, thought withdrawal), religious, grandiose (special powers)</td>
<td>Paranoid in nature typically related to jealousy, infidelity, abandonment, paranoia</td>
</tr>
<tr>
<td>Mania</td>
<td></td>
</tr>
<tr>
<td>Can be present</td>
<td>Typically not present</td>
</tr>
</tbody>
</table>

Jakel & Stacy 2012

ETIOLOGY OF PDP

- Psychotic symptoms in untreated PD is thought to be low, but is unknown
- Little data on natural course of untreated PD, as rarely see untreated advanced disease
- Historical accounts of hallucinations in late-stage PD, especially with dementia and depression
- Majority PDP symptoms likely related to dopaminergic agents
- Increased risk with dementia, # of medications, pergolide treatment

<table>
<thead>
<tr>
<th>Dopamine agonists</th>
<th>Odds ratio (confidence interval)</th>
<th>Odds ratio adjusted for age, sex, dementia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pergolide</td>
<td>2.22 (1.01–4.87)</td>
<td>2.01 (1.22–5.45)</td>
</tr>
<tr>
<td>Rotineral</td>
<td>1.18 (0.60–2.32)</td>
<td>1.05 (0.55–2.11)</td>
</tr>
<tr>
<td>Pramipexole</td>
<td>0.52 (0.22–1.24)</td>
<td>0.94 (0.33–1.66)</td>
</tr>
<tr>
<td>Cabergoline</td>
<td>0.32 (0.16–0.63)</td>
<td>0.65 (0.39–1.09)</td>
</tr>
<tr>
<td>Levodopa</td>
<td>0.14 (0.07–0.26)</td>
<td>0.11 (0.06–0.19)</td>
</tr>
</tbody>
</table>

Eder et al 2009
DIAGNOSIS AND MANAGEMENT OF PDP

- Clinical history of psychotic symptoms
- Examination of patient
- Collateral histories from family and caregivers
- Rule-out other causes, such as delirium, Lewy body dementia, AD
- Treatment aims to reduce psychosis without worsening the movement symptoms
  - Reduce doses of dopaminergic agents as able
  - Reduce polypharmacy with adjuvants especially anticholinergics
- If reduction in medication does not work, can consider addition of another medication, typically an atypical antipsychotic
  - Low dose clozapine (50mg): effective in an RCT (Pollock 2004) without worsening of motor symptoms
  - Quetiapine also does not worsen movements in studies, but RCTs have failed to show benefits
  - Other antipsychotics worsen movement symptoms
  - Rivastigmine has data for improving hallucinations, but other AChE inhibitors do not
- Consider that ECT can improve psychotic symptoms in PD and improve movements (Usui et al 2011; Ueda et al 2010)

ANTIPSYCHOTICS IN PDP

### TABLE 3. CHANGES IN SCORES FOR PRIMARY OUTCOME MEASURES FROM BASELINE TO FOLLOW-UP.*

<table>
<thead>
<tr>
<th>PRIMARY OUTCOME MEASURE</th>
<th>PLACEBO GROUP (N=27)</th>
<th>CLOZAPINE GROUP (N=27)</th>
<th>P VALUE</th>
</tr>
</thead>
<tbody>
<tr>
<td>UDPRS, total score</td>
<td>-2.8±1.5</td>
<td>-6.4±2.9</td>
<td>0.36</td>
</tr>
<tr>
<td>UDPRS, motor score</td>
<td>-1.8±1.2</td>
<td>-3.6±1.9</td>
<td>0.34</td>
</tr>
<tr>
<td>UDPRS, tremor score</td>
<td>-0.2±0.4</td>
<td>-1.5±0.5</td>
<td>0.02</td>
</tr>
</tbody>
</table>

**Measures of parkinsonism**

<table>
<thead>
<tr>
<th>PRIMARY OUTCOME MEASURE</th>
<th>PLACEBO GROUP (N=27)</th>
<th>CLOZAPINE GROUP (N=27)</th>
<th>P VALUE</th>
</tr>
</thead>
<tbody>
<tr>
<td>BPRS score</td>
<td>-2.6±1.3</td>
<td>-9.3±1.5</td>
<td>0.002</td>
</tr>
<tr>
<td>BPRS-M score</td>
<td>-2.5±1.2</td>
<td>-8.6±1.3</td>
<td>0.003</td>
</tr>
<tr>
<td>CGI-S score</td>
<td>-0.5±0.2</td>
<td>-1.6±0.5</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>SAPS score</td>
<td>-2.8±1.9</td>
<td>-11.8±2.0</td>
<td>0.01</td>
</tr>
<tr>
<td>MMSE score</td>
<td>-0.1±0.4</td>
<td>0.0±0.5</td>
<td>0.90</td>
</tr>
</tbody>
</table>

