Drugs for the Treatment of Dementia – Shared and Transfer of Care, dementia with Lewy bodies, vascular dementia & Parkinson's disease dementia)

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Mental Health and LD (Luton & Bedfordshire Only)	✓
Community Health Services	

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Contents

PATIENT'S NAME: PATIENT'S ADDRESS: HOSPITAL NAME AND NHS NUMBER / (PATIENT IDENTIFIER): CONSULTANT'S NAME AND CONTACT DETAILS: GP's NAME:

INTRODUCTION & PURPOSE

What are key elements of the process to ensure good shared care arrangements are in place?

- The hospital clinician/specialist service should prescribe if the patient will be attending hospital/specialist service regularly for specialist monitoring, otherwise contact the GP/other health care professional to agree to share care. It will be assumed that the GP/other health care professional will accept shared care unless they advise the hospital clinician/specialist service to the contrary.
- Transfer of clinical responsibility to primary care should only be considered where the person's clinical condition is stable or predictable.
- **Transfer of care requires GP confirmation (see Transfer of Care Agreement – page 22).**
- Patients should be at the centre of any shared care arrangements. Individual patient information and a record of their preferences (including patient consent) should accompany shared care prescribing guidelines where appropriate.
- A copy of the shared care guideline should be provided by the specialist centre initiating the treatment to both the patient (where appropriate) and the clinician participating in the shared care. Failure to provide a copy of the shared care guideline could result in a delay in responsibility for prescribing/administration being accepted in primary care.
- Adhere to CCG policies.
- The GP/other health care professional should have sufficient information on the drug to either allow them to monitor the patient's response to therapy and adjust dosages as required or know in what circumstances they should refer the patient back to the hospital clinician
- Where the hospital clinician/specialist service retains responsibility for monitoring drug therapy or making dosage adjustments, the GP/other health care professional must be informed of any dose changes as soon as possible to avoid an incorrect dose being administered. Similarly if the GP/other health care professional changes the patient's medication then the hospital clinician/specialist service involved in the shared care agreement should be informed
- If a GP is unwilling to participate in a shared care agreement, the CCG medicines optimisation/management team should be asked for assistance in facilitating suitable prescribing arrangements for the patient.

- The patient should inform their usual community pharmacist that they will be starting the treatment to help ensure that supplies are available.

NICE guidance

Prescribing of cognitive enhancing drugs for the management of Dementia should be in accordance with:-

- NICE TA 217 (Mar 2011) (Donepezil, galantamine, rivastigmine and memantine for the treatment of Alzheimer's disease) updated as a result of NICE NG 97 (Dementia: assessment, management and support for people living with dementia and their carers) for the treatment of Alzheimer's Disease
- NICE NG 97 for Non-Alzhiemer's Dementia
- NICE NG 71 (Parkinson's Disease in Adults) for Parkinson's Disease Dementia

A summary of the recommendations are outlined below:-

Alzheimer's Disease

As per NICE NG 97 (Dementia: assessment, management and support for people living with dementia and their carers) & NICE TA 217 (Donepezil, galantamine, rivastigmine and memantine for the treatment of Alzheimer's disease).

- The three acetylcholinesterase (AChE) inhibitors donepezil, galantamine and rivastigmine as monotherapies are recommended as options for managing mild to moderate Alzheimer's disease.
- Memantine monotherapy is recommended as an option for managing Alzheimer's disease for people with moderate Alzheimer's disease who are intolerant of or have a contraindication to AChE inhibitors.
- Memantine monotherapy is also recommended as an option for managing severe Alzheimer's disease.

- For people with an established diagnosis of Alzheimer's disease who are already taking an AChE inhibitor, clinicians can:
  - **consider memantine in addition to an AChE inhibitor in moderate disease And**
  - **offer memantine in addition to an AChE inhibitor in severe disease.**
- For people who are not taking an AChE inhibitor or memantine, prescribers should only start treatment on the advice of a clinician who has the necessary knowledge and skills.
- Once a decision has been made to start an AChE inhibitor or memantine, the first prescription may be made in primary care (see below).
- For people with an established diagnosis of Alzheimer's disease who are already taking an AChE inhibitor, **primary care prescribers may start treatment with memantine without taking advice from a specialist clinician**.
- Treatment should be continued only when it is considered to be having a worthwhile effect on cognitive, global, functional or behavioural symptoms
- Patients who continue on treatment should be reviewed regularly using cognitive, global, functional and behavioural assessment. Carer's views on the patient's condition on follow-up should be sought.

- AChE inhibitor treatment should normally be started with the drug with the lowest acquisition cost (taking into account required daily dose and the price per dose once shared care has started). However, an alternative AChE inhibitor could be prescribed if considered appropriate taking into account adverse event profile, expectations about adherence, medical comorbidity, possibility of drug interactions and dosing profiles.

Following a review of the NICE guidance (outlined above), the mental health lead GP has had discussions at locality level as to when prescribing of CEDs should move to primary care, and a decision has been made that GPs wish to maintain the status quo (i.e. AChE inhibitors and memantine are initiated by the Specialist team and shared care can be requested once the patient is on a stabilised dose (usually after 3 months). The only change to this shared care guideline is to allow GPs the ability to initiate memantine when used as an adjunct to acetylcholinesterase (AChE) inhibitors in moderate and severe Alzheimer's disease if considered appropriate. This only applies to clinicians who have received training and are comfortable to manage this addition.

