Jintana Assanasen, MD

- Specialty: Geriatric Medicine
- Position: Instructor, faculty member
- Qualification & Education:
  - M.D. , Grad. Dip. in Clinical Sciences (Mahidol University)
  - Dip. Thai Board in Internal Medicine (Mahidol University)
  - Certificate in Geriatric Medicine (Mount Sinai School of Medicine, New York, U.S.A.)
  - Certificate Fellowship in Behavioral Neurology (University of California, San Francisco, U.S.A.)
- Areas of Interest:
  - Cognition and dementia in older patients

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Living with Dementia

Jintana Assanasen, MD
Geriatric Medicine
Siriraj Hospital

Medicine

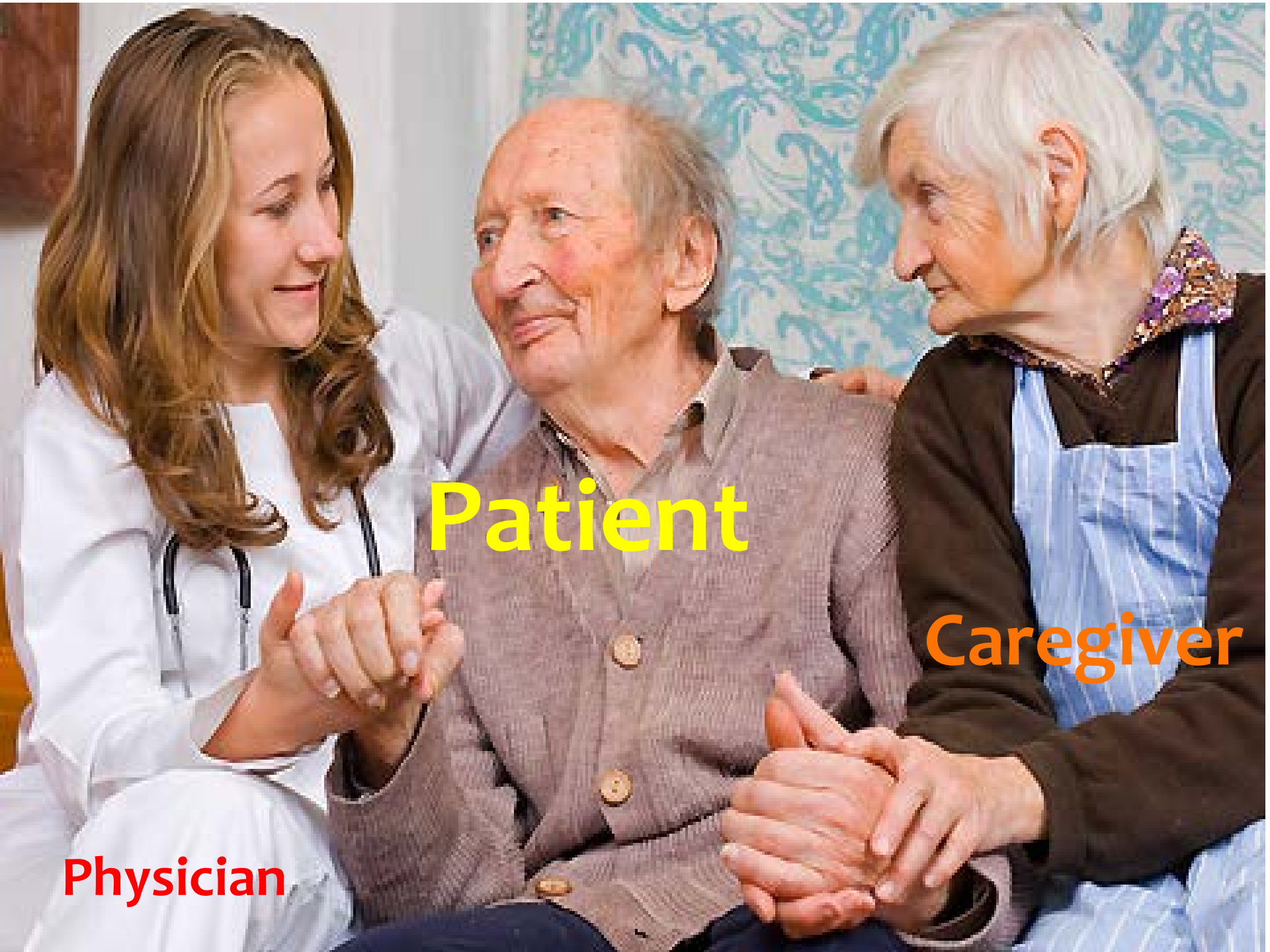
Advanced Medical Care

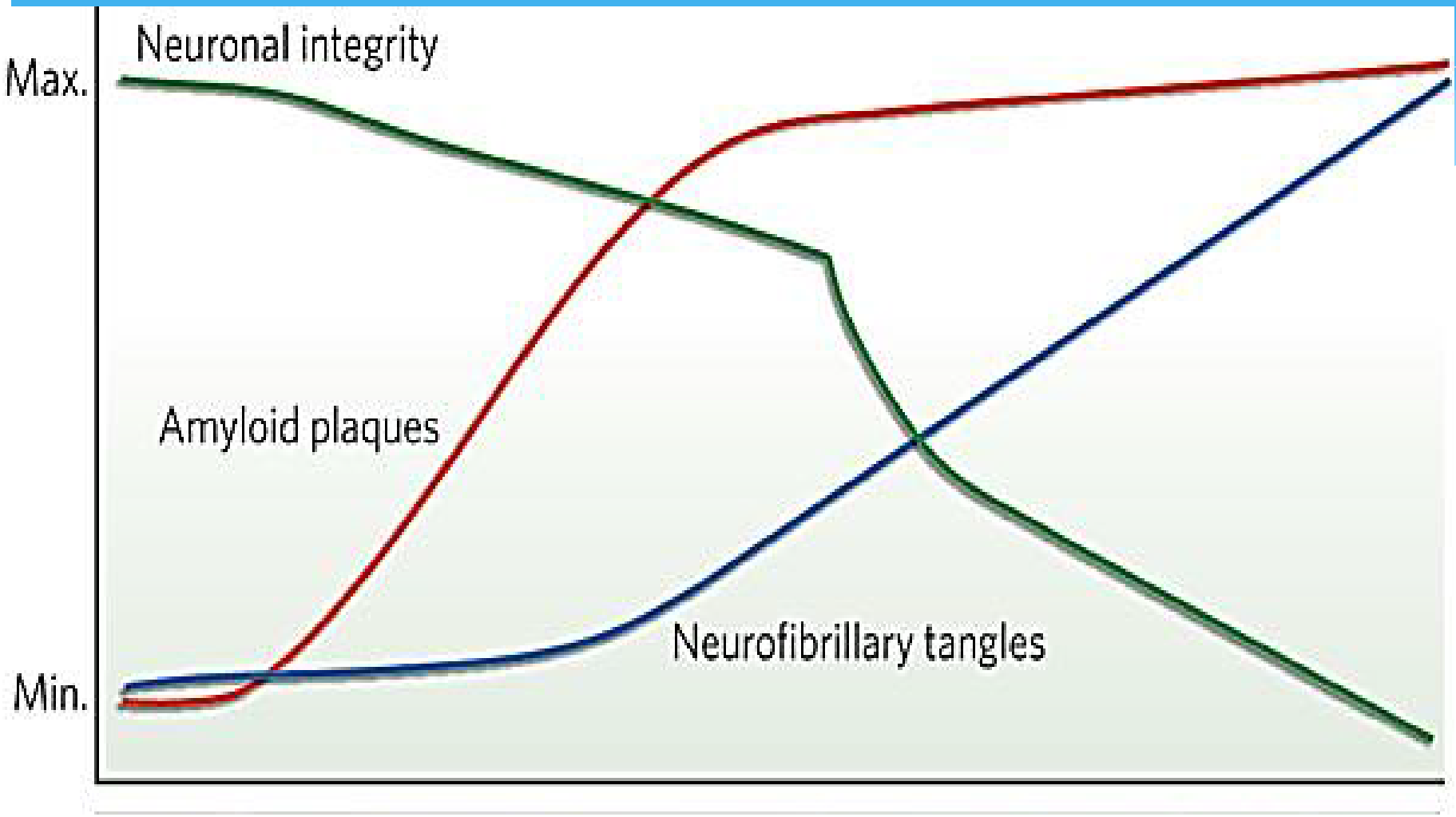
Older Patients

- Physically and cognitively active patients
- Physically impaired patients
- Cognitively impaired patients
- Physically and cognitively impaired patients

