

Cognitive Impairment in the Elderly – Recognition, Diagnosis and Management

For full Guideline please go to website: <http://www.bcguidelines.ca>

Step	Details																		
<p>New presentation of confusion:.....</p> <p>Rule out acute or treatable causes, particularly delirium and depression</p>	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 50%;">DELIRIUM</th> <th style="width: 50%;">DEPRESSION</th> </tr> </thead> <tbody> <tr> <td> <ul style="list-style-type: none"> • Abrupt onset • Fluctuating consciousness, or inattention, +/- hallucinations, hyper- or hypoactive • Consider assessment using <i>Confusion of Assessment Method</i> • Look for causes such as medications, sepsis, hepatic encephalopathy, hypoxia/hypercarbia, etc. </td> <td> <ul style="list-style-type: none"> • Psychomotor retardation or agitation • Disturbed sleep and appetite withdrawal, guilt, self-recrimination, somatic preoccupation • Mood-congruent delusions, diurnal variation symptoms • Consider assessment with <i>Geriatric Depression Scale</i> </td> </tr> <tr> <td colspan="2"> <p>If the condition is either not present or has been addressed and cognitive impairment is still present, then suspect dementia and proceed with history, etc. (below).</p> </td> </tr> </tbody> </table>	DELIRIUM	DEPRESSION	<ul style="list-style-type: none"> • Abrupt onset • Fluctuating consciousness, or inattention, +/- hallucinations, hyper- or hypoactive • Consider assessment using <i>Confusion of Assessment Method</i> • Look for causes such as medications, sepsis, hepatic encephalopathy, hypoxia/hypercarbia, etc. 	<ul style="list-style-type: none"> • Psychomotor retardation or agitation • Disturbed sleep and appetite withdrawal, guilt, self-recrimination, somatic preoccupation • Mood-congruent delusions, diurnal variation symptoms • Consider assessment with <i>Geriatric Depression Scale</i> 	<p>If the condition is either not present or has been addressed and cognitive impairment is still present, then suspect dementia and proceed with history, etc. (below).</p>													
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Assess against the diagnostic criteria
for dementia

Criteria for dementia includes all of:

- Objective and subjective evidence of memory impairment (may not be identified for fronto-temporal dementias in early stages)
- At least one other area of cognitive dysfunction (one of aphasia, apraxia, agnosia, executive function)
- Deficits causing significant impairment in social or occupational functioning
- Decline from previous functioning with no obvious medical, neurologic or psychiatric explanation for cognitive impairment

If all these criteria are NOT met, consider MCI which is diagnosed as a result of:

- Subjective complaint of memory loss and objective impairment of memory with other cognitive abilities preserved
- Day-to-day functioning preserved
- No other obvious medical, neurological or psychiatric explanation for memory problems

If MCI criteria ARE MET, may progress to dementia – follow up every six months, counsel as necessary.

If MCI criteria ARE NOT MET, reassure and re-examine if condition worsens.

If criteria for dementia are met, determine dementia subtype (often mixed Alzheimer’s disease [AD] and vascular dementia [VaD]).....

<u>Probable AD</u>	<u>VaD</u>	<u>Dementia with Lewy Bodies (DLB)</u>	<u>Fronto-temporal Dementia</u>	<u>Other, e.g.,</u>
<ul style="list-style-type: none"> • Gradual progression • Negative CNS exam • No early gait involvement 	<ul style="list-style-type: none"> • Abrupt onset and stepwise decline • Temporal connection between dementia and cerebrovascular disease • Cerebrovascular disease by focal signs and imaging 	<ul style="list-style-type: none"> • Dementia present • At least two of: <ul style="list-style-type: none"> - Marked fluctuation in cognition - Visual hallucinations - Parkinsonism 	<ul style="list-style-type: none"> • Insidious onset and gradual progression • Early impairment in control of personal, social and interpersonal conduct • Emotional blunting, loss of insight • Language deficits 	<ul style="list-style-type: none"> • Normal pressure hydrocephalus • Dementia of late-stage Parkinson’s Disease or HIV • Dementia associated with alcohol dependence

Provide disclosure and counselling, considering each case individually

- Consider timing/extent of information provided and patient/caregiver readiness for coping with the diagnosis
- Use open-ended questions, e.g., “What do you think is causing the change in your memory and thinking?”
- Establish a relationship – patient/caregiver expertise/input is valued and integral to goal setting and care planning
- Discuss anticipated prognosis in a sensitive manner and indicate your commitment to providing follow-up care
- Provide written information about dementia care and information around support and resources as appropriate (See *Patient/Caregiver Guide*)

Develop an on-going care plan/clinical action plan.....

