Cognition and Dementia

Part I

Matt Schlough MD
Assistant Professor, UNM Dept of Family and Community Medicine
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Goals and Objectives

Goal: Introduce topic of Dementia and garner basic skills for evaluation and treatment in primary care

Objectives:

Part I

- Identify who and how to screen for cognitive impairments
- Differentiate between normal aging, mild cognitive impairment, and dementia
- Recognize common dementia subtypes

Part II

- Summarize current pharmacologic treatment options for dementia and behavioral disturbances
- Describe the needs for caregiver support, housing, advanced care planning, and Hospice

Mrs Smith

78 year old Female
Cc: left knee pain

PMHx:

HTN
Hx of CVA, no residual deficits
Insomnia
Knee OA
Osteopenia
Prediabetes
Urinary incontinence

Medications:

ASA 81mg
Amlodipine 10mg daily
Atorvastatin 40mg daily
Diclofenac gel 1%
HCTZ 25mg daily
Losartan 100mg daily
Metoprolol Succinate 100mg daily
Oxybutynin 5mg TID

CC: “My left knee hurts”

VS: AF, BP 174/98, HR 76, RR 14, 96%

HPI:

- Hurts when I walk on it
- No pain at rest
- What have you done for this?
    - “I haven’t done anything for it”

Chart review:

- Saw PCP for same issue 3 wks ago
- Knee injection 2 months ago
- Frequent visits for this issue
- Xrays 2018: b/l moderate DJD

What are some f/u questions for Mrs Smith?

1. How did the injections help 2 months ago
2. Do you have any trouble with your meds
3. Do you need any help at home

VS

1. When was the last time you saw your PCP
2. Do you take any medications
3. What's your living situation

Real quick screens:

1. Whats todays date
2. Who's the president
3. If I give you $10 and you buy two apples each $3, how much money do you have left?

Yikes. (you've got 5 mins left)

Get further information

- Medication refill history
- Permission to contact family member

What next?

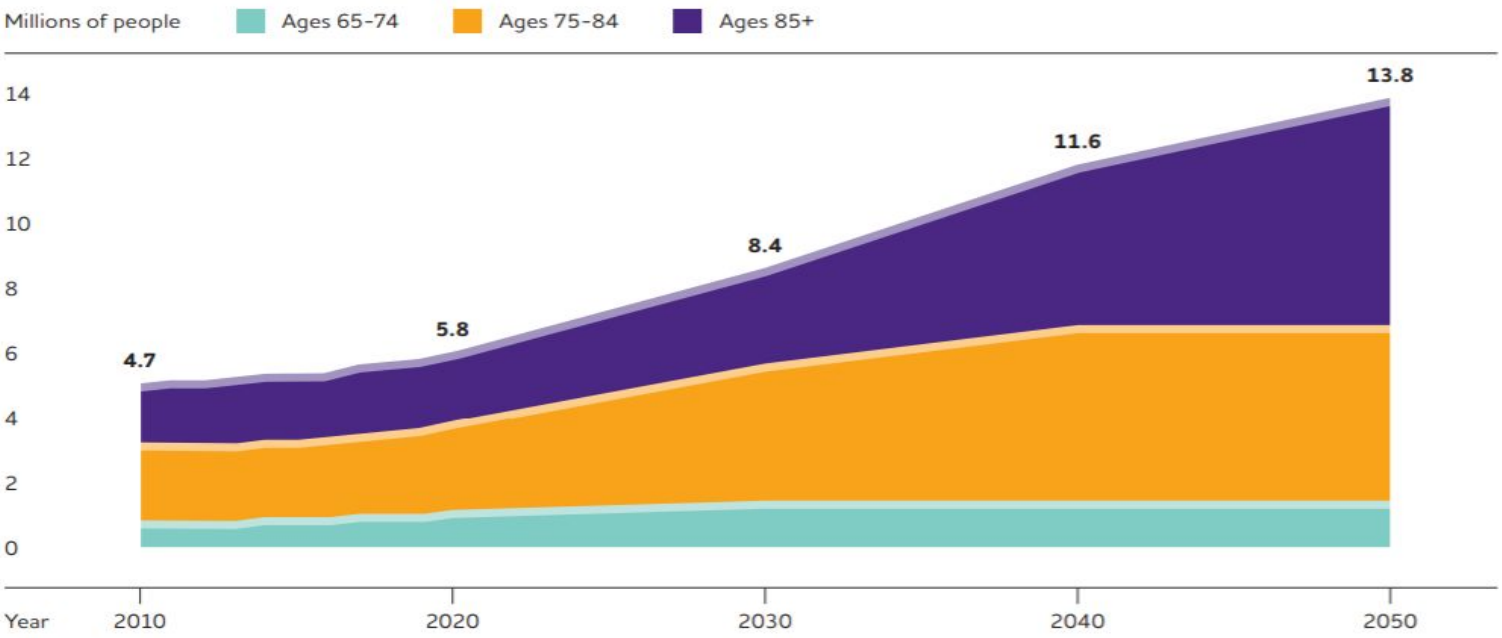
- What's your responsibility?
- Your patient vs acute visit
- Document cognitive concern on problem list
- Do you take this on or refer?
- Situations prompting further evaluation
  - Clinician suspicion (medication mgmt, ER visits, etc)
  - Family or patient concern
  - Abnormal screening on AWV (vs USPSTF recommendations [1])