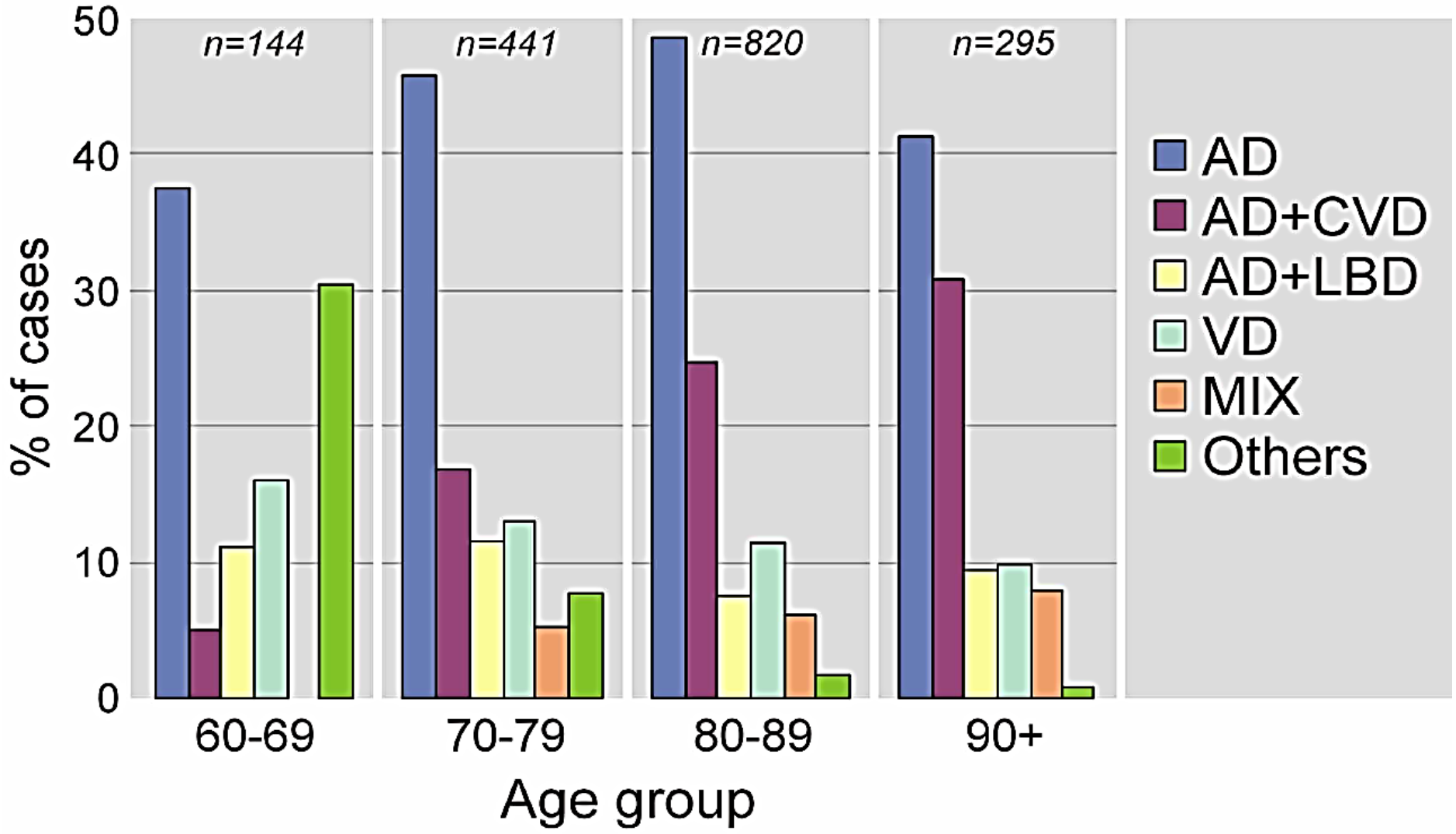
Pillars of Geriatric Care

Goals of Care


Patient
Caregiver
Physician


Max.
Min.
Neuronal integrity
Amyloid plaques
Neurofibrillary tangles

Neuropathologic Types of Dementia



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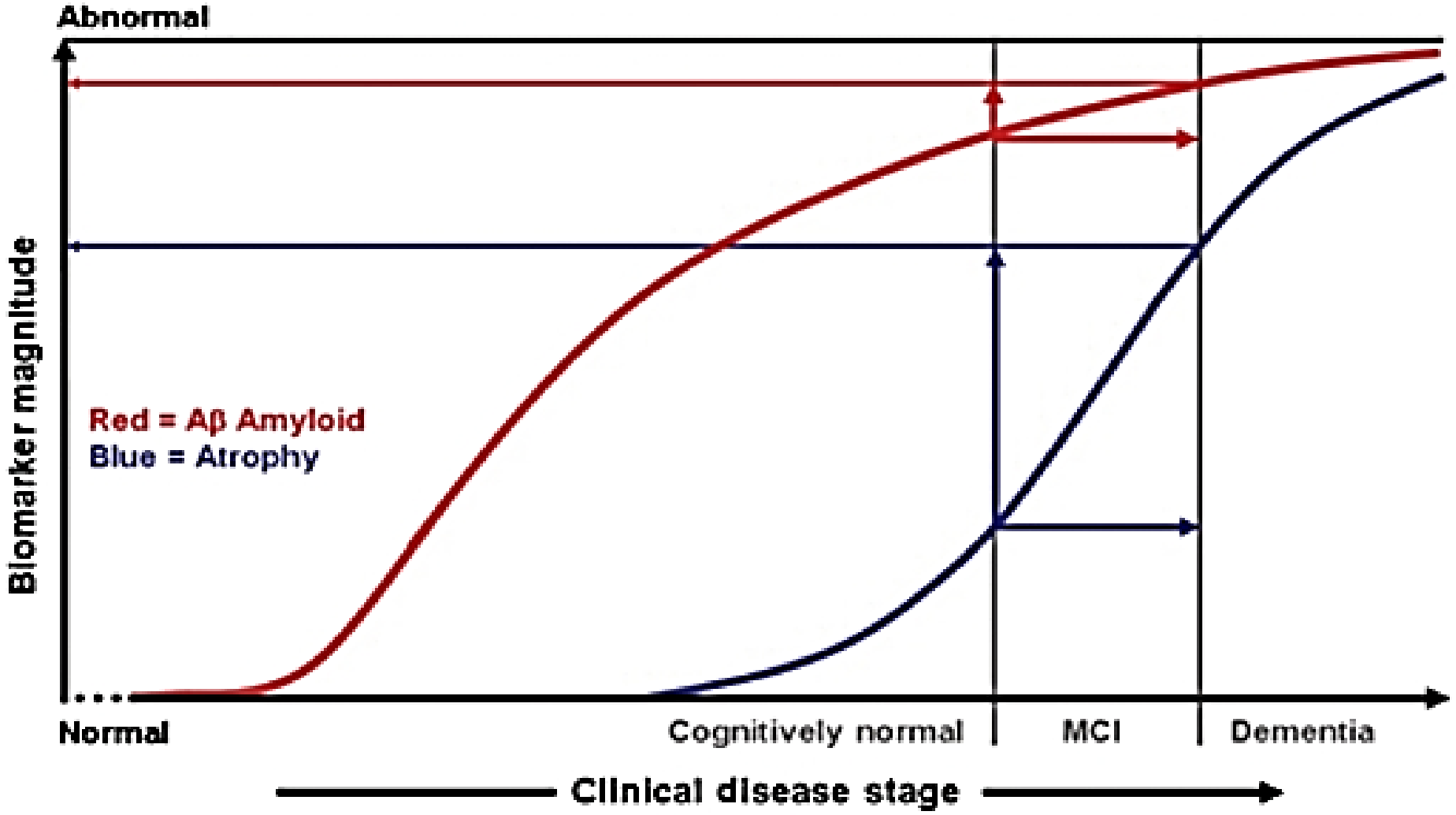
Pure AD Pathology

