

MEDICAL CARE FOR THE DEMENTIA PATIENT

OVERVIEW

Medical care for patients with dementia differs from the management of cognitively intact elders. Dementia patients cannot explain their symptoms, cannot remember instructions, often resist therapy, and these patients may have select physiological differences from non-brain damaged individuals. The type of physical problems and obstacles to medical care will depend on the type of dementia. When dementia is viewed as a progressive disease with terminal outcomes, it becomes clear that dementia patients need a broad range of healthcare interventions including basic medical care, health prevention, dental care, nutritional management and end-of-life management. This chapter discusses basic healthcare management issues for the dementia patient. These considerations apply to the four common conditions -- Alzheimer's disease, vascular dementia, diffuse Lewy body disease and alcoholic dementia.

The average life expectancy of Alzheimer's patients is approximately 8 years. Although the disease can be divided into multiple stages (e.g., 3 to 7), a simpler concept is early, middle and late. Patients with early phases of dementia have healthcare needs that reflect other elders who are cognitively intact. Patients in the middle stage have the additional complication of multiple ADL impairments, significant behavioral or psychiatric complications and caregiver fatigue. End-stage patients frequently reside in nursing homes where they require careful attention to end of life issues.

The Folstein mini-mental status exam is a short, cost-effective cognitive screen that can estimate the severity of dementia. The mini-mental scores range from 0 to 30 with normal above 26. Alzheimer patients lose two points per year. Mild dementia patients score 20 to 26, moderate score 10 to 20, and severe score below 10. The mini-mental can help assess medical decision-making competency, as patients with scores below 15 are usually unable to give informed consent.

The clinician must contend with both cognitive and psychiatric complications of dementia. Depression (25%) and psychosis (25%) are common in dementia. Medications to enhance cognition or lessen psychiatric morbidity have significant physical health side effects as well as mental health benefits. Studies show that primary care physicians find dementia patients difficult and unrewarding to manage. Management of dementia requires a bio-psychosocial approach that includes both the patient and the caregiver. The clinician must tend to the neuropsychiatric morbidity from the dementia, the psychological complications and the social support needs of the patient. Caregivers have a higher rate of physical morbidity and psychotropic medication usage. This article outlines a practical approach to the management of medical problems of patients with dementia.

CLINICAL HISTORY AND PHYSICAL EXAMINATION

The standard patient interview may produce erroneous information from a demented patient. Moderate or severely demented patients may become restless or disruptive in waiting areas. Office staff should schedule demented patients for the first visit for morning or afternoon. Patients may require a separate, quiet area to wait for service. The primary care physician gathers a clinical history from a dementia patient that is limited by reliability of the

patient's memory. Patients are more likely to remember remote events than recent symptoms. Psychotic or delusional patients may misunderstand questions or bodily experiences.

The clinician should never conduct a clinical interview without the caregiver or a second person available to confirm patient's statements and gather additional information. Family caregivers can be instructed to observe and record patient's symptoms and monitor compliance with medications. Short-term memory loss limits the patient's ability to accurately report recent symptoms such as chest pain or shortness of breath. The family caregiver must bring all the patient's medications from home -- both prescribed and over-the-counter to assure that the patient arrives with an accurate list of medications taken (i.e., a shopping bag full of medications).

The physical examination of a demented patient is usually uneventful; however, several precautions can lessen the likelihood of agitation. Mild to moderately impaired patients (i.e., mini-mentals above 15) can usually cooperate; however, patients with mini-mentals below 15 frequently become alarmed or uncooperative. First, a familiar individual may need to be in the room to reassure the patient. Second, demented patients should be continuously monitored in examining rooms to prevent falls or injuries from medical equipment. Third, disrobed, demented patients may become alarmed and clinicians should complete, as much of the exam with the patient dressed as possible or partially disrobed. Patients may become distressed with simple procedures such as chest X-rays, phlebotomies, EKG, etc.