*This analysis was based on the actual treatment each patient received. UDPRS denotes Unified Parkinson's Disease Rating Scale, BPRS Brief Psychiatric Rating Scale, BPRS-M the modified BPRS, CGI-S Clinical Global Impression Scale, SAPS Scale for the Assessment of Positive Symptoms, and MMSE Mini-Mental State Examination. Plus–minus values are means±SE, and negative values indicate improvement.

**CONVENTIONALLY, PSYCHOSIS IN PDP HAS BEEN TREATED WITH ATYPICAL ANTIPSYCHOTICS THAT BLOCK DOPAMINE**

- Goal is symptom reduction without worsened movements
- Data for clozapine has been replicated; considered an acceptable choice for PDP with required lab monitoring
- Quetiapine has had at least 7 trials (3 blinded)
  - Reduction in BPRS in the unblinded trials
  - Ineffective in blinded trials
- Quetiapine compared to clozapine (rater-blinded) and they were not found to differ (no placebo group; Eng et al 2010)
- Evidence for quetiapine is weak but it is frequently chosen due to ease of use as compared to clozapine
PIMAVANSERIN

- First FDA-approved med for PD psychosis (expedited with “breakthrough therapy” status) in 2016
- Serotonin 2A receptor inverse agonist (opposite effect of agonist) and antagonist
  - 5HT 2A activation: depression, dyskinesias, psychosis, and tremor
  - Dorsal raphe nuclei are lost before nigral neurons, reducing striatal 5HT (Huot & Fox, 2013)
  - Increased 5HT2A receptors in temporal cortex in patients with VH
- Some serotonin 2C antagonism
- Not dopaminergic, anticholinergic, histaminergic, adrenergic
- Metabolized through CYP3A4; strong CYP3A4 inhibitors increase NUPLAZID concentrations (Reduce the NUPLAZID dose by one-half); Strong CYP3A4 inducers may reduce NUPLAZID level
- 95% protein bound
- Recommended dose: 34 mg po qday; (two 17-mg tablets) without titration
- Mean plasma half-lives: pimavanserin (57h) and the active metabolite 200h

**Renal Impairment:** No dosage adjustment in mild to moderate renal impairment. Not recommended in patients with severe renal impairment.

**Hepatic Impairment:** Not recommended

- Costs around $39/17mg tab

---

**PIMAVANSERIN**

- Phase II and 2/3 phase III trials did not show efficacy, 1 trial stopped early (Bozymski et al 2017)
- FDA approval based on Phase III trial:
  - improvement in SAPS-PD (scale assessment for positive symptoms) and CGI (clinical global impression scale)
- Meta-analysis (Yasue et al 2016) shows improvement and well-tolerated (4 trials, N=417 receiving pimavanserin, N=263 receiving placebo)
PIMAVANSERIN SIDE EFFECT PROFILE

- Treatment-emergent adverse events group in all participants who received ≥1 dose of study drug (occurring in ≥5% in either treatment)

<table>
<thead>
<tr>
<th></th>
<th>Placebo (n=94)</th>
<th>Pimavanserin 40 mg (n=104)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nausea</td>
<td>6 (6%)</td>
<td>6 (6%)</td>
</tr>
<tr>
<td>Peripheral edema</td>
<td>3 (3%)</td>
<td>7 (7%)</td>
</tr>
<tr>
<td>Urinary tract infection</td>
<td>11 (12%)</td>
<td>14 (13%)</td>
</tr>
<tr>
<td>Fall</td>
<td>8 (9%)</td>
<td>11 (11%)</td>
</tr>
<tr>
<td>Confusional state</td>
<td>3 (3%)</td>
<td>6 (6%)</td>
</tr>
<tr>
<td>Headache</td>
<td>5 (5%)</td>
<td>1 (1%)</td>
</tr>
<tr>
<td>Hallucination (including visual)</td>
<td>4 (4%)</td>
<td>7 (7%)</td>
</tr>
</tbody>
</table>