- General Non-Pharmacologic Interventions**
- Identify and modify potential safety issues with patient and caregiver, e.g., driving, nutrition, medication management, kitchen safety, hygiene, wandering
 - Support patient functioning and decision making to maximize independence, e.g., socialization, financial and legal planning, neglect and abuse, end of life care
 - Treat co-morbid conditions, e.g., hypertension, depression, delirium, diabetes
 - Refer patient and caregiver to Home and Community Care for adult day care, home care, respite care, assisted living, long term care services as appropriate
 - Refer patient and caregiver to the Alzheimer Society of BC
 - Follow-up at least every six months

General Pharmacologic Interventions

- Discuss patient/caregiver goals and expectations for treatment, e.g., adverse effects, limitations and costs, versus potential benefits
- Determine if the patient is a suitable candidate for medications, i.e., consider the presence of serious co-morbidities and reduced life expectancy with dementia
- Rationalize the use of all medications and simplify drug regimens wherever possible
- Facilitate strategies to enable a patient to take medications as prescribed

Behavioural and Psychological Symptoms of Dementia (BPSD)

- Establish an understanding of the origins of the BPSD before developing a management plan
- Environmental and behavioural modifications are recommended as first line management
- Pharmacological interventions (atypical antipsychotic agents as first line of pharmacotherapy with cautions around increased risk of CV events, stroke, and mortality) for BPSD are only recommended when:
 - Alternate therapies are inadequate on their own
 - There is an identifiable risk of harm to the patient and others
 - Symptoms are severe enough to cause suffering and distress
- Use of antipsychotics in patients with DLB is associated with an increased risk of extrapyramidal side effects and should be used with extreme caution
- Once symptoms are controlled, regularly evaluate the need for continuing treatment and consider withdrawal of medication with close monitoring for emerging symptoms

Pharmacotherapy Points

- Not recommended for primary treatment: ginkgo biloba, vitamin E, NSAIDs, estrogen, statins
- Treatment notes about dementia subtypes:
 - VaD or mixed dementia: Treat vascular risk factors. Possible role for acetylcholinesterase inhibitors (AChEIs)
 - Mixed dementias: Treat both pathologies
 - DLB: Many patients respond to AChEIs
- If a trial of pharmacotherapy for AD is initiated using AChEIs [donepezil (Aricept®), rivastigmine (Exelon®), galantamine (Reminyl®)] or using memantine (Ebixa®):
 - Develop, implement and document a follow-up plan
 - Consider asking caregivers to keep a written record of personal impressions/historical data
 - After initiation of the medication, the initial visit schedule will be determined by the titration schedule (i.e. every 2-6 weeks until target dose reached). A review for side effects should be carried out within the first 3 months, usually at the titration visit(s)
 - At six months, ensure that ongoing therapy is based on evidence of effectiveness for an individual patient, especially whether patient and/or caregiver goals are being met
 - Every six months, monitor for changes from baseline in stabilization or deterioration of cognition, function, behaviour, and global assessment of change using a tool such as the SMMSE or the MoCA

Referral to a Dementia Clinic, Geriatrician, Geriatric Psychiatrist, Mental Health Team, Neurologist, etc.

- Course of dementia is atypical and diagnosis is uncertain
- Lack of response to standard treatment
- Difficult behavioural problems and/or safety is in question
- Adult guardianship and competency issues beyond what is manageable in a primary care setting
- Prominent mood disorder
- Recent unexplained cognitive decline

