Treatment of the Dementia Syndrome

Utah ACP 2019 Meeting

Meg Skibitsky MD, MPH

Objectives

1) Discuss the preferred screening strategy for dementia and cognitive impairment in the primary care setting

2) Describe resources within the community to provide support to family caregivers of patients with dementia

3) Discuss an evidence based approach to select pharmacotherapy in patients with dementia and cognitive decline

SCREENING AND DIAGNOSIS OF DEMENTIA

Normal Age Related Memory Changes or More?

When to Screen for Memory Loss

Patient and/or family reported cognitive changes

Observation of memory loss

Index of suspicion:

- poorly controlled BGs or BPs in someone who was stable
- missed or wrong appointments/frequent calls
- confusion with medication or treatment changes
- changes in appearance, mood/personality, weight

Annual Medicare Wellness Visits

Let’s Not Forget

Patients can be less than 65 years of age: FTD, early onset AD

Memory not always the first complaint

- Prominent word finding difficulty, personality changes: FTD
- Visuospatial changes, motor complaints: LBD
- hx CVA with cognitive changes: VD
- younger patient, psychiatric with family hx: Huntington’s
- new onset depression age 65 a warning sign for AD

Never is dementia diagnosed in context of delirium

Screening for Memory Loss: memory + function=dementia

Mini-Cog: 3 points recall of words, 2 points for clock

MOCA effective screening tool: sensitive and specific, picks up MCI

- 5 points visuospatial
- 3 points naming
- 6 points attention
- 3 points language
- 2 points abstraction
- 5 points recall
- 6 points orientation

Clock Drawing Requirements

Mini-Cog: Score is either 0 or 2

need all numbers, correct sequencing and approximately correct positions; no missing or duplicate numbers

need hands pointing to 11 and 2, length does not matter

MOCA: Score is 0-3

need correct contour

need numbers in correct sequence and spaced

need hands pointing to 11 and 2, size matters!

note while allows for numbers outside, we are sticking with inside

Typical Clock Drawing Errors in Dementia

Hands incorrectly set or absent
Missing numbers, including tick marks in place of numbers
Repeated numbers
Substitution: symbols or marks in place of numbers, or time written out
Number orientation: counterclockwise
Number order or spacing incorrect, including empty quadrant
Numbers outside circle
Clock like figure
Refusal or inability

Testing Errors

Not signing documents, indicating date/Pt ID

Distraction in environment

Others present

Environmental cues

Voice projection or clarity

Coaching

Allowing practice

“he knows it”

It’s just a clock….what’s the big deal?

What do we learn from clock drawing

Drawing requires the recall of semantic and perceptual images, spatial planning and motor processing—multiple brain function tasks!

Executive function: ability to organize, plan, carry out tasks efficiently and to achieve a goal; includes ability to self-monitor and control behavior, judgment/reasoning, decision making

Degree of global/general cognitive impairment

Semantic memory: the ability to recall facts and information

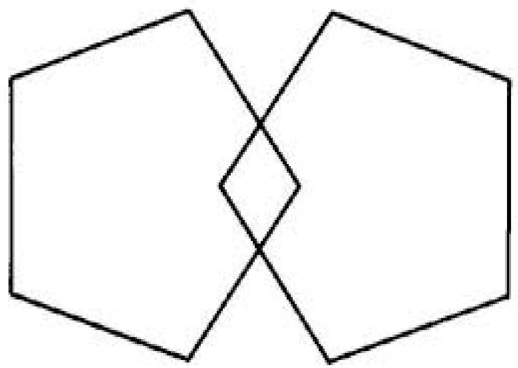
Visuospatial skills needed for planning, organizing, sequencing, orientation

One Man's Story

Write me a sentence (MMSE)

Copy this picture (MMSE)

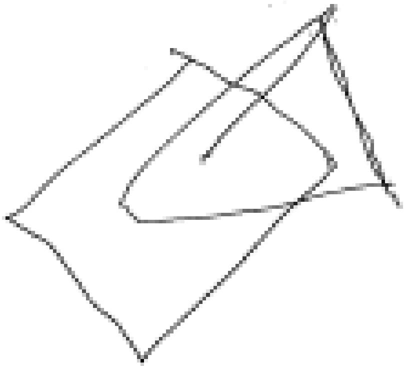
Draw me a clock (MOCA)

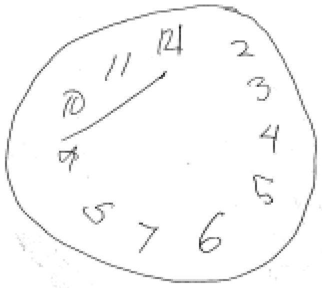


Sentence

I am at the doctor's office.

