DEMENTIA NEWSLETTER *for* PHYSICIANS

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Acute Agitation

Dr. Louise Carrier, MD, FRCP (C) , Medical Director, Geriatric Psychiatric Community Services of Ottawa

It's Monday morning when you get a panic call from Mrs A's daughter. Her 82 year old mother was acting "weird" over the weekend. She was speaking nonsense, paranoid and hallucinating, called in distress in the middle of the night stating that strangers were in her bedroom and that she had locked herself in the bathroom. She was agitated and not easily reassured. Mrs A is usually a pleasant woman with mild dementia who lives independently in her apartment. You arrange to see Mrs A. later that day.

What would be your next step? **New onset of behavioural problems in dementia is delirium until proven otherwise.** Delirium should be considered a medical emergency. The diagnosis is too often missed although it is common in the elderly, often superimposed on dementia, and has a high mortality rate. Risk factors to consider are age, frailty, multiple chronic diseases, dementia and multiple drugs. The hallmark of delirium is the inability to sustain attention, for example, patient having difficulties following a conversation. The diagnosis can be made by using the Confusion Assessment Method (CAM) which has a sensitivity of 94-100% and specificity of 90-95%.

Confusion Assessment Method
1) Acute onset and fluctuating course
2) Inattention AND
3) Disorganized thinking OR
4) Altered level of consciousness

Delirium= 1, 2 AND either 3 OR 4 Inouye S. Ann Intern Med 1990; 113:941

Next you want to find the cause of the delirium as this is treatable. Most common causes of delirium are: "drugs, drugs, drugs, infection, metabolic and system failure". In the elderly there are often multiple underlying causes rather than one single cause. All drugs can cause delirium, worse are those with anticholinergic effects.

(continued on page 2...)

Acute Agitation *(...continued from page 1)*

Ask about alcohol use, over-the-counter, herbal and prescription medications, new prescriptions or changes in dosing. A full physical examination needs to be conducted. Rule out infections such as urinary tract or pulmonary. Constipation and urinary retention can also be a culprit as also dehydration, poor nutrition and sleep deprivation. Routine initial investigation should include: CBC, electrolytes, blood sugar, urinalysis and culture, creatinine and BUN, calcium and albumin. Ancillary tests are ordered as clinically warranted, including possibly a chest xray or blood cultures.

Management should first address immediate safety needs, then identify and treat the underlying cause(s). Non-pharmacological management includes providing supportive measures such as ensuring proper fluids and nutrition intake, providing familiar faces for reassurance (family) and orientation (calendar, clock), correcting sensory impairments (lights on), keeping a low level of stimulation and avoiding restraints. Pharmacological management is at best avoided and should only be a last resort solution to control symptoms. A single agent is preferred, starting at low dose and titrating up, and stopping the medication as soon as possible. The treatment of choice in an acute situation is an oral atypical antipsychotic. When first-line atypical antipsychotics are ineffective or a rapid parenteral route of administration is needed for an emergency situation than a typical antipsychotic such as haloperidol may be preferred. Benzodiazepines are generally used for alcohol withdrawal, rare and episodic situational anxiety, or insomnia. Short acting benzodiazepines with no active metabolites, such as lorazepam, are the preferred choice.

Pharmacological Management in Acute Situation

Medication	Usual starting dose	Maximum dose/24hr
Risperidone	0.25-1mg PO (tabs, liquid, M-tab)	2 mg
Olanzapine	2.5-5 mg PO (tabs, Zydis)	10 mg
Quetiapine	12.5-25 mg PO (tabs)	150-200mg
Haloperidol	0.5-1mg PO/IM	2mg
Lorazepam	0.5-1mg PO/IM	2mg

Mrs A is found to be acutely confused and delirious. Her urinalysis suggests an urinary tract infection and the blood work revealed signs of mild dehydration .You prescribe an antibiotic. Her daughter is agreeable to care for her mother for the next few days until the delirium resolves, ensuring that she would hydrate and feed herself adequately. You opt not to start an antipsychotic medication as you suspect that with the appropriate treatment of the underlying cause for the delirium and the involvement of the family she will improve quickly from her paranoia and hallucinations. In reviewing her list of medication you decide to stop her Detrol LA that she was taking at bedtime as this is an anticholinergic agent. You request to see them again in 7-10 days to ensure that she continues to improve and to further discuss the need for considering a move to a retirement home as Mrs A lives alone and may be at increased risk due to her dementia for repeated delirium.

In summary, delirium should be highly suspected as the cause of any behavioural changes in the elderly. The CAM is a useful tool to make the diagnosis. Safety is to be addressed immediately. Underlying cause(s) are identified and treated promptly. Non-pharmacological management provides supportive measures while pharmacological management should be used only if absolutely necessary to control symptoms of agitation, aggression or psychosis.

