DEMENTIA

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Geriatrics Health Professionals.
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CLINICAL VIGNETTE (1 of 7)

- CJ is a 78-year-old retired engineer with a history of cervical spine stenosis status post laminectomy with resultant cervical myelopathy

- He comes to your rehab clinic for a follow-up visit after an inpatient acute rehab stay and is accompanied by his wife

- She reports he is motivated and has been working hard to recover and is happy with his progress to date
CLINICAL VIGNETTE (2 of 7)

• Upon further questioning it is evident that CJ is having issues with executive functioning, poor insight, and safety awareness

• His wife reports that staff and family have raised concerns about his having to be instructed repeatedly, with poor recall and difficulty learning new tasks

• His wife reports signs of forgetfulness and behavioral issues that have progressed over the past 6–8 months
CLINICAL VIGNETTE (3 of 7)

• She was thinking this was part of old age, but realized it was more serious when he got lost for several hours last week after taking a neighborhood walk

• Since his retirement CJ has kept himself busy volunteering at a local college

• A colleague recently brought to his wife’s attention that he is having more difficulty at work, confusing class times, forgetting names, and having trouble following instructions
CJ’s wife has noticed he repeats things several times, has difficulty concentrating, and more commonly is losing things.

He makes lists and notes; otherwise, he forgets.

Over the last several months he has been disengaged and more reclusive, and doesn’t enjoy his usual hobbies.

He has had angry outbursts, accusing his wife of hiding his keys and taking his money, and last week of having an affair with the neighbor.
CLINICAL VIGNETTE (5 of 7)

• CJ’s wife denies that he has had weight loss, changes in appetite, or headaches

• She denies deficits in verbal fluency, hallucinations, or fluctuations in his alertness

• CJ’s past medical history is significant for severe cervical spine stenosis and hypertension well controlled with lisinopril

• He takes a multivitamin, eats healthful food, and exercises twice weekly
• CJ is a nonsmoker and drinks 1–2 glasses of wine with dinner every night

• In the office today, his blood pressure is 125/80, pulse 66, respiratory rate 16, and BMI 24

• A general physical exam is remarkable for limited neck and shoulder range of motion

• The exam is otherwise unremarkable with normal gait, balance, and muscle strength
CLINICAL VIGNETTE (7 of 7)

• There are no focal neurologic or extrapyramidal signs and no tremors

• When asked to draw a clock, CJ finds it difficult with delay and is unable to complete the task

• On the Mini–Mental State Examination he loses points for recall, orientation, calculation, and construction

• Initial blood work (CBC, BMP, TSH, and B12 levels) is within normal

• Urinalysis and CXR are negative
VIGNETTE QUESTIONS (1 of 2)

• What type of dementia is most likely in this case?

• Identify and differentiate subtypes of dementia

• What are the DSM-IV diagnostic criteria for dementia?
VIGNETTE QUESTIONS (2 of 2)

• Identify red flags of dementia in the vignette

• What comments from patients, staff, or families would raise concern about dementia? Differentiate from typical aging.

• How can the rehab team effectively screen patients for dementia?
ALZHEIMER’S DEMENTIA

• Most common subtype, accounting for 55%–80% of dementia cases

• A general term for memory loss and other intellectual abilities serious enough to interfere with daily life
OTHER DEMENTIA SUBTYPES

• Dementia with Lewy bodies: ~15%
  ➢ Decreased attention; fluctuation in progression and mental status

• Vascular dementia: ~10%
  ➢ Often sudden onset; commonly seen after stroke; neurological and temporal deficits

• Mixed dementia: diffuse symptoms

• Frontotemporal: ~5%
  ➢ Behavioral and social issues, with toxic metabolites and movement disorders
DSM-IV DEMENTIA CRITERIA

• Chronic progressive decline from previous function in multiple cognitive areas, including memory plus visual-spatial, language, and executive function

• Significant impairment in social or occupational functioning
RED FLAGS

• Recent memory loss affecting daily life
• Difficulty with familiar work tasks
• Poor judgment with wandering and inability to retrace steps
• Challenge in planning (Clock Draw Test)
• Confused with orientation
• Misplacing items
• Withdrawal from work and social activities
• Changes in mood and personality
ROUTINE EVALUATION

• Clear history of onset and progression
• Medical problems
• Lifestyle
• CBC, electrolytes, glucose, B12, TSH, kidney and liver function tests
• Depression screening
• MMSE
• Head CT to rule out hydrocephalus, tumor, cerebrovascular disease
FURTHER TESTS

Specific screening tests for dementia include:

- MMSE
- 6-item screener
- Mini-Cog
- Clock Drawing Test
- Functional Activities Questionnaire
MANAGEMENT OF MILD DEMENTIA (1 of 2)

• Patient and family education

• Consultants:
  ➢ Geriatrician
  ➢ Neurologist
  ➢ Psychiatrist
  ➢ Speech language pathologist for cognitive evaluation and treatment
MANAGEMENT OF MILD DEMENTIA (2 of 2)

• Social worker and home health nursing for safety evaluation, psychosocial support, community resources, financial concerns

• Behavioral monitoring; cognitive follow-up in 6 months

• Management of moderate to severe dementia may include drug therapy
RESOURCES (1 of 3)

• Emory University Geriatric Medicine Resource Module: Dementia
  http://www.medicine.emory.edu/divisions/geriatrics/education/edu_resources/modules/Dementia.cfm

• American Academy of Neurology Guidelines for Dementia
RESOURCES (2 of 3)

• Recognition of Dementia in Hospitalized Older Adults
  http://www.nursingcenter.com/prodev/ce_article.asp?tid=762396%20

RESOURCES (3 of 3)

- Alzheimer’s Association
  http://www.alz.org

- American Academy of Neurology
  http://www.aan.com

- National Institute of Neurological Disorders and Stroke
  http://www.ninds.nih.gov
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