Young Onset Dementia

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Quod multum require ex nobis gentem

They ask much of us, these people

(Barnes, early 21st C)

A THOUGHT

We educate our patients and their friends to believe that every or almost every symptom and disease can be benefited by a drug

Some ignorant practitioners believe this

Outline

- Overview of YOD
- YOD service
- Patterns of referrals
- Diagnoses
- Cognitive impairment in certain areas
- Stable cognitive impairment

Causes of Dementia

- Alzheimer's disease
- Vascular dementia
- Lewy body disease
- Pick's disease
- Frontal lobe dementia
- Huntington's disease
- Creutzfeldt-Jacob disease
- Alcohol-related dementia
- Aids dementia complex
- Dementia pugilistica
- Binswanger's disease
- Gerstmann-Strausser
- Steele-Richardson-Olszewski syndrome

etc, etc, etc

Younger Onset Dementia

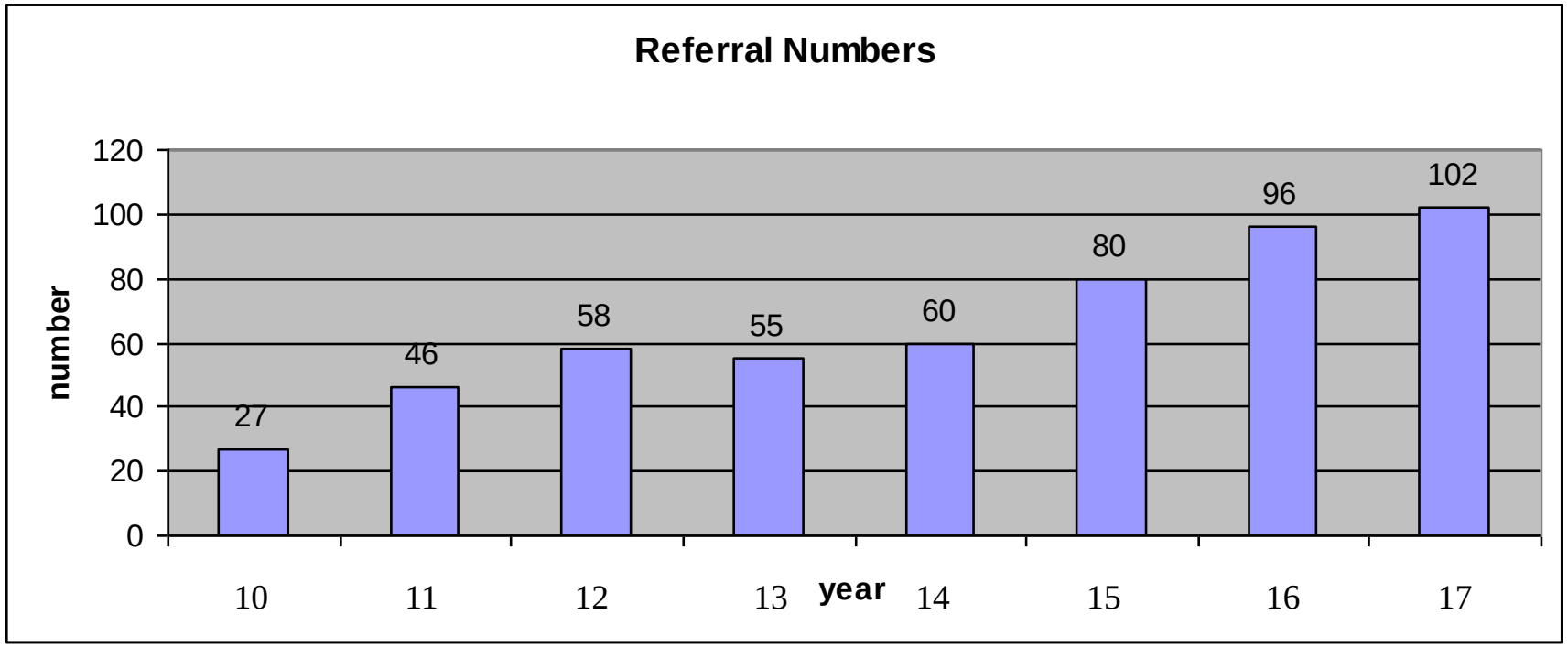
- Perhaps around 45,000 people in UK
- Perhaps 5% of dementia population
    - But figures are inaccurate
- Conditions broadly the same
- More likely to have “rare” conditions
- Impact very different
- Certain areas of higher risk

