# 失智症常合併精神作用藥物介紹

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# 大綱

- Behavior and psychological symptoms of dementia (BPSD)
- 失智相關精神行為症狀的處理流程
- 失智症精神行為症狀之藥物治療
- 結論

- 什麼是失智症之精神行為症狀

# Behavior and psychological symptoms of dementia (BPSD)

# 失智症之精神行為症狀

- Alzheimer 1907年首次發表。
- 51 y/o 女性，認知功能障礙，伴隨妒忌妄想及聽幻覺。
- **Behavior and psychological symptoms of dementia (BPSD)**

# Psychosis

- Psychosis is "loss of contact with reality."
- Hallucinations and delusions are core "positive" features.
- "Negative" features include apathy and psychomotor retardation.

# 神經精神評估量表

## Neuropsychiatric Inventory, NPI

表 12、神經精神評估量表

| 項目 | 有無此症狀 | | 頻率 | | | | 嚴重性 | | |
|---|---|---|---|---|---|---|---|---|---|
| | 是 | 否 | 偶爾 | 時常 | 經常 | 常常 | 輕 | 中 | 重 |
| 妄想 | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 幻覺 | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 激動 / 攻擊行為 | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 憂鬱 / 情緒不佳 | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 焦慮 | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 怡然自得 / 欣快感 | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 冷漠 / 毫不在意 | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 言行失控 | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 暴躁易怒 / 情緒易變 | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 異常動作 ( 主要指重複性動作 ) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

(失智症診療手冊，衛福部，2017)

# 失智症之精神行為症狀常見徵兆

- 「近的記不住，舊的一直講」
- 「躺著睡不著，坐著打瞌睡」
- 「到處漫遊走，出門就迷路」
- 「東西一不見，直覺被偷走」
- 「問話重覆說，行為反覆做」
- 「情緒欠穩定，憂鬱最早現」
- 「當面對質問，謾罵攻擊出」

(黃正平：臨床老年精神醫學)

# 失智症的精神行為症狀-BPSD

| | |
|---|---|
| Affect | 憂鬱 |
| | 焦慮 |
| | 躁症 |
| | 易怒 |
| Behavior | 自言自語 |
| | 反覆衝動 |
| | 坐立不安 |
| | 傷人或自傷 |
| Cognition | 妄想 |
| | 幻覺 |
| Drive | 失眠或嗜睡 |
| | 食慾高或低 |
| | 性慾過高或不適切的性行為 |

# 失智症精神行為症狀(1)

- **憂鬱症狀**
- 發生率為40-50%之間 。
- 無助感、無望感、無價值感
- 血管型失智症 > 阿茲海默氏失智症
- **焦慮症及恐懼症**：
- 即將來臨的事反覆提問
- 害怕、恐懼獨處(常見)

黃正平：臨床老年精神醫學 2012:93-101

# 失智症精神行為症狀(2)

- **妄想症狀**
  - 被偷妄想
  - 被害妄想
  - 忌妒妄想
- **錯認(Misidentification)**
  - 被冒充取代
- **幻覺(Hallucination)**：
  - 視幻覺 > 聽幻覺 > 觸、嗅、味幻覺

黃正平：臨床老年精神醫學 2012:93-101

# 失智症精神行為症狀(3)

- **行為障礙(behavioral disturbances)**
- **攻擊行為**：發生率為54.7% 。對負面感覺忍耐力降低、喪失是非判斷能力，容易誤解別人。
- **睡眠障礙**：發生率為60.5%。日夜節律顛倒、白天睡覺晚上失眠。
- **迷路**：發生率為61.7% 。失智症中後期出現較多。
- **重覆現象**：發生率62.7%。失智症早期已出現，重覆行為及言語。

黃正平：臨床老年精神醫學 2012:93-101

# 失智症精神行為症狀(4)

- **行為障礙(behavioral disturbances)**
- **漫遊**：發生率為45.3%。方向及地點之定向感逐漸喪失，容易在家裡及鄰近社區四處遊走
- **飲食改變**：發生率為36.0% 。貪食(最常見)、口味改變...
- **病態收集**：發生率為27.5% 。收集項目和失智嚴重度有關。
- **不恰當性行為**：發生率為15% 。性暴露、不恰當性接觸。

