ACTUALITÉS DE LA PRISE EN CHARGE DES COMPORTEMENTS SEXUELS INAPPROPRIÉS DES TROUBLES NEUROCOGNITIFS MAJEURS

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Conflits et liens d'intérêt

- Recherche: Acadia Pharmaceuticals (investigateur associé ACP-103-032 et ACP-103-033)

- Congrès: Biocodex (ECNP 2017)

Plan

- Définitions
- Epidémiologie
- Données physiopathologiques
- Prises en soins
  - Non-médicamenteuses
  - Médicamenteuses

Préambule

- Très peu de données

- Très peu d'études
  - Aucun essai thérapeutique randomisé versus placebo
    - Beaucoup de séries de cas, voire de cas cliniques isolés
      - Dont sont tirés des consensus d'experts

DÉFINITION

Définitions

- **Inappropriate** Sexual Behaviors (ISB)
- Comportements Sexuels **Inappropriés** (CSI)
  - *Un comportement problématique, verbal ou physique, de nature explicitement sexuelle, ou **perçu** comme telle, qui est inacceptable dans le **contexte social** au sein duquel il survient* (Johnson et al.; Brain Inj 2006)
  - *Un CSI est un comportement sexuel marqué par une apparente perte de contrôle, ou une recherche d'intimité **inadaptée** par rapport au **contexte social** ou par rapport à sa cible; le comportement pouvant n'être que **suggestif** et non explicite* (de Medeiros et al.; Dement Geriat Cogn Disord 2008)

Critériologie

Sachdev; Am J Geriatr Psychiatry 2017

Table 1: Proposed criteria for Inappropriate Sexually Behavior in Dementia (ISBD)

1. The individual has been diagnosed with Dementia or Major Neurocognitive Disorder.
2. The individual engages in behavior that is explicitly sexual or perceived to be sexual by others in the context in which it occurs. This behavior may be verbal or physical in nature.
3. The behavior is considered inappropriate for any of the following reasons:
    a. It is carried out in a public place such that it is actually or potentially offensive to others.
    b. It is directed at a person (or persons) who finds it unacceptable and wants it to cease.
    c. It is directed toward a person who is unwilling or unable (due to age or infirmity) to consent and therefore participate willingly.
    d. It is excessive such that it is pursued at inconvenient times, interferes with normal daily activities, or poses a risk of harm to the individual, but who shows incapacity to control the behavior.
4. The behavior does not predate the development of any cognitive decline in the individual.

Catégorisation

- Evaluation St Andrew (Knight et al.; Neuropsychol Rehabil 2008)
  - Commentaire oral
  - Comportement sans contact sur autrui
  - Exhibition
  - Comportement avec contact sur autrui

Catégorisation

Knight et al.; Neuropsychol Rehabil 2008

Catégorisation

- 3 catégories (Prakash et al.; Am J Alzheimers Dis Other Demen 2009. Stubbs; J Psychiatr Ment Health Nurs 2011)
  - Verbal
  - Comportemental
  - Actes suggestifs

- Conventionnel/non paraphilique VS Non-conventionnel/paraphilique (De Giorgi & Series; Curr Treat Options Neurol 2016)

Question spécifique type NPI

Canevelli et al; Am J Geriatr Psychiatry 2016

TABLE 1. Questionnaire Adopted for the Assessment of ISBs

Screening question	"Does the patient have excessive, bizarre, or unusual sexual behaviors/habits? Have these behaviors been source of embarrassment, discussion, argument? We refer to physical behaviors, verbal expressions, and emotional reactions that are unusual compared to the patient's previous sexual conduct."
	If YES proceed to subquestions
Subquestions	
	"Does the patient talk about sex, make sexual comments or proposals?"
	"Does the patient have unusual personal behaviors (such as masturbating, reading pornographic materials)?"
	"Does the patient have exhibitionistic behaviors (such as disrobing or getting undressed in unfamiliar places, exposing genitals)?"
	"Does the patient have physical behaviors directed toward other persons (such as touching, kissing…)?"
	"Does the patient have excessive emotional reactions related to sexuality (such as discontent, anger, or frustration when refused…)?"
	"Does the patient have other unusual sexual behaviors?"

