

Executive summary of recommendations



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Executive summary of recommendations

Details of recommendations can be found in the main text at the pages indicated.

Screening and assessment of dementia

C There is currently insufficient evidence for routine screening for dementia in older adults. Individuals who should be evaluated for dementia include those with progressive cognitive or behavioural complaints suggestive of dementia, as well as patients who arouse the physician's or caregiver's suspicion of cognitive impairment despite absence of complaints (pg 11).

Grade C, Level 2+

GPP Assessment of dementia should be done via a comprehensive evaluation. This approach will aim to diagnose dementia early, assess for complications of dementia and establish the cause of the dementia (pg 11).

GPP

B In individuals with suspected cognitive impairment, diagnosis can be made using the DSM-IV criteria for dementia with history from a reliable informant. This can be supplemented by an objective approach with cognitive tests (ECAQ/AMT/CMMSE) and/or neuropsychological assessment (pg 12).

Grade B, Level 2++

B The complications of dementia can be broadly divided into behavioural and psychological symptoms, functional problems and social problems. These should be evaluated in all patients with dementia as these issues are the major causes of stress on the caregiver and assessment would enable the clinician to target subsequent management effectively (pg 15).

Grade B, Level 2++

D The aim of determining dementia aetiology is to rule out potentially reversible causes of dementia and selecting appropriate treatment strategies for the irreversible dementias. This is done via clinical history and physical examination, followed by laboratory investigations and neuroimaging (pg 18).

Grade D, Level 4

B A number of well-validated clinical criteria for the two most common types of dementia (Alzheimer's disease and Vascular dementia) have been developed over the years. These can be used in the specialized dementia clinics for the definition of Alzheimer's disease and Vascular dementia (pg 20).

Grade B, Level 2++

Pharmacological management of dementia

GPP Pharmacotherapy should be part of a multi-pronged strategy to dementia management that encompasses a well-established diagnosis, education of patient and caregiver, non-pharmacological measures and comprehensive caregiver psychosocial intervention (pg 25).

GPP

B Although high dose vitamin E (2000 IU per day) may have a modest effect in delaying disease progression in moderately severe Alzheimer's disease, doses of vitamin E in excess of 400 IU a day should be avoided for the treatment of Alzheimer's disease until there is further data on its safety, especially in patients with cardiovascular disease (pg 26).

Grade B, Level 1+

A Anti-inflammatory agents (such as non-steroidal anti-inflammatory agents and cyclo-oxygenase 2 inhibitors) are not recommended for the prevention of cognitive decline in Alzheimer's disease (pg 27).

Grade A, Level 1++

B Prednisolone is not recommended for the prevention of cognitive decline in Alzheimer's disease (pg 27).

Grade B, Level 1+

A Oestrogen is not recommended for the prevention of cognitive decline in women with dementia (pg 27).

Grade A, Level 1++

A Acetylcholinesterase inhibitors should be considered for the management of all patients with mild to moderate Alzheimer's disease (pg 27).

Grade A, Level 1++

B Acetylcholinesterase inhibitors can be considered for the management of moderate to severe Alzheimer's disease (pg 28).

Grade B, Level 1+

A Acetylcholinesterase inhibitors have been shown to be of clinical benefit and may be considered for use in the management of mild to moderate vascular dementia (pg 28).

Grade A, Level 1+

B Acetylcholinesterase inhibitors can be considered for the management of dementia with Lewy bodies and Parkinson's disease dementia (pg 29).

Grade B, Level 1+

B All three available acetylcholinesterase inhibitors (donepezil, rivastigmine and galantamine) can be considered for the pharmacological management of dementia, since there is no definite evidence to support a difference in clinical efficacy between them (pg 30).

Grade B, Level 1+

A Where tolerated, acetylcholinesterase inhibitors should be titrated to recommended doses (5-10 mg/day donepezil; 6-12 mg/day rivastigmine; 16-24 mg/day galantamine), which have been shown to confer greater benefit compared with lower doses (pg 30).

Grade A, Level 1++

B N-methyl D-aspartate antagonists such as memantine can be considered for the management of moderate to severe Alzheimer's disease, either alone or in combination with acetylcholinesterase inhibitors (pg 31).

Grade B, Level 1+

B N-methyl D-aspartate antagonists such as memantine may be a treatment option for mild to moderate Alzheimer's disease, if acetylcholinesterase inhibitor therapy is contra-indicated, not tolerated or if there is disease progression despite an adequate trial of acetylcholinesterase inhibitor (pg 31).