黃正平：臨床老年精神醫學 2012:93-101

# 失智症精神行為症狀(5)

- **日落症候群 (Sun-down syndrome)**：病患早上頭腦清醒，大約從下午3點到晚上11點出現精神混亂、激躁行為。

# Identify BPSD Symptom Clusters

| Psychosis | Aggression | Agitation | Depression | Mania | Apathy |
|---|---|---|---|---|---|
|  |  |  |  |  |  |
| Delusions<br>Hallucinations<br>Misidentification<br>Suspicious | Defensive<br>Resistance to care<br>Verbal<br>Physical | Dressing/undressing<br>Pacing<br>Repetitive actions<br>Restless/anxious | Anxious<br>Guilty<br>Hopeless<br>Irritable/screaming<br>Sad, tearful<br>Suicidal | Euphoria<br>Irritable<br>Pressured speech | Amotivation<br>Lacking interest<br>Withdrawn |

Use of Antipsychotics in Behavioural and. Psychological Symptoms of Dementia (BPSD). Discussion Guide. Centre for Effective Practice. April 2016. Version 2.

# BPSD的處理_ DCBA

# 失智相關精神行為症狀的處理流程

找出引起BPSD的可能原因，
例如環境、譫妄、疼痛、藥物等。

失智症的精神行為症狀的治療仍以非藥物的治療為優先，須使用藥物時由低劑量，單純的藥物開始，隨時檢討藥物使用的必要性。

成效不足時，再考慮結合與藥物治療的協同治療模式。

1.Use of Antipsychotics in Behavioural and. Psychological Symptoms of Dementia (BPSD). Discussion Guide.Centre for Effective Practice. April 2016. Version 2.
2.失智症診療手冊，衛福部，2017

# BPSD處理

- 1.優先: D身體問題或譫妄
- 2.其次: C認知功能
- 3.再其次: B行為及情緒問題
- 4.最後: A日常生活功能。
- 不論非藥物或藥物治療，以「增進失智症患者獨立功能與生活品質」及「減輕照護者負荷、增進其因應技巧與照護能力」為目標。

- 失智症行為精神症狀之藥物治療

# Psychosis in old ages

| Characteristic Features | Delirium | BPSD | Late onset psychosis |
|---|---|---|---|
| Length of maintenance of antipsychotic medication | Brief | Brief | Long term |

(Gautam S, Jain A,et al,2018)

# BPSD 藥物治療原則

- 非藥物治療效果不佳時，再加上藥物處理。
- 藥物劑量能低就低，種類能少就少，減少藥物對身體造成的負荷與副作用。
- 老年失智症病人，神經精神類藥物的使用原則為低起始劑量、緩慢調整（start low, go slow!）

# Use of antipsychotics to treat BPSD

| Steps | Recommended procedures |
|---|---|
| Assessment of BPSD | 1. Patients with dementia should be assessed for the type, frequency, severity, clinical pattern, and timing of the symptoms (1C) |
| | 2. Assess for pain and other potentially modifiable factors and for subtypes of dementia that may influence the choice of treatment (1C) |
| | 3. Use quantitative measures to assess agitation and psychosis, if present (1C) |
| Development of comprehensive treatment plan | 4. Individualized treatment plan includes appropriate nonpharmacological and pharmacological interventions (1C) |
| Assessment of benefits and risks of antipsychotic treatment for the patient | 5. Antipsychotic medication should be used for treatment of agitation or psychosis only when symptoms are severe or dangerous and/or cause significant distress to the patient (1B) |
| | 6. Review response to nonpharmacological interventions prior to use of an antipsychotic medication (1C) |
| | 7. If feasible, discuss risk/benefit with the patient and obtain his/her or the caregiver's consent (1C) |
| AP treatment – dosage, duration, and monitoring | 8. Initiate at a low dose to be titrated up to the minimum effective dose as tolerated (1B) |
| | 9. If significant adverse effects occur, review the patient's status and taper or discontinue the antipsychotic medication (1C) |
| | 10. If no significant response occurs after 4 weeks of an adequate dose, taper and withdraw the medication (1B) |
| | 11. If positive response occurs, consider and discuss tapering the dose with the patient/surrogate regarding experience with tapering attempts (1C) |
| | 12. If adequate response occurs, the dose of antipsychotic medication could be tapered or withdrawn, unless the patient experienced recurrence of symptoms with prior attempts at tapering (1C) |
| | 13. If the dose of antipsychotic medication is being tapered, assess the symptoms at least monthly for a minimum of 4 months after discontinuation to identify recurrence of symptoms (1C) |
| Use of specific antipsychotic medication, depending on clinical context | 14. In the absence of delirium, haloperidol should not be used as a first-line agent (1B) |
| | 15. Long-acting injectable antipsychotics should not be used, unless it is indicated for co-occurring psychotic disorder (1B) |

