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New BPSD Guidelines

Treating the behavioural and psychological symptoms of dementia (BPSD) is a challenge in LTC. It is estimated that BPSD symptoms like agitation, aggression, hallucinations, delusions, anxiety, apathy, inappropriate sexual expression, etc., affect 80% of LTC residents. The *Canadian Coalition for Seniors' Mental Health* (CCSMH) has published guidelines to help us manage this challenging condition.

Much ink is dedicated to assessment, monitoring, and non-drug measures, but I'll skip to the pharma section on agitation (definitions and rating scales are provided in the document). The panel recommends NOT initiating treatment with cholinesterase inhibitors (donepezil, galantamine, and rivastigmine) or memantine for moderate to severe agitation in dementia. These drugs can slow cognitive and functional decline, but trials typically don't include advanced BPSD patients. As a result, there is no support for this indication. These meds may offer minimal benefit when treating dementia with a psychotic component. According to a large meta-analysis, memantine may reduce the emergence of agitation, so there may be value in starting it early in the disease process.

Citalopram is the only antidepressant recommended for treating agitation. Its use is based on a large trial that dosed citalopram at 30mg per day. Seniors are usually limited to 20mg due to QT concerns so effectiveness may suffer. Trazodone is often prescribed for agitation, but evidence supporting its use is sparse.

Three antipsychotics (risperidone, aripiprazole, and brexpiprazole – aka Rexulti®) are recommended for short-term use in Alzheimer's with severe agitation. Long-term use, particularly with risperidone, is associated with increased mortality, stroke and movement disorders. Quetiapine should not be used unless the antipsychotics above are ineffective or not tolerated. Olanzapine has the highest CVA and mortality risk, so it should be reserved for short-term emergency use. Older antipsychotics, like Haldol®, are similarly restricted. Lorazepam 0.5 to 1 mg i.m. is another emergency option. Nabilone has some support (natural cannabinoids do not) in agitation treatment. It may be considered after the above conventional agents. Carbamazepine has the least robust support. Valproic acid, on the other hand, should not be used. It causes a host of adverse effects and accelerates brain atrophy.

More recommendations for drug and non-drug treatment of depression, anxiety, and sexually inappropriate behaviour are provided. This is an exceptional reference for BPSD treatment.

Breztri or Trelegy

Burning question…which is better, Breztri Aerosphere® or Trelegy Ellipta®? The two triple therapy (steroid, β-2 agonist, antimuscarinic) COPD inhalers have never been compared head-to-head, but a large observational study attempted to do so.

The *British Med Journal* study evaluated 20,000 pairs of inhaler users (≥ 40 years) over 33 months. Breztri® users had the first moderate to severe COPD exacerbation 9% more often than Trelegy® users, and the first severe event 29% more often. It appears that Trelegy® was more effective, but we can't draw such conclusions from an observational study. I wonder how many Breztri® users added a spacer and if their technique was proper. Product safety appeared comparable, as pneumonia-related hospital admissions occurred at the same interval in each group.

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