SHARED CARE OF MCI/EARLY DEMENTIA

BY

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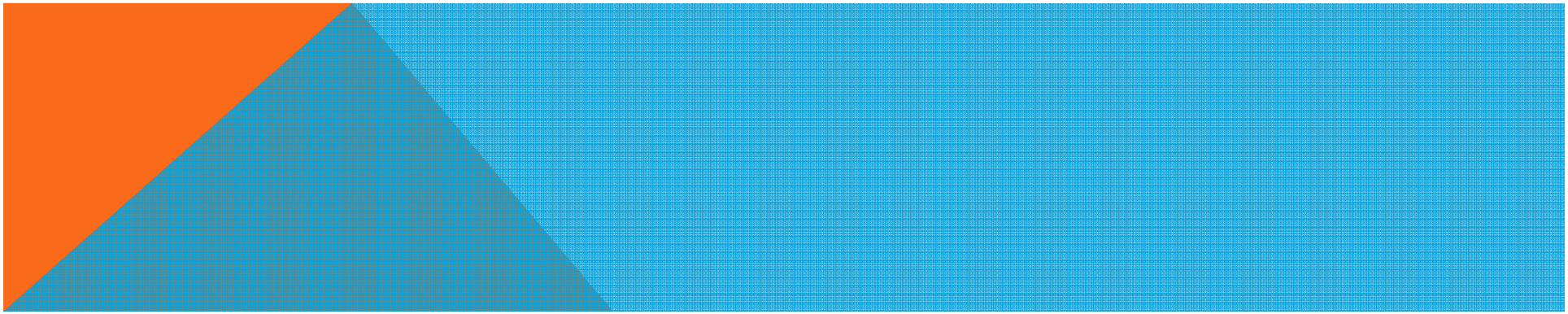
DECLARATION OF CONFLICT OF INTEREST

I DO NOT have any affiliation with any pharmaceutical and medical organization.

I DO NOT INTEND to make therapeutic recommendations for medications that have not received regulatory approval (e.g. ‘’off-label’’ use)



This Day in Psychiatry educational event has received unrestricted educational grants from the following organizations :

