

# AAN Guideline Summary for Point of Care

## Detection, Diagnosis and Management of Dementia

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This is a summary of three just-released American Academy of Neurology (AAN) guidelines on dementia. Although the guidelines address all forms of dementia, this summary focuses on Alzheimer's Disease, for which current evidence is strongest and clearest. The guidelines conclude that AD should be detected and treated early. Patients with Mild Cognitive Impairment should be identified and monitored for progression to AD—a likely event. The clinical criteria for diagnosing AD are reliable and valid. Although AD is not curable, there are treatment and care options available today that can manage symptoms, improve quality of life and delay time to nursing home placement. Please refer to the full guidelines for more information.

### **"Practice Parameter: Detection of Dementia-Mild Cognitive Impairment"**

- Alzheimer's disease is common in the elderly. 10 % of people over age 65 and 50% of those over 85 have AD.
- AD and MCI differ from normal aging. Know the ten warning signs of AD. Communicate the warning signs to your community, your colleagues, your patients and their families. Contact the AAN or the Alzheimer's Association for tools or ideas on how to do so.
- Identify and monitor Mild Cognitive Impairment patients for progression to AD. MCI is a classification of persons with memory impairment who are not demented (normal general cognitive function; intact activities of daily living). Between 6 and 25% of MCI patients progress to dementia or AD each year. MCI patients should be evaluated regularly for progression to AD using the assessment tools listed below.
- Be alert to cognitive impairment in all your patients; screen for dementia if cognitive impairment is suspected:

#### **Good evidence supports using:**

- General cognitive screening instruments:
  - Mini Mental Status Exam (adjusted for age/education)
  - Memory Impairment Screen

#### **Ten Warning Signs of AD**

- Memory loss that affects job skills
- Difficulty performing familiar tasks

- |   |                                  |
|---|----------------------------------|
| • Neuropsychological batteries<br>Weaker evidence supports using: | Problems with language           |
| • Other general cognitive screening instruments:                  | Disorientation to time and place |
| - Kokmen Short Test of Mental Status                              | Poor or decreased judgment       |
| - 7-Minute Screen   | Problems with abstract thinking  |
| • Interview based techniques:                                     | Misplacing things                |
| - Blessed Dementia Rating Scale                                   | Changes in mood or behavior      |
| - CDR   | Changes in personality           |
| - IQCODE  | Loss of initiative               |
| • Brief cognitive assessment instruments*:                        |                                  |
| - Clock Drawing Test  |                                  |
| - Time and Change Test  |                                  |

*Used with the permission of the Alzheimer's Association. Contact the Alzheimer's Association or the AAN for more information*

\*Caution should be used; these tools are limited in scope.

### "Practice Parameter: Diagnosis of Dementia"

- The clinical criteria for AD are reliable (DSM-III-R definition; NINCDS-ADRDA and DSM-IV diagnostic criteria)
- Vascular dementia, dementia with Lewy Bodies and fronto-temporal dementia should be excluded, but the current diagnostic criteria for those diseases are imperfect.
- Structural neuroimaging is appropriate to detect lesions which may result in cognitive impairment.
- The CSF-14-3-3 protein is useful when CJD is suspected and recent stroke or viral encephalitis can be excluded.
- Evidence supports the following tests in the **routine evaluation of the demented patient**:
  - Complete blood cell count
  - Serum electrolytes
  - Glucose - BUN/creatinine
  - Serum B12 levels
  - Depression screening - Liver function tests
  - Thyroid function tests
- Evidence indicates the following tests should not be included in the routine evaluation of the demented patient
  - Screening for syphilis (unless patient has a specific risk factor, e.g., living in a high-incidence region)
  - Linear or volumetric MR or CT measurement strategies
  - SPECT

- Genetic testing for DLB or CJD
- APOE genotyping for AD - EEG
- Lumbar puncture (unless presence of metastatic cancer, suspicion of CNS infection, reactive serum syphilis serology, hydrocephalus, age under 55, rapidly progressive or unusual dementia, immunosuppression, and suspicion of CNS vasculitis)
- At this time, there is not enough evidence to support or refute the use of the following tests:
  - PET
  - Genetic markers for AD not listed above
  - CSF or other biomarkers for AD - Tau mutations in patients with FTD
  - AD gene mutations in patients with FTD

**"Practice Parameter: Management of Dementia"**

- **Treat cognitive symptoms of AD with Cholinesterase Inhibitors and Vitamin E.** Consider the use of cholinesterase inhibitors in mild to moderate patients. Cholinesterase inhibitors may improve quality of life and cognitive functions including memory, thought and reasoning. They are proven effective for people who are mildly to moderately affected by the disease, and are under evaluation in patients with MCI and severe dementia. Therefore, the early recognition and diagnosis of Alzheimer's disease is important. Consider vitamin E to slow progression of AD; selegiline is also supported, albeit by weaker evidence. Do not prescribe estrogen to treat AD.
- **Treat agitation, psychosis and depression.** The patient's paranoia, suspiciousness, combativeness or resistance to maintaining personal hygiene can seem overwhelming to families and caregivers and significantly impact quality of life. Evidence indicates that several strategies can decrease problem behaviors. If environmental manipulation fails to eliminate agitation or psychosis, use antipsychotics. Selected tricyclics, MAO-B inhibitors and SSRIs should be considered to treat depression.
- **Encourage caregivers to participate in Caregiver Educational Programs and support groups.** Short term Caregiver Educational Programs can improve caregiver satisfaction. Long term Caregiver Educational Programs can delay time to nursing home placement for the AD patient. Caregiver training programs, and other support systems (computer support networks, telephone support programs, adult day care and other respite programs) may help delay time to nursing home placement for AD patient, as well.

**Strategies to Improve Functional Performance and Reduce Problem Behaviors**

Strategy	Strength of Evidence
<b>To improve functional performance</b>	

<ul style="list-style-type: none"> <li>• Behavior modification, scheduled toileting, prompted voiding to reduce urinary incontinence</li> <li>• Graded assistance, practice and positive reinforcement to increase functional independence</li> <li>• Low lighting levels, music and simulated nature sounds to improve eating behaviors</li> <li>• Intensive multi-modality group training may improve activities of daily living</li> </ul>	<p>Strong</p> <p>Good</p> <p>Weak</p> <p>Weak</p>
<b>To reduce problem behaviors</b>	
<ul style="list-style-type: none"> <li>• Music, particularly during meals and bathing</li> <li>• Walking or other forms of light exercise</li> <li>• Simulated presence therapy, such as use of videotapes of family</li> <li>• Massage</li> <li>• Comprehensive psychosocial care programs</li> <li>• Pet therapy</li> <li>• Utilizing commands issued at the patient's comprehension level</li> <li>• Bright light, white noise</li> <li>• Cognitive remediation</li> </ul>	<p>Good</p> <p>Good</p> <p>Weak</p> <p>Weak</p> <p>Weak</p> <p>Weak</p> <p>Weak</p> <p>Weak</p> <p>Weak</p> <p>Weak</p>

*This CareEssential™ Point of Care Tool is an educational service of the American Academy of Neurology. It is designed to provide members with evidence-based guideline recommendations to assist with decision-making in patient care. It is based on an assessment of current scientific and clinical information, and is not intended to exclude any reasonable alternative methodologies. The AAN recognizes that specific patient care decisions are the prerogative of the patient and the physician caring for the patient, based on the circumstances involved. Physicians are encouraged to carefully review the full AAN Practice Parameters so they understand all recommendations associated with care of these patients.*