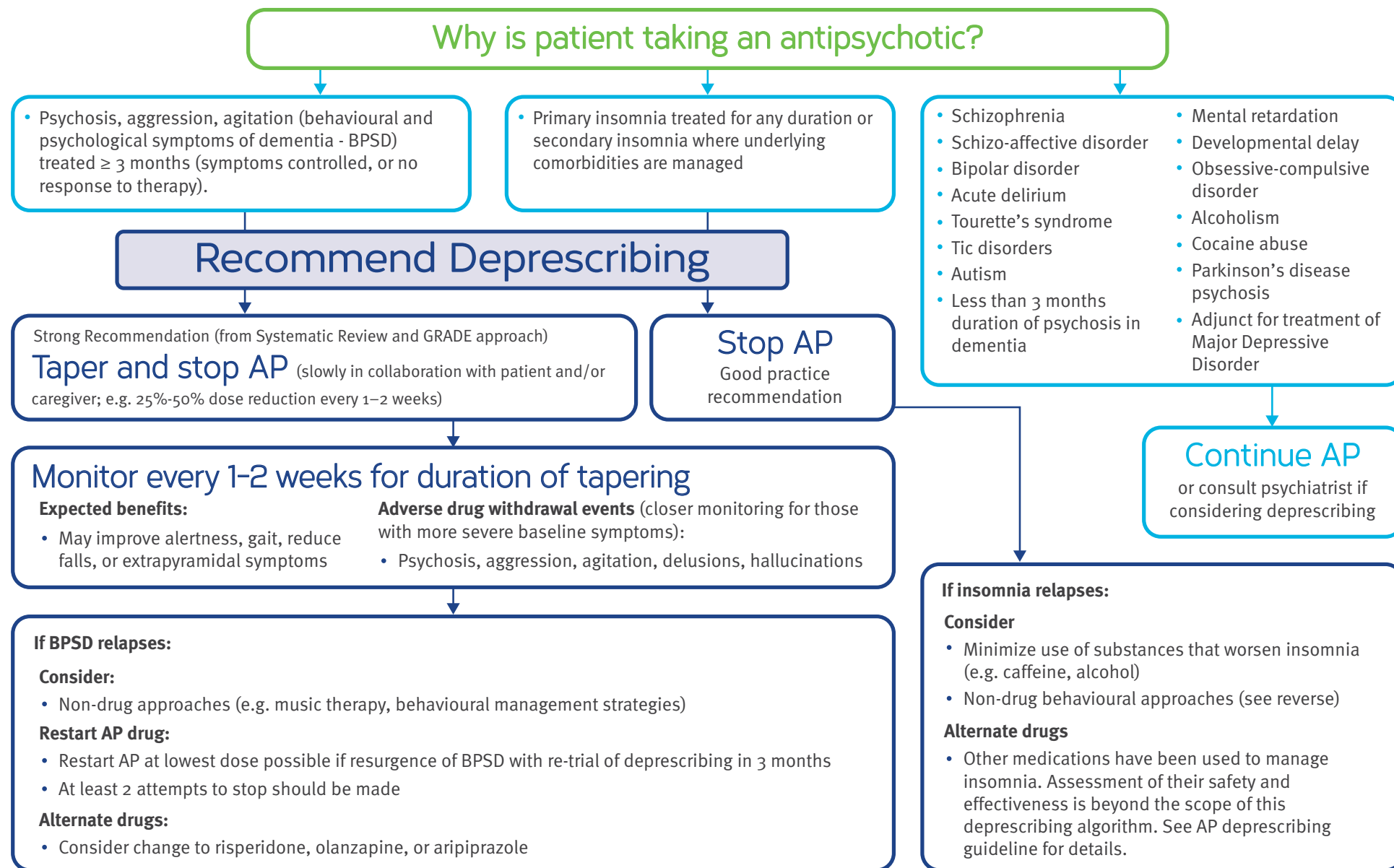


## Antipsychotic (AP) Deprescribing Algorithm



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Bjerre LM, Farrell B, Hogel M, Graham L, Lemay G, McCarthy L, et al. Deprescribing antipsychotics for behavioural and psychological symptoms of dementia and insomnia. Evidence-based clinical practice guideline. *Can Fam Physician* 2018;64:17-27 (Eng), e1-12 (Fr).