Lundbeck

Otsuka

Pfizer

Janssen

Purdue

Shire

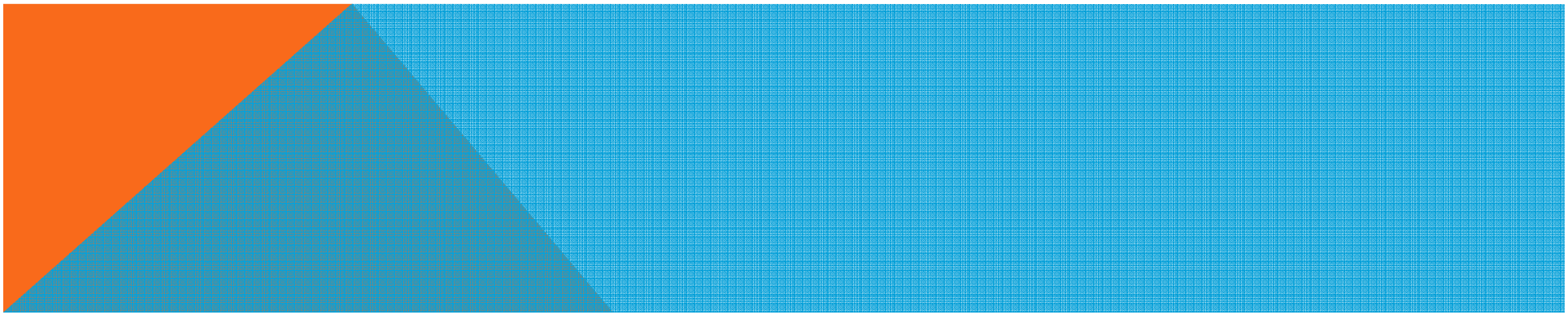
Sunovion

HLS therapeutics

KW Guardian Pharmacy

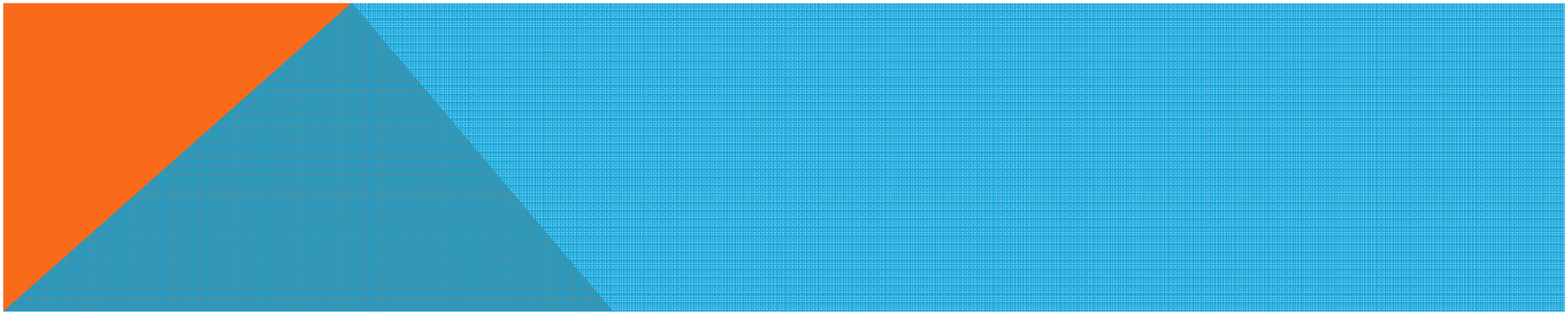
Mitigating Potential Conflicts of Interest-

Not applicable as this panel will not be dealing with specific pharmaceutical during this presentation.



Overview of Discussion:

- Review diagnostic criteria for MCI/ Early Dementia
- Incidence and prevalence on MCI/ Early Dementia
- Discuss differential diagnosis
- Treatment options for MCI/ Early Dementia.



Changes to classification in DSM- 5

- DSM-IV-TR (delirium, dementia, and amnestic disorders)

  Replaced by Neurocognitive Disorders in DSM-5

- Adding a category called '' minor neurocognitive disorder''

  Reason : Minor NCD can benefit from diagnosis and treatment,

  Similar concept to MCI due to Alz''s dx as outlined NIA/AA

  diagnostic guidelines.

- Use of the term Major Neurocognitive disorder rather than dementia

- Emphasis on etiological subtypes (Frontotemporal dementia, dementia with levy Bodies etc.)

  10 etiologies were developed based on clinical need and to reflect

  the best practices.

MCI

MCI is a syndrome that is defined by clinical, cognitive and functional criteria

Petersen et al. (1999)

- Memory complaint
- Normal general cognitive function
- No impairment in activities of daily living

Drawback of the criteria

- Focused on MCI as a prodromal condition for AD, laying importance on memory impairment in the criteria
- But, not all forms of MCI progress to AD

