Dementia - assessment - DRAFT

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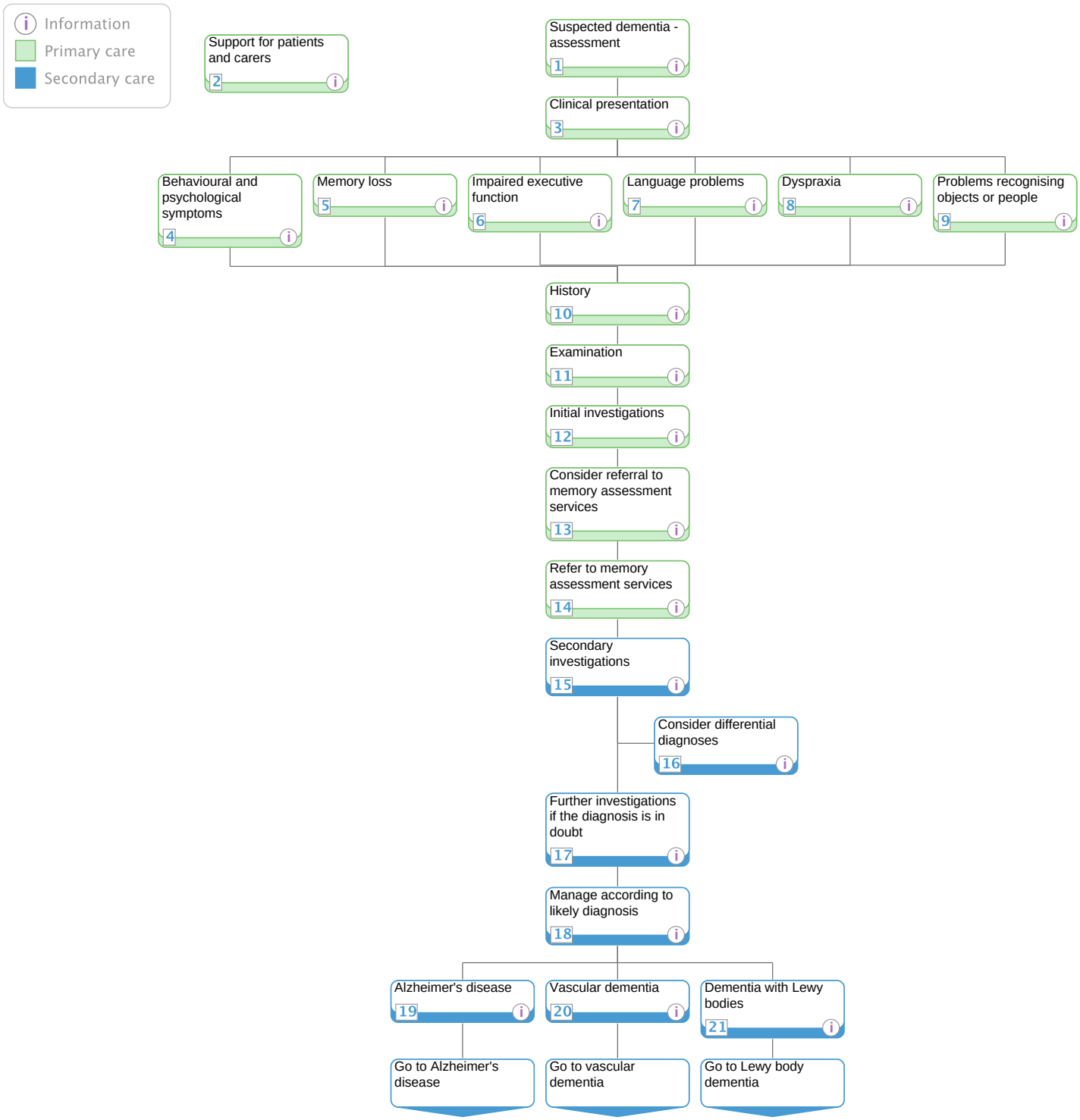

Locally reviewed: Due for review: Printed on: 03-Aug-2010

IMPORTANT NOTE
Locally reviewed refers to the date of completion of the most recent review process for a pathway. All pathways are reviewed regularly every twelve months, and on an ad hoc basis if required. Due for review refers to the date after which the pathway on this page is no longer valid for use. Pathways should be reviewed before the due for review date is reached.