Compliance is further complicated in patients with receptive or expressive aphasia. Patients with mini-mentals below 15 probably have significant language impairment that will limit their ability to understand questions and comply with requests. Although the physician may have treated a patient for over 20 years, visual agnosia will render him or her a complete stranger to the patient. Motor apraxias may limit the patient's ability to disrobe without assistance or even turn a doorknob. Patients may become alarmed when lead to small bathrooms to provide urine specimens. Patients may have difficulty urinating in a specimen cup and may urinate on the floor. Assistance and attendance by family lessens the likelihood that patients will become resistive or combative. Invasive procedures like venipunctures should be completed at the end of the examination as the pain may provoke some agitation in the moderate to severely demented patients. Mildly demented patients rarely pose a problem with examination unless other psychiatric morbidity exists. Moderate to severe demented patients may pose a challenge to the medical team.

Because some patients may not accurately report symptoms, the clinician must thoroughly examine the body and probe or examine all bodily orifices. Vital signs should include the blood pressure, temperature, pulse, respiratory rate and accurate weight as well as orthostatic blood pressure. Dementia patients may have a subnormal body temperature. About five percent of elders have primary orthostasis and many psychotropic medications worsen orthostatic drops. The ear, nose and throat examination must include a complete assessment of the oral cavity to exclude painful dental disease or malfitting dentures. Demented patients lose weight and experience alveolar bone loss that creates painful "high points" for the denture fit. This can cause agitation or poor oral intake. Clinicians should remove cerumen impaction to maximize auditory acuity and attempt to determine whether eyeglasses are required to improve vision. Unrecognized glaucoma can produce pain that causes agitation. An examination of the chest, heart and abdomen follows a typical medical outline. Patients with dementia receive many constipating medications and these individuals tend to drink less fluids and eat lower residue diets. Fecal obstipation and rectal impaction are common problems that need assessment and therapy. Obstipation or impaction will lead to

poor oral intake, agitation and vomiting. Examination of the genitourinary tract is important to exclude causes of pain and urinary tract infections. Elderly males have high rates of benign prostatic hypertrophy that results in urinary retention or infections. Elderly females can develop unrecognized UTI's or post menopausal thinning of the vaginal mucosa that result in pain or discomfort. All areas of skin should be inspected for infection and evidence of skin breakdown. Patients with dementia generally have poor personal hygiene as a result of bathing apraxias and these individuals are predisposed to dermatitis and problems with skin integrity particularly in contact areas such as the breast, perineal area, bony prominences and the extremities. Many demented patients pace and wander for extended periods of time causing skin breakdown over their lower extremities and dependent edema. Demented patients with diabetes are at risk for lower extremity skin infections. Family may need home health to provide simple wound or diabetic foot care. Nails should be assessed for length and cleanliness; trim and clean if necessary. Many severely demented patients will tenaciously grip attendants or caregivers as a result of the frontal lobe release sign (i.e., grasp response). Significantly demented patients often self-contaminate with feces and these basic hygiene interventions protect not only the patient but staff who may be gripped and scratched.

Significantly demented or combative patients who require painful or lengthy testing (i.e., MRI, IVP, etc.) may require sedation prior to testing. Administration of 0.5 mg of Ativan 30-45 minutes prior to the test usually provides sufficient sedation but these patients require constant monitoring, as they will be at risks for falls for up to 12 hours following medication. Testing should accommodate the patient's behavioral schedule and individuals who are combative at one time of the day should have testing done at other times of the day (e.g., schedule morning procedures for patients who sundown). Testing that requires patients to remain NPO can also pose problems because hungry patients oftentimes become irritable or hostile. Patients undergoing procedures that require NPO status past midnight must have direct observation at home because demented patients will forget about the restriction and fail to report oral intake to the anesthesiologist. Complicated preparations (e.g., laxatives, enemas, etc.) may pose problems for incontinent patients. Caregivers should be advised to recruit assistance when patients are scheduled for procedures.