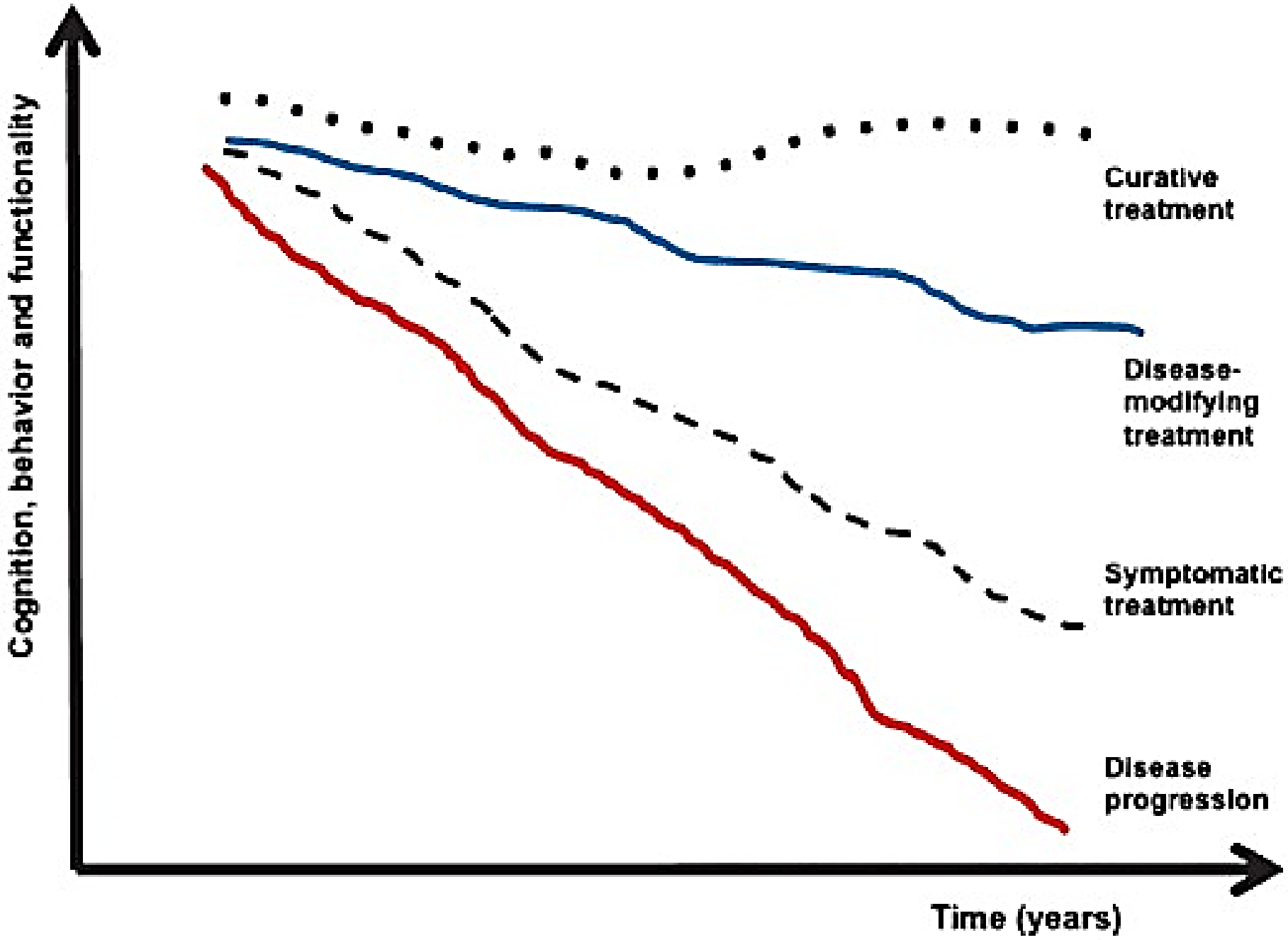


Mixed Pathologies

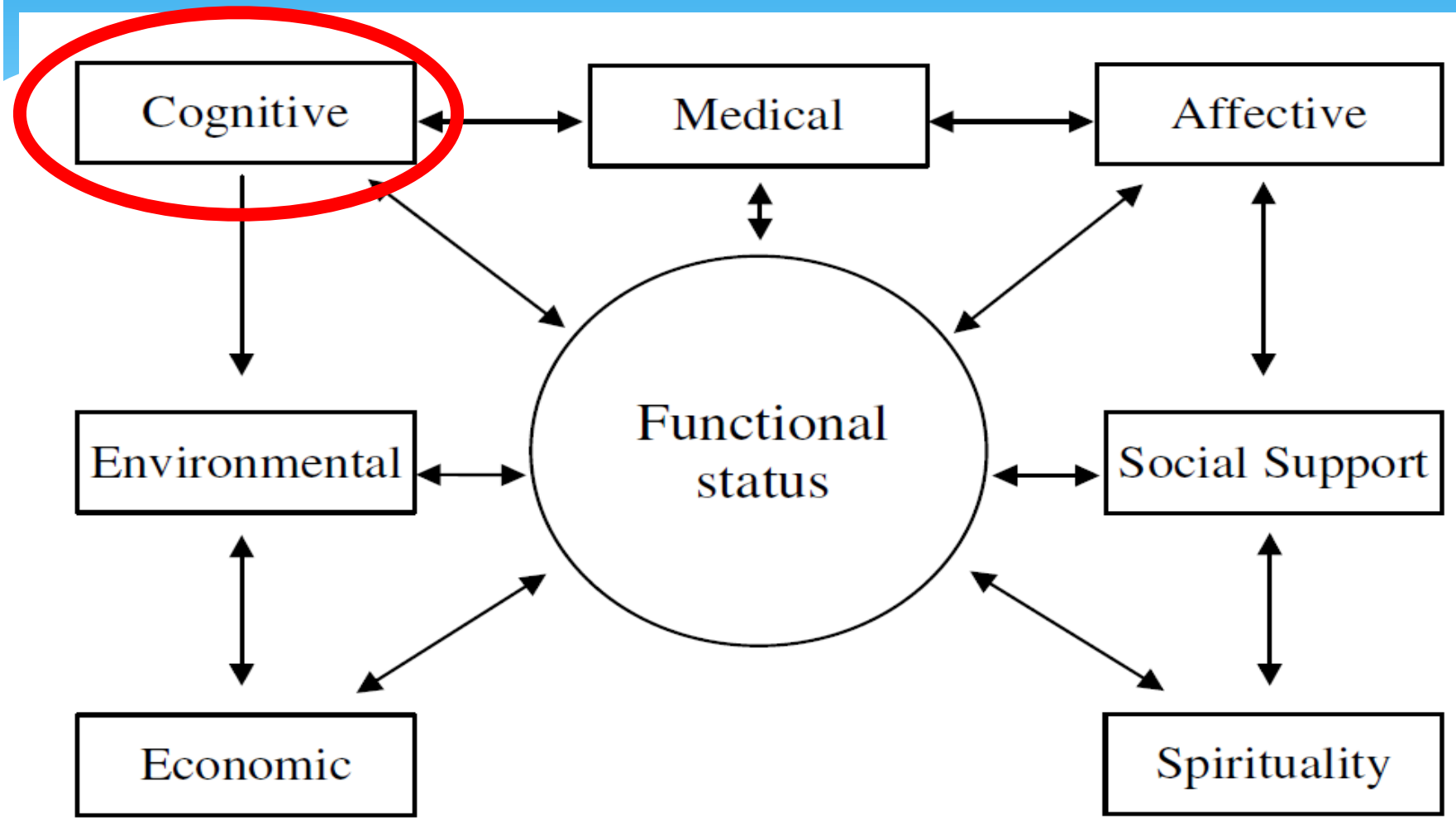
- Management should be based on diagnoses that are believed to be the predominant contributing causes

Dementia & Cognition

- Preclinical (cognitively normal)
- Subjective cognitive decline (SCD)
- **Mild cognitive impairment (MCI)**
- **Mild dementia**
- **Moderate dementia**
- **Severe dementia**
- **Terminal stage of dementia**


Cognition, behavior and functionality
Curative treatment
Disease-modifying treatment
Symptomatic treatment
Disease progression
Time (years)

Accurate Staging



Dementia

- Early detection
- Accurate diagnosis
- Accurate staging
- Diagnosis disclosure and caregiver education/support
- Assessing comorbid illnesses and life expectancy
- Discuss and establish realistic expectations and goals of care

Management in Dementia

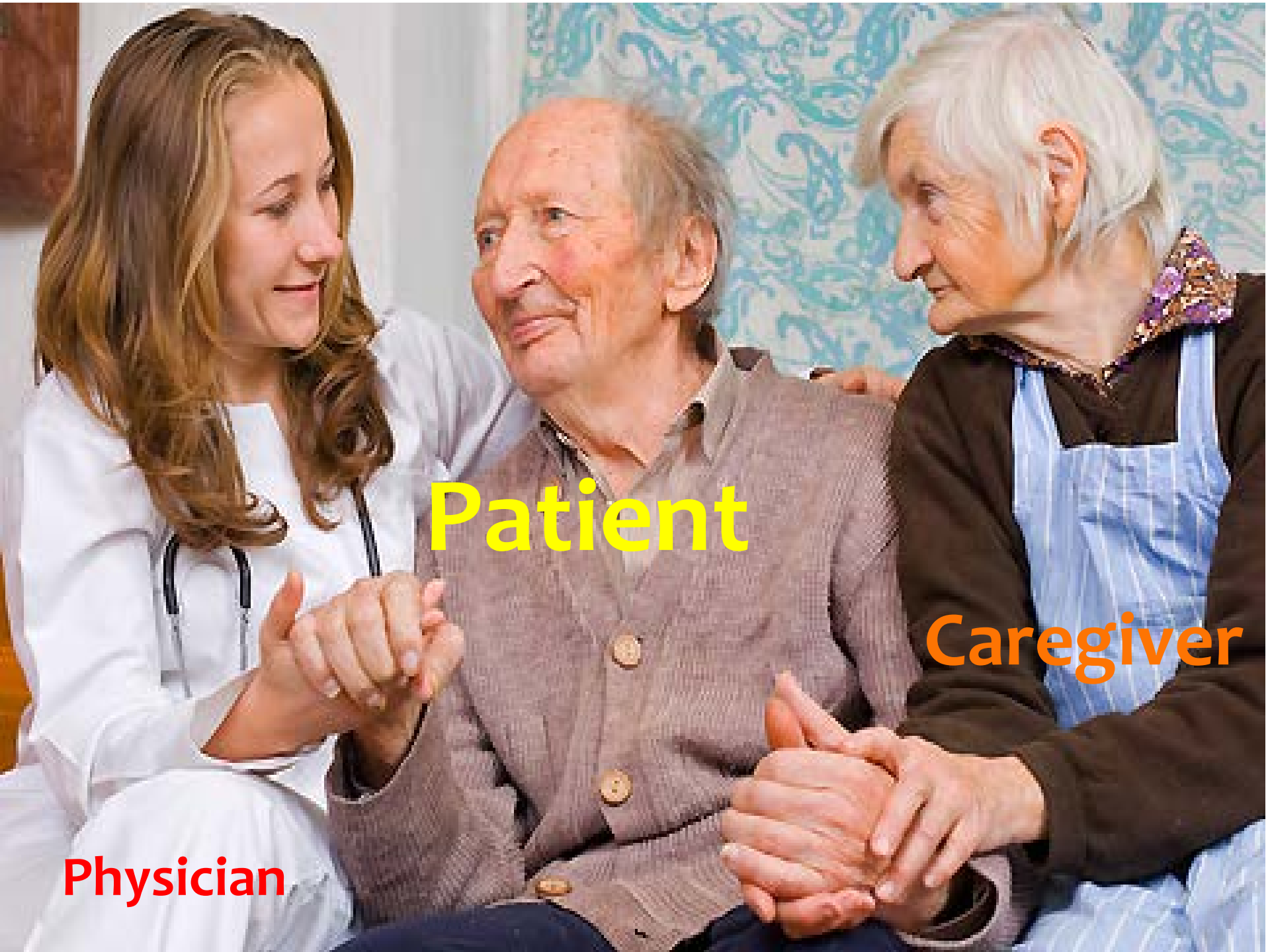
- Provide stage specific management
- Weighing benefits and risks of treatment
- Optimizing stage specific management
- Monitoring symptoms and adverse effects
- Discuss and establish advanced care planning and health care proxies
- Providing the best possible quality of life

