Société Alzheimer Society CANADA

THE COLLEGE OF FAMILY PHYSICIANS OF CANADA | LE COLLÈGE DES MÉDECINS DE FAMILLE DU CANADA

MEMBER INTEREST GROUPS SECTION (MIGS) | SECTION DES GROUPES D'INTÉRÊT DES MEMBRES (SGIM)

Practical tips to support patients with dementia and their families

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Faculty/Presenter Disclosure

- **Faculty: Jim Mann, Mary Schulz, Nancy Dixon, Fred Mather, Sid Feldman**
- **Relationships with commercial interests:**
  - **Grants/Research Support:** None
  - **Speakers Bureau/Honoraria:**
    - **Feldman: OCFP, GERAS Centre McMaster University, CFPC**
  - **Consulting Fees:** None
  - **Other:**
    - **Schulz: Salary support Alzheimer Society of Canada**
    - **Feldman: Salary support Baycrest Health Sciences, Centre for Effective Practice**

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Mitigating Potential Bias

- Will identify CEP materials

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Objectives

By the end of this session, participants will be better able to:

1. Recognize key transition points in the dementia journey of patients and families from initial diagnosis to end of life care;
2. Produce practical, evidence-based advice to support patients and family members at these key transitions;
3. Integrate available tools and resources into family practice settings to optimally care for patients and families living with dementia.

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Agenda

Mr. Jim Mann: Opening remarks
Diagnosis
Driving

Break

Behavioural symptoms
Management

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Diagnosis of Dementia

Practical Tips to Support Patients with Dementia and Their Families
Family Medicine Forum
November 2, 2019
Dr. Nancy Dixon

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Key Points

- Family physicians are the clinicians most likely to disclose dementia and be the main provider of ongoing care
- Take a step-wise approach to Recognize, Assess, Diagnose, Disclose, and Follow
- Well-planned, timely diagnosis will benefit your patient, their caregivers, and your relationship with them

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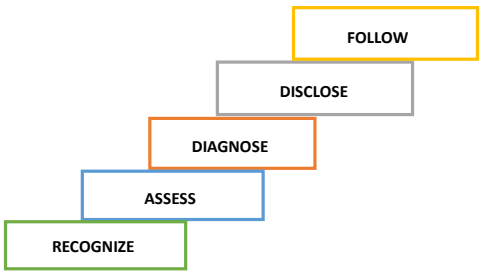

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RECOGNIZE

- Self-reported or family concerns
- Missed appointments
- Vague, repetitive, forgetful, word-finding difficulty
- Change in appearance, mood, behaviour, personality
- Turning to caregiver for help answering questions

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ASSESS

HISTORY

- Collateral history
- Onset and progression
- Types of cognitive problems (e.g. learning and memory, language, reasoning)
- Function – ADLs, IADLs
- Mood and behaviour
  - Hallucinations
  - Sleep
- Past medical history
- Head injury
- Medications
- Alcohol/substance use
- Family history
- Social history/education

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ASSESS

PHYSICAL EXAM

- Focused physical and neurological exam
  - VS, cardiac and respiratory
  - Eye movements, tremor, tone, bradykinesia, weakness, dystonia, gait
  - Speech and language
  - Sensory deficits (hearing, vision)

COGNITIVE TESTING

- MoCA if I/ADLs intact
- MMSE if I/ADLs impaired
- Quick screen: Mini-Cog
- RUDAS – multicultural cognitive assessment scale

https://mini-cog.com/
http://www.multiculturalmentalhealth.ca/wp-content/uploads/2014/04/20110311_2011NSWRUDAScoring_sheet.pdf

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ASSESS

Is it delirium?

Table 6: Confusion Assessment Method (CAM) Diagnostic Algorithm

1) Acute onset and fluctuating course
2) Inattention, distractibility
3) Disorganized thinking, illogical or unclear ideas
4) Alteration in consciousness

The diagnosis of delirium requires the presence of both features 1 AND 2, plus EITHER feature 3 or 4.

Adapted from: Inouye S, van Dyck C, Alessi C, et al. Clarifying confusion: The confusion assessment method. Ann Intern Med 113:941, 1990.

Is it depression?

