DEMENTIA NEWSLETTER *for* PHYSICIANS

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New (DRAFT) Third Canadian Consensus Conference Guidelines for Dementia 2006

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(Some selected guidelines, the full report will be available soon)

(1) MCI – Mild Cognitive Impairment

Physicians should be aware that most dementias may be proceeded by a recognizable phase of mild cognitive decline. Physicians should be familiar with the concept of MCI: mild cognitive impairment (or CIND: cognitive impairment not dementia) as a high risk state for decline and dementia.

There is fair evidence that physicians should closely monitor individuals who have MCI or CIND, because of the known increased risk of both dementia and death that has been documented. (Recommended grade B, Evidence level II)

There is currently insufficient evidence to recommend for the use of cholinesterase inhibitors in MCI. (Recommendation Grade C, Evidence level I).

There is currently fair evidence to recommend against the use of NSAIDs, estrogen, ginkgo biloka and Vitamin E in MCI. (Recommendation Grade D, Evidence Level I).

As vascular risk factors and comorbidities impact on the development and expression of dementia, they should be screened for and treated optimally in MCI. (Recommendation Grade B, Evidence)

(2) Treatment of Dementia

There is good evidence to treat systolic hypertension (>160mm) in older individuals. (Level I, Grade A) In addition to reducing the risk of stroke, the incidence of dementia may be reduced. The target BP should be 140 mm or less.

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All three cholinesterase inhibitors available in Canada are efficacious for mild to moderate AD. They are all viable treatment option for most patients with mild to moderate AD. (Grade A, Level I)

Memantine is an option for patients with moderate to severe stages of AD. Its use in mild stages of AD is not recommended. (Grade B, Level I)

Combination therapy of a cholinesterase inhibitor and memantine is rational (as the medications have difference mechanisms of action), appears to be safe and may lead to additional benefits for patients with moderate to severe AD. This would be an option for patients with AD of a moderate severity. (Grade B, Level I)

Patients with severe AD can be treated with ChEIs, memantine or the combination. Expected benefits would include modest improvements in cognition, function and behavior and/or slower decline. (I)

Treatment with ChEIs and/or memantine should persist until clinical benefit can no longer be demonstrated. Treatment should not be discontinued simply because of institutionalization. (III)

(3) Driving

Driving is contraindicated in persons who, for cognitive reasons, have an inability to independently perform multiple instrumental activities of daily living (e.g., medication management, banking, shopping, telephone use, cooking) or any of the basic activities of daily living (e.g., toileting, dressing). (Grade B, Level III)

A health professional-based comprehensive off- and on-road driving evaluation is the fairest method of individual testing. (Grade B, Level III)

In places where comprehensive off and on-road driving evaluations are not available, clinicians must rely on their own judgment. (Grade B, Level III)

For persons deemed safe to drive, reassessment of their ability to drive should take place every 6 to 12 months. (Grade B, Level III)

Monitoring of Psychotropic Medication

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Psychotropic medications are often required for the management of the behavioural and psychological symptoms of dementia (BPSD). The best studied class of psychotropics for the treatment of BPSD is the atypical antipsychotics (AP).

A non-pharmacological approach to BPSD should be sought initially. In urgent situations, when the patient is in severe distress or shows aggression towards himself or others, a medication will be necessary, most often this will be an AP. Although better tolerated than typical antipsychotics, AP are not without adverse effects and should therefore be used cautiously. Typically, the response is usually not very rapid in onset (few days to 2-4 weeks). In prescribing AP, one should 'start low go slow' to avoid unnecessary adverse effects. It is not rare to see patients who initially appeared to be responding well to the medication to become overly

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Monitoring of Psychotropic Medication

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sedated, confused, akathisic or parkinsonian a couple of weeks later as the medication starts to accumulate in the patient.