Physician

- Competent
- Holistic
- Respectful
- Flexible
- Realistic

Person-Centred Care

- **Treat the patient with dignity and respect**
- Understand their history, lifestyle, culture and preferences, hobbies and interests
- Look at situations from the point of view of the person with dementia


Patient
Caregiver
Physician

Subjective Cognitive Decline

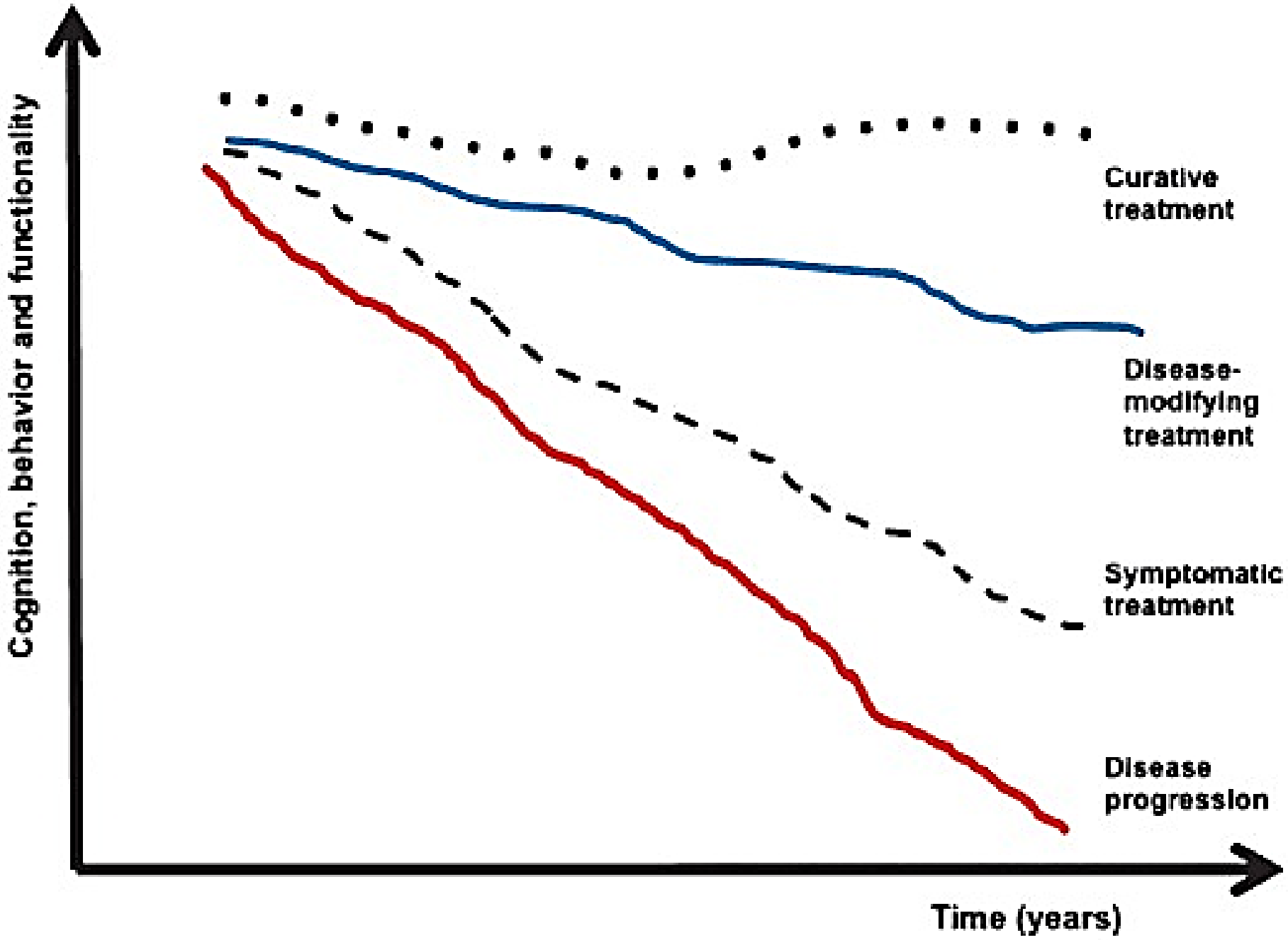
- Individuals feel as if they have memory lapses
- The problems are **not evident during a medical examination or apparent to friends, family or co-workers**

Mild Cognitive Impairment

- Patient, friends, family or co-workers begin to **notice cognitive impairment**
- **Objective cognitive impairment** in detailed medical interview or clinical testing in comparison with normal controls
- **Still able to maintain functional independence**

Goals of Care in MCI

- **Reverse to normal cognition or stabilize disease progression**
- **Identify and correct reversible causes**
- **Identify patients who are at high risk to progress to dementia**
- Good control vascular risk factors
- Avoid traumatic brain injuries
- Avoid potentially harmful medications that can worsen cognition
- Regular physical exercise
- Regularly engage in cognitive stimulating activities
- Regular follow-up on cognition, function, mood and behaviors
- Early detection, accurate diagnosis and treatment of dementia


Cognition, behavior and functionality
Curative treatment
Disease-modifying treatment
Symptomatic treatment
Disease progression
Time (years)

Mild Dementia

- **Mild cognitive deficits in clinical assessment**
- **Cognitive impairment significantly affecting social, occupational and functional independence**
- **Need assistance or supervision in instrumental/complex activities of daily livings**
- Subdue or withdraw in socially or mentally challenging situations
- Still able to maintain basic activities of daily livings

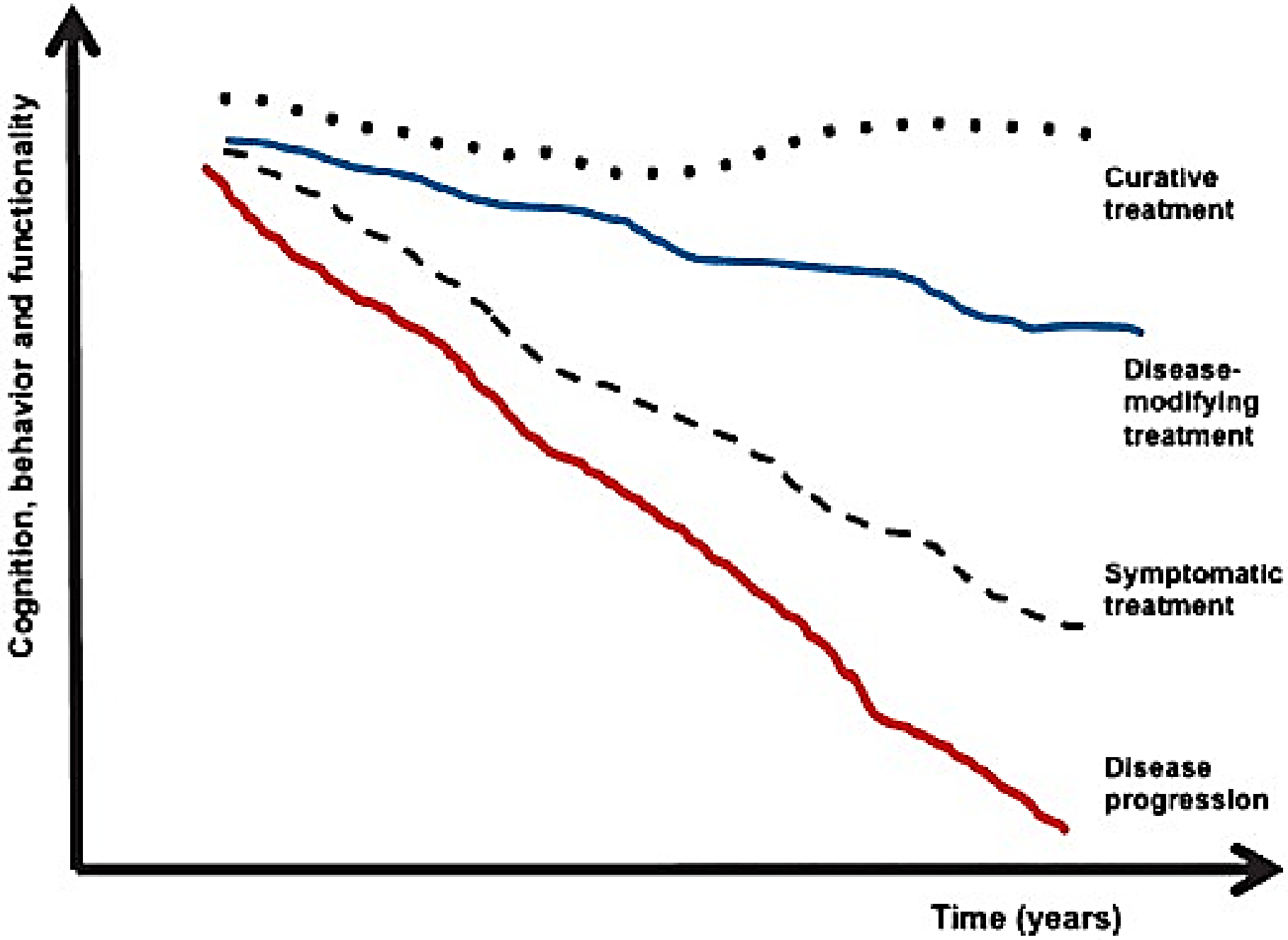
Mild Dementia

Common deficits include:

