Dementia

Dementia - F03 (Clinical term: Dementia in Alzheimer's disease Eu00.)

Presenting complaints

- Patients may complain of forgetfulness, decline in mental functioning (eg getting muddled making phone calls, deciding which bus to catch, sorting out change at the checkout), difficulty finding words (especially names and nouns) or feeling depressed, but may be unaware of memory loss.
- Families may ask for help initially because of failing memory, disorientation, and change in personality or behaviour. In the later stages of the illness, they may seek help because of distressing or dangerous behaviour (eg aggression, wandering, incontinence or leaving the gas on unlit).
- Dementia may also be diagnosed during consultations for other problems, as relatives might confuse early dementia with natural ageing.
- Changes in behaviour and functioning (eg poor personal hygiene or social interaction) in an older patient should raise the possibility of a diagnosis of dementia.

Diagnostic features

- Decline in memory for recent events, thinking, judgement, orientation and language.
- Patients may have become apparently apathetic or disinterested, but might also appear alert and appropriate, despite deterioration in memory and other cognitive function.
- Decline in everyday function (eg dressing, washing and cooking).
- Changes in personality or emotional control - patients may become easily upset, tearful or irritable, as well as apathetic, and have persecutory delusions.
- Common with advancing age (5% over 65 years; 20% over 80 years); very rare in youth or middle age.

Dementia has a number of causes. The most common include Alzheimer's disease (60% of cases) characterized by a gradual progression; vascular dementia (20%) with a classically step-wise progression; and Lewy body dementia (15%) with fluctuating cognition, visual hallucinations and parkinsonism, but the clinical picture is often not clear cut.

Owing to the problems inherent in taking a history from people with dementia, it is very important that information about the level of current functioning and possible decline in functioning is obtained from an informant (eg spouse, child or other carer), together with the use of formal memory tests and assessment of activities of daily living (ref 1).

Tests of memory and thinking include the following:

- The ability to repeat the names of three common objects (eg apple, table, penny) immediately, and recall them after three minutes.
- The ability accurately to identify the day of the week, the month and the year.
- The ability to give their name and full, postal address.

A short screening test can be found here.

References

1 World Health Organization. Schizophrenia: An International Follow-up Study. Chichester: John Wiley & Sons, 1979. (AIV) Large outcome study with two-year follow-up, showed that only 10-15% of patients did not recover from their illness in that two-year period. Another shorter-term follow-up study (Lieberman J, Jody D, Geisler S et al. Time course and biologic correlates of treatment response in first episode schizophrenia. Arch Gen Psychiatry 1993, 50: 369-376) showed that 83% of first-episode psychotic patients treated with antipsychotic medication remitted by one year post-inpatient admission.

Differential diagnosis

Examine and investigate for treatable causes of dementia. Common causes of cognitive worsening in the elderly are as follows:

- Delirium - F05. (Sudden increases in confusion, wandering attention or agitation will usually indicate a physical illness [eg acute infectious illness] or toxicity from medication).
- Acute psychosis - F23.9
- Chronic (persistent) psychosis - F20#.
- Depression - F32#. (Depression may cause memory and concentration problems similar to those of dementia, especially in older patients, if low or sad mood is prominent, or if the impairment is patchy and has developed rapidly.)
- Common organic causes of impairment include metabolic and endocrine disorders, neoplasms, any drug treatments.
  Helpful tests in distinguishing an organic cause include MSU, FBC, vitamin B12, folate, LFTs, TFTs, U and E, Ca2+and glucose.

Essential information for patient and family

- Dementia is frequent in old age but is not inevitable.
- Memory loss and confusion may cause behaviour problems, for example agitation, suspiciousness, emotional outbursts, apathy, disinhibition in aggression, inappropriate sexual behaviour, and an inability to take part in normal social interaction.
- Memory loss usually proceeds slowly, but the course and long-term prognosis vary with the disease causing dementia. Discuss diagnosis, likely progress and prognosis with the patient and family.
- Physical illness or other stress can increase confusion.
- The patient will have great difficulty in learning new information. Avoid placing patient in unfamiliar places or situations.
- Membership of a support group and information on dementia for the family can aid caring, although some carers might find this distressing in the short term.

