Dementia: Guidelines for Assessment and Differential Diagnosis

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Objectives

• Provide a brief overview of:
  – Maine’s State Plan for Dementia
  – American Geriatric Society Guide to dementia evaluation and management

• Review general clinical aspects of diagnostic assessment and treatment
Maine’s State Plan

• Sponsored by Maine’s State Chapter of National Alzheimer’s Association and DHHS
• Phase 1: Advocacy
  – June 2011: Law established task force
• Phase 2: Develop plan
  – May 2012: Final draft completed
• Phases 3/4: Implement & revise
State Plan for Alzheimer’s Disease and Related Dementias in Maine
Maine is Getting Old

Figure 1-2
Maine’s older population is projected to grow quickly between 2008 and 2020

Predicted change in the number of persons (in thousands):
- 0-14: +11.4
- 15-24: +11.7
- 25-34: -20.3
- 35-44: -11.6
- 45-54: +45.3
- 55-64: +20.4
- 65-74: +79.9
- 75-84: +3.0
- 85+: +77%

Predicted change as a percent of the 2008 population:
- 0-14: +5%
- 15-24: +8%
- 25-34: -12%
- 35-44: -6%
- 45-54: +25%
- 55-64: +30%
- 65-74: +11%
- 75-84: +30%
- 85+: +11%

Age Groups:
- 0-14
- 15-24
- 25-34
- 35-44
- 45-54
- 55-64
- 65-74
- 75-84
- 85+

Who Will Provide Care?

Figure 3-1
Maine's elderly dependency ratio
The Number of Persons of Working Age (20-64) for Each Person Age 65+

Although Maine's elderly dependency ratio held fairly steady from 1970 to 2005, it is projected to be in steady decline through 2020. While Maine had an estimated number of 4.2 working age (20-64) persons in 2005 for each person age 65-or-above, the ratio is projected to decline to just 2.7 working age persons in 2020 for each person age 65-or-above.

Contents of the State Plan

• Disease Background
• Public health and Safety Objectives
• Diagnosis and Treatment
• Home and Community-Based Services
• Facility-based LTC Services
• Financing LTC
• Education and Training
Diagnosis and Treatment: Goals of Maine’s State Plan

- Coordinate care across settings to improve recognition and management
- Expand PCMH Community Care Team model to provide coordinated care
- Promote screening within Primary Care
- Promote CME in diagnosis and treatment guidelines
Clinical Guideline:
“Comprehensive Roadmap” by John Campbell, MD

• Provides an expert overview of:
  – Screening and assessment of cognition and functional status
  – Differential diagnosis of dementia
  – Treatment of cognitive decline
  – Assessment and treatment of neuropsychiatric symptoms
  – General dementia care issues: driving, home safety, end of life care, caregiver support
Screening in Primary Care

• Routine screening often not recommended beyond questions regarding memory and executive functions (IADLS) as routine review of symptoms.
Alzheimer’s Assoc. Recommendations
Cordell CB et al. Alz Assoc 2013; 1-10

• ACA provides for Medicare reimbursement of AWV that includes screening for depression and dementia
• Alzheimer’s Association advisory group recommend incorporating screening into Medicare AWV:
  – CI missed in 27-81% of visits
  – Using structured tools improves detection (83% vs. 59%) Borson et al. 2006
Advisory Group Recommendations
Cordell CB et al. Alz Assoc 2013; 1-10

• 2-step process:
  – Screen with either Mini-Cog or GPCOG at AWV
  – Positive screen or clinical suspicion: reschedule for more evaluation with MoCA or SLUMS, plus labs, depression screen, neurologic exam or refer to dementia expert (geriatrician, geriatric psychiatrist, neurologist, neuropsychologist)
AGS Guidelines for Diagnosis

• Recommend screening only if patient or family member or clinician suspects a problem
• Use validated instrument
• If positive screen:
  – Document cognitive domains affected
  – Document functional impairment
  – Document time course and progression
  – R/O delirium and depression
The Overlapping Syndromes: The 3-D’s Often Co-Exist
History

• What has changed?
  – Functional status
  – Cognition
  – Behavior

• Gradual vs. abrupt onset?