Grade B, Level 1+

A N-methyl D-aspartate (NMDA) antagonists have been shown to be of clinical benefit and may be considered for use in the management of mild to moderate vascular dementia (pg 32).

Grade A, Level 1+

B Practitioners who prescribe ginkgo for the treatment of dementia should be aware of the unestablished benefit, variability of active ingredient among preparations, and potential for drug interactions (pg 32).

Grade B, Level 1+

A Selegiline is not recommended for the treatment of core or associated symptoms in Alzheimer's disease (pg 33).

Grade A, Level 1++

GPP Appropriate treatment of vascular risk factors is recommended for all patients. However, it should be noted that whilst promising observational data exists, it remains to be shown in a randomised controlled clinical trial if any prevention strategy such as blood pressure reduction or antiplatelet treatment for the secondary prevention of stroke, will reduce the incidence of vascular dementia (pg 33).

GPP

GPP The decision to initiate costly symptomatic dementia treatment, such as acetylcholinesterase inhibitors or N-methyl D-aspartate antagonists, should always be made in consultation with the patient and family after careful consideration of the expected magnitude of benefit, side effects, co-morbidities and costs of treatment (pg 33).

GPP

GPP Patients who are started on acetylcholinesterase inhibitors or N-methyl D-aspartate antagonists, should be carefully monitored for side effects and response to treatment (pg 34).

GPP

Management of behavioural and psychological symptoms of dementia (BPSD)

GPP Non-pharmacological methods to manage behavioural and psychological symptoms of dementia should be instituted, prior to consideration of pharmacological measures (pg 37).

GPP

GPP Antidepressants may be used for the treatment of comorbid depression in dementia provided their use has been evaluated carefully for each patient (pg 39).

GPP

A Conventional and atypical antipsychotics may be used with caution, given their side effect profile, to treat neuropsychiatric symptoms of dementia (pg 39).

Grade A, Level 1+

B Trazodone may be considered for patients with depressive symptoms and dementia associated agitation (pg 40).

Grade B, Level 1+

A Routine use of mood stabilizers, such as carbamazepine and sodium valproate, is not recommended for treatment of behavioural symptoms associated with dementia (pg 41).

Grade A, Level 1+

GPP An individualized approach to managing behavioural problems in dementia patients is required (pg 41).

GPP

GPP Cholinesterase inhibitor therapy may be considered in treatment of patients with behavioural problems if antipsychotics are inappropriate (pg 41).

GPP

GPP The decision to start antipsychotic therapy to control behavioural problems in dementia patients should be made in consultation with the patient and family, after careful consideration of the benefit, adverse-effects and comorbidities (pg 41).

GPP

B For patients with dementia with Lewy Body and behavioural problems, acetylcholinesterase inhibitors should be considered first for management of the behavioural problems (pg 42).

Grade B, Level 1+

GPP In all patients started on antipsychotic medication, they should be monitored carefully for side effects and response to treatment. In patients who are stable, antipsychotic withdrawal should be considered (pg 42).

GPP

Social and caregiver management of dementia and community resources

A Caregiver interventions via a multifaceted approach should be considered in the total management of the person with dementia (pg 44).

