

# The Prudent Prescriber

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Pharm Reps ≠ Rational Prescribing

(PR)



(RP)

### Antipsychotic Medications in Patients with Alzheimer's Dementia: Time for a Different Approach?

Clara Barton, the staff nurse from the Green Acres nursing home is calling and asking for a prescription for risperdal for your patient Larry Smith, an 85-year-old with Alzheimer's dementia who for the last week has intermittently yelled at the top of his lungs for hours on end. You can hear Larry droning his plaintive cry over Clara's palpable frustration. What do you do?

In the last few years, there have been several studies and an FDA decision that are important to know about if you are prescribing either typical or atypical antipsychotic medications to patients with Alzheimer's dementia.

☐ In the October 12th, 2006 NEJM, Schneider, et al. in a double-blind, placebo-controlled trial treated 421 outpatients with AD and psychosis, aggression or agitation with the atypical antipsychotics (olanzapine, quetiapine, and risperidone) or placebo.

Results:

1) There was no large clinical benefit of treatment with these atypical antipsychotic medications as compared with placebo.

2) Adverse effects limited the overall effectiveness of the atypicals in this clinical setting. The most common adverse events were extrapyramidal signs, gait disturbance, sedation, dizziness and dyskinesia.

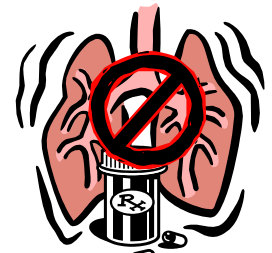
☐ Earlier this month, Ballard, et al. published (Lancet Neurology) a randomized placebo-controlled trial of 165 Alzheimer dementia patients who were randomized to antipsychotic treatment (risperidone 67% and haldol 26%) or placebo. They followed many of these patients for as long as 4 ½ years.

Results:

Timeframe	Survival rate antipsychotic	Survival rate placebo
12 months	70%	77%
24 months	46%	71%
36 months	30%	59%

(continued on page two)

**Antibiotics do NOT**

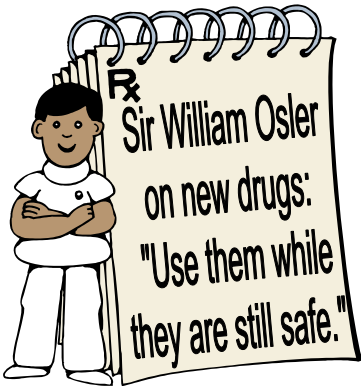


**help acute bronchitis**

**β-blockers in post-MI save lives**

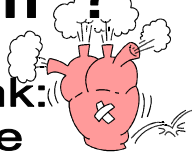


**Pill splitters save big**



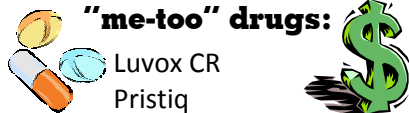
## CHF?

Think:



**Ace  
Aldactone  
B-blocker  
Dig  
Diuretic**

**Avoid these expensive "me-too" drugs:**



Luvox CR  
Pristiq  
Omnaris  
Soma 250  
AMrix XR  
Xyzal  
Veramyst  
Ambien CR

**Treat diabetics BP to 130/80**



**now available**  
on the  
**Generic Marquee**

**Razadyne** → galantamine  
**Sonata** → zaleplon  
**Fosamax** → alendronate  
**Norvasc** → amlodipine  
**Ambien** → zolpidem  
**Flonase** → fluticasone nasal

## Antipsychotic Medications... (continued)

☐ The FDA has placed a **BLACK BOX** warning on *all* antipsychotics: “**Not approved for dementia related psychoses. Increased mortality risk for cardiovascular and infectious deaths in elderly demented patients.**”

### My Take:

- 1) Bottom Line, we need to QUIT prescribing anti-psychotic meds for the neuropsychiatric manifestations of AD: they do not work well, have lots of side effects and kill patients (odds ratio of 1.5-1.7). In addition, the newer atypicals are expensive (Seroquel 200mg \$7/tab; Zyprexa 5mg tab: \$8.80/tab)
- 2) But... what do you tell Clara?
  - Are we missing something? UTI? Fall with an unidentified injury? Urinary retention? Constipation?
  - Behavioral issues: is the staff consistent in their approach to the patient? Reassurance, reorientation?
  - There is modest evidence to support the safety and efficacy of using these anticonvulsant mood stabilizers in AD patients with behavioral symptoms:
    - ♥ Lamictal (Int J Geriatr Psychiatry 2007 Oct; 22(10):945-50)
    - ♥ Carbamazepine (Encephale 2008 Sep; 34(4):409-15)
    - ♥ gabapentin (Drugs Aging 2008; 25(3):187-196)
    - ♥ valproate (Cochrane Review 2004, issue 2)
  - My favorite geriatrician, Amy, likes Depakote 125mg BID x 1 week, and if no response after 5-7 days, increase to 250mg BID x 1 week, 375mg BID x 1 week and max at 500mg BID. Stop if no response at 1gm per day. Do not check blood levels unless the patient develops common side-effects: headache, nausea, vomiting, somnolence. (60 tabs of 125mg = \$60; 60 tabs of 500mg= \$196)

## Fibromyalgia: Do Anti-Depressants Work?

In a nicely done meta-analysis, Hauser, et al. (JAMA January 14, 2009) reviewed 18 randomized placebo-controlled trials of use of antidepressants in 1427 patients with fibromyalgia syndrome (FMS).

### Results:

- Antidepressants do not help the fatigue associated with FMS.
- There were large effect sizes of TCAs for reducing pain and sleep disturbances.
- There were small effect sizes of SSRIs for reducing pain.
- There were small effect sizes of SNRIs for reducing pain, sleep disturbances and depressed mood.
- None of the head to head comparisons of different antidepressant classes allows a definitive conclusion regarding superiority of one class of antidepressants over another.
- Doses of TCAs used in the studies, between 12.5 and 50 mg per day, were typical for pain treatment but far below the doses of TCAs necessary for an antidepressant effect. In contrast, doses of SSRIs and asked SNRIs were equal to those used for treating affective disorders.

### My Take:

- \* This study presents a rationale for a short-term trial of amitriptyline (largest effect size) or duloxetine (greatest number of patients studied).
- \* Ongoing re-evaluation of symptom relief is necessary as there are no studies of long-term efficacy of antidepressant therapy for FMS.
- \* We do not know whether the benefits of antidepressant for treatment of FMS persist after cessation of therapy.
- \* Although only duloxetine (\$131/mo) is FDA approved for FMS, amitriptyline (\$4/mo) is much more cost-effective.

## What's New with Adult Immunizations?

In October, 2008, the Advisory Committee on Immunization Practices (ACIP) approved the adult immunization schedule for 2009. No new vaccines were added to the schedule, but there were some notable changes.

- \* The ACIP indicates that health care personnel are not at increased risk because of occupational exposure to the human papilloma virus, but should be vaccinated consistent with age-based recommendations.
- \* HPV vaccine may be given to girls as early as nine years of age.
- \* Asthma and cigarette smoking has been added as indications for pneumococcal vaccination.
- \* Re-vaccination with meningococcal conjugate vaccine after five years is appropriate for adults who remain at increased risk for infection (e.g...the “meningitis belt” of sub-Saharan Africa during the dry season).
- \* All adults without evidence of immunity to varicella should receive two doses of vaccine if not previously vaccinated or the second dose if they received only one dose.

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