



# CAGP

**Bulletin**

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**JANSSEN-ORTHO**

## A MATTER OF OPINION?

Lonn Myronuk

**I**n an information age of exponentially growing medical literature, it should only be with careful consideration that we proceed to add another medical publication to our inboxes. This having been said, the Academy is in the position to evolve its publications and so it is just this type of consideration that is now required.

The current incarnation of the CAGP Bulletin grew out of the Newsletter, which originally aimed to keep Academy members informed of activities in academic geriatric psychiatry across the nation. The Bulletin added to this an aspect of clinical geriatric psychiatry, with material potentially of interest to practicing non-academic geriatric psychiatrists such as Evidence-based Medicine and other reviews, including ECT. However, these were of necessity published without peer review, as our Bulletin has never been staffed or structured for such undertakings.

We, the CAGP, have been invited to consider collaboration with the Canadian Geriatric Society on an “official” publication that would be in a peer-reviewed format. This would obviate the need for clinical manuscripts to be part of the Bulletin, and the Bulletin would then revert to more of a “news” type publication.

Because the Bulletin is a benefit of mem-

bership in the Academy, subscription is not really voluntary, as such. You can not “vote with your feet” and cancel your subscription if you feel the publication is of no interest or value. You might toss it out (hopefully into recycling) but we would never know, or be able to change in response. We, the editorial staff and contributing authors, write what it is we believe you want and need to know. It is no coincidence that most of the contributions come from members of the CAGP board of directors, as these are the individuals among us motivated to contribute to a national organization of geriatric psychiatrists. The Bulletin becomes, in effect, an organ of the CAGP Board of Directors, and will tend to reflect in its content the values and beliefs of the Board members and Executive sitting at any given time.

For an internally-circulated news publication, this may be a reasonable set of circumstances. However, the Academy members should be aware that “editorials” may not reflect dissenting opinions or views critical of positions being taken by the Board. Should the membership desire this kind of “fourth estate” press, it will be imperative that you, as individual members, make this known to your Board representatives, to the Executive, and to us here at the Bulletin.

## PRESIDENT'S REPORT

David Conn

Once again it has been an exciting year for the CAGP. The last Annual Scientific meeting provided members with an array of excellent speakers, great networking opportunities as always, and a very hospitable Halifax setting. I anticipate this years Meeting in Montreal to be just as excellent. I would again like to thank Dr. Lilian Thorpe for her continuous hard work and outstanding commitment to the CAGP over the last 12 years.

This year has brought us a new Board of Directors. They are:

- *Martha Donnelly, Van.* Vice President
- *Marlene Smart, Calgary* Treasurer
- *Catherine Shea, Ottawa* Education
- *Francois Rousseau, Quebec City*  
Annual Scientific Chair & Membership
- *Lonn Myronuk, Nanaimo* Bulletin Editor
- *Nadine Gagnon, Quebec City*
- *Terry Chisholm, Halifax*
- *Marie-France Tourigny-Rivard, Ottawa*
- *Kiran Rabheru, London*
- *Barry Campbell, Edmonton*
- *Laura McCabe, Tor.* Member-in-training

I would also like to thank Evelyn Keller, Quebec City and Isabel Martins, St. John's NFLD as their terms on the Board have ended. They have both provided excellent support and dedication as we have moved the organization forward.

In 2003 we started a special award for "Outstanding Contribution to Geriatric Psychiatry in Canada". The first ever award was presented to Marie-France Tourigny-Rivard at the CPA meeting in Halifax. I

believe this is a start to an excellent tradition of awarding highly committed and innovative geriatric psychiatrists who have helped shape the future of the profession. Congratulations again Dr. Tourigny-Rivard. Next years application form and criteria is attached in this Bulletin.