(Masopust J,et al,2018)

# 治療失智症患者之行為精神症狀的藥物

| | 劑量 | 適應症 | 常見副作用 |
|---|---|---|---|
| 非典型抗精神病藥物 | | | |
| Quetiapine (Seroquel) | 睡前12.5 – 300 mg | 妄想、幻覺、激躁 | 鎮靜嗜睡、巴金森氏症、血糖升高、體重增加、心電圖變化(QT間隔延長)。美國食品藥物管理局警告使用者可能發生腦血管病變。 |
| Risperdone (Risperdal) | 睡前0.5-1.5 mg | | |
| Olanzapine (Zyprexa) | 睡前2.5-10 mg | | |
| 傳統抗精神病藥物 | | | |
| Haloperidol (Haldol) | 每日1.2-3.5 mg | 妄想、幻覺、急性激躁 | 鎮靜嗜睡、巴金森氏症、遲發性運動不能、肌張力不足、神經藥物惡性症候群、體重增加、光敏感、心電圖變化。 |
| 乙醯膽鹼酶抑制劑 | | | |
| Donepezil (Aricept) | 睡前10 mg | 激躁、冷漠 | 噁心、嘔吐、腹瀉。 |
| Galantamine (Reminyl) | 6-12 mg每日兩次 | | |
| Rivastigmine (Exelon) | 3-6 mg每日兩次 | | |
| 抗癲癇藥物 | | | |
| Carbamazepine (Tegretol) | 每日200-600 mg | 激躁、攻擊性、去抑制現象 | 鎮靜、運動失調、血鈉過低、顆粒球過低。 |
| Valproic acid (Depakine) | 每日375-1375 mg | | 鎮靜、震顫、肝功能異常、血小板過低。 |
| 抗憂鬱藥物 | | | |
| Citalopram (Cipram) | 每日10-40 mg | 憂鬱、激躁 | 腹瀉、頭痛、性功能異常、血鈉過低、厭食、煩躁不安。 |
| Fluoxetine (Prozac) | 每日5-40 mg | 憂鬱 | |
| Sertraline (Zoloft) | 每日25-200 mg | 憂鬱 | |
| Trazodone (Mesyrel, Cirzodone) | 睡前25-300 mg | 睡眠障礙 | 鎮靜嗜睡。 |
| 抗焦慮藥物 | | | |
| Buspirone | 每日15-30 mg | 焦慮、激躁 | 頭痛、噁心、暈眩、煩躁不安。 |
| Lorazepam(Ativan) | 每日0.5-5 mg | 急性激躁、焦慮 | 鎮靜、運動失調、精神混亂、憂鬱、跌倒 |

(謝美芬，顏兆熊，2008)

# 抗精神病藥物使用在BPSD–Schizophrenia-like syndromes

| 藥品名稱 | BPSD 常用劑量 | Schizophrenia 建議劑量 | 備註 |
|---|---|---|---|
| *Risperidone | 0.25-2mg/d | Initial, 2 mg/day orally, to a usual dosage of 4 to 8 mg/day. | Dose-related EPS |
| *Olanzapine | 2.5-10mg/d | Initial, 5-10mg/day orally, MAX, 20 mg/day | 1. 劑量小於5mg，EPS副作用發生機率低<br>2. 需注意metabolic side effects。 |
| *Quetiapine | 25-150mg/d | Initial, 25mg/day orally, MAX, 800 mg/day | 可能與白內障的發生有關，建議每六個月進行裂隙燈檢查。 |
| *Aripiprazole | 2-5mg/d initially, max 30mg/d | Initial, 10-15mg/day orally, MAX, 30 mg/day | 藥效達到穩定狀態需要2週，故在服藥達2週前不應該增加劑量。 |
| *Amisulpride | 50-200mg/d | 400-1200mg/d | CrC1 30-60ml/min劑量應降為 1/2。<br>CrC1 10-30ml/min，則劑量應降為 1/3。 |

