

Integrated Medication Guidelines for the use of Donepezil, Galantamine, Rivastigmine and Memantine in Dementia

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| **Donepezil, Galantamine, Rivastigmine and Memantine for the treatment of Dementia**  **NOTES to the GP** |
| The information in the integrated medication guideline has been developed in consultation with CCGs in South East London  This document should provide sufficient information to enable you to make an informed decision regarding the clinical and legal responsibility for prescribing **Donepezil, Galantamine, Rivastigmine and Memantine** for the treatment of **Dementia .**  Prescribing should follow requirements in the South East London Interface Prescribing Policy.  **The doctor who prescribes the medication legally assumes clinical responsibility for the drug and the consequences of its use. The patient’s best interests are always paramount.**  **The objectives of these guideline include the following:**   * **Safe Prescribing in Dementia** * **Innovative thinking in dementia prescribing and care** * **Prioritising patient and carer convenience** * **Improving efficiencies and timely access to services** * **Supporting primary care colleagues** * **Rapid re-entry to services on discharge**   These integrated medication guidelines form part of a wider management pathway for patients with Alzheimer’s disease. Healthcare professionals should also ensure that the patient’s social care needs are taken into consideration and that they are referred to local services as and when appropriate. |



1. **DEMENTIA MEDICATION PATHWAY**

**GP identifies possible cognitive impairment**

**Performs simple cognitive assessment and dementia blood screen (see page 3)**

**Referral to Memory Clinic**

**Memory Clinic assessment, diagnosis and further management including suitability for dementia medication**

**Inform GP of AD or DLB (or mixed dementia) diagnosis and request GP initiation of treatment. GP to contact memory service with any concerns**

**Where GP starts prescribing medication**

**to contact Memory Clinic with any concerns regarding recommendations**

**Memory Clinic monitors patient until dose stabilised (3-6 months)**

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**GP continues prescribing dementia medication with 6-12 monthly review**

**Medication is continued irrespective of cognitive performance1**

**If medication appears to be causing problems discontinue or refer back for advice**

**Memory clinic discharges stable patient to GP.**

**Memory Clinic prioritises re-assessment**

**within two weeks**

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**Memory Clinic prioritises re-assessment**

**within two weeks**

**Any concerns GP calls for advice or refers back to Memory Clinic**

**Any concerns GP calls for advice or refers back to Memory Clinic**

**Memory Clinic prioritises re-assessment**

**within 2-4 weeks**

\*AD = Alzheimer’s Disease

\*DLB = Dementia with Lewy Bodies

**1** Howard R, McShane R, Lindesay J et al. Donepezil and memantine for moderate-to-severe Alzheimer's disease. *N Engl J Med*. 2012;366:893-903.



**Donepezil, Galantamine, Rivastigmine and Memantine for the treatment of Dementia**

1. **Areas of responsibility**

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| **Memory Clinic Consultant / Specialist team responsibilities** |
| **Investigations, assessments and blood tests**   1. Confirm diagnosis & communicate cognitive score to the GP. The sMMSE, ACE or other validated tools may be appropriate. 2. Specialist assessment:    * Tests of cognitive domain    * Clinical evaluation of non-cognitive domains (e.g. hallucinations, delusions, agitation, behaviour that challenges)    * Assessment of activities of daily living (ADLs)    * Assessment of global function    * Likely compliance with treatment before drug is prescribed.    * The main therapeutic targets should be confirmed (Cognition, Psychosis, Behaviour that challenges, ADL) 3. When clinically appropriate request CT or MRI brain scan.   **Supporting adherence and ongoing treatment**   1. Discuss medication options with patient/carer and provide patient information leaflet (PIL) for drug prescribed. 2. Identify a carer who will undertake monitoring of adherence. 3. Seek agreement that treatment will be stopped if there are adverse effects. 4. Check for interactions with other medicines 5. Contact GP with plan or recommendation to initiate drug treatment. 6. Continue monitoring until patient stabilised on medication at optimum dose. 7. Review treatment at month one and again at month three before discharging patient to GP. 8. Seek carer’s views on patient’s condition at baseline & follow-up.   **Adverse effects and deterioration**   1. Stop treatment if any of the following occur:    * Poor concordance    * Major adverse effects    * Patient asks to stop 2. Report serious adverse effects to the MHRA via [‘yellow card system’](http://yellowcard.mhra.gov.uk/). 3. Advise patient/carer on future care (for patient in their own home or nursing home) in situations where patient needs further care support.   **Other**   1. If patient is prescribed concomitant antipsychotic by specialist team, ensure indication (and preferably duration/need for regular review is communicated to GP~~.~~ (see GP responsibilities below) 2. Review medication and cognitive burden with advice to GP. 3. Patients discharged to have easy and timely access back in to Memory Clinic/ alternative mental health service. | |