- **Keep repeating the same stories/questions**
- **Decrease ability to learn and retain new information**
- **Often lose or misplace personal items**
- **Decline in ability to plan, organize, multitask, make decisions or judgment**
- Word-finding difficulty and decline in ability to follow multistep instructions, conversations, or lose train of thoughts
- Decline ability to navigate or get lost in familiar neighborhoods
- Feel frustrated, anxious, depressed, less-confident, and poor self-esteem to his/her functional loss
- Poor/partial insight

Goals of Care in Mild Dementia

- **Early, accurate diagnosis and management**
- **Slow/stabilize disease progression and cognitive impairment**
- **Maintain functional independence as much as possible**
- Encourage social engagement and cognitive stimulating activities
- Initiate and discuss advanced care planning, healthcare proxies


Cognition, behavior and functionality
Curative treatment
Disease-modifying treatment
Symptomatic treatment
Disease progression
Time (years)

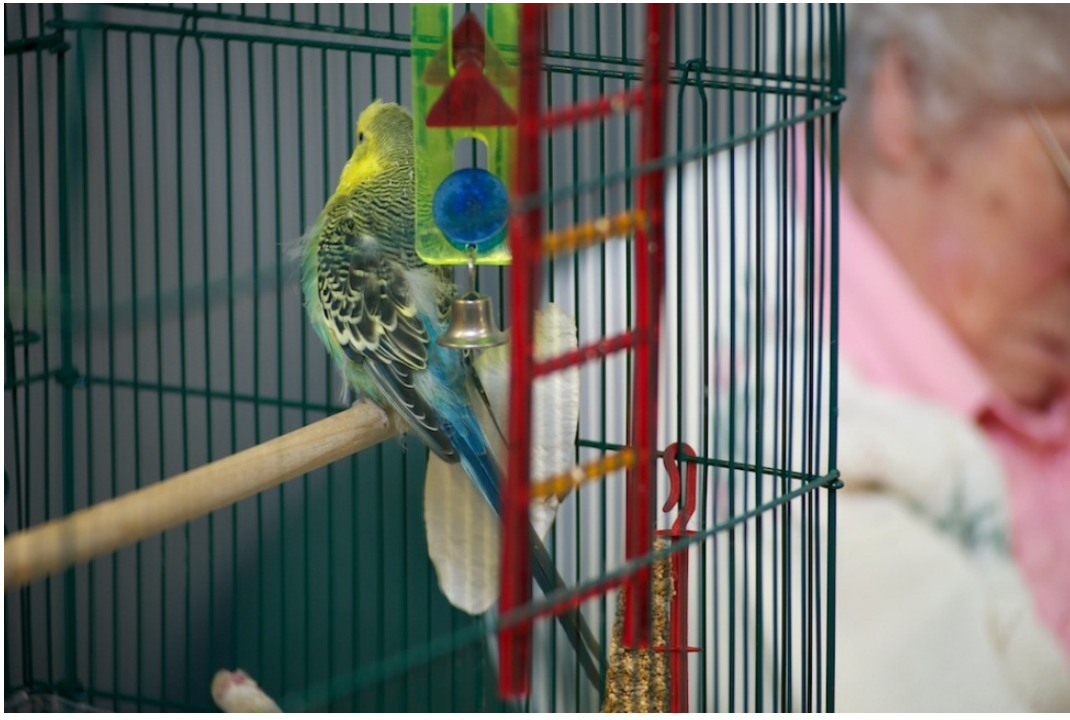
Moderate Dementia

- Moderate cognitive deficits in clinical assessment
- **Inability to perform instrumental/complex activities of daily livings**
- **Need partial assistances or supervisions in basic activities of daily livings**

Moderate Dementia

Common deficits include:

- **Rapidly forgetting recent events, repetitively asking**
- **Partial memory loss of his/her own personal history**
- Decreased speech output, poor comprehension to long/complex sentences, decline in ability to read and write
- **Disorientation, confusion, inattention, sundowning phenomenon**
- **Challenging/disruptive behaviors, agitation, aggression, hallucination, delusion, wandering, shadowing, clinging**
- **Inertia, apathy, depressed**
- Poor self hygiene, incontinence
- Decreased mobility, gait disturbances



Goals of Care in Moderate Dementia

- Improve/stabilize cognitive impairment
- **Improve/minimize behavioral/psychological symptoms**
- **Maintain the remaining cognitive function in daily activities**
- **Maintain mobility**
- **Delay institutionalization**
- **Improve quality of life of the patients, caregivers and family members**
- Initiate advanced care planning and healthcare proxies

Severe Dementia

- Severe cognitive deficits in clinical assessment
- **Totally dependence**
- **Poor ability to verbally communicate or comprehend**
- **Immobility**
- **Incontinence**
- Dysphagia
- Cachexia

Severe Dementia

Common deficits include:

- **Lose most awareness of his/her surroundings**
- Severe memory loss of his/her own personal history, names of his/her spouse, primary caregiver, family members
- **Verbalization, crying, rumbling, nearly mute or mute,** incomprehension to simple phrases and sentences
- Repetitive behaviors, motor/verbal stereotypes
- **Poor sleep/wake cycle, agitation at night**
- **Wheel-chair bound or bed-bound status**
- **Urinary and fecal incontinence**

Goals of Care in Severe Dementia

- **Symptom control and comfort-oriented approach**
- Minimize disruptive behaviors
- Prevent complications of immobility syndrome
- Improve the best possible quality of life of the patients, caregivers and family members

Terminal Stage of Dementia

Patients should have 1 of the following within the past 12 months:

1. Aspiration pneumonia
2. Pyelonephritis or other upper urinary tract infection
3. Septicemia
4. Decubitus ulcers, multiple, stage 3 or 4
5. Fever, recurrent after antibiotics
6. Inability to maintain sufficient fluid and calorie intake with 10% weight loss during the previous 6 months or serum albumin less than 2.5 g/dL

Hospice Determining Terminal Status

Goals of care in Terminal Stage of Dementia

- **Provide comfort care**
- **Minimize pain and sufferings**
- **Avoid invasive investigation/management**
- **Avoid life-prolonging treatment or procedures**
- Achieve the best possible quality of life
- Allow natural/good death in desired places

Alleviate Cognitive Symptoms

Symptomatic treatment

- Identify vulnerable older patients who need close monitoring of drug adverse effects
- Assess comorbid illnesses and life expectancy
- Weigh benefits and risks of treatment
- Early initiate anti-dementia drugs, if indicated

Cholinergic Therapy of AD

- Establish realistic expectations and goals of care
- The decision to initiate symptomatic treatment should be individualized and always made in conjunction with the patient and caregivers
- Optimize stage specific management

Cholinergic Therapy of AD

- Maximize clinical benefits and minimize adverse effects
  - Gradually titrate up to maximize tolerability
  - If appropriate, consider to achieve the recommended dosages of cholinergic therapy (dose and response relationship)
  - High dose of ChEIs in clinical trials showed mild improvements in cognitive functions, but no improvement in overall functioning
- Regularly reassess disease severity, clinical benefits and risks, life expectancy and quality of life

ChEIs & NMDA Antagonists of AD

Clinical trials of mild to moderate > moderate to severe AD, 24-week trials > 52-week trials