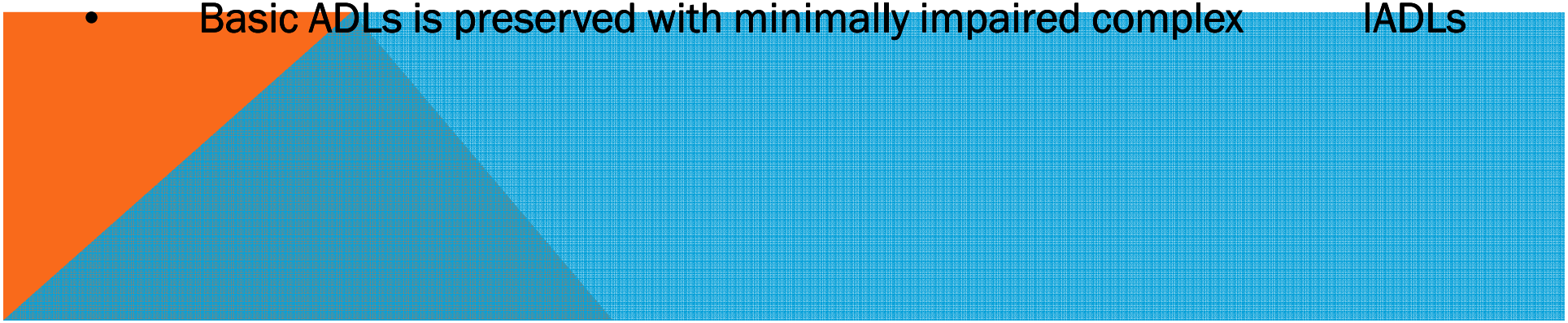
MCI- Revised criteria

At a 2004 international conference on MCI, the criteria was expanded to include other forms of cognitive impairment

International Working Group on MCI in 2004 defined MCI as :

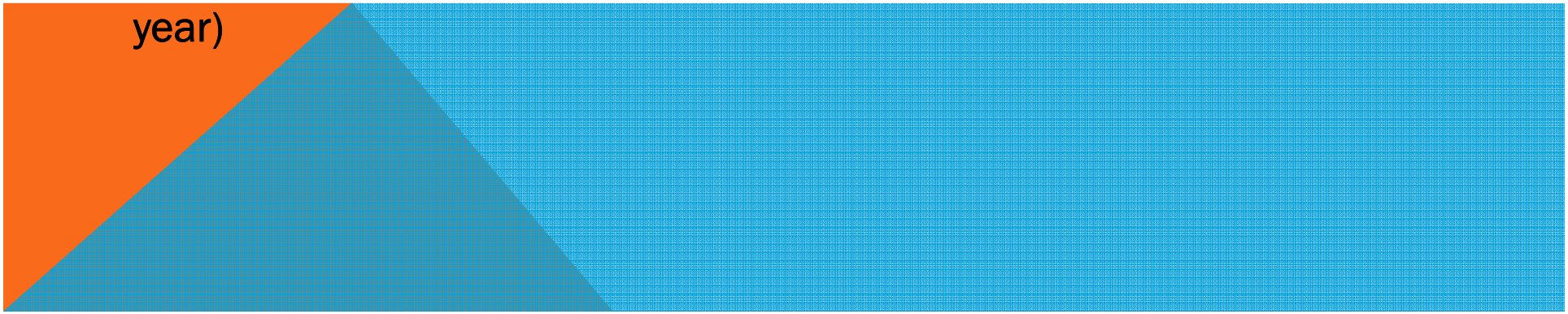
- Not normal, not demented
- Cognitive deterioration, shown by either of the follow

  self or informant report of cognitive decline
- Deficits on objective cognitive tests and decline over time.
- Basic ADLs is preserved with minimally impaired complex IADLs