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## Commonly Prescribed Antipsychotics

Antipsychotic	Form	Strength
Chlorpromazine	T IM, IV	25, 50, 100 mg 125 mg/mL
Haloperidol (Haldol®)	T L IR, IM, IV LA IM	0.5, 1, 2, 5, 10, 20 mg 2 mg/mL 5 mg/mL 50, 100 mg/mL
Loxapine (Xylac®, Loxapac®)	T L IM	2.5, 5, 10, 25, 50 mg 25 mg/L 25, 50 mg/mL
Aripiprazole (Abilify®)	T IM	2, 5, 10, 15, 20, 30 mg 300, 400 mg
Clozapine (Clozaril®)	T	25, 100 mg
Olanzapine (Zyprexa®)	T D IM	2.5, 5, 7.5, 10, 15, 20 mg 5, 10, 15, 20 mg 10mg per vial
Paliperidone (Invega®)	ER T PR IM	3, 6, 9 mg 50mg/0.5mL, 75mg/0.75mL, 100mg/1mL, 150mg/1.5mL
Quetiapine (Seroquel®)	IR T ER T	25, 100, 200, 300 mg 50, 150, 200, 300, 400 mg
Risperidone (Risperdal®)	T S D PR IM	0.25, 0.5, 1, 2, 3, 4 mg 1 mg/mL 0.5, 1, 2, 3, 4 mg 12.5, 25, 37.5, 50 mg

IM = intramuscular, IV = intravenous, L = liquid, S = suppository, SL = sublingual, T = tablet, D = disintegrating tablet, ER = extended release, IR = immediate release, LA = long-acting, PR = prolonged release

## Antipsychotic side effects

- **APs associated with increased risk of:**
  - Metabolic disturbances, weight gain, dry mouth, dizziness
  - Somnolence, drowsiness, injury or falls, hip fractures, EPS, abnormal gait, urinary tract infections, cardiovascular adverse events, death
- **Risk factors:** higher dose, older age, Parkinsons', Lewy Body Dementia

## Engaging patients and caregivers

### Patients and caregivers should understand:

- The rationale for deprescribing (risk of side effects of continued AP use)
- Withdrawal symptoms, including BPSD symptom relapse, may occur
- They are part of the tapering plan, and can control tapering rate and duration

## Tapering doses

- No evidence that one tapering approach is better than another
- Consider:
  - Reduce to 75%, 50%, 25% of original dose on a weekly or bi-weekly basis and then stop; or
- Consider slower tapering and frequent monitoring in those with severe baseline BPSD
- Tapering may not be needed if low dose for insomnia only

## Sleep management

### Primary care:

1. Go to bed only when sleepy
2. Do not use your bed or bedroom for anything but sleep (or intimacy)
3. If you do not fall asleep within about 20-30 min at the beginning of the night or after an awakening, exit the bedroom
4. If you do not fall asleep within 20-30 min on returning to bed, repeat #3
5. Use your alarm to awaken at the same time every morning
6. Do not nap
7. Avoid caffeine after noon
8. Avoid exercise, nicotine, alcohol, and big meals within 2 hrs of bedtime

### Institutional care:

1. Pull up curtains during the day to obtain bright light exposure
2. Keep alarm noises to a minimum
3. Increase daytime activity and discourage daytime sleeping
4. Reduce number of naps (no more than 30 mins and no naps after 2pm)
5. Offer warm decaf drink, warm milk at night
6. Restrict food, caffeine, smoking before bedtime
7. Have the resident toilet before going to bed
8. Encourage regular bedtime and rising times
9. Avoid waking at night to provide direct care
10. Offer backrub, gentle massage

## BPSD management

- Consider interventions such as: relaxation, social contact, sensory (music or aroma-therapy), structured activities and behavioural therapy
- Address physical and other disease factors: e.g. pain, infection, constipation, depression
- Consider environment: e.g. light, noise
- Review medications that might be worsening symptoms

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