YOD Impact

- Younger and fitter
- May still be working
- ?More likely to be familial
- ?More aggressive progression
- Dependants
- Family impact
- Lost hopes and dreams

Patterns of Referral

- Going up
- Getting younger
- ? Related to higher profile of dementia
- ? More positive family history
- “Memory Assessment”
- Expectations from service
- Gatekeeping/Access


Referral Numbers
number
120
100
80
60
40
20
0
27
46
58
55
60
80
96
102
10
11
12
13
year
14
15
16
17

Local Services

- Specialist Consultant
- CMHT
- Specialist support
- Day hospital
- Day care
- Specialist SW
- Carer support
- Others

- 2/week sessions
- 1 CPN (part time)
- Neurologist with SI
- Gone
- Gone
- Gone
- Gone
- ?

National Issues

- Importance of early diagnosis for dementia
- Low rate of dementia in referrals to YOD
  - Cornwall 19%
  - North Wales 28%
  - West London 12%
- ? Role in excluding dementia
- ? Sensible use of scarce resources
- Pathways and screening

Diagnoses

- Functional Memory Disorder (FMD)
- Subjective Cognitive Impairment (SCI)
- Minimal Cognitive Impairment
- Age Acquired Memory Impairment
- Stable Cognitive Impairment
- Dementia

Memory Clinics

- Euphemism
  - Though for what?
- Memory clinic vs…
- Dementia drug prescribing clinic vs…
- Dementia exclusion service
- What would you imagine you'd get?
  - cf Sleep Clinic

