

Aging and Dementia/Delirium

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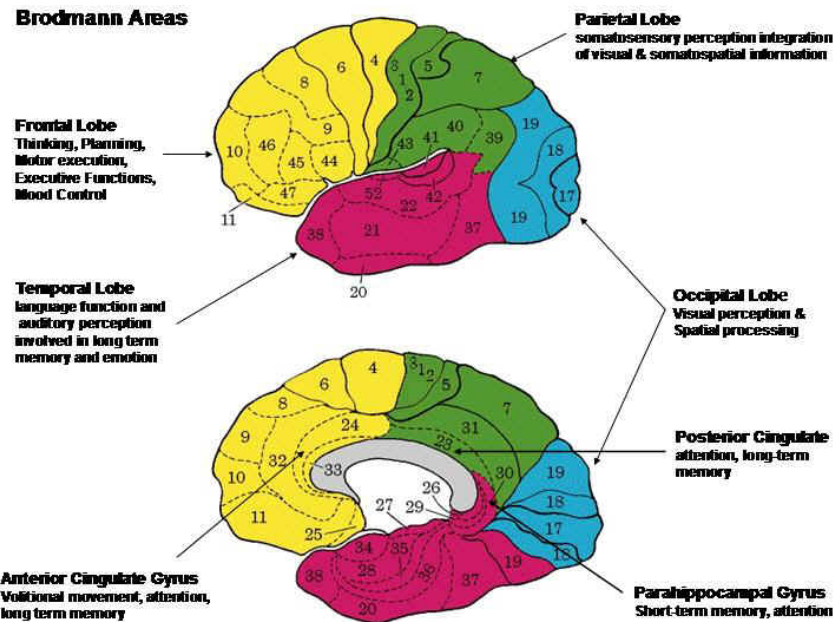