Excessive sedation is to be avoided. This often signals that the dose is excessive and a reduction of the dosage is required. The aim is to achieve 'calmness' without sedation. Extrapyramidal side effects (EPS) can occur with the AP and is dose dependent (Ris> Ola> Que). Shuffling gait and muscular rigidity can lead to unwanted falls and gait disturbance to increased time spent in bed with resulting increased risk for infections, CVAE and death. It is a good practice to actively verify for EPS in all patients prescribed antipsychotic medication. Akathisia can be confused with increased agitation or anxiety. In doubt, in a patient who initially responded well to the medication, a reduction of dosage may be the preferred approach. Tardive dyskinesia (TD) is rarer but not unheard of with the AP. Elderly, female gender, cognitive and/or affective disorder and EPS are risk factors to develop TD.

Although by themselves these medication are not very anticholinergic (Ola> Que> Ris), it may be sufficient when combined with other medication with anticholinergic activity to tip the balance for the patient. This can present clinically as increased confusion, delirium, constipation, urinary retention etc. which in turn are a major cause of agitation in nursing home patients. Falls are also a major concern in the elderly, a common cause of hospitalization, mortality and irreversible disability. Quetiapine (Que > Ris = Ola) may affect postural hypotension and this may lead to instability and falls. Blood pressure should be measured lying and then standing whenever possible to measure the postural drop.

Weight gain, diabetes, metabolic syndrome, cerebrovascular events and death have been previously discussed. (See Summer 2005 Newsletter: 'Prescribing atypical antipsychotics with caution.') Olanzapine is the more strongly associated with weight gain and diabetes (Ola> Ris= Que).

The following table summarizes the recommended monitoring. This must take into account the overall situation of the patient and feasibility or clinical relevance.

	Baseline	4 wks	8 wks	12 wks	Four times /year	One time /year	5 yrs
Personal /Family history	**X**						
(BMI)	**X**	**X**	**X**	**X**	**X**		
Waist circumf.	**X**					**X**	
Blood pressure	**X**			**X**		**X**	
Fasting plasma glucose	**X**			**X**		**X**	
Fasting lipid profile	**X**			**X**			**X**

Ref: Consensus Development Conference on Antipsychotic Drugs and Obesity and Diabetes. J Clin Psychiatry 65:2 Feb 2004

Used judiciously, AP are a major benefit to our patients and their caregivers. If after 4 weeks there is no improvement it would be appropriate to review the medical diagnosis, revisit behavioral and environmental interventions, or switch to a different AP or psychotropic medication. It is recommended that a trial to decrease and/ or discontinue the medication be attempted every 3 months as BPSD vary over the course of the illness and to avoid unnecessary exposure and risks.

Legend: Ris = risperidone (Risperdal), Ola = olanzapine (Zyprexa), Que = quetiapine (Seroquel)

Top Three Reasons to Refer You Patients to First Link

First Link Premier lien

1. **Caregiver support**
2. **Dementia education**
3. **Info about community services**

First Link is an Alzheimer Society of Ottawa program implemented in collaboration with the Champlain Dementia Network. When you refer a patient to First Link, they receive: a personal phone call from the Alzheimer Society, an information package about Alzheimer Disease and dementia, guidance, and information about community resources and care issues.

Driving Assessment

Location	Phone Number	Cost	Additional Info
The Rehabilitation Centre, Occupational Therapy Department, The Ottawa Hospital Ottawa, ON K1V 8Y5	613-737-7350 ext. 5311	$500.00	Waiting time almost zero with cognitive diagnosis (two week/ maximum)
Swanson& Associates 1729 Bank Street, Ottawa, ON K1V 7Z5	613-260-1935	$675.00	No waiting period after referral and form submission (two weeks)
DriveABLE Assessment Centre (Division of Larry's Driving School) 1893 Baseline Road Ottawa, ON K2C 0C7	613-224-7480	$585.00	Appointment in one week, results in three days. Necessary to fill in form re: medical referral
Capital Region Driver Rehabilitation Centre **(Capital Region Therapy Services)** 1530 Duford Dr Orleans, ON K1E 2M2	613-837-5086 or 1-866-680-0016	$575.00	No waiting period with doctor's referral, an updated eye exam, and agreement signature

THANK YOU

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