INFECTIONS IN THE DEMENTIA PATIENT

A. Viral Infections

Dementia patients are at the same risk as other elders for contracting typical epidemic viral infections (e.g., influenza) but symptoms can be complicated by delirium. Patients may fail to mount a typical febrile response. Dementia patients should receive yearly flu shots. Cold preparations and antihistamines should be used with caution to avoid drug-induced delirium. The gastrointestinal phase of viral infections may cause fecal incontinence. Anti-diarrheal agents should be used with care to avoid drug-induced confusion.

B. Bacterial Infections

The three common bacterial infections in dementia patients are 1) pneumonia, 2) urinary tract infections, and 3) infected skin wounds in advanced stage patients. The diagnosis of infection in a patient with dementia is limited by their ability to describe symptoms and mount a febrile response. Pneumonia is a common complication of dementia and aspiration pneumonia is common in advanced-stage patients with feeding or swallowing apraxias.

Patients who forget how to chew or swallow also forget how to clear secretions from their oropharynx. The typical triad of productive cough, fever and significant chest X-rays findings may be absent in patients with dementia. Studies show that many patients over age 65 do not develop cough with pneumonia. The febrile response in elderly patients is often blunted and many patients will not develop a temperature above 100. Patients with dementia often have lower basal temperatures than those of other individuals. Chests X-ray findings are absent in many individuals over the age of 65 with documented pneumonia. Conventional diagnostic techniques include examination and culture of sputum to determine the cause of the pneumonia. Dementia patients rarely comply with sputum production and suction trap methodology is quite difficult in these patients. Pneumonia is usually caused by the same organisms that infect other elders with similar health problems. Patients with dementia should receive pneumovax prophylaxis to lessen the likelihood of pneumococcal infections as well as yearly influenza shots to lessen the likelihood of upper respiratory tract infections. Sepsis can be difficult to identify in patients with dementia, especially those in the middle to late stages. Lethargy, hypothermia, and hypotension may be the presenting symptoms. There is no clinical evidence to suggest that PEG tube or NG tube will decrease the likelihood of aspiration pneumonia for patients with dementia. Patients require PEG or NG tube placement when the swallowing mechanism is so impaired that they can no longer eat. These individuals also fail to clear their secretion resulting in aspiration pneumonia.

Urinary tract infections are common in both females and males. Poor hydration, genitourinary problems that impair emptying of bladder and medications that disrupt normal GU function may predispose demented patients to UTI's. Demented patients are usually cooperative with clean-catch techniques in the early to middle phase of their illness, but more severely demented patients can rarely comply with instructions. These individuals need catheterization to assure accuracy of the tests. Patients with documented UTI's need meticulous treatment to eradicate the infection. Infected patients are often delirious, behaviorally disturbed and often stop eating as a result of the infection. The degree of leukocytosis or fever will not predict the severity of symptoms. Afebrile patients with normal white counts may show profound behavioral change from the infection.

Most middle to late stage dementia patients are incontinent and this should be managed with a toileting schedule or Attends (adult diapers). External catheters are usually impractical in males. Indwelling catheters should be avoided because of risks for infection and difficulties with patient removing catheters with balloons inflated.

MANAGEMENT OF DIABETES

Blood sugar regulation for the diabetic patient with dementia has numerous challenges. Blood sugars vary based on exercise, food consumption, dietary patterns, stress and medical problems. Dementia patients have changes in all of those factors and physicians can struggle to maintain a relatively normal glucose level. Most dementia patients are elderly and studies indicate that rigid blood sugar control has limited value in protecting against long-term medical complications such as kidney or retinal disease as well as limited impact on life expectancy in patients over age 65. Many Alzheimer's patients began to lose weight in the middle or later stages of their disease despite adequate nutrition.