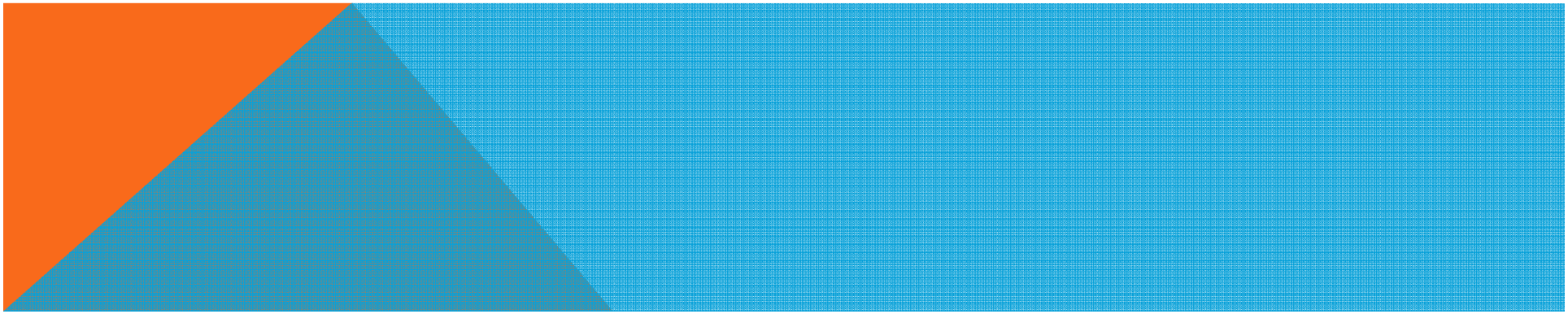
Prevalence of MCI

- Prevalence is approximately 15% in the Mayo Clinic Study of Aging (Peterson et al., 2009)
- This is a population study involving a random sample of nearly 3000 participants, ages 70-89 years, who were cognitively normal or had MCI at entry .
- 6-10% annual conversation rate
- 20-40% reversion rate to normal
- This exceed those that have been estimated for healthy elderly(1-2% per year)