Dementia - assessment - DRAFT

1 Suspected dementia - assessment

Quick info:

Scope:

- diagnosis of Alzheimer's disease, vascular dementia and dementia with Lewy bodies
- information on treatment to reduce cognitive, behavioural and psychological symptoms in adults

Out of scope:

- frontotemporal dementia (Pick's disease) and dementia due to other medical causes (eg. HIV, Parkinson's disease, head trauma) or substance abuse

Definition:

- dementia is a progressive and largely irreversible clinical syndrome that is characterised by a widespread impairment of mental function
- there is a decline in activities of daily living and impairment in social function
- there are different causes of dementia, the most common three being:
  - Alzheimer's disease:
    - characterised by gradual and progressive onset of cognitive impairment, including memory loss and leading to a decline in daily and social function
  - vascular dementia (due to small vessel disease or multiple infarcts and often co-occurring with other vascular risk factors)
  - dementia with Lewy bodies is characterised by:
    - impairment of executive function
    - parkinsonism
    - visuospatial dysfunction
    - fluctuation
    - visual hallucinations

Prevalence:

- dementia is principally a disease of the elderly affecting:
  - 6% of people over age 65 years
  - 30% of people over age 90 years
- Alzheimer's disease and vascular dementia are the most common forms of dementia
- Alzheimer's disease accounts for more than 60-65% of the cases of dementia
- dementia with Lewy bodies accounts for up to 15% of dementia in the elderly

Risk factors:

- causes of Alzheimer's and dementia with Lewy bodies are not fully understood
- risk factors for Alzheimer's disease include:
  - genetic
  - older age
  - female gender
  - head trauma
  - hypertension
  - cholesterol
  - obesity
  - diabetes
  - atrial fibrillation
  - smoking
  - past history of depression
- vascular dementia is related to stroke and cardiovascular risk factors (older age, smoking, diabetes, hyperlipidaemia, hypertension)

Prognosis:

- Alzheimer's disease is often difficult to diagnose in the early stages due to an insidious onset followed by a progressive decline in cerebral function
- people with Alzheimer's disease have an average life expectancy after diagnosis of approximately 8-10 years
- vascular dementia often follows a stepwise, fluctuating course although the onset can be gradual in those with subcortical ischaemic vascular dementia
- most people with dementia will eventually require assistance to perform even simple tasks

References:

American Psychiatric Association (APA). Practice guideline for the treatment of patients with Alzheimer's disease and other dementias of late life. Arlington, VA: APA; 1997.

Warner J, Butler R, Arya P. Dementia. Clin Evid 2004; 1361-90.

Scottish Intercollegiate Guidelines Network (SIGN). Management of patients with dementia. Clinical Guideline 86. Edinburgh: SIGN; 2006.

2 Support for patients and carers

Quick info:

Hambleton & Richmondshire

http://www.nyypct.nhs.uk/AdviceInformation/ReferralToolkit/_MoM_docs/Dem-H&R-CarerSupport.pdf

Selby

http://www.nyypct.nhs.uk/AdviceInformation/ReferralToolkit/_MoM_docs/Dem-Selby-CarerSupport.pdf

Contact number for details of North Yorkshire Carer's Emergency Card - 0845 872 7374

York

http://www.nyypct.nhs.uk/AdviceInformation/ReferralToolkit/_MoM_docs/Dem-Y-CarerSupport.pdf

3 Clinical presentation

Quick info:

North Yorkshire Carer's Assessment: Adult Community Services Assessment Line - 0845 034 9410

Selby Only

Selby Carers' Centre gives support and do carer's assessment. Unit 18, Ousegate, Selby YO8 4NN. Tel: 01757 292532. E-mail: selbycarers@wilfward.org.uk. Web: www.wilfward.org.uk

York Only

York Carer's Centre can signpost people to appropriate support and services for carers, including information on Carer's Assessments of Need, the Carer's Emergency Card and practical respite support. York Carer's Centre, 17 Priory Street, York YO1 6ET. Tel: 01904 715490

