#268 Dementia Made Simple

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SPEAKERS

Matt, Everyone, Josh, Emi, Stuart, Paul

Emi 07:09

Yes, thank you, Matt. So Miss Remy Embers is a 79 year old female retired professor who you've known several years with hyperlipidemia and osteoarthritis. She lives alone and her daughter Carrie Guyver is visiting on the weekends. She usually comes alone and is doing well. But today her daughter corners you between rooms to tell you she has been getting more forgetful. Carrie notice that her mother barely took her atorvastatin last month, and recently lashed out for stealing her necklace, which they later found in the drawer. Several times she mentions a dog in the fenced in backyard, though Carrie doesn't believe it. When you enter the room, you ask Miss Embers, how things are going and if she noticed any memory changes, she is upset that you asked and accuses her daughter of meddling. So first, Josh, this is quite the case. And I'd like you to kind of take us through just the basics and definition. So what what is kind of cognitive impairment dimension? And how do you kind of classify that?

Josh 08:12

So both cognitive impairment and dementia are umbrella terms. Cognitive impairment, being broad, can be congenital from birth can be lifelong. So dementia is an acquired cognitive impairment that's often related to aging. And dementia itself is an umbrella term, meaning that somebody has memory changes or cognitive changes, that's enough to impact their function. So you can think about shortness of breath, having a differential in one type of that might be due to congestive heart failure. But congestive heart failure itself is a syndrome of different subtypes. And so you're really going from one sort of umbrella term to a narrower umbrella term. And then from there, you actually have to get to a diagnosis.

Matt 08:56

Yeah, and we you know, we were talking about this beforehand. Josh, we've done we've done some episodes on dementia, it's been a while. So we wanted to refresh ourselves. We wanted to see what someone like yourself is doing these days. I'm sure this is a pretty common thing for you where you get cornered by the family member in the hallway. So like what what's your approach for this as you're

gonna start to delve into how are you going to diagnose this this patient and figure out like which type of dementia they may have?

Josh 09:26
Right, so the first thing I would say that my job as a geriatrician is often to play referee between a patient and the family member. And so I have to sort of look at it as a triad visit, I have to listen to the patient, i have to listen to the daughter take both of them quite seriously and not take sides up front. And so it's called a triad visit, where I do spend time with each person. What's interesting is when physicians aren't thinking about this specifically, they might just talk to the daughter and ignore the patient altogether. I've seen that happen some of my patients just come to me afterwards really ticked off that some doctor only talked to the daughter. I've seen the flip side where the physician will only talk to the patient, a demented patient in a room and shut the daughter out of the room, I've seen a patient who actually had an IRB consent all to them, and the family was left out. So I think you have to come to it with just an open mind that it's your job to explore what's going on. The second thing I noticed about this is there's medication management. So financial issues and medication management issues are the two instrumental activities of daily living, that are most likely to show up with deficits and cognition. They're the most cognitively taxing ideals. Now, what I think is also interesting is that there's this episode of lashing out, which speaks to maybe an emotional component to this. And that's not normal. So normally, when somebody has dementia, they have issues with their cognition, but layering on a mood aspect of it, to me is an independent variable. It's a separate category of its own, along with possible visual hallucinations or delusions. So a lot of times people mishmash cognitive changes together, where they think about memory, language, visual spatial issues, and then mood and psychiatric symptoms. And the reason I separate those two things out, is because you can have mild dementia with severe neuropsychiatric symptoms, you can have severe dementia with no neuropsychiatric symptoms, and you have to look at those variables, like an x and y axis, because if you overweight one or the other, it can really trick you into miss staging where the person is at.

Paul 11:44
And before we delve into how you determine those things, can I actually ask you to take a step back? And just tell me how you frame the triad visit? Like how, how do you introduce that just the way that you're gonna structure the visit to the family and the patient? Sort of how do you how do you organize that so no one gets hurt.

Josh 11:59
So a triad visit is probably one of the most important things I do at a new patient visit. And I often thank the family member for bringing the patient in. Sometimes if I can tell the patient is not the happiest about the situation, I say, you know, they brought you in because they love you. And I say you know what, I love talking to patients, I love talking to the family members. So I'm going to speak to both of you. And I really want to hear what both of you have to say, I usually do set up a ground rule that the patient is allowed to interrupt a family member, but the family member isn't allowed to interrupt the patient, mainly because usually it's the family member who brings it in. So there's already a little bit of a power differential. So yeah, so usually, that's what I bring in, or that's how I set up a triad visit.

Matt 12:43

I like that that framing is helpful because I have to admit, I don't think I'm doing as good of a job as I should at, like addressing both the patient and their family member. I think sometimes I'm probably making the mistake that you already you mentioned where I'm either talking mostly to the patient, or I'm talking mostly to the family member. And maybe I'll be more well liked. If I take your tact, I like this, this is already you're already helping us.

Stuart 13:09
I just wanted to kind of add in, I find that I run the same ways as you were I'm kind of focusing on one or the other and forget to kind of have them both communicate together. And I think it's a really good idea to basically put the patient in the pilot seat to say, Hey, you know, when they're talking, let's let's listen, let's all kind of back down and listen. And that's a common mistake that I think that even I've made when it comes to talking with these patients.

