OLD AGE PSYCHIATRY

Psychiatric disorders of the elderly
- Dementia
- Depression
- Delusional disorder/late onset schizophrenia
- Delirium

Dementia – definition
- Impairment of multiple higher cortical functions including memory
- Acquired
- In clear consciousness
- Progressive
- No reversible cause
- For research purposes – present for at least 6 months

LOCALISATION OF CEREBRAL FUNCTION

TYPES OF DEMENTIA
- Alzheimer’s disease [AD]
- Vascular disease [VaD]
- Mixed AD & VaD
- Lewy Body disease [LBD]
- Frontotemporal dementia [FTD]

Other causes
- Infective
- Inflammatory
- Neoplastic
- Metabolic
- Endocrine
- Toxic
- Traumatic
**Alzheimer’s disease**

- Most common form of dementia- 50% of all cases.
- Probably affects 500,000 in the UK.
- Estimated that at least 15 million people are affected worldwide.
- Prevalence rates doubles for every five years of age from age of 65.

**NEUROPATHOLOGY**

- Selective neuronal and synaptic loss – a cholinergic deficit.
- Symmetrical cortical atrophy – temporal and parietal lobes.
- Excess of extracellular senile plaques and intracellular neurofibrillary tangles.
- Related to degree of cognitive impairment

**PET scans in AD**

**AD - DEGENERATION**
Risk Factors for AD

- Age
- Female sex
- Genetic factors – APP, presenilin 1 and 2, Apo E on Ch 19
- Head Injury
- Downs syndrome
- Family history
- Severe depression
- Vascular Risk Factors

CLINICAL FEATURES

- Insidious onset and progression of memory loss and personality changes
- Affects cognition, ADL, and behaviour
- Progressive impairment in sufferer’s ability to function in daily life
- Most frequent kind of disability leading to institutionalisation
- Death occurs in most patients within 5–10 years of diagnosis
- Often progresses more rapidly in younger people

VASCULAR DEMENTIA

- Common in males; 20% of all dementias
- Mixed dementia – evidence of both AD and vascular dementia.

Vascular Dementia

- May be caused by:
  - multiple infarcts
  - white matter low attenuation
  - single strategic infarct, eg thalamus, angular gyrus, hippocampus
- Above 55 years may occur more frequently than AD
- Requires risk factor assessment
  (Amar and Wilcock 1996)

AETIOLOGY

- Older age
- Male sex
- Cardiovascular disease
- Cerebrovascular disease
- Valvular disease
- Coagulation disorders
- Hypertension
- Hypercholesterolemia
- Diabetes
- Smoking
- Alcohol

CLINICAL FEATURES

- Abrupt onset, stepwise progression.
- Mood and behavioural changes common.
- Insight usually retained till late.
- Clinical features depend on size of infarct.
- Shorter life expectancy than AD.

DEMENTIA WITH LEWY BODIES

- May form part of spectrum of Lewy body disorders – Parkinson disease.
- DLB – Lewy bodies more in cortical areas
- Parkinson's disease – more in basal ganglia
- Neuropathology – Cortical and sub cortical structures involved
CLINICAL FEATURES

Diagnosis of Lewy Body Dementia
(Based on McKeith et al 1996)

Supportive features include:
- repeated falls
- syncope
- transient loss of consciousness
- neuroleptic sensitivity
- systematised delusions
- hallucinations in other modalities

FRONTOTEMPORAL DEMENTIAS

- 5% of all dementias.
- More common in females.
- Peak age of onset 45-60 years
- Aetiology –unclear , familial forms exist
- Neuropathology – Pick cells, Pick bodies, Knife blade atrophy – frontal and temporal lobes.
- Early personality changes and behavioural disturbances, mood changes, language abnormalities, cognitive impairment, motor signs

DIFFERENTIAL DIAGNOSIS - DEMENTIAS

- Amnestic syndrome
- Mild cognitive impairment
- Delirium
- Depressive disorders
- Late onset schizophrenia
- Learning difficulties
- Substance misuse
- Iatrogenic causes
- Malingering

Investigations

Physical examination
Laboratory investigations include:
- FBC, B12, Folate
- U&E, LFT's, Ca, Glucose, Cholesterol
- Serology for syphilis, TFT's, CRP

