Dementia in Hospice Part II: Types of Dementia, Delirium, and Agitation

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Background

Wissahickon Hospice Geriatric Education Program Needs Assessment:

- 88% care for older adults with dementia
- 50% reported that 51-75% of their patients were over 65 years-old
Needs Assessment (cont)

• 30% reported assessing/managing delirium and pain in older adults at least once/week
• 97% reported that being comfortable caring for older adults with cognitive impairment was important to them
• 100% reported that being comfortable with the difference between delirium and dementia was important to them
Needs Assessment (cont)

• 93% of you agree/strongly agree that you would like to learn more and enhance your skills in the treatment of agitation/behavior problems

• 87% of you agree/strongly agree that you would like to learn more and enhance your skills in understanding the difference between delirium and dementia
Objectives

• To recognize different types of dementia encountered in hospice patients
• To assess and manage delirium in the hospice patient, especially terminal delirium
• To teach non-pharmacological management of agitation and delirium to caregivers/family
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Case #1

85y/o gentleman with mild dementia upon admission to a long-term care facility. He was admitted for self-neglect. He was allowing prostitutes and drug dealers to live in his apartment. Upon admission he was independent of all basic activities of daily living.
Case #1 (cont)

He did well for 2 years, but the staff started to notice paranoia (hide money in his socks), as well as hallucinating about people coming into his room. He exhibited some hypersexuality. He was resistant to any personal care.

He exhibited some Parkinsonism signs on physical exam.

He was started on anti-psychotic medication and responded well.
Can you name the different types of dementia?

- Mild Cognitive Impairment
- Alzheimer’s Disease
- Parkinson’s Disease with Dementia
- Lewy Body Dementia
- Vascular Dementia
- Fronto-temporal Dementia
- AIDS Dementia Complex
Mild Cognitive Impairment

- Gradual onset
- Primarily memory
- Rare motor symptoms
- 12% per year proceed to AD
- Possible global atrophy, small hippocampal volumes
- KEY: no overt functional impairment
Alzheimer’s Disease

- Gradual onset
- Memory, language, and visuospatial domains
- Rare early motor symptoms, but later apraxia
- Gradual progression over 8-10 years
- Possible global atrophy, small hippocampal volumes on head imaging
Parkinson’s Disease with Dementia

• Most commonly appears between 50 and 79 y/o
• Movement disorder that is a progressive neurodegenerative disease
• Insidious onset
• Constellation of signs: resting tremor (pill-rolling and asymmetric), bradykinesia, rigidity, and postural instability
• Dementia appears years later in the disease
Lewy Body Dementia

- Gradual onset
- Memory, visuospatial, hallucinations, fluctuating symptoms
- Parkinsonism motor symptoms (develop during onset of dementia)
- Gradual progression, but faster than AD
- Possible global atrophy
Vascular Dementia

• May be sudden or stepwise (related to cerebrovascular events)
• Cognitive domains affected depend on areas of ischemia
• Cortical or subcortical changes on MRI
Fronto-temporal Dementia

- Gradual onset, $\text{age} < 60$ y/o
- Executive, disinhibition, apathy, language, +/- memory
- Gradual progression, but faster than AD
- Head imaging with atrophy in frontal and temporal lobes
AIDS Dementia Complex

- AIDS-defining illness
- Seeing more cases in older adults
- Indicative of poor prognosis
Case #1 (follow-up)

He required hospitalization for falls and syncopal episodes felt to be related to medications and hypoglycemia. Had to stop anti-psychotics.

Continued to be resistant to care and would “swing” at staff. Paranoid felt to be due to hallucinations.

Became wheelchair bound with marked decrease in oral intake. Weight loss despite supplements.

Declined rapidly over next 4 months and died in the nursing home.

Possible Lewy Body Disease.
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Case #2

- 71 y/o veteran with metastatic prostate cancer who is admitted to the VANH from home hospice because his family could not handle his “agitation” and “seeing things that are not there”. He was recently started on morphine for bone pain, otherwise no new medication changes.
Definition of Delirium

• Acute change in the level of arousal
• May have an altered sleep/wake cycle
• Inattention and perceptual disturbances with delusions and hallucinations
• Hypoactive versus hyperactive
Assessment of Delirium

• Types of standardized questions include the following:
  – Vigilance A test (gold standard, most evidence)
  – Perform a simple math calculation
  – Spell a short word backward
  – Repeat a series of four or five numbers, in order and then in reverse order
  – Name the days of the week backward

• More formal and extensive testing may be able to better identify and monitor key symptoms, such as lack of attention.
What is the difference between delirium and dementia?

