CASE THREE

Short case number: 3_15_3
Category: Mental Health and Human Behaviour
Discipline: Psychiatry
Setting: General Practice
Topic: Dementia

Case
Anthea Hardcastle presents with her 75-year-old mother Constance. She is concerned that her mother is 'losing it'. This is the second time in the last 2 weeks that she has arrived at her mother's place to find bathwater overflowing into the hallway. The carpet is now ruined and her mother cannot remember turning the taps on. **Constance appears well, but she does not seem to think she has any problems. She acknowledges her memory is "not as good as it used to be", but thinks this is normal for anyone getting older. Constance feels her daughter is worrying over nothing.** **Anthea is concerned that her mother has dementia.**

1. Outline the key features of your history and examination that would assist in determining if Constance has dementia. What screening tools will be helpful in making the diagnosis?

In your assessment, you find out that Constance's MOCA is 22; her memory is worsening and she often misplaces objects. She reports he mood is good and that she sleeping well. Constance says she is cooking her own meals, but collateral from her daughter is that there is often out of date food in the fridge, and Constance has lost 7 kg in the last 5 months. Constance has a cleaner who comes once a fortnight which is paid for privately. Her daughter Andrea is her main support. Constance spends most of her day at home on her own, but enjoys going out for walks in the morning around her neighbourhood.

2. What further investigations would you undertake and why?

As a result of your assessment and investigation findings you explain that Constance likely has Alzheimer's disease.

3. Please outline your management plan for Constance using a biopsychosocial approach. Remember to assess her and manage any risks you have identified and to think about how to support her daughter.

4. Anthea is concerned about her mother continuing to live on her own, but is not sure what she should do. Explain the role of multidisciplinary aged care assessment teams in this clinical context, and discuss what options are available to Constance.

Suggested reading:

1. Management of Mental Disorders (5th edition) World Health Organisation, Collaborating Centre for Evidence in Mental Health Policy. Sydney 2013.

2. O'Connor D, Piterman L, Darval L. Common Mental Health Problems in the Elderly, Chapter 16 in Blashki G, Judd F, Piterman L. *General Practice Psychiatry*. McGraw Hill. Australia. 2007
3. Kumar P, Clark ML, editors. Kumar & Clark's Clinical Medicine. 9th edition. Edinburgh: Saunders Elsevier; 2016.
4. Australian Doctor, How to treat, Dementia, A/Prof S. Mcfarlane and Prof D. O'Connor,2010 http://search.ebscohost.com.ipacez.nd.edu.au/login.aspx?direct=true&db=anh&AN=108379873&site=ehost-live&scope=site
5. Macfarlane S, O'Connor D., (2016). Managing behavioural and psychological symptoms in dementia. Australian Prescriber. DOI 10.18773/austprescr.2016.052 https://www.nps.org.au/australian-prescriber/articles/managing-behavioural-and-psychological-symptoms-in-dementia

ANSWERS

1. **Outline the key features of your history and examination that would assist in determining if Constance has dementia. What screening tools will be helpful in making the diagnosis?**
2. **What further investigations would you undertake and why?**

Answers to Qs 1 and 2

It is important to recognise the features of 'normal ageing' and the spectrum that ranges from mild cognitive impairment (CI) to dementia. Age-related mild CI (or age-associated memory impairment or age-related cognitive decline) refers to a syndrome that may predate the development of dementia. It describes a syndrome of objective memory impairment that does not significantly affect activities of daily living.

The first step in evaluating a patient with memory complaints is deciding whether or not there is a cognitive impairment and if this impacts on their function. It is also important to differentiate between the '4 D's' of cognitive decline. Depression, delirium, dementia and normal age-related decline (as described above). The clinical examination must be focused on excluding a delirium or depression as a cause of the cognitive decline. **The history is the most important part of assessing a patient for dementia.**

Assess the degree of cognitive impairment

- Start in a non-confronting manner, asking where and when the patient was born; what school they attended; what work did they do; when the first child was born; then more specific questions, e.g., who is the prime minister? Current events or sporting results (if they are into sport)or favourite TV programs

Functional Assessment: the impact of cognitive impairment (collaborative history may be important here); managing finances; how do they manage their day (remember appointments, cooking, clothes washing, take medications, any problems with behaviour, dressing, showering).

Objective evaluation: Screening tests (Typical early changes of dementia include recall and orientation difficulties): MOCA (has more frontal lobe testing items than MMSE); MMSE; Rowland Universal Dementia Assessment Scale (RUDAS); The Alzheimer's disease assessment scale.

3. **Please outline your management plan for Constance using a biopsychosocial approach. Remember to assess her and manage any risks you have identified and to think about how to support her daughter.**

<u>Non-pharmacological strategies</u>

Improve cognition

- Memory aids
- Problem solving
- Word games

Preserve function and maintain safety

- Recreational activities
- Exercise
- Multisensory stimulation

- Reminiscence therapy

Manage difficult behaviour

- Environmental changes
- Social interventions

Pharmacological

Cholinesterase inhibitors - Memantine

Before starting cholinesterase inhibitors (ChI) or memantine, review current medications to identify drugs that may exacerbate the patient's clinical condition or that could interact with ChIs

Other management strategies

- Make contact with Alzheimer's Australia early while memory is improved
- Home support networks
- Occupational therapy assessment to ensure safety in the home, minimise risk of falls, etc.
- Establish good behaviours to keep the patient safe and at home (Keeping a calendar or diary and reading it every morning; using a blister pack; paying bills as soon as they arrive; giving up the drivers licence; giving up use of a gas stove and using a microwave; learning to use speed dial on the phone; preventing malnutrition – e.g. meal delivery)
- When dysfunction has been established, important to identify causes as this gives an indication of prognosis, although coexistence of several types is common (e.g., vascular and Alzheimer's) and has treatment implications for treatment. Alzheimer's disease (65%), Vascular dementia (15%), Dementia with Lewy Body (10%), Frontotemporal dementia (5%), Dementia of Parkinson's, Alcohol dementia, other

The rapidity of progression is generally unpredictable. However, in broad terms, the time of diagnosis to death in Alzheimer's is about 10 years; Lewy body dementia is more rapid, and frontotemporal dementia is more rapid again.

The benefit of treatment with ChI's varies according to the type of dementia. Treatment of people with mild and moderate Alzheimer's disease for 6 months improves cognition scores an average of 2-3 points compared with placebo. There is insufficient evidence for the use of ChI's inhibitors in Lewy body dementia so there is no PBS use for this. In patients with vascular dementia the most important management step is to control the vascular risk factors and, if safe, use aspirin. There is no support for the use of cholinesterase inhibitors in frontotemporal dementia.

4. Anthea is concerned about her mother continuing to live on her own, but is not sure what she should do. Explain the role of multidisciplinary aged care assessment teams in this clinical context, and discuss what options are available to Constance.

As a dementia advances, families will require access and referral to community or dementia specific aged care packages for assistance with personal care, meals, medication monitoring and domestic cleaning. Families may also need to consider respite or full-time placement for the person with dementia.

Service available to help relatives of patient with Dementia: NSW dementia Behaviours Management Advisory Service (DBMAS) is a service offering 24 hour assistance for people who care for patients with dementia; National Dementia Helpline 100 100 500; Aged Care Assessment Team –