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Prescribing dementia medication in Southwest London

Summary of Southwest London Dementia Pathway

Refer to Appendix 1 for an accessible version.

GP Investigates and conducts basic dementia assessment

- Confirm history of cognitive decline (including duration) from patient and informant
- Exclude delirium (acute/sub-acute onset of cognitive impairment) and conduct medication review to eliminate any potential medications that might be causing cognitive decline and/or a significant anticholinergic burden.
- Complete simple initial cognitive assessment
- Initial dementia blood screening: Full blood count (FBC), urea & electrolytes (U&E), bone profile, B12, folate, thyroid function test (TFTs), liver function tests (LFT), HbA1c, CRP and HIV and syphilis if indicated. Perform urinalysis, and measure blood pressure (BP) & heart rate (HR).
- ECG only where necessary; refer to Assessing cardiac status prior to commencing AChE inhibitors and ongoing monitoring. If ECG abnormal, suitability for dementia medication will be considered in secondary care. Cardiac re- assessment/ opinion may be required.

GP referral to a Memory Assessment Service (MAS)/ another appropriate specialist

Dementia assessment by MAS/specialist

Assessment, diagnosis, and further management including suitability for dementia medication.

MAS/specialist communicates

- Diagnosis/Indication for dementia medication
- Absence of contra-indications or cautions (e.g., pulse check findings)
- Recommended medication and dose along with titration plan
- Specialist monitoring arrangements for the MAS and those specified by the acute specialist
- How to contact service if require advice

This pathway covers the following indications as outlined in NG97

- mild to moderate and severe Alzheimer's disease (AD)
- mild, moderate, and severe Parkinson's dementia (PD)
- Dementia with Lewy Bodies (DLB).
- mixed vascular dementia (VaD) with predominant comorbid AD, PD or DLB.
- Prescribing for all other indications not listed above is considered **hospital or specialist only**

Specialist makes recommendation for prescribing dementia drugs:

AMBER 1 Recommendation by a specialist but is considered non-urgent and therefore could be started in primary care at the discretion of the GP. Note that recommended treatment can be used for licensed and off label indications as described in NICE NG97, NICE TA217 and NG71

MAS discharges stable patient to primary care

When medication might not be effective

When dementia gets worse

When and how to stop treatment

Primary care initiates/continues recommended dementia medication as clinically appropriate

- Key considerations for prescribing dementia medication in primary care for Alzheimer's disease and non-Alzheimer's dementia
- **Dementia** Drug treatments
- Titration and Monitoring of dementia medication.
- Managing common adverse effects and when medicine is not tolerated:

MAS/specialist monitoring for 4 to12 weeks until patient dose is optimised.

Duration will depend on indication & tolerability of the medication

Advice from specialist as required

GP undertakes ongoing monitoring where clinically indicated and at least annual patient medication review.

Medication is continued irrespective of cognitive performance

If medication is causing problems discontinue or refer to MAS/specialist for advice