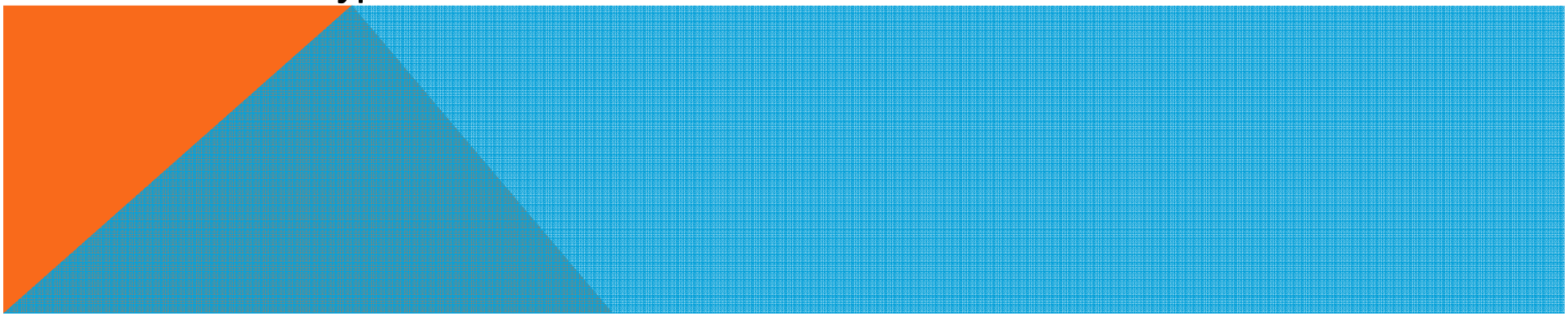
Predictors of Conversion

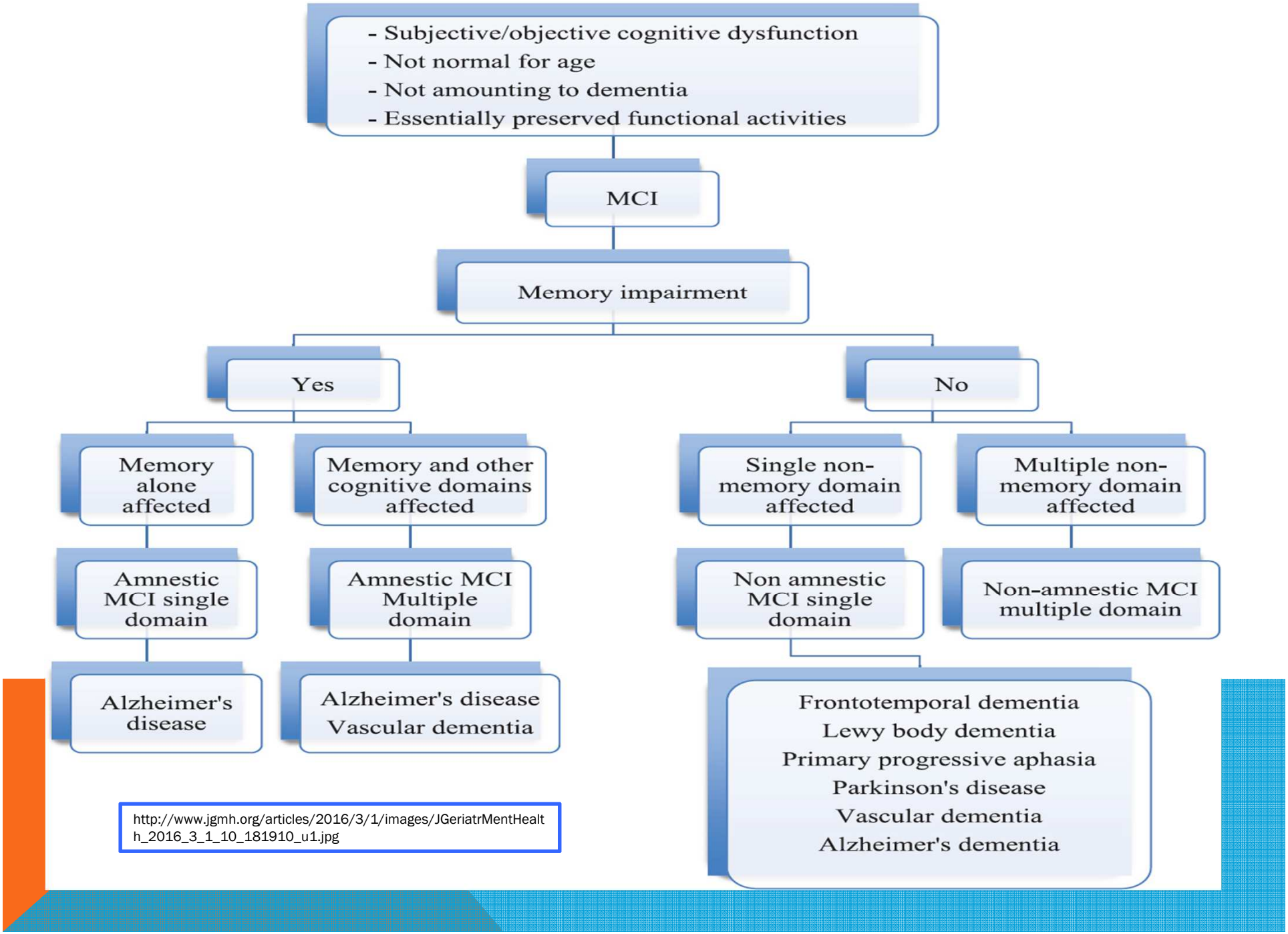
- Severity of Cognitive impairment
- Positive amyloid imaging scan
- CSF markers compatible with AD
- Atrophy on MRI
- ApoE e4 carrier status



MCI Subtypes :

- Once it has been determined that a person meets the criteria for MCI, it will be classified to one of the subtypes.
- These subtypes are intended to recognize that not all forms of MCI necessarily go on to AD, but rather may be a prodrome to other types of dementia.
- Most of what we know pertains to amnestic MCI
- Peterson & O'Brien (2006) suggest that non-amnestic MCI should remain a research entity until we learn about the criteria and outcomes associated to this subtype.





