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Psychiatry and Addictions Case Conference

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# DIFFERENTIATING DEMENTIAS: DIAGNOSIS AND MANAGEMENT STRATEGIES


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# SPEAKER DISCLOSURES

✓ Any conflicts of interest?

# PLANNER DISCLOSURES

The following series planners have no relevant conflicts of interest to disclose; other disclosures have been mitigated.

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# OBJECTIVES

1. Review general principles of identification and evaluation of cognitive impairment.
2. Discuss the most common types of dementia and how to differentiate.
3. Discuss best treatment strategies for different types of dementias and when to refer for subspecialty evaluation and management.

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# SCOPE OF THE PROBLEM

- More than 30% of those aged 80 and over have some form of dementia
- The number of those living with dementia is projected to double in the next 10-15 years
- Studies have shown that between 40-61% of patients who are developing dementia or already have it have not received an evaluation or their physician was unaware of their cognitive impairment
- Rates are even higher in underserved populations and those with lower educational attainment
- Patients themselves often do not come to their provider with a concern about their cognition as their primary complaint—clues can come from families and office staff

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# WHY ASSESS COGNITIVE IMPAIRMENT?

- To identify modifiable or reversible medical causes
- A negative assessment can be reassuring
- Advanced care planning
- Opportunities for anticipatory guidance for both patients and families
- Quality of life focus
- Safety---driving, home safety, financial safety
- Referrals for support, services, research, and planning
- Earlier diagnosis can help with earlier intervention
- Most people with cognitive concerns want an early diagnosis to know what to expect and to participate in their own care (85% in a survey by Alzheimer's Association)

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# INCENTIVE FOR SCREENING AND DETAILED EVALUATION

- Screening cognition and advanced care planning included in the Annual Medicare Wellness Exam (Mini Cog)

- To decide how high a priority a further cognitive assessment should be ask:
- 1. Have you noticed you more often forget things that just happened?
- 2. Have you noticed it's more difficult to finish a complex task that used to be easy for you
- 3. Have you noticed being unsure where you are in a place you've been to many times?

- If a patient presents with cognitive concerns, explore further with a longer visit (e.g. maximize health issues, sensory screening, mental health screening)
- A long visit can be scheduled for further detailed cognitive assessment which will be covered by Medicare—billable as high complexity visit (Cognitive Evaluation Visit)

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# THE NEED FOR COLLATERAL

- Best to have someone who spends a lot of time with the patient participate in a visit for collateral
- Do some screening evaluation in waiting room/by asking in the visit:
  - Alzheimers Disease Questionnaire 8 (AD8)
  - Quick Dementia Rating System (QDRS)
  - 3 questions:
    - Do you notice the person asking the same question 30 minutes later and not remembering that they just asked it?
    - Has the person had trouble completing a complex task that used to be easy for them?
    - Have you noticed the person getting disoriented while on a route or in a place that they should know very well?

# COGNITIVE CHECKLIST
# SMARTSET: COGNITION ON EPIC

- Harmful med assessment---review meds that can have cognitive assessment/assess for deprescribing (include OTC); encourage accurate med list
- Evaluate ETOH—motivational interviewing; goal 0-1 drinks/day
- Consider depression—may “give up” during cognitive assessment
- Assess for symptoms of OSA
- Assess for hearing impairment
- Ask about visual hallucinations
- Reorder B12 and TSH if not done within 1 year
- Montreal Cognitive Assessment—document in flow sheets

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# NEXT STEPS

- Need for referrals
  - sleep study if concern for OSA
  - hearing evaluation (and vision)
  - consider psychiatric referral if concerns about depression/substance use disorder/psychiatric comorbidity, behavioral disturbances in dementia
- CT scan without contrast is standard
- Neurology referral for consultation if:
  - Age <65
  - Visual hallucinations with concern for dementia with Lewy bodies after r/o delirium
  - Other neurologic symptoms (focal deficit, symptoms of NPH, tremor)
  - Clinician, patient or family wish to be referred for specialty evaluation
  - Considering frontotemporal dementia diagnosis
  - Desire/need for choosing more specific imaging, neuropsych testing, specialty management needs, research

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# WHAT DO RESULTS MEAN?