Josh 13:37
So the other thing I'll add about this is when a family member brings in a loved one for a memory evaluation, it is often not the happiest visit. Yeah. And so when I'm communicating, I'm not just communicating facts about memory loss and dementia. I'm also communicating to them how I want them to feel about it, which is not ashamed and not afraid. And so I find that especially when you're communicating in the setting of memory and cognitive issues, it's not the facts that you're communicating that are important. It's the emotions that you're communicating, you're communicating not just what you want them to know about memory loss, but how you want them to feel about memory loss, which is, this is something we can talk about in an open way without being afraid. And we can do things to manage it. So you bring that emotional context to the visit.

Stuart 14:31
So one of the things that I find is the most difficult part of this initial visit and I know that we've had an episode about this before is actually I always get the get this chief complaint issues with driving essentially, or concern with driving and the whole family comes in with a patient are like Oh no, she's not where he or she is not safe to drive. And that immediately puts the patient on the defense. And then you're just trying to because the way that they interpret it is you're trying to take away my independence.

Josh 14:57
Yeah, it is that so There's a couple of ways I would frame memory loss. One is, you know, tell me about your memory? Do you feel that your memory is not as good as it used to be? Which is such a softball, easy question to answer yes to even if you have normal age related memory loss, because whose memory is as good as it used to be? And so you make it easy for them to say yes, and start engaging this and you say, Well, you know, let's figure out how it's doing. And this would be true for function, for cognition, for independence for goals, and you're just asking these things in a very open way. And yes, the tension is there in the room, but sort of your job as the physician is to say, you know what, I love dealing with these issues. And you know, I'm glad you're here.

Stuart 15:46

oftentimes talk about Alzheimers dementia or vascular dementia. I think Paul wanted to kind of bring this up. How does that differ at least an initial presentation for frontal temporal eluding Lewy body dementia?

Josh 15:59
Yeah, so let me give you sort of my cheat sheet of how I subtype dementia, everybody gets focused on times 123. Probably the first thing I think about is I observe how fast they are like how fast do they move, and how fast do they speak, and to get that sense of rhythm. So if I watched them walk from the waiting room to my office, and I see them walking normally, or I see them walking slowly, it gives me a clue. And then when I interact with them, if they're speaking quickly or slowly, that also gives me a clue. So if somebody is speaking quickly, generally speaking, it's either going to be Alzheimer's or frontal temporal dementia. And if they're speaking and walking slowly, it's going to be either Parkinson's with dementia slash Lewy body dementia, or vascular dementia. And so that speed is the first thing that helps me separate out my dementia subtypes. If they're faster in older, it's more likely to be Alzheimer's because older people don't get frontal temporal dementia. If they're faster and younger, it can be 50:50. If it's a slower dementia, and they have vascular risk factors, it's probably going to be a vascular dementia, which tends to be a mixed type. And then if they're slower, and they have cog wheeling tremors, or rigidity, then it's either going to be Lewy body dementia, or Parkinson's dementia. And the only thing that distinguishes between those two things, is whether or not the motor symptoms preceded the memory symptoms by more than a year. So let me give you an example. So one day I was at dinner with my mother and father in law, and they had some family friends there. And this guy comes shuffling in with a mask faces and hypothermia and sits down across the table from me. And I'm just observing him said How are things going? How's your health? And his wife speaks up because he's not that engaged. And he says, oh, he was diagnosed with Alzheimer's dementia. Now without doing any cognitive testing, you know, right off the bat, this is not going to be a typical Alzheimer's dementia. It seems like Parkinson's. So then the only question is, does he have a history of Parkinson's? So, the first time I made a diagnosis of Lewy body dementia on my own, I was first year out of fellowship, I see this patient shuffle and very similar to this dinner guests. And I say to the wife, I said, Well, how long has he had Parkinson's? And the wife goes, he doesn't have Parkinson's. I'm like, Well, there you go. He has Lewy body dementia, because Parkinson's with dementia, you'll know that they had a diagnosis of Parkinson's for years before they developed the memory issues. And so if it came on concurrently, then it's Lewy body dementia. So again, the quick branch in your head is speed, which is something that, again, you have to speak to the patient with dementia to get a sense of speed. If it's fast, and they're older, most likely Alzheimer's fast, and they're younger. 5050, Alzheimer's FTD. If it's slow with a fib, hypertension, diabetes, vascular dementia, and if it's slow with Parkinson type features, it's either PD or Lewy body dementia. And as a non neurologist that gets me in the ballpark, nobody will laugh me out of the room. So the first time I tried diagnosing FTD wasn't somebody who's like 90 and the geriatric psychiatry has literally laughed, he goes, 90 year olds don't get FTD. So that's how I learned that one.

Stuart 19:29
What the age range you typically see FTD and

Josh 19:33
so FTD is usually under 65, which is why I don't see it a whole lot.

Stuart 19:40
So I've got a few patients in my panel. One was late 50s, early 60s when the initial symptoms came on and by even before 65 was just full blown. disinhibition, completely change personality. Very interesting case, actually, but yeah, the three that I have my panelists are all young In 65, yep.

