

Somerset Healthcare Community Shared Care Protocol for **Dementia including Alzheimer's Disease** **Acetylcholinesterase (AChE) Inhibitors or Memantine**

*This shared care protocol (SCP) sets out details for the sharing of care for **patients prescribed any of the following drugs in the management of dementia including Alzheimer's Disease – donepezil, rivastigmine, galantamine or memantine.***

It should be read in conjunction with the latest Summary of Products Characteristics (SmPC) available for each drug at <http://www.medicines.org.uk/emc/>

As outlined in [NHS England Guidance 2018 \(07573\), 'Responsibility for Prescribing Between Primary & Secondary/Tertiary Care'](#): When a specialist considers a patient's condition to be stable or predictable, they may seek the agreement of the GP concerned (and the patient) to share their care.

This document provides information on drug treatment for the shared commitment between the specialist and GP concerned. GPs are invited to participate. If the GP is not confident to undertake these roles, then they are under no obligation to do so. In such an event, the total clinical responsibility for the patient for the diagnosed condition remains with the specialist. The doctor who prescribes the medication has the clinical responsibility for the drug and the consequences of its use.

N.B. If the GP decides not to participate in shared care for a particular patient, they must inform the relevant specialist in writing, within 2 weeks of receipt of a request to share care.

Introduction

This shared care protocol sets out details to support the transfer of responsibility for prescribing acetylcholinesterase inhibitors (AChE inhibitors) or memantine from secondary to primary care.

It is intended to apply to patients who have been initiated on treatment, (and who have been assessed as benefiting) by secondary care services experienced in the care of people with dementia in accordance with the guidance from the National Institute for Health & Clinical Excellence: [NG97](#) & [TA217](#).

In Somerset, GPs should refer appropriate patients to the Older Persons Community Mental Health Team Service for assessment within a specialist service. Where indicated, treatment should be initiated in secondary care. Secondary care services should continue to prescribe for the first three months while response is assessed. In referring patients, GPs should be willing to continue prescribing after the first three months, as part of a shared care arrangement, for those patients who have been assessed as benefiting.

It is important to recognise that there is no cure for dementia, and no treatments exist to halt or reverse the course of the disease. Treatments are aimed at improving

cognitive and functional outcomes. Drug treatment for dementia and Alzheimer's disease should form part of a wider package of support and information for the patient and their carer.

Treatment with an AChE inhibitor or memantine should only be initiated if reasonable steps are taken to ensure adequate compliance.

Dementia is a term used to describe a range of cognitive and behavioural symptoms that can include memory loss, problems with reasoning and communication and change in personality, and a reduction in a person's ability to carry out daily activities, such as shopping, washing, dressing, and cooking.

The most common types of dementia include Alzheimer's disease, vascular dementia, mixed dementia, dementia with Lewy bodies and frontotemporal dementia.

Dementia is a progressive condition, which means that the symptoms will gradually get worse. This progression will vary from person to person, and each will experience dementia in a different way – people may often have some of the same general symptoms, but the degree to which these affect each person will vary.

Be aware that some commonly prescribed medicines are associated with increased anticholinergic burden, and therefore cognitive impairment. Consider minimising the use of medicines associated with increased anticholinergic burden, and if possible, look for alternatives:

- when assessing whether to refer a person with suspected dementia for diagnosis
- during medication reviews with people living with dementia ([NICE NG97](#))

See the NHS Somerset [Deprescribing - NHS Somerset](#) page for more information on anticholinergic burden.

For further information please click on the links below or visit:

<https://bnf.nice.org.uk/>

[Dementia | Treatment summaries | BNF | NICE](#)

<http://www.medicines.org.uk/emc/>

[NICE TA217](#) Donepezil, galantamine, rivastigmine and memantine for the treatment of Alzheimer's disease

[NICE NG97](#) Dementia: assessment, management and support for people living with dementia and their carers

[NG71 | Parkinson's disease in adults | Guidance | NICE](#)

Table 1: Pharmacological management of Dementia and Alzheimer's Disease (NICE NG97)

Disease type	AChE Inhibitor Monotherapy	Memantine Monotherapy	Combined AChE Inhibitor and Memantine Therapy
Alzheimer's Disease	The three AChE inhibitors donepezil, galantamine and rivastigmine as monotherapies are recommended as options for managing mild to moderate Alzheimer's disease	Memantine monotherapy is recommended as an option for managing Alzheimer's disease for people with: -moderate Alzheimer's disease who are intolerant of or have a contraindication to AChE inhibitors or -severe Alzheimer's disease.	For people with an established diagnosis of Alzheimer's disease who are already taking an AChE inhibitor: consider memantine in addition to an AChE inhibitor if they have moderate disease. Offer memantine in addition to an AChE inhibitor if they have severe disease.
Dementia with Lewy Bodies,	Offer donepezil or rivastigmine to people with mild to moderate dementia with Lewy bodies. Only consider galantamine for people with mild to moderate dementia with Lewy bodies if donepezil and rivastigmine are not tolerated. Consider donepezil or rivastigmine for people with severe dementia with Lewy bodies.	Consider memantine for people with dementia with Lewy bodies if AChE inhibitors are not tolerated or are contraindicated.	