- If MOCA score low and observer noticing any of 3 questions/other screens but still independent with ADLs (cooking, dressing, driving)->MILD COGNITIVE IMPAIRMENT
  - 70% of those with MCI will go on to develop dementia (likely AD) within 2-6 years
  - 30% will NOT go on to develop dementia
- If MOCA score low and observer noticing any of the 3 questions/other screens and unable to do one or more ADLs on own-> DEMENTIA

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# DEMENTIA DUE TO AD

- 50-60% prevalence
- Age >65 typical (unless FH of early onset)
- Insidious onset and progressive impairment
- Prominent memory impairment (impaired memory consolidation, rapid forgetting)
- Clinical features
  - Aphasia
  - Apraxia (forgetting how to do purposeful things-ADL deficits)
  - Agnosia (inability to recognize familiar people, objects, purposes of objects)
  - Executive dysfunction
  - Poor insight
  - Apathy

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# MILD AD
# (MMSE 20-30)

- Patient observations
  - Word finding, mild forgetfulness
  - Forgetting appointments
  - Trouble with planning/complex instructions
  - Social withdrawal
  - Depression/anxiety
- PCP Interventions
  - Diagnose/stage dementia
  - Diagnose and treat mood problems
  - Counsel about legal issues, driving, advanced care planning
  - Memory clinic/neuro referral for diagnostic dilemmas, complex behavioral problems
- Caregivers
  - Helping more with planning, remembering, finances
  - Fears about diagnosis and future

# MODERATE AD (MMSE 10-20)

- Patient observations
  - More language impairment
  - Trouble with short-term memory, chronologies
  - More trouble with iADLs/some trouble with ADLs
  - No longer able to driver/perform complex tasks
  - Paranoia/fearfulness
  - Safety—wandering, leaving stove on, financial exploitation
- PCP Interventions
  - Caregiver support groups
  - Help in home
  - Driving evaluation
  - Monitor for caregiver depression/burnout
  - Material/emotional support from family
  - Next steps

# MODERATE AD (MMSE 10-20)

- Caregivers
  - Increasing care burden
  - Frustration at patient language and memory problems
  - Need to decrease work/activities to provide care
  - Trouble leaving patient alone
  - Poor sleep
  - Depression, anxiety, resentment, anger, grief

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# AD SEVERE (MMSE <10)

- Patient observations
  - Weakness, gait impairment, falls, dysphagia
  - Difficulty recognizing familiar people
  - Can’t perform iADLs/ADLs very difficult
  - Apraxia
  - Paranoia, delusions, agitation, aggression
- PCP Interventions
  - Referral to palliative care for goals of care discussion
  - Caregiver f/u with own PCP
  - Encourage respite, self care, time away, exercise for caregiver
  - Encourage support group/personal therapy

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# AD SEVERE/END STAGE (MMSE <10)

- Caregiver Experience
  - Severe fatigue
  - Medical complications for own health
  - Guilt for placing patient in supervised care setting

- End Stage
  - Mute/bedbound
  - Total ADL care
  - Burden of daily care
  - Grief/relief from caregiver
  - Hospice referral
  - Bereavement support group

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# TREATMENT

- Supportive: exercise, socialization, learning new things, MIND diet, hydration, support groups
- Maximize management of sensory deficits, medical comorbidities, decrease alcohol, clean up meds
- Medication (after recommending above)
  - Identify a target symptom (language/word finding problems, anxiety) and monitor for improvement
  - Decide about whether or not to continue
  - AChE inhibitors
  - Memantine
  - Aducanamab—IV treatment, mild dementia
    - High risk
    - Long treatment series involving IV infusions\

