Different Types of Dementia Have Different Behavioral and Psychological Symptoms

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Introduction

Dementia-Related Behavioural And Psychological Symptoms (BPSD) are prevalent and debilitating issues, but current therapies are limited. Antipsychotic medications have some benefit in the treatment of BPSD, but their usage is limited because to the increased risk of cerebrovascular events and death. Mood stabilisers have been proven to be effective in the treatment of BPSD in studies, however comprehensive evaluations on the subject are lacking. The purpose of this article is to examine research on the efficacy of mood stabilisers for BPSD, as well as the quality of the existing data. We looked for studies published in English between 1990 and 2010 and included in the PubMed database that dealt with the treatment of BPSD with mood stabilisers such as carbamazepine, valproate, gabapentin, topiramate, lamotrigine, oxcarbazepine, and lithium. The quality of the research was determined by taking into account the trial designs, analysis, subjects, and findings. We discovered one meta-analysis and three Randomised Controlled Trials (RCTs) indicating the efficacy of carbamazepine in controlling global BPSD, notably aggressiveness and hostility. In the case of valproate, existing data from one meta-analysis and five randomised controlled trials did not clearly support its effectiveness for general BPSD, including agitation and aggressiveness. Only open studies or case series shown effectiveness of gabapentin, topiramate, and lamotrigine in the treatment of BPSD. The solitary randomised controlled trial that looked at the effect of oxcarbazepine on agitation and violence yielded unfavourable findings. Lithium case series reports tended to indicate it to be unsuccessful. So far, carbamazepine offers the most solid evidence of effectiveness on BPSD among mood stabilisers.

Behavioral and psychological symptoms are prevalent consequences in people suffering from various kinds of dementia. Psychosis, agitation and mood problems, disinhibited behaviour, disruption of the sleep and waking routine, roaming, perseveration, pathological collecting, or yelling are the most common. Their emergence is associated with faster illness development, early institutionalisation, the use of physical restrictions, and a higher risk of mortality. As a result, the manifestation of behavioural and psychological symptoms of dementia increases the cost of care delivered and causes more anxiety for carers. Nonpharmacological treatments are recommended as the first line of therapy for behavioural and psychological problems by clinical standards. Pharmacological therapy should be started only if the symptoms were not caused by somatic factors, did not respond to nonpharmacological measures, or were not caused by the previous drug. Acetylcholinesterase inhibitors, memantine, antipsychotic medications, antidepressants, mood stabilisers, and benzodiazepines are among the medications utilised. This review covers the most recent research on the efficacy and safety of using psychopharmaceuticals to treat neuropsychiatric symptoms in dementia patients.

Recommendations for antipsychotic therapy for this indication are detailed since this medication class is the most commonly administered and, at the same time, is associated with the highest risk of side effects and increased mortality.

Behavioral And Psychosocial Dementia Symptoms (BPSD) are prevalent consequences in people with various kinds of dementia. Psychosis, agitation and mood problems, disinhibited behaviour, disruption of the sleep and waking routine, roaming, perseveration, pathological collecting, or yelling are the most common. Neuropsychiatric symptoms are not usually isolated. They frequently appear in groups. These clusters might be characterised as primarily affective, psychotic, hyperactive, or apathic based on the most prominent symptoms. BPSD has been observed in the majority of dementias, including Alzheimer's Disease (AD), Vascular Dementia (VaD), dementia in Parkinson's disease, Frontotemporal Dementia (FTD), and moderate cognitive impairment.

To measure the existence and severity of symptoms, evaluation instruments such as the Neuropsychiatric Inventory (NPI) or the Behavioral Pathology in Alzheimer's disease Rating Scale are recommended. During the course of their dementia, the majority of individuals will develop at least one of the BPSD. Their presence generates further distress for the sufferer and everyone around them, most notably the carers. The presence of BPSD is associated with faster illness development (particularly in depressed and psychotic symptoms), earlier institutionalisation, usage of physical restrictions, and a greater risk of mortality. As a result, the expenses of providing care rise. Because of the scarcity of data from randomised controlled trials, it is difficult to select safe and effective pharmacological therapy (RCTs). Antipsychotic medications are often administered, despite the lack of good evidence of their usefulness in particular neuropsychiatric conditions. Concurrently, the use of antipsychotic medications raises the possibility of side effects.