How common is this ? [2]

- One in 10 people (10%) age 65 and older has Alzheimer’s dementia.
  - By age
    - 65-74 = 3%
    - 75-84 = 17%
    - >85 yrs = 32%
- One in 3 Seniors dies with Alzheimer's or another dementia
- Alzheimer's is 6th leading cause of death in US (more than breast and prostate CA combined)

FIGURE 5 [2]

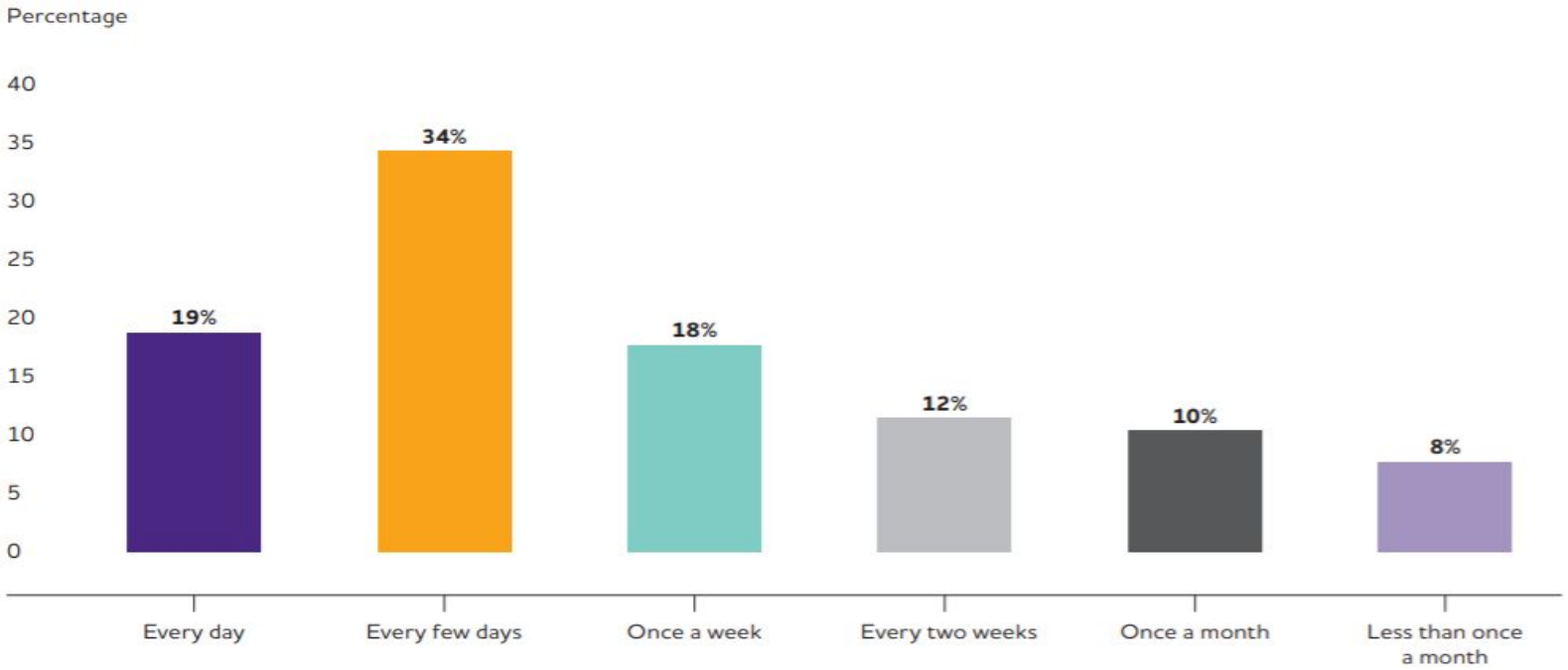
Projected Number of People Age 65 and Older (Total and by Age) in the U.S. Population with Alzheimer's Dementia, 2010 to 2050