• Progressive vs. stable?

• Hx of EtOH, depression, CVA/TIA, TBI, HTN, DM, sleepiness?
Functional Status

• ADLs
  – Dressing, bathing, toileting, hygiene, mobility and balance, motor skills

• IADLs
  – Finances, med management, driving, cooking, tools, hobbies
Emotions and Behavior

- Mood/Affect
- Thinking
- Sleep and wake
  - Insomnia, sleepiness, REM Behaviors
- Initiative/Motivation/Impulse Control
- Perceptions/Sensory
- Coordination and balance
Cognition

• Attention and concentration
• Speech and language
• Orientation, registration and recall
• Visuospatial
• Calculations
• Judgment, insight, reasoning
What’s Normal?

• What’s his name?
• What’s that called?
• Where did I park?
• Where did I put those?
• Did I tell you this already? Yes.
• Did I ask this already? Yes.
• Did you tell me this already? Yes.
What’s Not Normal

• Getting lost in a familiar place.
• Not being able to follow a directions/recipe
• Telling the same story more than twice without asking.
• Asking the same question more than twice.
• Losing interest in conversation, leaving home, hygiene, other people
Cognitive Exam

- Use standardized scale if possible:
  - Fast: Mini-Cog, Six-Item Screen, GPCOG
  - More sensitive and diagnostic: MMSE, MoCA, SLUMS

- No scale handy?
  - Good: Orientation, 3-word recall, clock
  - Better: add verbal fluency task, serial 3s or digit span and family/caregiver interview
Mini-Cog

- 3-word recall and clock draw test
- Pass/fail or 7-point scoring
- 2-4 minutes administration
- Validated across cultures
- Suitable for screening in primary care but not for diagnostic evaluation
Figure 1. The Mini-Cog scoring algorithm. The Mini-Cog uses a three-item recall test for memory and the intuitive clock-drawing test. The latter serves as an “informative distractor,” helping to clarify scores when the memory recall score is intermediate.

Mini-Cog Algorithm

Reference
Borson S. The mini-cog: a cognitive “vitals signs” measure for dementia screening in multi-lingual elderly
MOCA
(www.mocatest.org)
10-15 minutes
Educational bias
Sensitive enough for MCI
Diagnostic value
Available in many languages
In the public domain
MoCA vs. MMSE


• MoCA (≤ 26)
  – Sensitivity
    • MCI=90%
    • Mild AD=100%
  – Specificity
    • Mild AD=87%

• MMSE (≤ 26)
  – Sensitivity
    • MCI=18%
    • Mild AD=78%
  – Specificity
    • Mild AD=100%
VAMC
SLUMS Examination

Questions about this assessment tool? E-mail trgmg@slu.edu.

Name ____________________________ Age ____________________________
Is patient alert? ____________________________ Level of education ________

1. What day of the week is it?
2. What is the year?
3. What state are we in?
4. Please remember these five objects. I will ask you what they are later.
   Apple, Pen, Tie, House, Car
5. You have $100 and you go to the store and buy a dozen apples for $3 and a tricycle for $20.
   How much did you spend?
   How much do you have left?
6. Please name as many animals as you can in one minute.
   0-4 animals  5-9 animals 10-14 animals 15+ animals
7. What were the five objects I asked you to remember? I point for each one correct.
8. I am going to give you a series of numbers and I would like you to give them to me backwards.
   For example, if I say 42, you would say 24.
   87  98  649  95837
9. This is a clock face. Please put in the hour markers and the time at
   ten minutes to eleven o'clock.
   Hour markers okay
   Time correct
10. Please place an X in the triangle.
    Which of the above figures is largest?

11. I am going to tell you a story. Please listen carefully because afterwards, I'm going to ask you
    some questions about it.
    Jill was a very successful stockbroker. She made a lot of money on the stock market. She then met
    Jack, a devastatingly handsome man. She married him and had three children. They lived in Chicago.
    She then stopped work and stayed at home to bring up her children. When they were teenagers, she
    went back to work. She and Jack lived happily ever after.
    What was the female's name?
    What work did she do?
    When did she go back to work?
    What state did she live in?

