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Are Anticonvulsants an Evidence-Based Answer for BPSD?

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Based on findings that use of anticonvulsant medications among nursing home residents with dementia has been on the rise, Candon et al. conducted some deeper analysis, published in the Journal of the American Geriatrics Society. They commented, "Antiepileptics are commonly prescribed to nursing home residents with Alzheimer's disease and related dementias (ADRD) but there is little scientific support for their use in this population."

In all, anticonvulsants, also called antiepileptic drugs, have not been as well researched for dementia care, they say. Their analysis focused on MDS records and pharmacy claims for people with a diagnosis of dementia for the period 2015 to 2019 and who had 3-month or longer nursing home stays. They found that in this study group:

- Antipsychotic prescribing rates declined from 32.1% to 27.9% .
- Opioid prescribing rates declined from 39.8% to 31.7%.
- Antiepileptic prescription rates increased from 29.5% in 2015 to 31.3% in 2019.

The specific increases were for the antiepileptic drugs valproic acid and gabapentin.

They also identified a prescribing pattern. When disruptive behaviors were present, residents were "more likely to receive valproic acid" (e.g., brand names Depakote, Depakene). Gabapentin was more often used when residents were reporting pain.

Valproic acid - "no evidence" effective for agitation

Research indicates that "clinicians view valproic acid as an antipsychotic substitute for behavioral disturbances in dementia," said the authors. This raises questions about efficacy and safety.

A Cochrane review on valproate found "no evidence of beneficial effect on agitation or closely related behavioral outcomes". The review also highlighted a "higher risk of adverse effects, including serious adverse events" with valproate. Adverse effects can include falls, gait disturbances, sedation, tremor, weakness, depressed mood, gastrointestinal disorders, urinary tract infections, and thrombocytopenia, noted the reviewers.

Valproic acid & BPSD: "no good justification"

Carnahan and Saliba cited five studies included in the Cochrane review that specifically found valproic acid ineffective for treatment of BPSD. They also called attention to "likely" harms—brain atrophy and functional decline.

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They concluded there is "no good justification for using valproic acid to manage BPSD".

The valproic acid substitution is "likely worse on average than the treatment it is replacing due to the lack of evidence of benefit from valproic acid, its adverse effects on brain structure, and similar associated mortality risks," according to Candon et al.

Pain, gabapentin, & BPSD

"Pain often leads to BPSD of various types, such as insomnia, aggressiveness or agitation," note Tible et al. Detecting pain, diagnosing causes, and treating pain can be an important clinical strategy in dementia care, they explain. (Read about how to recognize pain in a patient with dementia.)

Candon et al. identified a trend in using gabapentin to manage pain in the backdrop of a dementia diagnosis. However, "the evidence base to support the use of gabapentin for many chronic pain conditions is minimal," they say.

They also cite a lack of randomized controlled trials evaluating effectiveness of gabapentin for BPSD. They hypothesize that the increase in gabapentin prescribing practices may relate to a desire to reduce use of opioids—unlike the increase in valproic acid prescribing, which they describe as "a valproic-acid-for-antipsychotic switch".

Adverse effects of gabapentin can include blurred vision, cognitive effects, dizziness, sedation, and weight gain, according to Carnahan and Saliba, who recommend that gabapentin should be used "with caution".

BPSD - comprehensive evaluation

While it is easy to think of BPSD as a single problem-to-be-solved, the term represents an array of clinical presentations, including "apathy, depression, anxiety, delusions, hallucinations, sexual or social disinhibition, sleep-wake cycle disturbances, aggression, agitation and other behaviors considered inappropriate," note Tible et al.

Importantly, there are many causes and mechanisms of behavioral disturbances in the presence of dementia, they add. Individual clinical presentation can change over time. Accordingly, they advocate for a comprehensive, multidisciplinary approach to identify neurological, psychological, and other medical underpinnings of symptoms.

As explained by GuideStar Senior Vice Pres. Anita Reid (Arthur), "If a person is on an antipsychotic drug for a symptom, it is important to know what disease is causing that symptom."

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She adds, “When we integrate proper diagnosis and care, looking at each patient as an individual, we see better clinical outcomes” (Reducing Antipsychotic Use in Nursing Homes: A Paradigm Shift). Reid was one of the researchers in a peer-reviewed study that reduced antipsychotic utilization by 68% in three nursing homes, building on a neurology-forward approach.

This is why it can be valuable to call on a multidisciplinary team with expertise in neurology, psychiatry, psychology, and geriatric medicine to support your own care teams. Together, we can advance the safety, functionality, dignity, and quality of life for your residents.

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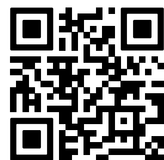

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