We are continuing to advocate for the CAGP with the CPA Council of Academies and the Royal College of Physicians and Surgeons regarding the subspecialty training recognition. A number of proposals have been reviewed. I anticipate that the Academies will be directly involved in all future discussions with the Royal College on this issue. I will keep you all informed as progress unfolds. In the meantime a group led by Cathy Shea have put together Core Competencies for mandatory training in Geriatric Psychiatry, which has been submitted to a CPA working group.

A few months ago I received an invitation for the CAGP to send 5 representatives to a "2nd Canadian Consensus meeting on the Development of Antidementia Treatment Guidelines in Canada", which is being organized by Howard Feldman and Serge Gauthier. In 1995 a similar process was initiated to establish Guidelines that could be a useful reference for academics, regulators, and pharmaceutical companies. This process worked well and led to the 1995 publication in the Canadian Journal of Neurological Sciences. The Board feels this is an important opportunity and supports our participation. A selection process for identifying representatives to attend the meeting was established. I will provide more updates in following Bulletins.

I look forward to seeing many of you at the next Annual Scientific Meeting in Montreal October 18th, 2004.

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## PHARMACOLOGIA

### *BPSD Pharmacotherapy: Warnings Without Weighing*

Nathan Herrmann

*In the wake of the “Dear Doctor” letter that circulated recently regarding olanzapine and the risk of CVA, we asked Dr Herrmann to comment on this latest warning regarding serious adverse effects of atypical antipsychotic medication. This article also appears in the current issue of Old Age Psychiatrist, from the Faculty of Old Age Psychiatry of the Royal College of Psychiatrists in the United Kingdom. –Eds.*

I, perhaps like many of my colleagues, was shocked by the UK Committee on Safety of Medicines’ warning about the use of atypical antipsychotics for agitated behaviours in dementia.<sup>1</sup>

A review of the history of these recommendations, the methodology which prompted the conclusions, and comments related to what I perceive as an anti-psychotropic bias in the UK, is beyond the scope of this article. Suffice it to say, that many of us who treat patients with severe BPSD still believe the atypicals are first-line therapies when all the evidence for risks and benefits are weighed. It was perhaps ironic that the UK warning was published at the same time as the American publication of the Expert Consensus Guidelines on using antipsychotic agents in older patients, which endorsed the use of atypical antipsychotics as first and second line therapy for agitated dementia with delusions.<sup>2</sup>

These concurrent publications demonstrate once again the effect of the Atlantic

on divergent therapeutic opinions.

Should the UK guidelines frighten my colleagues away from using atypicals, what alternatives might be available to treat severely agitated aggressive psychotic dementia patients? I will briefly review the alternatives in this article which include anti-epileptics, antidepressants, benzodiazepines, cholinesterase inhibitors, and other pharmacological interventions. I will not review data on the non-pharmacological approaches. Suffice it to say, that I am not impressed with the body of data on the latter, given significant methodological issues, not the least of which is that the majority of these studies include small numbers of individuals with BPSD far less severe than the typical studies with pharmacological interventions. Let’s assume however, that for the purposes of this review, the enlightened clinician has already appropriately assessed and diagnosed the patient and exhausted all possible environmental and behavioural interventions before resorting to the prescription pad.

Beyond antipsychotics, the largest body of RCT data resides with the anti-epileptic drugs. There are four double-blind placebo-controlled studies of carbamazepine, three of which are highly significant. Given

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concerns about hepatic and hematological toxicity, as well as the numerous well-known drug interactions, the use of carbamazepine has not been widely adopted. Valproic acid, often perceived to be a safer alternative to carbamazepine, has been studied in four double-blind placebo-controlled RCTs. It is important to note that none of these studies demonstrated efficacy beyond placebo in any of the primary outcome measures, though some of the secondary measures suggested benefit. More importantly, however, in some of these studies valproate was clearly not well tolerated and the risk of valproate-induced thrombocytopenia might be much higher in the elderly than in younger populations.<sup>3</sup> While there has been interest in other anti-epileptic drugs like gabapentin, lamotrigine, and topiramate, no RCTs have been published to-date.