TOTAL SCORE

Department of Veterans Affairs
SAINT LOUIS UNIVERSITY

Scoring

<table>
<thead>
<tr>
<th>High School Education</th>
<th>Less than High School Education</th>
</tr>
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<tbody>
<tr>
<td>27-30</td>
<td>Normal</td>
</tr>
<tr>
<td>21-26</td>
<td>MNCID*</td>
</tr>
<tr>
<td>1-20</td>
<td>Dementia</td>
</tr>
</tbody>
</table>

* Mild Neurocognitive Disorder

SH Tariq, NTurnosa, JT Chibnall, HM Perry III, and JF Morley. The Saint Louis University Mental Status
(SLUMS) Examination for Detecting Mild Cognitive Impairment and Dementia is more sensitive than the Mini-
Six Item Screen

• Time orientation (day, month, year) and 3-item recall
• Average administration time: 1 minute
• May not be as sen/spec as MMSE
• Add CDT and animal or letter fluency for an excellent ad hoc exam
Functional Status

• ADLs
• IADLs (instrumental or cognitive ADLs)
• Descriptive instruments
  – General Practitioner Assessment of Cognition (CPCOG)
  – Clinical Dementia Rating Scale
  – Functional Assessment Scale
• Patient assessment of memory, date and CDT (2-5 minutes)
• Family interview regarding function and symptoms (1-3 minutes)
• Use of direct assessment and both patient and caregiver interview of ADLs is unique and increases sensitivity
Patient name: ___________________________ Date: __________

**GPCOG Screening Test**

**Step 1: Patient Examination**

Unless specified, each question should only be asked once.

**Name and Address for subsequent recall test**

1. "I am going to give you a name and address. After I have said it, I want you to repeat it. Remember this name and address because I am going to ask you to tell it to me again in a few minutes: John Brown, 42 West Street, Kensington." (Allow a maximum of 4 attempts).

**Time Orientation**

2. What is the date? (exact only)

**Clock Drawing** – use blank page

3. Please mark in all the numbers to indicate the hours of a clock (correct spacing required)

4. Please mark in hands to show 10 minutes past eleven o'clock (11:10)

**Information**

5. Can you tell me something that happened in the news recently? (Recently = in the last week. If a general answer is given, e.g. "war", "lot of rain", ask for details. Only specific answer scores).

**Recall**

6. What was the name and address I asked you to remember

   John
   Brown
   42
   West (St)
   Kensington

(To get a total score, add the number of items answered correctly

Total correct (score out of 9)  /8

If patient scores 9, no significant cognitive impairment and further testing not necessary.
If patient scores 5-8, more information required. Proceed with Step 2, informant section.
If patient scores 0-4, cognitive impairment is indicated. Conduct standard investigations.

**Informant Interview**

Date: __________

Informant’s name: ___________________________

Informant’s relationship to patient, i.e. informant is the patient’s: __________

These six questions ask how the patient is compared to when s/he was well, say 5 – 10 years ago

**Compared to a few years ago:**

- Does the patient have more trouble remembering things that have happened recently than s/he used to?
- Does he or she have more trouble recalling conversations a few days later?
- When speaking, does the patient have more difficulty in finding the right word or tend to use the wrong words more often?
- Is the patient less able to manage money and financial affairs (e.g. paying bills, budgeting)?
- Is the patient less able to manage his or her medication independently?
- Does the patient need more assistance with transport (either private or public)? (If the patient has difficulties due only to physical problems, e.g. bad leg, tick 'no')

(To get a total score, add the number of items answered ‘no’, ‘don’t know’ or ‘N/A’)

