

## COGNITIVE DISORDERS: DEMENTIA

### Clinical Overview: Dementia

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- Dementia occurs most often in people over the age of 75.
- Dementia may change the patient's mood and personality.
- A mental status exam (MSE) is very helpful in screening patients for dementia (see page 9-3).
- Encourage caregivers of patients with dementia to take care of themselves.
- Talk to the family about creating a safe environment for the patient.
- Depression, particularly in the elderly, can mimic symptoms of dementia. This is termed pseudodementia. (For help in differentiating between dementia and pseudodementia see page 9-9.)

### Clinical Snapshot: Dementia

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- Brief "snapshot" of dementia patient's presentation:
  - Decline in cognitive abilities.
  - Difficulties remembering, learning and or communicating.
  - Family is concerned.
  - Patient may downplay the extent of the decline.
  - Irritability may be present.
  - Patient has difficulty pinpointing onset of the dysfunction.
  - Late to seek medical attention.
  - Deficits in recent (as opposed to remote) memory.

## Facts about Dementia

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- Most older people experience a decline in certain cognitive abilities that is not pathological. However, some declines do go beyond what may be considered “normal” and are progressive in nature.
- Dementia, makes it hard for a person to remember, learn and communicate.
- Dementia is caused by the destruction of brain cells.
- Dementia is a clinical state with many different causes, characterized by a decline from the previously attained intellectual level.
- Dementia is a consequence of dysfunction in the brain – particularly the parts of the cerebrum known as the association areas which integrate perception, thought and purposeful action.
- Some types of dementia may be arrested or reversed.

## How to Identify Dementia

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### ■ *DSM-IV Criteria for Dementia*

- *Definition:* the development of cognitive deficits that include memory impairment and at least one of the following:
  - ❑ Aphasia (communication impairment).
  - ❑ Apraxia (motor impairment).
  - ❑ Agnosia (impaired recognition).
  - ❑ Disturbance in executive functions.
- The cognitive impairment is severe enough to cause problems in occupational or social functioning and represents a decline from previous level of functioning.
- Deficits do not occur exclusively during the course of a delirium.

### ■ *Signs of Dementia*

- Recent memory loss.
- Difficulty performing familiar tasks.
- Problems with language.
- Time and place disorientation.
- Poor judgment.
- Problems with abstract thinking.
- Misplacing things.
- Changes in mood.
- Personality changes.
- Loss of initiative.

### ■ *Screening for Dementia*

- Patients should undergo a thorough medical examination to rule out underlying medical disorders or other medical causes of dementia or cognitive decline.
- Obtaining behavioral descriptions and subjective estimations of cognitive performance from friends and family members can be very useful.
- Patients should not be considered to have dementia solely on the basis of a poor score on a mini-mental status exam – one must take into consideration the changes that occur with normal aging versus changes that are greater than expected for the individual.
- Onset of dementia is typically subtle – patient and/or family notices minor forgetfulness, restlessness, apathy, increasing tendency to misplace things, small inconsistencies in ordinary tasks and repeating words or behaviors.
- Most persons with significant cognitive dysfunction are not aware of the problem.
- The following information is important to obtain during an initial evaluation:
  1. Thorough patient history.
  2. Chronological account of the current problems including:
    - > Mode of onset.
    - > Duration.
    - > Specific cognitive, memory, and behavioral changes including problems with disorientation, repetition, irritability and agitation.
- A mental status examination (MSE) is very helpful in evaluating patients with dementia.
- Patients who refuse to comply with an MSE may be attempting to hide an impairment.
- When patients respond incorrectly, errors should not be pointed out due to the impact that emotions may have on cognitive performance.
- Mental Status Examination:
 

*Appearance:*

  - Chronologic and apparent age.
  - Physical disabilities.
  - Grooming.
  - Gait Coordination.
  - Height/weight.
  - Posture.
  - Noteworthy gestures.

*Language:*

  - Speech (e.g., rate, volume, pressured, slow, impoverished, etc.).
  - Expressive language (e.g., circumstantial, tangential).
  - Receptive language (e.g., difficulty understanding questions).

*Mood:*

- How the patient feels most days (e.g., happy, sad, angry, etc.).
- Affect, including range of affect (e.g., constricted, blunt, flat, inappropriate, labile, etc.).
- Rapport.
- Suicidal (see Suicide chapter) or homicidal ideation.
- Impulsivity.

*Orientation:*

- Awareness of place, time, president, your name.

*Alertness:*

- Sleepy, alert, tired, etc.

*Concentration and Attention:*

- Serial 7s (count backward from 100 by 7s).
- Name the days of the week or months in reverse order.
- Spell the word “world” forward and then backward.
- ABCs backwards.

*Thought Process:*

- Flight of ideas, ideas of reference, perseveration, magical thinking, loose associations, etc.

*Hallucinations and Delusions:*

- Evidence or report of current/past presence of any type of hallucinations.
- “Have you ever heard voices that were not your own thoughts—voices that other people could not hear?”
- “Have you ever felt your mind was playing tricks on you?”
- “Have you ever felt someone was reading your mind or making you think things?”

*Recall and Memory:*

- Can patient explain recent and past events?
- Can patient recall three unrelated words after five minutes?
- Can patient recall your name after 30 minutes?