A Quick Guide to Services for Carers:

http://www.nyypct.nhs.uk/AdviceInformation/ReferralToolkit/_MoM_docs/Dem-Y-QuGdCarers.pdf

Carer's Assessment of Need: If you provide regular and substantive care for someone, you can have a carer's assessment to discuss the help you need. It is an opportunity to talk about your caring role. City of York Council undertakes the assessment and will look at the support available from a range of organisations. A small fund has been set up to provide flexible support for carers of adults to sustain them in their caring role. Please contact: Initial Assessment and Safeguarding Team, P O Box 402, 10-12 George Hudson Street, York YO1 6ZE. Tel: 01904 555111

http://www.nyypct.nhs.uk/AdviceInformation/ReferralToolkit/_MoM_docs/Dem-Y-CarerAssmnt.pdf

Carer's Emergency Card: is a partnership between York Carers Centre and City of York Warden Call Service. The scheme is free, has open access and allows carers to register an emergency plan. If an unplanned situation or emergency happens, the person they care for will not be left at risk. Carers are given an emergency carer's card which alerts other people to the fact that they are a carer. Tel: 01904 715490

http://www.nyypct.nhs.uk/AdviceInformation/ReferralToolkit/_MoM_docs/Dem-Y-CarerEmgCrdLft.pdf

http://www.nyypct.nhs.uk/AdviceInformation/ReferralToolkit/_MoM_docs/Dem-Y-CarerEmCdforContacts.pdf

http://www.nyypct.nhs.uk/AdviceInformation/ReferralToolkit/_MoM_docs/Dem-Y-CarerEmgCrdRegFm.pdf

Age Concern provides advice, information and practical help for older people over 60 and their carers, including benefits advice, community befriending and support services. The "In Safe Hands" scheme provides short breaks for carers of older people, including those with dementia. Tel: 01904 627995

Crossroads provides practical help and short breaks for carers, including carers of people with dementia. Tel: 01904 790200

National Guidance

- dementia is suggested by an impairment in two or more cognitive functions, such as memory, possibly with behavioural alteration, and the subsequent decline in the ability to carry out activities of daily living and normal social interaction
- diagnosis of dementia is determined by:
  - the presence of memory loss and at least one of the following:
    - apraxia
    - agnosia (problems recognising objects or people)
    - aphasia (impaired language comprehension and/or speech difficulties)
    - impaired executive function
  - deterioration from person's previous level of functioning and significant effect upon their daily life
  - not explained by other systemic causes or psychiatric illness
- mild cognitive impairment (MCI) is determined by impairment in one or more cognitive domains not associated with activities of daily living or social function
- healthcare staff should consider referring people who show signs of MCI for assessment by memory assessment services to aid early identification of dementia – more than 50% of people with MCI later develop dementia

References:

American Psychiatric Association (APA). Practice guideline for the treatment of patients with Alzheimer's disease and other dementias of late life. Arlington, VA: APA; 1997.

American Psychiatric Association (APA). Diagnostic and statistical manual of mental disorders. 4th edn (DSM-IV). Arlington, VA: APA; 2006.

National Institute for Health and Clinical Excellence (NICE). Dementia: Supporting people with dementia and their carers in health and social care. CG42. London: NICE; 2006.

4 Behavioural and psychological symptoms

Quick info:

- dementia can present with psychiatric symptoms such as:
  - depression
  - delusions
  - disinhibition
  - apathy

5 Memory loss

Quick info:

- short- and long-term memory loss is a characteristic feature of dementia and a required characteristic for diagnosis
- short-term memory is usually affected to a greater extent than long-term memory which is characteristic only late in the course of dementia

Worried About Your Memory leaflet:

http://www.nyypct.nhs.uk/AdviceInformation/ReferralToolkit/_MoM_docs/Dem-WAYMLft.pdf

References:

American Academy of Neurology (AAN). Practice parameter: diagnosis of dementia (an evidence-based review). St. Paul, MN: AAN; 2001.

Alberta Clinical Practice Guidelines Program. Cognitive impairment: Dementia. Diagnosis to management. Edmonton: Alberta Medical Association; 2005.