Cognitive Problems in Certain Areas

- Learning Disability
- Depression
- Schizophrenia
- Alcohol

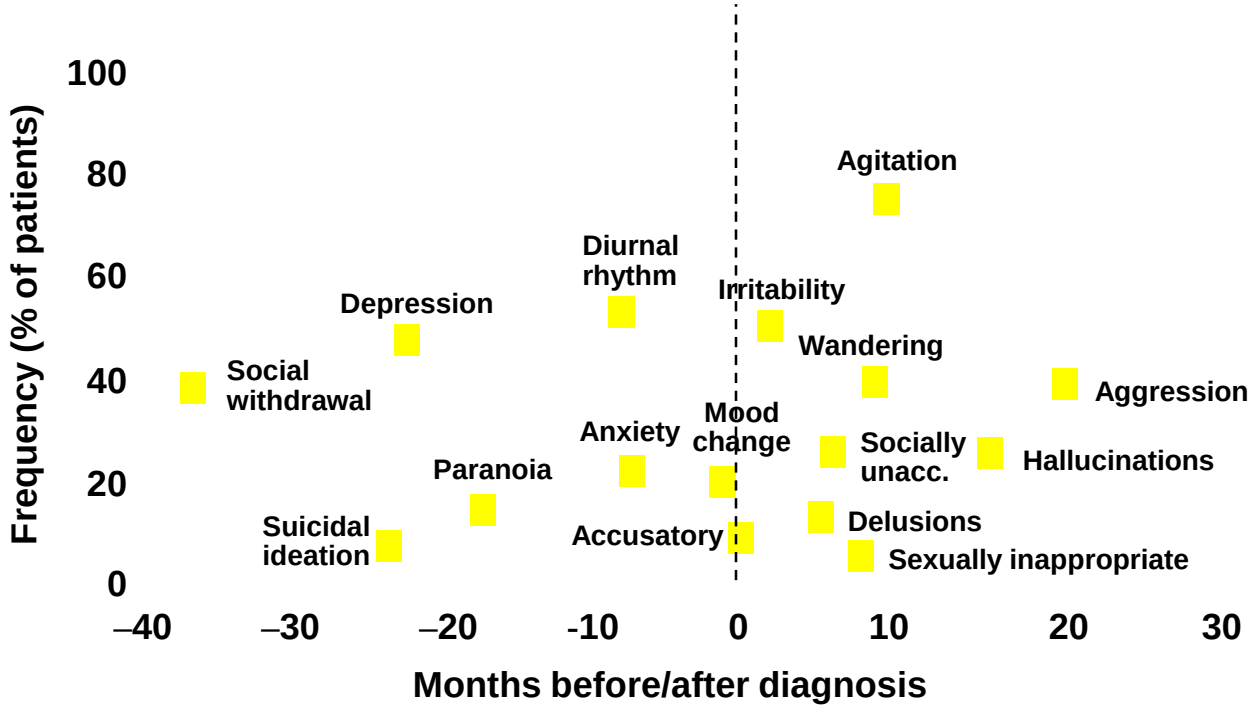
Learning Disability

- Main issue is Down's Syndrome
- Patients living longer
- Chromosome 21
- ? Inevitability of progression
- ? Different needs
- ? Specialist services

Depression

- Typically problems regarding memory
- Subjective vs objective
- Subjective common
- Registration, retention and recall
- Older/psychosis/melancholia/?anxiety
- YOD 1 in 20,000; depression 1 in 50

Peak frequency of behavioural symptoms as AD progresses



Depression Management

- Treat depression in first instance
- ? More likely to be severe
- ? More likely to need aggressive treatment
    - Higher doses
    - Combination therapies
    - ECT/light therapy/rTMS
- Review cognitive status
- Look for patterns in impairment

Castaneda AE: Journal of Affective Disorders [2008, 106(1-2):1-27]

Cognitive Impairment in Schizophrenia

- Dementia praecox
- Cognitive impairment common
    - Verbal memory and vigilance
- May be relatively stable
    - “static encephalopathy”
    - Only picked up with testing
- ? Epiphenomenon
    - Lack of motivation
    - Distracting hallucinations
    - Medication

Management of Cognitive Impairment in Schizophrenia

- Essentially the management of chronic syndrome
- Cognitive problems tend to be stable
- ? Aim for education in medications
  - Especially anticholinergics
- Little research on use of AChIs

www.apt.rcpsych.org/content/6/3/161.full

Alcohol-Related Cognitive Impairment

- Korsa-bloody-koff's
- Cognitive impairment in alcoholics common
  - Published statistics
  - Inferences from hospital admissions
  - Real life observations
- Course of A-RCI
  - Rule of fours
- Management

Whither A-RCI

- YOD services
- Alcohol services
- General adult services
- Specialist services

Alcohol and brain damage in adults with reference to high-risk groups: Royal College of Psychiatrists Report CR185 (2014)

Stable Cognitive Impairment

- Aetiology
  - "Brain injury"
- Diagnosis
- Prognosis
- Management
- Treatment goals