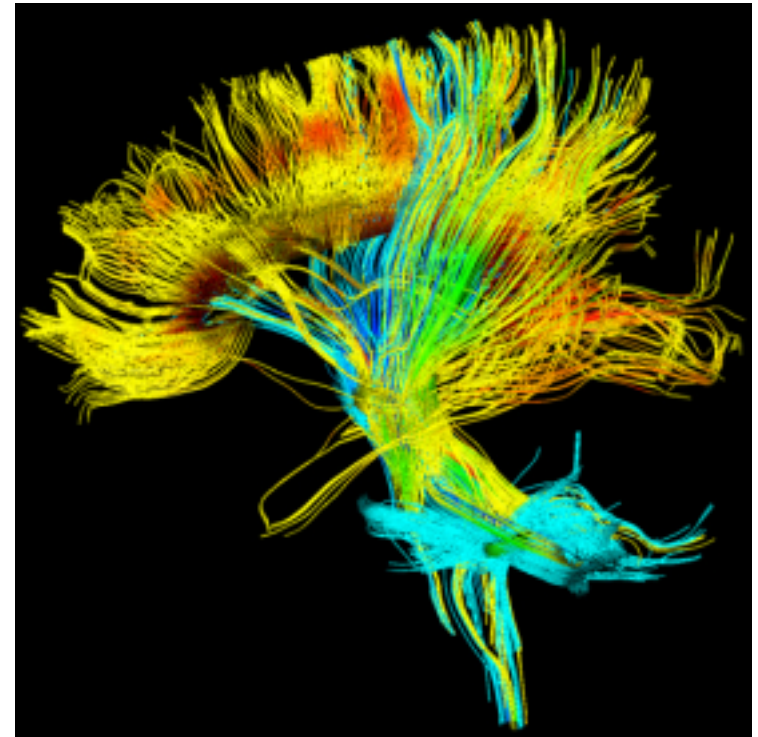




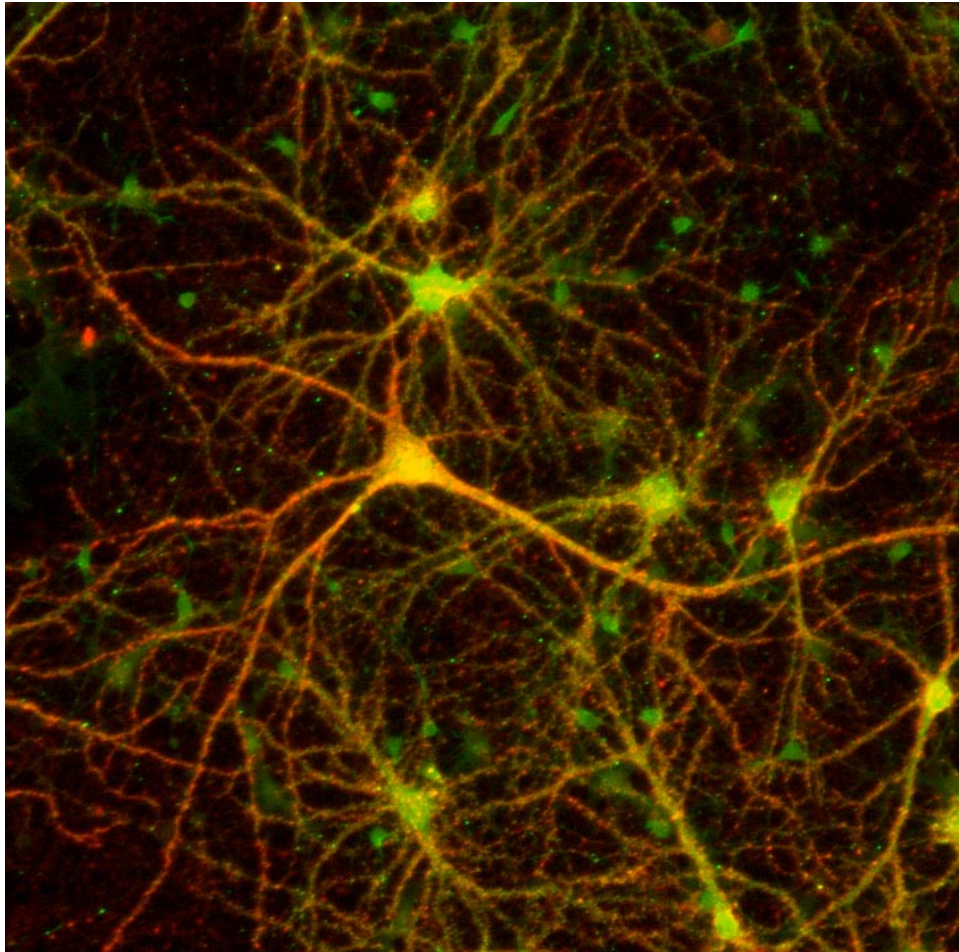
structure



connectivity



connectivity



Back to Fort Albany

- Concern re: memory raised by nursing staff
- No concern by patient or family
- Social preservation
- Community stable
- Aging context
- What is valued ?
- What is seen ?

So what ?

- What categories the brain ?
- How prioritize ?
- What, exactly, are we mapping where, and does this even make sense ?
- How does all this help us support and understand suffering ?

DSM V

Major Neurocognitive Disorder

introduces idea of cognitive domains

complex attention, executive
function, learning and memory,
language, perception, motor, social
cognition

DSM V

Major Neurocognitive Disorder

- a. significant decline in one or more cognitive domains
- b. interfere with ADLs
- c. not delirium
- d. Not something else

DSM V

Specifies types:

AD, FTD, Lewy Body, Vascular, TBI,
substance/medication induced, HIV, Prion,
Parkinson's, Huntington, due to another
condition, due to multiple etiologies

With or without behavioral disturbance

DSM V

Major neurocognitive disorder:

Mild: difficulty with instrumental ADL

Moderate: difficulty with basic ADL

Severe: fully dependent

(ADL: activities of daily living)

Dementia

65- 74: 2.4%

75- 84: 11.1%

85+: 35%

(overall about 8% of > 65)

Behavioural and Psychological Symptoms of Dementia (BPSD)

90%

Expected

Variable

NOT connected to “severity”

?screen/testing MMSE/MOCA/RUDAS

Rowland Universal Dementia Assessment

Originally developed in Australia, only cognitive assessment tool specifically developed for use in complex cross cultural context, accounting for variability in education/literacy

Treatment (in AD)

Well.....

MMSE 1.5 point change for some

Behaviours

Safety

(pessimistic, except for alcohol related dementia – more later....)

Prevention

- Treat illness
- “motherhood issues”
- Exercise
- A note on alcohol

Delirium

COMMON

Key concept

Sudden onset of confusion

Impaired attention, fluctuating level of consciousness

Underlying medical problem

One year mortality – around 25 %

Inter-relatedness

- Vulnerable brain
- Life time of insults
- Cognitive reserve

Cognitive reserve

holistic model of change over life span

discussion



Elder place within family

General vs specific

Variability

Isolation

Learning emotion/self/other

“we age the way we live”

Positive self concept

Negative self concept

Positive other concept

Secure

Pre-occupied

Negative other concept

Dismissive

Fearful/avoidant



Alcohol and Aging

- Alcohol abuse/dependence 65+ : 2-4 %,
- But really depends on local populations and how counted:
 - In primary care 8-15%
 - In LTC 8-50%

Uh oh

1 drink at age 20 ===== 3 drinks at age 80

Changes with aging

- Increase fat
- Decrease muscle
- Decrease renal function
- Decrease liver function
- Increased brain vulnerability
- Fall risk

At risk drinking

- In greater than 65,
- More than 7 drinks a week, or more than 3 drinks at one sitting

CAGE

- Cut down
- Annoyed when questioned
- Guilt
- Eye opener
- Positive if 1/4

MOCA

13/30 to 26/30

after 18 mo

- Alcohol related:
- Delirium tremens
- Intoxication
- dementia