Created from data from Hebert et al.[A9,62]

FIGURE 17 [2]

Frequency of Primary Care Physicians Receiving Questions about Alzheimer's or Other Dementias from Patients Age 65 and Older

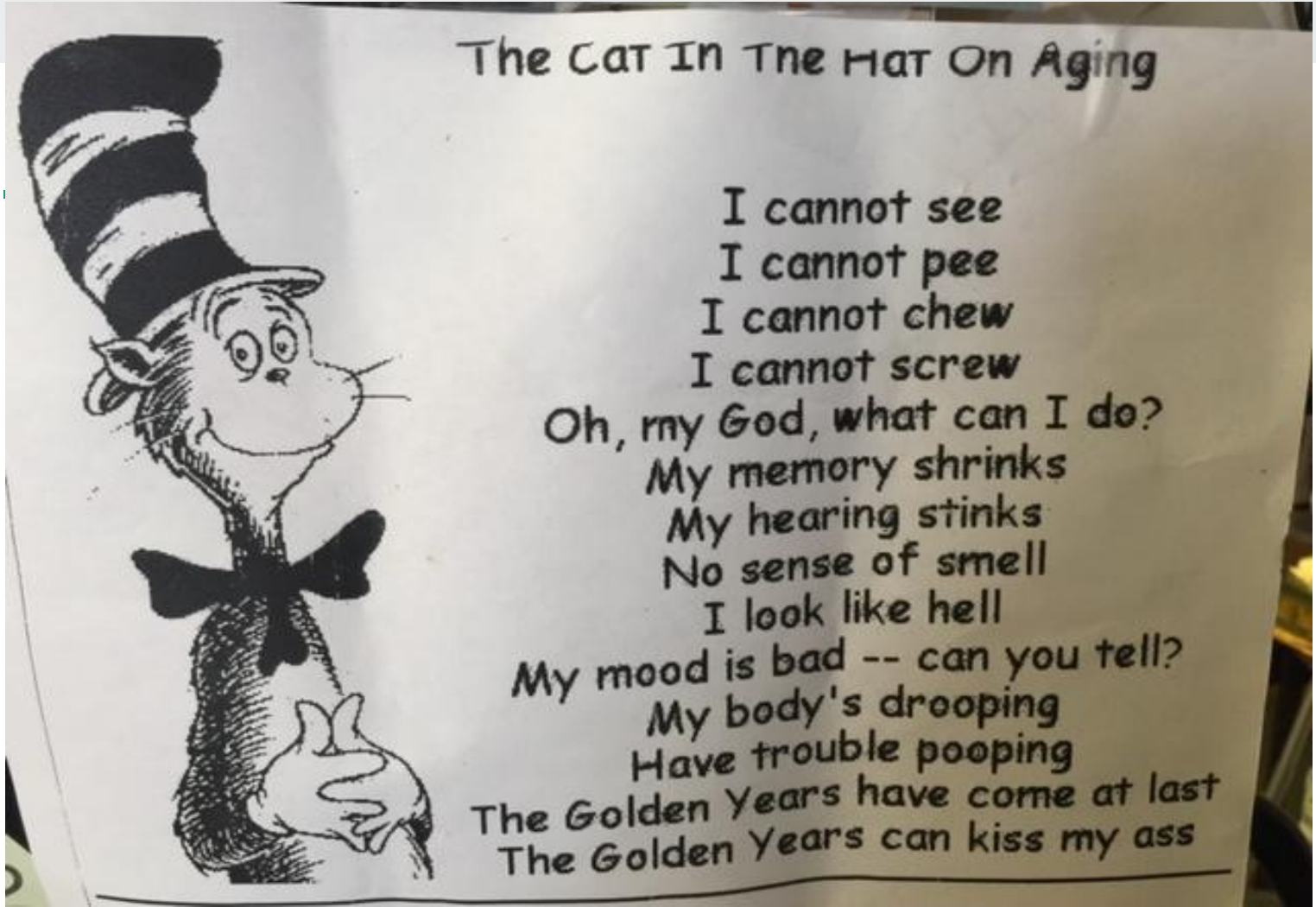


Created from data from the Alzheimer's Association Primary Care Physician Dementia Training Survey.[A20]

In Primary Care

Looking at >200,000 Medicare beneficiaries [3]:

- 85% of initial diagnoses made by non-specialist
- 1 year later <25% had seen a specialist
- At 5 yrs, it was 36%


The Cat In The Hat On Aging
I cannot see
I cannot pee
I cannot chew
I cannot screw
Oh, my God, what can I do?
My memory shrinks
My hearing stinks
No sense of smell
I look like hell
My mood is bad -- can you tell?
My body's drooping
Have trouble pooping
The Golden Years have come at last
The Golden Years can kiss my ass

Cognitive Evaluation [4]

- History
- Exam
- Labs/Imaging

Cognitive Evaluation - History

Key takeaways

- Get 3rd party corroboration!
- Duration (several years, several weeks), gradually progressive, waxing and waning
- Get concrete examples (missed appointments, repetitive conversations, etc)
- Vascular Hx (CVA, PAD, etc)