## Common Types and Causes of Dementia

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- Most frequent forms of dementia are not reversible – they are primarily in the brain and fall into two categories: cortical and subcortical dementias.
- Cortical dementia, such as Alzheimer’s typically involves:
  - Early aphasia.
  - Visuospatial impairment.
  - Frontal system impairment.
  - Normal mood.
  - Upright posture.
  - Normal motor speed.
  - Recall/recognition impairment.
  - Calculation impairment.
  - Normal speed of cognition.
  - Normal speech.
  - Normal coordination.
- Subcortical dementias, such as Parkinson’s, Huntington’s, and AIDS typically involve:
  - No aphasia.
  - Recall impairment but no recognition impairment.
  - Visuospatial impairment.
  - Preserved calculations.
  - Disproportionally affected frontal systems.
  - Slowed speed of cognition.
  - Apathetic personality.
  - Depressed mood.
  - Dysarthric speech.
  - Bowed or extended posture.
  - Impaired coordination.
  - Tremors, tics, dystonia.
  - Slowed motor speed.

### ■ *Common Causes of Dementia*

- Medications – such as neuroactive and psychoactive agents, opiates and steroids.
- Infections – any infection involving the brain.
- Metabolic disorders – hereditary metabolic diseases.
- Nutritional disorders – thiamine deficiencies.
- Vascular – hypertension and cardiac diseases.
- Space-occupying lesions – malignant brain tumors.
- Normal pressure hydrocephalus.
- Affective disorders.

## Treatment

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### ■ *Education*

- The Alzheimer’s Society recommends the following tips to help people cope with memory problems:
  1. Write things down.
  2. Keep a diary or notebook.
  3. Keep a weekly timetable.
  4. Keep important things in one place.
  5. Have a routine.
  6. Keep important phone numbers by the phone.
  7. Use sticky notes to remind you of things (e.g., “lock this door”).
  8. If you need to remember to bring something with you when you leave the house, leave it by the door.
  9. Do not panic, give yourself plenty of time.
  10. Use pill reminder boxes.
  11. Don’t be afraid to ask for help.
- See Memory Tips handout for patients in Appendix A.
- Encourage regular exercise and proper diet.
- Encourage caregivers to make sure they are taking care of themselves. This should include getting enough sleep, exercise, proper diet, and regular time alone for themselves.
- The family of a patient with dementia should try to create as safe an environment as possible and encourage the patient to maintain social activities, exercise and proper diet.

### ■ *Medication*

- Medication is used to slow cognitive impairments in dementia.
- Medication may also be used to treat the agitation, depression, anxiety and sleeping problems that sometimes accompany dementia.
- Antidepressant medication is often used to treat pseudodementia. Keep in mind that older adults are more susceptible to side effects. Lower initial doses and closer follow-ups are needed.

### ■ *Psychotherapy*

- While a person with advanced dementia may not benefit from psychotherapy, family members dealing with the stress of caring for their loved one may benefit from counseling services.

## **Pseudodementia**

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- One of the biggest challenges in treating patients with cognitive impairment is determining whether the impairment is due to dementia or pseudodementia.
- Pseudodementia is a type of depression which appears superficially as a problem with memory.
- Pseudodementia is characterized by:
  - Awareness that memory is insufficient.
  - An ability to precisely date the onset of the impairment.
  - Reversible cognitive deficits.
  - Intellectual impairment.
  - Impairment similar to that seen in CNS disorders.
  - Lack of a neurological condition.
  - Lack of organic brain disorder.
- Memory in pseudodementia patients appears to be affected, but on closer examination it becomes clear that they are inattentive and thus unable to retain information and form new memories.
- Typical behaviors that occur with pseudodementia include:
  - Slowness to respond.
  - Inattention.
  - Distractibility.
  - Confusion.
  - Disorientation.
  - Diminished conceptual abilities.
  - Difficulty with acquisition or retrieval of information.

- Errors of omission.
  - Concern about deficits.
  - Incomplete responses or “I don’t know.”
  - Poor concentration.
  - Short attention span.
  - Short and long-term memory deficits.
  - No sign of aphasia, apraxia or agnosia.
- Major characteristics of pseudodementia include (not all need to be present):
- Apathy, decreased motivation.
  - Depression or anxiety.
  - Persecutory delusion.
  - Psychomotor retardation.
  - Impaired memory retrieval.
  - Poor wordlist generation.
  - Variable performance.
  - Awareness of cognitive deficits.
  - Positive dexamethasone test.
  - Bradykinesia.
  - Stooped posture.
  - Slow speech.
  - Sleep disturbance.
  - Loss of appetite and weight.
  - Constipation.
  - Impotence.
  - Subacute and rapid onset.
  - Progression of intellectual decline.
  - Past history and/or family history of mood disorder.

■ *Dementia vs. Pseudodementia*

- Depression, particularly in the elderly, can mimic deficits found in dementia. This has been termed pseudodementia. This table can help you distinguish dementia from pseudodementia.

<b>Dementia</b>	<b>Pseudodementia</b>
Not aware of dysfunction.	Aware and concerned about dysfunction.
Patient unable to say when onset of dysfunction began.	Onset of dysfunction can be dated.
Typically seeks medical attention late.	Typically seeks medical attention early.
Slow, subtle progression.	Rapid progression.
No history of psychiatric illness.	Has history of psychiatric illness.
Patient tries to hide illness.	Patient describes illness in detail.
Patient is not very concerned about deficits.	Patient is very concerned about deficits.
Social skills maintained.	Social skills lost.
Faulty attention/concentration.	Attention/concentration skills intact.
Loss of recent not remote memory.	Memory loss for certain periods.
Poor performance.	Variable performance.