



UNIVERSITY
OF WYOMING

Wyoming Center
on Aging

Complications

By Tabitha Thrasher, DO

Objectives

- Understand how to assess symptoms of behaviors in dementia
- Understand indicators for end-stage dementia
- Understand when palliative care would be appropriate in dementia care

Case Presentation

- GC an 82yo F with Alzheimers dementia, diabetes mellitus type II, Depression, hypertension, hyperlipidemia, and osteoarthritis of left knee. She lived at an assisted living facility in a memory care unit.
- Visit with GC and son which was her POA in August 2019: Call from ALF, GC had increased anxiety and agitation a couple of weeks prior to this visit, and Sertraline was increased to 100mg from 50mg. Son stated that during that time she was calling 5-8x daily and that seems to be better. Labs had been assessed at the time without acute abnormalities. At this visit son requested moving towards more palliative care and as GC's biggest complaint was taking too many medications, he requested cessation of some of her medications.
- GC: "I don't want to live forever."

Medication List Aug 2019

- Tylenol 500mg 1-2 tabs every 8 hours as needed for pain control
- Alprazolam 0.25mg 1-2x daily as needed for anxiety (usually took 1 at night)
- Trazodone 50mg qhs
- Sertraline 100mg daily (just increased a couple of weeks ago)
- Metoprolol Tartrate 25mg BID
- Memantine 10mg BID
- Losartan 25mg daily
- Glimepiride 4mg daily
- Buspirone 10mg BID
- Donepezil 10mg daily

Plan Aug 2019

- Son requested starting with medications for dementia as he did not believe she was getting benefit from these, taper was started with Donepezil down to 5mg qhs, then plan to DC if she is doing ok
- Also began to taper Memantine, 10mg daily for 2 weeks, then off.
- Plan to stop Metoprolol after dementia medications were weaned, attempt to control BP with 1 medication instead of 2
- Would check A1C with plan to possibly DC glimepiride [A1C was 8.4, we decided to leave the glimepiride for now – she ate mostly sweets]
- Requested no more labs for cholesterol checks
- Discussed stopping Trazodone, Alprazolam, Buspirone, but since she was frequently having anxiety, agitation, sleeplessness, plan agreed upon to keep these for now.

Flipped Switch

- Sept 2019 – May 2020
 - Increased agitation, wandering, pacing, exit seeking, setting off door alarms
 - Aggression towards staff and other residents – ended up in ER once due to threatening staff with butterknife, throwing chairs at windows to bust out, physically assaulted a couple of staff and another resident
 - Increased anxiety – calling son numerous times a day
 - Paranoia – refusing to eat or drink much and spitting out medications
 - Weight loss
- Labs assessed many times, only notable for elevated glucose and A1C between 8-9, low protein and albumin

Ongoing Attempts

- Restart medications that were weaned
- Tried all of these over the next 9 months
 - Xanax – as was on her medication list prior to when I met her
 - Oral and topical Ativan
 - Clonidine – neurology recommendation
 - Seroquel – titrated up to 50mg at bedtime, 25mg morning and afternoon
 - Sertraline
 - Then switched to Citalopram
 - Mirtazapine
 - SL morphine
 - Risperidone liquid – geripsych recommendation (also recommended trial of Depakote sprinkles, but due to continued refusal of food, this wasn't tried)
 - Haldol oral and IM

-continued

- Titrated medications up
- Weaned medications down
- Finally stopped all medications in early June 2020 as nothing was helping as we were unable to get her to take them regularly

June 2020

- Son states that GC was always adamant that she did not want aggressive measures and that he watched another family member go through something similar, so when GC stopped eating he knew it was just a matter of time.
- She was so agitated and not eating or drinking anything that hospice was consulted. They recommended Haldol 2mg/mL 0.5-2mg q8
 - She continued to spit out oral meds – hospice requested switch to Haldol IM
 - 1 week after this, she had a fall as she was continuing to try to get out of bed, after this morphine and Ativan were initiated as she declined rapidly, but was calm and appeared comfortable when she passed a couple of days later

Progression of Dementia

- Stage 1: No cognitive impairment
- Stage 2: Very mild cognitive decline
- Stage 3: Mild Cognitive decline
- Stage 4: Moderate cognitive decline (mild or early-stage Alzheimer dz)
- Stage 5: Moderately severe cognitive decline
- Stage 6: Severe cognitive decline
- Stage 7: Very severe cognitive decline

Core and Disease-Specific End-Stage Indicators

- Dementia
 - Inability to walk or dress without assistance – **needed help with dressing**
 - Urinary and fecal incontinence
 - Absence of consistently meaningful verbal communication
 - *PLUS* any one of the following:
 - 10% weight loss in previous 6 months - **yes**
 - Serum albumin level <2.5g/dL
 - Recurrent fevers
 - Aspiration pneumonia
 - Pyelonephritis or upper-tract urinary infection
 - Multiple stage III or stage IV pressure ulcers

Assessment of Behaviors in Dementia

- Symptom of a new condition?
- Environmental precipitant?
- Stress in patient-caregiver relationship?
- Assessments:
 - Cohen-Mansfield Agitation Inventory (CMAI)
 - Neuropsychiatric Inventory (NPI)
 - Behavioral Pathology in Alzheimer Disease Rating Scale (BEHAVE-AD)

When To Initiate Palliative Care in Dementia?

- “Alzheimer’s disease is a progressive, ultimately fatal illness with a median survival at the time of diagnosis of 4.2 years for men and 5.7 years for women”
- “Palliative care is best understood as a system of care based on a patient-centered, quality-of-life model that values patient autonomy and focuses on anticipating, preventing, and treating the suffering of patients and families regardless of diagnosis or stage of illness.”
- Goals of Care and Advanced Care Planning with patient and family or friends that patient wishes to have involved.
- **ANYTIME** it is deemed that it would benefit

Discussion

References

- Medina-Walpole A, Pacala JT, Potter JF, eds. *Geriatric Review Syllabus: A Core Curriculum in Geriatric Medicine*. 9th ed. New York: American Geriatrics Society; 2016
- Smucker WD, et. Al. *Palliative Care in the Long-Term Setting*. Maryland: AMDA; 2007