Always give information about local services in addition to general advice about dementia.

General management and advice to patient and family

(ref 68)

- Regularly review the patient's ability to perform daily tasks safely, behavioural problems and general physical condition.

- If memory loss is mild, consider use of memory aids or reminders.
- Encourage the patient to make full use of remaining abilities.
- Encourage maintainance of the patient's physical health and fitness through good diet and exercise, plus swift treatment of intercurrent physical illness.
- Make sure the patient and family understand that the condition may impair the ability to drive. If the patient is incapable of understanding this advice, the GP should inform the DVLA immediately. In early dementia when sufficient skills are retained and progression is slow, a licence may be issued subject to annual review (car and motorbike drivers only) (ref 3).
- Regularly assess risk (balancing safety and independence), especially at times of crisis. As appropriate, discuss arrangements for support in the home, community or day care programmes, or residential placement.
- Review how the carer is managing, especially if they live with the patient. Consider ways to reduce stress on those caring for the patient (eg self-help groups, home help, day care and respite care). Contact with other families caring for relatives with dementia may be helpful, although this can be distressing at first. An assessment of the patient's needs and those of the carer (under the Carer's Recognition and Services Act) can be requested from the local Social Services Department. Carers may need continuing support after the patient has entered residential care or has died.
- Discuss planning of legal and financial affairs with family members, including information on seeking 'power of attorney' and 'enduring power of attorney'. Attendance allowance and a discount on council tax bills can usually be claimed. An allowance (Invalid Carers Allowance) can also be obtained by carers. An information sheet is available from the Alzheimer's Society (see Resources for patients and families) and further information and help can be obtained through local Social Services.
- Non-pharmacological methods of dealing with difficult behaviour can be adopted. For example, carers may be able to deal with repetitive questioning if they are given the information that this is because of the dementia affecting the patient's memory.

References

3 Driver and Vehicle Licensing Agency. At a Glance Guide to Medical Aspects of Fitness to Drive. URL http://www.dvla.gov.uk. Further information is available from The Senior Medical Adviser, DVLA, Driver Medical Unit, Longview Road, Morriston, Swansea SA99 ITU, Wales.

68 Eccles M, Clark J, Livingstone M et al. North of England evidence-based guidelines development project: guidelines for the primary-care management of dementia. Br Med J 1998, 317: 802-808.

Medication

- Antipsychotic medication in very low doses (BNF section 4.2.1) might sometimes be needed to manage some behavioural problems (eg aggression or restlessness). Behavioural problems change with the course of the dementia; therefore, withdraw medication every few months on a trial basis to see if it is still needed, and discontinue if it is not. Beware of drug side-effects (eg parkinsonian symptoms, anticholinergic effects) and drug interactions (avoid combining with tricyclic antidepressants, alcohol, anticonvulsants or L-dopa preparations.). Antipsychotics should be avoided in Lewy body dementia (ref 67).
- Avoid using sedative or hypnotic medications (eg benzodiazepines) if possible. If other treatments have failed and severe management problems remain, use very cautiously and for no more than two weeks; they may increase confusion.
- Aspirin in low doses can be prescribed in vascular dementia to attempt to slow deterioration.

- In Alzheimer's disease, consider referring to secondary care for assessment and initiation of anticholinesterase drugs, which may postpone the onset of more severe symptoms but do not affect the eventual outcome of the disease. NICE recommends that donepezil, rivastigmine and galantamine should be made available as part of the management of some people with mild-to-moderate Alzheimer's disease (ref 69). These drugs should be started by specialists and the patient assessed every six months by specialists or their GP following shared protocols.
- Memantine, which acts on the glutamate neuroreceptors, has been licensed in the UK for moderate to severe Alzheimer's disease, but the clinical evidence for its effectiveness is currently sparse (ref 70,71).

References

67 Ballard C, Grace J, McKeith I et al. Neuroleptic sensitivity in dementia with Lewy bodies and Alzheimer's disease. Lancet 1998, 351: 1032-1033. (CV) This is a case-register study. Other interventions should be explored before the use of neuroleptics in patients with dementia, particularly in those with dementia with Lewy bodies.

