How to approach the patient with memory impairment
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Mary

- Mary aged 77 presents to you at the end of your morning surgery a little flustered. As she is walking with you down to your office she tells you how sorry she is that she forgot her earlier appointment, and that she will keep it brief.
- When you log into her file you notice that she has failed to appear to the previous 2 booked appointments
- Could this be a clinical problem? – if so:
- Is it worth exploring?

What questions would you ask initially?

What could this problem be?

Acknowledgment to unsplash

Aims of this presentation

- By the end of the session, learners should be able to

1. Explain why it is important to explore the reason for memory problems
2. List the four main differential diagnoses for memory problems
3. Employ good communication skills to communicate with a person with memory problems about further investigations needed and why

What is Dementia?

- Dementia is a clinical *syndrome* which can be caused by a number of underlying diseases (including Alzheimer's disease).
- Dementia can affect not just memory, but also thinking, behaviour, communication and ability to perform activities of daily living.
- People with dementia describe the condition as disabling, challenging, life changing and stressful.

Is it important to consider dementia and if so when??

Put in the chat:

1. No
2. Yes but only in the later stages
3. Yes as early as possible
4. Yes but it depends on the openness of the person and the family to this diagnosis

The GP role

- Over 85% of the population attend their GP at least once per year
- Worldwide, GPs fail to detect 50% of mild/early dementia cases. Much better at identifying more obvious cases
- Timely diagnosis has benefits. It can allow the person with dementia to make choices about their future while they are still able; to plan finances, powers of attorney and care in advance; to access medications that may relieve symptoms; to receive support from community services which can enable them to continue living in their community for as long as they can.

- *Phillips et al. timely diagnosis of dementia: can we do better? Paper 24 Alzheimers Australia, 2011.*

The GP role continued

- GP awareness of the diagnosis may result in modification to disease management for all diseases eg Webster packs for medications, and simpler practical written instructions eg for wound management. Communication may need to be modified*. Work with practice nurse to identify when further support is needed eg when 75+ HA shows the person is not eating well and losing weight
- *See slide on communication

When we see someone with memory loss, how bad is it?

- How do we measure it?

When we see someone with memory loss, how bad is it?

Cognitive Function Tests

- The clock
- The MMSE
- The GPCOG
- The MOCA
- The RUDAS (esp CALD)
- The KICA (esp indigenous)
- The PAS (in RACF)

There are many others

Dementia Outcome Measurement Suite. Cognition assessment measures. Available at http://www.dementia-assessment.com.au/cognitive/index.html

The clock drawing (CDT)

Draw a clock face and mark in the hours

Then draw in the hands to indicate a particular time eg ten past 11

The CDT assesses frontal and temporo-parietal functioning.

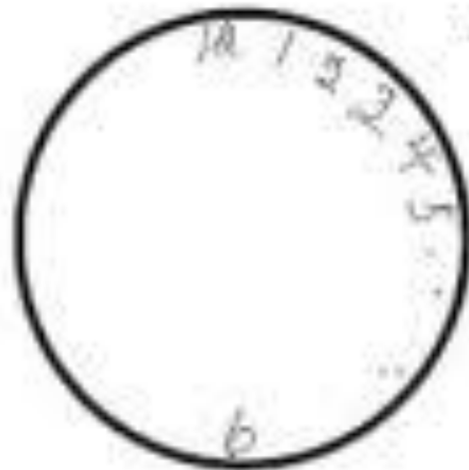
Scoring may vary

Scores

10

5

6



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Limitations of a cognitive function test

- False positives (ie score in the dementia range but do not have dementia). Especially a problem if used with a group who do not have symptoms
- False negatives especially if well educated
- May be affected by poor education, poor local language skills, poor hearing
- May be affected by the patient being anxious and upset, or unwell that day, or a recent increase in night sedation etc etc

IF the person falls into the dementia range – think 4 "Ds"

- Delirium (ie they are sick)
- Depression
- Drugs (medications)
- Dementia

4 “Ds”

So you asked me the first thing that I would do if a person is presenting with memory loss for example or confusion is actually to check for some other cause,

So a lady I can think of is a really good example – a lady came in about a year ago – her friend brought her in and said “my friend has dementia”, and uh, I said well before we rush into that lets do a blood test and she was severely hypothyroid, and it was a confusing presentation.

GP from medical student project

Causes of delirium

- Thyroid disorders
- CVA/TIA
- Subdural haematoma
- Brain Tumour
- Alcohol
- B12/folate deficiency
- Metabolic disturbances (BSL,calcium, uraemia)
- Water and electrolyte disturbances
- Infections
- Hypoxia
- Malnutrition
- Many others…..