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# DEMENTIA WITH LEWY BODIES

- 10-20% prevalence
- Typically age >65
- Memory impairment
- Fluctuations in alertness (sometimes diagnosed with recurrent delirium with unclear etiology)
- Visuospatial deficits
- Parkinsonism—tremor, bradykinesia, axial rigidity (more than peripheral)
- Visual hallucinations (usually animals, small people)—often not distressing to patient
- Falls (orthostatic hypotension)
- Neuroleptic sensitivity
- REM sleep behavior disorder
- Survival time typically shorter/more rapid decline

# DEMENTIA WITH LEWY BODIES

- Specialty referral can be helpful for management---may need co-management with neurology/psychiatry
- AChE inhibitors may have a larger impact on cognition, sometimes on neuropsychiatric symptoms
- If falling/significant motor symptoms, may be reasonable to initiate carbidopa-levodopa but possible risk of increased neuropsychiatric symptoms
- Sleep disturbance---melatonin then clonazepam if ineffective
- Hallucinations/psychosis---
  - Use neuroleptics only if distressing/leading to behavior problems for which non-pharmacologic interventions ineffective
  - Low dose (1/4 to ½ dose; start with quetiapine); titrate slowly; discontinue if not effective
  - Caution orthostasis; document black box warning morbidity/mortality discussion

# VASCULAR DEMENTIA

- 10-20% prevalence
- Age typically >65
- Variable syndrome based on location of lesions
- Language/memory retrieval deficits common
- Focal neurologic deficits on exam
- Abrupt/sudden onset
- Executive dysfunction
- Vascular risk factors
- Pseudobulbar affect

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# VASCULAR DEMENTIA

- Pure vascular dementia much less likely than comorbid with another type of dementia, especially AD
- Clinical presentation varies widely
- Managing vascular risk factors is the highest priority
- AChE and memantine not FDA approved but may have utility due to overlap with AD

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# FRONTOTEMPORAL DEMENTIA

- 1-5% prevalence
- Age 52-63; after 75 rare
- Prominent personality/behavioral change
- Cognitive rigidity
- Memory impairment less prominent (early)
- Significant executive impairments
- Disinhibition or apathy
- Hypersexuality
- Obsessive collecting/gathering behaviors
- May initially present to psychiatric attention (concern for bipolar disorder, substance use, personality disorder)

# FRONTOTEMPORAL DEMENTIA

- Neuroimaging can be helpful to identify frontal/temporal atrophy (but may not see early on)
- AChE inhibitors/memantine not shown to have clear benefit; may worsen behavior
- SSRIs and trazodone may be useful for impulsivity, sexually inappropriate behavior, compulsive behavior in some patients
- No RCTs for using antipsychotic medications for treatment in these patients
- Consultation with neurology may be helpful

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# TREATMENT OF BEHAVIORAL DISTURBANCES

- Review for polypharmacy (fewer meds, less to refuse)
- Evaluate for acute medical issue or symptom (UTI, constipation, pain)
- Caregiver education and support
- Environmental interventions
- Antidepressant if signs of depression or anxiety
- AChE inhibitor or memantine if not taking
- Antipsychotics if other interventions not working, risk to patient/caregiver safety or patient distressed
  - Evaluate for QTc prologation
  - Risk-benefit discussion with surrogate—increased risk of death or stroke; document
  - Evaluate monthly for efficacy and side effects; consider weaning/discontinuing every 6 months

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# RESOURCES

- Alzheimer's Association (alz.org)
- Lewy Body Dementia Association (LBDA)
- Association for Frontotemporal Dementia (AFTD)
- Cognition-PrimaryCare.org
- Dementia-directive.org
- https://www.thememoryhub.org/
- www.alzheimers.gov
- www.nia.nih.gov/alzheimers
- https://www.nia.nih.gov/health/health-care-professionals-information/talking-your-older-patients
- https://www.nia.nih.gov/health/health-care-professionals-information/healthy-aging-and-dementia-resources-health-care

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