- QTc interval change 13.5 msec at a 2x therapeutic dose
- Concentration-dependent QTc interval prolongation in the therapeutic range
- Mean increases in QTc interval of ~5-8 msec at 34mg
- Still has the same black-box warning for antipsychotics in dementia
- Causes phospholipidosis (lungs, kidneys, muscle, retina) in animal studies at supratherapeutic concentrations

SLEEP PROBLEMS IN PD

- Occur in 60-98% of patients with PD
- Disturbances include:
  - Sleep fragmentation, insomnia
  - Daytime somnolence
  - Sleep-disordered breathing
  - Restless legs/periodic limb movements
  - Nightmares
  - REM sleep behavior disorder
- Minimal studies to examine treatment specific to PD patients
  - Doxepin or CBTi + bright light therapy more effective than placebo in small study of 18 patients (Rios Romenets et al 2013)
  - Eszopiclone improved multiple awakenings, not total sleep time, in RCT of N=30 (Menzo et al 2010)
- Recommend directing treatment based on underlying symptom given lack of data
MEDICATION-INDUCED SYMPTOMS: IMPULSE CONTROL DISORDERS

- ICARUS trial examined outpatients on DA replacement therapy for 2 years, incidence of impulse control disorders: 26.5-29.3%

- Most common: compulsive eating, followed by punding, compulsive sexual behavior, gambling and buying disorder

- Punding: stereotyped, repetitive, stereotype movements including manipulations of objects, excessive grooming, hoarding, fidgeting with clothing

- Risk factors: male, younger, earlier age at onset, longer disease duration, more severe non-motor symptoms, depressive symptoms, sleep impairment and poorer PD-related quality of life

- PD motor severity and cognitive function did not predict impulse control disorders

- First line treatment is reduction of dopaminergic agent

- No evidence with naltrexone, amantadine

HUNTINGTON’S DISEASE

Enfermedad de Huntington (Corea de Huntington) ENFERMEDAD AUTOSÓMICA DOMINANTE CAUSADA POR REPETICIÓN DE TRIPLETES

HUNTINGTON’S DISEASE (HD)
HUNTINGTON’S DISEASE (HD)

- Gradual, progressive hyperkinetic disorder, insidious onset in 4-5/million worldwide
- Autosomal dominant, caused by a CAG repeat expansion in the first exon of the huntingtin gene on chromosome 4 (genetic test available)
  - Normal 6-26 polyglutamine repeats
  - 27-36: unstable repeats
  - 36 repeats disease phenotype with incomplete penetrance
  - 40 repeats and greater: 100% penetrant
  - Disease severity correlates with CAG repeat length
  - Age of onset negatively correlates with repeat length, death 15-20 y after onset
    - 10-14% are juvenile cases with more parkinsonian features, seizures, myoclonus
  - Genetic anticipation (↑ repeat length in subsequent generations); paternal
  - Multiple areas of the brain and body express huntingtin; striatum is vulnerable
  - Abnormal CAG repeat expansion results in toxic protein inclusions
  - Loss of medium spiny GABAergic interneurons in the striatum and cortex leading to changes in GABA, DA, and Glu transmission

HD SYMPTOMATOLOGY

- Motor symptoms: chorea, dystonia, gait disturbances, eye movements; late parkinsonism
- Neuropsychiatric symptoms:
  - Mood symptoms: depression, manic-like symptoms (irritability)
  - Obsessions and compulsions
  - Anxiety
  - Hypersexuality
  - Psychotic symptoms: paranoia, delusions
  - Disinhibition
  - Apathy
- Cognitive symptoms:
  - Poor judgment
  - Poor memory
  - Decreased insight
  - Inflexible thought
  - Decreased concentration
- Symptoms may be subtle and predate the chorea

MRI, T1-weighted (A) and T2-weighted (B) axial images show caudate atrophy and enlargement of the frontal horns. On CT, an axial image (C) from another patient shows similar findings.
HD: NEUROPSYCHIATRIC SYMPTOMS