Total score (out of 6)  6

If patient scores 0-3, cognitive impairment is indicated. Conduct standard investigations.
<table>
<thead>
<tr>
<th>CLINICAL DEMENTIA RATING (CDR)</th>
<th>0</th>
<th>0.5</th>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Impairment</td>
<td>None</td>
<td>Questionable</td>
<td>Mild</td>
<td>Moderate</td>
<td>Severe</td>
</tr>
<tr>
<td>Memory</td>
<td>No memory loss or slight inconsistent forgetfulness</td>
<td>Consistent slight forgetfulness, partial recollection of events; “benign” forgetfulness</td>
<td>Moderate memory loss; more marked for recent events; deficit interferes with everyday activities</td>
<td>Severe memory loss; only highly learned material retained; new material rapidly lost</td>
<td>Severe memory loss; only fragments remain</td>
</tr>
<tr>
<td>Orientation</td>
<td>Fully oriented</td>
<td>Fully oriented except for slight difficulty with time relationships</td>
<td>Moderate difficulty with time relationships; oriented for place at examination; may have geographic disorientation elsewhere</td>
<td>Severe difficulty with time relationships; usually disoriented to time, often to place</td>
<td>Oriented to person only</td>
</tr>
<tr>
<td>Judgment &amp; Problem Solving</td>
<td>Solves everyday problems &amp; handles business &amp; financial affairs well; judgment good in relation to past performance</td>
<td>Slight impairment in solving problems, similarities, and differences</td>
<td>Moderate difficulty in handling problems, similarities, and differences; social judgment usually maintained</td>
<td>Severely impaired in handling problems, similarities, and differences; social judgment usually impaired</td>
<td>Unable to make judgments or solve problems</td>
</tr>
<tr>
<td>Community Affairs</td>
<td>Independent function at usual level in job, shopping, volunteer and social groups</td>
<td>Slight impairment in these activities</td>
<td>Unable to function independently at these activities although may still be engaged in some; appears normal to casual inspection</td>
<td>No pretense of independent function outside home</td>
<td>Appears too ill to be taken to functions outside a family home</td>
</tr>
<tr>
<td>Home and Hobbies</td>
<td>Life at home, hobbies, and intellectual interests well maintained</td>
<td>Life at home, hobbies, and intellectual interests slightly impaired</td>
<td>Mild but definite impairment of function at home; more difficult chores abandoned; more complicated hobbies and interests abandoned</td>
<td>Only simple chores preserved; very restricted interests, poorly maintained</td>
<td>No significant function in home</td>
</tr>
<tr>
<td>Personal Care</td>
<td>Fully capable of self-care</td>
<td>Needs prompting</td>
<td>Requires assistance in dressing, hygiene, keeping of personal effects</td>
<td>Requires much help with personal care, frequent incontinence</td>
<td></td>
</tr>
</tbody>
</table>

Score only as decline from previous usual level due to cognitive loss, not impairment due to other factors.

Functional Activities Questionnaire

**Administration**

Ask informant to rate patient’s ability using the following scoring system:
- Dependent = 3
- Requires assistance = 2
- Has difficulty but does by self = 1
- Normal = 0
- Never did [the activity] but could do now = 0
- Never did and would have difficulty now = 1

<table>
<thead>
<tr>
<th>Activity</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Writing checks, paying bills, balancing checkbook</td>
<td></td>
</tr>
<tr>
<td>Assembling tax records, business affairs, or papers</td>
<td></td>
</tr>
<tr>
<td>Shopping alone for clothes, household necessities, or groceries</td>
<td></td>
</tr>
<tr>
<td>Playing a game of skill, working on a hobby</td>
<td></td>
</tr>
<tr>
<td>Heating water, making a cup of coffee, turning off stove after use</td>
<td></td>
</tr>
<tr>
<td>Preparing a balanced meal</td>
<td></td>
</tr>
<tr>
<td>Keeping track of current events</td>
<td></td>
</tr>
<tr>
<td>Paying attention to, understanding, discussing TV, book, magazine</td>
<td></td>
</tr>
<tr>
<td>Remembering appointments, family occasions, holidays, medications</td>
<td></td>
</tr>
<tr>
<td>Traveling out of neighborhood, driving, arranging to take buses</td>
<td></td>
</tr>
</tbody>
</table>

**TOTAL SCORE:**

**Evaluation**

Sum scores (range 0-30). Cutpoint of 9 (dependent in 3 or more activities) is recommended to indicate impaired function and possible cognitive impairment.
Neuropsychological Testing

• Referral to neuropsychologist for sensitive documentation of cortical function ("deeper biopsy").
• NOT diagnostic, although provides important cues to diagnosis and treatment.
• Not appropriate for acutely ill, >85 or more impaired patients.
Occupational Therapy

• Underutilized
• Provide functional assessment of IADLs
• Important both for diagnosis, treatment and safety planning.
• Driving? OT or driving school instructor.
Geriatric Depression Scale (GDS)  
Scoring Instructions

Instructions:  
Score 1 point for each bolded answer. A score of 5 or more suggests depression.