Copy





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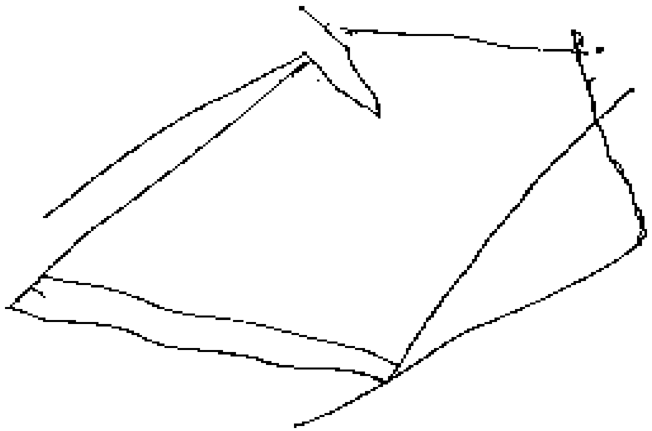

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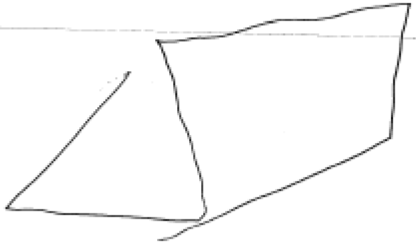

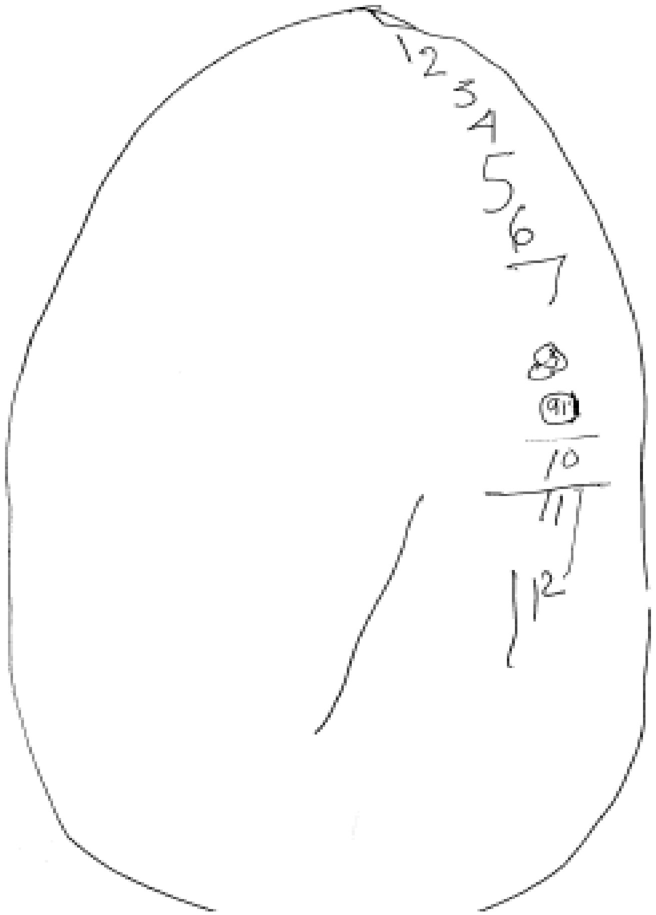

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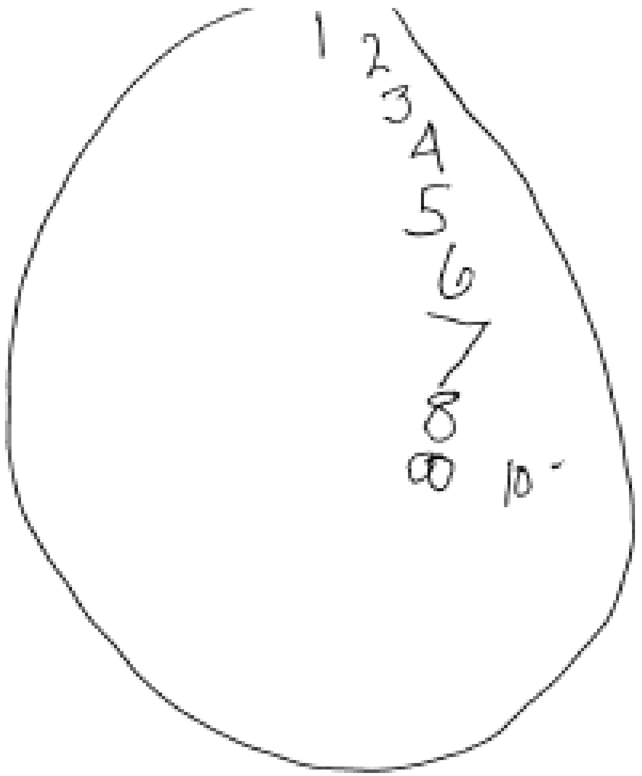

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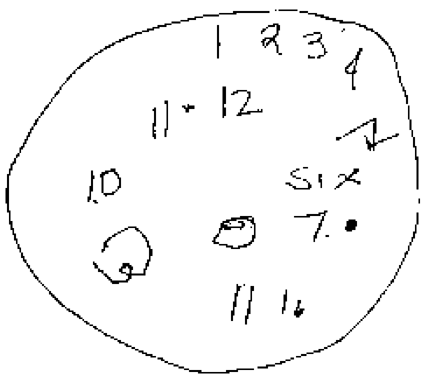


CAREGIVER RESOURCES

Changing needs with disease progression

Mild

Requires assistance for IADLs

Financial

Making/keeping appointments

Advanced care planning

Driving

Moderate

Unable to perform

IADLs; assist with ADLs

Vulnerability & safety

Nutrition

Finding meaningful activity

Behavior disturbance

Caregiver stress

Severe

Unable to perform

ADLs

Incontinence

Falls

Weight loss

Recurrent infections

Caregiver stress

Caregivers—Supports Needed

- Legal and financial counsel
- Advanced care planning
- Education
- Meals
- Transportation
- Respite care
- Adult day care
- End of life care

What support is available?