Evaluation

Knight et al.; Neuropsychol Rehabil 2008

ST ANDREW'S SEXUAL BEHAVIOUR ASSESSMENT SCALE (SASBA SCALE)

Knight, Alderman, Johnson, Green, Birkett-Swan & Yorston, 2008

SASBA
SEXUAL BEHAVIOUR ASSESSMENT
DEVELOPED BY ST ANDREW'S HEALTHCARE

1. BEHAVIOURS

	Verbal Comments VC	Non Contact NC	Exposure E	Touching Others TO
1	Intimate personal comments of mild severity, e.g. "Have you got a girlfriend?", "I love you", "You're gorgeous"	Blowing kisses, kissing self or staring at another persons groin, female breasts or buttocks, or makes obscene gesture	Appears unaware that is exposing genitals, female breasts or buttocks in a public setting	Touches for a prolonged period (excess of 2 seconds) or strokes another person – does not include groin, female breasts or buttocks
2	Comments of a sexual nature, clearly not person directed, e.g. "I've got a big dick"	Touches own groin, female breasts or buttocks over or under clothes (no exposure)	Wearing no clothes in a public setting, clearly not person directed	Kissing another person
3	Descriptions of another persons groin, female breasts or buttocks clearly directed to another person e.g. "You have a nice bottom", "She's got lovely breasts"	Masturbates in a non shared setting where staff are present (e.g. begins when staff enter bedroom or in bath)	Intentionally exposes genitals, female breasts or buttocks to another person (appears to be a deliberate premeditated behaviour)	Lifting skirts, pinching or touching buttocks, sitting on other's knee
4	Explicit accounts of sexual intent, requests or activity e.g. "Show me your knickers", "I want to shag you"	Masturbates without genitals being exposed in a public setting, including ward shared areas (e.g. dining room)	Masturbates with genitals being clearly exposed in a public setting, including ward shared areas (e.g. patient's lounge)	Touching others groin, female breasts, or rubbing own genitals or female's breast against another person

a) Masturbation = rubbing own genitals b) Bedrooms and bathrooms are non public/non-shared environments
c) Attempts to touch which are only prevented by staff intervention, should be rated as if contact occurred.

2. ANTECEDENTS

Set One
Contributing Factors (coded 1-3)

1 Structured activity
2 Noisy environment
3 Had epileptic fit in last 24 hrs

Set Two
Observed Directly Before Behaviour (coded 11-25)

11 Given direct verbal prompt to comply with instruction
12 Given verbal guidance/advice to assist completion of task/activity
13 Given verbal/visual feedback about performance
14 Direct response to other clients verbal behaviour
15 Request specifically denied by other person
16 Any other verbal interaction
17 Physical guidance/facilitation to complete a task
18 Direct response to other clients physically aggressive behaviour when directed at them
19 Direct response to other clients physically aggressive behaviour when directed at another person
20 During restraint
21 Given item e.g. food/therapy materials
22 Purposeful behaviour is ignored or "played down" by person to whom it is directed at
23 Obviously agitated or distressed
24 No obvious antecedent
25 Other (please specify on the back of the recording form)

3. INTERVENTIONS

(coded A-N)

A Behaviour ignored or "played down" completely
B Talking to patient including prompts
C Closer observation
D Holding patient (physical restraint)
E Immediate medication given by mouth
F Immediate medication given by injection
G Isolation without seclusion
H Seclusion
I Activity distraction
J Injury requires immediate medical treatment for patient
K Injury requires immediate medical treatment for other
L Special programme
M Physical distraction (leading the patient away)
N Other (please specify on the back of the recording form)

Evaluation

Knight et al.; Neuropsychol Rehabil 2008

ST ANDREW'S SEXUAL BEHAVIOUR ASSESSMENT SCALE RECORDING SHEET

SASBA

Date	Time	Observer Initials	Antecedents				Behaviour (type, rating)	Interventions (A-N)	Multiple Recordings (identical incidents take place in quick succession)
			Contributing Factors (1-3) – tick if applies			Observed Directly Beforehand (11-25)			
			Structured Activity	Noisy Environment	Epilepsy prev 24 hrs				

