

Alzheimer's Disease and Other Dementias

Clinical Practice Guideline Summary for Primary Care

DIAGNOSIS AND CLINICAL ASSESSMENT

Patients with Alzheimer's Dementia (AD) and other dementias develop multiple cognitive deficits that include memory impairment, including impaired ability to learn new information or to recall previously learned information. They also typically develop at least one or more of the following cognitive disturbances: aphasia (language disturbances), apraxia (impaired ability to carry out motor activities despite intact motor function), agnosia (failure to recognize or identify objects despite intact sensory information) or a disturbance in executive functioning (i.e., planning, organizing, sequencing, abstracting). AD is a progressive disease with gradual onset and continued deterioration in cognitive ability. One must differentiate AD from many other reasons for cognitive impairment, including delirium, vascular dementia and amnesia. Careful workup is required in formulating a diagnosis and exhausting other plausible reasons for the cognitive impairments. In addition, AD, along with other dementias, may exist comorbid to the onset of a medical problem or physical injury, or may be complicated by another behavioral health diagnosis such as major depression or schizophrenia.

When treating patients with AD and other dementias, it is important to incorporate a multimodal approach including establishing good relationships with the treatment team. In assessing and monitoring psychiatric symptoms, stable patients can be seen with less frequency every 3-6 months, whereas patients with current acute (complex or potentially dangerous symptoms) may require more frequent monitoring, typically weekly to monthly. Additionally, incorporating the caregivers and family into treatment is important, as well as providing education about the disease and referrals to support services to patients and families, watching for caregiver distress, and monitoring a patient's ability to continue to drive, remain unsupervised and in some cases, assessing for abuse and neglect.

POTENTIAL WARNING SIGNS IN TREATING PATIENTS WITH ALZHEIMER'S DISEASE OR OTHER DEMENTIA

- Any significant or sudden change in mental status, such as a new onset of self destructive behaviors or violent behaviors, warrant at least consultation with a behavioral health colleague and may require urgent or emergent treatment including hospitalization.

- Examples of patients who may require hospitalization include those with co-morbid depression who are at risk of suicide, or patients with co-morbid substance use disorders requiring detoxification.
- Examples of patients who may require additional support and supervision or may require additional levels of care due to cognitive impairments include any concerns regarding self preservation, e.g., wandering resulting in getting lost or putting oneself at risk, inability to care for themselves based on failure to complete activities of daily living, or creating risk related to unattended or forgotten items on the stove or concerns around the ability to drive safely.

EFFECTIVE TREATMENT

A complete history and understanding of the patient's individual circumstances is necessary for effective treatment planning. In addition determine if there are any present and treatable psychiatric and/or general medical conditions that are either the cause or co-morbid to the dementia. A complete evaluation and diagnosis of Alzheimer's include the following:

- Review of pertinent medical history including recent medical problems and medications.
- Psychiatric examination that focuses on the cognitive domains of attention, memory, language and visuospatial skills.
- Timeline and onset of impairment and possible exploration of etiology beyond AD.
- Accurate picture of functioning and impairment by potentially interviewing a care giver to allow for full disclosure of signs and symptoms.
- Coordination with other involved treators.

Developing a treatment plan based on the level of patient impairment is key.

Patients with AD are generally classified in one of three categories:

A. Minimally impaired:

- Have memory loss and poor memory of recent events.
- Have trouble naming common items.
- Ask the same thing over and over.
- Get lost easily.
- Lose interest in things they once liked to do.
- Lose things more often than normal.
- Have personality changes.
- Are worried or depressed.

B. Moderately impaired:

- Have a hard time dressing for the weather or occasion.

- Forget to shave or shower.
- Argue more often.
- Believe things are real when they are not.
- Wander, often at night.
- Need close supervision.
- Have trouble with tasks such as washing dishes or setting the table.

C. Severely or profoundly impaired:

- Have problems with eating.
- Have problems with speech or do not speak at all.
- Do not recognize you or other family members.
- Are not able to control bowels or bladder.
- Have problems with walking.

The goal of psychopharmacology for a member with AD is to delay the progression of the cognitive impairment and maintain the current functioning for as long as possible. There are a number of medications that are used to address this goal: cholinesterase inhibitors, including donepezil, rivastigmine and galantamine that are FDA-approved for the treatment of mild to moderate AD. In addition, donepezil has been approved by the FDA for the treatment of severe AD.

There is also Memantine, a noncompetitive N-methyl-d-aspartate (NMDA) antagonist has been approved by the FDA for use in patients with moderate and severe AD.

Vitamin E is no longer recommended for the treatment of cognitive impairments due to limited evidence for its efficacy. NSAIDs (nonsteroidal anti-inflammatory agents), statin medications and estrogen supplementation have shown lack of efficacy and safety and, therefore, are not recommended.

In addition to cognitive impairments, there are sometimes co-occurring psychosis, agitation, depression, and sleep disturbances that may be addressed and treated with medication.

With regards to treating an older population, it is important to factor medical concerns, other medications, and age into your decisions regarding medication treatment. Generally speaking, elderly patients have decreased renal clearance and slowed hepatic metabolism, and may be on other medications. It is advisable to start off with low doses, with small incremental increases, avoiding polypharmacy whenever possible, and making only one change at a time to a medication to determine the effects and side-effects, keeping in mind that elderly patients with dementia are especially susceptible to extrapyramidal side effects.

RESOURCES

For further information, see the complete version of the American Psychiatric Association's *Practice Guideline for the Treatment of Patients with Alzheimer's Disease and Other Dementias*, available at www.psych.org. You can also call the UBH Physician Consultation Service (1-800-292-2922) to discuss treatment concerns with a psychiatrist or contact UBH Customer Service (1-888-777-4742) if you would like to make a referral to a mental health professional.