Dementia with Lewy Bodies (DLB)

As per NICE NG 97 (Dementia: assessment, management and support for people living with dementia and their carers)

- Donepezil or rivastigmine can be offered to people with a diagnosis of mild to moderate DLB. (The use of these drugs for this indication is off-label.)
- Only consider galantamine for people with mild to moderate DLB if donepezil and rivastigmine are not tolerated. (The use of galantamine for this indication is off-label.)
- Donepezil or rivastigmine can be considered for people with severe DLB. (The use of donepezil or rivastigmine for this indication is off-label.)
- Memantine may be considered for people with DLB if AChE inhibitors are not tolerated or are contraindicated. (The use of memantine for this indication is off-label.)

Dementia in Parkinson's Disease

As per NICE Guideline 71 (Parkinson's disease in adults):

- AChE inhibitors can be offered to people with mild to moderate Parkinson's disease dementia. (The use of these drugs for this indication is off-label.)
- AChE inhibitors can be considered for people with severe Parkinson's disease dementia. (The use of these drugs for this indication is off-label.)
- Only consider memantine for people with Parkinson's disease dementia if AChE inhibitors are not tolerated or contraindicated. (Off-label.)

Vascular Dementia

As per NICE NG 97 (Dementia: assessment, management and support for people living with dementia and their carers)

- AChE inhibitors or mematine should only be considered if the person also has suspected comorbid Alzheimer's disease, DLB or Parkinson's disease dementia. (The use of these drugs for this indication is off-label.)
- Do not offer AChE inhibitors or memantine to people with frontotemporal dementia.
- Do not offer AChE inhibitors or memantine to people with cognitive impairment caused by multiple sclerosis.

SUMMARY OF SPECIALIST / MEMORY ASSESSMENT SERVICE (MAS) / COMMUNITY MENTAL HEALTH TEAM (CMHT) RESPONSIBILITIES.

1. Confirm the diagnosis of Dementia, including subtype.
2. Assess the likelihood of patient/carer compliance.
3. Counsel carers as to the likely benefits and risks of treatment, including the consequence of poor compliance.
4. Offer advice as to the limited effectiveness of treatment over time as the illness progresses.
5. Clear documentation of mental capacity assessments/power of attorney in patient notes.
6. **Shared Care: -** Contact the GP to request shared care; (shared care to be started once patient has been stabilised on CED medication - typically at around 3 months).
7. Offer an initial trial period of treatment for approximately 3 months of cognitive enhancing drug (CED), and assess response during, and at the end of the trial period. The dose should be titrated according to response and tolerance.
8. Provide the GP, in the form of a detailed report, information relating to the initial memory clinic assessment. The memory assessment Clinic will inform the GP of progress with dose titration at weeks 4 or 8, 12 or 16 (depending on the cognitive enhancing drug prescribed) during the medication titration phase.
9. On initiation, provide the GP and patient with information about treatment; particularly with regard to stopping treatment, the conditions/circumstances when treatment may be stopped; and the benefits that might be expected from a successful trial period for that patient in accordance with NICE TA217, NICE Guideline 97 and NICE Guideline 71, as appropriate.
10. **Transfer of Care**: - When a requisite response has been achieved at a dose commensurate with patient tolerability (usually after 6-8 months), consideration can be given to transferring the on-going monitoring of the CED to the GP.
11. The request for the transfer of care will usually be made when the patient has been stable on 6- 8 months of treatment.
12. The patient must have undergone the appropriate assessments and shown a beneficial response to treatment and the patient must be stable on a maintenance dose of dementia drug.
13. **The GP practice need to confirm the acceptance of the transfer of care.**
14. If the GP practice is happy to accept, the following information (as a minimum) have to be provided by the memory assessment service to the GP in order that the on-going prescribing and monitoring can be taken on by the primary care.
    - Transfer of Care guidelines
    - Clear diagnosis and care plan
    - Confirmation that the patient is stable on a maintenance dose and there has been benefit from treatment.
    - Specialist team contact details for GPs to obtain advice and support.

- That patient has been fully informed with regards to their treatment and consent has been discussed and documented including the change in where their future prescriptions will be issued from.
- Information and contact details of the rapid referral pathway needs to be provided to the GP.

15. Older Peoples CMHT will respond to GP requests for back-up advice by telephone ***within 24 hours*** (within normal working hours) and will provide access to consultant lead clinics ***within 4 weeks and*** **Urgent reviews within 3 working days** (when needed).
16. Older Peoples CMHT will review the patient if further mental health input is warranted, e.g. behavioural disturbances/deterioration in cognitive function, discontinuation of treatment. Information on re-assessments will be communicated to the GP after each clinic visit.
17. On discontinuing /adjusting treatment, consider restarting/switching treatment if the patient experiences a dramatic deterioration of cognitive function or unacceptable side effects. Inform GP and patient/carer of rationale.
18. Evaluate adverse events noted by the GP or the patient which require specialist intervention.
19. Patients with a diagnosis of Mild cognitive impairment along with a chronic disease, e.g. diabetes mellitus, hypertension, previous cerebrovascular accident (CVA) need to have a follow-up appointment at the memory clinic after 12 months.
20. Prescriptions should always be generated in the generic form.