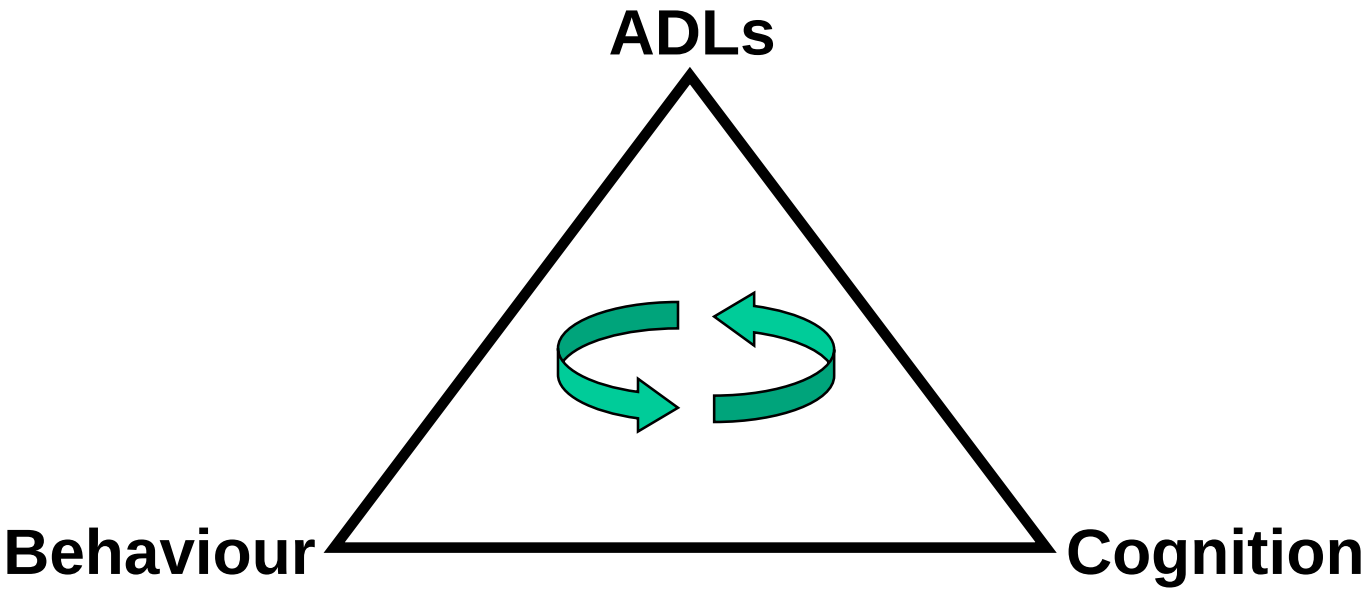
Management of Dementia

- Diagnosis
- Assessment
- “Treatment”
- Ongoing Care
- Carers

Organisation of Dementia Services

- Diagnosis
- Assessment
- Multidisciplinary team
  - medical
  - nursing (ward and community)
  - occupational therapy
  - social services
  - psychology
  - carers (voluntary and paid)

Key Symptom Domains



Activities of Daily Living

- The stuff we take for granted
- Cooking, cleaning, washing, shopping etc
- Vitally important to assess
- Significant impact on independent function
- May have big impact on all sorts of things
    - Inc medication compliance

Behavioural Problems

- BPSD
  - Agitation
  - Aggression (verbal and physical)
  - Depression
  - Insomnia
  - Wandering
  - Shouting
  - Resistance to interventions
  - Inappropriate sexuality/disinhibition
  - Interfering
  - Apathy and inactivity

Behavioural Problems We're Not Very Good With

- Wandering
- Insomnia
- Sexual Inappropriateness
- Apathy
- Social Withdrawal

Cognition

- Thinking, knowing, understanding
- “Higher functions”
- Easily assessed
    - Rating scales
- Not as important as you might think

Staging of Dementia

- Mild
- Moderate
- Severe

Mild Dementia

- Principally problems with cognition
  - Mood problems common however
- Memory, understanding
- Impaired social/work function
- Still managing self care
- Relatively intact judgement
- Independent functioning

Moderate Dementia

- Greater problems with cognition
  - Lack of understanding
  - Poor functional memory
  - Calculation etc
- Problems with self care
  - Personal hygiene
  - Self care
  - Nutrition
- May be behavioural problems
- Independent living increasingly risky

Severe Dementia

- Need constant care
- Very poor intellectual function
- May be significant BPSD
- Approaching ‘full nursing needs’
- Residential care very likely
- Increasing physical health needs