Clinicians should strive to maintain moderately normal blood sugar ranges while avoiding hunger and hypoglycemia. Hungry patients become irritable and fight. Agitation worsens glucose control. Physicians may wish to maintain diabetic dementia patients slightly on the hyperglycemic level because some patients may precipitously stop eating. The dietitian

should attempt to maintain a balanced oral intake; however, food preferences change with dementia patients and glucose control may have to adapt to dietary peculiarity especially consumption of large numbers of sweets. Hypothalamic and brain stem alterations probably contribute to dietary changes and food preference changes. Monitoring of blood sugars with finger sticks may avoid struggles over venipunctures. Patients with dementia should not be allowed to administer insulin. Patients who receive insulin need careful monitoring of PO intake to assure that food intake matches the dosing of insulin. Oral hypoglycemic agents are generally preferable to insulin injections and these medications have few interactions with psychiatric medications commonly prescribed for dementia patients. Clinicians should guard against hypoglycemia because it may precipitate agitation and the patient may be unable to explain prodromal symptoms such as diaphoresis, nervousness or change in mental status. Diabetic retinal disease should be treated when feasible because diminished vision increase confusion and psychiatric symptomatology. Patients with advanced dementia can rarely comply with interventions like laser therapy and usually remain untreated. Dementia patients develop painful diabetic neuropathy as frequently as cognitively intact patients; however, these individuals may be unable to explain the symptoms. Under-managed pain frequently precipitates agitated behavior. Diabetic foot care and wound healing becomes a major problem with dementia patients because they are unable to comply with treatment programs and frequently pace or wander on injured feet. Weight reduction in a mildly demented patient is not mandatory depending on the degree of obesity and stage of the dementia. Families need careful explanation about administration of hypoglycemic agents.

MANAGEMENT OF HYPERTENSION

Hypertension is a common problem in the elderly and many dementia patients have elevated blood pressures. Demented patients may become agitated when removed from the home and placed in a facility or taken to the doctor's office. Agitated, distressed, moderately hypertensive patients frequently become normotensive in the familiar surrounding of their home. Hypotension can be a major problem for dementia patients who are prone to episodes of dehydration. Although some types of dementia (e.g., Shy-Drager syndrome) can affect autonomic blood pressure control, the majority of dementia patients maintain premorbid autonomic tone. No specific antihypertensive agent is recommended for patients with dementia. Non-compliant patients (i.e., refusing to take medications) can be treated with clonidine patches. Although all antihypertensives have potential CNS side effects, no specific antihypertensive have advantage over others. Inderal may cause depression or worsening of psychosis, but it may lessen neuroleptic-induced side effects of akathisia. ACE inhibitors may cause elation or confusion and calcium channel blockers are sometimes used as a tertiary medication for agitated behavior. Each medication has pluses and minuses that should be considered by the clinician. Diuretics are better administered in the morning to minimize the risk for nocturnal incontinence.

The relationship between blood pressure regulation and cognition is unclear although recent studies suggest that long-term BP control may improve cognition. BP control may help prevent vascular dementia but hypotension can be quite dangerous in the elderly.

CORONARY ARTERY DISEASE

Atherosclerotic heart disease is common in the elderly. Some research suggests that numbers of senile plaques in the brain are related to severity of coronary artery disease and vascular dementia is related to heart disease. Studies do not exist for the outcome of patients

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treated with coronary artery bypass, angioplasty or stint placement in patients with dementia. The surgical management of coronary artery disease in the mildly demented patient differs from the cognitively intact patient in the post-operative management phase. Mildly demented patients are extremely sensitive to the effect of medication and anoxia. Post-operative patients may awaken more confused and fail to regain previous cognitive levels. The cumulative effect of stress and hypoxia probably accounts for these changes. The treating cardiologist and cardiothoracic surgeon should be prepared to manage a delirious patient in the recovery room. This management strategy includes the judicious prescription of analgesics, avoiding benzodiazepines, and the use of neuroleptics to manage agitation. Patients may become delirious not only from the procedure but also from secondary medical problems such as pneumonia or urinary tract infections as well as the disorienting effect of the ICU. Families should be alerted to the possibility of delirium or a sustained drop in cognitive function. Informed families are less likely to become angry over post-operative functional loss.