SUMMARY OF GP RESPONSIBILITIES

Pre-Assessment and Diagnosis

1. Provide a full drug/medical history (preferably as recorded on the GP computerised records) using the ELFT dementia referral template to the Memory Assessment Service as per referral pathway.
2. Prior to referral to the Memory Assessment Service, perform an initial blood screen to rule out possible causes for cognitive impairment (FBC, ESR, U&E, LFT, eGFR measurement, calcium profile, blood glucose, TFT, B12 and red cell folate).
3. ELFT may accept referrals without an ECG, however there may be instances where an ECG is required. In these individual cases the ELFT clinician will discuss with the patient's GP.
4. At the time of referral, inform the specialist clinician regarding the availability of a carer or care-worker in order to ensure compliance with treatment.

Post-Assessment, Diagnosis and Agreement to Accept Shared Care

5. Once the patient has been adequately stabilised and benefit from cognitive enhancing drug therapy has been demonstrated, the GP will accept prescribing responsibility for the relevant CED drug, usually after 3 months. (Shared care)
6. Review the request from the specialist to take on the transfer of prescribing and monitoring of the patient. (usually after around 6-8 months)
7. Once the patient has been adequately stabilised(psychologically, behaviourally and medication optimised) and benefit from cognitive enhancing drug therapy has been demonstrated, the GP will accept prescribing and monitoring responsibility for the relevant drug, usually after 6 - 8 months. (Transfer of care)
8. If prescribing responsibility is not accepted, GP should inform the memory clinic (within 2 weeks), using the transfer of care template letter, providing a clinical reason for not accepting the transfer of care.

9. Transfer of care can be refused by GP if information provided from the memory assessment service is insufficient.
10. Monitor the patients overall health and wellbeing during the normal consultation process and monitor progression annually. Refer back to Older Peoples CMHT if there is deterioration in cognitive function which requires further investigation or emergence of Behavioural and Psychological Symptoms of Dementia.
11. Undertake minor dosage adjustments if necessary in accordance with specialist advice.
12. Check for possible drug interactions when newly prescribing or stopping concurrent medication.
13. Report any suspected adverse event to the specialist clinician and, if appropriate, to the MHRA.
14. Deal with any concomitant illness, with specialist clinic support if appropriate.
15. Inform the specialist clinic of life situation changes which may require revaluation in the suitability of cognitive enhancing drugs for the patient.
16. For people with an established diagnosis of moderate Alzheimer's disease who are already taking an AChE inhibitor, GPs can consider the addition of memantine therapy to the AChE inhibitor.
17. For people with an established diagnosis of severe Alzheimer's disease who are already taking an AChE inhibitor, GPs should offer the addition of memantine therapy to the AChE inhibitor

NOTE : Primary care clinicians may start treatment with memantine as an adjunct to acetylcholinesterase (AChE) inhibitors, for people with a diagnosis of Alzheimer's disease, without taking advice from a specialist clinician. This only applies to those clinicians who have received training and are comfortable to manage this addition.

18. Patients should be referred back to the Specialist Service in the following:-

    - When discontinuation of treatment is being considered.
    - Difference of opinion between primary care team and carer about stopping medication.
    - Uncertainty about side effects or benefits.
    - Behavioural problems that would require the community team whether or not the patient is taking anti-dementia medication.
    - If the GP would prefer a specialist opinion before initiating memantine as an adjunct therapy in patients with moderate to severe Alzheimer's disease. (See above)

19. On discontinuation/amendment of treatment by secondary care, refer back to a specialist clinician if the patient is observed to experience a dramatic deterioration in cognitive function.
20. Monitor and if necessary refer back to secondary care, any patients with behavioural/physiological symptoms which require further investigation, assessment and management.

Ongoing Monitoring requirements in primary care.

Annual Monitoring Review in Primary Care
The following is summary of the components to be included in the annual monitoring review of the patient. For QOF there should be an annual face to face review done
A template is available on SystmOne and this incorporates links and guidelines (BCCG only). The Ardens template may replace this in the future.

Monitor for adverse effects and drug interactions the most relevant are:

- Exacerbation of asthma and COPD
- Anorexia and weight loss
- GI ulcer or bleed
- AV node block as a possible cause of collapse
- Potential additive effects with other drugs that share the same side effects (e.g. beta-blockers and bradycardia; SSRIs and anorexia)

Compliance –
Is the medication being taken properly?

Physical Health Monitoring	**Rationale for Required Monitoring**
Weight	If weight loss has started or accelerated after starting AChE inhibitor medication, this may be the cause.
Pulse	If <60, or irregular carry out an ECG. If PR interval > 200ms, stop drug or discuss with mental health specialist.
U+Es with eGFR and LFTs	Donepezil, Galantamine and Rivastigmine- avoid in severe hepatic impairment. Caution in mild to moderate impairment. Clinical benefit needs to be weighed before plan is made to continue anti dementia medications in patients with mild to moderate hepatic impairment. If concerns then refer to secondary care. Memantine should be avoided in severe hepatic impairment. Galantamine- avoid if eGFR is less than 9ml/min/1.73 m2 Rivastigmine- titrates according to individual tolerability. Memantine- Reduce dose to 10mg if eGFR 30-49 ml/min/1.73 m2. If well tolerated after at least 7 days dose than can be increased in steps of 5mg up to 20mg daily. Reduce dose to 10mg if eGFR 5-29 ML/min/1.73 m2, avoid if e GFR less than 5ml/min/1.73 m2. **For further information – see relevant drug fact sheet.**
Overall tolerance to medication	GI symptoms - anorexia, nausea, vomiting and diarrhoea Neurological symptoms – headaches, dizziness, drowsiness, syncope

Impact on global functioning
Functional and behavioural assessment. This is best made via a discussion with the patient and carer (it might be important to see the carer alone to elicit behavioural problems).

