Toward Optimized Practice

COGNITIVE IMPAIRMENT: SymptomsTo Management

Summary of the Clinical Practice Guideline | February 2017

OBJECTIVE

Alberta primary care physicians and their interdisciplinary teams will be able to assess patients presenting with cognitive concerns and manage the majority of these patients and support their caregivers.

TARGET POPULATION

Older adults (65 years of age and greater)

EXCLUSIONS

Children

Younger adults (less than 65 years of age) with early onset dementia

KEY MESSAGES

- Be alert to personal observations and reports from patients or collateral sources suggesting cognitive decline (see Table 1).
- Rule out/address depression and delirium when assessing a patient with a suspected dementia (see Table2).
- A planned stepwise approach over a series of visits can allow primary care physicians to safely assess, diagnose and manage patients with suspected dementia.
- Many cases of dementia have more than one contributing cause. Management should be based on dealing with the predominant contributing cause(s) of the dementia.
- Where available, the input of an interdisciplinary team providing person-centred care can add to the comprehensiveness and effectiveness of the assessment, diagnose management, and monitoring of a patient with suspected dementia.
- Always assess for safety concerns at each visit.
- Care needs evolve over time. Patients and their families require on-going regular contact with their primary care provider.

See Algorithm on page 6.

Table 1: Examples of Early Warning Signs

Early Warning Signs Suggesting Cognitive Decline	
Examples of possible signs detected by patient, family or other caregivers:	**Examples of possible signs detected by the primary care provider:**
1. Difficulty performing familiar tasks (e.g., managing financial affairs, driving) or learning to use a new device (e.g., remote) because of cognitive changes. 2. Frequent memory problems, repeating things over and over again, problems with language, disorientation to time (specifically month or year) or places previously known, and/or poor judgment. 3. Misplacing things. 4. Changes in mood, behavior, and personality such as loss of initiative or less interest in hobbies/ activities.	5. Formerly reliable but now misses or comes on wrong day for appointments. 6. Vague, repetitive, forgetful, poor comprehension, and/or word-finding difficulties in conversation. 7. Poor adherence with meds/ instructions. 8. Changes in appearance, mood, behavior, and/or personality such as withdrawal. 9. Unexplained change in function (e.g., driving) or weight loss. 10. Head turning sign (turning to caregiver for help answering).

Table 2: Key Features & Approach

Key Features & Approach to Detecting Delirium and Depression as Cause of Cognitive Decline	

Delirium	• Symptoms (inattention, disorganized thinking, altered level of consciousness) occur suddenly and fluctuate during an acute illness, following medication changes, or subsequent to trauma or surgery.
	• Use Mnemonic: A-FACT.
	  ○ Acute – onset
	  ○ Fluctuation – course
	  ○ Attention - ↓ concentration
	  ○ Consciousness - ↓ level
	  ○ Thoughts – disorganized
	• Defer dementia assessment until delirium has resolved but note that dementia is a strong risk factor for delirium and dementia is more likely to occur or worsen after a delirium in older patients (i.e., need follow-up).
	• If delirium is suspected, use the Confusion Assessment Method (CAM) to diagnose delirium - www.albertahealthservices.ca/assets/about/scn/ahs-scn-bjh-hf-delirium-screening-tool.pdf

Key Features & Approach to Detecting Delirium and Depression as Cause of Cognitive Decline	
Depression	• Symptoms of guilt, sadness and anhedonia (inability to feel pleasure) predominate. • To assess for possible depression consider using screening test (e.g., Geriatric Depression Scale - http://consultgerirn.org/uploads/File/trythis/try_this_4.pdf) • Please note that it is not unusual for depressive symptoms to co-exist with a dementia. • If depression present, assess for suicide risk (e.g., SAD PERSONS scale - www.camh.ca/en/hospital/health_information/a_z_mental_health_and_addiction_information/suicide/Documents/sp_handbook_final_feb_2011.pdf)

When and What Type of Brief Cognitive Test to Administer and the Probable Results of These Tests.		
Patient signs and symptoms	**What brief cognitive test(s) to administer**	**Findings and probable diagnosis**
Patients with cognitive complaints and functional impairments.	✓ Consider administering MMSE or Mini-Cog.*	Abnormal result suggests the patient likely has a dementia.
Patients with cognitive complaints and no functional impairments.	✓ Consider administering the MoCA.**	Normal result suggests the patient likely has subjective complaints but no significant objective cognitive impairment. Abnormal result suggests the patient likely has mild cognitive impairment (MCI).***
**If a normal result is obtained with these tests, consider administering the MoCA.* ***The MoCA is also generally better than the MMSE at detecting deficits in non-Alzheimer causes of impaired cognition.* ****In patients without functional impairments the MMSE or Mini-Cog will likely be normal.*		

PHARMACOLOGICAL THERAPY FOR SPECIFIC CONDITIONS

Condition	Treatment
Alzheimer Disease (AD)	✓ Consider a trial of any of the three available cholinesterase inhibitors for patients AD or AD with a cerebrovascular component: • Know the contraindications and precautions, common adverse effects (and their management), titration regimens and indications for stopping for these agents. • Treated patients should be reassessed regularly in order to gauge their response to therapy and/or detect the emergence of adverse effects.

