Dementia

Definition

Dementia is a **chronic and progressive syndrome caused by brain disease** characterized by decline in **memory, thinking, orientation, comprehension, and ability to perform daily activities**. It mainly affects older adults but **is not a normal part of ageing**. The most common cause is **Alzheimer's disease**.

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1. Assessment

Assessment Question 1: Are there symptoms of dementia?

Ask the person and a reliable informant (family/carer):

Memory and orientation problems

- Forgetting recent events
- Forgetting where they are
- Forgetting where items are placed

Functional decline

- Difficulty managing daily activities such as:
    - cooking
    - shopping
    - paying bills
    - social functioning

If **memory problems + decline in daily functioning** are present → suspect dementia.

Assessment Question 2: Are there other explanations for symptoms?

Check if symptoms:

- Have been **progressive**
- Present for **at least 6 months**

Rule out other causes.

Rule out delirium

Look for:

- sudden onset
- fluctuating symptoms
- disturbed consciousness
- confusion at night

If suspected:

- investigate infection
- review medications
- check metabolic causes
- treat medical cause.

Rule out depression (pseudodementia)

Check for:

- persistent depressed mood
- loss of interest
- reduced motivation

If present:

- treat depression
- reassess cognition after treatment.

Assessment Question 3: Evaluate other medical causes

Look for:

Early onset (<60 years)
History of:

- head injury

- stroke
- loss of consciousness

Medical conditions:

- hypothyroidism
- malnutrition
- anaemia
- HIV or other infections

Cardiovascular risk factors:

- hypertension
- diabetes
- smoking
- obesity
- previous stroke

If present → refer or manage accordingly.

Assessment Question 4: Assess carers' situation

Identify:

- main caregiver
- level of caregiver stress
- financial or social difficulties
- caregiver depression

Provide support if carers are struggling.

Assessment Question 5: Are behavioural or psychological symptoms present?

Common symptoms include:

Behavioural symptoms

- wandering
- agitation
- aggression
- sleep disturbance

Psychological symptoms

- hallucinations
- delusions
- anxiety
- emotional outbursts

These are called **Behavioural and Psychological Symptoms of Dementia (BPSD)**.

Box 19.4 Behavioural and psychological symptoms of dementia

Behaviours
Agitation
Shouting
Wandering
Apathy
Inappropriate sexual behaviour
Impaired sleep

Symptoms
Delusions
Hallucinations
Depression
Anxiety

Contributory factors
Constipation
Pain
Superimposed delirium
Sensory deficits

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2. Basic Management Plan

2.1 Psychoeducation

Explain to the patient and family:

- Dementia is a **brain illness that gradually worsens**
- It is **not caused by normal ageing**
- There is **no cure**, but supportive care can improve quality of life
- Many symptoms can be managed.

2.2 Manage Behavioural and Psychological Symptoms

First identify and treat physical causes such as:

- pain
- infection
- constipation
- medication side effects

Identify triggers such as:

- crowded environments
- unfamiliar places
- stress

Modify these triggers when possible.

2.3 Non-pharmacological Interventions

Recommended approaches include:

- calm environment
- simple communication
- structured daily routines
- exercise
- music therapy

- activities and schedules
- massage or relaxation

These should be **first-line management**.

2.4 Promote Functioning in Daily Activities

Encourage independence in:

- toileting
- dressing
- eating
- mobility

Home safety measures:

- remove floor clutter
- install handrails
- use clear signs for rooms
- adapt the house for safety.

Encourage:

- regular exercise
- social activities
- recreational activities.

2.5 Cognitive Stimulation

Carers should:

- regularly orient the patient (time, date, place)
- use photos, TV, newspapers for memory stimulation
- use short and simple sentences
- reduce background noise

- maintain consistent routines.

2.6 Support for Carers

Provide:

- education about dementia
- emotional support
- training in behaviour management
- respite care if available
- information on social or financial assistance.

2.7 Pharmacological Treatment

Medication is **not required for all patients**.

Consider medication only when:

- Alzheimer's disease diagnosis is likely
- specialist supervision is available.

Possible medications:

Cholinesterase inhibitors

- donepezil
- rivastigmine
- galantamine

Memantine

- particularly in vascular dementia.

