

Expert Insights from The Gerontological Society of America Agitation in Alzheimer's Disease Workgroup

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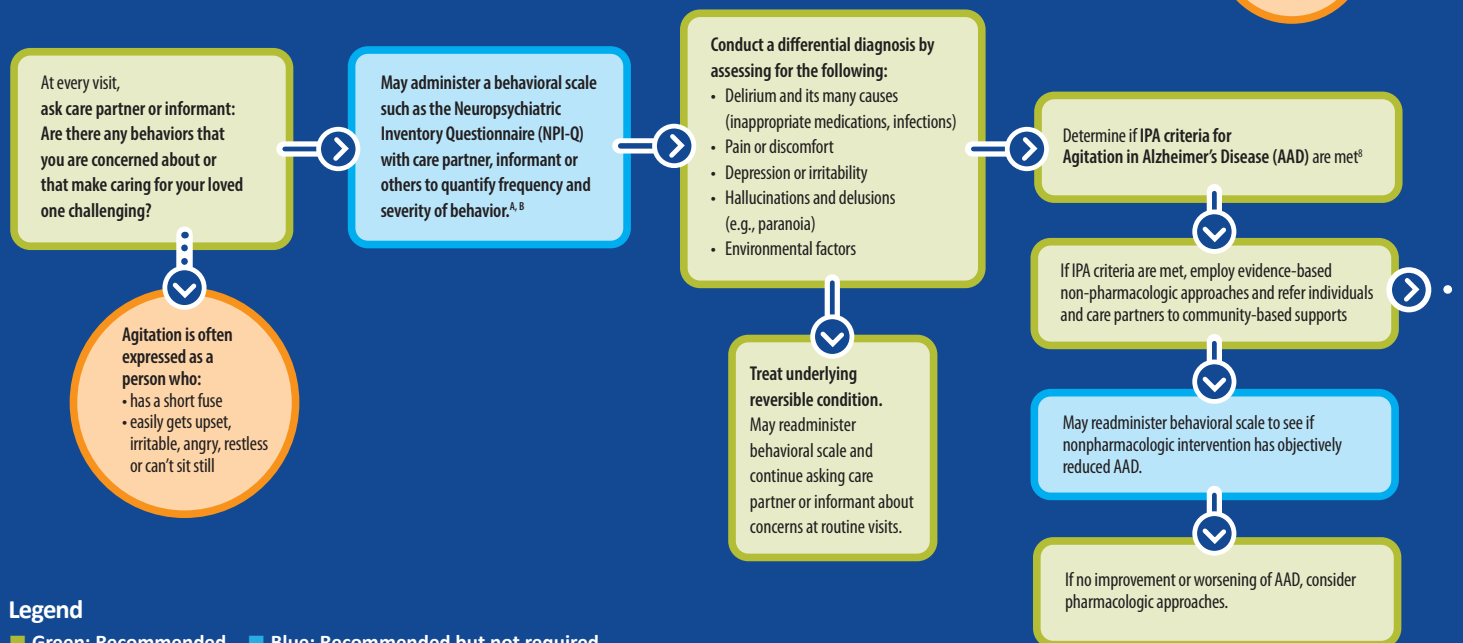
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The Importance of Proper Diagnosis & Management of Agitation in Alzheimer's Disease (AAD)

- The prevalence of agitation in Alzheimer's disease (AAD) is 76%.¹
- Patients suffering from AAD have more severe behavioral, depressive and frontal lobe symptoms than those without AAD.¹
- Nursing home agitation rates are 80%.²
- Agitation may be especially distressing and dangerous to patients and caregivers.³
- Informant/caregiver distress related to agitation in dementia is associated with increased ED utilization, inpatient hospitalization, and Medicare expenditures.⁴
- Agitation is a statistically significant predictor of nursing home placement in Alzheimer's disease.⁵
- Early agitation is a robust predictor of both accelerated progression and mortality in Alzheimer's dementia.⁶
- Off-label use of atypical antipsychotics for treating agitation in AD has only modest clinical benefits, with high side-effect burden and risk of mortality.⁷
- Considering all these factors, it is imperative that busy clinicians have guidance on assessment as well as the non-pharmacologic and pharmacologic management of agitation in Alzheimer's disease.

AGITATION IN ALZHEIMER'S DISEASE:

A DECISION TREE FOR HEALTHCARE PROVIDERS



Legend

■ Green: Recommended ■ Blue: Recommended but not required

^A This decision tree does not address acute AAD and/or aggressive behaviors that pose danger to self or others. In those cases, pharmacologic treatment may be the initial intervention to address risk to patient or others, and to allow time for proper evaluation of potential underlying triggers.

^B Others used: Cohen-Mansfield Agitation Inventory (CMAI) and Pittsburgh Agitation Scale (PAS)



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Updated March 2023 with IPA Consensus Criteria for Agitation in Alzheimer's Disease.

Does Patient Meet International Psychogeriatric Association (IPA) Criteria For Agitation in Alzheimer's Disease?⁸

1. Does the patient meet **criteria for cognitive impairment or dementia syndrome**?*
2. Does the patient exhibit **at least one** of the following behaviors that are associated with observed or inferred evidence of emotional distress (e.g., rapid changes in mood, irritability, outbursts)?
 - (a) Excessive motor activity (e.g., pacing, rocking, gesturing, pointing fingers, restlessness, performing repetitious mannerisms).
 - (b) Verbal aggression (e.g., yelling, speaking in an excessively loud voice, using profanity, screaming, shouting).
 - (c) Physical aggression (e.g., grabbing, shoving, pushing, resisting, hitting others, kicking objects or people, scratching, biting, throwing objects, hitting self, slamming doors, tearing things, destroying property).
3. Has the behavior been persistent or frequently recurrent for a **minimum of 2 weeks**** and does it represent a change from the patient's usual behavior?
4. Are behaviors **severe enough to produce excess distress or produce excess disability**, which in the clinician's opinion is beyond that due to the cognitive impairment, and include at least one of the following?
 - (a) Significant impairment in interpersonal relationships.
 - (b) Significant impairment in other aspects of social functioning.
 - (c) Significant impairment in ability to perform or participate in daily living activities.
5. While co-morbid conditions may be present, the agitation is **not attributable solely to another** psychiatric disorder, medical condition, including delirium, suboptimal care conditions, or the physiological effects of a substance

* (e.g., AD, FTD, DLB, vascular dementia, other dementias, a pre-dementia cognitive impairment syndrome such as mild cognitive impairment or other cognitive disorder).
** In special circumstances the ability to document behaviors over two weeks may not be possible and other terms of persistence and severity may be needed to capture the syndrome beyond a single episode.

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