Alberta Clinical Practice Guidelines Program. Cognitive impairment: Is this dementia? Symptoms to diagnosis. Edmonton: Alberta Medical Association; 2005.

American Psychiatric Association (APA). Diagnostic and statistical manual of mental disorders. 4th edn (DSM-IV). Arlington, VA: APA; 2006.

American Psychiatric Association (APA). Practice guideline for the treatment of patients with Alzheimer's disease and other dementias of late life. Arlington, VA: APA; 1997.

6 Impaired executive function

Quick info:

- deterioration in ability to plan, initiate, judge, carry out and stop complex behavioural tasks is commonly observed

References:

American Psychiatric Association (APA). Practice guideline for the treatment of patients with Alzheimer's disease and other dementias of late life. Arlington, VA: APA; 1997.

American Psychiatric Association (APA). Diagnostic and statistical manual of mental disorders. 4th edn (DSM-IV). Arlington, VA: APA; 2006.

7 Language problems

Quick info:

- deterioration in language comprehension and speech (aphasia) is a common feature of dementia

References:

American Psychiatric Association (APA). Practice guideline for the treatment of patients with Alzheimer's disease and other dementias of late life. Arlington, VA: APA; 1997.

American Psychiatric Association (APA). Diagnostic and statistical manual of mental disorders. 4th edn (DSM-IV). Arlington, VA: APA; 2006.

8 Dyspraxia

Quick info:

- despite intact comprehension, sensory faculties and motor abilities, people with dementia often exhibit deterioration in execution of motor activities, eg. dressing oneself

References:

American Psychiatric Association (APA). Practice guideline for the treatment of patients with Alzheimer's disease and other dementias of late life. Arlington, VA: APA; 1997.

American Psychiatric Association (APA). Diagnostic and statistical manual of mental disorders. 4th edn (DSM-IV). Arlington, VA: APA; 2006.

9 Problems recognising objects or people

Quick info:

- deterioration in ability to recognise objects or people despite intact sensory function (agnosia) is a feature

References:

American Psychiatric Association (APA). Practice guideline for the treatment of patients with Alzheimer's disease and other dementias of late life. Arlington, VA: APA; 1997.

American Psychiatric Association (APA). Diagnostic and statistical manual of mental disorders. 4th edn (DSM-IV). Arlington, VA: APA; 2006.

10 History

Quick info:

History:

- ideally ask the patient questions and then speak either together or separately with a family member or carer who is able to provide additional information
- assess onset and progression of dementia symptoms
- medical history, including current health and medication
- check for:

- depression
- acute onset indicating confusional state

- consider non-cognitive effects:
  - affective symptoms
  - behavioural or personality change
  - psychosis
  - disinhibition
  - feelings of restlessness or agitation
  - aggressive behaviour
  - patterns and triggers of agitated behaviour
- consider other mental health disorders, eg. sleep disturbance, vivid or physically acted out dreams (REM sleep disorder), suicidal ideation, psychoses (hallucinations and delusions)
- consider comorbid physical illness which may impact on cognition
- physical symptoms such as movement disorders
- social status
- risk (suicide risk, potential for violence, neglect and abuse, risk of falls)
- consider any medication that may adversely affect cognitive functioning
- enquire about driving, continence and alcohol consumption

References:

American Psychiatric Association (APA). Practice guideline for the treatment of patients with Alzheimer's disease and other dementias of late life. Arlington, VA: APA; 1997.

McGonigal-Kenney ML, Schutte DL. Non-pharmacologic management of agitated behaviors in persons with Alzheimer disease and other chronic dementing illnesses. University of Iowa Gerontological Nursing Interventions Research Center. Iowa City, IA; 2004.

Scottish Intercollegiate Guidelines Network (SIGN). Management of patients with dementia. Clinical Guideline 86. Edinburgh: SIGN; 2006.