MAS prioritises re-assessment within 2-4 weeks

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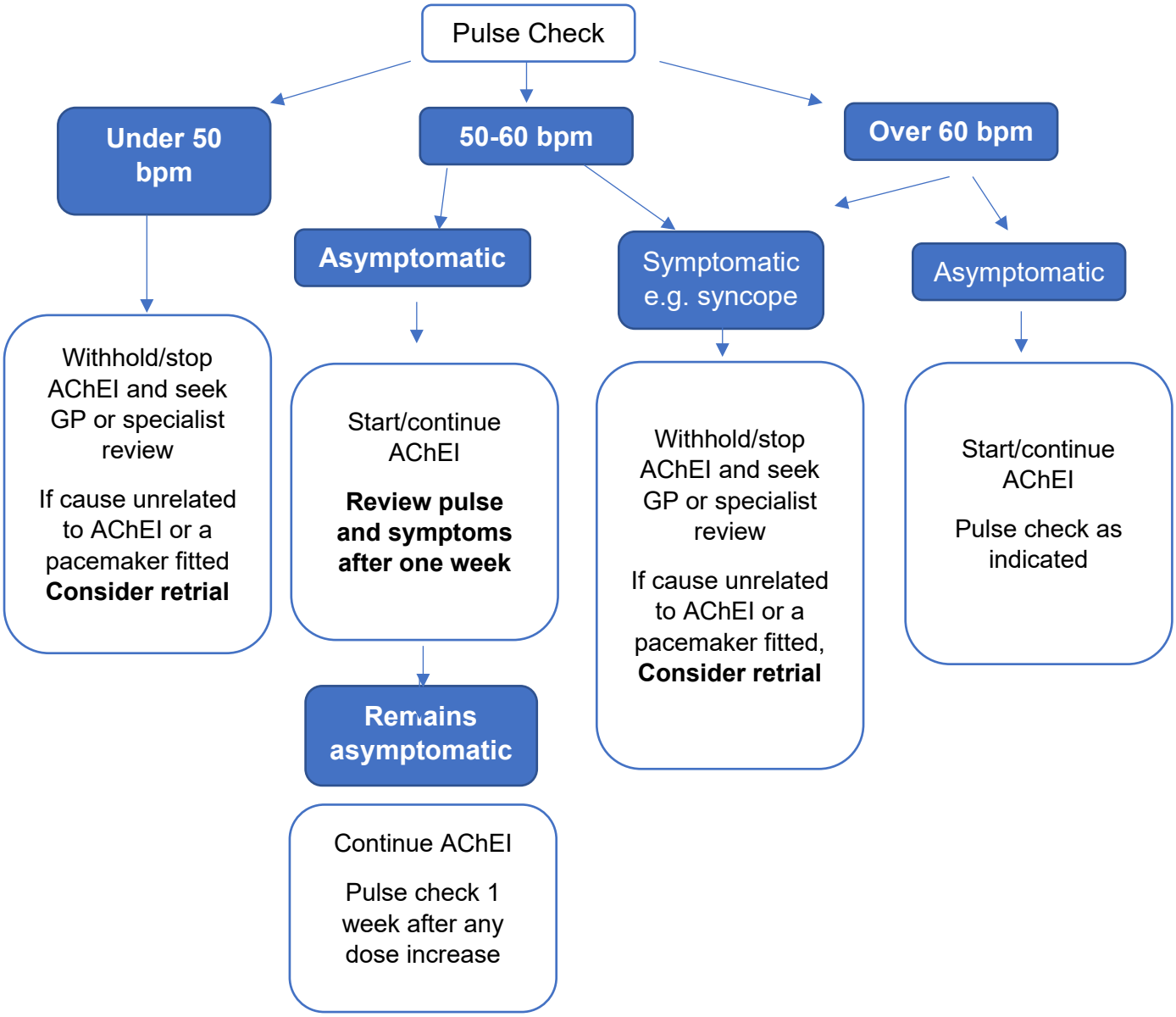
Assessing cardiac status prior to commencing Acetylcholinesterase inhibitors (AChEIs) and ongoing monitoring.

- A pulse check should be taken prior to advising primary care to prescribe AChE inhibitors; the result of this must be communicated to primary care.
- **ECG is not routinely required prior to prescribing AChE inhibitors.**
- Further clinical assessment, including ECG, should be undertaken prior to prescribing if the patient has unexplained syncope or a pulse less than 50 bpm. Refer to Assessment of Cardiac Status BEFORE Prescribing AChEIs for Dementia for further information. Caution should be exercised in prescribing AChE inhibitors in individuals with "sick sinus syndrome" or other supraventricular cardiac conduction disturbances, such as sinoatrial or atrioventricular block. In these conditions, specialist advice e.g., from a cardiologist should be obtained.
- **Pulse check pathway** (adapted from Rowland et al 1997) and Maudsley Prescribing Guidelines in Psychiatry 14th ed. (2021).



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Prescribing dementia medication in Southwest London

Scope

This evidence-based guideline is intended to support general practitioners (GPs) and other prescribers in prescribing dementia treatments in primary care, following an assessment by a Memory Assessment Service or other appropriate specialist. It provides guidance on making informed clinical and legal decisions about prescribing Donepezil, Galantamine, Rivastigmine, and Memantine for the treatment of dementia. **Refer to Appendix 1 for Summary of Southwest London Dementia Pathway.**

To be read in conjunction with:

- Dementia: assessment, management and support for people living with dementia and their carers NICE guideline [NG97] Published: 20 June 2018
- Donepezil, galantamine, rivastigmine and memantine for the treatment of Alzheimer's disease Technology appraisal guidance [TA217]
- Parkinson's disease in adult's NICE guideline [NG71] Published: 19 July 2017

This guidance does not override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or guardian or carer.