Disease type	AChE Inhibitor Monotherapy	Memantine Monotherapy	Combined AChE Inhibitor and Memantine Therapy
<p>Parkinson's Disease Dementia NG71</p>	<p>Offer an AChE inhibitor for people with mild or moderate Parkinson's disease dementia (NG71). Rivastigmine capsules are the only treatment with a UK marketing authorisation for this indication. Use of donepezil, galantamine and rivastigmine patches is off-label.</p>	<p>Consider memantine for people with Parkinson's disease dementia, only if AChE inhibitors are not tolerated or are contraindicated.</p>	
	<p>Consider an AChE inhibitor (donepezil or rivastigmine) for people with severe Parkinson's disease dementia.</p> <p>This is an off-label use of AChE inhibitors</p>		
<p>Specialist to always review antiparkinsonian and other medications first.</p>			
<p>Vascular Dementia</p>	<p>Only consider AChE inhibitors or memantine for people with vascular dementia if they have suspected comorbid Alzheimer's disease, Parkinson's disease dementia or dementia with Lewy bodies.</p>	<p>Only consider AChE inhibitors or memantine for people with vascular dementia if they have suspected comorbid Alzheimer's disease, Parkinson's disease dementia or dementia with Lewy bodies.</p>	
<p>Frontotemporal Dementia (including</p>	<p>Do not offer AChE inhibitors or memantine to people with frontotemporal dementia.</p>		

Disease type	AChE Inhibitor Monotherapy	Memantine Monotherapy	Combined AChE Inhibitor and Memantine Therapy
behavioural variant, Semantic, Primary Progressive Aphasia and Pick's disease)	Note that logopenic aphasia, which has previously been included in some diagnostic guidelines for frontotemporal dementia, has now been shown to most commonly be caused by Alzheimer's disease.		
Frontal-overlap syndromes (Cortico-basal Degeneration and Progressive supranuclear palsy) & Prion disease	Do not offer AChE inhibitors or memantine		
Cognitive impairment caused by multiple sclerosis	Do not offer AChE inhibitors or memantine to people with cognitive impairment caused by multiple sclerosis.		

Dose (posology & method of administration): see individual SmPCs at:
<http://www.medicines.org.uk/emc/>

Please refer to the individual manufacturer's summaries of product characteristics for full prescribing information on dose, including dose in impaired renal function. Only licensed doses should be used.

Rivastigmine patches should be reserved for patients with a particular clinical need

Contra-indications: see individual SmPCs for detail at:
<http://www.medicines.org.uk/emc/>

Special warnings and precautions for use: see individual SmPCs at:
<http://www.medicines.org.uk/emc/>

Drug interactions: see individual SmPCs for full details at
<http://www.medicines.org.uk/emc/>

Pregnancy and lactation: Seek urgent specialist input for pregnant or lactating patients. Very limited data are available See individual SmPCs for full details at:
<http://www.medicines.org.uk/emc/>

Adverse effects: see individual SmPCs at <http://www.medicines.org.uk/emc/>

Acetylcholinesterase inhibitors- See SmPC for full details

- The most common adverse effects include diarrhoea, nausea, vomiting, muscle cramps, dyspepsia, fatigue, insomnia, anorexia, weight loss, dizziness, headache and somnolence.
- Other side-effects include confusion, fall, injury, syncope, upper respiratory tract infection and urinary tract infection.
- Weight loss is also associated with Alzheimer's disease itself and therefore patients' weight should be monitored during therapy (if clinically appropriate).

Memantine- See SmPC for full details

- The most common adverse effects include constipation; hypertension; dyspnoea; headache, dizziness, drowsiness Other side-effects include vomiting, thrombosis, heart failure, confusion, fatigue, hallucinations, and abnormal gait and very rarely seizures, pancreatitis, psychosis, depression, and suicidal ideation.