Paul 20:02
Can I ask about one more entity? And then I will probably actually move on to the case, I suppose. But there's a doctor up to date, who I trust and many things, mentioned this, this alcohol related dementia, almost as a throwaway. But then they also say it's relatively common, which is funny because there's like three different pages on great celiac disease and not on alcohol related dementia. So is that a thing? And does that? And how does that sort of typically manifest if it is a thing? So I guess the second question is contingent upon the first.

Josh 20:27
Yeah. I don't know that I would ever diagnose somebody as having only alcohol related dementia. I can't say I'm an expert on this one, but I would I have had some pretty heavy drinkers, who developed dementia, but I feel like they often get diagnosis mixed type.

Matt 21:36
So we've given you Miss. Remy Embers and her her caregiver is with her. Very clever names. And we're wondering, I know this comes up a lot. Is this is this just like mild cognitive impairment? Or is this some type of dementia? And what sort of bedside testing other than talking to the patient? You've given us a lot of some of your physical exam and observation that you do? What what sort of bedside about do you like to do?

Josh 22:40
So the distinction between mild cognitive impairment MCI and dementia is somewhat of an arbitrary definition from a clinical standpoint, in the sense that it really depends if the change in cognition is enough to impair function. So I think her name was Pat Summitt, who is the head coach of the women's Tennessee's basketball team. She ended up getting diagnosed with dementia while she was still full time coaching, because it affected her cognition. And probably her version of mild dementia is better than me on my best day. Whereas other patients where if all they do is sit on a couch and watch TV, they can seem like their function is unchanged for years. And the family's like no, they're fine. And they're getting an MMSE of 18. So there is an arbitrary nature, I had a patient with mild dementia who was having trouble writing these 30 page grant applications. So there is an arbitrary nature to it, but it MCI is when you have cognitive changes that don't impair function. Dementia is when your cognitive changes impair your function. MCI is a broad umbrella category that includes all sorts of things that can impair cognition, both things that are degenerative, and things that are not degenerative.

Matt 24:03
And yeah, in my understanding, there's a pretty high, above 10% per year, cross over into meeting dementia, you know, a diagnosis because the lose function of some sort.

Josh 24:14
That's right.

Matt 24:15
So the neurology guidelines, and as of the recording of this, probably, Paul, will come out like next week, because we're because they haven't been updated since 2001. And we actually had the doctor,who has been on the show, was was one of the authors of those. And he mentioned that there were some labs that would be reasonable to check. So what sort of labs Do you employ if you're if you're working up? This is this is a pretty this patient. Let's say she hasn't had any testing and I mean, are you sending like a heavy metal screen on her or are you just starting a little bit more basic than that?

Josh 24:48
So I stay pretty basic. So if, if I get a hint that the patient has a rapidly progressive dementia, or if they're younger, those differentials are fundamentally different, right? So either I'm doing a basic workup on things I'm comfortable assessing, or I decide they need a specialist, where you give the specialist a very, very long leash to order tests in a systematic way. So as a geriatrician even though I see dementia, literally every day I see patients, I actually do not touch rapidly progressive dementia. To me, that is a really good reason to see a neurologist, yes, I can look things up and start ordering tests in a random fashion. But if I want the workup to be done in a systematic fashion in the setting of a framework, that's what the neurologists do, whether they go to PET scans, and EEG's, and even to brain biopsies, and things like that. So if I'm starting to reach for tests I'm not comfortable with, it should be because there's some feature that I'm seeing that makes me think this isn't a typical dementia. Honestly, I'll hand that off. So the tests that I order are very, very basic. The other thing to remember is that a dementia evaluation to a geriatrician is part of a comprehensive geriatric assessment. So I will order some basic labs like a CBC, a BMP, a B12, TSH, I will do a general evaluation because the differential for unintentional weight loss versus falls versus dementia overlaps enough that the geriatricians response to any sort of these functions of the clients is a comprehensive geriatric assessment. So my assessment isn't going to be just dementia specific, like B12, TSH, it's going to be a broader evaluation. So I will order some basic labs. But if I'm reaching for something like

Matt 26:45
CSF tau protein or something, right?

Josh 26:49
If I'm, if I'm reaching for something that tells me that I'm seeing something that I'm not quite comfortable with, and they might need a neuro psychology evaluation or neurology evaluation,

Matt 27:00
Yeah, I find that neuro psych eval is really helpful when you have the patient that's maybe in their like, mid 50s, or early 60s, and they're having some memory concerns, and you're just not sure if it's, if it's a mood disorder, or if it's something else, and I will often send them to neuro psych in that case,

Josh 27:18

quirky personalities, I think, also need to go to neuro psychology. So if somebody has a personality disorder, or they're just a bit odd at baseline, then I think that is also a good reason to do a neuro psychology evaluation,

Paul 27:32
Stuart, I'm screwed.

Matt 27:35
I send Stuart there, we used to work together all the time.

