

New Feature: Clinical Practice Corner

A new periodic feature for the AGS Newsletter, the AGS Clinical Corner highlights AGS Clinical tools that are available to our members for free. AGS members can download a pdf of these tools at www.americangeriatrics.org/myags.

DEMENTIA

A POCKET GUIDE to DEMENTIA DIAGNOSIS

From THE AMERICAN GERIATRICS SOCIETY

An estimated 5.2 million Americans have Alzheimer's Disease in 2008. The prevalence of Alzheimer's Disease and other dementias will continue to increase with the rapid growth of our older population. Managing these complex conditions can be a challenge for busy healthcare professionals. The American Geriatrics Society (AGS) is pleased to make this convenient pocket card on the Diagnosis and Treatment of Dementia available to healthcare providers and trainees who care for older adults.

The information in this card is based on two acclaimed AGS publications. *Geriatrics At Your Fingertips®* is a convenient, pocket-sized guide to the evaluation and management of diseases and disorders that most commonly affect older people. *The Geriatrics Review Syllabus: A Core Curriculum in Geriatric Medicine* is a comprehensive text for those who wish to expand and update their knowledge in the field.

The AGS is a nationwide, non-profit association of healthcare professionals dedicated to improving the health, independence and quality of life for all older people. The AGS has a diverse, multidisciplinary membership of healthcare professionals, researchers, educators, administrators and students. For more information on the AGS, its publications and membership benefits, please go to www.americangeriatrics.org or call 800-247-4779.

This pocket card is made available by an unrestricted education grant from Forest Laboratories.

Mini-Cog™ Screen for Dementia

The Mini-Cog™ screen combines an uncued 3-item recall test with a clock-drawing test (CDT) that serves as a recall distractor. The Mini-Cog™ can be administered in about 3 min, requires no special equipment, and is less influenced by level of education or language differences.

Administration

The test is administered as follows:

1. Make sure you have the patient's attention. Instruct the patient to listen carefully to and remember 3 unrelated words and then to repeat the words back to you (to be sure the patient heard them).
2. Instruct the patient to draw the face of a clock, either on a blank sheet of paper, or on a sheet with the clock circle already drawn on the page. After the patient puts the numbers on the clock face, ask him or her to draw the hands of the clock to read a specific time (11:10 or 8:20 are most commonly used and more sensitive than some others). These instructions can be repeated, but no additional instructions should be given. If the patient cannot complete the CDT in ~3 min, move on to the next step.
3. Ask the patient to repeat the 3 previously presented words.

Scoring

Give 1 point for each recalled word after the CDT distractor. Score 0–3 for recall.

Give 2 points for a normal CDT, and 0 points for an abnormal CDT. The CDT is considered normal if all numbers are depicted, once each, in the correct sequence and position, and the hands readably display the requested time.

Add the recall and CDT scores together to get the Mini-Cog score.

- 0–2 positive screen for dementia
- 3–5 negative screen for dementia

Source: Adapted from Borson S, Scanlan J, Brush M, Vitaliano P, Dokmak A. The Mini-Cog: a cognitive "vital signs" measure for dementia screening in multi-lingual elderly. *Int J Geriatr Psychiatry* 2000; 15(11):1021–1027, and Borson S, Scanlan JM, Watanabe J, Tu SP, Lessig M. Improving identification of cognitive impairment in primary care. *Int J Geriatr Psychiatry* 2006; 21(4):349–355.

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- Lantz MS, Lyketsos CG. Behavioral problems in dementia. In: Pompei P, Murphy JB, eds. *Geriatrics Review Syllabus: A Core Curriculum in Geriatric Medicine*. 6th ed. New York: American Geriatrics Society; 2006:231–238.
- For more information on the American Geriatrics Society publications *Geriatrics: At Your Fingertips* and the *Geriatrics Review Syllabus*, please visit www.geriatricsyourfingertips.org



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DEMENTIA SYNDROME

Chronic acquired decline in memory and in at least one other cognitive function (eg, language, visual-spatial, executive) sufficient to affect daily life.

PROGRESSION OF ALZHEIMER'S DISEASE (AD)

Under each stage, the left column lists examples of cognitive impairment; the right column, examples of behavioral and functional impairment. Examples are not meant to be exclusive. Impairments in the right column are influenced by type of dementia and personality, so they may be seen in different stages of cognitive loss. (MMSE = Mini-Mental State Examination)

Mild Impairment (MMSE 21–28)

- Recent recall problems
- Mild language dysfunction (eg, word-finding problems)
- Problems with executive function (eg, initiating, planning, sequencing daily tasks)
- Problems managing finances

Moderate Impairment (MMSE 11–20)

- Disordered to date
- Naming, other language difficulties
- Impaired learning
- Social withdrawal
- Mild construction, language dysfunction
- Getting lost in familiar places
- Problems with dressing, grooming
- Wandering
- Resistance

Severe Impairment (MMSE 0–10)

- Nearly unintelligible verbal output
- Remote memory gone
- Disordered to place
- Almost complete loss of grooming or dressing skills
- Unable to copy or write

NEUROPSYCHIATRIC SYMPTOMS

Consider superimposed delirium or pain as precipitating factor.

Psychotic Symptoms (eg, Delusions, Hallucinations)

- Delusions may be paranoid (eg, people stealing things, spouse unfaithful).
- Hallucinations (~1% of patients) are more commonly visual.

Depressive Symptoms

- Sadness
- Anxiety and irritability
- Loss of interest in usual activities
- Agitation or Aggression

EVALUATION

Although completely reversible dementia (eg, drug toxicity) is rare, identifying and treating general medical conditions may improve function.

History: Always obtain from family or other caregiver; time symptoms first noted; family history of dementia, head injury, falls, alcohol and other substance exposure, history of depression, focal weakness, gait disturbance.

Comprehensive physical and neurologic examination: check esp. for focal weakness, gait impairment, language impairment, extrapyramidal signs (rigidity, tremor, bradykinesia). Assess functional status. Ask about bathing, dressing, toileting, transferring, as well as intermediate activities (eg, managing finances, medications, cooking, shopping).

Evaluate mental status for attention, immediate and delayed recall, remote memory, executive function, depression. Useful screening tests are the Mini-Cog, MMSE, Geriatric Depression Scale.

Clinical Features Distinguishing AD and Other Dementias

AD: Memory, language, visual-spatial disturbances, indifference, delusions, agitation

Frontotemporal dementia: Relative preservation of memory; personality change, executive dysfunction, excessive eating and drinking

Lewy body dementia: visual hallucinations, delusions, extrapyramidal symptoms, fluctuating mental status, sensitivity to antipsychotic medications

Vascular dementia: abrupt onset, stepwise deterioration, executive dysfunction, gait changes

Neuropsychologic Testing

Reference standard for the presence of dementia or mild cognitive impairment:

- Especially helpful in mild, early disease and atypical presentations
- Quantifies and establishes the type of cognitive deficits
- Establishes baseline for comparison

Laboratory Testing

Complete blood cell count, thyroid-stimulating hormone, B_{12} , folate, serum calcium, liver and kidney function tests, electrolytes
Serologic test for syphilis (selectively)
Glucose and HIV for patients at risk

Neuroimaging (MRI or CT of the Brain)

The likelihood of detecting structural lesions is increased with:

- Onset age <60 years
- Focal (unexplained) neurologic signs or symptoms
- Abrupt onset or rapid decline (weeks to months)

Predisposing conditions (eg, metastatic cancer or anticoagulants)

Neuroimaging may detect the 5% of patients with clinically significant structural lesions that would otherwise be missed.