Key considerations for prescribing dementia medication in primary care for Alzheimer's Disease and non-Alzheimer's dementias

- Prescribe once confirmation of diagnosis by memory service or another appropriate specialist. This could include:
    - secondary care medical specialists such as psychiatrists, geriatricians and neurologists, other healthcare professionals (such as GPs, nurse consultants, and community dementia nurses), if they have specialist expertise in diagnosing and treating Alzheimer's disease or disease or where relevant Parkinson's dementia and/or dementia with Lewy bodies.
    - Private sector prescribers should prescribe in line with NICE recommendations and the SWL pathway. GP and other primary care prescribers should ensure a care plan is provided in line with this pathway before accepting any prescribing responsibility from the private sector. Refer to Good practice in prescribing and managing medicines and devices.
- This guidance covers the following indications as outlined in NG97
    - mild to moderate and severe Alzheimer's disease (AD)
    - mild, moderate, and severe Parkinson's dementia (PD)
    - dementia with Lewy bodies (DLB).
    - mixed vascular dementia (VaD) with predominant comorbid AD, PD or DLB.
    - Prescribing for all other indications not listed above is considered hospital or specialist only and not suitable for prescribing in primary care.

- AChEIs currently used in the treatment of dementia include **donepezil, rivastigmine and galantamine.**
- Prescribers must note that treatment can be used for licensed and off label indications as described in NICE NG97, NICE TA217 and NG71.
  Further details in NG97 section 1.5 Pharmacological interventions for dementia.
- The use of these medicines for 'Off label' indications is based on evidence and experience that supports NICE recommendations, Refer to Summary of Product Characteristics (SPC) and the British National Formulary (BNF)
- Once a decision has been made to start an Acetylcholinesterase (AChEI) inhibitor or Memantine as recommended by the specialist, **the first prescription may be made in primary care.**
- For people with established AD who are already taking an AChEI, GPs can start treatment with **memantine** without the advice of a specialist clinician; however, treatment should be under the conditions specified in NG 97 section 1.5.4.
- Check for interactions with other medications to make sure there have been no new initiations between the specialist recommendation and the start of treatment and during ongoing annual medication reviews.
  - Continue to review and consider stopping or reducing anticholinergic medicine(s) which may impact cognitive function.
  - The **Anticholinergic Effect on Cognition (AEC) scale** should be used to identify and assess the anticholinergic burden of drugs in patients using Medichec.
- The main side-effects of AChEIs are syncope and GI upset. They should be used with caution in heart block or significant cardiac conduction problems. See section **Managing adverse effects and when medicines are not tolerated**.
- If well tolerated, **follow BNF dose increments** for individual medicine at each review.
- If one AChEI is not tolerated e.g., due to diarrhoea, an alternative AChEI can be prescribed following a review with patient/carer, if it is appropriate considering adverse event profile, adherence, comorbidity, drug interactions and dosing profiles.
- Support & educate patients/carers; further information on NHS Choices Dementia
- Highlight the importance of adherence to treatment

Dementia Drug treatments

- Before prescribing, please refer to detailed prescribing information on dosing, interactions, cautions and contraindication e.g., product SPC and the BNF
- There is little to choose between AChEIs; cost and tolerability are the key deciders.
- Donepezil tablets are usually the recommended first line AChEI of choice due to cost effectiveness, once a day dosing and titration regimen.
- Donepezil is available in orodispersible tablets and oral solution which is recommended for people who have difficulties swallowing tablets.

- Prescribe generically and issue an ACUTE prescription for first 4 weeks.
- The Southwest London Joint Formulary recommends formulary choices of AChEIs and memantine.
    - AChEIs and memantine are considered AMBER 1: Recommendation by a specialist but is considered non-urgent and therefore could be started in primary care at the discretion of the GP.
    - Note that dose is titrated (where appropriate) in the first few weeks of initiation by the GP as recommended by specialist.
    - Doses of AChEI or memantine should not exceed the BNF maximum licensed recommended daily dose.
- Refer to Dose equivalence and conversion or to SPC when switching oral rivastigmine to transdermal therapy.
- When prescribing rivastigmine patches, ensure the patient/carer is informed to remove the old patch before applying the new one, and to not apply a new patch to the same skin area twice within 14 days.
- **Patient Information leaflets** are accessible via electronic medicines compendium (eMC) and Choice and medication website which offers access to easy read leaflets and decision aids (Handy Charts).

Titration and Monitoring of dementia medication

Titration and monitoring of patients who are taking AChEIs is important to ensure the medication is effective and well-tolerated, and to detect and manage any potential adverse effects. Once medication is titrated to optimum dose no further specific review is required other than general medication review appropriate to age and comorbidities.