11 Examination

Quick info:

Examination: (examination criteria below mandatory prior to referral to secondary care):

- perform mental state examination using a standardised instrument to assess cognitive function such as the Mini Mental State Examination (MMSE):
  - when interpreting test results consider, where possible, the patient's educational level and prior capacity, and any sensory impairment or other comorbidity that may be affecting performance
- assess hearing and vision and ensure patients are using reading glasses if necessary when carrying out tests like MMSE
- perform a full physical examination considering any differential causes
- use DSM-IV, ICD-10 or other specific criteria for diagnosis, eg. NINCDS-ADRDA, NINDS-AIREN, International Consensus criteria for dementia with Lewy bodies

Consider:

- other standardised testing or rating scales, including those for mood, memory and cognitive functioning, eg. Addenbrooke's Cognitive Examination may improve initial cognitive testing
- directly observing behaviour, eg. consider observing patient imitating putting on a shirt, waving goodbye, brushing teeth etc. to test for apraxia
- assessing reports from informants (eg. carers) through interview
- if vascular dementia is suspected, look for other signs of vascular disease (check peripheral pulse, listen for carotid bruit, consider carotid doppler)
- normal neurology or non-localised findings which may be associated with Alzheimer's disease
- focal neurology associated with vascular dementia, parkinsonism associated with dementia with Lewy bodies

Also assess:

- carers (coping, knowledge, physical and mental health, relationship to patient)

- decision making capacity and identify surrogate decision maker in a sensitive way
- as far as possible, the cultural values and norms of the family to ensure that care is tailored sensitively

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American Psychiatric Association (APA). Practice guideline for the treatment of patients with Alzheimer's disease and other dementias of late life. Arlington, VA: APA; 1997.

McGonigal-Kenney ML, Schutte DL. Non-pharmacologic management of agitated behaviors in persons with Alzheimer disease and other chronic dementing illnesses. University of Iowa Gerontological Nursing Interventions Research Center. Iowa City, IA; 2004.

Scottish Intercollegiate Guidelines Network (SIGN). Management of patients with dementia. Clinical Guideline 86. Edinburgh: SIGN; 2006.

National Institute for Health and Clinical Excellence (NICE). Dementia: Supporting people with dementia and their carers in health and social care. CG42. London: NICE; 2006.

12 Initial investigations

Quick info:

Perform a basic dementia screen at the time of presentation, including:

- full blood count
- ESR, CRP, Lipid profile
- urea, electrolytes and creatinine
- glucose
- liver function
- calcium
- serum vitamin B12 and folate levels
- thyroid function tests

Consider performing:

- midstream urine test if considering acute confusional state
- chest X-ray or electrocardiogram if pulse is <60 or serious cardiovascular history

Consider screening for comorbidities, such as:

- depression

- syphilis or HIV – not routinely indicated; only perform if there is clinical suspicion

Unusual presentations, particularly in young people, may indicate rare disease, eg. tumours, frontotemporal dementia or normal pressure hydrocephalus.

Refer to memory assessment services for appropriate further investigations.

Refer patients with memory problems of uncertain significance to memory assessment services.

References:

American Psychiatric Association (APA). Practice guideline for the treatment of patients with Alzheimer's disease and other dementias of late life. Arlington, VA: APA; 1997.

American Academy of Neurology (AAN). Practice parameter: diagnosis of dementia (an evidence-based review). St. Paul, MN: AAN; 2001.

American Psychiatric Association (APA). Diagnostic and statistical manual of mental disorders. 4th edn (DSM-IV). Arlington, VA: APA; 2006.

Scottish Intercollegiate Guidelines Network (SIGN). Management of patients with dementia. Clinical Guideline 86. Edinburgh: SIGN; 2006.

National Institute for Health and Clinical Excellence (NICE). Dementia: Supporting people with dementia and their carers in health and social care. CG42. London: NICE; 2006.

13 Consider referral to memory assessment services

Quick info:

http://www.nyypct.nhs.uk/AdviceInformation/ReferralToolkit/_MoM_docs/Dem-Dep-guide.pdf

14 Refer to memory assessment services

Quick info:

Hambleton & Richmondshire

http://www.nyypct.nhs.uk/AdviceInformation/ReferralToolkit/_MoM_docs/Dem-H&R-refcon.pdf

Selby & York

http://www.nyypct.nhs.uk/AdviceInformation/ReferralToolkit/_MoM_docs/Dem-S&Y-refcon.pdf

15 Secondary investigations

Quick info:

Perform:

- non-contrast magnetic resonance image (MRI) or CT scan (MRI is the preferred modality for the assessment of dementia, but CT can be used):
  - for diagnostic evaluation
  - to exclude other cerebral pathologies
  - to help establish the subtype diagnosis
- request view of temporal lobe in CT scan
- carry out comprehensive assessment (as detailed in the history and examination node), including further neuropsychological assessment carried out by a specialist at secondary care level

Reference:

National Institute for Health and Clinical Excellence (NICE). Dementia: Supporting people with dementia and their carers in health and social care. CG42. London: NICE; 2006.