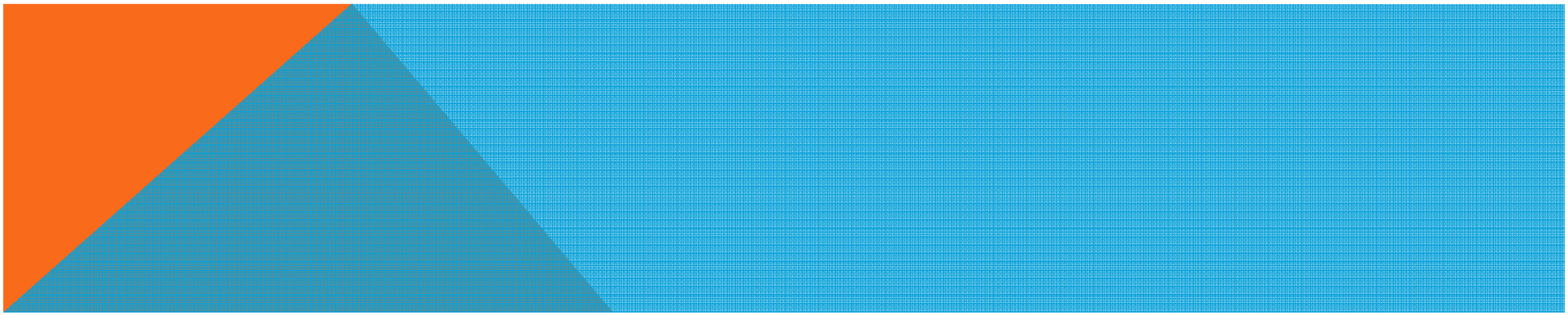
http://www.jgmh.org/articles/2016/3/1/images/JGeriatrMentHealth_2016_3_1_10_181910_u1.jpg

Dementia affects :

- 1 in 11 Canadians > 65
- 1 in 3 Canadians > age 85

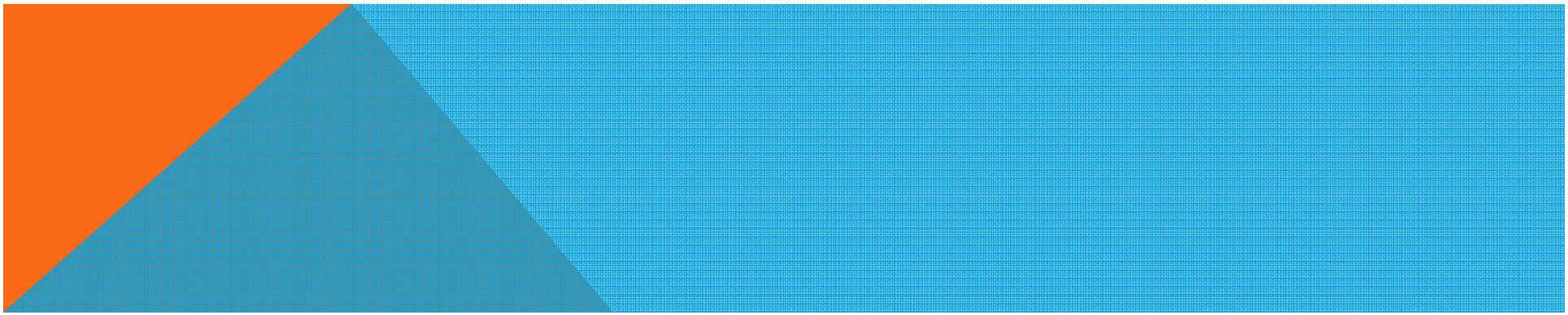
- An estimated 500,000 Canadians are currently living with AD or a related dementia. This number is expected to more than double over the next generation

(Alzheimer Society of Canada, 2010)