Neurimaging:
- CT scan on all patients,
- MRI, SPECT when appropriate
Other investigations as clinically indicated
Neuropsychological assessment
MMSE

Common Treatable Causes of Dementia

Normal pressure hydrocephalus
Hypothyroidism
Pseudo dementia of depression
Nutritional deficiencies
-B12, folate, thiamine (Wernicke’s encephalopathy)
Chronic alcoholism
Space occupying lesions
-primary and secondary tumours
-cerebral abscess
Chronic disturbance of calcium metabolism
Subdural haematoma
Neurosyphilis
MANAGEMENT
AD and LBD – Cholinesterase inhibitors
Three currently licensed that have been “accepted” by NICE:
- Galantamine (Reminyl)
- Donepezil (Aricept)
- Rivastigmine (Exelon)
All very similar in effect, and help about half the people they are given to.

Memantine - Moderate to severe AD
Non-competitive glutamate NMDA receptor antagonist.
Reduces postsynaptic excitotoxicity
Benefits functional ability, global function, cognition

OTHERS
- Functional problems - environmental modifications, memory aids, daily routine, graded assistance
- Social problems – financial, legal matters, accommodation.
- Carer education and support

DEPRESSION - ELDERLY
- Community studies show prev. rates similar in young and old.
- High rates among physically ill.
- Worsens prognosis
- Slower rehab
- Poor motivation/compliance
- Effects on immune system

OTHERS
- Similar presentation to young but may present atypically-
  - Less psychological symptoms
  - More somatic ones - insomnia, hypochondriacal concerns, fatigue
  - Apparent late onset anxiety state
  - Self medication with alcohol

Depressive pseudodementia

Assessment 2. Mental state exam
depression vs. dementia

DEPRESSION
- Onset acute
- Looks depressed
- Biol. Sx.
- D.V.M.
- PAST/ family Hx.
- Inconsistent,"D.K." - answers
- Distressed by mistakes

DEMENTIA
- Insidious onset
- Affect may be flattened
- A.D.L.s affected
- S.T.M. particularly poor
- Consistently impaired
- Other cog. Disabilities
- Minimises deficits

OTHERS
- Look for other causes - secondary depression
- Consider-
  - Parkinson's disease
  - Early dementia
  - Endocrine disorder
  - Carcinoma
  - "Vascular depression" – sub cortical ischaemia – central executive dysfunction, loss of motivation treatment resistance
Treatment

- Antidepressants
- Delayed or inadequate treatment predicts poor outcome.
- Antidepressants + CBT - more effective
- Avoid TCAs as first line treatment
- E.C.T is highly effective and may be life saving

Late onset schizophrenia like psychosis

- Schizophrenia first presenting over the age of 65 (0.5% of cases)
- Typical patient
  - Female (M:F = 1:7)
  - Alone (spinster, widow)
  - Deaf (+ often visually impaired)
  - Abnormal premorbid personality
  - Subtle cognitive impairment (frontal)

Late onset schizophrenia like psychosis

Symptomatic differences (cf schizophrenia)
- Preservation of personality
- Functioning well
- Less negative symptoms
- Less formal thought disorder

Hard to engage patients
- First step is to develop rapport (with CPN)
- Antipsychotic meds at lower dose.

DELRIUM

Syndrome – fluctuating global cognitive impairment with behavioural abnormalities
- Common in medical and surgical inpatients – 10 to 20%
- Vulnerable groups – elderly, dementia, young, postoperative, burns, drug misuse, physical illness.

DELRIUM - features

Impaired level of consciousness
Global impairment of cognition
Sleep wake cycle disturbances
Perceptual distortions / hallucinations
Psychomotor agitation
Emotional lability
Paranoid delusions
Onset – rapid/fluctuations

Aetiology – Delirium

- Multifactorial
- Drugs
- Metabolic
- Endocrine
- Infective
- Substance misuse
- Hypoxia
- Neurological
- Others
Management

- Identify and treat cause
- Environment and supportive measures
- Avoid sedation unless to minimise risks
- Regular review and follow up.

References

- NICE guidelines – Dementia
- Understanding biology of mental health disorders Timothy G. Dinan
- Key topics in psychiatry ,Sheena Jones and Kate Roberts
- Evidence based dementia practice(2002)
- www.rcpsych.ac.uk