Key points to consider when monitoring patients taking AChEIs/memantine:

- Acetylcholinesterase inhibitors monitoring provides details for preinitiation monitoring and ongoing monitoring.
- Titrate the medicine as outlined in care plan by the MAS/specialist at each review where necessary.
- Before issuing the second prescription, review care plan and determine whether significant adverse effects are present; if so, consider a reduction in dose or a change in treatment.
- MAS/specialist will continue to review at 4 to 12 weeks, to ensure medication is well tolerated and patient is on a stable dose prior to discharge.
- If the medication is tolerated, it should be continued indefinitely in primary care, even if the benefits are considered minimal as it may be difficult to assess objectively in some cases.
- Inform patient/carers that any improvement is usually symptomatic only and often modest, and that there is no effect on disease progression. About 60 per cent of patients with Alzheimer's disease have useful improvements in functioning with dementia medications; they may be brighter in mood, more interested in things, and capable of doing and enjoying things that they could

not do before. Cognitive testing results may improve, but the most important thing is that the patient shows some improvement in functioning.

- GP to monitor in line with care plan and continue to review at **least annually** once discharged from specialist.
- However, there is no routine ongoing monitoring required specifically for these medicines in primary care, other than for monitoring for possible adverse effects. Acetylcholinesterase inhibitors monitoring provides details for preinitiation monitoring and ongoing monitoring.
- Monitor pulse rate (refer to Assessing cardiac status prior to commencing AChE inhibitors and ongoing monitoring), blood pressure, patient tolerance, presence of adverse effect, and carer's view on any improvement at each assessment.
- Memantine: For people with renal impairment, the dose will depend on the estimated glomerular filtration rate (eGFR) Titrate dose slowly and monitor closely for adverse effects.
- **The use of objective clinical tools to assess cognition is not advised.**
    - Evidence now supports continuing AChEI for the treatment of severe dementia, even after the Mini-Mental State Examination (MMSE) score has reached 10/30. It is no longer advised to discontinue the use of AChEI at this stage.
- If treatment is interrupted for longer than several days due to adverse effects or compliance, treatment should be re-initiated starting with lower dose.
- Follow-up is considered within the remit of a practice nurse with knowledge of dementia and its management.

Managing common adverse effects and when medicine is not tolerated

- **Reminder: this list is not exhaustive - for full details of adverse effects and all potential drug interactions refer to latest Summary of Product Characteristics (SPC) for the drug.**
- Refer to Alzheimer's disease and dementia handy chart to aid discussions with patients on adverse effects.
- Treatment should be continued if mild adverse effects are experienced during initiation or up titration. Some adverse effects are dose dependent therefore first consider reducing the dose.
- AChEIs:
    - **Gastrointestinal (GI) e.g., nausea, vomiting, diarrhoea:**
        - Generally, tend to be mild and transient which usually disappear within a few days of commencing treatment. Advise patient to take with or after food.
        - If symptoms persist reduce dose, try an alternative AChEI, consider rivastigmine patch preparation or switch to memantine.
        - Monitor the person's weight during treatment with galantamine as it can cause weight loss.
        - Consider stopping AChEIs if causing severe nausea which continues after a couple of weeks or causes weight loss.
    - **Agitation, confusion, insomnia, abnormal dreams/nightmares:**
        - Consider changing to morning dose if donepezil causes nightmares otherwise reduce dose or switch to another AChEI.

