HealthPathways Melbourne

Putting knowledge into practice

CASE STUDY 35:

Patient with possible dementia

Inderjit, 78, is a retired agronomist and university lecturer. She has a history of hypertension, hyperlipidaemia and type 2 diabetes mellitus, all well controlled with oral medications: perindopril 4mg, atorvastatin 40mg and metformin 1g.

Inderjit has never smoked or drunk alcohol. Her husband died 18 months ago. Three months ago, she moved from Perth to Melbourne to be closer to her daughter and her family.

In Perth, she lived independently and managed her personal and domestic activities. She remained active in, and highly regarded by, the local academic and Sikh communities.

Inderjit presents to her GP, accompanied by her daughter, Jashleen, and requests repeat prescriptions for her medications. Jashleen mentions that she is concerned because her mother seems unusually flat and disengaged from the family.

Jashleen attributes these changes to grief and the stress of settling into a new city. She adds that she wants to support her as much as possible.

The GP takes a history. He suspects that Inderjit may be suffering from depression, so conducts screening measures for that and cognitive impairment. These are listed on the HealthPathways Melbourne Depression in Older Adults pathway.

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Inderjit's scores for are:

- Geriatric depression score (GDS): 5/15, suggesting mild depression.
- Mini-mental state examination score (MMSE): 24/30, reflecting normal cognition with reduced scores on recall and drawing tasks.

The GP expected the MMSE score to be higher, based on Inderjit's background educational level, so suspects mild cognitive impairment or early dementia.

He interviews Inderjit alone, and she acknowledges that she is concerned about her declining short-term memory, which began shortly after her husband died.

She has started to experience word-finding difficulties and has forgotten some appointments and engagements with friends. Feeling embarrassed, she has withdrawn from a number of activities.

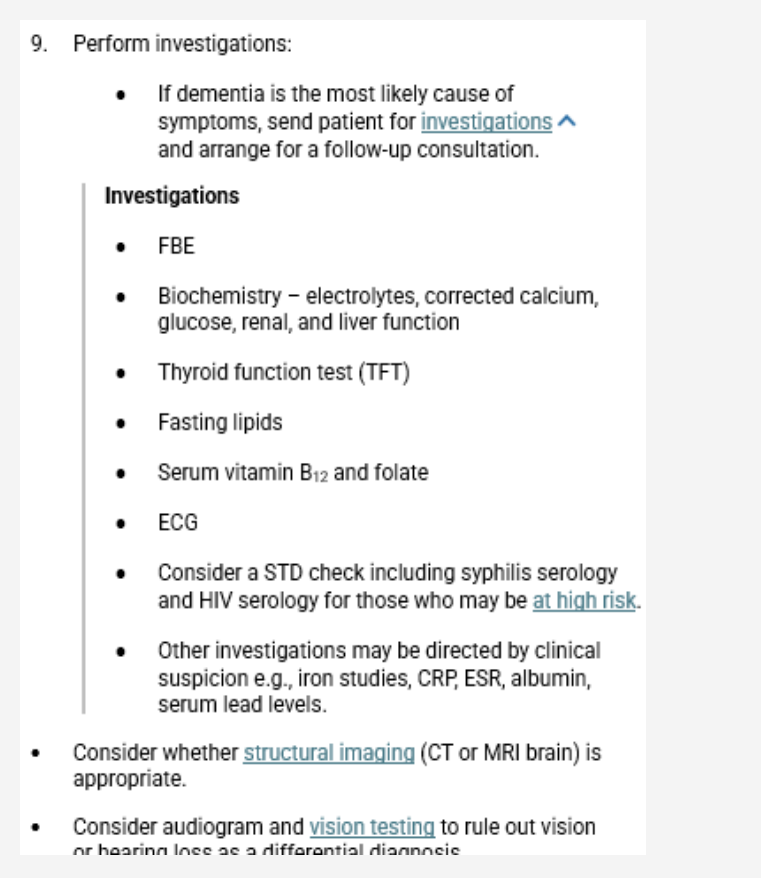
She doesn't want her family to know because she feels she will be a burden on them. She would like to do as much as she can to prevent further decline.

The GP thanks Inderjit for her openness, acknowledges that it will be a difficult subject to talk about, and offers to further explore her concerns about her memory.

