DEMENTIA UPDATE 2009

Dr Tan Boon Yeow, A/Prof Goh Lee Gan

SFP2008; 35(1): 56-57

The first College of Family Physicians Singapore's Dementia skills course was conducted in March 2006. Shortly after that, a second update was conducted on 2nd Jan 2007 touching on areas like ethics and driving assessment which were not covered in the original skills course. Later that year, the Ministry of Health (MOH) clinical practice guideline was revised and launched in May 2007. Various talks organized by various hospital departments and drug companies followed.

The National Dementia Network, together with the College of Family Physicians, decided that it would be useful to do this re-run of the skills course and to conduct this course on a regular basis so as to provide the opportunity for all primary care doctors in Singapore to refine their skills in the care of dementia patients.

The current day management of the patient with cognitive complaints has a firmer basis for action compared to the past. Dementia is also increasingly becoming a key area of diagnosis and management as our population greys in the coming years. The key concepts covered in this family practice skills course are summarised below.

Overview of dementia

In Singapore the prevalence of dementia and cognitive disorders is likely to increase rapidly over the coming years. We have the fastest ageing population in the Asia-Pacific region with15-20% of the total population being above the age of 65 by the year 2030. At the present time it is estimated that we have about 25,000 patients with dementia and this number is set to increase to 53,000 by 2020.

Dementia represents a late stage of disease along the continuum of cognitive impairment. The diagnosis of dementia requires the presence of dysfunction in memory and other cognitive domains which are progressive, resulting in a decreased level of function.

TAN BOON YEOW, Chairman, Eldercare SIG, College of Family Physicians Singapore; Member, National Dementia Workgroup, MOH; Adjunct Assistant Professor, Division of Family Medicine, National University Health System; Consultant and Head, Medical Division, St. Luke's Hospital

GOH LEE GAN, Associate Professor, Department of Community, Occupational and Family Medicine, Yong Loo Lin School of Medicine, National University of Singapore; Senior Consultant, Institute of Family Medicine, College of Family Physicians Singapore

Making the diagnosis

A four-step approach to dementia evaluation presented in this skills course provides a succinct framework to aid the primary care physician in evaluating the individual who presents to the clinic with cognitive complaints such as forgetfulness or confusion. The first step requires the exclusion of delirium as the cause of the forgetfulness or confusion. The second step involves establishing the diagnosis of dementia. The third step assesses for the behavioural, functional and social problems associated with dementia. The final step, with the use of a focused history, physical examination, investigations and selected use of neuroimaging, attempts to establish the aetiological diagnosis of the dementia.

Overview of management

The various treatment strategies in dementia target the 'ABC' domains of the disease: 'ADL-Activities of daily living (ADL) or the functioning level', 'BPSD' (Behavioural and Psychological Symptoms of Dementia), and 'Cognitive' functions. The holistic treatment of dementia encompasses pharmacological and psychosocial interventions for the patients as well as supportive services for the caregivers.

Dementia related services include: dementia day care centres, support group for carers, home care services, counselling services, nursing home for people with dementia, community hospitals and specialist services in acute hospitals.

Medico-legal issues faced by patients with dementia include decisional capacity and driving risk assessment. The integration of such services is a major challenge. Primary care practitioners can play a bigger role by participating in training and shared care programme.

Pharmacotherapy

Pharmacotherapy is a vital part of the multi-pronged strategy in dementia management. Specific pharmacological agents that can be used include the cholinesterase inhibitors (ChEIs) and NMDA-Antagonist., Antipsychotics, Antidepressants, and Benzodiazepines may be used at times.

From the standpoint of pharmacological management, it is foreseeable that the primary care physician would be involved in one of two ways: initiation of treatment in a newly diagnosed dementia patient, or more commonly, continuation of treatment in dementia individuals whose treatment regimes have been initiated and stabilized by the hospital-based dementia specialist.

All dementia patients should be evaluated for suitability of pharmacological strategies to address the underlying disease,

enhance cognitive symptomatology, and treat attendant behavioural complications. Once a definitive diagnosis of dementia has been made, the choice of symptomatic treatment hinges mainly on dementia etiology and stage of severity. While skilful use of symptomatic treatment can offer tangible but modest benefits in many cases, the decision to initiate such costly treatment should be individualized and always made in conjunction with the patient and caregiver. In future, disease-modifying treatment which goes beyond a primary symptomatic effect to target the underlying disease process may be available.

Behavioural and psychological symptoms of dementia (BPSD)

BPSD are common in dementia. They cause significant distress to people with dementia and their carers. In managing BPSD, medical causes such as delirium must be excluded. Non pharmacological management, such as environmental and behavioural interventions are effective first line strategies. Medication may be useful in moderate to severe BPSD but must be used carefully in view of the risk of side-effects.

Family caregivers and caregiving in dementia

Good care is important in the overall management of a person with dementia. Although good care has not been shown to alter the natural progression of the disease, it can improve well-being in the sufferer and certainly helps avert excess disability. Dementia caregiving is primarily provided by family caregivers who often feel overwhelmed in the task. An overburdened carer is unlikely to provide good care. Thus, assessing for caregiver burden must form an essential part in any dementia assessment. Where appropriate, caregiver intervention should be instituted to help provide well-meaning carers with the necessary skills and support. The ultimate goal in caregiver management is to indirectly help the patient by empowering the caregiver.

ACKNOWLEDGMENTS

Thanks are due to the National Dementia Network and the College of Family Physicians for organising this family practice skills course. Thanks are also due to the various speakers, resource persons, course facilitators, chairpersons, and editorial team who together make this course happen.