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Patient-Centric Approaches to Optimizing Outcomes in AAD: Case Review

### Announcer Intro:

Welcome to CME on ReachMD. This activity, titled "Patient-Centric Approaches to Optimizing Outcomes in AAD: Case Review" is provided by Total CME, LLC.

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### Dr. Porteinsson:

Early diagnosis and management of agitation and Alzheimer's disease is part of a comprehensive plan to get patients treated. How can primary care physicians enhance communication with caregivers to help recognize the subtle signs of agitation in Alzheimer's disease, or AAD?

This is CME on ReachMD and I'm Dr. Anton Porteinsson.

### Dr. Montano:

And I'm Dr. Brendan Montano.

### Dr. Porteinsson:

Brendan, let me review a case. This is one of my patients.

T Smith was a 69-year-old retired Caucasian male who was diagnosed with Alzheimer's disease 2 years ago and he was seen by his primary care doctor, Doctor B, for an evaluation of some newer neuropsychiatric symptoms. When he was seen today, he and his wife described new onset neuropsychiatric symptoms. What was going on? His mood has been more labile, he chokes up easily, and is overall a little more down. He attributes that to fear and frustration over what is happening to him. There's no anhedonia, though. No apathy, no decreased motivation. He denies feeling hopeless or worthless. At times, feels helpless. He denies social withdrawal. His sleep and his appetite are good, and this is important because it makes depression be a little less likely.

There were no hallucinations or delusions, although he worries more about being the victim of theft and routinely locks his doors and window. He admits to anxiety and feeling restless. His wife often finds him pacing around the house. He cannot relax. There is excessive frustration and irritability, especially if things are outside of his routine or when he struggles with decision making or cannot manage tasks that used to come easily. Whereas he was consistently mild mannered, he now swears, he cusses, and he yells at his wife.

She has occasionally been worried about the intensity of his anger, but he hasn't been physically aggressive. He gets resistive and upset when she offers to help him, when she wants to drive or take-over paying the bills, and then routinely storms out, slams the doors, will pace in the yard until he calms down.

These behaviors were fairly infrequent, but they are now happening a few times per week. They're clearly increasing in frequency as well as intensity. The behaviors are causing increased distress to both Mr. Smith as well as his wife, and Mrs. Smith admits frequently being brought to tears.

We did a medical workup and lipid laboratory values were unremarkable, and cognitive testing showed an MSSE score of 23/30, which is consistent with mild Alzheimer's disease, and the MoCA score of 17/30. Basically, a physical and neurological exam was non-focal. There was a faint bilateral palmomental reflex, and on mental status examination, basically, unremarkable except for a couple of episodes of tearfulness when he was talking about the changes in his life and being a burden to his wife due to his behaviors. He did, though, become upset during cognitive testing and threatened to leave, but could be convinced to stay in complete testing.

Brendon, what is your impression of this patient and what are some of the subtle signs of agitation in Alzheimer's disease that should be considered?

**Dr. Montano:**

Yes. No, very interesting that you point out a gentleman who doesn't have classical symptoms that you would think of when it comes to depression. Retired 2 years ago, so you think maybe he's depressed, not happy, but it's not that. He has started to pace more, be much more restless and is having cognitive difficulties, clear cognitive difficulties. He also is showing a lot more anxiety and restlessness, even perhaps a little paranoia worrying about someone breaking into the house, as if he's losing his abilities to care for himself and his wife. So, I would be very concerned here about – and with the 23 on his Mini Mental status, I'd be concerned about early Alzheimer's dementia. I think that would be important to rule out.

**Dr. Porteinsson:**

Yeah. In fact, we had diagnosed him with Alzheimer's disease 2 years earlier, and his course had been fairly benign, and suddenly there's this emergence of neuropsychiatric symptoms that clearly are becoming more disruptive, more intense, and increasing the distress both for the patient and the care partner.

**Dr. Montano:**

Right. His symptoms. And you said it was increasing not only in intensity but in frequency. So, it seems like it's progressive.

**Dr. Porteinsson:**

And I think that, as with many patients that have some insight into their disease, they are distressed by it. They become tearful. But the type of behaviors here that we're kind of overriding was actually the motor restlessness, the irritability, the resistiveness to care, and the verbal aggression, which was so different for this mild-mannered, gentle guy. And, I think that that was basically the most striking aspect of his presentation.

Now, Brendan, can you tell me in the primary care setting, what about the communications between the primary care provider and the care partner of the patient with dementia? How can the interaction be facilitated?