Josh 27:39
Well, so let me just point this out. There's several domains of cognition, and all of us are biased to over weight one versus the other. So I know that my bias is that if somebody is socially intact, they will come across to me as non demented. And that has fooled me more times than I can count where then I do an MMSE. And it's like 16. And I think to myself, how did I miss this. And so the whole point of a systematic workup is that in our heads, we have certain biases towards different domains, whether it's language, cognition, memory, and if somebody is intact in one area, it can really fool us. And so that's why a more structured exam can be used,

Stuart 28:16
Which means if I see you on a bad day, and I'm not socially intact, you can be like, Oh, my gosh, this guy's demented.

Matt 28:23
I'm glad we're mixing in Stuart as a parallel patient in this case. Well, if Josh, if Miss. Ember was seeing you and you only had like a 15 minute visit, and you weren't expecting this to be brought up? Do you ever do something like a mini cog, or just like a three item recall, which I know at least just like, as a temporary stopgap measure, you can at least get a sense. Do you ever employ something like that? Where do you bring people back and do like a MOCA? Which one of those tests you like, if any?

Josh 28:56
So I usually split my cognitive tests into really short ones that are binary. So things like a mini cog or a clock draw for the answers, yes or no. Ideally, those are used for asymptomatic people. Now in this case, she has a complaint of memory loss that the daughter has lodged. And so I would do an assessment test, like the MMSE, MOCA or the slums. The moca is probably best for when the history and physical don't quite match. So by history, they seem intact, but on physical exam, they're not quite right, or vice versa. By history, they're not intact. And when you see them, you think they're really with it. So the moca, the thing I see people do wrong is if you get a moca score of eight to 10. You just tortured everybody you should have you picked the wrong test. That's just really mean. And I know that MMSE is copywritten. And I know slums is not in the moca needs training. I hate to say I probably do pull out the MMSE most of the time, just because it's quick. It's easy. It's probably best for moderate dementia. Because

Matt 29:57

and I think what you're pointing out is that it's moca is a hard test. So if someone has moderate to severe, they're going to do terrible on it. And it's painful. MMSE is much easier. So if they have more severe dementias, you're recommending that.

Josh 30:09
So I would do two things, I always get my ADLs and IDLs, because it's a functional diagnosis. So I want to know what their activities of daily living are. And then second, I will do probably an MMSE on somebody like this, because I can do in about five minutes.

Matt 30:24
Do you? Are you did you get an MRI? Or were you gonna say? Sorry, I

Stuart 30:28
realized I was muted. And I asked a question, and his answer was actually somewhat appropriate. So I thought I was unmuted. Do you ever use the Addenbrooke?

Josh 30:35
I don't.

Stuart 30:37
Okay, it's like several pages long, it takes a long time. But

Everyone 30:41
Sound great! Not helpful. (Laughter)

Stuart 30:43
So the reason I ask is because it has a higher sensitivity and specificity.

Josh 30:47
So you have to be really careful about a lot of these cognitive scales, especially when you're interpreting research studies, okay, about how clinically relevant they are. So the fast scale, which is a functional staging of dementia of Alzheimer's dementia, is based off of ideals and ideals, and is probably the most validated staging instrument for mild, moderate, severe, even better than any cognitive test. So I do live and die by my ADLs and IDLs. I'm getting to imaging studies, man, I feel like a lot of older adults get a head CT when they go into the emergency room for some reason. So a lot of them already have had had imaging, if I'm going to be sending them to a neurologist that really likes looking at structure, and hippocampal size and hippocampal atrophy and they know what to do with that information. I will order an MRI using the Alzheimer's Disease Center protocol, which looks at certain brain structures in a more taking measurements of certain brain structures. But honestly ahead, a noncon head CT, if you're going to order imaging at all, is probably sufficient to look at things like strokes and cancers. In normal pressure hydrocephalus and big structural things is probably good enough. But a lot of times I don't even order imaging, just because the pattern of what I see in front of me seems so routine.

Matt 32:13
Yeah. Okay.

Paul 32:14
Great. Josh, I wanted to go back to our case a little bit. And something that you said were sort of the emotionality that the patient was displaying was not part of dimension necessarily, and maybe think about sort of also sort of pseudo dementia that you sometimes see with patients who are older and depressed. And I'm just wondering, when you're evaluating patients like this, how do you evaluate mood or sort of for underlying mood disorders as part of your workup? Or do you even do you sort of take that on a case by case? I guess I'm wondering what your overall framework for the for the mood component is?

Josh 32:41
Yeah, so the most important thing is even noticing a typical patient with dementia should not have a mood component, they should actually be happy. And so what I noticed first and foremost is a lot of physicians don't even notice when a patient with dementia is anxious, depressed or having psychosis. So on a new patient visit, if I am doing a memory valuation, I will usually pair that with a geriatric depression scale, just to keep myself honest, and I will think specifically, are they having trouble with anxiety and depression? And then either thought content delusions, or thought perception, hallucinations, and I will ask about mood and psychosis, if I'm doing a dementia evaluation, because it sort of gives me the x and y axis for giving me a more complete picture of what's going on with them cognitively.

Stuart 33:30
It's interesting. So you say that, that mood disorders generally don't occur with dementias? What about someone who's more high functioning like that coach who can't remember her name? would you expect some degree of, of depression with a patient like that? Who is otherwise typically high functioning and has insight recognize their memories slipping?

