

## Diagnosing Dementia

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## Alois Alzheimer 1864 - 1915



## Emil Kraepelin 1856 - 1926



## Keeping dementia front of mind:

*Incidence and Prevalence  
2009 to 2050*

*Released September 1, 2009*

## Prevalence of dementia in Australia

Four-fold rise from: 245,000 (2009)  
to: 1,113,000 (2050)

2010: 257,275

2030: 591,531

2050: 1,130,691

## Incidence of Dementia in Australia

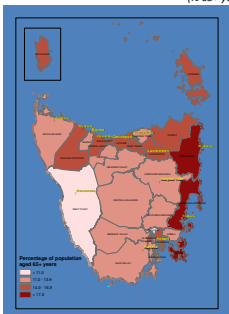
- 2010 75,336
- 2030 187,443
- 2050 385,176

1.1% of population in capital cities in 2009  
*(1.2% in the balance)*

2.9% of population in capital cities in 2050  
*(3.8% of balance of the population)*

## Coastal and contiguous but..

(% 65+ years by LGA, 2004)



Source: ABS

- One-third of Tasmanians aged 65+ do not reside in a major urban centre
- More than half live outside Greater Hobart-Southern

- **Half** of those with moderate to severe dementia **live in their own home** or in the home of their carer
- The other half live in residential facilities

## Diagnosis

**Autopsy findings show diagnosis of dementia made before death in:**

- 3% mild dementia
- 24% moderate dementia

## Diagnosis

- In general practice, nearly **75%** of patients with moderate to severe dementia are **unrecognised** by primary care **physicians** as having cognitive impairment

*(Gifford, Neurology, 1999)*

- **20%** of **family** informants failed to recognise memory problems in those fulfilling the criteria for dementia

## Who diagnoses dementia?

- Specialists do it: neurologists, psychiatrists, geriatricians, general physicians, neuropsychologists
- General practitioners do it sometimes

## Diagnosing Dementia in General Practice

Emily Hansen  
Andrew Robinson  
Georgina Routley  
Clarissa Cook  
University of Tasmania

## Tasmanian and Australian Research

- In a small qualitative study in 2002 it was found that **relatives felt that they had to wait a long time** before they had a formal diagnosis of dementia for their loved one.
- They felt that **GPs were reluctant to pursue a diagnosis** of dementia in some cases

*(Hansen et al 2003)*

## Holistic Viewpoint

- GPs take a holistic view of elderly patients; **dementia is rarely seen as a discrete disease** entity. Instead it is seen as part of an elderly patient's overall state of health/illness
- **Accessing services and shortages of services, arthritis, diabetes, depression, loneliness and heart failure** were described as bigger problems than dementia
- Dementia is viewed by GPs as being **part of the aging process**

## Diagnosis unnecessary

- It is apparent throughout these findings that **GPs feel there is nothing or very little they can do about dementia**
- This leads to a **reluctance to diagnose** dementia unless they feel there is a good reason to do so
- The main reasons described for this were **helping families to access services or providing information** about dementia.
- **GPs were doubtful that a diagnosis held many benefits for the actual patient**

## Why GPs do not diagnose dementia

- Not sure how to
- Not sure why it should be done
- Lack the time required

## Diagnosing dementia

- History
- Examination *(for exclusions)*
- Investigations *(for exclusions)*

## How do we diagnose dementia?

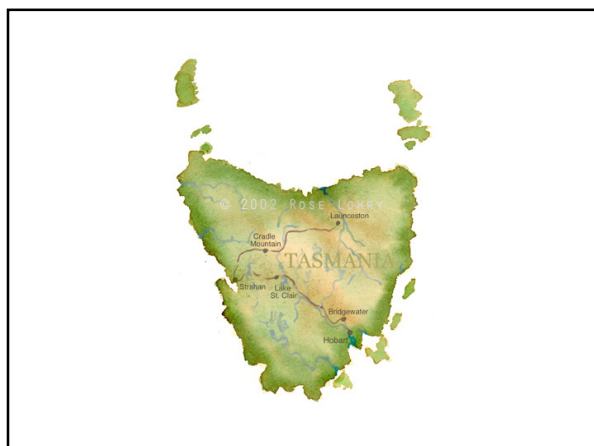
- Tests: MMSE, MOCA, Addenbrooke's...
- Structural MRI
- Molecular neuroimaging with PET
- CSF analysis
- Neuropsychology review

## DSM-4 Criteria for Alzheimer's Disease

- A. **Multiple cognitive deficits** with both
1. *Memory* impairment
  2. At least one of:
    - *aphasia* (language)
    - *apraxia* (motor activities)
    - *agnosia* (recognition)
    - disturbance in *executive function* (planning, organising, sequencing, abstracting)
- B. *Gradual onset & continuing* cognitive decline
- C. Significant impairment of *social or occupational* functioning
- D. Exclusion of other causes of the cognitive decline:
- CNS: P.D., Huntington's, NPH, SDH, CVD
  - Systemic illness: hypothyroid, Vit B<sub>12</sub> or folate deficiency, HIV, hypercalcaemia
  - Substance induced conditions
- E. Not exclusively due to delirium
- F. Not due to other psychiatric diagnoses

## DSM-5 (due for release in May 2013)

- Drops the term *Dementia*
- Uses terms *Minor* and *Major Neurocognitive Disorders*
- Categorises **behavioural disorders**
- Selects specific **cognitive domains** and **measures of severity**



## Aims

- To make dementia simpler for the community
- Have easy to understand criteria which are accepted by all the specialists
- Spread the word about the **five domains of dementia**: , cognitive, functional, behavioural, psychiatric, physical (with acknowledgement to Professor Henry Brodaty)
- Simple schema about the stages of dementia: **Independence, Safety and Palliation**

## Diagnostic criteria for Alzheimer's disease

### **Inclusion Factors:**

- Gradual onset of poor memory
- Worsening of memory problem
- Failure of function
- Cortical or executive dysfunction:
  - dysphasia
  - agnosia
  - dyspraxia
  - planning, organisational problems

### **Exclusion Factors:**

- Delirium
- Other organic causes
- Psychiatric illness

## Dementia Assessors' Programme

- Health professionals around the state
- Day of education about dementia
- Internship in diagnosing dementia: watch a few diagnoses, then be supervised for a few
- Use of structured tool
- Report back to the general practitioner who may elect to undertake investigations
- Diagnosis is made in collaborative process

## General Practitioner Dementia Programme

- In conjunction with *GP Tas*, the *Alzheimer's Association* and *Aged Care Assessment Teams*
- Target their practices
- Provide food
- Teach a **simplified version of the DSM IV** diagnostic criteria for Alzheimer's Disease
- Emphasise the importance for families of making a diagnosis

## Future

- In conjunction with the *Wicking Dementia Research and Education Centre* provide on going support to GPs and dementia assessors
- Assessment of the programme
- Maintenance of enthusiasm