- Up to 73% will be diagnosed with a psychiatric disorder, at any time during the disease course
- Mood symptoms: depression, manic-like symptoms (irritability with disinhibition) 33-76%
- Obsessions and compulsions 10-76%
- Psychosis 3-11%
- Anxiety
- Hypersexuality
- Disinhibition
- Apathy
- Risk of suicide is higher than population rate, and extends to non-affected family members (as high as 20%)
- Psychotic symptoms treated with antipsychotics may have beneficial effects on the motor disorder
- Trials without effect: Lamotrigine, Lithium
- No quality trials of sufficient size or duration to make conclusions regarding antidepressants
- No Trials: depakote

HD: COGNITIVE SYMPTOMS

- Cognitive symptoms (subcortical dementia: executive function, multi-tasking, decision-making)
  - Poor judgment
  - Poor memory
  - Decreased insight
  - Inflexible thought
  - Decreased concentration
- Rivastigmine for 6 months did not show improvements in cognition as based on neuropsych testing in early HD (N=18; Sesok et al 2014).
- No effect with memantine and donepezil, citalopram (for cognition), L-acetyl carnitine, riluzole, amantadine, atomoxetine
- Modafinil: improved attention but not cognition or mood with worsened working memory and visual recognition (Blackwell et al 2008)
APPROACH TO MANAGEMENT OF HD SYMPTOMS

● There are no disease-modifying treatments → symptomatic treatment
● There is minimal data high quality to support specific medications for neuropsychiatric and cognitive symptoms
● Motor symptoms: antidopaminergic agents (tetrabenazine approved)
● Mood symptoms: antidepressants (avoid bupropion), mood stabilizers
● Psychotic symptoms: antipsychotics (D2 blockade may improve chorea)
● No effects with:
  ● Coenzyme Q10: for total functional capacity. No difference (McGarry et al 2016)
  ● Sativex (nabiximols), equimolecular combination of delta-9 THC and cannabidiol: no effect on motor, behavioral, and cognitive domains (Moreno et al 2016).
  ● Ethyl-eicosapentaenoic acid (EPA) treatment (Ferreira et al 2015)
● Recommend multi-modal care (neurology, psychiatry, PT/OT, speech, SW)

UNIQUE CHALLENGES TO HD

● Knowing about the disease (i.e. having a positive HD gene testing) prior to overt onset of symptoms is itself a serious psychological burden
● Impact of being raised by, living with and/or caring for ill family member also with the disease can impact stress
● Familial financial toxicity of an autosomal dominant illness that strikes during working years
● Impact on family planning, child rearing
● Stigmatization as a carrier
**MULTIPLE SCLEROSIS (MS)**

- Demyelinating disease of the CNS that can affect any region
- Cognitive impairment (40-60%) and depression are common complaints
- Cognitive impairment is generally mild and in mild dementia range in 20%
  - Found in all subtypes and worsens with time
- Not all cognitive domains are affected evenly
  - Typically memory and executive function
  - Rarer: semantic language, attention
- Correlation with MRI findings is robust; however, only 1/3 to 1/2 of variance is explained by MRI
- Impacts ability to maintain employment, ADLs, IADLs, benefit from physical rehab
- Evaluation of cognition is challenging
  - Patient report may not correlate with severity and may reflect depression
- Neuropsych testing may be needed to assess for subtle deficits
- Treatments aimed at:
  - Disease modification
  - Symptomatic management

Amato et al 2012
DISEASE MODIFYING TREATMENTS FOR COGNITION IN MS

- Potential to reverse the processes that lead to cognitive dysfunction
- Approved agents reduce nervous system damage on MRI, reduce atrophy
- Treatments aimed at improving the underlying neuroimmunological processes such as interferon beta-1b and beta-1a are associated with modest cognitive improvements
- Limited data due to methodology (typically a secondary endpoint, studies underpowered to detect effect)
- Patients will typically be on these medications prior to coming to psychiatry for further assistance with cognition