Josh 33:49
Oh, so mood disorders are common in dementia, sometimes because people perceive it but a lack of insight is often part of the cognitive deficit, and so the person doesn't appreciate their memory loss. So depression and anxiety and psychosis are common enough. That's why I do check for it. It's just that they're fairly independent in the sense that you can have mild dementia severe psychiatric symptoms and vice versa. But they don't go in lockstep like a lot of people sort of have an impression where they just mishmash it together.

Matt 34:23
I think we have another part of the case here. did you want to do the honors? I think this is going to set up we're going to get into talk about treatment and counseling.

Emi 34:30
Definitely. Yeah, so testing for Miss Remy Embers showed no reversible causes and some of the basic lab workup. a CT scan showed mild parenchymal volume loss and small vessels scheming changes,

and for further neurocognitive testing revealed impaired short term memory apathy and visual hallucinations. She was lost to follow up a few months and returns with her daughter Carrie Guyver, who has been sleeping over every day after work since the mother left the store. On twice and burn two pots. Her mother is not sleeping well at night and takes long daytime naps. She now has a slight tremor is walking slowly and is more withdrawn. So what are you thinking about Now in the case, we've lost her follow up, she didn't have a chance, kind of for more medications. And where do you take it from here, Josh?

Josh 35:21
tough case, I would take one step back. And I would just want to make sure that to see if the mood symptoms preceded the dementia or memory symptoms. So I had a patient once that came to me with a diagnosis of dementia. But when you sort of went back and reviewed what had been going on with her, the patient was clearly depressed for about six months before they became demented. Now that can be a prodrome to dementia. So some dementia types like Lewy body can present with psychiatric symptoms first, and I've missed that before too. So sometimes you just want to see if the mood symptoms came first. And really what you're dealing with is depression, just because there's such a large affective component to this case, or at least the psychiatric symptoms to it. So at this point, I would say she seems to have a diagnosis of maybe Alzheimer's dementia with depression. The tremor is less specific as you get older. So you can see even unilateral tremors in any type of dementia. And so, again, given that that wasn't the presenting symptom, I don't know that it would make as much of a difference in terms of subtyping it. So the most important thing at this point for me is that the patient is safe. And I run through my ideals and ideals and make sure that she has what she needs to be safe on a daily basis. And then I accompany that with assessing the caregiver and making sure she's not burned out because it's like a two hand clap. You just have to make sure that the patient's cared for without burning out the caregiver.

Matt 36:54
Josh, the speaking of the caregiver, something that just came to mind was I came across that there was a nighttime adult daycare because I knew there was daytime adult daycare, but that in some places, there's actually a nighttime adult daycare for patients who were up all night, which I just I just wanted to mention that to the audience. I don't know how available that is. I just thought it was super cool. Hopefully COVID will be going away. But in the in the current era, are adult daycares even open right now? I feel like caregivers must be really struggling.

Josh 37:25
Yeah, that's a great point. They're not open. And caregivers are definitely struggling. and home health aides are intermittently available. So yes, this whole time has been quite challenging for patients with dementia and the families. So yeah, the first thing that I would be concerned about is sort of the caregiving aspects of this, maybe bringing in some home health aide support in the short term, and getting the patient on a schedule, not because that matters to the patient so much as it just makes a living situation at home more tolerable for everybody else, and it has to be a win for everybody. So yeah, that would be the goal is to get the patient on a schedule of sorts and make sure nothing is causing an acute decompensation. In other words, nothing's causing delirium.

Matt 38:12
In the at the first visit where you were doing the triad visit, and I think we probably had enough at that first visit to call this a dementia. Or let's say whatever visit you first saw Miss embers and you thought you had enough to call the dementia in a triad visit? What would it sound like when you're making giving that diagnosis? Or do you use the word dementia? Or do you use your Do you just talk about memory, and we're going to try to support you.

Josh 38:40
So I'll introduce the topic as saying that your memory is not as good as it used to be. And usually people will agree with me on that one. And then I say, well, it's more than age related memory loss, I think you have dementia, and then I'll just pause. And if I don't have the comfort in bringing it up, all I do is add to the discomfort in the room, because everybody's already thinking it anyway. And so one thing I've learned to do is to bring up uncomfortable topics like dementia, and to do it comfortably, it's better for me to bring it up while everybody's there, then for them to go home and think about it on their own. And so I'll bring up the word, I'll show them that I'm not afraid of bringing up that word. And then I'll tell them that the best way this is getting a little bit into treatment. But the best way to manage dementia is to make sure that they live life as fully as possible. And then that sense, nothing changes, that the best things that they can do for themselves. The day after a diagnosis with dementia is the same thing that they should have done the day before, which is get a good sleep, good nutrition, good physical, intellectual social activity. And the best thing they can do for themselves is whatever they enjoy to the fullest extent possible. So I try to give the diagnosis but then reframe it that life actually can go on.

Matt 40:01
It's, we were talking about this in pre recording, but this in The Lancet in 2020, there was, I believe it was Livingston et al. They talked about dementia prevention, which I remember hearing a couple years ago that that term was even was controversial to suggest that you could prevent it. But the authors of this, were suggesting that that you could prevent up to something like 40% of cases, just by doing these things, and it's a lot of the stuff that we're just trying to get all our patients to do what you just mentioned, live it live an active, healthy lifestyle, be surrounded by people, you know, be social. It's easier said than done.

