

# Geriatric Optimization

## Antipsychotics

### First Generation Antipsychotics

**Chlorpromazine (Thorazine®)**  
**Fluphenazine (Prolixin®)**  
**Haloperidol (Haldol®)**  
**Loxapine (Adasuve®, Loxitane®)**  
**Perphenazine (Trilafon®)**  
**Thioridazine (Mellaril®)**  
**Thiothixene (Navane®)**  
**Trifluoperazine (Stelazine®)**

### Second Generation Antipsychotics

**Aripiprazole (Abilify®)**  
**Asenapine (Saphris®)**  
**Brexpiprazole (Rexulti®)**  
**Cariprazine (Vraylar®)**  
**Clozapine (Clozaril®)**  
**Iloperidone (Fanapt®)**  
**Lumateperone (Caplyta®)**  
**Lurasidone (Latuda®)**  
**Olanzapine (Zyprexa®)**  
**Paliperidone (Invega®)**  
**Quetiapine (Seroquel®)**  
**Risperidone (Risperdal®)**  
**Ziprasidone (Geodon®)**

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## WHY ARE THESE MEDICATIONS INAPPROPRIATE?

Despite the risk of harm in older adults, antipsychotics are often prescribed off-label for the treatment of insomnia and to control behavioral and psychological symptoms of dementia (BPSD).<sup>1</sup> Adverse events of antipsychotics include<sup>1,2</sup>:

- Increased risk of cerebrovascular accident (stroke)
- Falls and gait disturbances
- Syndrome of inappropriate antidiuretic hormone secretion (SIADH) or hyponatremia
- Extrapyramidal symptoms
- Metabolic effects and weight gain

### Alzheimer's Disease and Dementia

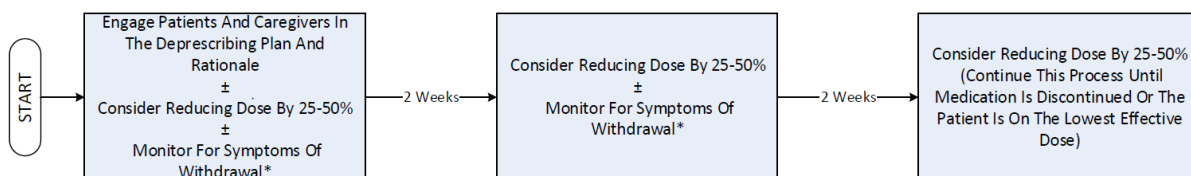
- **FDA black boxed warning:**
  - **Increased risk of death in older adults treated with antipsychotics for dementia-related psychosis<sup>3</sup>**
- The CATIE-AD trial results demonstrated **minimal benefit of using antipsychotics for Alzheimer's disease behaviors** and that **adverse effects offset clinical efficacy** of atypical antipsychotic drugs<sup>4</sup>
- Atypical antipsychotics are associated with **greater rates of decline in cognitive function** compared to placebo in patients diagnosed with Alzheimer's disease who have psychotic or aggressive behavior<sup>5</sup>
- A cohort study comprised of community dwelling adults diagnosed with Alzheimer's disease receiving antipsychotics showed that these medications may **increase the risk of head and traumatic brain injuries** in this patient population indicating **increased risk of falls and injury<sup>6</sup>**

### Insomnia

- In a large cohort study of community-dwelling older adults, antipsychotics were associated with an **increased risk of all-cause mortality in patients with and without dementia** and without preexisting serious mental illness<sup>7</sup>
- There is a **lack of clinical evidence** that supports the efficacy of antipsychotic use in insomnia and prescribing these medications inappropriately contribute to polypharmacy which can lead to an increased risk of adverse effects, drug-drug interactions, emergency department visits, and hospitalizations<sup>1</sup>

## APPROACH TO OPTIMIZATION<sup>1</sup>

- Evaluate the reason for initiating antipsychotic therapy through chart review and discussion with the patient, caregivers, and other health care professionals
- Deprescribing should be considered for older adults who have been treated with antipsychotics for:
  - Insomnia
  - BPSD for at least 3 months and have symptoms that are controlled or who have not responded to therapy
- Older adults prescribed antipsychotic therapy for psychiatric indications (i.e., schizophrenia, bipolar disorder, etc.) may be clinically appropriate for continued antipsychotic therapy and a psychiatrist should be consulted if deprescribing is considered



- Tapering may not be needed for low dose antipsychotics prescribed for insomnia only
- In patients with severe baseline BPSD symptoms or long-standing antipsychotic use, slower tapering may be appropriate
- Consider available tablet sizes when decreasing doses for ease of patient administration
- While deprescribing monitor for psychosis, aggression, agitation, delusions, and hallucinations in patients prescribed antipsychotics for BPSD

#### Symbol Key

\*Nausea and vomiting, diarrhea, abdominal pain, headache, tachycardia, vertigo, increased perspiration, restlessness, anxiety, insomnia, myalgia, and hyperkinesia<sup>8</sup>

**GOAL: Full discontinuation OR adjusting regimen to lowest effective dose**

## ADDITIONAL BEST PRACTICES

### Behavioral and Psychological Symptoms of Dementia (BPSD)<sup>1</sup>

- If BPSD relapses, consider nonpharmacological approaches such as behavioral therapy and management strategies (i.e. relaxation, social contact, music or aroma therapy, structured activities)
- Review and address other conditions (i.e. depression, pain, etc.) and/or medications that might be worsening symptoms
- Consider environmental causes that may effect symptoms such as light and noise
- If patients relapse and nonpharmacological approaches are not effective, restart antipsychotic therapy at the lowest effective dose and re-trial deprescribing in 3 months- at least two attempts to stop antipsychotic therapy should be made

### Insomnia

- Sleep hygiene education
- Cognitive behavioral therapy
- Melatonin (0.3-2 mg orally 1 hour before bedtime)<sup>9</sup>

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