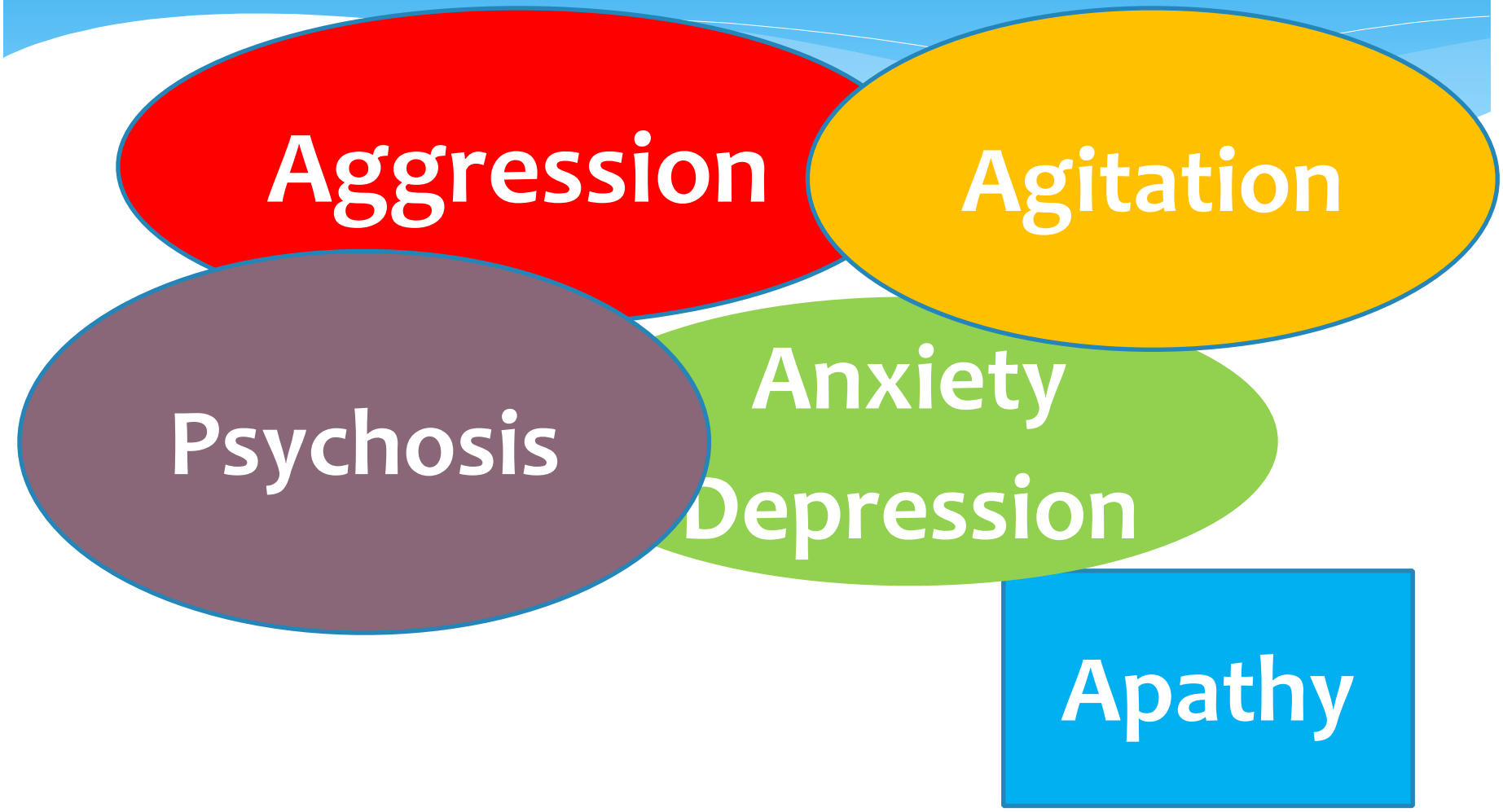
- Stabilize or slow decline of cognitive symptoms of AD
- The efficacy of ChEIs, but not memantine, was independent from dementia severity on cognition
- Improve or delay challenging BPSD of AD
- Stabilize or slow decline of function (ADLs)
- Delay placement in long-term care facilities

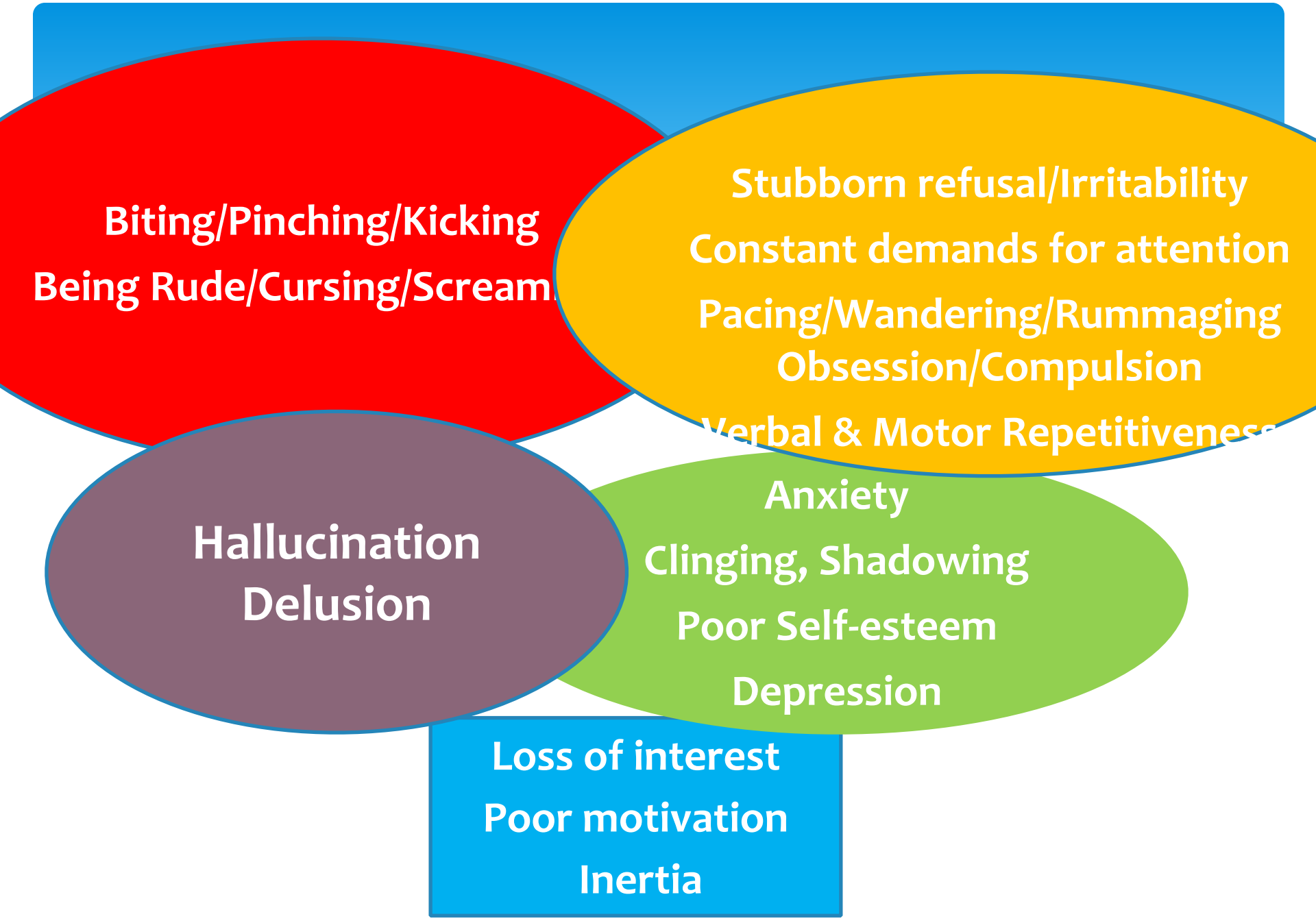
Journal of Alzheimer's Disease 41 (2014) 615–631
ScientificWorldJournal. 2013 Oct 29;2013:925702
J Alzheimers Dis. 2013;35(2):349-61

ChEIs—Adverse effects

- Increase the risk of gastrointestinal bleeding, particularly in patients with ulcer disease
- Less commonly produce bradycardia or heart block in patients with or without cardiac impairment or current use of beta blockers
- Exacerbate asthma or bronchospasm
- Cause urinary outflow obstruction
- Prolong the effects of succinylcholine (muscle relaxant)

Behavioral & Psychological Symptoms in Dementia




Biting/Pinching/Kicking
Being Rude/Cursing/Scream
Stubborn refusal/Irritability
Constant demands for attention
Pacing/Wandering/Rummaging
Obsession/Compulsion
Hallucination
Delusion
Anxiety
Clinging, Shadowing
Poor Self-esteem
Depression
Loss of interest
Poor motivation
Inertia