Family

Friends

Faith community

Local government

Not-for-profit organizations

Adult day care

Private-pay personal care agencies

Healthcare team

First step

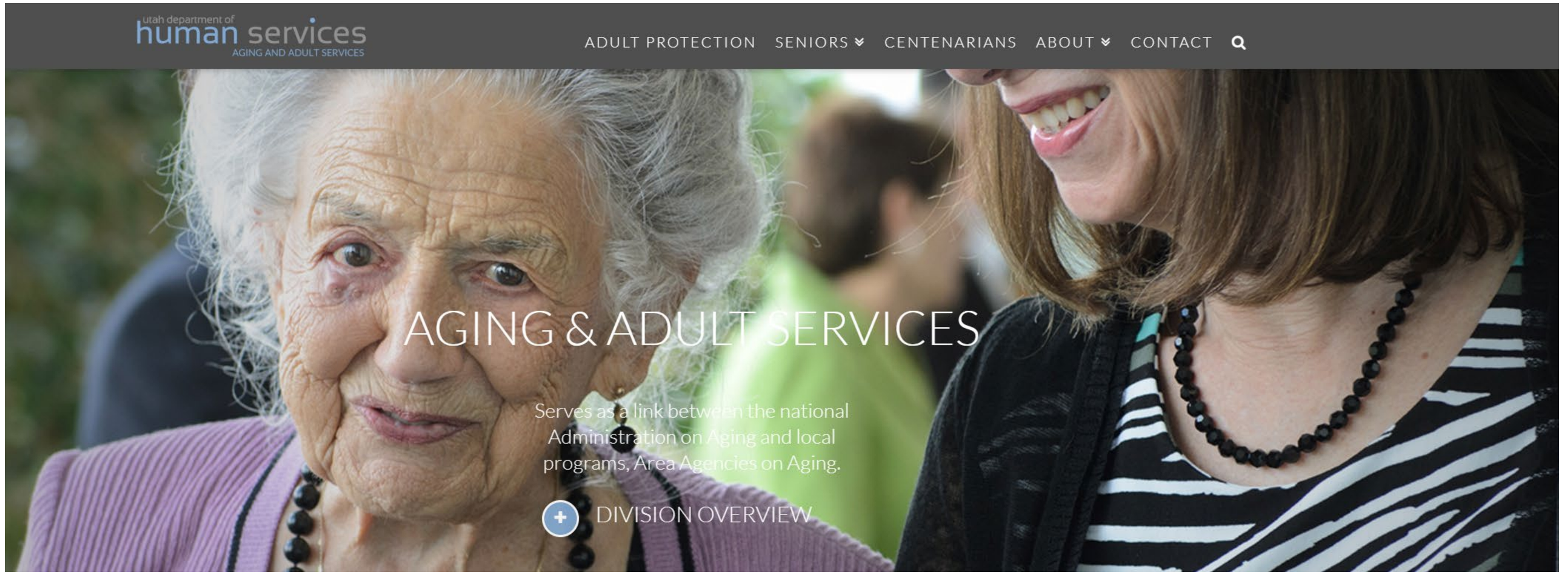
Encourage caregivers to ask for and seek out help!

Care team can assist family to organize care

- Clarify who in the family is available to help
  - Consider physical availability, emotional availability, and financial availability.
  - Different family members may be suited to different tasks
- Consider patient and family preferences
  - Prefers to remain in home vs. willing & able to consider a move to a higher level of care (independent living → assisted living → memory care)
  - Comfort level with strangers providing care
- Help point families toward resources to fill gaps in care
- Help caregivers understand what services are covered by Medicare/insurance

Utah Department of Aging Services

- Meals on Wheels
- Rides for Wellness
- Legal services
- Respite services



https://daas.utah.gov/. Accessed online 10.19.18

Respite Care: Available for patients requiring ADL assistance

- Allows caregivers a temporary break from caregiving
- Funding: LTC insurance, VA Aide & Attendance, Area Agencies on Aging, mostly private-pay
- Can be provided in a variety of settings: home, day center, or residential facility