• **Functional assessment**	Impact on daily living. Is there declining function?
• **Carer Impact**	Does the carer value the effect of the medication?
• **Behavioural assessment**	New behavioural problems? Is the patient displaying behavioural and psychological symptoms of dementia (BPSD)?
• **Functional assessment**	Impact on daily living. Is there declining function?

▪ **Cognitive Assessment**

-Some patients are distressed by repeated use of formal cognitive scoring tests. Therefore it is not always necessary to repeatedly use a formal scale to measure cognition as this can also be assessed via patient and carer interview.
-It is also important to consider the global functioning of the patient by discussion with the carer/relatives. It is often the case that no management
-When the use of a formal cognitive scoring test is appropriate (e.g. when there has been a significant deterioration in the global functioning), consider using either of the following open access primary care validated scales – 6CIT (six item cognitive impairment test) or GPCOG (the General Practitioner assessment of Cognition).

Is the medication still of overall beneficial to the patient?

Stopping Medication - *Medication should be stopped if:*

1. There is no cognitive, behavioural, functional or global benefit.
For GP management it is anticipated that if there is still an overall benefit and providing the patient is tolerating the treatment and there are no contraindications, the treatment will be maintained until such a time as it becomes inappropriate such as in extreme frailty.

3. If the patient cannot tolerate side effects
It is advisable to give reducing doses – e.g. donepezil 5 mg od for a month if the patient has been taking 10mg. Similar gradual reduction with other drugs may be used.

If there are concerns about response to treatment or if the patient develops adverse effects, refer back to the specialist for a review of treatment and discontinuation if necessary. If adverse effects are significant, the GP should stop treatment in advance of the specialist's review.

Factors that need to be taken into account when/if considering stopping cholinesterase inhibitor ChEI:

- *A subacute decline in cognitive performance, in the absence of other causes, may indicate that the ChEI is no longer effective.*
- *Family/patient views and expectations need to be taken into account.*
- *Medical complications? For patients with increasing physical problems, the risks of stopping ChEIs need to be weighed against the likelihood of developing new complications on continuing ChEIs.*
- *To what extent is the ChEI contributing the patient's quality of life if they are increasingly physical frail?*
- *For patients at risk of entering care home, stopping a ChEI may disrupt care and hasten*

admission.

- *Once a patient is in a care home individual patient factors need to be taken into account when deciding if memory-enhancing medication is right for them.*

There is no firm evidence on how to stop AChE inhibitors however it is recommended that discontinuation should be by gradual dose reduction (see table 1). The patient should be closely monitored for any subsequent deterioration and consideration given to the need to reinstate treatment.

Table 1: Stopping AChEIs

Donepezil	*Long half-life, so can be stopped without the need for tapering, however it may be advisable to reduce to 5 mg daily for a month and monitor for deterioration before stopping altogether.*
Rivastigmine	*Short half-life, reverse titration recommended – i.e. a reduction of 1.5 to 3 mg every 2 to 4 weeks.*
Galantamine	*Long half-life, so can be stopped without the need for tapering, however it may be advisable to gradually reduce the dose over a month and monitor for deterioration before stopping altogether.*

Contact Details (August 2019)
Older Peoples **CMHT**
Bedford
Consultant: Dr Chelimella
Dementia Nurse Specialist: Teresa Polman
Phone: 01234 880345
e-mail:elt-tr.BedfordBOPScmht@nhs.net

Mid Beds
Consultant: Locum cover.
Dementia Nurse Specialist: Clare Warren
Phone: 01767 224181 (and for MAC)
e-mail:elt-tr.midbedsopcmht@nhs.net

South Beds
Consultant: Dr Dabiri (Locum)
Dementia Nurse Specialist: Anita Olson
Phone: 01582 657588 (and for MAC)
e-mail:elt-tr.sbop@nhs.net

Memory Assessment Clinic
Dr Anwar (Clinical Lead for Memory Assessment Services, Bedfordshire & Luton.) 01234 275464

Manager, if unable to contact any of the above: Alison Lawrie-Skea- Alison.lawrie-skea@nhs.net, 07500 100305

Annex 1 – Definitions

Severity of Dementia

(from ICD -10)

- Mild – New learning mainly affected. Impaired performance in daily living but not to a degree it makes the individual dependent on others.
- Moderate – Degree of memory loss represents a serious handicap to independent living. Unable to function without assistance of another in daily living.
- Severe – Complete inability to retain new information, failure to recognise close relatives. Absence of intelligible ideation.

In clinical trials staging of dementia has tended to be defined by Mini Mental State score.

- Scores above 18/30 defined as “mild”,
- 10 to 18 defined as “moderate”
- And below 10 “severe”

Specialist Clinicians

Specialist clinicians (for the purpose of starting and monitoring treatment with cholinesterase inhibitors and memantine) are those with the appropriate knowledge and skills and include secondary care medical specialists (for example psychiatrists, geriatricians and neurologists) and other healthcare professionals (for example GPs, nurse consultants and advanced nurse practitioners) with specialist expertise in diagnosing and treating dementia**.**

Annex 2: DONEPEZIL drug fact sheet[1,2]

Dosage and Administration

Initial dose is 5mg (orally) once a day, in the evening just prior to bedtime. This initial dose should be continued for at least a month.

