SPECIALTY

Geriatric Medicine

Arista|MD

CHIEF COMPLAINT

Cognitive Impairment with and without behavioral problems

COMMENTS TO SPECIALIST

A 79-year-old female presents to the clinic this morning in follow-up regarding a review of recent head CT and ultrasound results. The patient does have a past medical history, including primary biliary cirrhosis, osteopenia, and Raynaud's disease. The patient was seen, and an assessment was performed, as well as a referral for an eConsult last year related to her ongoing memory loss. At that time, it was recommended the patient have a head CT or head MRI to aid in the underlying structural cause contributing to her symptoms. Her MoCA test revealed a score of 22 out of 30. As the year progressed, her forgetfulness became more prevalent. The family also noted that the patient's forgetfulness is slightly worse and did agree to have a head CT performed. This was suggested approximately 1 year ago, but at that time, the patient and her husband deferred this option.

We reviewed the CT results during this visit, which does indicate cognitive impairment is related to atrophy, mild cerebellar and cerebral atrophy, chronic periventricular and subcortical deep white matter microvascular ischemic disease, which I suspect may indicate some underlying dementia. Regarding this patient's exam findings, as well as head CT results, I did advise both patient and husband that the patient does have underlying dementia, last year around this time, we discussed the use of medications to aid in the treatment of what appeared to be underlying dementia, these were Aricept, Exelon, as well as Donzipil.

MAIN QUESTION

I would like further input regarding a possible diagnosis and treatment options regarding possible dementia. Please review all notes related to the patient's memory loss from last year for a baseline of the patient's status. Please review the head CT results and recent labs performed on 02/02/2022.

Response from eConsult Specialist

DANA RICHARDS, MD, GERIATRIC MEDICINE

NPI: 1000000002

SUMMARY

Treatment options are available at the primary care level.

For reference only. This eConsult is based on an actual request for specialist consultation. The primary care provider, specialist, and patient are de-identified to protect private health information (PHI).

DETAILS

1. Cognitive impairment may be multi-factorial:
   - Most likely etiology is the underlying cerebrovascular disease (Vascular Cognitive Impairment). Age-related cerebral atrophy may be a normal finding. Still, it may also be accelerated by the underlying microvascular disease - in Alzheimer's dementia, temporal lobe atrophy tends to be more prominent, and MRI may better identify the hallmark features, such as mixed cognitive impairment (vascular and AD type) is also a possibility.
   - Consider contributing factors like presumptive underlying depression as the patient is on Sertraline (assess if depression is well controlled as it may easily mimic MCI/dementia).
   - Consider reassessing potential contributing medications such as alprazolam and Ambien. Many elderly patients experience significant neurocognitive symptoms as a result of benzodiazepine use as well as benzodiazepine withdrawal. I suggest careful medication history with the patient and family/caregivers to determine actual benzodiazepine use in recent months. Ambien may also contribute to cognitive dysfunction. Review another potential over-the-counter medication the patient might be taking that can affect cognitive function (especially those with anticholinergic side effects, such as antihistamines, etc.)
   - Consider a vision and hearing assessment if not recently done, as impairment in either one can contribute to decreased cognition, making MCI appear worse than it is.
   - Undiagnosed alcohol consumption is also not uncommon in the elderly, resulting in cognitive dysfunction. Consider verifying through additional history if needed.
   - If the patient has persistent bradycardia, this may also affect the patient's cognition. Consider reassessing the choice of blood pressure medication if that's a concern. Beta-blockers may also contribute to decreased energy and mood).

2. Follow-up/monitoring: Use MMSE for longitudinal follow-up and functional assessment (ADLs and IADLs). The range of MMSE and MoCA scores for MCI vs. dementia vary; I recommend ranges MMSE 19-23, MoCA 11-21, or a Clinical Dementia Rating of 1 for diagnosis of mild dementia. Take the patient's education into account, as the cut of scores differs significantly based on educational levels. A mild dementia diagnosis may warrant additional pharmacotherapy.

3. Treatment: Continue ASA and blood pressure management with a target systolic blood pressure of 135-140. Recommend diet modification and increase physical activity to improve cholesterol. Regarding cholinesterase inhibitors, data suggest they have a minor impact on slowing cognitive decline in patients with VCI and vascular dementia. Once a decision to add a cholinesterase inhibitor is made, if the patient's cognitive testing suggests mild dementia, consider starting Donepezil 5 mg PO QD, increasing it to 10 mg PO QD after 1= month (monitor for GI side effects and bradycardia, especially if the patient will be kept on her beta-blocker).

4. Neurological exam and consultation: Perform a detailed neurological exam and neurological consultation for insight into the diagnosis/treatment of cognitive decline, if appropriate.

5. Safety assessment: Assessment for falls, wandering, cooking, money management, and driving safety. Review goals of care and advance directives if not already in place. Offer caregiver support resources to the patient's family.

6. Other geriatric assessment recommendations:
   - Review bowel history. It's not uncommon for MCI patients to report normal bowel frequency when it may be significantly decreased. Episodic constipation with overflow diarrhea is not unusual. This might explain some of the patient's recent GI history/complaints. If constipation is present, consider Dulcolax daily since the patient tolerates it well. Fiber may be consumed as a part of a regular diet. However, fiber supplements are not recommended for the elderly since their water intake is generally inadequate, which may increase constipation with fiber supplements.
   - ENT referral for chronic sinus disease. If a fungal infection is present, an in-office procedure may reduce symptoms and eliminate the need for an antihistamine/decongestant.
   - Patient's calculated GFR is 50. Monitor renal function and adjust medication dose accordingly. Discontinue omeprazole, as PPIs can worsen renal function with prolonged use.
   - Reduce pill burden by reassessing all medications (including OTC) and supplements. Consider stopping vitamin D since the patient takes Calcium + D, and vitamin D levels were normal/elevated on previous testing.

Dana Richards, MD

02/10/22 10:29 a.m. PST

Dana Richards, MD, Geriatric Medicine

Response Date Stamp