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HDSA encourages all attendees to consult with their primary care provider, neurologist or other healthcare provider about any advice, exercise, medication, treatment, nutritional supplement or regimen that may have been mentioned as part of any presentation.
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No relationships to disclose or list
Pharmacologic Management of Behavioral Disorders

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OUTLINE

Behavior in HD
Behavioral Medicines
• Antidepressants
• Antipsychotics
• Mood stabilizers
Paths to Progress
General Management Guidelines
BEHAVIOR IN HD

Depression
Irritability

Apathy
Aggression

Anxiety
Psychosis

Obsessions
Insomnia
BEHAVIOR IN HD

Prominent
- Major contributors to disability, placement
- Most important caregiver concerns

Prevalent
- Affect at least 80% of individuals with HD
- Start even before motor symptoms

Persistent
- Apparent in all stages
Why so little information?

- HD is rare
  - Small population = small studies
  - Difficult investment for pharma
- HD symptoms are variable
- HD patients are sensitive
  - Enrollment difficult
  - Dropout rates can be high
BEHAVIORAL MEDICINES

Antidepressants & Antipsychotics
• Easily available
• Large selection
• General effects well known
• Broad range of behavioral effects
• Fairly easy to use
ANTIDEPRESSANTS

Therapeutic targets

• Sadness
• Insomnia
• Anxiety
• Anorexia
• Poor energy
• Suicidal thoughts
• Obsessions and compulsions
ANTIDEPRESSANTS

Usually well tolerated
Multiple types
• Serotonin reuptake (SSRI)
• Serotonin/norepinephrine (SNRI)
• Tricyclic (TCA)
• Other agents
ANTIDEPRESSANTS

STUDY DESCRIPTION
• 26 participants
• Venlafaxine (Effexor)
• Dose 75-300 mg/day
• Open-label, 4 weeks

RESULTS
• Reduced depression
• Significant side effects

Holl et al, International Clinical Psychopharmacology 2005
ANTIDEPRESSANTS

Other uses
• Irritability
• Apathy

Common side effects
• Nausea
• Diarrhea
• Dizziness
• Headache
• Drowsiness
ANTIPSYCHOTICS

Symptoms of schizophrenia
• Delusions
• Hallucinations
• Aberrant behavior

Symptoms of bipolar disorder
• Irritability
• Hyperactivity
• Impulsivity
• Depressed or elated mood
ANTIPSYCHOTICS

Risperidone (Duff 2008)
• Improved UHDRS psychiatric score
• Stable UHDRS motor score
• Side effects not evaluated

Quetiapine (Alpay 2006)
• Reduced aggression and agitation
• Helped with sleep and socialization
ANTIPSYCHOTICS

Aripiprazole (Lin 2008, Ciammola 2009)
• Reduced psychosis
• Decreased irritability
• Treated depression

Olanzapine (Squitieri 2001)
• Reduced aggression
• Relieved obsessions and depression
ANTIPSYCHOTICS

Motor Effects
• Antipsychotics sometimes helpful
• Dopamine blockade ↓ chorea
• *Can also worsen movement*
  • Shaking
  • Slowness and stiffness
• Gait disturbance and falling
• Swallowing difficulty
ANTIPSYCHOTICS

Other side effects
• Drowsiness
• Weight gain
• Diabetes
• Motor restlessness
• Dry mouth
• Constipation
• Sudden death (elderly)
MOOD STABILIZERS

Therapeutic targets
• Impulsivity
• Mood fluctuation
• Hyperactivity
• Irritability

Drug Classes
• Antipsychotics
• Valproic acid
• Lithium
PATHS TO PROGRESS

Citalopram—antidepressant
Olanzapine—antipsychotic
Memantine—dementia drug
tiapride—antipsychotic

Others
PATHS TO PROGRESS

Expert guidelines
Treatment algorithms
Support groups
• Web communication
• Research participation

Algorithm for the treatment of OCBs in Huntington’s disease

**Serotonin reuptake inhibitor (SSRI)**
First choice drug for OCBs

**Steps:**
1. Start with low to moderate dose
   - citalopram (20 mg)
   - sertraline (50 mg)
   - paroxetine (20 mg)
   - fluoxetine (20 mg)
   - escitalopram (10 mg)
   Though many survey experts chose 2-4 weeks or more, the authors suggest a shorter 1-4 week dosing interval
2. Dose optimization
   - Symptom control often requires mid to high level dosing
   - citalopram (20-40 mg)
   - sertraline (50-200 mg)
   - paroxetine (20-60 mg)
   - fluoxetine (20-60 mg)
   - escitalopram (10-20 mg)
   - Reassess responses and side effects at each dosage increment
3. Alternate mono- or combination therapy
   - If inadequate response to SSRI, experts choose the following alternatives (listed in order of preference):
     - Switch to another SSRI
     - Add CMI
     - Add APD
     - Switch to SNRI
     - Add BDZ
   - If response remains inadequate, authors suggest second trial of switching drugs within class
   - Check for adherence

**Abbreviations**
- APD = antipsychotic
- BDZ = benzodiazepines
- CMI = cholinesterase inhibitor
- SNRI = serotonin-norepinephrine reuptake inhibitor
- SSRI = selective serotonin reuptake inhibitor

Referral to specialist is advised prior to any other intervention
MANAGEMENT GUIDELINES

• Select specific targets
• Maintain focus
  • Target symptoms, not syndromes
  • Prioritize
• Who is the patient?
• Disease progression
  • New problems will appear
  • Solved problems can come back
MANAGEMENT GUIDELINES

• Start with low doses
• Aim for high doses
• Set deadlines
  • 8-12 weeks for antidepressants
  • 4-6 weeks for antipsychotics
• Use “therapeutic side effects”
CONCLUSIONS

• Behavioral problems common
• Knowledge is inadequate
  • Limited data available
  • Difficult to study
• Available medicines can help
• Some progress being made
• Persistence pays
Comprehensive Integrated Care

- Motor Meds
- Behavioral Meds
- Clinical Trials
- Physical Exercise
- Dietary Supplements
- Cognitive Exercise
- Non-Med Treatments
- Medical Foods