Following a one-month clinical assessment of treatment at 5mg/day, the dose may be increased to 10mg once a day, which is the maximum recommended daily dose.

For patients with renal impairment, the dosage schedule is the same. Due to possible increased exposure in mild to moderate hepatic impairment, dose escalation should be performed according to individual tolerability. No data is available for patients with severe hepatic impairment.

Precautions and Warnings

- *Reports of syncope and seizures. In investigating such patients the possibility of heart block or long sinus pauses should be considered.*
- *Not recommended for use in children and adolescents below 18 years of age.*
- *May affect the heart rate (e.g. bradycardia) which may be of particular importance in patients with sick sinus syndrome or other supraventricular cardiac conduction conditions*

e.g. sinoatrial or A-V block.

- *Patients at increased risk for developing ulcers e.g. those with a history of ulcer disease or those receiving nonsteroidal anti-inflammatory drugs (NSAIDs) should be monitored for symptoms.*
- *May cause Neuroleptic Malignant Syndrome (rarely). If patient develops hyperthermia, muscle rigidity, fever or unexplained weight loss, discontinue treatment.*
- *Drugs of this class may cause bladder outflow obstruction, are believed to have some potential to cause generalised convulsions and may have the potential to exacerbate or induce extrapyramidal symptoms.*
- *Prescribe with care to patients with a history of asthma or chronic obstructive pulmonary disease.*
- *Patients with rare hereditary problems of galactose intolerance, the Lapp lactase deficiency or glucose-galactose malabsorption should not take tablet formulations.*
- *Do not use in pregnancy unless clearly indicated.*

Contra-indications

- *Patients with a known hypersensitivity to donepezil, piperidines (e.g. terfenadine, azatadine, cyproheptadine, astemizole, loratadine) or any excipients used in the formulation. (e.g. lactose, maize, starch, cellulose, hyprolose, magnesium stearate*
- *Breast feeding mothers.*

Interactions

- *Avoid concomitant administration of donepezil with other cholinesterase inhibitors or agonists/antagonists of the cholinergic system.*
- *In vitro studies suggest that some enzyme inhibitors such as ketoconazole, quinidine, itraconazole, erythromycin and fluoxetine could inhibit the metabolism of donepezil, resulting in increased donepezil levels.*
- *Enzyme inducers such as rifampicin, phenytoin, carbamazepine and alcohol may reduce the levels of donepezil. Synergy may occur with concomitant treatment with succinylcholine, other neuro-muscular blockers or cholinergic agonists or beta blocking agents, which have effects on cardiac conduction.*
- *The above drug combinations should be used with care.*

Side-Effects

Common or very common *nausea, vomiting, anorexia, diarrhoea; fatigue, insomnia, headache, dizziness, syncope, psychiatric disturbances; muscle cramps; urinary incontinence; rash, pruritus;* ***less commonly*** *bradycardia, seizures, gastric and duodenal ulcers, gastro-intestinal haemorrhage;* ***rarely*** *sino-atrial block, AV block, liver dysfunction including hepatitis; potential for bladder outflow obstruction; extrapyramidal symptoms;* ***very rare*** *neuroleptic malignant syndrome, rhabdomyolysis*

Effects on ability to drive and use machines

Alzheimer's Dementia may cause impairment of driving performance or compromise the ability to use machinery. Furthermore, donepezil can induce fatigue, dizziness and muscle cramps, mainly when initiating or increasing the dose. The ability of Alzheimer patients on donepezil to continue driving or operating complex machines should be routinely evaluated by the treating physician.

For full information consult the latest Summary of Product Characteristics and the BNF

References

1. *Donepezil (Aricept) SPC, updated May 2018. Accessed May 19*

2. *Electronic BNF accessed May 19*

Annex 3: GALANTAMINE drug fact sheet[1,2,3]

Dosage and Administration

- *Galantamine tablets and oral solution should be administered twice a day, preferably with morning and evening meals. Galantamine prolonged release capsules should be administered once-daily in the morning, preferably with food. The capsules swallowed whole together with some liquid. The capsules must not be chewed or crushed. Ensure adequate fluid intake during treatment.*
- *Initial dose – 8mg/day for at least 4 weeks.*
- *Maintenance dose – 16mg/day for at least 4 weeks. An increase to the maintenance dose of 24mg/day should be considered on an individual basis depending on response to drug and tolerability.*
- *In individual patients not showing an increased response or not tolerating 24mg/day, a dose reduction to 16mg/day should be considered.*
- *Renal impairment (except severe – see below) – normal dosing schedule applies.*
- *Moderate hepatic impairment – using the tablets/oral solution initiate at 4mg daily for 1 week then 4mg twice daily for at least 4 weeks. – using the prolonged release capsules initiate at 8mg every other day for one week then 8mg once-daily for 4 weeks. Daily doses in these patients should not exceed 16mg.*