American Geriatrics Society Guideline: Management of psychotic disorders in older adults. https://www.nhqualitycampaign.org/files/ AGS_Guidelines_for_Telligen.pdf
Amisulpride in Refractory Behavioral and Psychological Symptoms of Dementia. Ann Alzheimers Dement Care. 2017.1(1): 001-006. UpTodate/Micromedx

# 抗精神病藥物使用在BPSD-Schizophrenia-like syndromes

| 藥品名稱 | BPSD 常用劑量 | Schizophrenia 建議劑量 | 備註 |
|---|---|---|---|
| Clozapine | 25-150mg/d | Initial, 12.5mg/day orally, MAX, 900 mg/day | 1. 可用於parkinsonism和tardive dyskinesia的病人。<br>2. 可能造成顆粒性白血球缺少。前18週使用時，每週需作白血球檢驗，使用18週後，每月作一次白血球檢驗。 |
| Paliperidone | 3-12mg/d | Initial, 6mg/day orally, MAX, 12 mg/day | CrC1 51-80ml/min, max 6mg/d;<br>CrCl≤50ml/min, max 3mg/d |
| Ziprasidone | 20-80mg/d | Initial,20 mg twice daily, up to 80mg twice daily | 可能造成QTc延長，需定期監測EKG。 |

American Geriatrics Society Guideline: Management of psychotic disorders in older adults. https://www.nhqualitycampaign.org/files/ AGS_Guidelines_for_Telligen.pdf
Amisulpride in Refractory Behavioral and Psychological Symptoms of Dementia. Ann Alzheimers Dement Care. 2017.1(1): 001-006. UpTodate/Micromedx

# 抗憂鬱藥物使用在BPSD-depressive features

| 藥品 | 老人建議劑量(mg/d) | 作用 | 注意事項 |
|---|---|---|---|
| 選擇性血清回收抑制劑 (Selective Serotonin Reuptake Inhibitor, SSRI) | | | SSRI類藥品副作用：EPS、低血鈉、自殺風險(用藥早期)、腸胃不適、增加上消化道出血機率、失眠 |
| citalopram | 10-40mg | 抗憂鬱、抗焦慮 | SSRI中交互作用最少藥品。有文獻支持可降低病人Agitation。須注意QT間隔延長。 |
| Escitalopram | 5-20mg | 抗憂鬱、抗焦慮 | 須注意QT間隔延長。 |
| Fluoxetine | 10-40mg | 抗憂鬱、抗焦慮 | 半衰期長。CYP450 2D6的強效抑制劑 |
| Paroxetine | 10-40mg | 抗憂鬱、抗焦慮 | CYP450 2D6的強效抑制劑。抗膽鹼副作用。 |
| Sertraline | 25-100mg | 抗憂鬱、抗焦慮 | |
| 血清素正腎上腺素回收抑制劑 (Serotonin-Norepinephrine Reuptake Inhibitor, SNRI) | | | |
| Duloxetine | 20-60mg | 治療重鬱症、抗焦慮 | 噁心、口乾、暈眩、高血壓。CrCl 30-60ml/min需降低劑量，禁用於CrCl < 30ml/min |
| Venlafaxine | 25-150mg | 抗憂鬱、抗焦慮 | 可能導致血壓持續性升高(dose-dependent)與QT間隔延長。 |

American Geriatrics Society Guideline: Management of psychotic disorders in older adults. https://www.nhqualitycampaign.org/files/ AGS_Guidelines_for_Telligen.pdf