First Link™ … Thank You Physicians for Your Support

Kelly Robinson, RSW, First Link Coordinator, Alzheimer Society of Ottawa and Renfrew County

Making a Difference

Thank you Ottawa physicians. Your referrals to First Link have made an incredible difference to those affected by Alzheimer's disease or a related dementia (ADRD). Thanks to your support, First Link has been able to reach over 2000 individuals and families in the Ottawa area who are navigating through the system with a dementia diagnosis. This past year alone, First Link has served over 600 people dealing with a diagnosis of ADRD.

What is First Link?

After diagnosis and a referral to First Link, individuals and families benefit from an initial phone call offering information and support. During and after this first contact, linkages are made to the appropriate community and health care services as well as informed of the various opportunities for learning and support. A referral to First Link ensures that persons with dementia and their caregivers gain the necessary knowledge and skills to better cope with their circumstances. Not only does a referral to First Link save you valuable time, but also, the resulting connections ensure people know that they are not alone. If individuals and their families are better prepared right from the point of diagnosis, then caregivers will be more equipped to manage their circumstances.

First Link Goes Provincial!

Thanks to your support, the First Link program has proven to be an overwhelming success. In response to this success the Alzheimer Society of Ontario has initiated a 2-year First Link pilot project. There are now three other First Link sites in Ontario (Kingston, Grey-Bruce, and Sudbury-Timmons).

We Need Your Help

It is wonderful that we have been able to connect with over 2000 individuals and families affected by ADRD. Wonderful, but not enough. It's only a fraction of the number of people we still need to reach. There are still thousands of people in our region affected by ADRD who may be searching for more information and more support.

We'll Take it from Here

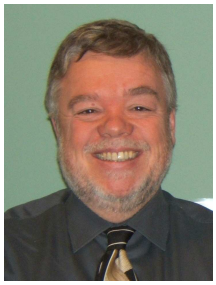
You will notice First Link will save you time by minimizing the number and intensity of crises calls to your office. You will also notice your patients and families possess enhanced coping skills and are better prepared for their challenging journey. First Link is a valuable resource for family physicians.

In a recent conversation with Dr. Mary Comerton (a regular referral source) I asked why she referred to First Link, she responded, *"As a family physician, who cares for individuals with a multitude of chronic diseases, I welcome any help I can access to assist my patients and their families. In these days of limited resources, other professionals often have more time and information to share with the public than I have, as I juggle the demands generated by caring for an aging population."*

Making a referral to First Link is a simple two-step process: 1) Fill out the First Link a referral from the First Link scrip pad; and 2) Fax referral to our office at 613-523-4004.

As the First Link Coordinator of Ottawa I am highly motivated to make this program work best for you and for your patients. Please call me, Kelly Robinson at 613-523-4004, to request your referral pad.

DEMENTIA ASSESSMENT APPROACH AND BILLING



Dr. Bill Dalziel, Chief, Regional Geriatric Program of Eastern Ontario, Associate Professor, Geriatric Medicine, University of Ottawa

Here is an approach to dementia assessment that is GP "time" and "billing" friendly. A sequential multiple visit approach is described in the chart below (left side = clinical activities/ right side = billing possibilities)

Appropriate Billing for Dementia - Multi-Visit Assessment

Visit/Time	Billing
1. "History" (incl. informant) Look for **CHANGE**:"ABC" – **A**DL (function) **B**ehaviour, **C**ognition (5-10 minutes)	A003 ($61) or 1o mental health K005 ($52/30 minutes) +/- K002 (interview for collateral Hx)
2. Cognitive assessment (MMSE, MOCA, clock, animals etc.) (20 minutes)	K032 (20 minute cognitive assessment $52) or another complaint A007 ($31.45)
3. Targeted red flag, physical lab, neuro imaging – make dx (5-10 minutes)	A003 ($61) or A007 ($31.45)
4. Disclosure of diagnosis, start cholinesterase inhibitor Rx. Refer to Alzheimer Society. (20-40 minutes)	K013 (counselling $52/30 minutes)
5. Monitoring Cholinesterase inhibitor Rx at 3/12 (20 minutes)	K032 ($52) +/- A007 ($31.45)
6. Assess other problems (driving/capacity/CCAC needs/LTC need) (10-20 minutes)	A003 $61, report MOT (K035 - $34.85). Refer to CCAC (K070 - $17. 45) LTC application K038 ($41)

Did You Know That...

You can download all previous editions of the Dementia Newsletter for Physicians at the Champlain Dementia Network website at: www.alzheimerott.org

THANK YOU

The Champlain Dementia Network would like to thank Janssen-Ortho, Novartis, Pfizer and Lundbeck for supporting this edition of the Dementia Newsletter for Physicians.