Josh 40:38
In many cases, It is.

Matt 40:41
Yeah. So I'm sure that Miss Carrie is going to be interested in like, you know, we're going to get her set up with home health, we're making sure her mother's safe. We're putting plans into place and routines. What about medications, patients, they always want to know about medications? What are your What are your thoughts on the common ones?

Josh 41:07
Yeah, so that was one of my goals of my jury fellowship is how do you know when to prescribe a cholinesterase inhibitors. And the way I think about it, and when the American College of Physicians actually had a guideline, written 2008, which has since been archived, where they did a fantastic

evidence review, which I still think is one of the best evidence reviews up to this point. And they showed that after six months of being on a cholinesterase inhibitors, it can improve your, let's say, MMSE, by an average of one to two points. And it can improve your neuro psychiatric inventory, which is a research scale of psychiatric symptoms by about four points out of 100. And then there's a functional scale called the Civic plus. And it can improve it by point five out of seven. And when you look at whether or not these research scales correlate to real world outcomes, but the correlation actually isn't that great. And so the conclusion was that these drugs have proven statistical benefit of minimally clinically important changes. And so that's why I always joke that, you know, if somebody is going to eat a hotdog, and they're going to choose to eat organic hotdog, they're not really better off. And, you know, you have to think about what are the big interventions that actually give real world benefit. And what are the ones that give very, very small benefit. The downside to these medications is that they have a number eight to harm about of 10, with gi side effects and vagal symptoms, and so they're not risk free medications, in some trials up to 50% withdrew due to side effects and the treatment arm. So they have solid harms, quantifiable harms, and the benefits are on these research scales that are really challenging to translate to real world clinical benefit. That's why a lot of times you start these medications and you think to yourself, I can't tell if anything changed. And then you stop it and you think, well, it still seems like nothing changed. These are not rescue medications. So these are not medications that are meant to be started In the hospital setting. These are medications that exert a mild gentle benefit that is statistically proven over 60, plus really well done RCTs. So there is proven benefit, they are more effective if the person is more symptomatic. So in the same sense that somebody who's pain free will not benefit from taking pain medications, somebody with no dementia, MCI will not benefit from taking these medications. So anytime you see a drug study or a drug rep, try to talk about pathophysiology of how the medication works. It's because they don't have data. Because if they had data, they would just say, you know, we prevented hospitalizations, institutionalization caregiver burden, but when they start talking about how prevents cell death, it gives you the implication that these are preventative. But actually, when you look, amantadine is only indicated for moderate to severe dementia, they couldn't get a mild indication, and none of these medications could get an MCI indication. So these are actually not medications that are meant to be started early. They actually are more effective when you're more symptomatic.

Paul 44:32
This is probably a weird question. And we can cut this part out. But has there been any benefit proven to the caregivers with the initiation of these types of medications? You know, the word inexorable is used a lot when talking about dementia. And I feel like there's a lot of powerlessness and feeling like helplessness. And so much of that is just desperation to do something to kind of sort of slow things down or help. And so even though there's like the possible harms of these medications, just the illusion of doing something meaningful, might help them somewhat so I'm just wondering was that should work if it helps the caregivers out to any extent even though it may not be all that helpful for the patients.

Josh 45:04
Yeah, so for FDA approval, you need to do a caregiver rating. And these drugs have benefit on the caregiver rating scale at about 0.5 out of seven. So the question is that enough to be meaningful, right? If you improve somebody's sleep by seven minutes per night, is that enough to be meaningful? And so that's the challenge of a clinician is we don't think about things in binary, everything's a

continuous variable. And at what point do you say that this is a clinically meaningful change? You know, I think if you have a conflict of interest with a drug company, that definition is going to be a lot smaller than if you're the clinician or the family member, you're going to want to see a much bigger difference. So you know, I would say, if everything else in life is going fine with the patient with dementia, they have enough home health aide support, their other medical problems are stable, the family's like I have money, and I don't know what to do with it, and they want to just give an extra medication, you know, then by all means, go for it. I mean, there are dozens of studies that show changes in well done cognitive, psychiatric and caregiver scales. But again, it's like I said this last time, but if somebody has food insecurity, you know, you're not going to tell them to go to Whole Foods, like they have bigger issues they need to deal with. So to me, these medications are the icing on the cake. The bigger issues are, education for the family is the most likely thing to prevent institutionalization and helping them with support at home. Those are probably the bigger interventions.

Matt 46:35
So I guess, before we leave the medication topic, I would just ask Josh, when you start these do you do you have a trial period? Like where you say, You're not just gonna give a one year supply and not follow up? Do you say, Okay, here's 60 days, here's 90 days let's decide at that time if we're going to stop it or continue it. Because, as you mentioned, with the colon esterase inhibitors, gi side effects people lose weight. The vago side effects of bradycardia Dr. Wu Dara told us that he saw someone get a pacemaker because they were on I think it was Donepezil. So what's what kind of lease you give people when you put them on these meds?