# 抗憂鬱藥物使用在BPSD-depressive features

| 藥品 | 老人建議劑量(mg/d) | 作用 | 注意事項 |
|---|---|---|---|
| 多巴胺與正腎上腺素回收抑制劑 (Dopamin-Norepinephrine Reuptake Inhibitor, DNRI) | | | |
| Bupropion | 75-225mg | 抗憂鬱。可用於活力降低或性功能障礙的病人。 | 容易降低癲癇發作閥值 |
| 血清素調節劑 (serotonin modulator ) | | | |
| Trazodone | 25-150mg | 抗憂鬱。鎮靜、助眠。 | 鎮靜、低血壓 |
| 正腎上腺素和血清素調節劑 (Norepinephrine Serotonin Modulator, NSM ) | | | |
| Mirtazapine | 7.5-30mg | 抗憂鬱、助眠、促進食慾 | 鎮靜、低血壓、促進食慾 |

American Geriatrics Society Guideline: Management of psychotic disorders in older adults. https://www.nhqualitycampaign.org/files/ AGS_Guidelines_for_Telligen.pdf

# 抗癲癇藥物使用在BPSD-Manic like features

| 藥品 | 老人建議劑量 (mg/d) | 副作用 | 備註 |
|---|---|---|---|
| Carbamazepine | 200-1000mg/d | 噁心、疲倦、皮膚疹、史帝強生症候群、視力模糊、低血鈉 | 老年人耐受性較差。監測CBC、肝功能、電解質。 |
| Lamotrigine | 25-200mg/d | 皮膚疹、史帝強生症候群、顆粒性白血球減少 | 與Sodium valproate併用會增加副作用。 |
| Lithium | 150-1000mg/d | 噁心、嘔吐、細微動作顫抖、運動失調 | 老年人耐受性較差。監測甲狀腺與腎功能。 |
| Sodium valproate | 250-2000mg/d | 噁心、腸胃不適、鎮靜、運動失調 | 監測CBC、血小板、肝功能。老年人耐受性較其他藥物好。 |

主要使用於”像躁症”的病人

American Geriatrics Society Guideline: Management of psychotic disorders in older adults. https://www.nhqualitycampaign.org/files/ AGS_Guidelines_for_Telligen.pdf

# 藥物治療BPSD-agitation

| 症狀 | 藥物及常用劑量 |
| --- | --- |
| Angitation in context of psychosis | Aripiprazole 2.5-12.5mg/d, Olanzapine 2.5-10mg/d, Quetiapine 12.5-100mg/d, Risperidone 0.25-3mg/d |
| Angitation in context of depression | SSRI, eg. Citalopram 10-30mg/d |
| Anxiety, imild to moderate irritability | Bupropion 15-60mg/d, Trazodone 50-100mg/d |
| Agitation or aggression unresponsive to first-line treatment | Carbamazepine 300-600mg/d, Sodium valproate 500-1500mg/d |
| Sexual aggression, impulse-control symptoms in men | SGAs, Sodium valproate 500-1500mg/d |
| Agitation in Lewy body or parkinson's dementia | Possible Cholinesterase inhibitors, very low dose quetiapine or clozapine |

American Geriatrics Society Guideline: Management of psychotic disorders in older adults. https://www.nhqualitycampaign.org/files/ AGS_Guidelines_for_Telligen.pdf