The medical management of atherosclerotic heart disease does not differ from non-demented patients. Symptomatic treatment of angina is complicated by the patient's inability to describe pain as well as their inability to remember frequency and severity of attacks. Agitation or fighting may be a symptom of angina in an aphasic, demented patient. Agitated, diaphoretic patients who have no reasonable explanation for their agitation and a history of coronary artery disease deserve a trial with a short-acting nitrate to assess improvement. Patients who respond to nitrates should undergo a trial of long-acting nitrate or calcium channel blockers to assess their impact on agitation. Diminished exercise tolerance or physical activity suggests that some secondary medical problem is present or the patient is depressed. Calcium channel blockers, a management of angina, may have mild, mood stabilizing effect and lessen agitation in a few patients. The common dementias (e.g., Alzheimer's, vascular, diffuse Lewy body disease) do not effect the cardiovascular system although patients with vascular and alcoholic dementia may have related diseases (e.g., atrial fibrillation or alcoholic cardiomyopathy).

COPD

Chronic pulmonary disease can be difficult to manage in dementia patients who cannot cooperate with respiratory therapy. Hypoxia can worsen confusion and pulmonary medications (e.g., theophylline, steroids, and sympathomimetic agents) may worsen behavioral symptoms. Although cigarette smoking may have a slight protective effect against Alzheimer's disease, demented patients should stop smoking as soon as feasible both for health and safety issues. Moderate to severely demented patients with multiple apraxias may forget how to use inhalation devices or resist oxygen therapy.

ARTHRITIS

Arthritis and arthralgia occur in 52% of elderly patients. Pain can produce agitation in demented patients but anti-inflammatories should be used with care because of GI symptoms. Heat and physical therapy are valuable. Osteoporosis is a major health problem in females and back pain may result from compression fractures. Recent studies show that estrogen therapy may decrease the risk for Alzheimer's disease and slow the progression of symptoms. The protection that estrogen provides against coronary artery disease, osteoporosis and Alzheimer's disease makes long-term estrogen replacement a viable treatment in females. Recent studies suggest that long-term use of NSAIDS reduce the risk of Alzheimer's disease.

Presently, the “protective” effect of NSAIDs for Alzheimer’s disease does not balance the risk for GI bleed.

END OF LIFE MANAGEMENT

Patients with dementia usually survive for 8-10 years from onset of symptoms to end of life. End-stage dementia patients manifest a constellation of symptoms including gait apraxia, feeding apraxia, inability to communicate and withdrawal. Families must decide whether to resuscitate patients, insert nasogastric or PEG tubes or even hospitalize the patient for basic medical problems (i.e., infections, sepsis, myocardial infarctions, etc). Dementia is a fatal disease and hospice care is appropriate when the patient is in the final stage of the disease.

Studies demonstrate that older patients with advanced dementia and families that prohibit instructions for resuscitation usually survive approximately 6 months. Outcome studies on antibiotic treatment of end-stage dementia patients with fever indicate that therapy does not significantly alter patient outcome. Studies show that patients with PEG tubes or feeding tubes suffer an equal rate of complications as those given oral feedings. Feeding tubes do not necessarily reduce complications but they may prolong survival. Most dementia patients with NG tubes require physical restraints in facilities where permitted or 1:1 nursing care to maintain the tube in place. The decision to place a PEG or NG tube should be made by the family after they understand the risks and complications of tube placement, including the need for restraints and immobilization. Federal laws do not mandate parenteral feedings; however, federal laws do prohibit restraint use in nursing homes. This decision is left to the physician and family.

Dementia patients who cease eating follow the typical course of terminal patients who can no longer eat. They suffer some hunger and thirst within the first 24 hours but ketosis, hypernatremia, and dehydration eliminate this sense.