Precautions and Warnings

- *Weight loss during therapy has been reported – monitor patient's weight.*
- *May cause bradycardia – particularly important in patients who have sick sinus syndrome, or other supraventricular cardiac conduction disturbances or who are already receiving drugs which significantly reduce the heart rate e.g. digoxin, beta blockers, or for patients with uncorrected electrolyte disturbance.*
- *Caution should be exercised when administering galantamine to patients with cardiovascular diseases e.g. immediate post-myocardial infarction period, new-onset atrial fibrillation, second degree heart block or greater, unstable angina pectoris, or congestive heart failure, especially NYHA group III – IV.*
- *In a pooled analysis of placebo-controlled studies in patients with Alzheimer dementia treated with galantamine an increased incidence of certain cardiovascular adverse events were observed (supraventricular extrasystoles, AV block, sinus bradycardia).*
- *Serious skin reactions (Stevens – Johnson syndrome) has been associated with galantamine. Discontinue treatment at the first appearance of a skin rash.*
- *Patients at increased risk of developing peptic ulcers e.g. those with a history of ulcer disease or predisposed to these conditions should be monitored for symptoms. Not recommended in patients with gastro-intestinal obstruction or recovering from gastro-intestinal surgery.*
- *Drugs of this class are believed to have some potential to cause generalised convulsions.*
- *Cerebrovascular events were uncommonly observed in pooled placebo studies with galantamine. This should be considered when administering galantamine to patients with cerebrovascular disease.*
- *Prescribe with care in patients with a history of severe asthma or obstructive pulmonary disease or active pulmonary infections.*
- *Not recommended in patients with urinary outflow obstruction or recovering from bladder surgery.*
- *Refer to spc regarding allergies and contraindications to excipients*
- *Use with caution in a pregnant patient.*

Contra-indications

- *Known hypersensitivity to galantamine, or any excipients in the formulation.*
- *Severe hepatic (Child-Pugh score greater than 9) and/or renal (creatinine clearance less than 9 ml/min) impairment.*
- *Patients who have both significant renal and hepatic impairment.*
- *Breastfeeding women.*

Interactions

- *Should not be given concomitantly with other drugs of this class.*
- *May interfere with the activity of anticholinergic medication.*
- *May interact with drugs which significantly reduce the heart rate e.g. digoxin, beta blockers, certain calcium-channel blocking agents and amiodarone. Caution should be taken with medicinal products that have potential to cause torsade de pointes.*
- *May exaggerate effect of succinylcholine (and related) muscle relaxants.*
- *Drug interaction studies indicated that some enzyme inhibitors reduced the metabolism of galantamine resulting in higher bioavailability. Therefore, during initiation of treatment with potent enzyme inhibitors (e.g. quinidine, paroxetine, fluoxetine, fluvoxamine, ketoconazole, ritonavir, erythromycin) patients may experience an increase in cholinergic side-effects, predominantly nausea and vomiting. A reduction in galantamine maintenance dose (based on tolerability) may be considered.*

Side-effects

Common and very common *nausea, vomiting, diarrhoea, abdominal pain, dyspepsia, syncope; rhinitis; sleep disturbances, dizziness, confusion, depression, headache, fatigue, anorexia, tremor, fever, weight loss;* ***less commonly*** *arrhythmias, palpitation, myocardial infarction, cerebrovascular disease, paraesthesia, tinnitus, and leg cramps;* ***rarely*** *bradycardia, seizures, hallucinations, agitation, aggression, dehydration, hypokalaemia and rash;* ***very rarely*** *gastrointestinal bleeding, dysphagia, hypotension, exacerbation of Parkinson's disease, sweating and Steven's Johnson syndrome.*

Effects on ability to drive and use machines

Galantamine may cause dizziness and somnolence, which could affect the ability to drive or use machines, especially during the first weeks after initiation of treatment.

Reference

1. *Galantamine oral solution (Reminyl) SPC, updated June 2017. Accessed May 19*
2. *Galantamine 16mg XL caps (Reminyl XL) SPC, updated Jul 17. Accessed May 19*
3. *Electronic BNF accessed May 19*

Annex 4: RIVASTIGMINE drug fact sheet[1,2,3,4]

Dosage and Administration

- *Rivastigmine should be administered twice a day, with morning and evening meals. Capsules should be swallowed whole. The prescribed dose of the oral solution should be administered via the oral dosing syringe supplied.*
- *Initial dose is 1.5mg twice daily for a minimum of two weeks treatment.*
- *Subsequent dose increases to 3mg bd, then 4.5mg bd and finally 6mg bd should be undertaken at a minimum of fortnightly intervals, only if the patient is tolerating the current dose.*
- *Maintenance dose: the effective dose is 3 to 6mg twice a day. 6mg twice a day is the recommended maximum daily dose.*

- *Re-initiation of therapy – if treatment is interrupted for more than three days, it should be re-initiated at 1.5mg twice daily. Dose titration should then be carried out as described above.*
- *Renal and hepatic (except severe – see below) impairment: titrate dose according to individual tolerability.*
- *Treatment with rivastigmine patch starts with 4.6 mg/24 h. Apply 4.6 mg/24 hours daily for at least 4 weeks, increased if tolerated to 9.5 mg/24 hours daily for a further 6 months, then increased if necessary to 13.3 mg/24 hours daily, increase to 13.3 mg/24 hours patch if well tolerated and cognitive deterioration or functional decline demonstrated. If treatment interrupted for more than 3 days, re-titrate from 4.6 mg/24 hours patch.*
- *Transdermal patches should be applied once a day to clean, dry, hairless, intact healthy skin on the upper or lower back, upper arm or chest, in a place which will not be rubbed by tight clothing. It is not recommended to apply the transdermal patch to the thigh or to the abdomen due to decreased bioavailability of rivastigmine observed when the transdermal patch is applied to these areas of the body.*