<table>
<thead>
<tr>
<th>Dementia</th>
<th>Delirium</th>
</tr>
</thead>
<tbody>
<tr>
<td>Slow onset</td>
<td>Sudden (hours to days)</td>
</tr>
<tr>
<td>Normal speech</td>
<td>Slurred speech</td>
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<tr>
<td>Conscious/attentive</td>
<td>Inattentive, easily distracted</td>
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<tr>
<td>Memory loss</td>
<td>Memory loss</td>
</tr>
<tr>
<td>Language difficulties</td>
<td>Language difficulties</td>
</tr>
<tr>
<td>Possible hallucinations</td>
<td>Common hallucinations</td>
</tr>
<tr>
<td>Possible agitation, mood changes</td>
<td>Agitated, anxious, fearful, suspicious, react less</td>
</tr>
<tr>
<td>Often no signs of illness</td>
<td>Often have signs of illness (i.e. fever, chills, pain, change in medication)</td>
</tr>
</tbody>
</table>
2 Roads to Death

THE DIFFICULT ROAD

Confused → Tremulous
Restless → Hallucinations
Sleepy → Mumbling Delirium
Lethargic → Myoclonic Jerks
Obtunded → Seizures
Semicomatose → Comatose
Dead

THE USUAL ROAD

Normal → Confused → Restless
Sleepy → Lethargic
Obtunded → Semicomatose
Comatose

Penn University of Pennsylvania
Treatable/Reversible Causes

- THINK MEDICATIONS!
- Anti-cholinergics (anti-secretion drugs, anti-emetics, anti-histamines, tricyclic anti-depressants, etc.)
- Sedative-hypnotics (e.g. benzodiazepines) and opioids
- Untreated or undertreated PAIN
Pharmacological Management

• Haloperidol is administered in a dose escalation process similar to treating pain. Start haloperidol 0.5-2 mg po or IV q1 prn
• Benzodiazepines can be used, but may cause paradoxical worsening of symptoms, especially in older adults
• Phenobarbital can be used when all else fails
Other Common Causes

- Metabolic derangements (elevated sodium or calcium, low glucose or oxygen, etc.)
- Infections
- CNS pathology
- Drug/alcohol withdrawal
Common in Older Adults

- Fecal impaction
- Urinary incontinence/retention
- Restaints (including foley catheter)
Case #2 (follow-up)

- Started on risperdol qhs
- Changed to dilaudid from morphine
- Private room
- Re-orientation frequently
- Moved to window bed
- Better BM regimen
- No longer delirious!
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Non-pharmacological

- Re-orientation techniques—tell me your experiences and ways that worked?
- Calendar in view of the patient
- Frequent reminders of time/place
- Have family stay in the room overnight
Non-pharm (cont)

• Environmental modifications—give me your ideas?
• Move to window bed to help with sleep/wake cycle
• Reduce or increase the sensory stimulation as needed (i.e. remove restraints, play music)

- Interventions reviewed:
  - Hearing aids
  - Functional analysis (PT/OT)
  - Redirection (individualized)
  - Reinforcement (individualized)
  - Behavior training
  - Exercise programming
EBM Findings

- Several hundred studies, but only a few met all American Psychological Association criteria for methodological quality
- Many non-pharm approaches considered gold standard did not have the evidence to back them up
- Behavior itself did not always improve, however impression/perception did reduced caregiver distress, disability and staff turnover
Recommendation

• Individualized and tailored behavior plan/approach:
  – Treat symptoms of pain, fatigue, and other physical symptoms
  – Address stimulation issues (under or over)
  – Environmental changes
Families/Caregivers

- Coping strategies
- Respite
- Monitor closely for caregiver distress
- NORMALIZE
Summary…hopefully you are now comfortable with:

• Recognizing different types of dementia encountered in hospice patients

• Assessing and managing delirium in the hospice patient, especially terminal delirium

• Teaching non-pharmacological management of agitation and delirium to caregivers/family
Acknowledgements

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References

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