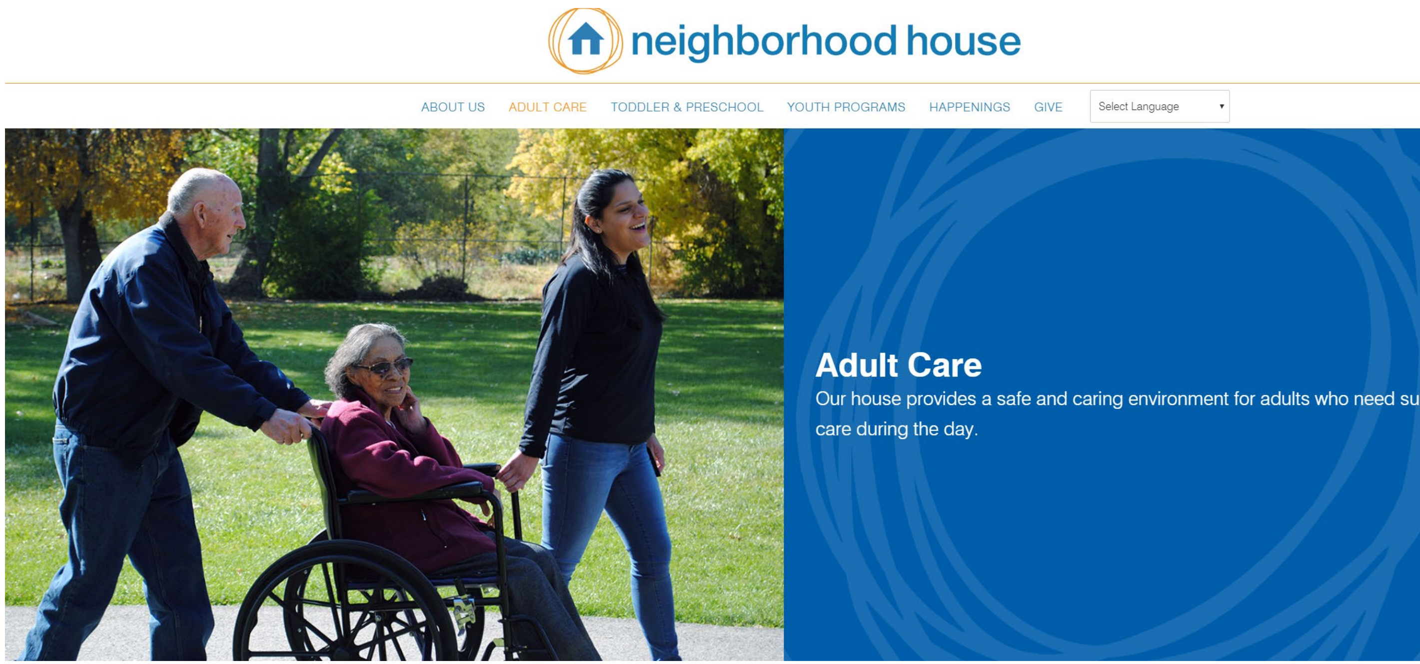
Personal Care Agencies

ADLs
Meals, housekeeping
Companionship
Provide transportation
Shopping
Recreation
Socialization

Not covered by insurance
Ask if patient has a Long Term Care insurance policy

Adult Day Care

- Can allow a safe place for loved ones while caregivers attend to own needs
- Not covered by insurance
- Options vary by location



https://www.nhutah.org/adult-care Accessed 10.19.2018

Music and Memory Program

Uses personalized playlists of favorite songs loaded on iPods

Offered by Jewish Family Services (dementia support for persons of all faiths) https://www.jfsutah.org

Caregiver education—Dementia Dialogues Program

FREE 5 session training course designed to educate individuals who care for persons with dementia.

Over 21,000 individuals trained

Session 1: Introduction to Dementia

Session 2: Creating Dialogue and Keeping it Going

Session 3: It's a Different World: The Environment and Quality of Live

Session 4: It's Nothing Personal: Addressing Challenging Behaviors

Session 5: Now What do We Do: Creative problem Solving

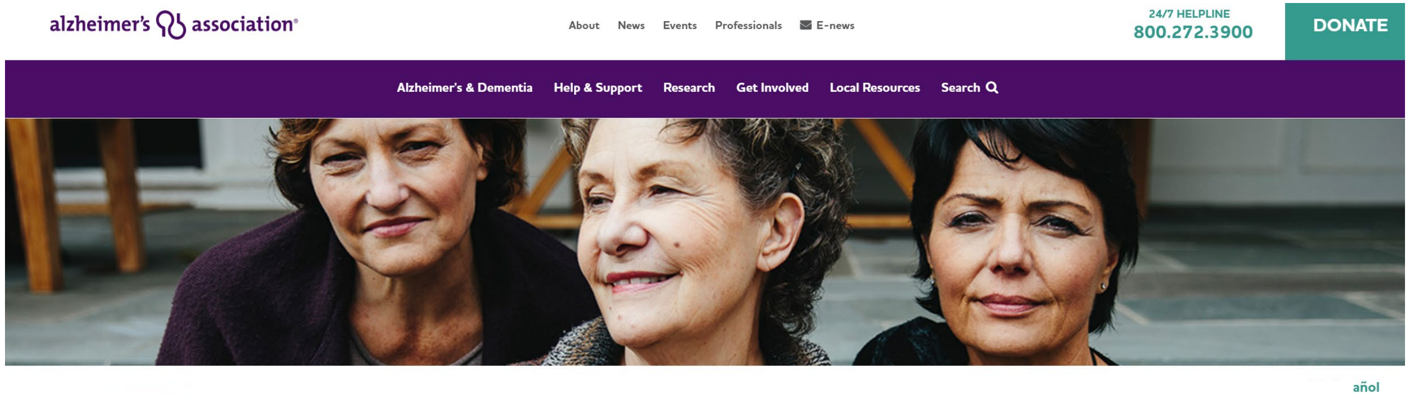
UTAH DEPARTMENT OF HEALTH
www.livingwell.utah.gov