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| **General Practitioner responsibilities** |
| ***Before referral****:*   1. Confirm history of cognitive decline from patient or independent informant. 2. Simple initial cognitive assessment 3. Initial dementia blood screening (HbA1c, FBC, U&E, Bone profile, B12, folate, TFTs, LFTs, CRP - HIV and syphilis if indicated) 4. Urinalysis, BP & heart rate. 5. Consider performing ECG if a cardiac caution to cholinesterase inhibitor treatment is suspected (e.g. sick sinus syndrome or other supraventricular conduction abnormalities); or where indicated. Use community ECG hub if available. 6. Ensure that the patient’s social care needs are taken into consideration and that they are referred to local services as and when appropriate. 7. 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 and during medication reviews. The Anticholinergic Effect on Cognition (AEC) scale should be used to identify and assess the anticholinergic burden of drugs in patients ([www.medichec.com](http://www.medichec.com) ).   ***After confirmation of diagnosis by Memory Clinic:***   1. Initiate medication as recommended or continue prescribing treatment. 2. Check for interactions with other medicines 3. Highlight the importance of adherence to treatment. 4. Support & educate patients/carers   **Monitoring of adverse effects and deterioration:**   1. Review patients discharged from secondary care [stable on dementia medication] at least 12 monthly. 2. Monitor for adverse effects and report any serious reactions to the MHRA via the [‘yellow card system’](http://yellowcard.mhra.gov.uk/). 3. Call Memory Clinic for any concerns regarding memory or dementia medication. 4. Refer back to Memory Clinic if reassessment is required. 5. Stop treatment if urgent need arises. 6. If patient is prescribed concomitant antipsychotic drugs – ensure clear indication and duration of therapy is documented and that antipsychotic is reviewed at least every 6 weeks initially until the patient is clinically stable and tolerating it. Thereafter, antipsychotic review can be every 3-6 monthly but ensure there are procedures in place for regular reviews and reporting of adverse effects.   **Other**   1. Ensure patient is on the QOF dementia register. |

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| **Patient's / Carer’s responsibilities** |
| * Ensure adverse effects, deterioration and response to medicines is reported to Mental Health Team/ consultant and GP * Report any changes in disease symptoms to the GP or specialist. * Take medicines as agreed and do not share medicines. |

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| **Test Results/ Investigations** |
| Results of all tests and investigations should be copied by/ to both consultant and GP. |

1. **CLINICAL INFORMATION**

**NOTE:** The information here is not exhaustive. Please also consult the current Summary of Product Characteristics (SPC) for **Donepezil, Galantamine, Rivastigmine or Memantine** prior to prescribing for up to date prescribing information, including detailed information on adverse effects, drug interactions, cautions and contraindications (available via [www.medicines.org.uk](http://www.medicines.org.uk))