Families need proper information to determine advance directives for patients. Most elderly patients residing in nursing homes do not wish to be resuscitated and most family caregivers do not want life extending procedures performed on their family member. Unfortunately, a minority of Alzheimer patients have advanced directives and families usually are asked to make the decision. Studies show that fewer than 10% of elderly patients (i.e., those over 70) survive resuscitation and the number is probably lower (3% or less) for demented patients. Dementia patients frequently have significant, further cognitive decline following catastrophic illnesses. Few studies examine the role of hospice care for dementia patients. Demented patients who can no longer eat, drink, walk or talk tend to follow the typical course of dying patients with dehydration, obtundation, hypernatremia, coma and death.

ASSESSMENT AND MANAGEMENT OF WEIGHT LOSS

Weight loss is a persistent problem throughout all phases of dementia. Studies in nursing homes indicate that patients with dementia lose weight in comparison to non-demented control groups even in the setting of comparable nutrition. Patients with dementia may lose weight for a variety of reasons including increased caloric demand, diminished oral intake or unrecognized medical problems such as malignancy. Patients with dementia should not undergo extensive medical evaluations for weight loss before a careful dietary and behavioral assessment has been completed to exclude behavioral causes of weight loss. The first step is a calorie count that requires direct observation of the amount of consumed food. Many patients will empty their plate but hundreds of calories of food are on the table, clothing

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and floor (i.e., environmental loss). Patients who are pacing, wandering and moving furniture may burn more calories than those patients with sedentary behaviors. These patients require more calories to sustain body weight than normal elders. Patients may have diminished oral intake for a variety of reasons. Depressed patients may not wish to eat and those with significant oral pathology may not eat because of pain. Patients often lose alveolar bone and dentures began to fit poorly or develop high points that can be painful. Patients may develop other types of oral pathology and dentate patients may develop carious disease or broken teeth that make eating painful. Advanced stage dementia patients may lose the ability to explain dental symptoms. Any patient with weight loss should have a careful examination of their oral cavity to exclude oral pathology.

Depression and psychosis can cause weight loss. Depressed patients lose the desire to eat and psychotic patients may fear poisoning or harm. Appropriate psychotropic medications will remedy this problem.

The dietitian or home health nurse should observe any Alzheimer patient with weight loss to determine eating skills. Patients with Alzheimer's disease began to lose eating motor skills in the mid phases of their dementia. Feeding apraxias progress from loss of table manners and ability to use utensils through total inability to self-feed. Patients also develop swallowing and feeding apraxias (i.e., the patients may either hold food in their mouth for prolonged periods of time or over-masticate food and spit it back). Dietitians must adjust diets and staff must feed patients with the appropriate consistency for their feeding and chewing skills. Eventually patients completely forget how to feed, chew and swallow. At this point, the treatment team must decide whether to use an interventional approach or a hospice management strategy.

A medical cause of weight loss can be investigated when oral disease, feeding apraxias, depression and psychosis have been excluded. All patients with diminished oral intake should be checked for rectal impaction and assessed for possible delirium. Common medications that suppress appetite in dementia patients include serotonin reuptake inhibitors, psychostimulants (e.g., Ritalin) and a range of other non-psychotropic medications (e.g., theophylline). Antidepressants and antipsychotics can disrupt esophageal and gastric motility resulting in dysphasia or obstipation.

Patients with dementia develop a range of physical ailments to include esophagitis, peptic ulcer disease, and gastrointestinal malignancies that will lead to diminished oral intake.

A variety of medications are available to treat weight loss in Alzheimer patients. Periactin has not been demonstrated to be effective in enhancing appetite. Marinol, the non-psychoactive component to marijuana, has not been demonstrated to be effective in Alzheimer patients using placebo crossover studies. The hormone, Megace, can sometimes improve appetite in both males and females.