# Comparison of Antipsychotics

| | Drug<br>Generic (Brand) | Efficacy or evidence in BPSD therapy | ↑ BP[32] | Ach | Sedation | EPS | TD[33] | Diabetes | Weight Gain[27] | Usual Dose |
|---|---|---|---|---|---|---|---|---|---|---|
| Atypicals | **Risperidone*** (Risperdal)[25, 26, 34] | • Indicated for severe dementia of the Alzheimer type (Health Canada)<br>• Evidence for efficacy in agitation, aggression & psychosis | ++ | ++ | ++ | ++ | + | ++ | ↑↑↑ (0.7lb/ month) | 0.125mg – 2.0mg/d QHS (or divided BID) |
| Atypicals | **Olanzapine*** (Zyprexa)[25, 26, 34] | • Off-label use in BPSD<br>• Evidence for efficacy in agitation & aggression | + | +++ | +++ | ++ | + | +++ | ↑↑↑ (1.0lb/ month) | 1.25mg – 7.5mg/d |
| Atypicals | **Aripiprazole*** (Abilify)[34] | • Off-label use in agitation or aggression[18]<br>• Evidence for efficacy in agitation & aggression<br>• Not eligible for dementia or BPSD in the elderly(ODB criteria, Therapeutic Note)<br>• Not for psychosis(same as placebo) | + | + | ++ | + | + | – | ↑ | 2.0mg – 12.5mg QHS |
| Atypicals | **Quetiapine** (Seroquel)[25, 26, 34] | • Off-label use in BPSD<br>• Lacks evidence for efficacy in BPSD agitation, aggression & psychosis<br>• Consider in Lewy Body dementia, Parkinson's (low EPS)<br>• Note: although used, not indicated, and lacking evidence for insomnia | ++ | +++ | +++ | + | + | +++ | ↑↑ (0.4lb/ month) | 12.5mg – 200mg/d (divided QHS-TID) |
| Typicals | **Haloperidol** (Haldol) | • Useful short term in acute BPSD or delirium | + | + | + | +++ | +++ | ++ | ↑↑ | 0.25mg – 2.0mg/d |
| Typicals | **Loxapine** (Loxapac, Xylac)[2] | • Consider if other agents have failed and severe, persistent, dangerous behaviour continues<br>• Severe, acute BPSD<br>• Not to be used long-term due to adverse effects | ++ | ++ | +++ | +++ | +++ | + | – | 5.0mg – 10mg BID |

Use of Antipsychotics in Behavioural and. Psychological Symptoms of Dementia (BPSD). Discussion Guide.Centre for Effective Practice. April 2016. Version 2.

# 抗精神病藥物的副作用

| Table 2. Adverse Events of Second-generation Antipsychotics | | | | | | | |
|---|---|---|---|---|---|---|---|
| | **Aripiprazole** | **Clozapine** | **Olanzapine** | **Paliperidone** | **Quetiapine** | **Risperidone** | **Ziprasidone** |
| ***Cardiovascular*** | | | | | | | |
| **Level of Evidence** | CR | CR | RCT | RCT | RCT | RCT | CR |
| Hypotension | ? | 0/+++ | + | + | +++ | + | ? |
| QTc prolongation* | ? | + | + | + | + | + | ++ |
| ***Endocrine/Metabolic*** | | | | | | | |
| Weight gain | ? | +++ | +++ | ++ | ++ | ++ | ? |
| Diabetes | ? | +++ | +++ | ++ | ++ | ++ | ? |
| Hypertriglyceridemia | 0 | + | + | ? | 0 | ? | 0 |
| Hyperprolactinemia | ? | ? | ? | +++ | ? | +++ | + |
| ***Gastrointestinal*** | | | | | | | |
| Nausea, vomiting, constipation | 0 | ? | 0 | ? | + | ? | ? |
| ***Neurologic*** | | | | | | | |
| Extrapyramidal symptoms | ++ | + | + | +++ | + | +++ | + |
| Seizures | ? | +++ | ? | ND | ? | ND | ND |
| Sedation | ? | +++ | + | + | + | + | ? |
| ***Systemic*** | | | | | | | |
| Anticholinergic | 0 | +++ | ++ | 0 | + | 0 | ? |
| Neuroleptic malignant syndrome | ND | + | ND | ND | ND | + | ND |
| *QTc upper limit of normal = 44 millisec | | | | | | | |
| CR = case reports; RCT = randomized clinical trials; ND = no data | | | | | | | |
| ? = uncertain effect | | | | | | | |
| 0 = no effect | | | | | | | |
| + = mild effect; ++ = moderate effect; +++ = severe effect; 0/+++ = no effect to severe effect in the case of drug interactions | | | | | | | |

# 抗精神病藥物的副作用及處理方法

| 副作用 | 處置 |
| --- | --- |
| 藥物引發的帕金森氏症(Drug-induced parkinsonism) | 降低劑量(通常是dose related)；換藥；避免使用抗膽鹼藥品(anticholinergic agent) |
| 靜坐不能(Akathisia) | 考慮使用β-blocker(例如：propranolol 20-40mg/d)或是低劑量BZD(例如：lorazepam 0.5mg q12h) |
| 低血壓(Hypotension) | 慢慢調升其治療劑量(slow titration)；降低劑量；換藥 |
| 鎮靜(Sedation) | 降低劑量；換藥；睡前給藥 |
| 遲發性運動不能(Tardive dyskinesia) | 停用藥品；考慮使用SGAs中EPS風險較小的藥品，例如：aripiprazole、quetiapine。 |