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| **Place in Therapy** | | | | | | | |
| Acetylcholinesterase inhibitors (donepezil) are recommended (and licensed) for the 1st line treatment of people with Alzheimer’s Disease (AD) of mild to moderate severity (and treatment of Parkinson’s Disease Dementia with rivastigmine only). Memantine monotherapy is recommended as an option (and licensed) for people with moderate AD where acetylcholinesterase inhibitors have not been tolerated or are contraindicated and for severe AD.  In line with NICE guidance1:  For people with established AD who are already taking an acetylcholinesterase inhibitor:   * Consider memantine in addition to an acetylcholinesterase inhibitor if they have moderate disease * Offer memantine in addition to an acetylcholinesterase inhibitor if they have severe disease   (GPs may start treatment with memantine without taking advice from specialist clinician)  For people with 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.   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.  Do not offer AChE inhibitors or memantine to people with frontotemporal dementia or to people with cognitive impairment caused by multiple sclerosis. | | | | | | | |
| **Dose & route of administration** | | | | | | | |
| **Medicine** | **Dosing** | **Titration week and dose (mg)** | | | | | |
| **1** | **2** | **3** | **4** | **6** | **8** |
| **Donepezil** (tablets, orodispersible tablets, oral solution) | Daily (oral) | 5mg |  |  | 10mg |  |  |
| **Galantamine** (modified release capsules) | Daily (oral) | 8mg |  |  | 16mg |  | 24mg |
| **Galantamine** (tablets, oral solution-) | Twice daily (oral) | 4mg |  |  | 8mg |  | 12mg |
| **Rivastigmine** (oral capsules, oral solution) | Twice daily (oral) | 1.5mg |  | 3mg |  | 4.5mg | 6mg |
| **Rivastigmine** (patch) | Daily (clean dry skin) | 4.6mg/ 24hrs |  |  | 9.5mg/ 24hrs |  |  |
| **Memantine** (scored tablets, oral solution) | Daily (oral) | 5mg | 10mg | 15mg | 20mg |  |  |

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| **Duration of treatment** |
| Medication is continued even with evidence of cognitive decline so long as it is tolerated and patient is able to take it regularly. |
| **Criteria for stopping treatment and how to stop** |
| If a patient does not tolerate one acetylcholinesterase inhibitor (e.g. due to diarrhoea), it may be reasonable to try another acetylcholinesterase inhibitor (see SPC for full details) prior to changing to memantine.  Stop treatment if any of the following occur: • Poor concordance  • Major adverse effects  • Patient asks to stop  Do not stop acetylcholinesterase inhibitors in people with AD because of severity of disease alone.  If stopping treatment, a gradual withdrawal over 1-4 weeks (depending on drug, preparation and dose) is suggested where possible. Keep the patient under regular review. If serious adverse effects occur, stop immediately.  Contact specialist or Medicines Information for advice if needed. |
| **Monitoring Requirements including frequency** |
| |  |  |  | | --- | --- | --- | | **Parameter** | **Frequency of monitoring** | **Action** | | Mini Mental State Examination (sMMSE) / global, functional and behavioural assessment | At diagnosis and review within three-six months after commencing treatment (specialist). | Continue acetylcholinesterase inhibitor (AChEI) treatment unless medication not tolerated  Continue prescribing even where an sMMSE is less than 10, particularly where the medication is tolerated and the score does not represent severe dementia, e.g. patients with learning difficulties, speech problems or where English is not the first language. | | Heart rate (HR) | By primary or secondary care before starting treatment and then as and when clinically indicated and annually during a patient medication review. | If HR is less than 50bpm do not initiate AChEI. If AChEI associated bradycardia occurs (less than 50bpm) stop treatment. Cardiology assessment/ opinion may be required. | | Blood Pressure (BP) | By primary or secondary care before starting treatment and then as and when clinically indicated and annually during a patient medication review. | Review medication, adjust dose (consider discontinuing) and refer to secondary care for advice if:  (a) syncope occurs (donepezil and galantamine) or  (b) hypertension occurs (galantamine and memantine) | | ECG (in patients with cardiac history) | By primary or secondary care before initiation of treatment where there are suspected cardiac cautions (e.g. sick sinus syndrome or other supraventricular conduction abnormalities); or where indicated. Where there is access to a community hub refer there for ECG. | If ECG abnormal, suitability for dementia medication will be considered in secondary care. Cardiac re-assessment/ opinion may be required. | | Renal and liver function | By GP before starting treatment. | If deterioration in renal or liver function, follow recommendation for individual medicine. Liaise with specialist if required. | | Side effects | Review regularly at start of treatment by specialist and GP.  By GP annually, or as requested by patient/carer by appointment. | Persist with treatment if mild side effects are experienced during initiation or up-titration of treatment.  Stop treatment if severe persistent gastro-intestinal side effects and refer to Memory Clinic specialist.  Serious side effects should be reported to the MHRA through the yellow card scheme (yellowcard.mhra.gov.uk) |   **NB Teams will work together to make sure tests and monitoring are done in a patient-centred way** |