        - Anxiety or agitation might prompt a trial without AChEIs as they are stimulant drugs. The result might be more apathy but less agitation.
    - **Syncope:**
        - Arrange ECG and consult cardiac specialist. May require dose reduction or discontinuation. In investigating seizures, the possibility of heart block or long sinusal pauses should be considered
    - **Bradycardia:**
        - If HR is less than 50bpm do not initiate AChEI.
        - If AChEI associated bradycardia occurs (less than 50bpm) stop treatment and consult specialist. Caution in "sick sinus syndrome", sinoatrial or atrioventricular block or concomitant treatment with digoxin or beta-blockers.
        - Refer to Assessing cardiac status prior to commencing AChE inhibitors and ongoing monitoring.
    - **Serious skin reactions:** Galantamine has been reported to cause Stevens-Johnson syndrome and acute generalised exanthematous pustulosis. Patients should be informed of the signs of serious skin reactions and to discontinue galantamine at the first appearance of skin rash. Refer to Reminyl_dhpc.pdf (publishing.service.gov.uk)
- **Memantine:**
    - **Somnolence or Dizziness**: Evaluate the patient's ability to continue driving or operating complex machinery. Reduce the dose or titrate dose slowly. Consult specialist if problematic for the patient.
    - **Hypertension**: Caution in uncontrolled hypertension or cardiac disease. Review treatment with a specialist if this develops. May need dose reduction/discontinuation
    - **Dyspnoea**: Caution in COPD or asthma, consult specialist to review treatment
    - **Constipation**: Refer to specialist if severe or not self-limiting. Consider when required or regular laxative.
    - **Headache**: Refer to specialist if severe or not self-limiting
    - **Renal impairment** — if deterioration in renal function refer to BNF dose adjustments. Memantine should be avoided if estimated glomerular filtration rate (eGFR) is less than 5 mL/minute/1.73 m2. Refer to specialist.
    - **Elevated liver function tests**: Refer to specialist for review
    - **Drug hypersensitivity**: Stop and refer to specialist

- Discontinue medication if patient experiences severe and intolerable adverse effects and contact dementia assessment service/specialist for advice.
- Continue to monitor for adverse effects at annual reviews and report any serious reactions via Yellow card reporting

When dementia medication might not be effective

- AChEIs result in improvements in functioning in about 60 per cent of patients with Alzheimer's disease (they may be brighter in mood, more interested in things, and capable of doing and enjoying things that they

could not do before). However, there will be some in whom there is no objective improvement. Treatment should still be maintained in this group as there may be clinical stabilisation rather than improvement.
- Assess patient compliance with treatment.
- There is no difference in efficacy between AChEIs; the only reason to switch is to see if a different drug is better tolerated.
- If two AChEIs have been tried there is no benefit in trying a third.

When dementia gets worse

- Dementia is a progressive condition. AChEIs and memantine have proved to be very safe medicines throughout the disease course.
- Primary care prescribers can begin treatment with memantine for people with Alzheimer's disease who are already taking AChEI without the advice of a specialist doctor or the need for reassessment by a dementia service.
- In moderate or severe dementia, memantine may be used in addition to treatment with donepezil.

When and how to stop treatment

Consider stopping treatment if any of the following occur:

- Poor concordance and reasonable measures to support a person with cognitive impairment to comply with taking medication have been made and failed.
- Major adverse effects such as worsening of cognitive, functional, and behavioural symptoms or intolerable adverse effects.
- Patient asks to stop after being advised on the risk and benefits of stopping treatment.
- If a patient is on an end of life pathway.

- **Do not stop acetylcholinesterase inhibitors in people with AD because of severity of disease alone.**
- If stopping treatment, gradual withdrawal over 1 to 4 weeks (depending on drug, preparation, and dose) is suggested where possible. Monitor patient for evidence of significant decline over next 4 to12 weeksConsider reinstating treatment if decline noted.
- Keep the patient under regular review.
- If serious adverse effects occur, stop at once.
- For further information contact specialist or health professionals:
    - **Merton, Kingston, Richmond, Sutton, and Wandsworth** prescribers can contact SWL STG MH Medicines Information
    - **Croydon** prescribers contact South London and Maudsley (SLaM) Medicines Information service on 020 3228 2317.

When to seek advice from a specialist

- If patient experiences severe adverse effects refer to section on managing common adverse effects and when medicine is not tolerated on page 4.
- Following dose titration, the specialist will recommend continuation treatment based on tolerability and patient preference. Tolerability may change over time due to ageing process and the emergence of medical co-morbidities and

frailty. In this situation it may appropriate to reduce the dose or discontinue treatment and/or consider an alternative drug.

- Consult a specialist/MAS if you need to switch to an alternative AChEI; in some instances, a referral back to services may be recommended.
- Where behavioural and psychological symptoms of dementia (BPSD) are suspected seek advice from a specialist for suitable intervention. Further information is available on NHS England — London » Dementia 'Guidance for appropriate prescribing of antipsychotic medication for patients with Dementia.'

Contact details and Memory Assessment Service (MAS)

For further information contact specialist or health professionals:

- **Merton, Kingston, Richmond, Sutton, and Wandsworth** prescribers can contact SWL STG MH Medicines Information
- **Croydon** prescribers contact South London and Maudsley (SLaM) Medicines Information service on 020 3228 2317.