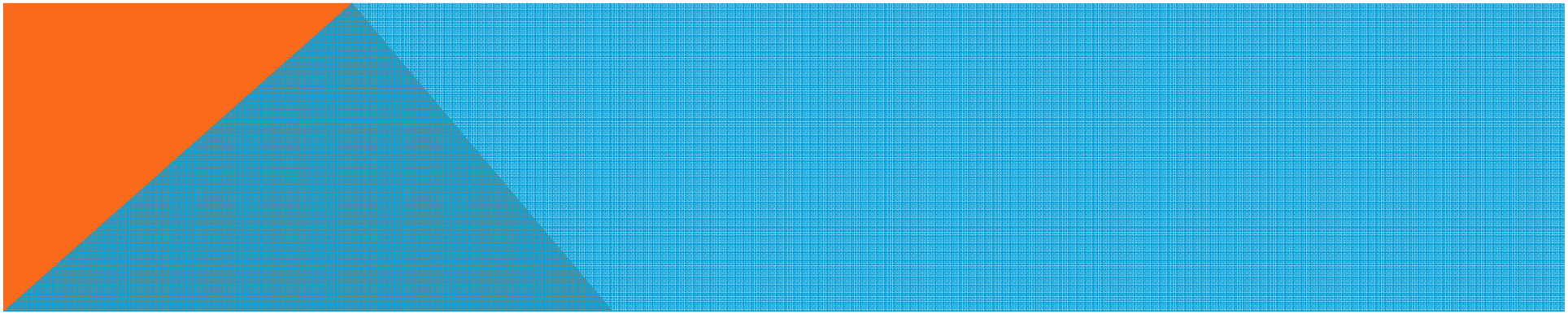
DIFFERENTIAL DIAGNOSIS :

- Depressive Disorder, Schizophrenia
- Delirium



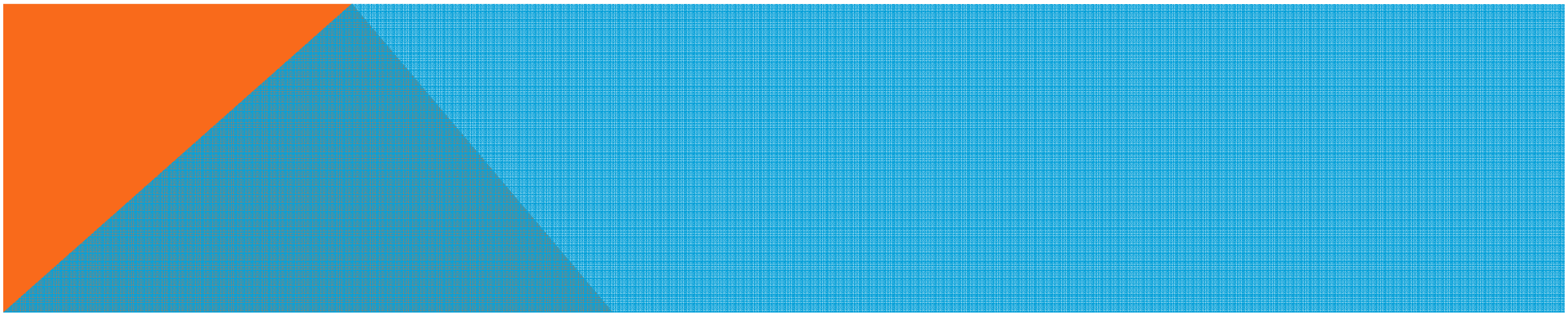
Evaluation :

- Assessment of type, frequency, severity, pattern and timing of symptoms- this may influence the choice of treatment.
- Level of Impairment and progression of illness.
- Laboratory testing to include CBC, Lytes, Cr, Vitamin B12, thyroid function tests and neuroimaging as indicated.



