DEMENTIA NEWSLETTER *for* PHYSICIANS

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A Publication of the Dementia Network of Ottawa

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Supporting the Family Physician

The mandate of the Dementia Network is:

- to develop a more coordinated and efficient system for service delivery, education and research

This is accomplished through:

- membership from 18 programs and organizations, the local Alzheimer Society, a residential care association, a day program provider, and a family physician
- meetings held quarterly
- regular reports from sub-committees to keep abreast of changes and resulting impact within dementia care

Earlier Diagnosis of Alzheimer Disease (AD)

The theme for January 2001's Alzheimer Awareness Month is "Voices of Alzheimer Disease: The Individuals with Alzheimer Disease and Related Dementias Speak Out".

- Two new brochures are available for your patients and their families focusing on first steps to take after diagnosis as well as kinds of changes to expect and ways to cope.
- These and other brochures such as "Is It Alzheimer Disease? 10 Warning Signs" are available from the Alzheimer Society of Ottawa-Carleton.
- As a family physician, you may want to suggest to your dementia patients that they contact the Alzheimer Society for counselling, support, education and resource material.
- Currently, there are 7,000 people in Ottawa-Carleton with AD or related dementias and it is expected that there will be 1,000 new cases diagnosed by 2005.

FIRST EDITION!

The Dementia Network of Ottawa is pleased to provide this newsletter to all physicians in order to share information about clinical care, education and research on patients with memory loss.

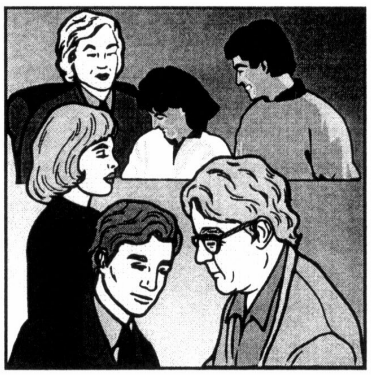
Treatment of Alzheimer Disease (AD)

By Dr. Bill Dalziel, Chief, Regional Geriatric Assessment Program

By 2001, 3 Cholinesterase Inhibitors (CI) will be available for use in patients with mild to moderate AD in Canada, (Donepezil or Aricept, Rivastigmine or Exelon, and Galantamine or Reminyl). A trial with one of these 3 CIs should be prescribed to all patients with mild to moderate AD in the absence of contraindications.

The key pathological change in AD is degeneration of cholinergic neuronal pathways associated with decreased levels of acetylcholine in the synaptic cleft, CIs represent symptomatic treatment as opposed to disease modification agents. Such symptomatic treatment is not only important to patients and families but also may delay institutionalization with important cost implications (approximately 3/4 of all AD patients are admitted to a nursing home within 5 years of diagnosis).

In extensive clinical trials, these 3 CIs have produced similar levels of improvement in cognitive function with additional benefits seen in terms of activities of daily living and behavioural symptoms.



In the average patient, cognitive testing shows an initial modest improvement, only falling below the pretreatment baseline at approximately one year. However, within this average response, there are generally 3 different patterns:

- Approximately 1/4 (25%) show no response with continued deterioration at the pretreatment rate with no discernable benefits.
- Approximately 1/2 (50%) show modest symptomatic improvement typical of the average response.
- Approximately 1/4 (25%) have a much more obvious benefit with functional improvements and sometimes significant increments in Folstein MMSE scores.

At the present time, there is no way to predict responders versus non-responders and, therefore, ***all AD patients should be given a trial with a CI once the diagnosis of mild to moderate AD (MMSE 10 - 26) is made.***

The steps in initiating and monitoring CI treatment are as follows:

1. Diagnosis of AD.
2. Establishment of a baseline for evaluation of treatment benefits:
   - global functioning
   - cognition (typically the MMSE)
   - activities of daily living
   - behavioural symptoms (The diagnosis and baseline assessment of dementia can be made in three to four 15 minute billable office sessions — see the next newsletter!).
3. Evaluate health status, especially concomitant diseases and drugs with respect to interactions/precautions (caution is advised with seizure, obstructive airway disease, peptic ulcer, and conduction blocks except first degree heart block and right bundle branch block). The most important drug interactions are with other anticholinergic or cholinergic agents.

with Cholinesterase Inhibitors (CI)

The major side effects are cholinergic (nausea, vomiting, and diarrhea) and usually mild and transient.

