Dementia

Caring for the Aging patient (and ourselves)

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Disclosure

Board certified in Adult and Addiction Psychiatry
Not Geriatric Psychiatry
No financial arrangements related to the content of this activity
Mild Neurocognitive Disorder (CIND)

Decline in cognition “(complex attention, executive function, learning and memory, language, perceptual-motor, or social cognition) based on:

1. Concern of person, provider, or informant
2. “Modest impairment in cognitive performance” preferably demonstrated in standardized testing
Symptoms do not interfere with ADL’s
Not in context of delirium, or due to another disorder (e.g., depression)


Mild Cognitive Impairment (MCI)

- Most common subtype of cognitive impairment/no dementia (CIND)
- Amnestic or nonamnestic
- Amnestic subtype is precursor to Alzheimer’s dementia
- Estimated 16% of 70-89 year olds have MCI
- 46% develop dementia within 3 years vs. 3% of cohorts without MCI
- 1/3 appear to recover
Mild Cognitive Impairment
Conversion to Dementia

Increased risk for never married, male, older, less educated, APOE*E4 carriers, CSF markers (lower β-amyloid peptide 1-42, higher p-tau and t-tau), PET scans with lower temporoparietal activity, amyloid deposition, neuropsychiatric impairments (NPI’s)
Neuropsychiatric Symptoms (NPI’s)

1. Affect and Motivation changes are present in 50% of dementias (depression, apathy)
2. Psychosis (hallucinations, delusions)
3. Change in drives (appetite, sex, sleep)
4. Disinhibition (aggression, sex, wandering, verbal): “executive dysfunction syndrome”
Neuropsychiatric Impairments continued

Nighttime NPI’s increase risk of all dementias
Hallucinations increase risk of vascular dementia
Anxiety and depression increase risk of conversion from CIND/MCI to dementia
NPI’s increase risk of caregiver depression and mortality, nursing home placement of elder
Dementia

Cognitive decline is “significant” in 1 or more of these: complex attention, executive function, learning and memory, language, perceptual-motor, social cognition

Concern noted by patient, informant, or provider AND substantially affects cognitive performance, ADL’s

Does not occur only during delirium, is not better explained by other disorder (e.g., depression)
Delirium

Disturbed attention (ability to sustain or shift focus)
Develops quickly (hours to days)
Disturbed cognition (memory, language, orientation, perception, visuospatial skills)
Changes are due to medical, drug, toxin substance/withdrawal
Changes are not from evolving neurocognitive disorder or coma
Normal Changes in the Aging Brain

Increased time to retrieve data from memory
Increased time to learn new data
Slower complex reaction time, including response and movement (driving)
Maintenance of attention declines
Ability to multitask declines
Dementia Assessment

1. Are changes greater than expected for age?
2. Do they meet criteria for dementia?
3. Are deficits cortical or subcortical?
4. Are deficits progressive or static?
5. How severe are the deficits?
6. What are the functional impairments?
7. Are there neuropsychiatric symptoms?
8. Are there motor/neurological symptoms?
Clinical evaluation

Family history of dementia, late-life behavior changes
Gait, ability to stand, orthostasis, tremor
Fluidity of movements, hx of falls
Personality, behavior changes
Serial 3’s from 20, similarities, differences
Draw a clock face
Describe a multi-step task
Review pill bottles, supplements
Speak with family, if possible
Assessment of Dementia

Interview with informant, if possible
Frontal Assessment Battery
Mental Alternation Test
Severity: Mini mental status exam (or equivalent): 20-24/30 is mild, 13-20 moderate, 12 or less is severe
Occupational therapy can measure functional impairment by evaluating ADL’s
Dementia Workup

CBC, SMAC, Thyroid function tests, B12, folate
Consider: urinalysis, HIV, RPR/VDRL, toxicology, ECG, CXR, heavy metal screen, homocysteine
EEG for myoclonus, gait changes
Cerebrospinal fluid studies in special cases
Types of Dementia

Alzheimer’s disease, Frontotemporal lobar degeneration, Lewy body disease, Vascular disease, Traumatic brain injury, Substance/medication-induced, HIV infection, Prion disease, Parkinson’s disease, Huntington’s disease, Another medical condition, Multiple etiologies, Unspecified
What about Resveratrol?

Antioxidant produced by plants to “shield against stress from the environment”
In dark chocolate, berries, red grapes, red wine
“Activates sirtuins...family of deacetylases” that “link energy metabolism to gene expression”, and may “transmit resilience to stress”
Calorie restriction also activates sirtuins in animals
Resveratrol

119 w mild-moderate Alzheimer’s dementia
Followed 1 year. Oral resveratrol increased to 2000mg daily
Recipients had lower brain volume on MRI, more Aβ40 in CSF and plasma vs. placebo
Resveratrol and metabolites found in CNS and plasma
No difference in cognitive decline
Ability to Consent to Treatment

1. The decision is VOLUNTARY: free from undue influence of providers, family, friends
2. The decision is INFORMED: there is understanding of the potential risks, benefits, and alternatives of treatment
3. There is CAPACITY to decide
Capacity to Consent Requires:

1. The ability to “COMMUNICATE a stable choice” through speech, sign language, qualified interpreter
2. The ability to UNDERSTAND the information required to make that particular decision
3. The ability to “USE that information to make a decision”
4. The ability to WEIGH (and REMEMBER) risks, benefits, alternatives of that decision
Capacity to Consent

Is specific to the situation
Can fluctuate with time
Standard increases with increasing risk of proposed treatment (basic lab tests vs. bone marrow studies)
Is determined by health care providers related to health care (court decides ability to make decisions related to finances, etc)
Durable Health Care Power of Attorney is NOT a guardian

Makes health care decisions that can be specified in the document IF the person becomes incapacitated

May be specific for mental health (for chronic illness that is episodic)

“The patient continues to make decisions while clinically judged to have the capacity to do so”
Guardianship

Can be appointed by a will, petitioned by “an interested person”, requested by the incapacitated person, family

May not be needed with “valid Health Care Power of Attorney, Mental Health Care Power of Attorney, and Living Will”

But may STILL be needed with the above, example: need for inpatient psychiatric treatment
What to talk about:

- When you think about the last phase of your life, what’s most important to you? How would you like this phase to be?

- Do you have any particular concerns about your health? About the last phase of your life?

- What affairs do you need to get in order, or talk to your loved ones about? *(Personal finances, property, relationships)*

- Who do you want (or not want) to be involved in your care? Who would you like to make decisions on your behalf if you’re not able to? *(This person is your health care proxy.)*

- Would you prefer to be actively involved in decisions about your care? Or would you rather have your doctors do what they think is best?