MANAGEMENT OF CHRONIC PAIN

Pain assessment and management is important for patients with dementia. Patients with mild to moderate dementia can generally report the symptoms of pain; however, individuals with moderate to severe cognitive impairment may underreport or misinterpret pain. Pain is common in the elderly, especially those in nursing homes with 26% reporting chronic pain. Elderly patients report joint and extremity pain as most common followed by abdominal pain. Severely demented patients are unable to ask for PRN pain medication and the clinician must determine whether to place the patient on a standard dose of analgesic. Narcotics should be used with great care because they produce confusion. Demerol is particularly problematic with a significant anticholinergic side effect. Tylenol with Codeine can

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be effective; however, constipation becomes a major issue. Newer medications (e.g., Tramadol) may be helpful for short-term analgesics but these drugs have multiple side effects. End-stage dementia patients with significant pain from contractures, decubiti or other lesions should receive adequate analgesic therapy regardless of potential CNS depression.

Dementia patients retain the ability for physical addiction and will develop abstinence syndrome if precipitously withdrawn from long-term narcotic usage. Patients with long-term narcotic usage who are in the final stages of dementia should have narcotic medications continued. Alzheimer patients have limited ability to localize and describe pain due to neurological damage; however, there is no literature that indicates that Alzheimer patients suffer with pain any less than non-demented individuals. Subcortical (i.e., thalamic) pathways may remain intact even as cortical pathways are disconnected. Adequate pain management may lessen agitation and increase oral intake in demented patients who are unable to explain their symptoms.

CHRONIC RENAL FAILURE

Chronic renal failure can develop in dementia patients and this condition poses a significant medical and ethical dilemma for the clinicians. Mild azotemia is common in the elderly demented individual. Dementia patients are often mildly dehydrated and aggressive hydration may significantly reduce BUN and creatinine. Significant azotemia causes delirium and diminished oral intake.

Elderly patients with dementia are not candidates for renal transplantation. Patients can be maintained on home dialysis or hemo-dialysis based on their overall health and cognitive ability. Azotemia worsens cognitive function by producing delirium. Severely demented patients make poor candidates for any type of dialysis due to non-compliance with dietary restrictions, medication and dialysis procedures. Studies indicate that most clinicians believe that dialysis is not indicated for moderate to severely demented patients. Patients with moderate to severe azotemia should be considered for hospice care.

MEDICAL COMPLICATIONS OF ANTIPSYCHOTIC MEDICATIONS

Approximately 20% of patients residing in nursing homes will require antipsychotic medications for control of neuropsychiatric symptoms. These classes of drugs have a variety of neurological complications including drug-induced Parkinsonism, tardive dyskinesia and akathisia (i.e., an inner sense of restlessness and need to move) as well as autonomic effects. Low-potency neuroleptics, as well as some atypical neuroleptics, may produce orthostatic hypotension. The medical complications of antipsychotic medications are less well understood. Standard neuroleptics such as Haldol and Mellaril frequently produce suppression of the white blood cell line and mild elevation of liver enzymes. The precise etiology for this phenomenon is unknown. The fatal complications of malignant neuroleptic syndrome (i.e., autonomic instability, rigidity with elevated CPK, delirium) are seen with all antipsychotic medications and carry the risk for fatal outcomes.

INCONTINENCE/ FALLS/ DECUBITI/ WEIGHT LOSS

Falls are common in the elderly and very common in demented patients. Studies show 5% of community dwelling elders fall every year with 11% sustaining fractures. Many Alzheimer patients (40-60%) fall each year and their fracture risk is increased threefold in comparison to intact elders. Gait impairments occur with dementia because of gait apraxias or medication side effects. Every dementia patient who falls needs a basic evaluation including orthostatic BP, examination of lower extremity strength, gait assessments, and neurological

examination. Some patients with hip fractures continue to ambulate despite pain. Dementia patients that fall and have gait changes require X-rays to exclude hip fracture. Ambulatory patients with hip fractures should have repairs to maintain mobility and quality of life. Pain medications should be judiciously prescribed to avoid confusion and facilitate rehabilitation. Physical therapists can perform gait evaluations and suggest interventions or strengthening exercises.

CONCLUSION

Patients with dementia have multiple healthcare needs that require careful attention to lessen behavioral consequences and improve quality of life. Medical management of these patients differs from cognitively intact elders and physicians must alter their management strategies to accommodate these disabilities.