

Medications used in dementia: a review of evidence

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Background

Dementia is an acquired global impairment of intellect, memory and personality, without impairment of consciousness. It is usually progressive in nature. The management of dementia is mainly two faceted; pharmacological and non-pharmacological.

Aims

To review the evidence regarding the efficacy of cholinesterase inhibitors, memantine and antipsychotics, in the treatment of dementia.

Methods

We searched ALOIS, Cochrane database, PubMed, Scopus and Google scholar using key words; dementia, cognitive enhancers, cholinesterase inhibitors and memantine as individual words for relevant review articles.

Results

There is evidence of efficacy of donepezil, rivastigmine and galantamine in mild to moderate Alzheimer's dementia (AD). Evidence also suggests that memantine has efficacy in moderate to severe AD. Further, memantine may benefit behavioural and

psychological symptoms of dementia (BPSD), and has also being considered for the treatment of dementias of lesser severity.

Evidence also supports the use of AChE inhibitors in vascular dementia and dementia due to Parkinson's disease (PDD). But evidence regarding efficacy in dementia of Lewy Body (DLB) is not very strong.

Antipsychotics can be used for the management of BPSD if other measures fail, keeping in mind the black box warning for the risk of stroke. The use of antidepressants and mood stabilisers are limited by the lack of strong evidence.

Conclusion

The current evidence supports the use of cholinesterase inhibitors and memantine in patients with Alzheimer's dementia, vascular dementia and PDD, with a positive impact on global assessment, cognitive function, behavioural disturbance and activities of daily living rating scales. The effect in DLB remains unclear.

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Introduction

Dementia is an acquired global impairment of intellect, memory and personality, but without impairment of consciousness. It is usually progressive in nature. The pattern of cognitive impairment depends on the type and severity of dementia. Impairments of cognitive function are commonly accompanied, and occasionally preceded by, deterioration in emotional control, social behaviour, or motivation resulting in significant impairment in activities of daily living (1). The non-cognitive symptoms associated with dementia such as mood, psychotic and sleep-wake cycle disturbances – i.e., the behavioural and psychological symptoms of dementia (BPSD) – and are seen in about 50-80% of patients (2).

The two main classification systems used in the world to diagnose psychiatric illness are the Diagnostic and Statistical Manual of Mental Disorders – 5 (DSM-5) and the International Classification of Diseases (ICD-10) (1). The DSM-5, released in 2013, has replaced the word dementia with the term 'major neurocognitive disorder (NCD)' (3). Both the ICD-10 and DSM-5 require

impairment in two or more cognitive domains, sufficient to cause difficulties in social and occupational functioning, for the diagnosis of dementia. Screening tests for dementia include the Mini Mental State Examination (MMSE) and the Montreal Cognitive Assessment (MoCA). More definitive tests for diagnostic and monitoring purposes of dementia include the Alzheimer's Disease Assessment Scale (ADAS), Addenbrook's Cognitive Assessment-Revised (ACE-R) and the Repeatable Battery for the Assessment of Neuropsychological Status (RBANS).

Alzheimer's disease (AD) is the commonest type of dementia, accounting for about 50-60% of all dementias. The prevalence of AD is 1 to 2% at the age of 65, but the prevalence doubles every 5 years after that (4). Memory impairment is prominent although it is not the only cognitive domain that is affected (5). Vascular dementia (VaD) accounts for about 20-25% of all dementias. The management options include controlling of cerebrovascular and metabolic risk factors (5,6). The clinical features of dementia with Lewy bodies (DLB) and Parkinson's disease with dementia (PDD) are similar. The diagnosis of PDD rests on the occurrence of dementia in