Dementia

Definition

A clinical diagnosis of dementia encompasses disordered thinking and memory severe enough to interfere with a person's life that is a change from previous levels. The diagnosis should only be made after depression and delirium are excluded. The most common causes are Alzheimer's disease and vascular dementia.

The screening tests outlined below, KICA (Kimberley Indigenous Cognitive Assessment tool) and MMSE (Mini Mental State Examination) in combination with other assessments can be used to assess those with suspected cognitive impairment. The diagnosis and management of dementia should be undertaken as a multidisciplinary approach

When to Screen for dementia

i. Indigenous patient over 45, or non indigenous patients over 60 whom you suspect has cognitive impairment (e.g. forgetting appointments, giving up activities, showing evidence of language problems)

ii. families indicate change in behaviour or forgetfulness

iii. patient complains of forgetfulness, feeling muddled, "not quite right"

Always consider use of interpreter (Kimberley Interpreting Service ph: 9192 3981), or an ALO or AHW to be present.

Note: For those patients younger than the ages indicated above, other causes need to be considered and investigated as appropriate

Initial Assessment

1. KICA-Screen for Indigenous patients over 45 years (Less then 21/25 suggests dementia). The KICA-COG can then be undertaken where a score of less then 34/39 is more strongly suggestive of dementia)
   (KICA available at www.wacha.org.au or via www.kamsc.org.au). Use MMSE for non Indigenous > 60 years (a score of less then 25/30 is suggestive of dementia)
2. Obtain collaborative history from family/ carers/ health workers to determine acuity of onset, associated behavioural and psychological symptoms (BPSD-see box 1).
   • For Indigenous consider using KICA-Carer as a quick check for cognitive decline noticed by others (greater then 2/16 suggests dementia).
   • For non-indigenous consider using GP COG (available at www.kamsc.org.au or http://www.gpcog.com.au/downloads.php) for brief cognitive assessment and informant evidence of cognitive decline.
3. General examination addressing cerebrovascular risk factors
4. Neurological examination
5. Discuss alcohol intake with patient and/or carers
6. Screen for depression (see KICA-Depression, or Geriatric Depression Scale- 15 found at www.kamsc.org.au)
7. Review medication list for potential medications contributing to confusion, and also medication compliance and monitoring
8. Consider delirium (see below)

Blood screen to include: FBE, UEC, calcium, LFT, B12, red cell folate, thyroid function and possibly syphilis serology. Perform a U/A to exclude UTI.

Consider CT brain in the majority of cases, especially if recent onset, young person, history of fall or head injury or new neurological signs.

BOX 1

- Behavioural and Psychological Symptoms of dementia (BPSD)
- Common symptoms (up to 90% of people with dementia display one form of BPSD during the course of their illness), causing distress to those with the condition and their family and carers
- Anxiety, agitation, depression, hallucinations, and delusions occur frequently
- Other features such as wandering shouting, pacing, insomnia, apathy are less likely to respond to medications
- Non pharmacological measures should always be trialled first after possible contributing factors such as delirium, pain, medication adverse effects etc are excluded
- These may include, orientation, exercise, social groups, music therapy and others.
- A search for a trigger to the behaviour and a trial of possible strategies to alleviate the symptom is important
- See below for medications if above measures are not useful and the behaviour is causing distress to patient or impacting on safety. Being aware of significant adverse effects of antipsychotics and limited

Principles of Management

1. Joint management by primary health care (PHC) team and key community care providers [eg ACAT [Aged Care Assessment Team] / Home and Community Care [HACC].
2. Identify and manage cerebrovascular risk factors (see hypertension, Dyslipidaemia and healthy living protocols)
3. If diabetic, check for hypoglycaemia as a contributing factor – ensure regular food intake and reduce/cease sulphonylureas/glitazones/insulin if required.
4. Review medications:

Dementia

- Eliminate / minimise medications that can contribute to cognitive impairment (benzodiazepines, narcotic and non-narcotic analgesics, antihistamines, antiparkinson medications, antidepressants, psychotropics and anticholinergics);
- Reduce medications where benefit may be marginal: and
- Simplify dosages and ensure medications monitored to reduce risk of overdose &/or non-compliance - Webster pack, dosette box, carer to supervise where appropriate.

5. Discuss with carers/family – family/community stress and coping capacity
6. If evidence of BPSD consider non-pharmacological strategies first (see table 4 for suggestions and for further resources : www.alzheimers.org.au www.racgp.org.au/silverbookonline/pdf/RACGPsilverbook2006.pdf)
7. Monitor for depression
8. Consider low dose antipsychotic for Behavioural and Psychological Symptoms of dementia (BPSD) - anxiety, depression, psychotic features, agitation, wandering etc. (see BPSD Box 1, pg 1)
9. Educate patient and carers regarding dementia, discuss respite care – early intervention can reduce institutionalisation.
10. Consider need for personal affairs planning for Enduring Power of Attorney [if client still mentally competent]/ Guardianship or Administration.