Sign up at livingwell.utah.gov or 888-222-2542

Not-for-profit organizations

For example, Alzheimer's Association, Memory Matters

- Patient education and support
- Caregiver education and support
- Assistance in locating resources
- Alzheimer's Association Helpline



Memory Matters Utah Nevada
you are not alone

Support Our Cause

435-319-0407

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www.alz.org
www.memorymattersutah.org
Accessed online 10.19.18

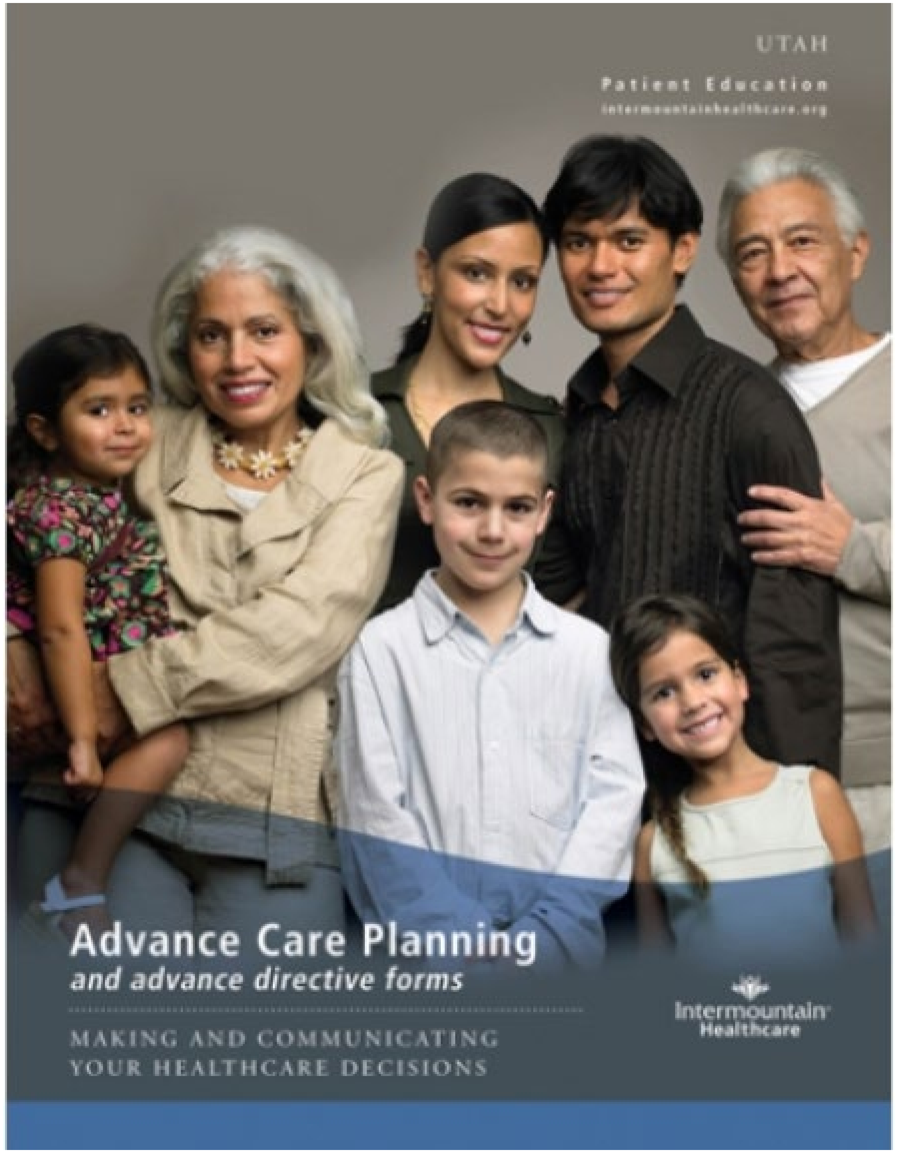
Veterans Administration services

- Personal care
- Respite care
- Medications
- Hearing aides
- Aide and Attendance
- Veteran’s Homes (patients requiring assisted, skilled nursing, or memory care)
- Palliative care & hospice services