There have been numerous RCTs of the use of antidepressants for depression in dementia but much less on their use for severe agitation and aggression. In one double-blind study, citalopram was found to be better than placebo or perphenazine.<sup>4</sup> While anecdotal studies suggest SSRIs are useful for BPSD in frontotemporal dementia patients, two small RCTs have provided conflicting results about both efficacy and tolerability.<sup>5</sup> Finally, while there are three RCTs with trazodone, one of these studies were negative<sup>6</sup> and questions persist about its use over a very large dose range (25 - 450 mg per day).

As geriatric psychiatrists, we have an inbred disdain for benzodiazepines. It is our “dirty little secret”, however, that most of us spend as much time starting patients on benzodiazepines as stopping them. There is RCT data from decades ago describing the use of benzodiazepines for patients with dementia, but there is little in the way of modern studies which utilise

current diagnostic criteria and outcome measures. It is, therefore, not surprising that regular use of benzodiazepines for the management of BPSD has not been endorsed in treatment guidelines and when used, it tends to be prescribed p.r.n. for acute agitation or aggression. The latter usage has recently received support from a double-blind placebo-controlled study comparing IM olanzapine to IM lorazepam for the acute management of agitation in patients with dementia.<sup>7</sup> In this large well designed study, one to three doses of lorazepam 1 mg. IM were found to be as safe and well tolerated as the olanzapine, with both active treatments being superior to placebo.

There has been increased interest paid to the effects of the cholinesterase inhibitors on BPSD. Unfortunately, the RCTs on Alzheimer’s disease patients’ to-date have generally included subjects with only mild BPSD. A recent meta-analysis of these studies concluded that the cholinesterase inhibitors have small but significant benefits on BPSD in Alzheimer’s disease.<sup>8</sup> Studies in patients with more severe BPSD are about to be published. In the single RCT of patients with dementia with Lewy bodies, rivastigmine demonstrated significant benefit on behavioural measures. While these patients (average baseline NPI scores 20-23) were much more behaviourally disturbed than the Alzheimer’s disease patients studied above (average baseline NPI score 9-13), the severity of these behavioural problems pale in comparison to patients in the RCT of olanzapine for BPSD (average baseline NPI 41-44). It would, therefore, seem that further evidence is necessary before convincing clinicians that the cholinesterase inhibitors have significant benefit in severely disturbed patients.

A large variety of other pharmacological

approaches have been tried including beta-blockers, buspirone, lithium, anti-androgens, and ondansetron, though there is insufficient data to recommend any of these as first or even second line therapies.

So where does this leave us? Unfortunately, the drug treatments I have reviewed above are clearly lacking enough RCT data in severely disturbed patients. Many may not be safe or effective enough to truly improve the quality of life for our patients and their caregivers. By far, the most convincing evidence for efficacy in severe BPSD is with risperidone and olanzapine. If the UK Committee on Safety of Medicines effectively manages to ban the use of these drugs in dementia, clinicians might be forced to return to typical antipsychotics like haloperidol. Is this a bad thing? No and yes. There is good RCT data on the use of typical antipsychotics that have been summarised in meta-analytic studies.<sup>9</sup> They may or may not cause fewer of the evils blamed on atypicals like weight gain, diabetes, hyperlipidemia and cerebrovascular adverse events. They certainly cause more acute extrapyramidal symptoms, more tardive dyskinesia, and worsen cognitive impairment; all things the atypicals do much less of. How would our cardiology colleagues feel if they were told they could not use ACEIs, ARBs, or CCBs for hypertension? Would they feel comfortable going back to reserpine or alpha-methyl dopa? I doubt it! As I have mentioned frequently in past columns, pharmacotherapy always involves weighing risks and benefits. As long as we can provide our patients and their families with appropriate (and legitimate) data on the

risks and benefits, atypical antipsychotics should still have an important role to play in the management of BPSD. One thing all my colleagues will agree with, is that we certainly need more studies and more therapeutic options for these challenging clinical problems.

