ECHO Idaho: Alzheimer's Disease and Related Dementias
CASE RECOMMENDATION FORM

ECHO Session Date: 6/10/25

Thank you for presenting your patient at ECHO Idaho –Alzheimer's Disease and Related Dementias session.

Summary:
This case was of a 69-year-old female with complex medical and psychiatric comorbidities, including moderate Lewy Body Dementia with hallucinations, bipolar II disorder, PTSD, generalized anxiety disorder, and a significant trauma history (as reported by her daughter). She also has a history of suicidal ideation and one attempt, with recent passive suicide ideation. Medical history includes CKD stage 3a, atrial fibrillation, PMR, asthma, obesity, osteoarthritis, ulcerative colitis, migraines, and malnutrition. Psychotropic regimen includes duloxetine, quetiapine, buspirone, and lamotrigine, with goals to stabilize mood, eliminate psychotic symptoms, and reduce polypharmacy. She resides in a trailer with her 90-year-old husband, faces financial stress, and is religious with limited family support nearby.

After reviewing the case presentation and discussion of this patient's case among the ECHO Community of Practice, the following suggestions have been made:

Overall, recommendations focused on simplifying medications, targeting symptoms through the lens of neurocognitive decline, ensuring safety at home, and bolstering support systems.

1. POTENTIAL PHARMACOGENTIC TESTING

- This patient might be a good person to have pharmacogenetic testing done regarding her metabolism of mental health medications to further tailor her medication management. While not for every patient, this testing might be useful if not already done, given her failed trial of so many medications.

2. MEDICATION ADJUSTMENTS:

- **Anxiety treatment:**
  - Buspirone can worsen symptoms of Parkinsonism which (here is an article referencing a small pilot study—to our knowledge there isn't a bigger or better designed trial to date).
  - Consider prazosin as an alternative to buspirone for anxiety, particularly because of her trauma history and likely neurocognitive etiology. Although she previously did not tolerate prazosin, it may be worth a cautious re-trial, starting low and slow, if side effects can be better managed now.
  - Venlafaxine was suggested as an option due to its possible blood pressure–raising effects, which could benefit her mild orthostatic hypotension. However, we understand she had an inadequate response in the past. Given her history of trying multiple SSRIs and SNRIs (e.g., Sertraline, Fluoxetine), options are limited.

- Consider viewing anxiety not as a primary psychiatric issue, but through the lens of neurocognitive disorder with agitation, which may influence future pharmacologic choices (e.g., cholinesterase inhibitors).

- **Hallucinations and psychosis:**
  - Introduce an acetylcholinesterase inhibitor such as donepezil or rivastigmine (transdermal patch may be better tolerated), if her bradycardia (HR 59–62) and tolerability allow. Reducing the dose of metoprolol may allow for use of an acetylcholinesterase inhibitor. These may help both hallucinations and cognitive symptoms. Neither rivastigmine nor donepezil require renal dosing.

- **The algorithm for managing hallucinations in Lewy Body Dementia was outlined:**
  - Acetylcholinesterase inhibitor (AChEI)
  - Pimavanserin
  - Quetiapine (currently on quetiapine 100 mg, which is a mood-stabilizing dose. If other treatments are introduced and effective, consider tapering quetiapine in the future to reduce sedation and fall risk)
  - Clozapine (used rarely due to monitoring needs)
- **Mood stabilization:**
  - Reassess the long-term need for lamotrigine, especially if quetiapine is providing adequate stabilization. Concerns include complexity of dosing, adherence risks, and Stevens-Johnson syndrome if discontinued and restarted improperly.
- **Blood pressure and cardiovascular medications:**
  - Consider discontinuing or tapering metoprolol if it's only being used for blood pressure control, as it may worsen orthostatic hypotension and limit the use of other needed medications (e.g., cholinesterase inhibitors).
  - Her blood pressure readings (110s/70s) suggest she may not require antihypertensives, and switching to an ARB could be more appropriate, particularly in the context of CKD.
- As you discussed, continue to avoid polypharmacy where possible and evaluate all medications for continued necessity, renal dosing appropriateness, and fall risk.

3. PSYCHOSOCIAL AND ENVIRONMENTAL SUPPORTS

- We agree with you to continue advocating for individual counseling, which has led to significant improvements in anxiety, boundary-setting, and mood regulation.
- Involve the daughter more directly in care planning and medication oversight, especially due to the patient's resistance to change and complexity of her regimen.
- OT Support
  - Reassess IADL and safety support using a dementia-informed OT or alternative strategies; the previous OT experience may have failed due to lack of dementia training and the patient's perception of being evaluated for loss of independence.

- Conduct a comprehensive home safety assessment (e.g., ramps, grab bars, fall prevention), and prioritize caregiver education by involving other family members if the spouse is not ready to engage.

- Prepare for the likely transition to assisted living, despite the patient's current resistance. Frame conversations around safety and the burden on her husband.
  - Explore faith-based or community support systems, potentially through her church, to reduce isolation and provide informal support.
  - Discuss advance directives and care planning, especially in light of progressive dementia and her husband's aging status.

4. DIAGNOSTIC CLARIFICATION:

- Formal neurocognitive testing is pending and supported by the team. Even though her cognitive decline is clinically apparent, documentation is important for care planning and potential medication changes.
- Consider biomarker confirmation (e.g., alpha-synuclein skin biopsy) if the Lewy Body Dementia diagnosis remains uncertain. This can guide whether dementia-specific medications are appropriate.
- Avoid memantine for now due to renal function, unless executive dysfunction becomes a clear target; if used, reduce to 5 mg BID instead of the standard 10 mg BID**.**