

Dementia Diagnosis and Support – A Psychiatric Perspective

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Dementia presenting with non-cognitive psychiatric symptoms

- Depressive symptoms
- Psychotic symptoms
- Personality change
- Odd behaviour
- Physical symptoms (HD, NPH, CJD)

Depressive symptoms

- Many overlapping symptoms such as social withdrawal, sleep disturbance, irritability
- Affective lability particularly common in context of cerebrovascular disease
- Tempting to consider trial of antidepressants but little evidence regarding efficacy

Psychotic symptoms

- Psychotic symptoms common in all forms of dementia but a core feature of Lewy Body Dementia
- Common themes are persecutory paranoid delusions
- If visual hallucinations think delirium, LBD and visual impairment

Personality Change

- Common early feature of most dementias
 - Irritability
 - Disinhibition
 - Withdrawal

Core early and profound feature of FTD
(behavioural variant)

Odd Behaviour

- Hoarding
- Sexual disinhibition
- Squalor

How to Know What's Going On

- Corroborative History
- Past psychiatric history
- Always assess cognition
- Play the numbers game (up to 30 % of your 80+ patients will have a dementia)

Medications - antipsychotics

- Some role in treatment of psychotic symptoms and aggression
- Benefit above placebo modest (20% at best)
- Lots of nasty side effects esp falls, CVA risk
- Consider carefully rationale and expectation of treatment
- Review

Medications- antidepressants

- Avoid multiple antidepressants (eg SSRI for depression TCA for sleep)
- Growing body of evidence showing no sig benefit of antidepressants used to treat dementing depressed patients
- May be useful in managing emotional lability
- ??role in impulse dysregulation

Decision Making Capacity

- Task specific
- Individuals understanding of the task at hand
- Awareness of options available
- Ability to weigh up benefits/risk of options and enact decision
- Think of need for proxy decision makers