Advanced Care Planning

Advanced Directives

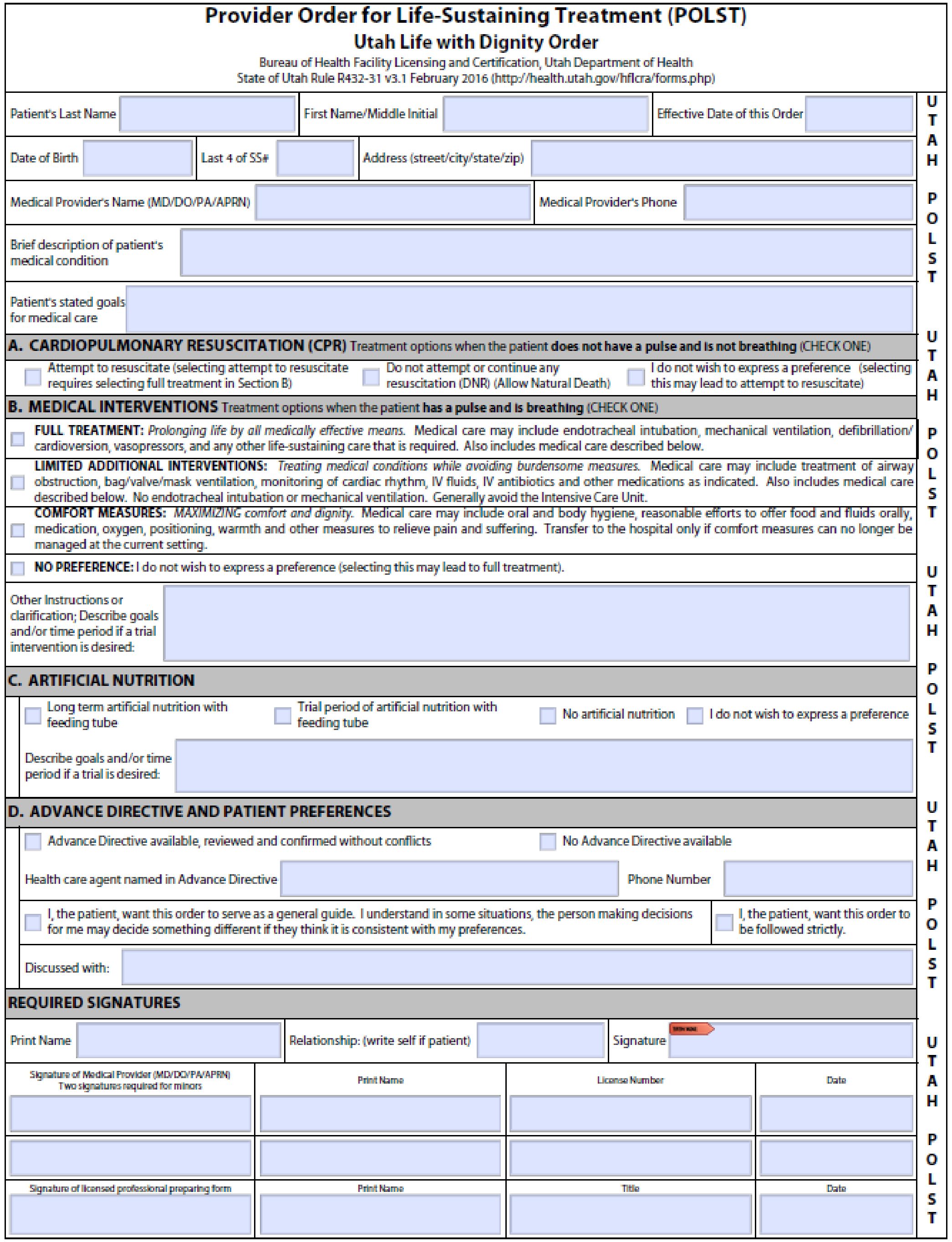
- Identification of surrogate decision makers
- General preferences in care
- Requires decision making capacity to complete (not present in moderate to severe stages of dementia)



Advanced Care Planning

Provider Order for Life-Sustaining Treatment (POLST)

- Specific preferences about resuscitation, life support, artificial nutrition
- If patient does not have decision making capacity may be completed by surrogate (if identified in advanced care document or by default if no such document available)



Provider Order for Life-Sustaining Treatment (POLST)

Utah Life with Dignity Order

Bureau of Health Facility Licensing and Certification, Utah Department of Health
State of Utah Rule R432-31 v3.1 February 2016 (http://health.utah.gov/hflcra/forms.php)

Patient's Last Name | First Name/Middle Initial | Effective Date of this Order

Date of Birth | Last 4 of SS# | Address (street/city/state/zip)

Medical Provider's Name (MD/DO/PA/APRN) | Medical Provider's Phone

Brief description of patient's medical condition

Patient's stated goals for medical care

A. CARDIOPULMONARY RESUSCITATION (CPR) Treatment options when the patient **does not have a pulse and is not breathing** (CHECK ONE)

- Attempt to resuscitate (selecting attempt to resuscitate requires selecting full treatment in Section B)
- Do not attempt or continue any resuscitation (DNR) (Allow Natural Death)
- I do not wish to express a preference (selecting this may lead to attempt to resuscitate)

B. MEDICAL INTERVENTIONS Treatment options when the patient **has a pulse and is breathing** (CHECK ONE)

- **FULL TREATMENT:** *Prolonging life by all medically effective means.* Medical care may include endotracheal intubation, mechanical ventilation, defibrillation/cardioversion, vasopressors, and any other life-sustaining care that is required. Also includes medical care described below.
- **LIMITED ADDITIONAL INTERVENTIONS:** *Treating medical conditions while avoiding burdensome measures.* Medical care may include treatment of airway obstruction, bag/valve/mask ventilation, monitoring of cardiac rhythm, IV fluids, IV antibiotics and other medications as indicated. Also includes medical care described below. No endotracheal intubation or mechanical ventilation. Generally avoid the Intensive Care Unit.
- **COMFORT MEASURES:** *MAXIMIZING comfort and dignity.* Medical care may include oral and body hygiene, reasonable efforts to offer food and fluids orally, medication, oxygen, positioning, warmth and other measures to relieve pain and suffering. Transfer to the hospital only if comfort measures can no longer be managed at the current setting.
- **NO PREFERENCE:** I do not wish to express a preference (selecting this may lead to full treatment).