16 Consider differential diagnoses

Quick info:

Consider differential diagnoses and comorbidities at the time of diagnosis and at regular intervals subsequently, such as:

- depression

- psychosis or schizophrenia
- delirium
- amnestic disorder
- head trauma
- substance abuse

References:

American Psychiatric Association (APA). Practice guideline for the treatment of patients with Alzheimer's disease and other dementias of late life. Arlington, VA: APA; 1997.

American Psychiatric Association (APA). Diagnostic and statistical manual of mental disorders. 4th edn (DSM-IV). Arlington, VA: APA; 2006.

Scottish Intercollegiate Guidelines Network (SIGN). Management of patients with dementia. Clinical Guideline 86. Edinburgh: SIGN; 2006.

17 Further investigations if the diagnosis is in doubt

Quick info:

- if the diagnosis is in doubt, HMPAO single photon emission CT scan (SPECT) may be used to help differentiate Alzheimer's disease from frontotemporal dementia and vascular dementia
- consider FDG positron emission tomography (FDG PET) if HMPAO SPECT is not available
- FP-CIT SPECT is the preferred imaging modality if dementia with Lewy bodies is suspected
- HMPAO SPECT is not helpful in people with Down's syndrome
- cerebrospinal fluid examination should be used if Creutzfeld-Jakob disease or other form of rapidly progressive dementia is suspected
- electroencephalography is not recommended as a routine investigation in people with dementia
- electroencephalography can be considered if a diagnosis of delirium, frontotemporal dementia or Creutzfeld-Jakob disease is suspected or in the assessment of seizure disorder in those with dementia
- brain biopsy should only be considered in highly selected people whose dementia is thought to be a potentially reversible condition that cannot be diagnosed in any other way

Reference:

National Institute for Health and Clinical Excellence (NICE). Dementia: Supporting people with dementia and their carers in health and social care. CG42. London: NICE; 2006.

18 Manage according to likely diagnosis

Quick info:

- delirium, delusions and depression can complicate diagnosis of dementia
- diagnosis of particular type of dementia must be according to standard diagnostic criteria and should be made in a specialist centre by appropriately trained professionals
- many cases of dementia may have mixed pathology (particularly Alzheimer's and vascular dementia); such cases should be managed according to the condition that is thought to be the predominant cause

References:

American Psychiatric Association (APA). Practice guideline for the treatment of patients with Alzheimer's disease and other dementias of late life. Arlington, VA: APA; 1997.

American Psychiatric Association (APA). Diagnostic and statistical manual of mental disorders. 4th edn (DSM-IV). Arlington, VA: APA; 2006.

National Institute for Health and Clinical Excellence (NICE). Dementia: Supporting people with dementia and their carers in health and social care. CG42. London: NICE; 2006.

19 Alzheimer's disease

Quick info:

- memory loss and disturbance in executive functioning in the presence of at least one of the following:
-
  - aphasia
  - apraxia
  - agnosia
- characterised by gradual onset and continuing cognitive decline
- effect upon the person's social and daily functioning
- other causes of dementia are excluded, eg.:
  - central nervous system conditions
  - systemic disease
  - substance abuse
- diagnosis of Alzheimer's disease is primarily based on clinical features and after excluding other systemic and brain disorders that could account for the cognitive impairment
- the preferred diagnostic criteria (as recommended by the National Institute for Health and Clinical Excellence [NICE]) are the NINCDS/ADRDA; alternatively the DSM-IV and ICD-10 may be used

http://www.nyypct.nhs.uk/AdviceInformation/ReferralToolkit/_MoM_docs/Dem-WhatisAlzheimers.pdf

http://www.nyypct.nhs.uk/AdviceInformation/ReferralToolkit/_MoM_docs/Dem-WhatisDementia.pdf

References:

American Psychiatric Association (APA). Diagnostic and statistical manual of mental disorders. 4th edn (DSM-IV). Arlington, VA: APA; 2006.