MANAGEMENT :

- Onset and progression of symptoms .
- Baseline level of functioning
- Assessment of Capacity
- Assessment of risk of abuse and neglect
- Driving issue.
- Legal will and Power of Attorney



MANAGEMENT :

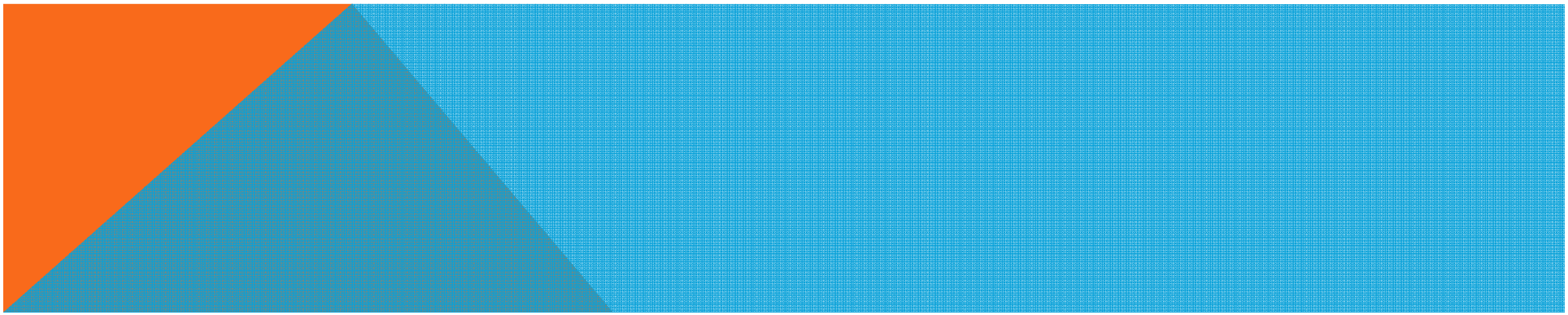
- Non-pharmacological :

  - Exercise

  - Environmental Manipulation

  - CBT

  - Other non- behavioral interventions.



MANAGEMENT :

- Pharmacological for Cognitive Symptoms :

  - Treat risk factors

  - Cholinesterase inhibitors i.e. Donepezil, Rivastigmine and Galantamine

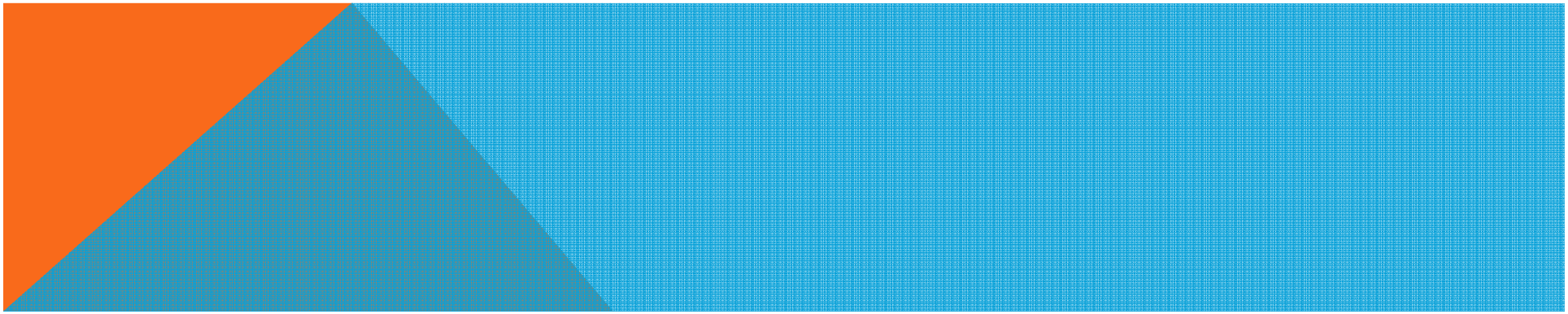
- Pharmacological for Behavioral Symptoms :

  -SSRI

  -Antipsychotics

  - BZP

THANK YOU FOR LISTENING



QUESTIONS WILL BE TAKEN AFTER THE

WHOLE PRESENTATION