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| **Summary of Adverse Effects**  **Reminder: this list is not exhaustive - for full details of adverse effects and all potential drug interactions refer to latest Summary of Product Characteristics (SPC) for the drug, available via www.medicines.org.uk.** |
| |  |  |  |  | | --- | --- | --- | --- | |  | **Adverse effect** | **Frequency** | **Management** | | **Acetylcholinesterase inhibitors**  *(See* [*Summary of Product Characteristics*](http://www.emc.medicines.org.uk) *(SPC) for full list or BNF)*  Very common: >1/10  Common: >1/100, <1/10  Uncommon: >1/1000, <1/100  Rare: >1/10,000, <1/1000 | Gastro-intestinal symptoms (incl. anorexia, nausea, vomiting, diarrhoea) | Very common | Generally mild and transient and disappear within a few days of treatment. Can be minimised by taking drug after food. If symptoms persist discuss with/refer to specialist who may reduce dose or try an alternative acetylcholinesterase inhibitor or switch to memantine. | | Headache, fatigue, dizziness and muscle cramps | Common | Generally mild & transient. The ability of the patient to continue driving or operating complex machinery should be evaluated. Consult specialist if problematic for the patient. May need dose reduction/discontinuation. | | Agitation, confusion, insomnia, abnormal dreams and nightmares | Common | Consult specialist if problematic for the patient. May need dose reduction/discontinuation. | | Syncope | Common | Consult specialist. May need dose reduction/discontinuation. In investigating seizures, the possibility of heart block or long sinusal pauses should be considered. | | Bradycardia | Common/ Uncommon | Seek urgent review. Stop treatment and consult specialist. Caution in “sick sinus syndrome”, sinoatrial or atrioventricular block or concomitant treatment with digoxin or beta-blockers. | | May enhance predisposition to peptic ulceration | Uncommon / rare | Care with active or predisposition to gastric or duodenal ulcers. Consult specialist to consider discontinuation of treatment. Patient should be regularly monitored for symptoms. | | May lower seizure threshold | Uncommon / rare | Extreme caution in epilepsy. Review treatment with specialist if seizures develop as may be caused by underlying disease. The possibility of heart block or long sinusal pauses should be considered. | | May cause bronchoconstriction | No data available | Caution in COPD or asthma, consult specialist to review treatment. | | May exacerbate bladder outflow problems | No data available | Caution if history of prostatic conditions, urinary retention. (Avoid galantamine in urinary retention or post bladder surgery). | | Hepatic impairment | No data available | Avoid in severe impairment, caution in mild/moderate impairment. See BNF guidance for each drug and seek advice from consultant hepatologist. | | Renal impairment (galantamine, rivastigmine) | No data available | Avoid in severe impairment (except donepezil which is not affected by renal impairment). Caution in mild/moderate impairment. See BNF guidance for each drug and seek advice from consultant nephrologist. | | **Memantine**  *(See* [*Summary of Product Characteristics*](http://www.emc.medicines.org.uk) *(SPC) for full list or BNF)*  Common: >1/100, <1/10  Uncommon: >1/1000, <1/100  **Memantine continued**  *(See* [*Summary of Product Characteristics*](http://www.emc.medicines.org.uk) *(SPC) for full list or BNF)*  Common: >1/100, <1/10  Uncommon: >1/1000, <1/100 | Somnolence  Dizziness | Common | The ability of the patient to continue driving or operating complex machinery should be evaluated. Consult specialist if problematic for the patient. | | Hypertension | Common | Caution in those with uncontrolled hypertension or cardiac disease. Review treatment with a specialist if this develops. May need dose reduction/discontinuation | | Dyspnoea | Common | Caution in those with COPD or asthma, consult specialist to review treatment. | | Constipation | Common | Refer back to specialist if severe or is not self limiting. Consider prn or regular laxative. | | Headache | Common | Refer back to specialist if severe or is not self limiting | | Elevated liver function test | Common | Refer back to specialist for review | | Drug hypersensitivity | Common | Stop and refer back to specialist | | Fungal infections | Uncommon | Refer back to specialist if severe. | | Gait abnormal | Uncommon | Refer back to specialist if severe. | | Venous thrombosis/ thromboembolism | Uncommon | Refer for treatment of VTE, and review memantine with a specialist. | | Confusion, hallucinations, psychosis, fatigue | Uncommon | Refer back to specialist for review. | | Pancreatitis | Unknown | Stop if severe, refer back to specialist. | | Vomiting | Uncommon | Stop if severe, refer back to specialist. | | Cardiac failure | Uncommon | Stop and refer back to specialist | | May lower seizure threshold | Very rare | Extreme caution in epilepsy. Review treatment with specialist if seizures develop as may be caused by underlying disease. | | Hepatic impairment | No data available | Avoid in severe impairment. Stop treatment and consult hepatologist. | | Renal impairment | No data available | See BNF guidance: Avoid if eGFR <5mL/min/1.73m2; reduce dose to 10mg/day if eGFR 5-29mL/min/1.73m2; reduce dose to 10mg/day if eGFR 30-49mL/min/1.73m2 and if well tolerated after 7 days increase to 20mg in 5mg steps. | |