Other Instructions or clarification; Describe goals and/or time period if a trial intervention is desired:

C. ARTIFICIAL NUTRITION

- Long term artificial nutrition with feeding tube
- Trial period of artificial nutrition with feeding tube
- No artificial nutrition
- I do not wish to express a preference

Describe goals and/or time period if a trial is desired:

D. ADVANCE DIRECTIVE AND PATIENT PREFERENCES

- Advance Directive available, reviewed and confirmed without conflicts
- No Advance Directive available

Health care agent named in Advance Directive | Phone Number

- I, the patient, want this order to serve as a general guide. I understand in some situations, the person making decisions for me may decide something different if they think it is consistent with my preferences.
- I, the patient, want this order to be followed strictly.

Discussed with:

REQUIRED SIGNATURES

Print Name | Relationship: (write self if patient) | Signature

Signature of Medical Provider (MD/DO/PA/APRN) Two signatures required for minors	Print Name	License Number	Date

Signature of licensed professional preparing form	Print Name	Title	Date

UTAH POLST

Hospice

- Covered under Medicare Part A
- Provides nursing care, ADL assistance, palliative care, caregiver support
- Available for persons with a 6 month life expectancy and a qualifying diagnosis
- Dementia is a qualifying diagnosis HOWEVER patients must be unable to ambulate, dress, bathe, or communicate
- BUT some patients with other symptoms of terminal decline (>10% weight loss, recurrent infections, etc) may qualify for hospice under another diagnosis

MEDICATION MANAGMENT

Approach to Treatment

1) Eliminate contributing medications
2) Treat underlying diseases
3) Start dementia medications
4) Evaluate home medication management
5) Re-evaluate effectiveness and tolerability

Medications to Avoid

Antihistamines

Diphenhydramine, hydroxyzine, chlorpheniramine

BENZODIAZEPINES

**(Remember LOT)

TCAs

Consider nortriptyline or desipramine if MUST be used

Antiemetics

Choose ondansetron

Antispasmodics/Antimuscarinics

Antipsychotics

MUSCLE RELAXANTS

Z-DRUGS

Beers Criteria. J Am Geriatr Soc. 2015

DEMENTIA DIAGNOSED

↓

BEGIN non-pharmacologic treatment care planning (page 9)
AND
DISCUSS pharmacologic treatment

↓

CONSIDER prescribing medications by dementia type

Refer to medication tables (pages 15–16) for dosing and details about specific medications

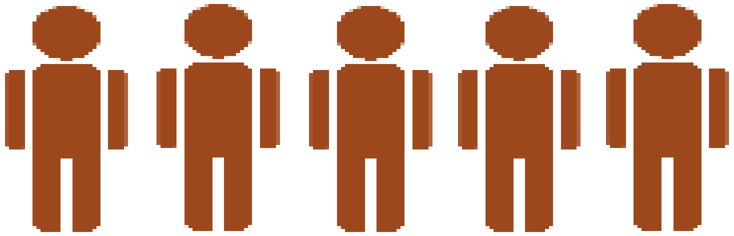
Alzheimer's disease		Vascular and mixed dementias[KAV]	Frontotemporal, Lewy-body, and Parkinson's Dementias
Mild	**Moderate/ severe**		
Donepezil* (If nightmares occur, switch to morning dosing.)	• **Donepezil*** • **Add memantine***	• **Aspirin** (unless contraindicated) • **Treat vascular risk factors as appropriate** (hypertension, diabetes, high cholesterol) • **Donepezil*** • **Consider memantine*** (moderate to severe stages)	• **Refer to neurology** • **Avoid antipsychotics in Lewy-body and Parkinson's dementias** (if anti-psychotic needed, choose seroquel at lowest possible dose: 12.5 mg QHS) • **Cholinesterase inhibitors may or may not be helpful in frontotemporal dementia** • **Memantine is not recommended**
*See medication tables on pages 15–16 for more detailed dosing and side effects.			

↓

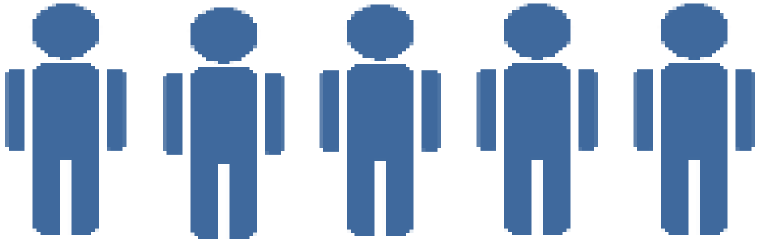
ASSESS medication and adjust dosing as necessary at each follow-up appointment

How Effective is Treatment?