- Psychiatric Hx
- TBI Hx
- Alcohol, Alcohol, Alcohol
- Medications
- Hx of falls, gait issues, tremors, hallucinations
- Functional assessment (bADLs, i ADLs)

Cognitive Evaluation - Exam

Physical Exam

- Hearing, Hearing, Hearing
- Gait and Neuro

Cognitive Testing

- Basic Screening - MiniCog (free), GPCOG (free)
- More in depth - MMSE ($), MOCA ($), SLUMS (free)
- Very in depth - Neuropsych testing

Functional Evaluation - bADLs, iADLs

+/- Mood - PHQ9 or Geriatric Depression Scale

Cognitive Evaluation - Labs/Imaging [5]

Labs

- Everyone - CBC, CMP, TSH, B12
- Think about - HIV, RPR

Imaging

- General trend for MRI > CT. No contrast.
- What about FDG- PET, amyloid PET, SPECT scans?

PRIMARY CARE BARRIERS

How can you practically do this evaluation?

1. 50 minute appt if you have availability
2. If not
    a. Break it into History appt and a Cognitive exam appt
    b. Outsource the Cognitive exam (Soc Work, Behav health, MA)
    c. Have family member do ADL and dementia severity forms outside visit
3. Consider remote family member conference call in to physical visit
4. What if the patient is resistant to any further evaluation?