Condition	Treatment
	✓ Consider memantine as an option for patients with moderate to severe AD. ✓ There is insufficient evidence to recommend for or against combination therapy with a cholinesterase inhibitor and memantine.
Vascular Dementia (VaD)	✓ Identify and mange vascular risk factors (e.g., hypertension, diabetes, smoking, sedentary lifestyle, lipid abnormalities). ✓ Consider antiplatelet therapies for the prevention of recurrent ischemic events in appropriate patients. ✓ Consider cholinesterase inhibitors as a treatment option for patients with AD and a cerebrovascular component. ✓ There is insufficient evidence to recommend for or against the use of cholinesterase inhibitors for VaD.
Dementia with Lewy Bodies (DLB)/ Parkinson Disease Dementia (PDD)	✓ Consider cholinesterase inhibitors for patients with DLB who likely have concurrent AD. ✓ Consider a trial of levodopa-carbidopa at low dosages for parkinsonism arising in the context of DLB. ✓ Suggest caregivers modify the sleep environment (e.g., placing mattress on the floor, padding corners of furniture) for patients with sleep-related injuries or REM-sleep behaviour disorder (RBD) emerging in DLB. ✓ Consider melatonin (few side effects) or a cautious trial of clonazepam for RBD. X Avoid use of antipsychotics. If antipsychotics are required, a low dose of an atypical antipsychotic can be attempted but should be managed by a clinician who is experienced, has specialized skills and can provide close follow-up.
Frontotemporal Dementia (FTD)	✓ Emphasize a non-pharmacological approach targeted at controlling symptoms (especially behavioural) and supporting patients and their families. ✓ Drug options are limited for FTD. Consider: ✓ Selective serotonin reuptake inhibitors for severity of compulsion, agitation, aggression, impulsivity, and aberrant eating behavior. ✓ Atypical antipsychotics are reserved for severe agitation and aggression that cannot be managed by other means. ✓ Refer to a speech and language therapist when language issues are prominent. ✓ Consider referral to a specialty service because of the unique and challenging nature of this condition.
Note: Alberta Blue Cross requires special authorization for Donepezil, Rivastigmine, Galantamine. See Alberta Health Drug Benefit List and special authorization criteria at: https://idbl.ab.bluecross.ca/idbl/load.do.	

General Pharmacological Approaches for Behavioural and Psychological Symptoms of Dementia (BPSD)

Agent	Recommendation
Anti-depressants	✓ Consider a trial of an antidepressant if the patient had an inadequate response to non-pharmacological interventions or has a major depressive disorder, severe dysthymia, or severe emotional lability. ✓ If an antidepressant is used, avoid tricyclics because of their anticholinergic side effects. ✓ There is insufficient evidence to recommend for or against the use of selective serotonin reuptake inhibitors or trazodone for managing agitation.
Atypical Antipsychotics	✓ Potential benefits must be weighed against the significant risks such as cerebrovascular events and mortality. ✓ Prescribe risperidone, olanzapine and aripiprazole for severe agitation, aggression and psychosis associated with dementia when there is risk of harm to the patient and/or others. ✓ Start medication at a low dose and then carefully titrate based on response and emerging adverse effects. ✓ Reassess medications periodically with attempts to taper and discontinue. X DO NOT use these medications to manage behavioural concerns e.g., insomnia especially when safer more effective alternatives are available. ? There is insufficient evidence to recommend for or against the use of quetiapine. *Note: risperidone is the only antipsychotic with an indication for short-term use in Canada for the management of the neuropsychiatric symptoms of AD.*
Cholinesterase Inhibitors	✓ Cholinesterase inhibitors and/or memantine are generally not recommended for the primary treatment of neuropsychiatric symptoms.
✓ Refer to "Appropriate Use of Antipsychotics (AUA) Toolkit for Care Teams" for additional details and information regarding assessment and management of responsive behaviours associated with dementia: http://www.albertahealthservices.ca/auatoolkit.asp ✓ For medication costs of various treatment options see: https://www.acfp.ca/2016-price-comparison-of-commonly-prescribed-drugs-available/	

See Algorithm on page 6.

ALGORITHM

Cognitive Impairment CPG Summary Algorithm