Treatment of the Dementia Syndrome

Utah ACP 2019 Meeting

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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)
I am at the doctor's office.
How do they work with each other.
Today, we
collected money.
The 11th senta is hard to fill.
To be was a

mine to day.
Changing needs with disease progression

**Mild**
Requires assistance for IADLs

**Moderate**
Unable to perform IADLs; assist with ADLs

**Severe**
Unable to perform ADLs

Financial
Making/keeping appointments
Advanced care planning
Driving

Vulnerability & safety
Nutrition
Finding meaningful activity
Behavior disturbance
Caregiver stress

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

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

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

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

www.alz.org
www.memorymattersutah.org
Accessed online 10.19.18
Veterans Administration services

- Personal care
- Respite care
- Mediations
- 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)
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 MANAGEMENT
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

**BENZODIAZEPINES**
**(Remember LOT)**

**TCA**
Consider nortriptyline or desipramine if MUST be used

**Z-DRUGS**

**Antihistamines**
Diphenhydramine, hydroxyzine, chlorpheniramine

**Antiemetics**
Choose ondansetron

**Antispasmodics/Antimuscarinics**

**MUSCLE RELAXANTS**

**Antipsychotics**
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

<table>
<thead>
<tr>
<th>Alzheimer's disease</th>
<th>Vascular and mixed dementias&lt;sup&gt;kw&lt;/sup&gt;</th>
<th>Frontotemporal, Lewy-body, and Parkinson's Dementias</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mild</td>
<td>Donepezil* (if nightmares occur, switch to morning dosing.)</td>
<td>Aspirin (unless contraindicated)</td>
</tr>
<tr>
<td>Moderate/ severe</td>
<td>* Donepezil*</td>
<td>Treat vascular risk factors as appropriate (hypertension, diabetes, high cholesterol)</td>
</tr>
<tr>
<td></td>
<td>* Add memantine*</td>
<td>Donepezil*</td>
</tr>
<tr>
<td></td>
<td>* Consider memantine* (moderate to severe stages)</td>
<td>Consider memantine*</td>
</tr>
</tbody>
</table>

<sup>kw</sup>See medication tables on pages 15–16 for more detailed dosing and side effects.

*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

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.

# Cholinesterase Inhibitors

<table>
<thead>
<tr>
<th>Drug</th>
<th>Dose</th>
<th>Side Effects</th>
<th>Pearls</th>
</tr>
</thead>
</table>
| Donepezil (Aricept©)  | 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.*

## N-methyl-D-aspartate Receptor Antagonist

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

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

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.
Tips for Managing Medications

Put your eyes on all medications and any pill boxes.

FAMILY
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
<table>
<thead>
<tr>
<th>Supplements</th>
<th>PREVENT</th>
<th>TREAT</th>
<th>Neither</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Vitamin E</td>
<td>Vitamin E</td>
<td>Prevagen</td>
</tr>
<tr>
<td></td>
<td>Fish Oil</td>
<td>Gingko Biloba</td>
<td>Folic Acid</td>
</tr>
<tr>
<td></td>
<td>Coconut Oil</td>
<td></td>
<td>Vitamin B6, B12</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Axona</td>
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</tbody>
</table>