




Cognitive impairment and dementia in older people

The following questions can be used as discussion points for primary care peer groups or self-reflection of practice.

 It is strongly recommended that the following linked articles are read before considering the questions.

- Age-related cognitive decline: prevention and future planning: <https://bpac.org.nz/2020/cognitive.aspx>
- Recognising and managing early dementia: <https://bpac.org.nz/2020/dementia.aspx>
- Managing the behavioural and psychological symptoms of dementia: <https://bpac.org.nz/2020/bpsd.aspx>
- Understanding the role of palliative care for people with advanced dementia: <https://bpac.org.nz/2020/palliative1.aspx>
- Symptom management in palliative dementia care: <https://bpac.org.nz/2020/palliative2.aspx>

Cognitive ageing eventually happens to everyone, despite this it is a difficult issue to raise with patients; younger people are frequently disinterested in talking about it and older people often avoid the subject.

When a person is in their 40s and 50s, talking about cognitive ageing encourages them to implement strategies to maintain brain health, e.g. being physically, mentally, socially and culturally active. Later in life, it also facilitates an early diagnosis in the minority of people who will experience a clinically significant cognitive decline, i.e. mild cognitive impairment or dementia. Older patients should be encouraged to plan for their future during these conversations which may cover potential issues with their home, mobility and transportation, who could provide care for them and who might make decisions for them if they were not mentally competent.

Symptoms of cognitive decline should be assessed when first reported or noticed. The initial consultation should focus on the clinical history to establish the type of symptoms, their pattern, duration and impact on the patient. Alternative explanations for a change in cognitive function should be considered.

If cognitive impairment is suspected, a brief cognitive screening test should be used, e.g. the Mini-Addenbrooke's Cognitive Examination (Mini-ACE). Referral to secondary care is generally only necessary if there is complexity, e.g. severe symptoms or rapidly deteriorating function, or diagnostic or management uncertainty. Encourage early engagement with the local branch of Alzheimer's New Zealand or Dementia New Zealand.

At some stage on their journey, at least 80% of people with dementia develop behavioural and psychological symptoms. Depression and anxiety can be among the first symptoms, while others such as agitation and aggression more commonly occur later, especially as the person's ability to communicate and influence their environment diminishes.

The first approach to managing BPSD is understanding why the behaviour is occurring, and, where possible, resolving the underlying factors, e.g. untreated pain, separation from family or a lack of privacy. Understanding the patient's previous vocation, interests, abilities, social and family roles, cultural background and spirituality helps to individualise interventions.

Pharmacological interventions have a limited role in the management of BPSD as they are associated with a range of serious adverse effects and the indications for which they are effective is relatively limited. The increased risk of stroke, cardiovascular events and death associated with antipsychotic medicines in people with dementia, is a significant concern. If an antipsychotic is required, it should be appropriate for the behaviour requiring modification, and frequent monitoring of treatment response and adverse effects should occur. Trial withdrawal of the antipsychotic within three months, except in patients with long-term psychiatric illnesses, e.g. bipolar disorder. Antipsychotics should not be used to sedate patients with dementia who are difficult to manage or as a routine alternative to benzodiazepines.

When a patient enters advanced stages of dementia, palliative care is often appropriate. Managing palliative care may be complicated by an unclear prognosis, patients not being able to make their preferences known and by a significant time period between the initial diagnosis of dementia and death. Focusing on the person's goals of care and quality of life, rather than life expectancy is the best guide for a palliative approach.

As the end of their journey nears, people with advanced dementia may have pain, difficulties eating and swallowing, limited or no speech or mobility, incontinence, BPSD and infections; 24-hour care is required. Non-pharmacological approaches are generally first-line, with medicines used as needed to meet the goals of care. Cultural or spiritual practices may help to address the patient's psychosocial needs. A dementia specific pain tool, e.g. the Abbey Pain Scale can be used to identify and assess pain. Parenteral administration of medicines may be necessary for patients in the terminal phase of dementia who have difficulty swallowing.

The decision to use life-prolonging interventions in a patient receiving palliative care should be guided by their care plan and discussions with their EPOA or welfare guardian and family and whānau.

Questions for discussion

1. Do you find it difficult to initiate or engage people in discussions about cognitive decline? If so, what strategies have you found most effective to counteract this reluctance to discuss brain health? These conversations can often take a considerable amount of time: how much of a factor do you feel this is for clinicians and are there any techniques you use to help with this?
2. Distinguishing between normal age-related cognitive decline, mild cognitive impairment and dementia can be challenging. In your experience are there any specific questions, symptoms or signs that can make this distinction easier?
3. There are a number of cognitive assessment tools available. Do you favour a particular tool and if so why? The Montreal Cognitive Assessment (MoCA) has now been replaced as the preferred test in New Zealand by Mini-Addenbrooke's Cognitive Examination (Mini-ACE – online training is available at www.nzdementia.org/mini-ace) due to training and costs associated with MoCA. Were you aware of this change? If you have started using the Mini-ACE, have you found it reliable and practical to use? Who else administers cognitive testing in your practice?
4. Clinicians are encouraged to initiate discussion with older people about setting in place an enduring power of attorney and advance care planning. Are these things that you include in your routine care of older people? If not, why not? Is time often the main constraint here?
5. Are you aware of the beneficial role of cognitive stimulation therapy (CST) for people with mild to moderate dementia? Is it available in your area? If not, have you found any good alternative strategies for helping people with dementia remain mentally active?
6. Acetylcholinesterase inhibitors can have modest benefits for some patients with dementia, however, it is impossible to predict who will respond to the medicine. Do you offer these medicines to patients? In your experience, do you find that the beneficial effects outweigh the adverse effects or vice versa?
7. Do you have concerns about the prescription of antipsychotics for patients with behavioural and psychological symptoms of dementia (BPSD)? If you work in a rest home setting, are they suggested by staff as an immediate treatment option in preference to a trial of non-pharmacological interventions? If they are prescribed, how effective are they and is their use regularly reviewed?
8. There is an increasing need for palliative care for patients with advanced dementia. How comfortable are you with caring for these patients? Do you have more confidence in this area after reading the palliative care articles in our series?