Croydon Memory Service :

- Telephone: 020 3228 9500
- Email: CMS@slam.nhs.uk

Kingston Memory Assessment Service

- Telephone: 020 3513 5000
- Email: Kingstonadministrator@swlstg.nhs.uk

Richmond Memory Services

- RichmondOlderPeople@swlstg.nhs.uk

Merton Memory Assessment Service

- Telephone: 020 3513 6301
- Email: MertonOPAdminTeam@swlstg.nhs.uk

Sutton Memory Assessment Service

- SuttonOlderPeopleServices@Swlstg.nhs.uk

Wandsworth Older People's Community Mental Health Team

- Email: Wandsworthopservice@swlstg.nhs.uk

Department of Neurology

- Kingston Hospital
  - khn-tr.neurology@nhs.net
  - 020 8934 6156 option 3
- St George's Hospital
  - Phone: 020 8672 9944

Reference/resources

1. BNF (British National Formulary) | NICE
2. Pathway for prescribing acetylcholinesterase inhibitors (donepezil, rivastigmine, galantamine) and memantine in the treatment of Alzheimer's disease, Parkinson's Disease dementia and Dementia with Lewy bodies London Dementia Clinical Network (NHS England and Improvement) London Region
3. Dementia: assessment, management and support for people living with dementia and their carers NICE guideline [NG97] Published: 20 June 2018
4. Donepezil, galantamine, rivastigmine and memantine for the treatment of Alzheimer's disease Technology appraisal guidance [TA217] 23 March 2011, Last updated: 20 June 2018
5. Parkinson's disease in adult's NICE guideline [NG71] Published: 19 July 2017
6. Maudsley Prescribing Guidelines in Psychiatry 14th ed. (2021)
7. Home - electronic medicines compendium (eMC)
8. NHS England — London » Dementia

Disclaimer

The recommendations in these guidelines do not override the responsibility of healthcare professionals to make decisions according to the circumstances of the individual patient, in consultation with the patient and/or their carers or guardian.

Document History

Version: V 1.0

Author & contributors: **SWL Mental Health Interface Prescribing Forum**

Approved by: Integrated Medicines Optimisation Committee (IMOC)

Approval date: **14th June 2023**

Review Date: 2 years from approval date or sooner where appropriate.

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Appendix 1: Summary of Southwest London Dementia Pathway

1. **GP Investigates and conduct basic dementia assessment and completes referral to Memory assessment service (MAS)/specialist** with the following requirements for referral:
   - Confirm history of cognitive decline (including duration) from patient and informant.
   - Exclude delirium with acute/sub-acute onset of cognitive impairment.
   - and conduct medication review to eliminate any potential medications that might be causing cognitive decline and/or a significant anticholinergic burden.
   - Complete simple initial cognitive assessment
   - Complete initial dementia blood screening: Full blood count (FBC), urea & electrolytes (U&E), bone profile, B12, folate, thyroid function test (TFTs), liver function tests (LFT), HbA1c, CRP and HIV and syphilis if indicated. Perform urinalysis, and measure blood pressure (BP) & heart rate (HR). ECG only where necessary; refer to Assessing cardiac status prior to commencing AChE inhibitors and ongoing monitoring. If ECG abnormal, suitability for dementia medication will be considered in secondary care. Cardiac re- assessment/ opinion may be required.
2. **Memory assessment service/specialist** assessment, diagnosis and further management including suitability for dementia medication.
3. **Memory assessment service/specialist to inform GP of diagnosis**:
   a. Alzheimer's Disease, Parkinson's dementia, dementia with Lewy bodies or mixed dementia diagnosis
   b. Request GP to initiate or continue recommended dementia treatment as appropriate.
   c. Requests for prescribing for other indications outside this guidance are considered hospital only and not suitable for primary care.
   d. Provide a care plan
4. Where GP agrees to prescribe and initiate first prescription, they can contact MAS/specialist with any concerns on recommendation.
5. MAS/specialist provides a care plan and continues to monitor the patient until dose stabilised (4 to 12 weeks).
6. MAS/specialist discharges patient to GP once patient is considered stable.
7. GP continues prescribing dementia medication with at least 12 monthly reviews as considered appropriate. Medication is continued irrespective of cognitive performance.
8. Prescriber can contact the MAS/specialist to discuss any issues regarding treatment.
9. MAS prioritises re-assessment within 2 to 4 weeks
10. MAS/specialist discharges patient to GP once patient is considered stable
11. GP undertakes ongoing monitoring where clinically indicated and annually during patient medication review.