EPIDEMIOLOGIE

Données épidémiologiques

- Prévalence
  - 2 – 30% (Torrisi et al; Geriatr Gerontol Int 2016)
  - MA: 2,9 – 7% (Devanand et al. Int Psychogeriatrics 1992)

- Sex ratio
  - Prédominance masculine (?)
  - Plus de CSI physique chez l'homme VS plus de CSI verbal chez la femme ?

- Etiologie des troubles neurocognitifs
  - Pas de consensus (pas de différence VS plus grande prévalence chez les patients souffrant de TNC cérébrovasculaire)

- Sévérité des troubles neurocognitifs
  - Pas de consensus (pas de différence VS plus grande prévalence chez les patients souffrant de TNC à un stade sévère)

Données épidémiologiques

Canevelli et al; Am J Geriatr Psychiatry 2016

TABLE 2. Sociodemographic and Clinical Characteristics of the Study Sample According to the Presence or Absence of ISBs

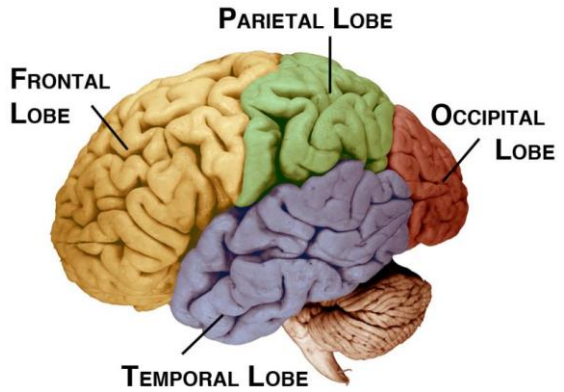
	ISBs (N = 35)	non-ISBs (N = 160)	Significance[a]
Age, yr	75.3 ± 8.2	76.5 ± 7.7	$t_{(193)} = 0.88, p = 0.38$
Sex, women	28.6	53.1	$\chi^2_{(1)} = 6.93, p = 0.01$
Education time, yr	9.6 ± 4.1	9.5 ± 5.1	$t_{(193)} = -0.06, p = 0.95$
Marital status			$\chi^2_{(3)} = 2.81, p = 0.42$
Married	79.4	69.5	
Separated/divorced	0.0	6.6	
Unmarried	2.9	2.6	
Widow/widower	17.7	21.3	
Family history of dementia	54.2	36.1	$\chi^2_{(1)} = 2.68, p = 0.11$
Diagnosis			$\chi^2_{(4)} = 5.28, p = 0.26$
Alzheimer disease	64.7	73.7	
Vascular dementia	8.8	3.9	
Mixed dementia	8.8	13.2	
Frontotemporal dementia	11.8	7.9	
Other dementias	5.9	1.3	
CDR			$\chi^2_{(2)} = 3.21, p = 0.20$
1	50.0	62.9	
2	23.5	22.6	
≥3	26.5	14.5	
MMSE	17.4 ± 6.8	18.6 ± 6.5	$U = -0.98, p = 0.33$
ADL	3.6 ± 2.1	4.3 ± 1.8	$U = -1.71, p = 0.09$
IADL	2.2 ± 2.2	2.9 ± 3.2	$U = -1.56, p = 0.12$
NPI	28.0 ± 17.0	16.6 ± 16.0	$U = 3.70, p < 0.001$

