GUIDELINES FOR THE TREATMENT OF ALZHEIMER’S DISEASE

The National Institute for Health and Clinical Excellence (NICE) examined the use of drug treatments for Alzheimer’s Disease within Technology Appraisal Guidance (TAG) 111 which was published in 2006. Broader Guidelines for the Management of People with Dementia were published in November 2006 (NICE Clinical Guideline 42). This led to the development of a Local Prescribing Framework for the use of Acetylcholinesterase Inhibitors, which was approved in October 2007 and were due for review in October 2009.

Since the above Guidelines have been published, evidence and practice has developed in a number of areas:

1. The use of acetylcholinesterase inhibitors in conditions other than pure Alzheimer’s Disease, for example in Lewy Body Dementia or in Alzheimer’s Disease with concomitant Vascular Dementia (i.e. Mixed Alzheimer’s/Vascular Dementia).

2. The use of Memantine in people with Alzheimer’s Disease of moderate severity. The NICE Dementia Guidelines makes a clear statement that Memantine should not be used in people with moderately severe to severe Alzheimer’s Disease except as part of well designed clinical studies. They did not examine the evidence for these drug treatments in people with moderate stage Alzheimer’s Disease.

3. The treatment of individuals where there is a necessity to consider alternatives to acetylcholinesterase inhibitors in situations whereby:

   a) Patients are unable to tolerate an acetylcholinesterase inhibitor

   b) There are medical contraindications to the prescription of such drugs

   c) There is loss of treatment effect from acetylcholinesterase inhibitors.

4. There is emerging evidence that antipsychotic drugs may increase the risk of cerebro-vascular accidents and increase mortality in patients with dementia associated with behavioural and psychological symptoms (BPSD), and that Memantine can be a safe and effective alternative to antipsychotic treatment, particularly in people with pre-existing cardio-vascular or cerebro-vascular risk factors.

It is important to follow the broad principles of NICE Guidance; however it is also imperative that treatment decisions are made for each individual patient, taking into account individual patient characteristics and the most suitable treatment available. In these circumstances, it is necessary to provide guidance which allows the degree of flexibility that is required, whilst recognising that the evidence base for drug treatments such as Memantine is less robust than that for the cholinesterase inhibitors.

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It is therefore suggested that cholinesterase inhibitors are used as first line drugs, with the use of Memantine reserved for specific circumstances, defined within this guidance.

**Scope of Guideline**

This guideline covers the use of cholinesterase inhibitors: Donepezil, Rivastigmine and Galantamine for moderate to moderately severe Alzheimer’s Disease, Lewy Body Dementia and Alzheimer’s Disease with concomitant Vascular Dementia. It also considers the use of Memantine and the process for selecting patients appropriate for such treatment.

These guidelines should be used by secondary care staff within the Hull and East Riding Prescribing Committee healthcare community

1. All patients should meet the diagnostic criteria for Alzheimer’s Disease, Lewy Body Dementia or Alzheimer’s Disease with concomitant Vascular Dementia.

2. There will be no age discrimination in the use of these drugs.

3. These guidelines will also apply to people with learning disabilities, such as Down’s Syndrome with associated Alzheimer’s Disease.

4. Treatment decisions will be made on an individual basis, taking into account the individual patient’s characteristics in terms of the underlying diagnosis, concomitant medical conditions and associated drug treatments.

5. Healthcare professionals should not solely rely on the Mini Mental State Examination score to diagnose Alzheimer’s Disease of moderate severity, but use clinical judgement to ascertain the diagnosis, supplemented by such cognitive testing as is judged to be necessary and appropriate.

6. Decisions as to the choice of cholinesterase inhibitor will be made, taking into account diagnosis, side-effect profile, medical co-morbidity, possibility of drug interactions, the formulation (i.e. patch or oral), level of carer support, etc.

7. Clinical judgement about the benefit from such drugs should take into account the fact that Alzheimer’s Disease (and Lewy Body Dementia) are progressive disorders, and that a lack of deterioration may indicate a positive response to such treatment. Activities of daily living, non-cognitive symptoms (such as behavioural and psychological symptoms in dementia) and clinical global impression are all important in reaching a conclusion, though a Mini Mental State Examination score may also be helpful information, when making a judgement about the success or failure of such treatment.

8. Patients who have failed to tolerate, failed to benefit or lost benefit from a cholinesterase inhibitor may be switched to another drug of the same class if they remain within the criteria of a prescription of a cholinesterase inhibitor.

9. Memantine will be used as an alternative to cholinesterase inhibitors for patients in the following categories:
a) Patients with moderate stage Alzheimer’s Disease who are unable to
tolerate cholinesterase inhibitors.

b) Patients with moderate or moderate to severe Alzheimer’s Disease who
have failed to respond to cholinesterase inhibitors, and in whom it is
judged to be clinically appropriate to prescribe Memantine.

c) Patients with moderate or moderate to severe Alzheimer’s Disease in
whom there may be medical contraindications for the prescription of a
cholinesterase inhibitor.

d) Patients who have lost clinical benefit from the cholinesterase
inhibitors, and it is judged to be clinically appropriate to try to stabilise
the situation via the use of Memantine.

e) In addition, in light of the increasing evidence of the adverse effects of
the prescription of antipsychotic drugs for the treatment of behavioural
and psychological symptoms of dementia, the use of Memantine is to
be considered as an option for the management of behavioural
disturbances in dementia when:

1. The patient has cerebro-vascular and cardio-vascular risk factors
   which makes the use of an antipsychotic inappropriate.

2. There is a lack of response to an antipsychotic and other drug
treatments are not clinically appropriate.

10. It is proposed that shared care frameworks for Memantine and each individual
    Acetyl Cholinesterase Inhibitor be agreed via Hull and East Riding Prescribing
    Committee.

11. Continued audit of these drugs will monitor compliance with these guidelines,
    and contribute toward the further development of the guidelines and protocols
    which will be incorporated into the Hull and East Riding Formulary, currently
    being developed.