Depression Screening Tool
Patient Health Questionnaire (PHQ-2)

Over the past 2 weeks, have you often been bothered by:

1. Little interest or pleasure in doing things? ☐ Yes ☐ No
2. Feeling down, depressed, or hopeless? ☐ Yes ☐ No

If the patient responded "yes" to either question, follow-up using the PHQ-9, a nine-item, self-administered questionnaire.

https://www.albertahealthservices.ca/frm-19825.pdf

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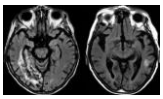
ASSESS

INVESTIGATIONS

- Laboratory testing
  - CBC
  - Serum B12
  - TSH
  - Electrolytes
  - Calcium
  - Glucose
- MRI or CT
  - Suspect cerebrovascular disease
  - Red flags on history or physical



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ASSESS

RISK ASSESSMENT




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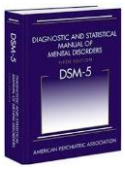
DIAGNOSE

+Dementia-Major Neurocognitive Disorder (DSM V)

- Evidence of significant cognitive decline from a previous level of performance in one or more cognitive domains*:
  - - Learning and memory
  - - Language
  - - Executive function
  - - Complex attention
  - - Perceptual-motor
  - - Social cognition
- The cognitive deficits interfere with independence in everyday activities
- The cognitive deficits do not occur exclusively in the context of a delirium
- The cognitive deficits are not better explained by another mental disorder (eg, major depressive disorder, schizophrenia)



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DIAGNOSE

- **Dementia**
  - Objective findings of cognitive loss **with** impairment of Activities of Daily Living
- **Mild Cognitive Impairment (MCI)**
  - Objective findings of cognitive loss **without** impairment of Activities of Daily Living
- **Subjective Cognitive Impairment (SCI)**
  - No objective findings of cognitive loss

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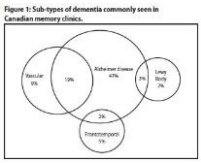
DIAGNOSE

- **AD**: older age, slowly progressive, initial short term memory loss
- **VaD**: vascular risk factors, stroke on neuroimaging
- **FTD**: younger age, early behavioural symptoms and/or language impairment



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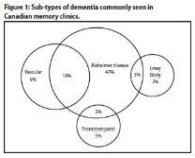
DIAGNOSE

- **DLB**: bradykinesia, Parkinsonism, fluctuating cognition, visual hallucinations, REM sleep disorder
- **PDD**: dementia occurring >1 year after onset of motor Parkinson's disease symptoms



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DIAGNOSE

When to refer?

If diagnosis appears to be other than MCI, SCI, AD or DLB or if there are atypical features for these disorders

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DISCLOSE

- In most cases, disclosure is the best approach
- Disclosure is not a single event
- Set the stage
- Patient-centred approach
- Be clear
  - Use the word dementia
  - Discuss the prognosis and expected rate of decline

https://www.cfp.ca/content/64/7/518

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FOLLOW

DEMENTIA

- Discuss brain health recommendations, health promotion
- Safety assessment at each visit
- Attention to medical issues and medications that may impact cognition

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FOLLOW

DEMENTIA

- Plan for the future
  - Advanced Care Plan
  - Power of Attorney
  - Decision making
- Focus on quality of life – foster a sense of hope and meaning
- Monitor for anxiety, depression, and isolation

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FOLLOW

DEMENTIA

- Identify support services
- Consider referral to local Alzheimer Society
- Online resources:
  - ASC resource list

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COGNITIVE IMPAIRMENT
Clinical Action Plan (Flow Sheet)

https://www2.gov.bc.ca/assets/gov/health/practitioner-pro/bc-guidelines/cogimp-clinical-action-plan.pdf

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FOLLOW

MCI/SCI

- Discuss brain health recommendations, health promotion
- Plan for the future
- Provide info for programs
- Monitor for progression

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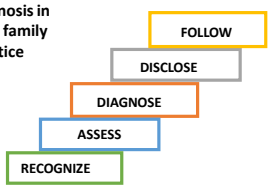
Approach to diagnosis in your family practice



Visit 1: Recognize, start gathering information, Mini-Cog, MMSE or MoCA, +/- call family for collateral history

Visit 2: Focused physical examination, information gathering, medication review, risk assessment, order investigations

Visit 3: Review investigations, disclose diagnosis, start to discuss treatment options

Visit 4 and beyond: Follow, support, answer questions, monitor

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Resources

- Toward Optimized Practice

http://www.topalbertadoctors.org/download/2110/Cogn%20Imp%201-Symptoms%20to%20Diagnosis.pdf?_20170228112440

- BC Guidelines

https://www2.gov.bc.ca/gov/content/health/practitioner-professional-resources/bc-guidelines/cognitive-impairment

- Canadian Consensus Conference

https://alzheimer.ca/sites/default/files/files/national/for-hcp/for_hcp_recos_cccdtd4_en.pdf

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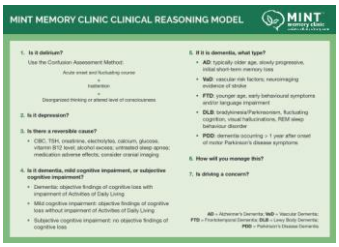
Resources



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Small Group Discussion

- What is your approach to the disclosure of a dementia diagnosis?
- Do you have any tips to share with your colleagues?

"The task of breaking bad news is a testing ground for the entire range of our professional skills and abilities. If we do it badly, the patients or family members may never forgive us; if we do it well, they will never forget us."

-Robert Buckman

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