Grade A, Level 1+

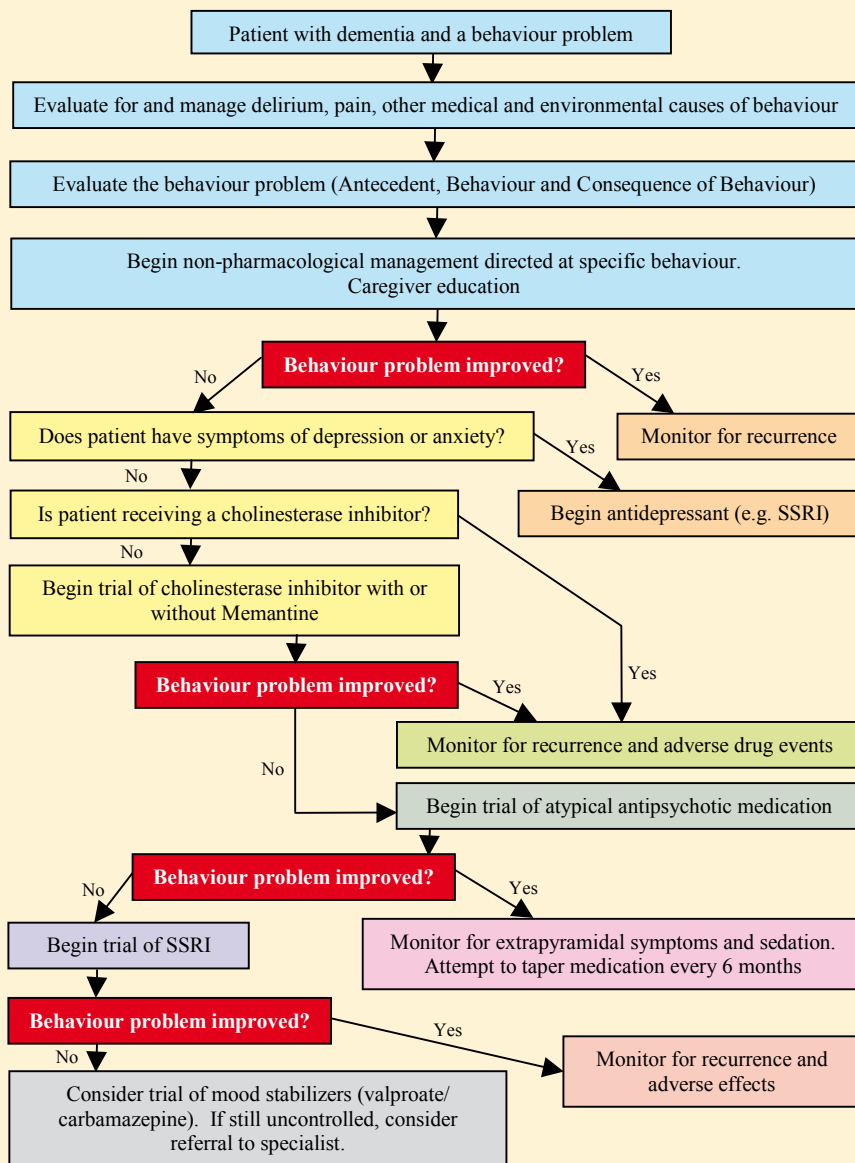
GPP Where appropriate, respite care can be offered to relieve the burden of caregiving on the family caregiver (pg 45).

GPP

GPP Referral to community resources to meet the care needs of the person with dementia and his/her carer should always be considered (pg 46).

GPP

Algorithm for management of neuropsychiatric symptoms of dementia



SSRI = selective serotonin reuptake inhibitor

Adapted with permission from KM Sink et al. JAMA 2005;293: 596-608. Recommended algorithm for management of neuropsychiatric symptoms of dementia.

Levels of evidence and grades of recommendation

Levels of evidence

Level	Type of Evidence
1 ⁺⁺	High quality meta-analyses, systematic reviews of randomised controlled trials (RCTs), or RCTs with a very low risk of bias.
1 ⁺	Well conducted meta-analyses, systematic reviews of RCTs, or RCTs with a low risk of bias.
1 ⁻	Meta-analyses, systematic reviews of RCTs, or RCTs with a high risk of bias
2 ⁺⁺	High quality systematic reviews of case control or cohort studies. High quality case control or cohort studies with a very low risk of confounding or bias and a high probability that the relationship is causal
2 ⁺	Well conducted case control or cohort studies with a low risk of confounding or bias and a moderate probability that the relationship is causal
2 ⁻	Case control or cohort studies with a high risk of confounding or bias and a significant risk that the relationship is not causal
3	Non-analytic studies, e.g. case reports, case series
4	Expert opinion

Grades of recommendation

Grade	Recommendation
A	At least one meta-analysis, systematic review of RCTs, or RCT rated as 1 ⁺⁺ and directly applicable to the target population; or A body of evidence consisting principally of studies rated as 1 ⁺ , directly applicable to the target population, and demonstrating overall consistency of results
B	A body of evidence including studies rated as 2 ⁺⁺ , directly applicable to the target population, and demonstrating overall consistency of results; or Extrapolated evidence from studies rated as 1 ⁺⁺ or 1 ⁺
C	A body of evidence including studies rated as 2 ⁺ , directly applicable to the target population and demonstrating overall consistency of results; or Extrapolated evidence from studies rated as 2 ⁺⁺
D	Evidence level 3 or 4; or Extrapolated evidence from studies rated as 2 ⁺
GPP (good practice points)	Recommended best practice based on the clinical experience of the guideline development group.