

FAST FACTS AND CONCEPTS #174
DEMENTIA MEDICATIONS IN PALLIATIVE CARE**Laura J Morrison MD and Solomon Liao MD**

Background: In recent years, medications have been marketed to delay the progression of dementia. No studies have specifically addressed when or if these drugs should be stopped as cognition and function decline in serious illness. Palliative care professionals are frequently asked about the continued role of these drugs in the face of a limited prognosis. This *Fast Fact* will suggest guidelines for continued use or discontinuation in the hospice/palliative care setting.

Mediations:

- 1. Cholinesterase Inhibitors (ChEIs):** e.g. galantamine, donepezil, rivastigmine
Indication: mild to moderate dementia—usually started as first line agents. **Evidence:** A systematic review indicated that ChEIs lead to cognitive, functional, and global benefits in mild to moderate dementia which wane at about one year after initiation and are of relatively unclear clinical significance (1). Few studies have looked at efficacy in moderate to severe dementia, which limits the applicability of ChEIs to patients who qualify for hospice based on dementia. Some studies have suggested ChEIs have a role in controlling behavior problems (2) and lessening opioid related somnolence (3). One study suggested a potential precipitous cognitive decline if ChEIs are stopped suddenly (4). **Cost:** ~ \$191-255/month (5). **Side Effects:** diarrhea, nausea, anorexia, insomnia, bradycardia.
- 2. N-methyl-D-aspartate (NMDA) receptor antagonist:** memantine.
Indication: moderate to severe dementia. **Evidence:** Studies suggest a modest beneficial effect with decreased cognitive and functional decline in patients with moderate to severe dementia (6). Again, the clinical significance for patients is debated. **Cost:** \$366/month at 10mg twice daily (5). **Side Effects:** dizziness, headache, constipation, somnolence, weight gain

Recommendations:

- 1) Use a shared decision-making model with patients/surrogates guided by the goals of care (e.g. life prolongation and/or symptom relief), carefully weighing the expected benefits and burdens (see reference 7 for specific guidance on medication appropriateness late in life). Be prepared to make a clear recommendation based on best available evidence. Due to the advanced status of many dementia patients entering hospice or being seen by palliative care programs, it's reasonable to recommend stopping ChEIs and memantine, as the evidence for their benefit is marginal at best. These medications may be viewed as prolonging a poor quality of life and/or the process of dying.
- 2) If there is uncertainty, consider a time-limited trial of medication continuation or discontinuation, with serial reassessment of target cognitive or behavioral indicators. Families should be made aware that a decline following discontinuation may not be reversible.
- 3) In the case of a patient with dementia-related behavior problems, clinicians or family may feel that medications play an important role in lessening the behaviors; continuing medications may be reasonable. Alternatively, using non-pharmacologic strategies and/or increasing or starting an antipsychotic can often help control behavior problems without the use of ChEIs or memantine.
- 4) When the decision is made to stop a medication, common geriatrics wisdom supports a gradual dose taper rather than abrupt discontinuation.
- 5) Clinicians should inform all involved healthcare team members of a recommendation to discontinue medication along with the rationale for discontinuation (8).

Working with Families: The reaction of families to a discussion of discontinuing these drugs is often emotional and may be a source of tension between family members. Some will view these medications as a final hope for prolonged life or improved function and will resist discontinuation. For others, permission to let go, to accept impending death and remove a perceived burden of cost and daily pill taking, will be welcomed. Clinicians can best help families by focusing discussion around the overall goals of care (see *Fast Facts* #29, 65).

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