69 National Institute for Clinical Excellence. Guidance on the Use of Donepezil, Rivastigmine and Galantamine for the Treatment of Alzheimer's Disease (Technology appraisal guidance 19). London: NICE, 2001. URL http://www.nice.org.uk. (AI)

70 Areosa Sastre A, Sherriff F. Memantine for dementia (Cochrane Review). In: The Cochrane Library, Issue 1, 2003. Oxford: Update Software. (BI) Seven studies were analysed. Results are awaited from two large trials, but those to date suggest a small beneficial effect from 20 or 30 mg/day of memantine on cognitive function measured at 6 and 28 weeks and on global function in patients with mild to moderately severe Alzheimer's disease, vascular and mixed dementia. 259 References 05-WHO-(Refs)-resize-cpp 19/1/2004 2:33 pm Page 259

71 Reisberg B, Doody R, Stoffler A et al. Memantine in moderate-to-severe Alzheimer's disease. N Engl J Med 2003, 348(14): 1333-1341. (BII) Memantine reduced clinical deterioration in moderate to severe Alzheimer's disease, a phase associated with distress for patients and burden on caregivers, for which other treatments are not available. It was not associated with a significant frequency of adverse events.

Referral

- Refer early to a specialist for assessment and possible treatment with anticholinesterase treatment in the case of early Alzheimer's.
- Consider referral to Social Services for practical help: needs assessment, formal care planning, home help, day care and help with placement and benefits.
- Refer to a physician if complex medical co-morbidity or sudden worsening of dementia.
- Refer to psychiatric services if there are intractable behavioural problems, unusually complex family relationships or if depressive or psychotic episode occurs.

Resources for patients and families

Alzheimer's Society 0845 300 0336 (helpline)
Email: helpline@alzheimers.org.uk; website: http://www.alzheimers.org.uk
Provides support to people with all forms of dementia -not just Alzheimer's - their family and friends, and supports research on education and training for primary care.

Age Concern http://www.ace.org.uk
England: 0800 009 966 (Information line 7am–7pm, seven days a week); Email: ace@ace.org.uk
Northern Ireland: 02890 245 729; Email: info@ageconcernni.org
Wales: 029 2037 1566; Email: enquiries@accymru.org.uk
Scotland: 0131 220 3345; Email: enquiries@acscot.org.uk
Provides information and advice relating to older people.

Help the Aged http://www.helptheaged.org.uk
England: 020 7278 1114; Email: info@helptheaged.org.uk
Wales: 02920 346 550; Email: infocymru@helptheaged.org.uk
Scotland: 0131 551 6331; Email: infoscot@helptheaged.org.uk
Northern Ireland: 02890 230 666; Email: infoni@helptheaged.org.uk
Provides advice and support to older people

Carers UK 0808 808 7777 (helpline 10am–12noon and 2–4pm, Monday–Friday)
Email: info@ukcarers.org.uk, website: http://www.carersonline.org.uk
Formerly the National Carers Association. Provides information and advice on all aspects of care for both carers and professionals.

Counsel and Care 020 7485 1566 (10.30am–4pm, Monday–Friday)
Website: http://www.counselandcare.org.uk
Advice and information on home and residential care for older people.

Crossroads Association 0845 450 0350
Email: communications@crossroads.org.uk; website: http://www.crossroads.org.uk
Regional centres throughout the UK, providing practical support and help for carers, including respite care, day centres, befriending and night care. There is also a scheme for young carers.

Benefits Enquiry Line 0800 882 200
Advice and information for people with disabilities and their carers about benefits and assistance with claim form completion.

Leaflets are available from the Royal College of Psychiatrists (http://www.rcpsych.ac.uk):
Memory and Dementia, Alzheimer's disease and dementia, Drug Treatment of Alzheimer's.

The Mental Health Foundation produces the information booklets All About Dementia and Because You Care (which includes suggestions to carers about how to deal with difficult behaviour in people with dementia). Publications, The Mental Health Foundation, 7th Floor, 83 Victoria Street, London SW1H 0HW, UK. Tel: 020 7802 0304; website: http://www.mentalhealth.org.uk.

Alzheimer's at your Fingertips, 2nd edition, by Harry Cayton, Nori Graham and J Warner. Class Publishing, 2002.
For patients and carers, this book answers commonly asked questions about all types of dementia.