Antipsychotics, cognitive decline and death in Alzheimer's disease

Antipsychotics, cognitive decline and death in Alzheimer's disease: the London and South-East Region Alzheimer's Disease longitudinal study

D Ames

The LASER-AD study provides limited reassurance in relation to the occasional prescription of novel antipsychotics to elderly people with dementia

For psychiatrists in the business of helping old people who exhibit delusions and challenging behaviours related to dementia, it will be a relief to read some good news at last. Apparently, even if we may not be helping old people with dementia very much when we treat them with an atypical antipsychotic,¹ we may after all not be hastening their deaths or irreversibly worsening their cognitive function at the same time. In their paper, Livingston *et al*² (see p 25) report that in an epidemiologically representative cohort of 224 people affected by Alzheimer's disease, the consumption of antipsychotic drugs did not correlate with more rapid cognitive decline over a 6-month period, nor did people taking antipsychotics have a higher death rate than those who were not prescribed such

drugs, once age and severity of dementia were taken into account. The study had robust methods and its results in relation to cognitive decline are based on repeated assessments with a variety of well-accepted cognitive measures.

Of course it is true that too many old people with dementia are treated too often and for too long with antipsychotic drugs,¹ and efforts to diminish the prevalence of such prescriptions is to be greatly applauded, but the merit of the London and South-East Region Alzheimer's Disease study is in examining in an everyday context the potential negative consequences of novel antipsychotic use, which have caused great concern in recent years. As a coauthor of the paper³ that prompted the original panic over novel antipsychotics and the

putative risk of stroke in people with dementia¹ (if we had never conceived our investigator-initiated study, concerns about risk of stroke in people with dementia prescribed antipsychotics might not have surfaced for years to come), I am relieved to find that my inability to manage every single person I see with dementia and distressing ideas, or severe aggression that puts other frail old people at serious risk, without occasional use of a novel antipsychotic drug in an n = 1 trial, may not be wholly irresponsible.

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REFERENCES

- 1 Ames D, Ballard C, Cream J, *et al*. For debate: should novel antipsychotics ever be used to treat the behavioral and psychological symptoms of dementia (BPSD)? *Int Psychogeriatr* 2005;**17**:3–29.
- 2 Livingston G, A E Walker, C L E Katona, C Cooper, *et al*. Antipsychotics and cognitive decline in Alzheimer's disease: The LASER-AD longitudinal study. *J Neurol Neurosurg Psychiatry* 2006;**78**:25–9.
- 3 Brodaty H, Ames D, Snowdon J, *et al*. A randomized placebo-controlled trial of risperidone for the treatment of aggression, agitation and psychosis of dementia. *J Clin Psychiatry* 2003;**64**:134–43.

Symptoms of dementia

Behavioural and psychological symptoms of dementia associated with Parkinson's disease

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Assessment of behavioural and psychological symptoms is important in brain disorders

The recognition that psychiatric symptoms and behavioural disturbances are important in organic brain disorders has grown inexorably over the past 15 years. Their contribution to carer stress and institutionalisation is well recognised.¹ More specifically, in Parkinson's

disease, researchers are becoming increasingly aware of the need to include the assessment of behavioural and psychological symptoms as important outcome measures in clinical trials, and clinicians are starting to recognise the need to identify and manage these

symptoms in addition to focusing on the motor symptoms and their complications.

The study by Aarsland *et al* in this issue² (see p 36) reports the results of a cluster analysis of the symptoms in a larger study in people with dementia associated with Parkinson's disease,³ using the gold standard of the assessment for neuropsychiatric symptoms, the Neuropsychiatric Inventory.⁴ The findings support the fact that these symptoms are common in Parkinson's disease (89% had at least one symptom, and 77% had two or more). The most common symptoms were depression, apathy, anxiety and hallucinations (in this order, all with rates of between 44% and 58% of patients). Five clusters were identified and shown to be related to other aspects of dementia (in particular, psychosis/agitation was associated with carer distress, cognitive impairment and Parkinsonian signs).

The population-based Cache County Study of Memory in Ageing,⁵ focusing