SYMPTOMATIC TREATMENTS FOR COGNITION IN MS

<table>
<thead>
<tr>
<th>Reference</th>
<th>Drug</th>
<th>Number treated</th>
<th>Design</th>
<th>Duration</th>
<th>Primary outcome</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Snijders et al. [80]</td>
<td>4 aminohippuride</td>
<td>20</td>
<td>DB, PC, RCT, CO</td>
<td>4 weeks</td>
<td>Cognitive function</td>
<td>-</td>
</tr>
<tr>
<td>Bevers et al. [74]</td>
<td>3,4 diaminopyridine</td>
<td>28</td>
<td>DB, PC, RCT, CO</td>
<td>2 x 30 days</td>
<td>Leg strength</td>
<td>-</td>
</tr>
<tr>
<td>Rossini et al. [76]</td>
<td>4 aminohippuride</td>
<td>49</td>
<td>DB, PC, RCT, CO</td>
<td>6 months</td>
<td>Fatigue (NP Tests secondary)</td>
<td>-</td>
</tr>
<tr>
<td>Geisler et al. [61]</td>
<td>Amantadine or pemoline</td>
<td>16</td>
<td>DB, PC, RCT</td>
<td>6 weeks</td>
<td>Multiple NP Tests</td>
<td>-</td>
</tr>
<tr>
<td>Wilken et al. [72]</td>
<td>Modafinil</td>
<td>23</td>
<td>Randomized, evaluator blind</td>
<td>4 months</td>
<td>Multiple NP Tests</td>
<td>+</td>
</tr>
<tr>
<td>Lange et al. [69]</td>
<td>Modafinil</td>
<td>8</td>
<td>DB, PC, RCT</td>
<td>8 weeks</td>
<td>D2 Alertness Test</td>
<td>+</td>
</tr>
<tr>
<td>Starkoff et al. [71]</td>
<td>Modafinil</td>
<td>59</td>
<td>DB, PC, RCT</td>
<td>5 weeks</td>
<td>MPS1 cognitive deterioration</td>
<td>-</td>
</tr>
<tr>
<td>Möller et al. [68]</td>
<td>Modafinil</td>
<td>62</td>
<td>DB, PC, RCT</td>
<td>8 weeks</td>
<td>Symbol Digit Modalities Test Paired Auditory Serial Addition Test</td>
<td>-</td>
</tr>
<tr>
<td>Hantel et al. [64]</td>
<td>Methylphenidate</td>
<td>14</td>
<td>DB, PC, RCT</td>
<td>Single dose</td>
<td>Paired Auditory Serial Addition Test</td>
<td>+</td>
</tr>
<tr>
<td>Benedikt et al. [65]</td>
<td>L-amphetamine</td>
<td>19</td>
<td>Counterbalanced, within-subject</td>
<td>4 x single does</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Morrow et al. [66]</td>
<td>L-amphetamine</td>
<td>108</td>
<td>DB, PC, RCT</td>
<td>4 weeks</td>
<td>Symbol Digit Modalities Test</td>
<td>-</td>
</tr>
<tr>
<td>Sumowski et al. [67]</td>
<td>L-amphetamine (re-analysis of 66)</td>
<td>108</td>
<td>DB, PC, RCT</td>
<td>4 weeks</td>
<td>California Verbal Learning Test 2; Brief Visuospatial Memory Test Revised</td>
<td>+</td>
</tr>
<tr>
<td>Krupp et al. [77]</td>
<td>Donepezil</td>
<td>35</td>
<td>DB, PC, RCT</td>
<td>24 weeks</td>
<td>Selective Reminding Test; Self Report</td>
<td>-</td>
</tr>
<tr>
<td>Krupp et al. [78]</td>
<td>Donepezil</td>
<td>61</td>
<td>DB, PC, RCT</td>
<td>24 weeks</td>
<td>Selective Reminding Test; Self Report</td>
<td>-</td>
</tr>
<tr>
<td>Shagasskand et al. [79]</td>
<td>Rivastigmine</td>
<td>30</td>
<td>DB, PC, RCT</td>
<td>12 weeks</td>
<td>Wechsler Memory Scale</td>
<td>-</td>
</tr>
<tr>
<td>Lovara et al. [81]</td>
<td>Memantine</td>
<td>58</td>
<td>DB, PC, RCT</td>
<td>16 weeks</td>
<td>Paired Auditory Serial Addition Test and Selective Reminding Test</td>
<td>-</td>
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COGNITION IN MS: COCHRANE REVIEW