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| **Drug-drug interactions4** |

**The table below is reproduced from the Maudsley Prescribing Guidelines 13th edition. The list of drug interactions presented in the table is not exhaustive, prescribers should also refer to individual SPCs for the medicines concerned for further detail on potential drug interactions (via www.medicines.org.uk). Caution is advised with other drugs that are also inhibitors or enhancers of CYP 3A4 and 2D6 enzymes.**

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| **Drug** | **Metabolism** | **Plasma levels**  **increased by** | **Plasma levels decreased by** | **Pharmacodynamic interactions** |
| Donepezil  (Aricept®) | Substrate at 3A4 and 2D6 | **Ketoconazole Itraconazole**  **Erythromycin**  **Quinidine**  **Fluoxetine**  **Paroxetine** | **Rifampicin**  **Phenytoin**  **Carbamazepine**  **Alcohol** | Antagonistic with **anticholinergic drugs** and **competitive neuromuscular blockers (**eg **tubocurarine)**.  Potential for synergistic activity with **cholinomimetics** such as **depolarising** **neuro-muscular blocking agents** (e.g. **succinylcholine**), **cholinergic agonists** and **peripherally acting cholinesterase inhibitors eg neostigmine.** **Beta blockers, amiodarone or calcium channel blockers** may have additive effects on cardiac conduction. Caution with concomitant use of **drugs known to induce QT prolongation and/or torsade** **de pointes**. Movement disorders and Neuroleptic Malignant Syndrome have occurred with concomitant use of **antipsychotics** and cholinesterase inhibitors.  Concurrent use with **seizure lowering agents** may result in reduced seizure threshold. |
| Rivastigmine  (Exelon®) | Non-hepatic metabolism | Metabolic interactions appear unlikely.  Rivastigmine may inhibit the butyryl-cholinesterase mediated metabolism of other substances e.g. **cocaine**.  Smoking **tobacco** increases the clearance of rivastigmine | | Antagonistic effects with **anticholinergic** and **competitive neuromuscular blockers (**eg **tubocurarine)**.Potential for synergistic activity with **cholinomimetics** such as **depolarising neuro-muscular blocking** agents (e.g. **succinylcholine) -** **cholinergic agonists** e.g. **bethanecol or peripherally acting cholinesterase inhibitors e.g. neostigmine**. Synergistic effects on cardiac conduction with **beta blockers**, **amiodarone, calcium channel blockers**. Caution with concomitant use of **drugs known to induce QT prolongation and/or torsade de pointes.** Movement disorders and Neuroleptic Malignant Syndrome have occurred with concomitant use of **antipsychotics** and cholinesterase inhibitors. Concurrent use with **metoclopramide** may result in increased risk of EPSEs. |