Precautions and Warnings

- *Pregnancy – should not be used unless clearly necessary.*
- *Patients with body weight below 50 kg may experience more adverse reactions and may be more likely to discontinue due to adverse reactions.*
- *Gastrointestinal disorders (e.g. nausea and vomiting) may occur particularly when initiating treatment and/or increasing the dose. More common in women.*
- *Monitor patient's weight.*
- *In case of severe vomiting, it may be necessary to temporarily reduce the dose or discontinue treatment (consult SPC for further information).*
- *Use with care in patients with sick sinus syndrome or conduction defects (e.g. sino-atrial or A-V block).*
- *May increase gastric acid secretions; use with care in patients with active gastric or duodenal ulcers or those predisposed to these conditions.*
- *Use with care in patients with a history of asthma or obstructive pulmonary disease.*
- *Drugs in this class may induce or exacerbate urinary obstruction and seizures. Caution is recommended in treating patients pre-disposed to these diseases.*
- *Rivastigmine may exacerbate or induce extrapyramidal symptoms; including worsening in patients with dementia associated Parkinson's disease.*
- *Skin application site reactions may occur with rivastigmine patch and are usually mild or moderate in intensity. Patients and caregivers should be instructed accordingly.*
- *For allergies and contra-indication regarding the excipients refer to the spc*

Contra-indications

- *Not recommended for use in children.*
- *Known hypersensitivity to rivastigmine, or other carbamate derivatives (e.g. physostigmine, pyridostigmine) or any excipients in the formulation.*
- *Severe liver impairment*
- *Women on rivastigime should not breast-feed*
- *Previous history of application site reactions suggestive of allergic contact dermatitis with rivastigmine patch.*

Interactions

- *Should not be given concomitantly with other drugs in this group.*
- *May interfere with the activity of anticholinergic medication.*
- *Metabolic drug interactions appear unlikely, although rivastigmine may inhibit the butyrylcholinesterase mediated metabolism of other drugs (e.g. neuromuscular blockers).*
- *Rivastigmine may exaggerate the effects of succinylcholine type muscle relaxants during anaesthesia.*
- *Combined use of various beta blockers and rivastigmine may lead to bradycardia, and*

potential fainting.

Side-effects

Common and very common *nausea, vomiting, diarrhoea, dyspepsia, anorexia, abdominal pain; dizziness, headache, drowsiness, tremor, asthenia, malaise, agitation, confusion; sweating, weight loss and rash (with patches)* ***less commonly*** *syncope, depression, insomnia;* ***rarely*** *gastric or duodenal ulceration, angina pectoris, seizures****; very rarely*** *gastro-intestinal haemorrhage, pancreatitis, cardiac arrhythmias, bradycardia, hypertension, hallucinations, extrapyramidal symptoms (including worsening of Parkinson's disease), and rash. (****Note*** *– Gastro-intestinal side-effects more common in women).*

Effects on ability to drive and use machines

Alzheimer's disease may cause gradual impairment of driving performance or compromise the ability to use machinery. Furthermore, rivastigmine can induce dizziness and somnolence, mainly when initiating treatment or increasing the dose. Therefore, the ability of Alzheimer's patients on rivastigmine to continue driving or operating complex machines should be routinely evaluated by the treating physician.

For full information consult the latest Summary of Product Characteristics and the BNF

Reference

1. *Rivastigmine oral solution SPC, updated Sep 17 accessed May 19*
2. *Rivastigmine capsules (Imvastid) SPC updated May 16 accessed May 19*
3. *Rivastigmine patches (Exelon) SPC updated May 18 accessed May 19*
4. *Electronic BNF accessed May 19*

Annex 5: MEMANTINE drug fact sheet[1,2,3]

Dosage and Administration

- *Initial dose is 5mg (orally) once a day. This initial dose should be continued for 1 week*
- *In order to reduce the risk of undesirable effects the maintenance dose is achieved by upward titration of 5 mg per week over the next 3 weeks*
- *The recommended maintenance dose is 20 mg per day.*
- *In patients with eGFR of 30-49 ml/min/1.73 m2 (moderate renal impairment) the daily dose should be reduced to 10mg. If well tolerated after at least 7 days, dose can be increased in steps of 5mg up to 20mg daily. Reduce dose to 10mg if eGFR 5-29 ml/min/1.73 m2. Avoid if eGFR is less than 5ml/min/1.73m2. Memantine is not recommended in patients with severe hepatic impairment.*
- *Memantine should be taken orally once daily at the same time each day. The solution or orodispersible tablet or film-coated tablet can be taken with or without food. The solution must not be poured or pumped into the mouth or directly from the bottle or pump but should be dosed onto a spoon or into a glass of* ***Precautions and Warnings***
- *Caution is recommended in patients with epilepsy.*
- *Concomitant use of N-methyl-D-aspartate (NMDA)-antagonists such as amantadine, ketamine or dextromethorphan should be avoided.*
- *Memantine should not be used during pregnancy unless clearly necessary.*

Contra-indications

- *Women taking memantine should not breastfeed.*
- *For allergies and contra-indication regarding the excipients refer to the spc*

Interactions

- *The mode of action suggests that the effects of L-dopa, dopaminergic agonists, and anticholinergics may be enhanced by concomitant treatment with memantine.*
- *Concomitant use of memantine and amantadine should be avoided, owing to the risk of*

pharmacotoxic psychosis.