1. Are you basically satisfied with your life?  
   yes    no
2. Have you dropped many of your activities and interests?  
   yes    no
3. Do you feel that your life is empty?  
   yes    no
4. Do you often get bored?  
   yes    no
5. Are you in good spirits most of the time?  
   yes    no
6. Are you afraid that something bad is going to happen to you?  
   yes    no
7. Do you feel happy most of the time?  
   yes    no
8. Do you often feel helpless?  
   yes    no
9. Do you prefer to stay at home, rather than going out and doing things?  
   yes    no
10. Do you feel that you have more problems with memory than most?  
    yes    no
11. Do you think it is wonderful to be alive now?  
    yes    no
12. Do you feel worthless the way you are now?  
    yes    no
13. Do you feel full of energy?  
    yes    no
14. Do you feel that your situation is hopeless?  
    yes    no
15. Do you think that most people are better off than you are?  
    yes    no

A score of ≥ 5 suggests depression  
Total Score

Ref. Yes average: The use of Rating Depression Scale in the Elderly in Foster (21): Clinical Memory Assessment of Older Adults, American Psychological Association, 1986
The Confusion Assessment Method (CAM) Diagnostic Algorithm

**Feature 1: Acute Onset and Fluctuating Course**
This feature is usually obtained from a family member or nurse and is shown by positive responses to the following questions: Is there evidence of an acute change in mental status from the patient’s baseline? Did the (abnormal) behavior fluctuate during the day, that is, tend to come and go, or increase and decrease in severity?

**Feature 2: Inattention**
This feature is shown by a positive response to the following question: Did the patient have difficulty focusing attention, for example, being easily distractible, or having difficulty keeping track of what was being said?

**Feature 3: Disorganized thinking**
This feature is shown by a positive response to the following question: Was the patient’s thinking disorganized or incoherent, such as rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject?

**Feature 4: Altered Level of consciousness**
This feature is shown by any answer other than “alert” to the following question: Overall, how would you rate this patient’s level of consciousness? (alert [normal]), vigilant [hyperalert], lethargic [drowsy, easily aroused], stupor [difficult to arouse], or coma [unarousable])

The diagnosis of delirium by CAM requires the presence of features 1 and 2 and either 3 or 4.

Assess sleepiness by speaking with family, asking key questions and referring for OSA rule-out if ESS ≥ 10.

Epworth Sleepiness Scale

Name: ____________________________  Today’s date: __________________

Your age (Yrs): _____________  Your sex (Male = M, Female = F): ________

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired?

This refers to your usual way of life in recent times.

Even if you haven’t done some of these things recently try to work out how they would have affected you.

Use the following scale to choose the most appropriate number for each situation:

0 = would never doze
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

It is important that you answer each question as best you can.

<table>
<thead>
<tr>
<th>Situation</th>
<th>Chance of Dozing (0-3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sitting and reading</td>
<td></td>
</tr>
<tr>
<td>Watching TV</td>
<td></td>
</tr>
<tr>
<td>Sitting, inactive in a public place (e.g. a theatre or a meeting)</td>
<td></td>
</tr>
<tr>
<td>As a passenger in a car for an hour without a break</td>
<td></td>
</tr>
<tr>
<td>Lying down to rest in the afternoon when circumstances permit</td>
<td></td>
</tr>
<tr>
<td>Sitting and talking to someone</td>
<td></td>
</tr>
<tr>
<td>Sitting quietly after a lunch without alcohol</td>
<td></td>
</tr>
<tr>
<td>In a car, while stopped for a few minutes in the traffic</td>
<td></td>
</tr>
</tbody>
</table>

THANK YOU FOR YOUR COOPERATION
Natural History of Cognitive Change

Normal Aging

Noticeable symptoms

Diagnosis

Dementia
Progression of Memory Decline

- **Age-associated memory impairment**
  - Primarily episodic memory and noun retrieval
  - Not disabling or progressive