Medications

In some circumstances cholinesterase inhibitors have a role in mild to moderate Alzheimer's disease (donepezil, galantamine, rivastigimine). Their use requires specialist initiation by geriatrician or psychogeriatrician (KACS will organise specialist assessment if required, can be via teleconference/videoconference).

All neuroleptic medications have been associated with an increased risk of cardiovascular disease and deaths – only use if benefits outweigh risks. For BPSD, if non pharmacological measures are not helpful, Risperidone 0.25mg daily increasing to a maximum of 0.5 mg bd if required may be used. Watch for side effects – in particular extrapyramidal syndrome, falls and increased confusion.

If signs of parkinsonism or diagnosis of Diffuse Lewy Body Dementia use Quetiapine (12.5mg BD and increasing slowly to a maximum dose of 100mg BD) . Always review need for ongoing medications

Anti depressants may be required as depression and anxiety are common features of dementia. Start low go slow! Use SSRI (e.g. citalopram 10mg – 40 mg) or mirtazepine (15mg – 45 mg). Use Mirtazepine if night time sedation is desirable. Monitor for side effects including hyponatremia, falls, increased confusion, drowsiness. If there is no improvement consider referral to Kimberley Mental Health team.

Follow up

Dementia is ever changing. The client needs regular review to assess cognitive decline, changes in behaviour, and episodes of delirium or depression. Assess coping capacity of family.

Regular review (at least 3 monthly) of the need for medications, particularly antispychotics.

Refer/ Discuss

1. Aged Care Assessment, support at home and when required for respite care and longer term placement – Kimberley Aged and Community Services (KACS) (ACAT). Involve ACAT early particularly with significant changes in circumstance. ACAT also provides information to families regarding dementia management and has education resources that can be made available to families.
2. Confirmation of diagnosis, general review, advice re management - Geriatrician review visit or telemedicine. ACAT hold monthly Videoconferences with Royal Perth Department of Geriatric Medicine.
3. Depression or BPSD not responding to simple measures, strategies - Kimberley Mental Health team or try DBMAS - Dementia Behavioural Management Advisory Services (phone 1800-699-799
4. Unresolving psychiatric conditions, including depression, severe behavioural issues - Psychogeriatrician review or telemedicine.
5. Management of medical problems not controlled in PHC setting - Regional physician
6. Education and information - Alzheimer's Australia WA.
7. To help families plan for respite needs and discuss alternatives / options that may be available locally - Kimberley Commonwealth Carelink and Respite Centre, Kimberley Aged & Community Services, phone 1800 059 059

Personal care, day centre, transport, shopping, social support etc - HACC. There are HACC services in each of the 6 Kimberley towns. Remote communities can also operate their own HACC services, enquiries via Kimberley Aged & Community Services.

Contact List:

ACAT: 9192 0333

Kimberley Mental Health: 9194-2640

Alzheimers Australia- 0893882800

Kimberley aged and community services 9192 0333

DBMAS-1800699799

Dementia

Dementia, delirium and depression

Box 2	DELIRIUM	DEMENTIA	DEPRESSION
Onset	Acute	Chronic, usually insidious	Often abrupt, coincides with life change
Course	Short, diurnal fluctuation	Long, progressive	Diurnal, typically worse in morning
Progression	Abrupt	Slow but even	Variable
Duration	Hours to < 1 month	Month to years	Weeks to months
Awareness	reduced	clear	Clear
Attention	Impaired , fluctuates	Generally normal	Distractible
Memory	Recent and immediate impaired	Recent and remote impaired	Selective and patchy impairment
Thinking	Disorganised, fragmented, incoherent	Impoverished thought, poor judgement, word finding difficulties	May be intact, themes of hopelessness, self deprecation
Perceptions	Distorted, illusions, delusions and hallucinations	Misperceptions	Usually intact. Delusions and hallucinations mood congruent in severe cases
Sleep	Nocturnal confusion	Often disturbed, wandering	Early morning awakening
Other	Physical illness may be present		Past history mood disorder

Kimberley Indigenous Cognitive Assessment (KICA)

BOX 3

KICA	KICA tool, all sub-sections available at: www.wacha.org.au
Patient assessment	
KICA-Cog	Cognitive assessment (total score 39)
KICA-Depression	Emotional well-being questions
KICA-Screen	Brief screening tool, short version of the KICA-Cog (total score 25)
Carer report	
KICA-Carer	Carer cognitive report (total score16)
KICA-Behaviour	BPSD- Carer report
KICA-ADL	ADL section- Carer report

Non Pharmacological approaches to BPSD

BOX 4

Non pharmacological management

- Exclude delirium, pain, depression, anxiety etc
- Identify precipitants, time of day, hunger, tiredness, pain, ADL's eg showering, noisy environment, loneliness
- Interdisciplinary collaboration
- Carer education
- Other interventions
  - Music
  - Pet therapy
  - Exercise
  - Care training
  - Memory aids
  - Social activities
  - Respite
- Avoid conflict – do not argue with the patient - try to distract the person, offer a pleasant alternative