### *Selected References*

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## EVIDENCE BASED MEDICINE GROUP

Department of Psychiatry - Baycrest Centre for Geriatric Care

**CONTRIBUTOR: LAURA MCCABE**

### **CLINICAL CASE**

A patient with dementia presented for management of behaviour with significant agitation. Family members involved in the patient's care requested that alternatives to psychotropic medication administration be explored.

### **Clinical Question:**

What is the evidence supporting the use of aromatherapy for the management of agitation in dementia?

### **Search Keywords:**

Dementia, psychomotor agitation, phytotherapy, plant-extracts, plant preparations, aromatherapy, plant oils, volatile oils.

### **Findings:**

One well designed, double-blind randomized control trial showed that melissa balm oil (*melissa officinalis*, also known as lemon balm) with lotion applied topically to the skin is an effective treatment for agitation in severe dementia.(1) In this study, 60% of the active treatment group had a 30% reduction in their score on the Cohen Mansfield Agitation Inventory. There is also some evidence suggesting that lavender oil through massage(2) or disseminated by a diffuser(3) may reduce agitation in severe dementia.

### **Clinical Recommendation:**

Aromatherapy with melissa, and possibly lavender, appear safe and effective for the treatment of agitation in severe dementia.

[Bird's Encyclopedia of Aromatherapy(4) warns that melissa can be an irritant and that it should only be used in low concentrations. It is also cautioned that melissa products offered for sale may be "frequently adulterated" - a difficulty for research evaluating this and other non-drug treatments as well as for their clinical use. -Eds.]

### **Research Priority:**

Longer-term multicenter trials investigating aromatherapy for treatment of agitation in patients with severe dementia should be considered. Information is lacking regarding the most effective delivery method of aromas, and predictors of response (e.g., whether type of dementing disorder influence patient responsiveness).

### **References**

- 1 *Ballard et al.* Aromatherapy as a Safe and Effective Treatment for the Management of Agitation in Severe Dementia: The Results of a Double-blind Placebo Controlled Trial with Melissa. *J Clin Psychiatry* 63(7): 553-558, 2002.
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## EDUCATION REPORT

Catherine Shea

The education subcommittee of the CAGP Board has developed a draft “core competency” guidelines for general psychiatry residents. The “Working Group on a National Strategy for Postgraduate Education, subcommittee on core competencies” of the Canadian Psychiatric Association met in April to review and discuss a process for the core competencies objectives. Representatives from general psychiatry and each of the Academies (Forensic, Child and Geriatric) were to develop competencies reflective of their specialty believed to be required of general psychiatry training. This work will be ongoing over the coming months. The overall goal of the proposed CAGP objectives is “To make the residents competent in their knowledge, skills and attitudes so that they can diagnose, treat and manage aging patients successfully.” Specific objectives relate to knowledge, skills, attitudes, communications, collaborator, manager advocate, scholar and professional as is directed in the CANMED Objectives of Training 2001. A near to final version will be sent to the CAGP subcommittee and Board members, program directors, residents, plus a cross section of general psychiatrists for review. We will report on progress in upcoming bulletins. I would like to thank Drs’ David Conn, Martha Donnelly, Ken LeClair, Susan Lieff and Kiran Rabheru as well as the Board for their excellent guidance in the process. As usual, Shelly Haber was instrumental in keeping us focused and productive and we are indebted to her. Anyone interested in reviewing these guidelines please feel free to contact Shelly Haber at s.haber@sympatico.ca or 416 781-2886.

The Education Subcommittee has been asked to update subspecialty objectives for the training of geriatric psychiatrists. These objectives will be developed, based on a

review of current guidelines (1994), the literature, collaboration with the Board, geriatric psychiatry coordinators across the country and other geriatric psychiatrists who indicate an interest. The objectives will provide a foundation for the speciality as we move forward.