4. Establish with the family/patient the most clinically meaningful target symptoms to evaluate treatment impact (see following page — Checklist for Alzheimer Disease Treatment).
5. Follow-up at 2 to 6 weeks to check compliance, counsel with respect to side-effects, and initiate dose titration.
6. Follow-up to assess treatment benefits at 3 to 6 months (3 months in Ontario because of ODB formulary issues). If the patient is clearly better, the same, or deterioration is less than expected, drug therapy should be continued.
7. Then follow-up visits should take place every 6 months using a reset of the baseline compared to the status 6 months earlier. If it is felt that the patient is still benefiting, therapy should not be discontinued only because the MMSE falls below the initial baseline or below 10, or if the patient enters a nursing home or develops behavioural problems.

Benefits have also been seen in functional abilities, and behavioural problems including nursing home patients with moderate to severe AD and patients with Lewy body dementia (in particular with behavioural problems).

Drug therapy is not the only intervention available to manage AD patients. Reducing caregiver burden with the appropriate use of services, dealing with specific complicating problems such as falls, incontinence, and neuropsychiatric symptoms, etc., and caregiver support and education are all critical. AD patients of caregivers who received counselling, support and education were able to remain at home for almost one year longer than those receiving no support. However, often such education and caregiver support occurs at low levels and late in the disease. Once the diagnosis is made, the caregiver should be referred to the Alzheimer Society for education and, when appropriate, to community services.

Is It Alzheimer Disease? 10 Warning Signs

1. Memory loss that affects day-to-day function
2. Difficulty performing familiar tasks
3. Problems with language
4. Disorientation of time and place
5. Poor or decreased judgement
6. Problems with abstract thinking
7. Misplacing things
8. Changes in mood and behaviour
9. Changes in personality
10. Loss of initiative

This list is excerpted from the brochure "Is It Alzheimer Disease? 10 Warning Signs" adapted with permission from the Alzheimer's Association, U.S. and supported by Pfizer, Novartis, Manulife Financial, and Janssen-Ortho. Call the Alzheimer Society at (613)523-4004 for a copy.

Target Symptom Checklist for Alzheimer Disease: Monitoring Impact of Therapy

Global (A) Caregiver overall impression.
(B) Caregiver stress / burden impression.

Specific Target Symptoms: (The client/caregivers should choose those symptoms which have significantly changed within six months).

BASIC PROBLEM	FOLLOW-UP #1	FOLLOW-UP #2
1. MEMORY / ORIENTATION / COMMUNICATION		
Forgetfulness – names/events/ instructions/activities	❑ Yes ❑ No	❑ Yes ❑ No
Recognizing – family and friends	❑ Yes ❑ No	❑ Yes ❑ No
Orientation – time and place	❑ Yes ❑ No	❑ Yes ❑ No
2. INTERACTIVENESS		
Attention – able to keep attention focused (e.g., TV)	❑ Yes ❑ No	❑ Yes ❑ No
Alertness – being "present/tuned in"	❑ Yes ❑ No	❑ Yes ❑ No
Social Connectedness – interest in people/ participation in discussions	❑ Yes ❑ No	❑ Yes ❑ No
Initiative – taking part/starting up activities	❑ Yes ❑ No	❑ Yes ❑ No
Overall – more like his/her "old self"	❑ Yes ❑ No	❑ Yes ❑ No
3. ADL/FUNCTION		
Personal/Basic		
Bathing (initiating, using taps/shower)	❑ Yes ❑ No	❑ Yes ❑ No
Hygiene/grooming, dressing (choosing what to wear/changing)	❑ Yes ❑ No	❑ Yes ❑ No
4. HOUSEHOLD TASKS		
Using the telephone	❑ Yes ❑ No	❑ Yes ❑ No
Preparing snacks/meals	❑ Yes ❑ No	❑ Yes ❑ No
Handling the mail	❑ Yes ❑ No	❑ Yes ❑ No
Shopping	❑ Yes ❑ No	❑ Yes ❑ No
Handling money/finances	❑ Yes ❑ No	❑ Yes ❑ No
Using appliances	❑ Yes ❑ No	❑ Yes ❑ No
Hobbies/Leisure – e.g., playing cards/ sewing/knitting	❑ Yes ❑ No	❑ Yes ❑ No
5. BEHAVIOUR		
Apathy, lack of interest, withdrawal	❑ Yes ❑ No	❑ Yes ❑ No
Anxiety, nervousness	❑ Yes ❑ No	❑ Yes ❑ No
Irritability, anger	❑ Yes ❑ No	❑ Yes ❑ No
Agitation, restlessness, pacing	❑ Yes ❑ No	❑ Yes ❑ No
Depression, sadness, emotional outbursts	❑ Yes ❑ No	❑ Yes ❑ No
Hallucinations, delusions, paranoia	❑ Yes ❑ No	❑ Yes ❑ No