- **Mild cognitive impairment**
  - Significant episodic memory impairment
  - Not disabling but does progress

- **Dementia**
  - Disabling memory or executive dysfunction
Mild Cognitive Impairment
Peterson R et al. Arch Neurol 1999; 56:303-308

- Subjective memory complaint
- Normal ADLs
- Normal general cognition
- Abnormal memory for age (lowest 10%)
- At high risk for dementia
  - Initial report of conversion rate 12-15% per year vs. 1-2% for those w/normal recall
  - Subsequent cohorts convert at lower rates
# Cognitive Changes

<table>
<thead>
<tr>
<th></th>
<th>Aging</th>
<th>MCI</th>
<th>Dementia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recall and learning</td>
<td>Intact</td>
<td>Impaired</td>
<td>Impaired</td>
</tr>
<tr>
<td>Executive</td>
<td>Intact</td>
<td>Intact</td>
<td>Dependent</td>
</tr>
<tr>
<td>Reasoning</td>
<td>Abstract</td>
<td>Abstract</td>
<td>Concrete</td>
</tr>
<tr>
<td>Navigation</td>
<td>Intact</td>
<td>Transition</td>
<td>Impaired</td>
</tr>
<tr>
<td>Speech</td>
<td>Mild WFD</td>
<td>Transition</td>
<td>Anomia</td>
</tr>
<tr>
<td>Behavior</td>
<td>Normal</td>
<td>Changing</td>
<td>Changed</td>
</tr>
</tbody>
</table>

UNE GEC Dementia Conference
When Does Dementia Start?
Dementia Diagnosis:
McKhann GM et al. Alz & Dem 2011; 7:263-269

• Cognitive problem interferes w/ function
• Decline from previous level of function
• Not due to delirium or mental illness
• Impairment is validated by testing
• Impairment is present in ≥ 2 domains:
  – New learning and memory, executive, visuospatial, language, behavior
Causes of Dementia

• **Primary Dementia:** gradual, progressive
  – Alzheimer’s disease
  – Multi-infarct vascular dementia
  – Dementia with Lewy Bodies
  – Parkinson’s Disease Dementia
  – Frontotemporal Dementia

• **Secondary dementia:** acute or subacute:
  – Traumatic Brain Injury
  – CNS Infections
  – Alcohol-related (Korsakoff’s)

• **“Reversible” Causes**
  – Medical and psychiatric causes
Reversible Causes

- Metabolic
- Endocrine
- Alcoholism
- Drug toxicity
- Nutritional
- Vasculitis
- Brain tumor
- Subdural hematoma
- Hydrocephalus
- Psychiatric
- Infection
Labs and Imaging

- Labs: CBC, CMP, B12/folate, TSH
- Imaging: CT in most, especially with motor or gait findings unless very old and dementing > 3 years
- MRI if need to assess white matter
- PET/SPECT/LP if FTD suspected
- EEG if with rapid onset, myoclonus
AD Diagnosis:
McKhann GM et al. Alz & Dem 2011; 7:263-269

• Probable AD: dementia, insidious onset, worsening with time, either amnestic or nonamnestic presentation, no other disease accounts for findings
  – Supportive evidence (genetic, imaging and CSF biomarkers) add “increased level of certainty”
• “Possible” and “mixed” types remain
Figure 1. Positron emission tomography (PET) images from a 76-year-old patient with dementia. Fluorodeoxyglucose (FDG) and Pittsburgh Compound B (PiB) scans were performed within 3 years of each other. A and B, Positron emission tomography images from coregistered transaxial FDG (A) and PiB (B) PET images at the level of the striatum. Red areas represent higher metabolist of FDG and higher PiB retention. There is diffuse hypometabolism and PiB retention in frontal and temporal cortices. Regions with relatively normal metabolism, such as striata and medial occipital cortex, demonstrate relatively less PiB retention. Subject’s left is at right. Evidence of the known subdural effusion occurring in the interval between FDG and PiB imaging is seen in the right frontal convexity of the PiB image. C and D, Coregistered left parasagittal FDG (C) and PiB (D) images at level of the insula. In this view, PiB retention is greatest in the inferior temporal gyrus, and there is relative sparing of the primary sensorimotor cortex where FDG uptake is highest.
### Clinical Features At Diagnosis