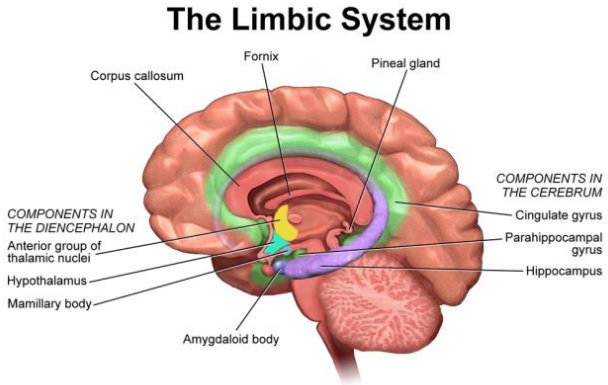
DONNÉES PHYSIOPATHOLOGIQUES

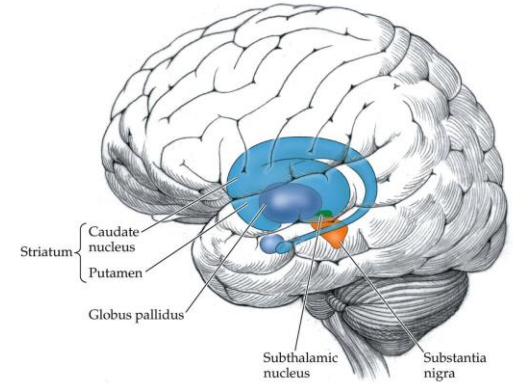
Physiopathologie

De Giorgi & Series; Curr Treat Options Neurol 2016

- 4 structures cérébrales impliquées
  - Lobe frontal
  - Réseau temporo-limbique
  - Circuit cortico-striatal
  - Hypothalamus
- Données limitées et discutables







Biological Psychology 6e, Figure 11.18

PRISE EN SOIN

Préambule

- Nécessairement **INDIVIDUALISÉE**

- Approches non-médicamenteuses (E^2D^2)
  - Chalencon & Lepetit *in press*
    - Éviction
    - Empêchement matériel
    - Distraction
    - Dérivation

Approches non-médicamenteuses

Éviction

« Sectorisation »
Zone homme/Zone femme

Empêchement matériel

Approches non-médicamenteuses

Dérivation

- Tune & Rosenberg. Nonpharmacological treatment of inappropriate sexual behavior in dementia: **the case of the pink panther**. Am J Geriatr Psychiatry 2008

Distraction

Thérapeutiques médicamenteuses proposées pour les CSI

Joller et al. Can Fam Physician 2013

Table 1. Pharmacologic treatments proposed for ISB: *Evidence supporting these drug treatments is level II or level III.*

DRUG CLASS	STUDIED DRUG (FORMULATION AND DOSAGE)	POTENTIAL ADVERSE EFFECTS
Antidepressants	SSRIs (20 mg oral paroxetine once daily, 20 mg oral citalopram once daily)	Nausea, tremor, hyponatremia
	15-30 mg mirtazapine nightly	Sedation, weight gain, myelosuppression
	150 mg oral clomipramine once daily	Orthostatic hypotension, urinary retention, constipation, worsening cognition
	100-500 mg oral trazodone once daily	Sedation, orthostatic hypotension, priapism
Antiandrogens	100-500 mg IM medroxyprogesterone acetate weekly	Fatigue, weight gain, hot or cold flashes, depression, elevated blood glucose, insomnia
	10 mg oral cyproterone acetate once daily	Gynecomastia, galactorrhea, worsening diabetes control, depression, osteoporosis, adrenal insufficiency on withdrawal, hepatotoxicity (liver enzymes should be checked if it is used)
	5 mg oral finasteride once daily	Gynecomastia, testicular pain, depression
Estrogens	0.625 mg oral conjugated estrogen once daily	Weight gain, depression, gynecomastia, venous thromboembolism
	0.05-0.1 mg/d estrogen transdermal patch	
	1 mg oral diethylstilbestrol once daily	
GnRH analogues	7.5 mg IM leuprolide monthly	Weight gain, bone pain, osteoporosis, pituitary apoplexy (rare)
Antipsychotics	1.5-3 mg oral haloperidol once daily	Sedation, extrapyramidal symptoms, falls, weight gain, ventricular arrhythmias
	25 mg oral quetiapine once daily	
Anticonvulsants	100-300 mg oral gabapentin 3 times daily	Sedation, depression, ataxia, tremor
	200 mg oral carbamazepine once daily	Sedation, depression, motor ataxia, hyponatremia, Stevens-Johnson syndrome, agranulocytosis, hepatotoxicity Use of carbamazepine requires monitoring with regular laboratory testing
Cholinesterase inhibitors	1.5-6 mg rivastigmine twice daily	Nausea, urinary incontinence, syncope Potential for emergence of hypersexuality
	5-10 mg oral donepezil once daily	
H_2 receptor blockers	400-1600 mg/d oral cimetidine (nightly or divided doses; eg, 400 mg twice daily)	Worsening cognition, dizziness, multiple drug-drug interactions
-blockers	5-20 mg oral pindolol twice daily	Hypotension, fatigue, bradycardia, bronchospasm
	40-80 mg oral propranolol twice daily	
Antifungals	100-200 mg ketoconazole once daily	Sedation, headache, rash, photosensitivity, gastrointestinal upset, pruritus, hepatotoxicity
Potassium-sparing diuretics	12.5 mg spironolactone once daily	Hyperkalemia, gynecomastia, change in hair growth, upper gastrointestinal ulcers, agranulocytosis