- 4 RCTs with all subtypes of MS and at least mild memory complaints
- Examined: donepezil, ginko biloba, memantine and rivastigmine vs placebo
- No serious adverse events
  - Nausea, diarrhea, somnolence, constipation
- Low quality data, poorly matched variables, small samples
- Conclusion: No evidence to support pharmacologic intervention to target cognition with existing data

DEPRESSION IN MS

- Etiology unclear:
  - May be due to demyelinating lesions
  - Some disease modifying treatments could promote depression
- There has been concern that interferon-beta-1b and glatiramer worsened depression, but data don’t support this (Schippling et al 2016)
- Therapeutic trials have limited data, small numbers, many patients lost to follow-up
- Cochrane review for antidepressants showed only quality studies of paroxetine and desipramine for 12 weeks compared to placebo with a trend toward efficacy
- Recommend treating depression as per general guidelines
CONSIDERATIONS FOR CARE
(WITH LIMITED DATA)

MANAGING CONDITIONS WITH LIMITED DATA

- Many disease conditions affect multiple neurotransmitter systems and our understanding is evolving
- Patients may present with features of multiple types of dementia, let this guide medication choices
- Consider that some symptoms may be related to the specific neurologic rather than a separate DSM 5 diagnoses
- Despite limited evidence base, we still have patients with specific concerns
- Some conditions have no FDA-approved medications
- At this point, treating specific symptoms with knowledge of disease and comorbidities is warranted
  - Monitor side effects, including the specific impact on the motor aspects of the disease
  - Attention to interactions with the medications used to target motor symptoms
HOW TO APPROACH NEUROPSYCHIATRIC SYMPTOMS

- Counsel patients and families before neuropsychiatric symptoms occur, if possible; risk of delirium
- Identify target symptoms; follow with a rating scale like the NPI, CGI, BPRS
- When symptoms arise, full medical, neurologic, environmental assessment
- Select intervention with least risk and monitor results
  - Environmental modification
  - Redirection
  - Caregiver education
- If this fails, consider pharmacologic management with least risky medication
- If this fails, consider atypical antipsychotic, after thorough discussion with patient and caregiver re: risks and black box warning
  - Medication monitoring for effect
  - Symptom monitoring
- Reassess and stop medication if clear benefit is not seen

Keenon & Sulzer 2013

PHARMACOLOGY IN THE ELDERLY

- “Everything” increases falls risk
- Start low and go slow
- Think about renal and liver function
- Get an ECG and follow QTc and pulse (particularly with antipsychotics and ACHe inhibitors)
- Think about polypharmacy and medication burden
- If possible, avoid benzos, anticholinergics, and excessive pain medications
- Medications may not be tolerated as well
  - TCAs may have more side effects (worsening glaucoma, sedation, cognition, delirium)
CONSIDER THE BASICS

- Consider impact of general comfort care:
  - Bowel regimen/GERD – constipation is common in PD
  - Pain (may need to schedule if pain is chronic and patient cannot reliably convey pain)
- Maximize improvements in sensory impairment
  - Glasses, hearing aids
  - Lights on during day/off at night
- Enrich the sensory environment
  - Manipulatives
  - Calming music
  - Warm milk at night
- Same conditions and life stressors often seen as those without (substance use, crises of aging, caregiver stress, other medical illness)

ATTENTION TO SAFETY

- Medications (other chemicals) stored properly
  - Administered by family/caregiver
- Driving:
  - DMV notification for need for reassessment
  - Also consider riding lawn mowers, ATVs, motorcycles, motorbikes
- Firearms
  - Locked, unloaded
- Knives, other weapons, tools
- Loose rugs, stairs, bathroom safety
- Supervision, chimes, home alarms

"Any tool is a weapon if you hold it right."
~ Ani DiFranco
CAREGIVER BURNOUT

- Impact of burden of previously shared responsibilities (housework, cooking, bills, taxes, etc)
- Additional burdens of caring for individual
  - Physical care (ADLs such as bathing, feeding, dressing, toileting)
  - Care of agitated patient
- Loneliness of losing aspects of the relationship to the disease
- Lack of a break or assistance
- Caregiver factors
  - Physical and cognitive impairments
- Lack of understanding of pathology
  - “Bad” behaviors can appear volitional
  - Repetitive conversations can be annoying and frustrating
- Expectations for improvement or difficulty accepting that symptoms will likely worsen
- Relationship factors
  - Old relationship dynamics often persist

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