Summary of NICE guidance for the treatment of Alzheimer's disease[78,79]

- The three AChE-Is donepezil, galantamine and rivastigmine are recommended for managing mild-to-moderate AD.
- Memantine is recommended for managing moderate AD for people who are intolerant of or have a contraindication to AChE-Is, or for managing severe AD.
- For people with an established diagnosis of AD who are already taking an AChE-I:
  - consider memantine in addition to an AChE-I if they have moderate disease;
  - offer memantine in addition to an AChE-I if they have severe disease.
- Treatment should be under the following conditions:

For people who are not taking an AChE-I or memantine, prescribers should only start treatment with these on the advice of a clinician who has the necessary knowledge and skills.

This could include:

- secondary care medical specialists such as psychiatrists, geriatricians and neurologists; and
- other healthcare professionals (such as GPs, nurse consultants and advanced nurse practitioners), if they have specialist expertise in diagnosing and treating AD.

- Once a decision has been made to start an AChE-I or memantine, the first prescription may be made in primary care.
- For people with an established diagnosis of AD who are already taking an AChE-I, primary care prescribers may start treatment with memantine without taking advice from a specialist clinician.
- Ensure that local arrangements for prescribing, supply and treatment review follow the NICE guideline on medicines optimisation.[80]
- Do not stop AChE-Is in people with AD because of disease severity alone.
- Therapy with AChE-I should be initiated with a drug with the lowest acquisition cost (taking into account required daily dose and the price per dose once shared care has started). An alternative may be considered on the basis of adverse effects profile, expectations about adherence, medical co-morbidity, possibility of drug interactions and dosing profiles.

Summary of NICE guidance for the treatment of non-AD dementia[78,79]

- Offer donepezil or rivastigmine to people with mild-to-moderate DLB.
- Only consider galantamine for people with mild-to-moderate DLB if donepezil and rivastigmine are not tolerated.
- Consider donepezil or rivastigmine for people with severe DLB.
- Consider memantine for people with DLB if AChE-Is are not tolerated or are contraindicated.
- Only consider AChE-Is or memantine for people with vascular dementia if they have suspected co-morbid AD, Parkinson's disease dementia or DLB.
- Do not offer AChE-Is or memantine to people with frontotemporal dementia.
- Do not offer AChE-Is or memantine to people with cognitive impairment caused by multiple sclerosis.
- For guidance on pharmacological management of Parkinson's disease dementia, see Parkinson's disease dementia in the NICE guideline on Parkinson's disease.

Medicines that may cause cognitive impairment[1]

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- Be aware that some commonly prescribed medicines are associated with increased anticholinergic burden, and therefore cognitive impairment.
- Consider minimising the use of medicines associated with increased anticholinergic burden, and if possible look for alternatives:
  - when assessing whether to refer a person with suspected dementia for diagnosis
  - during medication reviews with people living with dementia.
- Be aware that there are validated tools for assessing anticholinergic burden but there is insufficient evidence to recommend one over the others (see section 'Safer prescribing for physical health conditions in dementia').
- For guidance on carrying out medication reviews, see medication review in the NICE guideline on medicines optimisation.

NB: The Anticholinergic Effect on Cognition (AEC) scale can be accessed at www.medichec.com

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Antipsychotics for severe behavioural symptoms

Use **only when there is risk of harm** to patient or others.

Principles:

- start low, go slow
- use lowest effective dose
- review regularly
- monitor for extrapyramidal side effects.

Box 19.6 Daily doses of drugs used to treat behavioural and psychological symptoms of dementia

For mild agitation

Trazodone 50–100 mg
Benzodiazepines, e.g. lorazepam 0.5–4 mg
SSRIs, e.g. citalopram 10–20 mg
Carbamazepine 50–300 mg
Sodium valproate 250–1000 mg
Rivastigmine (for Lewy body dementia) 1.5–6 mg

For severe agitation with psychosis

Quetiapine 25–200 mg
Risperidone 0.5–3 mg
Olanzapine 2.5–10 mg

For depression

SSRI, as above
Mirtazapine 15–45 mg

For severe behavioural problems

Consider haloperidol in small doses (0.5–4 mg), for a limited time

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3. Follow-Up

Frequency

- **Every 3 months** if stable.

At each follow-up assess:

- cognitive decline
- behavioural symptoms
- medication side effects

- daily functioning
- safety risks (driving, cooking)
- depression or suicide risk
- caregiver burden.

Adjust management accordingly.