- *Memantine is predicted to increase the risk of CNS side-effects when given with ketamine. Manufacturer advises avoid.*
- *In post-marketing experience isolated cases with international normalized ratio (INR) increases have been reported in patients concomitantly treated with warfarin, although no causal relationship has been established.*

Side-Effects

Common *balance disorders, elevated LFTs, somnolence, drug hypersensitivity, dizziness, hypertension, dyspnoea, constipation and headache.* ***Less common*** *fungal infection, confusion, hallucinations, cardiac failure, VTE, abnormal gait, vomiting and fatigue.*

Effects on ability to drive and use machines

Moderate to severe Alzheimer's disease usually causes impairment of driving performance and compromises the ability to use machinery. Furthermore, memantine has minor or moderate influence on the ability to drive and use machines, such that outpatients should take special care.

For full information consult the latest Summary of Product Characteristics and the BNF

Reference

1. *Memantine 10mg film coated tablets (Ebixa) SPC, updated Mar 19 accessed May 19*
2. *Memantine 5mg/pump actuation oral solution (Ebixa) SPC updated Mar 19 accessed May 19*
3. *Memantine Orodispersible Tablets (Valios®), SPC updated Aug 18 accessed May 19 https://www.medicines.org.uk/emc/product/2073/smpc*
4. *Electronic BNF accessed May 19*

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Management of Dementia - Transfer of Care Guidance

NHS Foundation Trust

Clinical Commissioning Group

Pre-assessment – GP to provide full drug/medical history using referral template
Perform initial blood screening.

Memory Assessment Service – Patient is diagnosed with dementia sub-type and is suitable for treatment.

Drug for dementia is initiated by Memory Assessment team.
Dose is titrated until patient is stable and patient is **monitored and reviewed for 6-8 months.**

Good therapeutic response, patient stable on treatment,

Patient either does not have a good therapeutic response or cannot be stabilised on treatment.

GP agrees to take on prescribing and monitoring and completes acceptance template

GP unhappy to take on prescribing and monitoring and completes refusal template

Managed by the Memory Clinic
(Note: patient's who decline medication may receive post-diagnostic support/signposting and be discharged to GP.)

Prescribing and monitoring transferred onto the GP with all the supporting documentation

- Transfer of care guidelines
- Diagnosis and care plan
- Drug treatment and dose.
- Specialist team contact details
- Details of Fast track referral

At any stage of treatment the GP can refer back to the specialist service if

- the patient does not have a good therapeutic response
- If the patient cannot be stabilised on treatment
- There is uncertainty about side effects or benefits
- There is deterioration in cognitive needs
- Has behavioural issues requiring community team input (whether or not the patient is taking medication for the treatment of dementia.

Annual monitoring review in primary care including cognitive, functional, behavioural and global assessment

Good effect on cognitive, global, functional or behavioural symptoms

Good response -continue treatment

For patients with an established diagnosis of Alzheimer's disease who are already taking an AChE inhibitor, primary care clinicians may start adjunct treatment with memantine without taking advice from a specialist clinician if they are happy to do so

Contact Details Older Peoples **CMHT Bedford**
Consultant: Dr Anwar
Dementia Nurse Specialist: Teresa Polman
Phone: 01234 880345
e-mail:elt-tr.BedfordBOPScmht@nhs.net

Mid Beds
Consultant: Dr Kapila (locum)
Dementia Nurse Specialist: Clare Warren
Phone: 01767 224181
e-mail:elt-tr.midbedsopcmht@nhs.net

South Beds
Consultant: Dr Dabiri
Dementia Nurse Specialist: Anita Olson
Phone: 01582 657588
e-mail:elt-tr.sbop@nhs.net

NHS East London NHS Foundation Trust

NHS Bedfordshire Clinical Commissioning Group

Transfer of care agreement

GP Practice details:
Name……
Address……
……
Tel no……
Fax no……

Patient details:
Name……
Address……..
……..
D.O.B……
NHS Number……..

Consultant name……
Clinic name……
Contact details……
Address……
……
Tel no……..Fax no……

Rapid referral number –

Diagnosis

Current medication and dose

The following investigations have been performed on……. /……. /……. and are acceptable for transfer of care.
MMSE
BP
PULSE

Dear GP,

Mr / Mrs /Ms ---------- has been prescribed dementia treatment for the above diagnosis. He/she has been on the treatment under shared care and is now stable and benefiting from this treatment.
We would like to transfer the care of this patient and would like to request your agreement to receive the care of this patient from …./……/…….in accordance with the transfer of care guidelines (approval date ---------) enclosed.
Patient information has been given outlining potential aims and side effects of this treatment. The patient has given me consent to treatment under this transfer of care (with your agreement) and has agreed to comply with instructions and follow up requirements. We have also informed the patient that the medication may be discontinued if not proving effective.

Memory Nurse Name:
Consultant Name:
Signature: Date

GP - Refusal to accept transfer of care

Consultant name……

Clinic name……
Contact details……
Address……
……
Tel no……..Fax no……

Patient details:
Name……
Address……..
……..
D.O.B……
NHS Number……..

Dear Consultant,
I am unable to accept the transfer of care due to following reasons,

- I would like further information
  ……
  ……..
  ……
  …
- I am not willing to undertake transfer of care for this patient for the following reason……
  ……
  ……

GP Name:……
GP Signature:……
GP surgery…
Date:

Reply to memory service within 14 days of receiving this request.
Fax number-