American Geriatrics Society Guideline: Management of psychotic disorders in older adults. https://www.nhqualitycampaign.org/files/ AGS_Guidelines_for_Telligen.pdf

# 失智症BPSD治療比較

| | 阿茲海默症 | 血管性失智症 | 額顳葉失智症 | 路易體失智症 |
|---|---|---|---|---|
| 抗精神病藥物的使用 | 抗精神病藥物有效，但長期增加中風與死亡風險；高劑量抗精神病藥要減藥時須緩慢減藥，以避免復發。 | 儘量短期低劑量使用，對幻覺妄想可能有效。 | 抗精神病藥物對激躁不安無實證支持。 | 對所有抗精神病藥都十分敏感，容易產生帕金森症副作用或抗精神藥物惡性症候群，建議考慮使用極低劑量quetiapine，並緩慢加藥。 |
| 乙醯膽鹼酶抑制劑的使用 | 有效；輕、中、重度可以使用。 | 部分個案有效 | 無效 | 有效 |

(失智症診療手冊，衛福部，2017)

# Drug interactions

| Drugs | Metabolism | Drugs increasing levels | Drugs decreasing levels | Pharmacodynamic interactions |
|---|---|---|---|---|
| Donepezil | CYP3A4 and 2D6 | Fluoxetine<br>Ketoconazole<br>Itraconazole<br>Erythromycin<br>Quinidine | Rifampicin<br>Phenytoin<br>Carbamazepine<br>Alcohol | Anticholinergic medication – An<br>Cholinomimetics (succinylcholine) – S<br>Peripheral ChE-I (neostigmine) – S<br>Beta blockers – CV<br>Amiodarone – CV<br>Ca channel blockers – CV |
| Rivastigmine | Extrahepatic | – | – | Anticholinergic medication – An<br>Cholinomimetics (succinylcholine) – S<br>Peripheral ChE-I (neostigmine) – S<br>Beta blockers – CV<br>Amiodarone – CV<br>Ca channel blockers – CV |
| Galantamine | CYP3A4 and 2D6 | Paroxetine<br>Fluoxetine<br>Fluvoxamine<br>Amitriptyline<br>Ketoconazole<br>Erythromycin<br>Ritonavir<br>Quinidine | ? | Anticholinergic medication – An<br>Cholinomimetics (succinylcholine) – S<br>Peripheral ChE-I (neostigmine) – S<br>Beta blockers – CV<br>Amiodarone – CV<br>Ca channel blockers – CV |
| Memantine | Primarily extrahepatic, renal excretion | Cimetidine<br>Ranitidine<br>Procainamide<br>Quinidine<br>Nicotine<br>Urine alkalizing drugs[b] | ? | Increase in effect of L-dopa, dopaminergic and anticholinergic medication<br>Amantadine, ketamine, dextromethorphan – FTP<br>It is necessary to adjust the dosage of spasmolytic medication, dantrolene, and baclofen |

(Masopust J,et al,2018)

# 結論

# 藥物使用前的考量

- 安全性與藥效(safety and efficacy)—需要用藥嗎?
- 起始劑量，有效劑量與維持劑量
- 足夠劑量到有治療效果所需的時間
- 使用頻次/半衰期，代謝
- 副作用(side effect or adverse effect)
- 服藥規律性(compliance/adherence)
- 多久該減藥或停藥
- 藥物交互作用

# 抗精神病藥物使用前考量

- 診斷、適應症 —建立治療性關
- Target symptoms(目標症狀)
- Initial dose (starting dose,起始劑量)
- Target dose(目標劑量)
- Maintenance dose(維持劑量)
- Days to mid-target dose (藥物調整間隔)
- Days to effect(等待藥效開始的時間)
- Days to maintenance dose(減至維持劑量的時間)
- Full dose, Full term (考慮有效的最大劑量及時間)

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