How pharmacists can help their dementia patients

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I READ WITH GREAT INTEREST THE “FOCUS ON Dementia” piece by Chang et al.¹ published in the July/August issue of *CPJ*. As a community pharmacist and a previously active caregiver to my mother, who suffered from frontotemporal dementia, I think I am in a unique position to share my experience from the dual vantage points of health care professional and caregiver. I would like to expand on some of the “5 main pillars” and Box 5 discussed in Chang et al.¹ because they resonate well with what I learned as I helped my mother progress through the disease and the system caring for her. Specifically, I would like to call on all pharmacists to become more involved in the health of their dementia patients, especially those without strong advocates.

Optimize medication needs

- Recommend pharmacologic therapy and/or prescribe based on patient needs and changing goals of care.
- Deprescribe whenever possible, keeping in mind that the goal of care in dementia patients shifts from prolonging life to optimizing quality of life.²⁻⁵ Deprescribing is one of the most basic standards of pharmacy practice that every pharmacist is trained to perform, but to my knowledge, it is not commonly practised. Start this process early, preferably before a patient enters long-term care (LTC), while he or she can still communicate to give feedback about a therapy that has been stopped, started or altered. Some medications may require slow down-titration before they can be safely stopped. Place emphasis on medications with central nervous system effects. Also, since dementia patients invariably lose significant amounts of body weight, their obesity-associated conditions such as diabetes mellitus, hypertension,

dyslipidemia, arthritis and so forth may progressively require less intensive or no pharmacologic therapy.

Don't blame everything on the dementia diagnosis

Always consider nondementia causes of the patient's complaints.

- **Example 1:** Resting tachycardia, excessive sweating and weight loss in a dementia patient may be attributed to the disease, when in fact the culprit could be exogenous hyperthyroidism caused by ingestion of excessive amounts of thyroid hormone (previously adequate doses of thyroid hormone may become excessive in older dementia patients because of their reduced physical activity, body weight and metabolic rate).
- **Example 2:** Difficulty swallowing accompanied by loss of interest in food, weight loss and choking cough (especially after a meal) are expected in advanced dementia patients but sometimes could be due to gastroesophageal reflux disease (GERD) or oral candidiasis, which are easily and rapidly responsive to proton pump inhibitors (PPIs) or antifungals, respectively. The patient may have suffered from GERD previously, and the symptoms were successfully treated with a PPI until well-intentioned deprescribing efforts removed it from their list of medications and now the mute or debilitated patient cannot convey that the GERD symptoms have recurred.
- **Example 3:** A patient's inability to recognize details may not be caused by the dementia but could be due to age-related cataracts building up in the lenses of the eyes.

A thorough understanding of the patient's previous medical, surgical and nonmedical history is vital during such investigations. The patient's caregivers are usually an excellent resource when searching for such information.

Have a list of vital medications programmed into the LTC pharmacy software

Medication errors could originate at the dispensing pharmacy and may not be discovered by the nursing staff at the LTC facility when/if they consult the medication administration records (MARs; most MARs are electronic now). Such errors could be disastrous to the patient if they involve vital and critical medications such as insulin, thyroid hormones, corticosteroids, warfarin, anticonvulsants, and so on. For this reason, it would serve the patient well and reduce chances of serious harm if a list of such critical medications is incorporated into the pharmacy medication-filling software to prevent accidental/automatic deactivation, reactivation or addition of these drugs for any patient.

Example 4: A frail patient's sudden inability to walk, dehydration, reduced level of consciousness and eventual hospitalization could be discovered to be due to unintentional cessation of the patient's insulin by the pharmacy. The pharmacist cannot and should not assume that such mistakes will be caught in time by the nursing staff at the LTC facility.

Remember that you are the medication expert

- Assume that other health care practitioners (even physicians in some cases) don't have an adequate understanding of medications. Sometimes the nurses administering and the prescribers ordering such medications do not fully know what the medication is supposed to treat (many drugs have more than one clinical use), its adverse effects, how long it would take to show a benefit, and so on.
- Don't be afraid to recommend initiation of pharmacologic therapy, alter dosages of existing medications, stop or switch to another medication, and so forth. Some prescribers and nursing staff may wish to receive such medication advice from experts.
- When needed, consult with a compounding pharmacy to find solutions for medication administration issues caused by the

worsening dementia. Dysphagia is one of the biggest challenges in advanced dementia patients, and the pharmacist, for example, should advise the prescriber and nursing staff if certain medications cannot or should not be crushed/split and should try to find alternative ways of administering a medication if oral administration is unsafe or not possible (e.g., rectal application, transdermal, intranasal, injection, etc.).

- Screen for drug interactions and give your professional opinion in writing for the prescriber to consider. Although not all drug interactions flagged by medication-filling software or a drug interaction checker are clinically relevant, keep in mind that frail elderly patients are more sensitive to drug effects, and mild drug interactions may have a noticeable effect in this patient population.
- Solve medication access issues for patients and find cheaper/covered alternatives when costs are prohibitive for the patient.

Example 5: Botulinum toxin injections used to relieve chronic joint contractures in dementia patients are expensive, and the patient may not be able to afford their costs every 3 months. Check with the specialist whether the patient could use the Botox meant for office use at reduced or no cost.

- Ask the LTC staff if they are noticing new symptoms in their patients, and try to determine if such symptoms are drug induced or if they need pharmacologic intervention.
- Screen medications for appropriate dosing, and report your findings to the prescriber with your recommendations.

Be available to relatives

- Have clinic days or question-and-answer sessions for the patients, their caregivers and the LTC facility staff.
- Make sure that the clinical pharmacist's availability is advertised in a conspicuous place/manner for patients and their caregivers.
- Seek the advice and approval of the patient's family members/caregivers before instituting a drug recommendation and before consulting with the prescriber. Let the caregivers know what your rationale is and what you're hoping to achieve with your pharmacologic recommendation.

Look for ways to educate

- Give medication workshops/presentations to nursing staff to educate them about names of medications, side effects, benefits, their pharmacologic classes, and so on.

Example 6: When a dehydrated and debilitated patient needs it the most, he or she could miss an entire day of therapy with the antidiarrheal diphenoxylate/atropine if the nurse looking for this medication does not search for it in the locked narcotic drawer in the nurses' medication cart.

- Team up with physicians for such education sessions and coordinate the presentation to also cover the basics of dementia as a disease and what the nursing staff should expect to see in terms of signs/symptoms.

Example 7: The staff may not be aware that constant pacing and agitation, especially in the evening/night, is common in dementia. Also, the staff may be familiar with only the most common type of dementia (Alzheimer's disease) and may not understand that patients living with other dementias (e.g., frontotemporal dementia) display different symptoms and behaviours, particularly before the end stage of the disease.

Such disease state and medication education should help adjust the expectations of the staff in the LTC facility to provide better care for their vulnerable patients.

Look beyond medications

- Whenever possible, suggest nonpharmacologic solutions and refer the patient or caregiver to other health care practitioners as necessary (e.g., optometrist, physiotherapist, speech language pathologist).
- Combining different treatment modalities may be necessary to treat some conditions.

Example 8: Constant and painful joint contractures in advanced dementia patients are common and may be adequately treated by

combining pharmacologic therapy with physical therapy when neither of these treatments is sufficiently effective on its own.

Thanks to *CPJ* for focusing the spotlight on dementia. Let's remember that patients living with dementia were effective working members of their community who previously enjoyed life and paid their dues to society. This commentary is dedicated to the memory of my mother, Sonia Riachi, who actually experienced all the issues discussed in the above examples, despite my very active role in her care. ■

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