He checks Inderjit's blood pressure and BMI and conducts a brief cardiovascular and neurological examination including '5 Minute Neurological Exam for Patients with Possible Dementia', also found on HealthPathways Melbourne. There are no significant findings apart from mildly raised blood pressure.

The GP suspects Inderjit has Alzheimer's or mixed dementia. He returns to HealthPathways Melbourne and refers to the Cognitive Impairment and Dementia pathway to check for relevant investigations. He arranges blood tests and a CT brain scan, adding HbA1c and urine ACR to monitor glycaemic control and renal function.

Following suggestions on the pathway, he also arranges optometry and audiology referrals.



9. Perform investigations:
    - If dementia is the most likely cause of symptoms, send patient for investigations and arrange for a follow-up consultation.

    Investigations

    - FBE
    - Biochemistry – electrolytes, corrected calcium, glucose, renal, and liver function
    - Thyroid function test (TFT)
    - Fasting lipids
    - Serum vitamin B_{12} and folate
    - ECG
    - Consider a STD check including syphilis serology and HIV serology for those who may be at high risk.
    - Other investigations may be directed by clinical suspicion e.g., iron studies, CRP, ESR, albumin, serum lead levels.
    - Consider whether structural imaging (CT or MRI brain) is appropriate.
    - Consider audiogram and vision testing to rule out vision or hearing loss as a differential diagnosis

The GP also encourages her to optimise healthy lifestyle measures and social networks. The GP refers to the Dementia Support and Resources pathway and links her to the national peak organisation, Dementia Australia.

Inderjit acknowledged she struggled with her mood some days and agreed to a referral to the St Vincent's Hospital Healthy Ageing Service found on the Non-acute Older Adults' Mental Health Referral pathway. (The GP notes eligibility for this service is determined by postcode and confirms his patient lives in an appropriate suburb.)

Two weeks later, Inderjit returns for her results. Her blood tests indicate good glycaemic control and mild renal impairment. Her CT brain scan shows mild generalised atrophy and evidence of chronic small vessel disease. Other results were unremarkable.

Jashleen accompanies her mother again. She tells the GP that she recently found several unopened packets of her mother's prescription medication. She concludes that she purchased them but then forgot that she did so.

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She raised this discovery with Inderjit, who then disclosed her memory difficulties. Together they looked at the information on the Dementia Australia website. They have now booked a time with a peer support person to learn more about navigating services.

The GP discusses the test results and says Inderjit likely has mixed vascular and Alzheimer's dementia. He reiterates the importance of optimising a healthy diet, lifestyle activities, psychological health and social engagement as part of holistic management of her condition.

Jashleen says she and her mother have read about medications for dementia. Inderjit is keen to commence.

The GP refers to the HealthPathways Melbourne Medications for Dementia pathway to discuss options available. He arranges a referral to the local Cognitive Dementia and Memory Service (CDAMS), which is listed on the Non-acute Geriatric Referral pathway. CDAMS, he explains, will enable a more comprehensive assessment, which will clarify medication options.

Inderjit is managing her activities well and her daughter visits daily, so she did not feel she needed referrals for further community supports. However, she did agree to a referral to a Home Medicines Review and a Health Assessment for Older Adults, which takes place six weeks later and is conducted by the GP and the clinic practice nurse.

By the time this takes place, Inderjit has started using a webster pack to regulate her medications. Her blood pressure is excellent.

Four months later Inderjit returns, having seen the geriatrician at CDAMS.

The geriatrician started her on donepezil 5mg. She has been taking this for two weeks and is tolerating it well but tells the GP she is also experiencing some vivid dreams, which she finds disturbing.

The geriatrician also instructed her to increase the dose to 10mg after one month, and gave her a prescription for this. The GP refers again to the Medications for Dementia pathway.

He suggests Inderjit take the medication in the morning to reduce the risk of the dreams and then change to the higher dose if tolerated.

The GP continues to monitor Inderjit at three monthly intervals. After 12 months, she reports feeling less flat and more engaged with her family. She has made some friends through the temple and a U3A group.

She still has short term memory difficulties but continues to manage day-to-day activities independently. Her GDS is 3, indicating a significant easing of her depression. Her MMSE score 25, indicating a small improvement in cognition.

Inderjit and Jashleen have been considering getting further supports, so the GP makes a referral for an Aged Care Community Assessment. Inderjit subsequently receives a level 2 package. She uses the funding for an occupational therapy assessment and interventions to optimise her independence and quality of life.

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