Understanding Behaviors

Fatigue

Excessive demands

Environmental stress

Too many or low stimuli

Failure

Being frustrated
Being criticized
Being humiliated

Physical discomfort

Pain

Misinterpretation

Misunderstanding

Medical Illnesses

Medications

Cognitive impairment

Fear

Social isolation

Boredom

Defensiveness

BPSD

Non-pharmacological Management AND

Aggression

Antipsychotics

Antidepressants with sedative effects

NMDA antagonist/ChEIs

Agitation

Antipsychotics

Mood stabilizers

Antidepressants with sedative effects

NMDA antagonist/ChEIs

Psychosis

Antipsychotics

ChEIs/NMDA antagonist

Depression

Antidepressants

Apathy

ChEIs

A Six-step Approach of BPSD

1

- Caregiver education

2

- Identify target symptoms

3

- Identify precipitating causes

A Six-step Approach of BPSD

4

- Establish goals of care and treatment plan

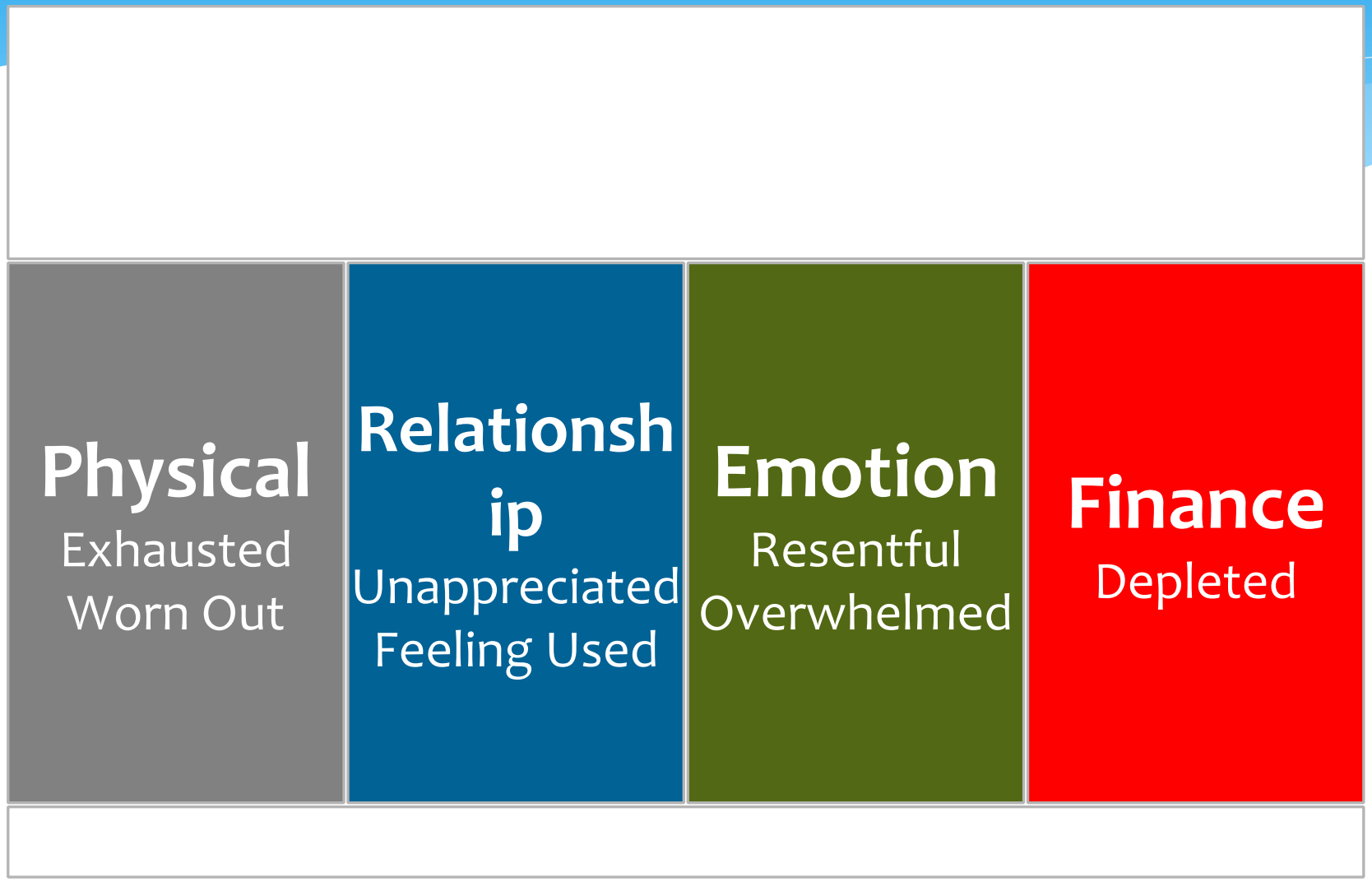
5

- Monitoring responses and adverse effects

6

- Considering tapering or discontinuing psychoactive drugs

Caregiver Stress



Living Well with Memory Problems

- **Regular routine, b**ut keep some variety and stimulation
- **Focus on one thing at a time**
- **Break tasks down into smaller steps,** and ask for help from others if you think you need it
- **One place for everything**
- **Take your time**
- **Memory works better with no distractions**

Memory Aids

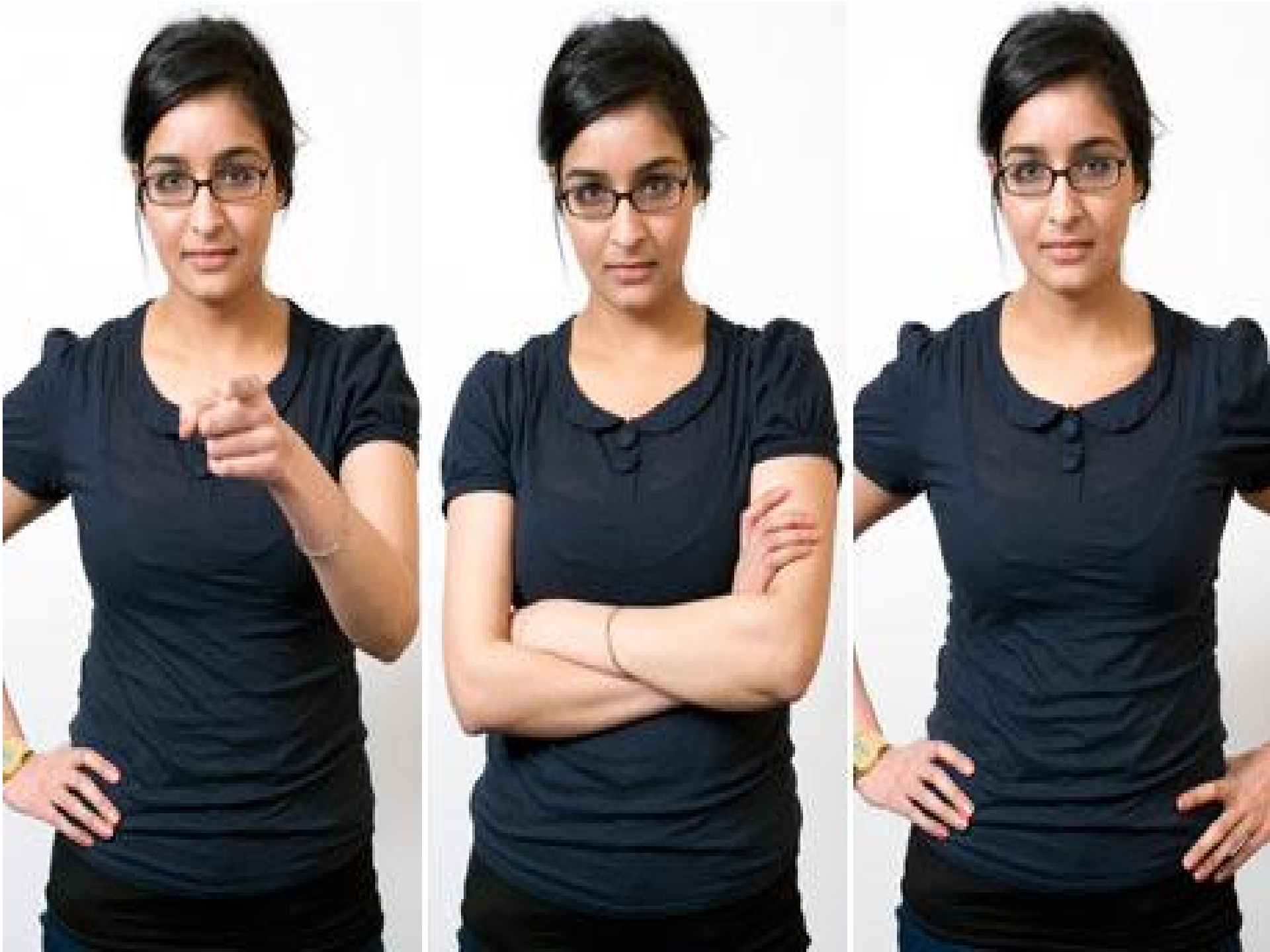
- Reminder or a noticeboard for messages
- Large clocks and calendars
- Pill boxes
- Label cupboards and drawers

Safety

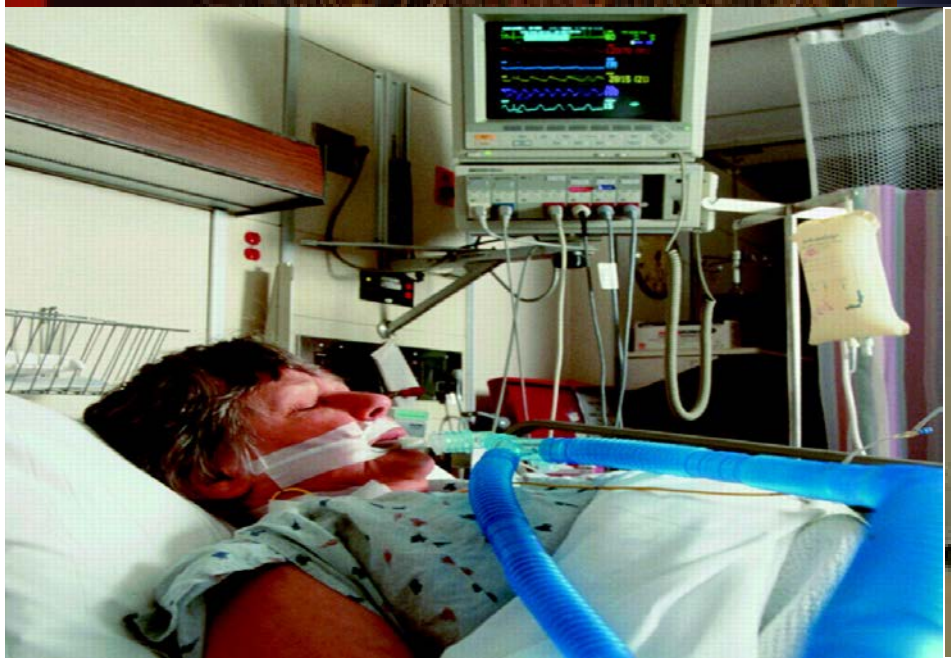
- Improve lighting
- Avoid falls
- Safety outdoors
- Store dangerous substances safely
- Avoid fire
- Record contact names and numbers