Blood tests for delirium

- FBC/ESR
- Biochemistry (renal function, electrolytes,
- liver function, BSL)
- Serum calcium and phosphate
- TSH
- B12/Folate
- TPHA/HIV (if indicated)
- Urinalysis/MSU
- ECG
- CT scan or MRI

Screen for depression

- What scale would you use?

Medication side effects may mimc dementia

- Drugs with anticholinergic side effects or sedative effects may cause or exacerbate cognitive decline. This effect is called anticholinergic load
- A home medication review may assist. Pharmacists have tools to look at anticholinergic load
- Ask for Drug Burden Index

IF you think it is dementia – what do you do next?

Consider referral to the memory clinic

- This implies having a conversation about the possibility of dementia

Barriers:

- Patient/carer - *lack of social support, misunderstanding the diagnosis*, and *denial*
- Clinician - *difficulty giving bad news, difficulty communicating uncertainty*, and *lack of time.*
- Contextual - *challenges meeting multiple goals or needs* and *family requests for non-disclosure*

- *Wollney EN, Armstrong MJ, Bedenfield N, et al. Barriers and Best Practices in Disclosing a Dementia Diagnosis: A Clinician Interview Study. Health Services Insights. 2022;15. doi:10.1177/11786329221141829*

Best practice in communication around the possibility of dementia

- ***Communication*** - build rapport, use empathic communication, and develop and maintain connections
- ***Education*** - tailor communication, explain how the diagnosis was reached, educate patients and caregivers about the diagnosis, and follow up to ensure understanding.
- ***Involve family*** - meet with family members prior to the diagnosis and involve the caregiver or family when delivering information.

Communicating the news

- *You prepare people that this may be bad news. You set up the appointment. You make sure that their significant other is with you, and with them, and you give them the bad news. And you say, "and I want to see you tomorrow – or I want to see you next week". "I want to see you in three days' time – to talk about all the ways forward from here". "Here's some information – just take it away and look at it". But I don't expect them to take in anything more at that moment. That is not the moment…. they need to go away and cry. They need to go away and be with their family and they will come back with a thousand questions. But right then, it is not much point in giving them information. (Suggestion from the GP Forum)*

Broad Communication guidelines for dementia

- Use a non-threatening, face-to-face position.

• Maintain comfortable eye contact.

• Keep introductions simple i.e. just one or two sentences. This will help the person with dementia focus on the conversation itself.

• Focus on one question or idea at a time.

• Speak in short simple sentences of four to six words with one verb per sentence and using the active voice.

• Wait for a response, pause between ideas and/or signal topic changes to allow for slowed cognitive processing (e.g. Can we talk about your medications now?).

- https://cdpc.sydney.edu.au/wp-content/uploads/2019/09/GP-Care-Communication-Section-FINAL-CLEAN-16-08-2019.pdf

Photo by Ravi Patel on Unsplash

Multidisciplinary team - nurses

Practice nurse role (may be pivotal):

- Identification of functional issues in 75 Plus HA eg falls, nutrition, self-care (COPD puffers, insulin, other medications)- each needs attention
- Identification of social isolation
- Practice nurse may add "social prescribing" to the care plan. Potential for pharmacy review for medication management. Potential for allied health input

Functional assessment

- Bathing
- Dressing
- Toileting
- Oral health
- Transfer
- Continence
- Feeding
- Housework

- Using telephone
- Shopping
- Travelling
- Preparing meals
- Managing money
- aking medications

Functional assessment - formal

- This is needed to identify if or how the cognitive impairment is affecting activities of daily living and to assess needs for support
- There are a number of functional assessment scales eg Barthel, Lawton and Brody

Dementia Outcome Measurement Suite. Function assessment measures. Available at http://www.dementia-assessment.com.au/function/index.html

Multidisciplinary team – allied health

- Consider a GPMP and TCA
- +physiotherapist/exercise physiologist (exercise)
- Occupational therapist (home assessment)
- Dietician (Mediterranean diet)
- Psychologist (depression/anxiety) – may need Mental Health Plan. *Note: dementia not an indication for a MH Plan, but depression is*

Loneliness

- Feelings of loneliness, but not social isolation, predict dementia onset: results from the Amsterdam Study of the Elderly (AMSTEL)
- https://jnnp.bmj.com/content/85/2/135
- *Photo by Danie Franco on Unsplash*

Multidisciplinary team - Social prescribing

- Social prescribing is a personalised approach in general practice that supports the needs of consumers and carers who are experiencing social issues or emotional concerns that are impacting on their health.
- https://connectedau.com.au/about
- Wellbeing-Scripts-System-Building.pdf (adma.org.au)
- Healthpathways

THANK YOU

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