| Galantamine  (Reminyl®) | Substrate at 3A4 and 2D6 | **Ketoconazole**  **Erythromycin**  **Ritonavir**  **Quinidine**  **Paroxetine**  **Fluoxetine**  **Fluvoxamine**  **Amitriptyline** | None known | Antagonistic effects with **anticholinergic** and **competitive neuromuscular blockers (**eg **tubocurarine)**. Potential for synergistic activity with **cholinomimetics** such as **depolarising neuro-muscular blocking** agents (e.g. **succinylcholine), cholinergic agonists** and **peripherally acting cholinesterase inhibitors eg neostigmine**. Possible interaction with agents that significantly reduce heart rate e.g. **digoxin**, **β blockers**, **certain calcium-channel blockers** and **amiodarone**. Caution with concomitant use of drugs known to induce QT prolongation and/or torsade de pointes (manufacturer recommends ECG in such cases). Movement disorders and Neuroleptic Malignant Syndrome have occurred with concomitant use of **antipsychotics** and cholinesterase inhibitors. |

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| **Drug-drug interactions4 continued** |

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| **Drug** | **Metabolism** | **Plasma levels**  **increased by** | **Plasma levels decreased by** | **Pharmacodynamic interactions** |
| Memantine  (Exiba®) | Primarily non-hepatic metabolism  Renally eliminated | **Cimetidine**  **Ranitidine**  **Procainamide**  **Quinidine**  **Quinine**  **Nicotine**  **Trimethoprim**  Isolated cases of INR increases reported with concomitant warfarin (close monitoring of prothrombin time or INR advisable).  Drugs that alkalinize urine (PH ~8) may reduce renal elimination of memantine eg **carbonic anhydrase inhibitors**, **sodium bicarbonate.** | None known  (Possibility of reduced serum level of **hydrochlorothiazide** when co administered with memantine). | Effects of **L-dopa**, **dopaminergic agonists, Selegiline** and **anticholinergics** may be enhanced.  Effects of **barbiturates** and **antipsychotics** may be reduced.  Avoid concomitant use with **amantadine**, **ketamine** and **dextromethorphan** -increased risk of CNS toxicity. One published case report on possible risk for **phenytoin** and memantine combination  Dosage adjustment may be necessary for **antispasmodic agents,** **dantrolene** or **baclofen** when administered with memantine.  A single case report of myoclonus and confusion when co-administered with **co-trimoxazole** or **trimethoprim** |

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| **Information provided to the patient** |
| **Patient information leaflets** (from NHS Choices)  [NHS Choices Dementia](http://www.nhs.uk/conditions/Dementia/Pages/Introduction.aspx)  Patient information leaflets for specific medicines available at [www.medicines.org.uk](http://www.medicines.org.uk) (patient leaflet)for **memantine, rivastigmine, galantamine and donezepil** |