**Dr. Montano:**

That's where it is all at. They are often bringing in their loved one and saying he's much harder for me to manage. I'm unable to take care of his needs, and he gets angry with me. He is frustrated with me. And I see him getting worse. He's losing it. Those are the kinds of things I'll tend to see. And that's when you begin to have a discussion and you say well, you know, he has mild dementia, but it's a progressive illness. You need to talk with people who know how to deal with this. From all of our indications, it's Alzheimer's disease and this is not an unusual behavioral change to occur, but there are ways that we can manage this. We need a team approach. So, you introduce the team, and you introduce the Alzheimer's Association. You do a good general medical evaluation in every way, and you bring a neurologist in, if at all possible, to document and know exactly where he's at. And then working very carefully with the caregiver to know that the problems that she has now are unlikely to improve, but are likely to get worse.

**Dr. Porteinsson:**

And what was fascinating in this situation is that I had been managing this patient for 2 years, but this was actually brought up to his primary care physician. In the primary care physician's lap first. I think that's partly because of the longstanding relationship that you may see between patients and care partners and their primary care physicians. This is a trusted relationship for a long time. And also because they may see their primary care provider more often than the specialist. And I think for primary care providers, being aware of the emergence of neuropsychiatric symptoms, and how common they are and how distressing they are, and the negative outcomes not only for the patient but also the caregiver, is critical. And that when you have patients that have memory disease, you may actually have to proactively screen. Are there any behavioral changes that are of concern?

Because the patients may not recognize that their behavior is disruptive, they may not want to admit it, but more surprising, actually, the caregiver may not want to admit this because they see this as maybe a personal failure. They see this as somehow a personality change in the patient and that this is a sign of some sort of a friction between the two of them that they find hard to admit. So, appropriate education about the fact that this is a common component of the disease, I think, is critical.

So, let's continue this case focusing on treatment. So, Doctor B, the primary care physician, did the necessary evaluation, looked at the possibility of medical contributors such as pain or infection, and did not feel that there were acute medical contributors to the behaviors, and she basically told the patient and his wife that this behavioral pattern was consistent with the diagnosis of agitation and Alzheimer's disease. She reviewed non-pharmacological interventions using then the nurse in her office to reach out to social work if needed and to connect with community resources, such as the Alzheimer's Association. She also pointed out that with the increased aggression that safety parameters were important and what to do in a crisis situation, that you may have to, in crisis situation, call 911 and ask for help if for example, the patient becomes physically aggressive.

In view of the fact that this seemed to be fairly classical agitation with Alzheimer's disease and that there was this degree of verbal aggression that was present, she suggested treatment with brexpiprazole, that was recently approved for this indication, starting at half a milligram a day for one week, then increasing to 1 milligram daily for another week, and finally to 2 milligrams daily after that. She pointed out that you might possibly need to increase the dose to 3 milligrams daily, but that wouldn't be done right away.

They did set up an appointment 4 weeks later. She reminded them that she would be available, that they could reach out to the office, and that at the next visit, they would talk about whether additional dose increase was needed. Appropriately, she made certain that they were aware of why they were using this medication. Also, about what the likely benefits were, what to look for in terms of that, and of possible side effects. She pointed out that the drug has a boxed warning like the other atypical antipsychotics, but that that boxed warning has been modified because this is now an approved indication. And basically, then they had a conversation about the where they would go from now. And she asked them to keep her updated.

But what do you think? How do you feel about this kind of plan and this progress?

**Dr. Montano:**

Early intervention at this time is important because, what often will precipitate her loved one going into a facility because she can no longer manage him. So, if you can keep things under much better control as far as the agitation, physical or verbal abuse, it's going to make his life calmer, it's going to make her life much calmer, much better. And I'm glad you brought up the dosing. It's so important to realize that the operative dose for use of this drug is when it gets to 2 or 3 milligrams, 2 being the first place where you're going to see a real change. And in the data that we've collected when we've looked at not only clinical global impressions from doctors who did the research, but evidence base with the Cohen-Mansfield Agitation index, you don't necessarily see it at all at half a milligram or 1 milligram. You see it at 2, after a full week, and that's 3 to 4 weeks into the treatment, you know? So, I really think you've made a very good point that this was an excellent way of treating this patient.

**Dr. Porteinsson:**

Brendon, this has been a fantastic conversation. And we're out of time, so thanks and I hope the audience finds this informative.

**Dr. Montano:**

Thank you.

**Announcer Close:**

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