Return to Mrs Smith

History

- Gradual progression
- Hx of CVA, medications (oxybutynin, turns out taking 2 tabs benadryl every night)
- Functional - Not leaving house as much, still driving, medication mgmt, a few missed bills

Exam

- Physical exam is unremarkable
- SLUMS 17/30

Labs/Imaging

- Labs normal
- MRI - “old lacunar infarct, age consistent volume loss, white matter changes consistent with chronic microvascular disease”

NORMAL AGING	ALZHEIMER'S DISEASE
• Making a bad decision once in a while	• Making poor judgments and decisions a lot of the time
• Missing a monthly payment	• Problems taking care of monthly bills
• Forgetting which day it is and remembering later	• Losing track of the date or time of year
• Sometimes forgetting which word to use	• Trouble having a conversation
• Losing things from time to time	• Misplacing things often and being unable to find them

Making the Diagnosis

Normal -> Mild Cognitive Impairment [7] -> Dementia [8]

MCI

1. Cognitive concern
2. Impaired testing
3. *Preservation of Function*
4. Not otherwise explained

Dementia

1. Cognitive impairment
   a. History and cognitive testing in 2 domains
2. Progressive
3. Leading to Functional Impairment
4. Not otherwise explained

Red flags- rapid onset, motor symptoms

YOU HAVE TIME !!!!!!

How severe is it?

- Dementia Severity Rating Scale
- Neuropsychiatric Index
- FAST staging

Dementia (Major Neurocognitive Disorder)

Subtypes [2]

- Alzheimer's Disease - 60-80% of cases.
- Vascular Dementia - classically stepwise decline, in practice more based on history/risk factors
- Dementia with Lewy Body - sleep disturbance, visual hallucinations, parkinsonism
- Frontotemporal Dementia - personality changes and language comprehension, typically younger
    - subtypes: FTLD, primary progressive aphasia, progressive supranuclear palsy
- Parkinson's Dementia - onset generally following Parkinson's symptoms
- OTHER - HIV, alcohol, normal pressure hydrocephalus, thyroid, b12, prion disease, Huntington's

Conclusions

- Commonly unrecognized
- Document concern in problem list
- Going to be prevalent in your primary care practice
- Develop strategies to try to begin addressing in your practice
- Try to standardize approach with a few tools
- Involve family members or loved ones

Resources

AAFP Cognitive Care Tool Kit

Washington state Clinical Provider Practice Tool

NIH Resources

Basic ADLs form

Instrumental ADLs form

Geriatric Depression Scale

Short cognitive screens: GPCOG, MiniCog

Longer cognitive tests: SLUMS, MOCA, MMSE

Dementia severity: Dementia Severity Scale (DSRS), Neuropsychiatric Index, FAST staging

References

1 *JAMA.* 2020;323(8):757-763. doi:10.1001/jama.2020.0435. **Screening for Cognitive Impairment in Older Adults** US Preventive Services Task Force Recommendation Statement

2 Alzheimer's Association. 2020 Alzheimer's Disease Facts and Figures. Alzheimers Dement 2020;16(3):391+

3 Drabo EF, Barthold D, Joyce G, Ferido P, Chui HC, Zissimopoulos J. Longitudinal analysis of dementia diagnosis and specialty care among racially diverse Medicare beneficiaries. Alzheimers Dement 2019;15:1402-11

4 https://www.alz.org/aaic/downloads2018/sun-clinical-practice-guidelines.pdf

5 https://www.alz.org/national/documents/LabEvaluDementiaTable.pdf

6 https://www.nia.nih.gov/health/assessing-cognitive-impairment-older-patients

7 Albert et al.. The diagnosis of mild cognitive impairment due to Alzheimer's disease: Recommendations from the National Institute on Aging-Alzheimer's Association workgroups on diagnostic guidelines for Alzheimer's disease. Alzheimers Dement. 2011 May; 7(3): 270–279.

8 McKhann et al.The diagnosis of dementia due to Alzheimer's disease: recommendations from the National Institute on Aging-Alzheimer's Association workgroups on diagnostic guidelines for Alzheimer's disease. Alzheimers Dement. 2011 May;7(3):263-9. doi: 10.1016/j.jalz.2011.03.005. Epub 2011 Apr 21.