Scottish Intercollegiate Guidelines Network (SIGN). Management of patients with dementia. Clinical Guideline 86. Edinburgh: SIGN; 2006.

20 Vascular dementia

Quick info:

- memory loss and at least one of the following:
  - aphasia
  - apraxia
  - agnosia; or
  - disturbance in executive functioning
- memory is variably affected
- the main cognitive effects are in attentional dysfunction, executive dysfunction and slowed information processing
- a gradual progression can occur in subcortical disease
- effect upon social and daily function
- no other systemic or psychiatric cause
- associated with cerebrovascular disease
- typically more abrupt onset – often stepwise, fluctuating decline in function
- usually a temporal relationship between vascular disease and dementia symptoms
- evidence of current and older lesions should be detectable on CT scan and magnetic resonance image (MRI)
- focal neurological signs (gait anomalies, hemiparesis, etc.)
- compatible history, eg. presence of risk factors, past transient ischaemic attack (TIA) or cerebrovascular accident (CVA), associated ECG changes
- the preferred diagnostic criteria (as recommended by the National Institute for Health and Clinical Excellence [NICE]) are the NINDS-AIREN; alternatively the DSM-IV and ICD-10 may be used

http://www.nyypct.nhs.uk/AdviceInformation/ReferralToolkit/_MoM_docs/Dem-WhatisVascD.pdf

http://www.nyypct.nhs.uk/AdviceInformation/ReferralToolkit/_MoM_docs/Dem-WhatisDementia.pdf

References:

American Psychiatric Association (APA). Practice guideline for the treatment of patients with Alzheimer's disease and other dementias of late life. Arlington, VA: APA; 1997.

American Psychiatric Association (APA). Diagnostic and statistical manual of mental disorders. 4th edn (DSM-IV). Arlington, VA: APA; 2006.
Scottish Intercollegiate Guidelines Network (SIGN). Management of patients with dementia. Clinical Guideline 86. Edinburgh: SIGN; 2006.

21 Dementia with Lewy bodies

Quick info:

- memory loss and at least one of the following:
  - aphasia
  - apraxia
  - agnosia; or
  - disturbance in executive functioning
- progressive cognitive decline, particularly affecting visuospatial and executive functioning combined with:
  - fluctuation
  - cognition and parkinsonism
  - recurrent and persistent visual hallucinations
- no other systemic or psychiatric cause
- similar progressive decline as in Alzheimer's but with parkinsonian features (eg. bradykinesia, tremor) and prominent psychotic symptoms (visual hallucinations, delusions)
- marked sensitivity to extrapyramidal adverse effects of antipsychotic medication
- neuroleptic sensitivity
- REM sleep behaviour disorder
- may be history of repetitive falls and syncope
- the preferred diagnostic criteria (as recommended by the National Institute for Health and Clinical Excellence[NICE]) are the International Consensus Criteria for Dementia with Lewy Bodies

http://www.nyypct.nhs.uk/AdviceInformation/ReferralToolkit/_MoM_docs/

http://www.nyypct.nhs.uk/AdviceInformation/ReferralToolkit/_MoM_docs/Dem-WhatisDwithLewyBodies.pdf

http://www.nyypct.nhs.uk/AdviceInformation/ReferralToolkit/_MoM_docs/Dem-WhatisDementia.pdf

References:

American Psychiatric Association (APA). Practice guideline for the treatment of patients with Alzheimer's disease and other dementias of late life. Arlington, VA: APA; 1997.
American Psychiatric Association (APA). Diagnostic and statistical manual of mental disorders. 4th edn (DSM-IV). Arlington, VA: APA; 2006.
Scottish Intercollegiate Guidelines Network (SIGN). Management of patients with dementia. Clinical Guideline 86. Edinburgh: SIGN; 2006.

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Key Dates

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