Dementia Newsletter for Physicians

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Apathy…So What?

Dr. Andrew Wiens, Geriatric Psychiatry Services, Director of Outreach Services Royal Ottawa Hospital, Assistant Professor of Psychiatry, University of Ottawa

Apathy is one of the most common behavioural changes in Alzheimer's disease, affecting up to 80% in the mild-to-moderate stage. It is also found in other dementing disorders as well as patients with Minimal Cognitive Impairment. Despite this it is often not recognized.

It is characterized by loss of motivation and initiation, social withdrawal, indifference and blunted emotional responses. Apathetic patients have been found to have more pronounced cognitive impairment. Family members frequently feel the apathetic patient is depressed and suffering. Although it can be distinguished from depression by the absence of dysphoria, guilt, suicidal ideation and pessimism, up to almost 40% of patients with Alzheimer's have both apathy and depression.

Apathetic patients often require more support due to their lack of initiation and motivation, thus, placing great burden on the part of caregivers and can lead to early institutional care. Apathetic patients are perceived as insensitive, uncaring and lazy and their caregivers often suffer significant levels of distress and depression and report dissatisfaction with caregiving.

Apathy is felt to be due to dysfunction of frontal subcortical distributed networks and may be related to loss of cholinergic input into prefrontal and subcortical structures. An association with extra-pyramidal symptoms in more severe apathy suggests involvement in dopamine pathways responsible in mediating the activity level of frontal circuits.

There are several instruments available to assess apathy. The Neuropsychiatric Inventory (NPI) includes an apathy item; its scores have been shown to correlate with frontal pathology at autopsy. The NPI includes a depression item that may help distinguish these syndromes. Other longer rating scales include the Frontal Systems Behaviour Scale, the Apathy Evaluation Scale and the Apathy Inventory.

Non-pharmacological interventions include education of caregivers, both to help them understand that the patient isn't suffering but also to lessen blame directed at the patient. This may allow caregivers to alter their perception of the apathetic patients and increase their ability to provide care. Verbal prompts, setting up daily routines and activities, and social stimulation have all been found to be beneficial.

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Cholinesterase inhibitors have been shown to reduce severity and/or appearance of apathy and are the first line treatment in most of the common forms of dementia. Given the overlap between apathy and depression, a trial of antidepressants would be warranted especially in the presence of dysphoria. Other possible treatment modalities include dopaminergic agents such as bupropion or amantadine. Finally, there is some preliminary evidence supporting the use of psychostimulants including methylphenidate and dextroamphetamine.

Group Health Assessment Program

Paula Sirie, Geriatric Assessment Nurse, Group Health Assessment Program

Purpose: to provide a multidisciplinary assessment and initiate a treatment plan in order to maximize the independence and well being of the elderly with multiple complex, medical, functional and psychosocial problems.
Patients are referred to the Geriatric Assessment Program ,by the family physician or a nurse practitioner. The geriatric assessment nurse will then book an appointment for the patient to see her and then a consult with one of the three physicians. These doctors are Dr. Clarke, Dr. Cziffer and Dr. Ianni. Certain criteria should be followed to refer to the clinic and that is frail elderly with complex medical problems, multiple medications, failure to thrive, multiple falls, or who may be at risk for long term placement or social withdrawal. For the last several years most of the referrals have consisted of memory loss, confusion, or depression.

A full assessment by a geriatric assessment nurse is done lasting approximately 1 hour and at that time the patient's medical history, living environment, IADL's and ADL's are discussed. Memory and depression testing are done. Driving is also discussed. It is very important to have a caregiver with the patient to aid in input. On a following day the patient and caregiver will see one of the three physicians and have an hour consult. The physician will do a physical as well as talk extensively with the patient and family member or caregiver. A letter will be then sent to the family physician regarding a plan that they may initiate or that we have already initiated in our Geriatric Clinic. They may then be booked to follow in GAC at a three or six month interval. Patients are advised that they are to continue with their family physician and we are only here to assist him/her. Information given to patient/caregiver regarding community services such as Day Away, Life Line, Alzheimer Society, CCAC, Meals on Wheels etc.

Some of the physicians who practice at the Group Health Centre send their patients to the geriatric nurse, only, for an assessment and they follow them in their own practices. Physicians outside of the GHC are accepted if patient is to have a full assessment with one of the doctors in GAC.

Education Resources for Family Physicians

www.dementiaeducation.ca Physician education website for Ontario's Strategy for Alzheimer's Disease and related dementias

www.rpgs.on.ca Regional Geriatric Programs of Ontario

www.mocatest.org Montreal Cognitive Assessment Test

www.candrive Canadian Driving Research Initiative for Vehicular Safety in the Elderly

www.cma.ca Determining Medical Fitness to Drive: A Guide for Physicians

www.neostrokestrategy.com Northeastern Ontario Regional Stroke Network

THANK YOU

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All past issues of this publication can be obtained at **www.dementiaalgoma.org.**