This year two **CAGP Fellowships** are being awarded. We are pleased to announce that Dr Cheryl Murphy and Dr Laura McCabe will be awarded the CAGP 2005 Fellowships. Dr. Murphy will be a fellow at Dalhousie University. Her project will explore the question of how best to increase awareness regarding stigma in geriatric psychiatry patients for medical students and residents. Dr McCabe will be a fellow at the University of Toronto. She will examine data from the 2002 Canadian Community Health Survey (CCHS) to provide epidemiologic data of mental health in the Canadian geriatric population. We look forward to their presentations at the next Annual Scientific Meeting in Montreal.

Please note that there is information regarding these awards and grants in your package. The Canadian Academy of Geriatric Psychiatry offers three programmes:

- 1) The Fellowship Award programme, open to Canadian psychiatric residents or fellows with at least one year remaining in their programmes as of July 2004.
- 2) The Canadian Academy of Geriatric Psychiatry Research in Education Grant.
- 3) The Canadian Academy of Geriatric Psychiatry Research in Education Award open to residents or fellows in Canadian psychiatric training programmes and Canadian psychiatrists.

I hope that you will circulate these notices widely, particularly so that residents and fellows in your training programmes will have an opportunity to apply for these programmes and awards.

## Executive Directors Report

Shelly Haber, MHSc.

I will be working a little more closely with the CAGP over the next while. There are many opportunities to strengthen the CAGP profile among psychiatrists, other health system stakeholders and the general public. Representatives of the CAGP (David Conn and Ken LeClair) continue to chair the Canadian Coalition for Seniors Mental Health (CCSMH). The CCSMH is an original initiative of the CAGP and is housed within our administrative structures. The CCSMH has received another Health Canada grant to support its activities until December 2004. Future plans include;

- a two day Research Workshop to define and recommend funding priorities for seniors mental health and to use these recommendation to influence funding allocations of research agencies such as Canadian Institute for Health Research,
- a Best Practices Conference on September 25th and 26th 2005, and
- a communication plan to improve the public perception of aging and mental illness.

In September 2004, the CCSMH will be hosting a 2 day workshop with researchers, providers, consumers and research funders. The purpose of the workshop is to determine priorities for future research activities related to seniors' mental health. These priorities will be used to encourage targeted funding

for seniors mental health research. A cross representation of disciplines, issues and sectors will be invited to participate. The recommendations arising from the workshop will be describe in the next CAGP Bulletin.

The **CAGP website** requires continual attention to stay current and function as a resource for both geriatric psychiatrists as well as other health care providers. Since September 2003, there have been 29,716 hits on **www.cagp.ca**. Of these the Education page had 1,308 views, the Coalition initiative, 875 views; Members Publications, 839 views and the Resources page, 782 views. If you have any items you would like to see posted on the site please let me know.

As was described in the Presidents Report and the Education Committee Report, the Board has been actively involved in the development of core competencies for both general psychiatry and subspecialty training. When these are in final draft they will be available on the website.

I look forward to identifying and establishing new initiatives for the CAGP. If you have any ideas you would like to see developed, please feel free to contact me at [s.haber@sympatico.ca](mailto:s.haber@sympatico.ca). I hope to see many of you at the next Annual Scientific Meeting, October 18th in Montreal. We expect an exciting agenda for the day.

## Annual Scientific

Francois Rousseau

I am pleased to be the chair of the 2004 Annual Scientific Meeting, October 18th in Montreal with support from Drs. Michel Elie, Kiran Rabheru and Martha Donnelly. This year's theme for the meeting will be "Culture and Aging". We have lined up a number of excellent speakers and interesting

workshops. Some of the details of the meeting are still being finalized. Once they are complete an announcement will be sent out and will also be available on the website. I hope you can join us in Montreal as it promised to be an exciting meeting.