Shared Care Responsibilities

Responsibilities of Old Age Psychiatry Service

1. Diagnosis of probable or possible Alzheimer's disease (excluding other forms of dementia) and any appropriate assessments required.
2. Ensure that the patient has access (if needed) to care and support through the multidisciplinary team.
3. Assess the patient's suitability for AChE inhibitor or memantine therapy as defined by NICE guidelines.
4. Ensure patient/carer understands what the drug is, and why it has been prescribed.
5. Ensure patient/carer understands how and when it should be taken and any potential side-effects, and that the drug will be stopped when it is no longer beneficial to the patient.
6. Either provide the first prescription or, ask the GP to prescribe. NICE guidance states that once a decision has been made to start an AChE inhibitor or memantine, the first prescription may be made in primary care.
7. Assess the patient during the first three months.
8. Thereafter, assess the patient after three months and approach the GP regarding continued prescribing if treatment is having a worthwhile effect on cognitive, global, functional, or behavioural symptoms.
9. Discontinue treatment after 3 months where there has not been benefit or where there has been a deterioration of the condition.
10. When treatment is to be continued after 3 months, to undertake regular reviews (every 6-12 months) as clinically appropriate to assess ongoing benefit.
11. If discontinuing treatment, care should be taken to phase out the medication gradually and monitor for a potentially significant deterioration of patient functioning or a worsening of behavioural symptoms.
12. Treatment should be discontinued if the drug becomes unsuitable or no longer beneficial e.g. due to side-effects, inter-current illness or compliance issues.

General Practitioner responsibilities

1. It is recommended good practice for there to be a pre-referral assessment including physical examination, exclude delirium/depression, and baseline investigations such as MSU, and blood tests (FBC, U&E's, LFT's, glucose, TFT's, B12, folate and calcium) in accordance with the "Dementia assessment pathway" for Primary Care.

Review patients' use of medicines associated with increased anticholinergic burden (ACB), and if possible, look for alternatives. Include over the counter medications in the assessment. The presence of a substantial ACB may mimic the symptoms of dementia and therefore lead to a false diagnosis of dementia.

Long-term heavy alcohol consumption can result in a lack of thiamine and Korsakoff's Syndrome - review patient alcohol intake and consider prescribing thiamine in accordance with [RMOC](#) as appropriate.

2. To refer appropriate patients to Somerset Old Age Psychiatry Team services.
3. To reinforce educational points in 4 and 5 above.
4. To prescribe an AChE inhibitor and/ or memantine for those patients who the psychiatrists believe would benefit from treatment in accordance with NICE. NICE guidance now states that the first prescription can be made in primary care. It is recommended that there should be consultation with the responsible Old Age Psychiatrist before discontinuation of an established acetylcholinesterase inhibitor or memantine.
5. To undertake any necessary monitoring including weight, as agreed with the Old Age Psychiatry service.
6. To consider any side-effects reported by the patient and to discuss with the Old Age Psychiatry service if necessary.
7. To contact the Old Age Psychiatry service for advice and support if there are any clinical changes or concerns requiring specialist input or review.

Patient/ carer responsibilities

To report any significant signs or symptoms relating to their condition, including side effects, to the GP or member of the Old Age Psychiatry team.

Further support

- Medicines Information department, Musgrove Park Hospital: 01823 342253
- Medicines Information department, Yeovil District Hospital: 01935 384327
- Prescribing & Medicines Management Team, NHS Somerset: 01935 384123
- Medicines Management Team, Somerset NHS Foundation Trust: 01823 368265
- <https://www.somersetft.nhs.uk/memory-assessment-service/>

Version:	3.0	Date
Drawn up by:	Karen Hochmuth, Acting Chief Pharmacist, Somerset Partnership NHS FT	Oct 2013
Updated by:	Catherine Henley, Medicines Manager, Somerset CCG	Jan 2016
Updated by:	Catherine Henley, Medicines Manager, Somerset CCG Updated to reflect new NICE Guidance	Sept 2018
Updated by:	Catherine Henley, Medicines Manager, Somerset CCG Updated to reflect comments from PAMM committee.	Oct 2018
Approved by:	Somerset Prescribing Forum, NHS Somerset	
	Drug & Therapeutics Committee, Taunton & Somerset NHS FT	
	Drug & Therapeutics Committee, Yeovil and District NHS FT	
	Medicines in clinical practice Committee, Somerset Partnership NHS FT	
Version	4.4	
Updated by:	Hels Bennett, Sam Morris and Victor Aziz Updated to reflect comments from PAMM committee.	October 2022
Approved by:	Somerset Prescribing and Medicines Management Group.	October 2022
Review required by:		October 2025

References

- [NICE Guidance NG97 \(2018\): Dementia: assessment, management and support for people living with dementia and their carers](#)
- [NICE TA217 \(2018\): Donepezil, galantamine, rivastigmine and memantine for the treatment of Alzheimer's disease](#)
- [NICE Guidance NG71 \(2017\): Parkinson's disease in adults](#)
- Summaries of Product Characteristics <http://www.medicines.org.uk/emc/>
- British National Formulary <https://bnf.nice.org.uk/> [Online]
- Acetylcholinesterase inhibitors monitoring – Specialist Pharmacy Service Guidance <https://www.sps.nhs.uk/monitorings/acetylcholinesterase-inhibitors-monitoring/>
- Starting & stopping treatment – Alzheimer's Society <https://www.alzheimers.org.uk/about-dementia/treatments/drugs/starting-stopping>