Josh 47:13
So I always explain these medications are not worth tolerating side effects. The second thing is, I know for sure, and I'll have to send you the article later, that a serial MMSE will not tell me if the medication is effective or not, because I don't know what their trajectory would have been. And when you see the randomness of how people proceed through memory loss, it's not one point per year, some people drop five points, some people will stay stable for a couple of years, that there isn't an MMSE target or a moca target where you say this medication is working. So to me, it comes down to tolerability. So as long as you tolerated, go for it, as long as it you know, if you're hiring a home health aide to make sure the person remembers to take amanatade twice a day, that's not worth it. But the other question is, what's their goal of care if their goal of care is to stay out of a nursing home, for example, and they end up in a nursing home? Well, then maybe it's time to stop it? Or if their goal is to be able to remember their spouses name or to have a relationship with their spouse or to remember a certain hobby. But the question is, what's the goal of care that you're trying to achieve? Nobody says, You know, I just want my MMSE to be as high as it can be. So the question is, what is their goal? So that way, you have some sort of stopping point. So one stopping point is side effects, the not another would be when it can no longer meet their goal of care.

Matt 48:34
And if somebody if you stop it, or have you had this happen, where you stop the medicine, and the person falls off a cliff, I know that was the worry. And so what's your tack there? Have you seen it happen? And if it did happen, what would you do?

Josh 48:48
So it happened to me once that I can think of where I stopped a medication the person typed in, I restarted it, and they acquired their previous cognitive function. And this was the same patient where I had done MMSE is on for about 18 months, and they were in the mid teens. And I started her on Donepezil and it went up to like 25. And this is like the one patient that actually saw an effect from these medications. Usually what happens is, you start the med, you can't tell you stop the med, you can tell right there was just a Cochrane Review that came out in February of this year that talked about discontinuation of these medications. And it basically said that if you stop these medications, there's a measurable decline in function of these really small numbers. And so to me, it actually proves that these numbers are small enough that you wouldn't notice. So even though the conclusion was that stopping medications causes a cognitive decline, when you look at the magnitude that decline, overall the entire scale, the research scale, yeah, it actually confirmed to me that nobody would actually notice right,

Matt 49:53
so it's a statistical difference but not a minimal it's probably what didn't meet the minimal, clinically important difference on that scale, which we see a lot when we're looking, evaluating trials.

Josh 50:04
So it is a little bit of an old wives tale or a myth that if you stop the medication, you're going to see the sudden irreversible decline in cognition and you're going to regret it. And it it's just one of those myths that keeps people prescribing medications with side effects longer than they should.

Matt 50:21
Josh, I wanted to ask you, we did an episode with a geriatric psychiatrist, Dr. Popo, and we were talking about the anti psychotic medications and some of the behaviors. And his point was probably he sees a lot of challenging cases. He says, In the real world, a lot of the behavioral interventions, even though that's like the gold standard, what you should always try first, they just don't work. And if you're trying to keep someone in the home, sometimes the family just needs a medication. And he was talking about the anti psychotics. So what's your thought there? Is there any role because when you read about them, they have Blackbox? Warning, increased risk of death? How do you think about those? How do you talk to families about those medications?

Josh 51:02
So the anti psychotics that have a number need to harm over six months of about 30 to 50, to cause a death. So those are real harms are medications that should be used at the lowest dose for the shortest time possible, with specific outcomes. So in order to have specific outcomes, you have to define the behavior, is it verbal agitation, physical agitation? Is it apathy? Is it withdrawal? Is it psychosis? And so is it insomnia, so you're trying to describe it? So that way, you know if it's getting better or not, you still have to make sure that there's no unmet needs that the person isn't hungry, thirsty, frustrated, bored, they need toileting, help repositioning help things like that, and that they're on a schedule. So you still have to do all the non pharmacologic interventions first. And then if you do decide to use a medication, it's absolutely through an informed consent. Because these medications have quantifiable harms, and very fuzzy benefits. But if you're at a point where you're thinking about institutionalization, caregiver

burnout, or using a medication, then yes, I will use these medications for the shortest duration lowest dose possible, and just see how things are going. And you know, they're tough medications to use, you always feel like you should give up your geriatric membership card whenever you got one of these medications. You guys get card?

52:31
Yeah.

Josh 52:33
But yeah, I think, you know, at some point, you do not always try an SSRI. First, there was the CIT ad study, which showed that citalopram was beneficial. But when you look at meta analyses of SSRIs, it's less so I mean, if you do 500 studies, you know, 20% of them will have a p value less than point five. So even if they're large, well done studies, at some point, one of these medications will have a positive study, but you do try to use SSRIs first, and then again, I will use the medications that I shouldn't.

Matt 53:08
And you're there with a with the SSRIs Are you saying if they have independent of mood, like independent of depression or anxiety, just if they have like agitation are difficult behaviors, you might use an SSRI, because if someone has actual like psychosis, the anti-psychotics then they then they, that there's an actual indication for them, right? Correct. So that's, that's a little different than what we're talking about. If it's just someone's agitated, and they don't want to, they don't want to bathe. So you put them on an anti psychotic, that's, you know, that's what you're trying to, to avoid.