<table>
<thead>
<tr>
<th></th>
<th>AD</th>
<th>VaD</th>
<th>DLB</th>
<th>FTD</th>
<th>NPH</th>
<th>MDD</th>
<th>Delirium</th>
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</thead>
<tbody>
<tr>
<td><strong>age</strong></td>
<td>older</td>
<td>older</td>
<td>older</td>
<td>younger</td>
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<td><strong>memory</strong></td>
<td>poor</td>
<td>slow</td>
<td>slow</td>
<td>variable</td>
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<td>poor</td>
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<td>recent</td>
</tr>
<tr>
<td><strong>executive</strong></td>
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UNE CEC Dementia Conference
Outline of Dementia Care:
Early Stages

• Pre-diagnosis: Assessment, counseling and reduction of risk factors
• Mild dementia: Discussion of diagnosis and prognosis, driving, supervision and support, quality of life activities, cognitive maintenance, medications
Mindful Practices

• Meditation, adequate sleep, exercise and stress reduction may help many of your middle-aged patients with memory complaints (“ADD by habit”).

• Frontal activation compensates (up to a point) for age-related declines in memory.
Effects of Stress on Neurons

FIGURE 3. Exposure of rats to 6 weeks of unpredictable chronic mild stress (CMS; pink) induces depressive-like behaviors (e.g., anhedonia, learned helplessness) and multiple detrimental effects in the hippocampus and medial prefrontal cortex (mPFC), including decreases in neurogenesis, dendritic length, and synaptic density, as compared with control conditions (white). Both behavioral and structural deficits can be reversed by administration of antidepressants (Tx) during the final 2 weeks of CMS (CMS + Tx; blue). Schematic representations of mPFC neurons under the three conditions illustrate average dendritic changes. The authors of this study noted that these results were independent of neurogenesis, suggesting that restoration of normal dendritic length and synaptic density underlie behavioral recovery.
Cholinesterase Inhibitors

- AD: Start and maintain for at least 1 yr.
  - expect improvement in some, slowed decline in most, mild psychotropic effect
- LBD/PDD (rivastigmine): Expect better response and moderate psychotropic effect (VH, delusions)
- VaD: Off label, less response (?) but often mixed with AD
- FTD, EtOH, TBI: No benefit
Memantine (Namenda)

• Typically added after several months on cholinesterase inhibitory (ChEI)
• Complementary mechanism to ChEI
• Very modest benefit when used alone
• Well tolerated
• FDA approved for moderate to severe AD
Cognitive Rehabilitation

• Promoting diet, exercise and cognitive activity interventions are not likely to help memory or cognition once dementia develops, but these efforts can provide hope.

• Various psychosocial interventions can improve mood, appetite, sleep, morale and quality of life.
Providing Information

- Diagnosis and prognosis
- Community resources for day programs and long term care
- Home safety (falls, fires, wandering)
- Driving evaluation
- Support groups and classes
- Alzheimer’s Association, Alzheimer’s Foundation of America, Family Caregiver Alliance
He comes every day to eat lunch and sit with her in the sun room. Sometimes he reads letters out loud from their children or friends; sometimes he reads the paper as she sleeps. One day the staff makes her favorite cake to celebrate their anniversary, and he tells how, to buy her ring, he worked months of overtime at the factory, so she thought he was seeing someone else. "As if I would look at other women when I have Pearl," he says, shaking his head. She begins to cry and tells him, "You're sweet, but I miss my husband." He pats her hand. "I know," he says, "It's all right. Try some cake."
Resources

• Alzheimer’s Association
  – www.alz.org and www.alz.org/maine

• Alzheimer’s Disease Education and Referral Center
  – www.nia.nih.gov/Alzheimer’s

• Family Caregiver Alliance
  – www.caregiver.org

• Alzheimer’s Foundation of America
  – http://www.alzfdn.org

• Nameste End of Life Dementia Care
  – http://namastecare.com
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