GnRH—gonadotropin-releasing hormone, IM—intramuscular, ISB—inappropriate sexual behaviour, SSRI—selective serotonin reuptake inhibitor.

Thérapeutiques médicamenteuses

THE PRIMARY CARE COMPANION FOR CNS DISORDERS

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Prim Care Companion CNS Disord. 2015; 17(1): 10.4088/PCC.14l01695. PMCID: PMC4468877
Published online 2015 Feb 19. doi: 10.4088/PCC.14l01695

Nabilone for the Treatment of Dementia-Associated Sexual Disinhibition

Daria M. Zajac, MSc,✉ Sarah R. Sikkema, MSc, and Ranjith Chandrasena, MD

- Nabilone = dronabinol = agoniste synthétique des récepteurs cannabinoïdes endogènes
- 1 cas clinique
- Efficacité en 24 à 48h
  - ATU possible en France (Marinol 2,5mg, liste des stupéfiants)

Proposition de prise en soin hiérarchisée

Tucker; Int Psychogeriatr 2010

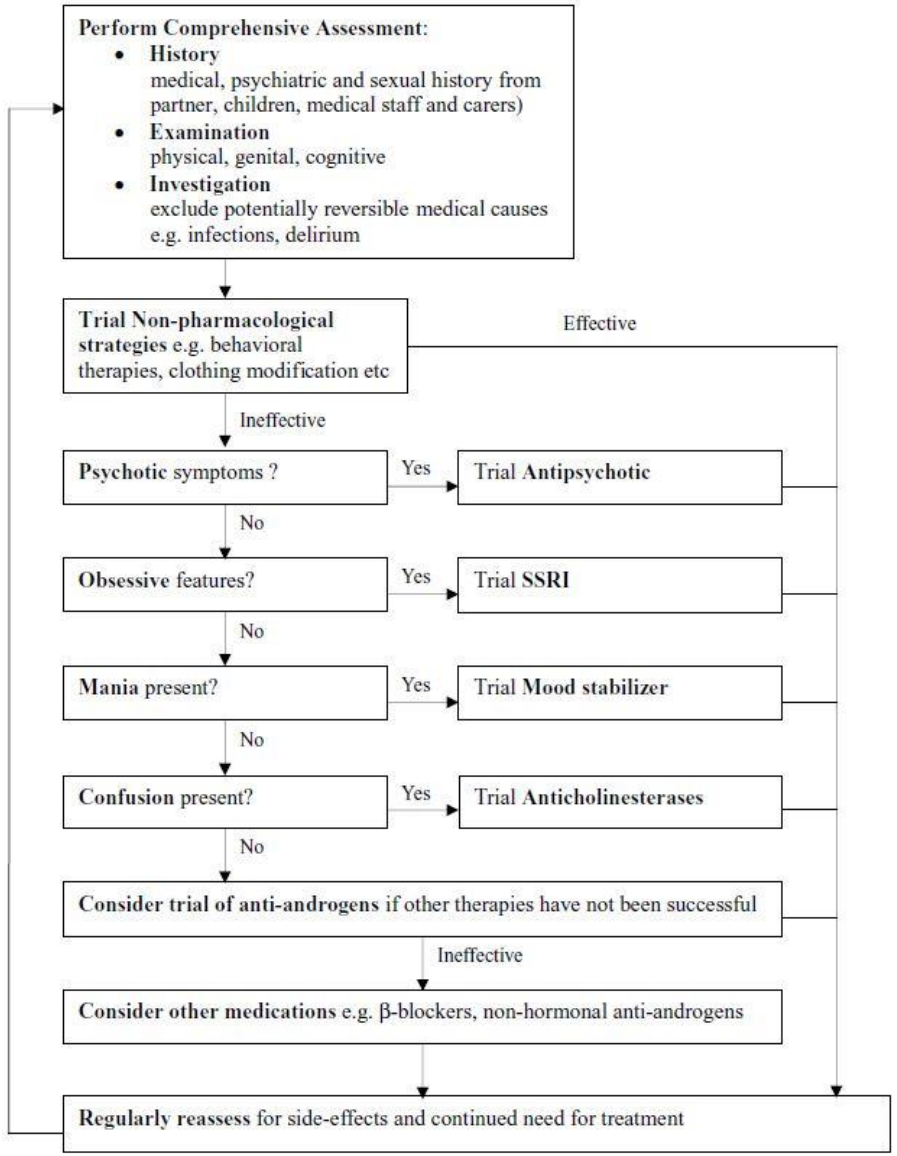

Figure 1. A suggested approach to managing inappropriate sexual behavior in dementia.

Thérapeutiques médicamenteuses

- Approches conseillées (Guay; Am J Geriatr Pharmacother 2008. Joller et al.; Can Fam Physician 2013; Thom et al.; Curr Psychiatry Rep 2017)
  - **1ère intention**: ISRS
    - Citalopram (Torrisi et al. Geriatr Gerontol Int 2016)
    - Sertraline, Paroxetine
  - **2e intention**: traitement hormonaux +/- maintien de l'ISRS
    - Per os possible
      - 1ère intention: Acetate de ciproterone (ANDROCUR, AMM) 50-300mg/j
      - 2e intention: Medroxyprogestérone (pas de forme PO en France)
    - IM retard nécessaire ou résistance au traitement per os