Communication

- **Be patient and supportive**
- Focus on **feelings, not facts**
- **Use gentle, short, simple words**
- Encourage **nonverbal communication**
- **Avoid criticize, challenge or argue**



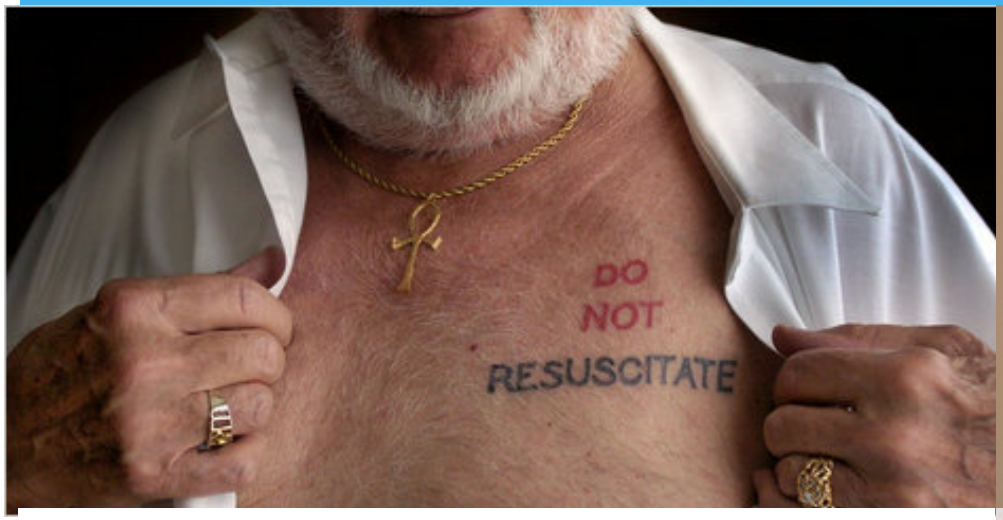

Emergency

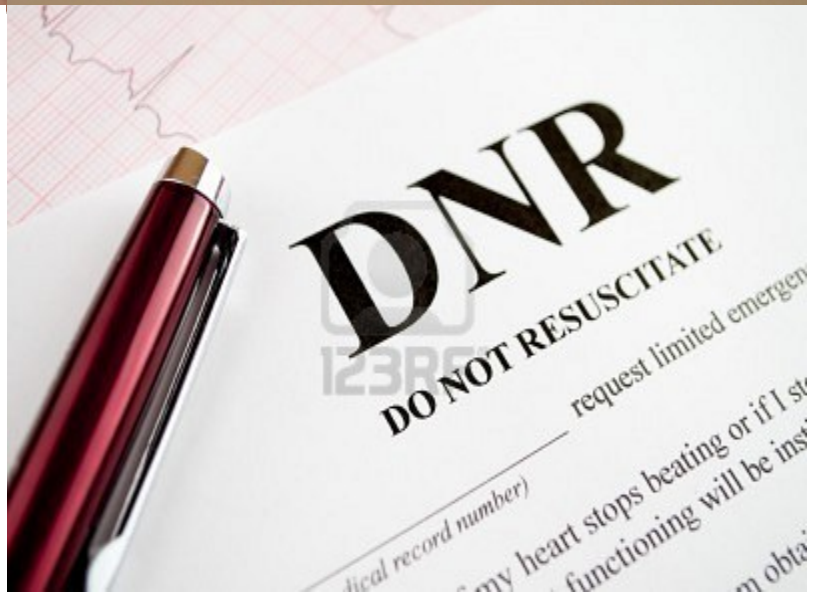


Continuity of Care

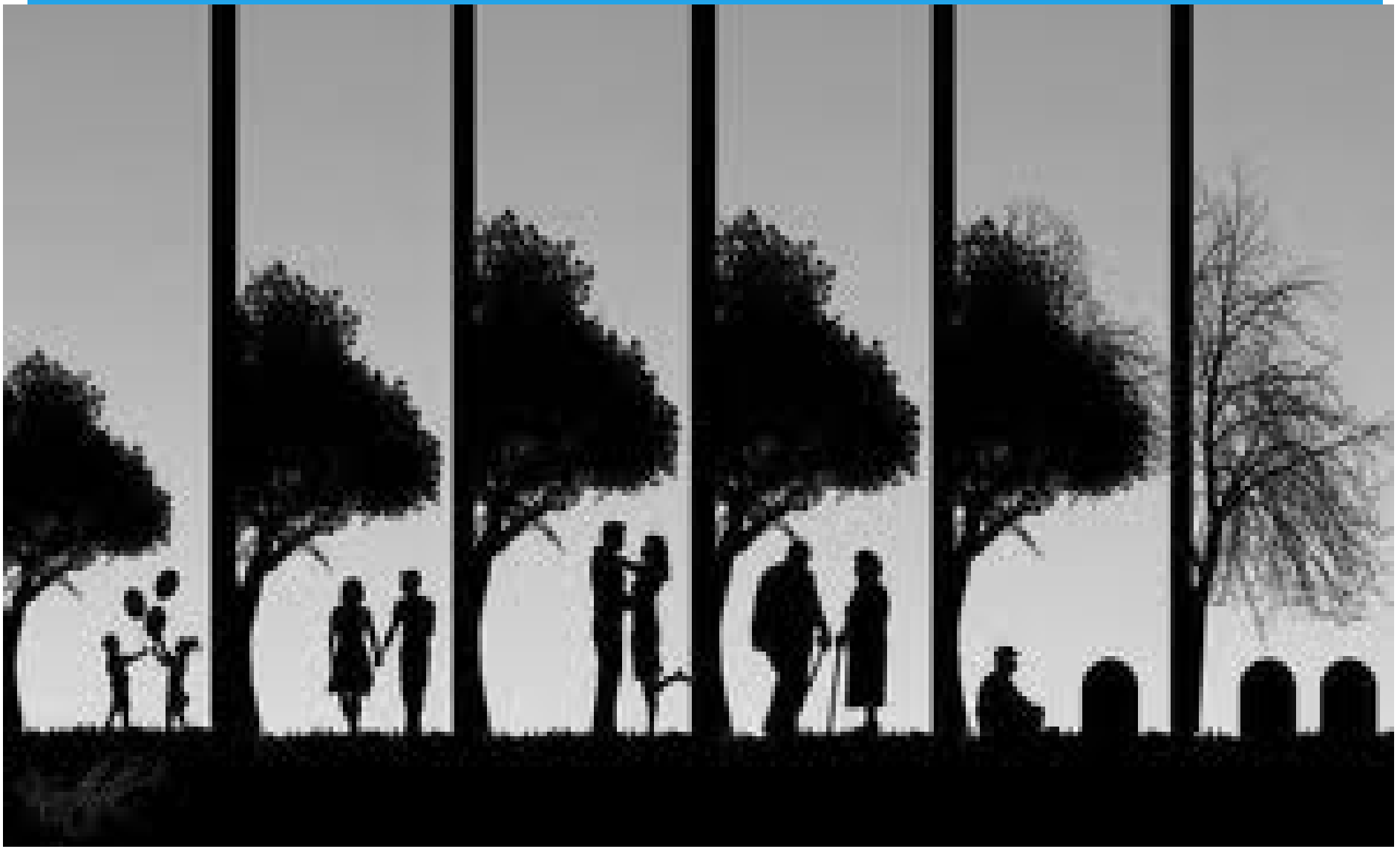
- **Continuity of *management*--**consistent and coherent management responsive to changing needs
- **Continuity of *information*--**use of information on past events and personal circumstances
- **Continuity of *relationship*--**ongoing therapeutic patient–provider(s) relationship

Final Prescription






NOTICE
'Do not resuscitate' does not mean 'do not treat'




Doing the Right Thing
For Patients With Advanced Dementia


ถึงจะมองไม่เห็นฝั่ง
เราก็ต้องพยายามว่าย
อยู่ท่ามกลางมหาสมุทร
โภคะทั้งหลาย
มิได้สำเร็จ
ด้วยเพียงคิดเท่านั้น
ขอจงมีความสุขความเจริญ
๒๕๕๕
Happy New Year
2012
ก.ส.9 ปรุง 185029 ธ.ค. 54
พิมพ์ที่โรงพิมพ์สุวรรณชาด ท.พรหมบุตร, ผู้พิมพ์โฆษณา Printed at the Suvarnnachad, D Bramaputra, Publisher