The 2010 WHO study emphasised the relevance of dementia's rising prevalence and the urgent need for a solution to adequate dementia patient care, given its worldwide costs and hazards. According to the WHO estimate, 682 million people would most likely suffer from Alzheimer's disease or other forms of old-age dementia by 2050, up from the current 36 million dementia sufferers. Dementia, according to the DSM-IV, is a progressive loss in cognitive skills that leads to occupational and social dysfunctions. Aside from memory problems, at least one of the following symptoms must be present: aphasia (language disturbance), apraxia (impaired ability to carry out motor activities despite intact motor function), agnosia (failure to recognise or identify objects despite intact sensory function), and executive functioning disturbance (i.e., planning, organizing, sequencing, abstracting). Given its potential stigmatising effect, the word dementia was replaced in DSM-5 with neurocognitive disorder (NCD), which can be defined as moderate or severe, as well as by its aetiology. NCD encompasses all disorders in which the primary symptom is cognitive impairment manifested as a decrease from a prior level. Meanwhile, the ICD-10 is still in use across the world; the nomenclature and diagnostic criteria for dementia remain intact in that system. Because Hungarian clinical practise uses ICD-10 and our study began before the release of DSM-5, we utilise the diagnostic category of dementia and the word according to ICD-10 in this paper. Alzheimer's disease and vascular dementia are the two most common aetiological kinds of dementia; a mixed form is also common. Cognitive, emotional, and behavioural symptoms are the most widely acknowledged categories for dementia clinical symptoms.

The fundamental aspect of dementias is cognitive symptoms, although emotional and behavioural symptoms are usually characterised as "behavioural and psychological symptoms of dementia," or BPSD. Differentiation, identification, and quantification of cognitive symptoms linked with dementia are more convenient for physicians in ordinary practise than identification and evaluation of BPSD symptoms. BPSD symptoms have previously been characterised as a "neglected area" of geronto-psychiatry.

In 1996, the International Psychiatric Association (IPA) coined the acronym BPSD (IPA Complete Guides to Behavioural and Psychological Symptoms of Dementia). PSD is classified as a non-disease–specific clinical condition, a sub-syndrome characterised by heterogenic mental symptoms. The combination of biological, psychological, and social variables is thought to be at the root of the development of BPSD, which has two categories of symptoms, psychological and behavioural. Delusion, hallucination, misidentification, despair, apathy, and anxiety are some of the psychological symptoms. Irritability, agitation, aggressiveness, wandering or abnormal motor activity, disinhibition, sleep-wake cycle disruption, and eating problems are among the behavioural signs. In terms of the importance of BPSD symptoms, relevant data reveals that their significance in disease-related expenses and other economic indicators much outweighs that of cognitive symptoms. A recent study examined the findings of the last 30 years of dementia research and stressed the significance of BPSD symptoms. This overview emphasises the importance of BPSD symptoms for both people with dementia and their careers. According to the findings of that analysis, at least two BPSD symptoms showed in more than 90% of dementia patients, showing a link between extended medical care, medication misuse, and greater healthcare expenses. According to the study, the relevance of BPSD symptoms rests in their contribution to the process through which dementia patients' main features and identity are inexorably lost. These BPSD symptoms have a significant impact on caregiver distress, which is a critical consideration in the choice to place dementia patients in social welfare. The impact of BPSD symptoms also have a significant influence in the patients' growing death rates. To the best of our knowledge, Hungary has no data on the systematic examination of BPSD symptoms in dementia patients. Thus, the initial goal of this study was to assess the incidence and severity of BPSD symptoms in a randomly selected sample of Hungarian dementia patients. We anticipated that the frequency and severity rates would be comparable to those reported in the literature. The second goal of this study was to look at the link between cognitive and BPSD symptoms, as well as the possibility of employing BPSD symptoms to distinguish clinically various kinds of dementia, namely Alzheimer's, vascular, and mixed dementia. We predicted that the appearance of BPSD symptoms would follow a consistent pattern across dementia types.

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