ELDERConsult
GERIATRIC MEDICINE
Housecalls + Education

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Agitation:
Think About Pain

Objectives

At the completion of this training, participants will be able to:

- Determine the common causes of agitation in dementia
- Identify behavioral techniques to use to address the causes of agitation without sedation (like Ativan)
- Assess medication effects:
  - Remove of medications that make agitation worse
  - Treat pain
  - Only then consider medications for agitation

Symptoms

- Work to define particular symptoms
- Delusions, psychosis and paranoia
- Mood lability : rapid, often exaggerated changes in mood, where strong emotions or feelings occur
  - Easy tearfulness
  - Sudden anger
  - Hitting
- Depression
  - Irritability
  - Withdrawn
- Categories often overlap

Behaviors

Always include work on behavior modification
Typically Not Amenable to Pharmacologic Intervention

- Wandering
- Perseverative Activity
- Repetitive Activity
- Poor Self Care
- Hoarding Objects & Food
- Hiding & Misplacing Things
- Inappropriate Voiding
- Poor Social Skills

Behavioral Intervention

From a physicians perspective

- **Over** stimulation
  - Keep nocturnal interruptions minimal
  - More personal space
  - Assess intervention necessity
- **Under** stimulation
  - Disruptive vocalization
  - Reinforce other behavior or ignore
  - Stimuli- music, tactile object
  - Activities- dance, art, music

Allen-Burge Int J of Ger psych 1999

Medications

Remove medications that lead to agitation

- Start low, go slow if medications used
- Medications should target specific symptoms so their effect can be monitored
- Non-medical personnel observe, document and report to physician



Assessment

- Global assessment is crucial

- Agitated behaviors may signal that the patient is distressed, depressed, or ill



Delirium

- Geriatric consult
  - Reduced post op (hip fracture) delirium from 50% to 32%
  - Decreased severity of delirium 50%
  - No change length of stay

Marcantonio JAGS 2001

- Interventions to prevent delirium did not reduce duration

Inoyue NEJM 1999

Medical Causes

Look for:

- Infection
- Impaction
- Pain (prostate, teeth, bones, back, disease)
- Decubiti (pressure sores)
- New medications
- Non-medical personnel observe, document and report to physician

Medical Causes: Case Study

- 83 year old woman with dementia MMSE (Mini Mental Status Exam) of 13 has been more aggressive, hitting at his facility and was sent to the Emergency Department.
- Returned, Diagnosis "Dementia"
- Brief exam is normal, except swelling of the right lower jaw



Goals of Care

- Address goals of care with patient and family early in hospitalization
- If near end of life, emphasis comfort
- Discontinue restraints
- Use morphine for dyspnea
- Sitters are preferable to physical restraints
- Restraints when patient is a danger to self or others

Goals of Care: Case Study

- 83 year old White Female
- End-stage COPD (Chronic obstructive pulmonary disease)
- Is restrained to keep oxygen mask on her.
- Patient is thrashing and confused.



Behavioral Intervention

RNs, CNAs and staff are trained to approach agitation with effective behavior management such as:

- Appropriate eye contact
- Announcing single activities
- Delaying assistance after verbal prompt
- Distraction and diversion
- Not arguing with patient

Behavioral Intervention

CNA group that were given training and motivation had decreased use of ineffective approach and decreased patient agitation at 6 months



Burgio Geront 2002

Behavioral Intervention

- RCT (Randomized Controlled Trial) Increased daytime activity and decreased nighttime sleep disruptions 29 patient measured activity with wrist actigraphy (a non-invasive method of monitoring human rest/activity cycles

- 7/15 Intervention group had decreased agitation (1/14 in placebo)

Case Study



- 74 year old paraplegic White Male
- With moderate dementia
- Diabetes and PVD (peripheral artery disease)
- Is at elevator holding staff at bay with a cane
- You are paged and asked to take care of the situation
- What do you do?

The Medical doctor came from the side, spoke calmly and pleasantly, and took the patient to his room.



Pain

- Nociceptive (Arthritis) v Nerve Pain
- Long acting Tylenol
- Gabapentin
- NSAIDs (Nonsteroidal anti-inflammatory drugs) (Motrin, Naprosyn..)
- Norco
- Morphine/Oxycontin
- Fentanyl patch

Case Study: Pain



- 83 year old woman evicted from facility. Has history of spinal stenosis, and was treated with Percocet in the past. Now on Seroquel and Ativan, still aggressive.
- Treated with Methadone ½ tab twice a day
- Tapered off the Seroquel and Ativan, used Gabapentin 100 mg 3 x a day. Alert, not aggressive.

Medications

- **Neuroleptics**:(antipsychotics)

  Haldol, Risperdal, Zyprexa, Seroquel

- **Anxiolytics:** (anti anxiety) **Benzodiazepines**

  Ativan, Valium, Halcion, Xanax

- **Antidepressants**: Serotonin Reuptake Inhibitors:

  Zoloft, Paxil, Prozac, Celexa



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Neuroleptics (antipsychotics)

- Aripiprazole (Abilify)
- Olanzapine (Zyprexa)
- Quetiapine (Seroquel)
- Risperidone (Risperdal)
- Haloperidol (Haldol)

2% increased stroke risk and 1 % increased sudden death risk, falls, tremor

Anxiolytics (anti anxiety)

- Ativan, Valium, Halcion, Xanax
- Have been shown to lead to falls and contribute to decreased cognition
- Fast withdrawal often leads to delirium
- **NEVER USE XANAX**



Antidepressants

Serotonin Reuptake Inhibitors:

- Citalopram (Celexa)
- Fluoxetine (Prozac)
- Paroxetine (Paxil)
- Sertraline (Zoloft)
- Venlafaxine (Effexor)

- Nausea, Vomiting, Weight Loss, Decreased Sodium,
- Insomnia, Falls, Agitation

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Mood Labiality

Rapid, often exaggerated changes in mood, where strong emotions or feelings occur

Mood Stabilizers:

- Depakote, Lithium
- To address mood lability (Anecdotal)
- Drowsiness, Liver and blood cell abnormalities, falls

Sleeping Pills

- Can cause agitation
- Avoid Benadryl & other anticholinergic medications
  - Tylenol PM
  - Unisom
  - Nyquil
  - Ambien
  - Restoril



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Case Study: Delusions, Hallucinations

- 74 year old with dementia MMSE 16
- Thinks he is on a boat and sees a variety of creatures which he enjoys talking to.
- He has been bedbound for years and is eating and sleeping well.
- What should be done?



Case Study: Delusions, Hallucinations

Leave patient alone, he is not bothered by hallucinations, AND the care is not affected.



Summary

If patient has Agitation:



- Work to define particular symptoms
- Always include work on behavioral modification
- Start low, go slow if medications used
- Team assessment often is helpful
- Non-medical personnel observe, document and report to physician

Review

- How do you assess the causes of agitation?
- How do you use behavioral techniques to alleviate agitation?
- How do you utilize medications for pain and other physical symptoms?

Questions?

Thank You!

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Thank you,
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