Josh 53:40
And I will ask, how long do these agitation episodes last? Do they last minutes or hours? And then how much do they escalate? how intense are the episodes to sort of get me in an idea of intensity? It gives me a sense of how close to burnout the caregiver is psychiatric symptoms. And I think fecal incontinence are the two most predictive things of nursing home placement and when it comes to dementia. So these are serious things to consider.

Matt 54:11
Paul, I think we had time maybe for one more question. What else did you want to get into?

Paul 54:16
Was I can't remember if we talked about this on air OFF AIR very early in the episode because my I'm also having issues with short term memory. But I think Josh, you mentioned it was important to actually talk to the patients, which I think in prior episodes I've mentioned, I do not like doing that, and I can't get on board with it. But I know that's something that I want to hear actually maybe a little bit more about, maybe you can talk me into it.

Josh 54:35
Yeah, I would say that talking to patients with dementia has forced me to be a better communicator for a variety of reasons. And it's something I actually really enjoy. So if you are the type of physician that just likes communicating facts, that just won't fly with the patient with dementia. So, communicating with

somebody with dementia, you have to think about what you're saying. You have to think about how you're saying it. You're trying to communicate Hate an emotion. And to certain extent, you're also communicating with the goal of just letting them know that you are in relationship with them that you are close to them. And so you have to remember that all three of these things are purposeful. So if I have a patient with agitation, sometimes my main tool is the emotion that I'm communicating not even what I'm saying. Sometimes it's just my physical presence being there. Sometimes my physical presence makes things worse, in which case I have to leave. But it's important to understand that communication with somebody with dementia has to be very complete. And I think as physicians, we often cheat, and we just think it's about the facts that we're communicating. Now, the other thing that you are assessing, though, when you're communicating with a patient with dementia, is their mood and their thought content, and how they're piecing thoughts together. And because that gives you the flavor of whether there's an affective component or a psychotic component to their dimension. So if I'm talking to somebody with dementia, and I'm talking to them, and then finally I say, Well, do you ever see things people don't see? And they're like, Well, yeah, there's snakes in the room. So many times 10 other physicians have spoken to that patient and never under uncovered that it's dementia with psychosis, because they didn't talk to the patient long enough to figure that out. So you have to sort of stew in their middle you have what's going on to get their flavor and subtype of what's happening. And it takes time. I mean, it takes 1530 minutes of just sitting with them and having conversation. And to certain extent you're giving that person the dignity that even though they have dementia, that they are a person worth being with.

Matt 56:40
Paul, I can't wait for you to start stewing in this

Paul 56:45
I love that so much. I make the joke all the time, except it's our job that 90% What I do is just make reassuring noises. Like that's really most of my job. And I'm thinking of a specific patient is the same thing. We're just sort of I very much enjoyed talking with this patient but had underlying dementia. And it was probably a couple years in where eventually they just conversationally like well, then of course, there's the demons with the woman's face, like excuse. And like it was just it was a it's been having sort of active auditory visual hallucinations that I just did not uncover that I got there eventually just by having a relationship and making him feel kind of heard. I think so it's I love that whole point.

Josh 57:17
I mean, let's face it, most physicians treat dementia like they treat rashes, they acknowledge it's there, they want to put a steroid cream on it in the issue, is that no. Right or antifungal or a combination? But, you know, yes, it's great when a physician even knows that a patient has memory issues, that's fantastic. But at some point, you know, understanding the severity of the dementia, how it's impacting the patient, how it's impacting the family being able to manage it is probably more important than whether their fifth obtuse marginal has a 60% occlusion like at some point, these things really matter. And, again, dementia to me is like a rash to dermatologist like, it's just the starting point, and then you know, I dive in.

Matt 58:05

So this is a perfect spot for you to remind the audience like two or three things that you really want them to remember from what we've talked about today.

Josh 58:14
You know, I would say that both the prevention and treatment of dementia does not depend on medications at this point. From a patient perspective. It's about physical, social, intellectual activity, good sleep, it's about overall good health. Supporting the caregiver matters a lot. And one of the jobs is to take away the stigma and fear and shame of dementia and to demonstrate to the patient and family that this is something that can be acknowledged that life doesn't end it can be managed, and you can actually have good years ahead of you even with a diagnosis of dementia. I would say I don't want to make the management of dementia really complicated. I saw one of the readers had or listeners had a question about very complicated multi point interventions for dementia. And I would keep things really simple. Like, I'm a big fan of simplicity. Some of my boss, my previous division chief said that the goal of geriatrics is to manage complexity as simply as possible. So I don't order complex tests. I don't put patients on a ton of medications, order imaging. But again, the simple interventions are best my uncle actually had dementia. And he was in California, his wife, my aunt died and his children realize he had dementia. And the neurologist said, you know, keep him in Los Angeles, even though my cousin is an Oregon, and we have the specialized cognitive program. Now taking care of a loved one with dementia out of state is incredibly stressful. And I said to my cousin, there is no cognitive training program that is so special that it's worth trying to manage this out of state. I said, Bring your debt close to you. That's going to matter more than anything else. So just really keep it simple and keep your big goals in mind.

Paul 1:00:06
This has been another episode of the curb ciders bringing you a little knowledge food for your brain.

Oh, yummy.

Transcribed by: MJ Allen, DO