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| **Evidence Base for treatment and key references** |
| 1. NICE Clinical Guideline 42, [Dementia: supporting people with dementia and their carers in health and social care](http://www.nice.org.uk/guidance/CG42) (updated June 2018 ) 2. British National Formulary last updated 25 Jul 2018 or [www.BNF.org](http://www.BNF.org) 3. Summaries of Product Characteristics for Aricept®, Exelon®, Reminyl®, Ebixa® <http://www.medicines.org.uk> accessed 08/01/2019 4. Taylor D, Barnes T, Young A. The Maudsley Prescribing Guidelines in Psychiatry 13th ed. 2018.Wiley-Blackwell |

# **COMMUNICATION AND SUPPORT**

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| **Memory Services** | | | | |
| **Southwark & Lambeth Memory Service (SLMS)**  151 Blackfriars Road  London SE1 8EL  Tel: 020 3228 0570  slmsreferrals@slam.nhs.uk | **Bexley Memory Service**  Bexleyheath Centre  4 Emerton Close  DA6 8DX  Tel: 020 8301 7900 | **Bromley Memory Service**  Bridgeways  Turpington Lane  BR2 8JA  Tel: 020 8629 4900 | **Greenwich Memory Service**  Memorial Hospital  Shooters Hill  SE18 3RZ.  Tel: 020 8836 8519 | **Lewisham Memory Service**  91 Granville Park  Lewisham  SE13 7DW  Tel: 020 3228 0939 |
| **South London and Maudsley (SLAM)** | | **Oxleas NHS Foundation Trust** | | |
| **Consultant/specialist team**  Dr Justin Sauer, Consultant Psychiatrist  Tel: 020 3228 1640  Email: [Justin.sauer@slam.nhs.uk](mailto:Justin.sauer@slam.nhs.uk)  **Medication-Prescribing advice, interactions etc**  Delia Bishara, Consultant Pharmacist, MHOA  Tel: 020 3228 1624/ 1629  Email: [delia.bishara@slam.nhs.uk](mailto:delia.bishara@slam.nhs.uk) (Tue, Thu & Fri)  **Medicines Information**: 020 3228 2317 | | **Medicines information:** 01322 625002 or  [oxl-tr.medicinesinfo@nhs.net](mailto:oxl-tr.medicinesinfo@nhs.net) | | |
| **Dementia Support Hubs** | | |
| **Greenwich Dementia information hub:** [www.greenwichcommunitydirectory.org.uk](http://www.greenwichcommunitydirectory.org.uk)  or call 020 8921 8533  **Bromley Dementia support hub:** <https://www.bromleydementiasupporthub.org.uk/> | | |
| **Links and Referral Options to other Services** | | | | |
| **These integrated medication guidelines form part of a wider management pathway for patients with dementia. Healthcare professionals should also ensure that the patient’s social care needs are taken into consideration and that they are referred to local services as and when appropriate.**  **Social services:** Lambeth Duty phone : 020 7926 5555  Southwark Duty phone: 020 7525 3324  **Alzheimer’s Society:** <http://www.alzheimers.org.uk/>  Alzheimer’s Society for Southwark & Lambeth Tel: 020 7735 5850 [southwarkandlambeth@alzheimers.org.uk](mailto:southwarkandlambeth@alzheimers.org.uk)  Alzheimer's Society for Greenwich Tel : 01322524950/ 01322 559308 Email: [dagreenwich@alzheimers.org.uk](mailto:dagreenwich@alzheimers.org.uk)  You can request a dementia advisor at the society branch who can signpost and organise peer support, carer support and advice  **Age UK :** <https://www.ageuk.org.uk/>  **Lambeth:** <https://www.ageuk.org.uk/lambeth> Ring 020 7346 6800  **Lewisham & Southwark**: <http://www.ageuk.org.uk/lewishamandsouthwark/> Ring 020 7701 9700  **National dementia helpline:** 0300 222 1122 can provide information, support, guidance and signposting to other appropriate organisations.The Helpline is usually open from:  9am - 8pm Monday to Wednesday  9am - 5pm on Thursday and Friday  10am - 4pm on Saturday and Sunday | | | | |