

## PATIENT INFORMATION

**Sex:** Male

**Age:** 84

### Key Questions for the Panel

- What are best practices for managing severe exit-seeking behavior in advanced Alzheimer's disease while minimizing antipsychotic exposure?
- Are there medication adjustments or deprescribing strategies that may better support agitation and sleep in this patient?

### Check all that apply or relate to your main question:

- Behavioral symptoms: wandering, elopement, safety concerns, aggression
- Psychiatric symptoms: anxiety, insomnia, agitation
- Issues with ADLs and IADLs
  - Requires cueing for ADLs
  - Requires assistance with all IADLs
- Caregiver support
- Medication recommendations

### Describe challenges or concerns regarding this patient's medication regimen?

Concerns include potential medication-induced delirium and adverse cognitive effects, particularly with antipsychotics. Rapid titration of Quetiapine (Seroquel) was associated with transient slurred speech, confusion, and weakness. There is also interest in minimizing long-term antipsychotic exposure and optimizing medications for agitation and sleep while prioritizing non-pharmacologic interventions.

### Rough timeline:

- Quetiapine 25 mg at bedtime was initiated for nighttime agitation and exit-seeking behavior. He was on 20 mg fluoxetine for history of depression. Due to his exit-seeking, the facility called his son. The staff had checked UA and it was negative. His son noted unusual behaviors the following day, including wearing multiple pairs of underwear and acting increasingly confused.
- He was brought to the ED, had a medical workup including blood tests and CT head that did not identify an acute medical cause, and he was discharged back to the facility. He did well for two days, then had another episode of severe exit seeking including attempting to break a door using a chair, having slurred speech, increased confusion.
- He was brought back to the ED. No medical condition was found but the care home refused to take him back until he was not aggressive, so he was admitted to the medical floor. He was assessed to have a Clinical Frailty Score of 6.
- He was put on 0.25 mg Risperidone in the afternoon and night and Quetiapine was discontinued. He had only mild agitation in the hospital. Trial of scheduled acetaminophen initiated.

### Current and past medical history

- Hyperlipidemia (previously treated)
- Depression
- Hearing loss (recent cerumen impaction and decreased hearing noted)

## Has your patient ever been formally diagnosed with dementia or another brain health condition?

Alzheimer's disease dementia (diagnosed 2022)

### MEDICATIONS

#### Current

- Risperidone 0.25 mg afternoon and bedtime
- Fluoxetine 20 mg daily
- Melatonin immediate release 3 mg nightly
- Scheduled acetaminophen

#### Previously used

- Quetiapine 25 mg at bedtime (initial nighttime agitation and exit-seeking leading to Quetiapine initiation; discontinued due to suspected adverse effects including confusion and slurred speech)
- Donepezil
- Memantine (Namenda)

### Cognitive screening

- **SLUMS score:** 9/30 (2022)

### Social History

He is a widowed retired physician and Army veteran who currently lives in a personal care home with two other residents with dementia and typically one caregiver present at a time. He has supportive adult children (one son and one daughter) and several grandchildren who are involved in his care.

He does not use mobility devices and has no history of falls, although family has noted intermittent difficulty with ambulation and generalized weakness in recent weeks.

### Goals of Care

The patient has DNR/DNI status. Goals of care focus on comfort, safety, maintaining dignity, minimizing distress and agitation, and supporting care in the current residential setting if possible. Family is interested in approaches that reduce medication burden while maintaining quality of life and safety.

### Recommendations/changes following ED visit:

- During hospitalization, cerumen impaction was identified and treated.
- Initiated immediate-release melatonin 3 mg nightly.
- Non-pharmacologic interventions for agitation and insomnia.
- Recommended OT, and family and staff were encouraged to consider a complementary consultation with Teepa Snow ([www.teepasnow.com](http://www.teepasnow.com)), an OT and dementia care expert.

- Medication changes:
  - Chamomile extract or lavender (Silexan) for anxiety or agitation
  - Switch to extended-release melatonin if insomnia persists
  - Switch from fluoxetine to citalopram if agitation persists despite non-pharmacologic interventions
  - Taper and discontinue risperidone as tolerated
  - 1 mg haloperidol for severe agitation, if intramuscular medication is needed
  - Discontinue atorvastatin, fenofibrate, and aspirin to align medications with current goals of care.
- Registered in Aware Care Ada County, a voluntary registry that assists emergency responders in supporting vulnerable individuals during emergencies.