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DEMENTIA NEWSLETTER FOR PHYSICIANS

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Editorial Committee

Editor

Dr. Andrew R. Frank
B.Sc.H. F.R.C.P.(C)
Cognitive and Behavioural Neurologist,
Memory Disorder Clinic,
Elisabeth Bruyère Hospital,
Ottawa, Ontario

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For more Information

Ontario Dementia Network
c/o Alzheimer Society of Ottawa and Renfrew County
Tel: 613-523-4004
Fax: 613-523-8522
Email: info@asorc.org

WHEN IT'S NOT ALZHEIMER'S DISEASE: DEMENTIA WITH LEWY BODIES

Dr. Patricia Lepage, MD, FRCP, Program Medical Director, Seniors Mental Health Programs, St. Joseph's Care Group, Lakehead Psychiatric Hospital, Thunder Bay, ON

KEY POINTS:

- Dementia with Lewy Bodies (DLB) is a neuro-degenerative condition, which causes cognitive loss, parkinsonism, visual hallucinations, and REM Behavioural Sleep Disorder
- A trial of cholinesterase inhibitor therapy should be attempted in cases of DLB

With our rapidly aging population, the modern medical practitioner will be confronted increasingly with dementia, given the prevalence of this debilitating, and largely neuro-degenerative, class of disorders.

There are five common causes of dementia: Alzheimer's disease, Lewy Body disease, Frontotemporal degeneration, Parkinson's disease, and Vascular disease. Despite extensive research at our disposal, differentiating between these causes is rarely an easy task.

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WEBINAR FOR FAMILY PHYSICIANS

Topic: Hallucinations in the Elderly

Presenter: Lisa McMurray, MD, FRCPC
Royal Ottawa Mental Health Center

Date/Time: Wednesday, January 16, 2013 12 noon to 1pm

Link: http://tinyurl.com/ccf6w97

Register now

Technical Requirements:

Visual Support — The presentation will be accessible via an internet connection. This connection can be any web-enabled laptop or desktop computer of your choice.

Audio Support — Audio support for the presentation will be provided through your telephone via a toll-free line.

You will receive a confirmation email 24-48 hours prior to the session. Thank you, we look forward to your participation!

WHEN IT'S NOT ALZHEIMER'S DISEASE: DEMENTIA WITH LEWY BODIES (CONT'D FROM PAGE 1)

Here, we deal with differentiating between Alzheimer's disease (AD) and Lewy body disease, which causes Dementia with Lewy Bodies (DLB). Alzheimer's disease is known to be the most common of the dementing illnesses, and DLB follows a close second. Importantly, both AD and DLB are criterion-based diagnoses, and are classified as probable or possible at the time of presentation, and definite at autopsy. Many cases of DLB are diagnosed as AD clinically, while postmortem studies show that up to 40% of demented patients have histopathological evidence of DLB.[1]

The clinical diagnosis of Alzheimer's disease requires the presence of progressive memory impairment, and additional impairment in one or more cognitive functions such as apraxia, agnosia, aphasia, or executive function. There must be evidence of decline which has impacted the patient's social or occupational functioning.[2] Importantly, systemic (i.e. metabolic, drugs, infection, and structural lesions), as well as psychiatric causes of dementia must be excluded.

Dementia with Lewy bodies is a neurodegenerative disorder of abnormal alpha-synuclein accumulation in the central nervous system. In addition to dementia, it has three core features: spontaneous parkinsonism, recurrent well-formed visual hallucinations, and fluctuating attention and concentration (over minutes, hours, or even days). There are supportive clinical features such as rapid eye movement (REM) sleep behaviour disorder (characterized by repeated flailing of limbs or acting out during dream activity), falls, syncope, autonomic dysfunction, delusions, and depression. DLB may show striking neuroleptic sensitivity, such that treatment with antipsychotic medication requires considerable forethought.[4]

Neuropsychological testing in DLB often shows prominent visuospatial or executive dysfunction, as compared to AD, which shows prominent short-term memory decline. DLB generally follows a more rapid course compared to AD, with more psychiatric pathology, shorter time to nursing home placement, and a shortened survival.

Importantly, cases of DLB may be quite responsive to cholinesterase inhibitor therapy (e.g. Aricept/donepezil, Reminyl/galantamine ER, or Exelon/rivastigmine), so a course of this medication class should be attempted.

Considerable research has been made into enhancing the diagnosis of AD and DLB with biomarkers such as cerebrospinal fluid and PET imaging. Ultimately, the diagnosis remains a clinical one, with cognitive testing, medical work-up, and neuroimaging.

REFERENCES

1. Tarawneh, Rawan, Galvin, James E. Distinguishing Lewy body dementias from Alzheimer's Disease in Expert Review of Neurotherapeutics. 7.11 (Nov. 2007) p1499
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3. Boeve, Bradley F. Mild cognitive impairment associated with underlying Alzheimer's disease versus Lewy body disease in Parkinsonism and Related Disorders 1851 (2012) s41-s42
4. Bertram, Kelly, Williams, David R. Visual hallucinations in the differential diagnosis of parkinsonism in J Neurology Neurosurgery Psychiatry. 2012, 83:448-452

FOR FAMILIES:

Lewy Body info sheet from Alzheimer Canada
www.alzheimer.ca/en/About-dementia/Dementias/Lewy-Body-Dementia