About half the patients who take dementia medications have a response



50% of patients will have usual symptom progression (3 points on MMSE per year).



50% of patients will have symptom progression delayed for 6 to 12 months.

Birks J. Cochrane Database Syst Rev. 2006. Hansen RA. Et al. Clin Interv Aging. 2008. Kaduszkiewicz H. et al. BMJ 2005.

Cholinesterase Inhibitors

Drug	Dose	Side Effects	Pearls
Donepezil (Aricept©) 5 mg, 10 mg tablet 23 mg tablet	Start: 5 mg daily Titrate: 10 mg daily after 4 weeks High dose: 10 mg BID or 23 mg daily after 3 months	• > 10%: **N**/V/D, insomnia • Weight loss, decreased appetite • **Bradycardia**, syncope • Abnormal dreams, hallucinations • Rhinorrhea • Leg Cramps **Titrating too fast leads to agitation and worsening SEs*	• Approved for mild-moderate and moderate-severe dementia • Do NOT use 23 mg tab → 10 mg BID is less expensive • High dose (>10 mg/day): substantially more side effects with minimal benefit • Starting dose is therapeutic dose • Give in the morning to avoid nightmares • GI SEs improve after the first month

GI SIDE EFFECTS:

Rivastigmine > IR galatamine > ER galantamine/rivastigmine patch > donepezil

Aricept (donepezil) [prescribing information]. Woodcliff Lake, NJ: Pfizer, Inc; February 2012.
Farlow MR, et al. Clin Ther. 2010

N-methyl-D-aspartate Receptor Antagonist

Drug	Dose	Side Effects	Pearls
Memantine (Namenda©) 5 mg, 10 mg tablet Namenda XR© 7, 14, 21, 28 mg capsule	**Week 1**: 5 mg daily **Week 2**: 5 mg BID **Week 3**: 10 mg in AM, 5 mg in PM **Week 4**: 10 mg BID ***Titration pack very useful** **Taper off: reverse titration schedule*	• Fatigue • Hypertension • CNS: **dizziness**, HA, ataxia vertigo • Constipation (IR) • Diarrhea (XR) • Psych: confusion, somnolence, hallucinations • Can cause agitation	• Approved for moderate-severe dementia • Titration packs available • Less side effects vs cholinesterase inhibitors • Can continue even if no clinical improvement as thought to be disease modifying • XR formulations $$$ however may help improve compliance • **Renal impairment (CrCl 5-29 ml/min): target dose 5 mg BID** • Use with caution in severe hepatic impairment

Intermountain Healthcare

Namenda (memantine) [prescribing information]. St. Louis, MO: Forest Pharmaceutical, Inc; October 2013.
Namenda XR (memantine) [prescribing information]. St. Louis, MO: Forest Pharmaceutical, Inc; June 2010.

Combination Therapy

Drug	Dose	Side Effects	Pearls
Memantine/Donepezil (Namzanric©) 7-10 mg capsule 14-10 mg capsule 21-10 mg capsule 28-10 mg capsule	**Start:** 7-10 mg capsule once daily **Titrate:** increase memantine by 7 mg every week **Taper off: reverse titration schedule*	• Similar to individual agents	• Approved for moderate-severe dementia • **Start in patients already tolerating donepezil 10 mg daily** • **$$$** • Renal impairment (CrCl 5-29 ml/min): target memantine dose is 14 mg daily

Intermountain® Healthcare

Namzaric (memantine XR and donepezil) [prescribing information]. Clonshaugh, Dublin 17, Ireland: Forest Pharmaceutical, Inc; Dec 2014.
Schmidt R, et al. European J Neurology 2015.

Stopping medication

Realistic expectations: frequently evaluate the effectiveness and tolerability of medications as well as progression of the disease.

If concern for side effects, primary vs contributory, hold medication for 2 weeks and assess. Can resume at previous level if no change. Also, BID dosing may be better tolerated.

If slowing decline is no longer a goal, often in severe or advanced stage, consider stopping the medication.

If it has been decided to stop the medication**, taper the medication slowly** over at least 4 weeks.

Sometimes a sharp decline is observed immediately after stopping the medication. In this case, it may be beneficial to restart the medication.

Gauthier S et al. Can J Neurol Sci. 2012.

Tips for Managing Medications

Put your eyes on all medications and any pill boxes

FAMILY

Medication List

+ Add | Document Medication by Hx | Reconciliation ▾ | Check Interactions | External Rx History ▾ | Rx Plans (1): Plan name not... ▾

Monitoring Medications

“Don’t prescribe cholinesterase inhibitors for dementia without periodic assessment for perceived cognitive benefits and adverse gastrointestinal effects.”

Talk to families about what changes they have noticed!

MoCA
BEHAVE-5
Global Cognitive Impairment tracking sheet

Choosing Wisely. AGS. Updated April 2015. Accessed 10/10/2018

Supplements

PREVENT	TREAT	Neither
• **Vitamin E** • Fish Oil • Coconut Oil	• **Vitamin E** • Gingko Biloba	• Prevagen • Folic Acid • Vitamin B6, B12 • Axona

Natural Medicines database. Professional monographs. Accessed 10/5/18. Dysken MW, et al. JAMA 2014.