      - 1ère intention: Medroxyprogestérone (DEPO-PRODASONE, pas d'AMM) IM 1/semaine 100-200mg/sem
  - **3e intention ?**: Leuproréline (Enantone LP, pas d'AMM) IM 1/mois

Thérapeutiques médicamenteuses

- RCP ANDROCUR
  - ***Dans l'indication « réduction des pulsions sexuelles dans les paraphilies »***
    - ***Une décision pluridisciplinaire de mise sous traitement est nécessaire, associant, par exemple, psychiatre, psychothérapeute et endocrinologue***

CSI et équipes soignantes

Hayward et al.; Dementia 2013

Inappropriate sexual behaviour and dementia: An exploration of staff experiences

Laura E Hayward
University of Leicester, UK

Noelle Robertson
University of Leicester, UK

Caroline Knight
St Andrews Healthcare, UK

Table 1. Main and major categories

Main category	Major categories
Beyond My Construing	Being shocked & embarrassed
	Incomprehending
	Loosening expectations
Contextualising	Defining behaviours
	'That's dementia'
	Knowing patients
	Upholding social norms
	Holding the whole person in mind
Interpreting	Assessing capacity
	Feeling towards
	Reflecting
Dealing With	Minimising
	Being risk aware
	Managing boundaries
	Doing your best

Conclusion

- Symptomatologie complexe et polymorphe
  - Fréquente
  - Mais souvent non-évoquée

- Prise en soin
  - Complexe sur le plan institutionnel
  - Vectrice de iatrogénie et paradoxale sur le plan médicamenteux

Merci de votre attention

SAVE THE DATE

3e journées de Psychiatrie de la Personne Âgée

Vendredi 30 novembre et Samedi 1er décembre 2018