

## Case Study - Diagnosing Dementia using DTA Inclusion/Exclusion Criteria

<b>Topic</b>	Making a diagnosis of Dementia		
<b>CPD</b>	Education Activity	<b>Estimated Duration</b>	1-2 hours
<b>Aim</b>	To assist practitioners in using the DTA Inclusion and Exclusion criteria to make a diagnosis of Dementia.		
<b>Learning Outcomes</b>	Improved confidence in using inclusion and Exclusion criteria Review video case to examine consultation skills in a patient presenting with cognitive decline		

### Part 1

Anna is a 75-year-old long term patient of her GP, Dr George. She is a widow, has controlled hypertension and mild arthritis. Her only medications are:

- Perindopril 5mg daily
- Paracetamol 1g prn

Anna normally attends her appointments with Dr George on her own, but on this occasion has come with her daughter Sophie, who is also a long-term patient of Dr George

#### Question 1

What goes through your mind when an older patient who usually comes on their own attends with a family member for the first time?

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#### **Feedback**

Having a family member attend with an elderly patient usually signifies there is something that the family wants to communicate with the GP. Sometimes this can occur with the patient and sometimes they want to tell you anonymously after the consult. Always be aware for this possibility and create space during the consultation for any issues to be aired.

Obtaining a collateral history is an essential step in the process of making a diagnosis of dementia. When a family member attends, view this as a golden opportunity to start this process and to make arrangements for follow up.

## Part 2

Watch the [video of Dr George taking an initial history from Anna and her daughter Sophie](#)

### Question 2

Which inclusion criteria were demonstrated during this part of the interview?

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### Feedback

The four inclusion criteria for dementia are;

1. Gradual onset of poor memory:

- not collecting repeat prescriptions
- not responding to reminder letters re flu vaccination
- history of forgetting pills
- leaving the stove on

Need to confirm if sudden onset in STM loss or gradual onset.

2. Worsening of memory problem

- appears to be worsening, given Dr George knows the patient from previous consultations and she has been ok in past with immunization recalls and tablet compliance.
- could be explored further with patient and daughter.

3. Failure of function - There are 2 clues mentioned:

- not doing the gardening as much as prior
- leaving the stove on

There are many reasons why elderly patients may be doing fewer physical activities that can be unrelated to dementia and the examples above need to be explored further.

Whilst leaving the stove on overnight could have been an issue of memory, it might also signify that she is not functioning appropriately in her cooking tasks. Asking about her ability to cook the same meals as the past, in both variety and complexity, may give further information to a decrease in function.

4. Cortical dysfunction – There was no obvious dysphasia, although specific tests such as asking the patient to name words starting with the letter P, were not completed. There were no tests for agnosia or dyspraxia although these are completed within most cognitive assessment tools such as MMSE or GPCOG.

### Question 3

Briefly describe the communication techniques used by Dr George during this part of the interview

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### **Feedback**

Dr George was very good at having the patient and the daughter do “the work” of providing the important points in the history. This was done by asking open ended questions and then providing time for the patient AND the daughter to express any concerns and tell their story.

Dr George asked for consent from Anna, and arranged time to speak to the daughter independently.

### Question 4

At this point, describe what do you think might be going on for Anna?

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## Feedback

The differential diagnoses for Anna include:

1. Cognitive decline
  - neurodegenerative (eg Major neurocognitive disorder, Alzheimer's Dementia, Vascular Dementia) \*
  - Organic cause for cognitive decline (eg thyroid dysfunction, B12 deficiency, subdural haematoma, malignancy)
  - Iatrogenic cognitive decline secondary to medication (unlikely in this case) or alcohol (needs to be checked)
2. Psychological (Adjustment disorder, Depression)

\*NB she doesn't fit the criteria for mild cognitive impairment as she also has functional decline

## Question 5

What are your next steps?

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## Feedback

Dr George has done a great job in acknowledging the patient and daughter concerns about memory. It is important not to dismiss any concerns about cognitive decline made by patients and their family.

The next steps include:

- Taking a further history, especially from the daughter, to obtain more details to satisfy the inclusion criteria.
- Complete a cognitive assessment tool (CAT). While this is not essential to make a diagnosis for Dementia, it adds weight to making or excluding a diagnosis of cognitive decline. It also normally involves testing beyond STM loss to include other cortical functions like dyspraxia. The CAT can also be used to monitor for changes in cognitive function over time.
- Exclusion criteria need to be considered and investigated as appropriate.
- Medications, alcohol or illicit drug use (such as THC) need to be reviewed as a possible contributor or cause to cognitive decline.

### Part 3

Watch the [video of Dr George interviewing Anna's daughter Sophie](#)

#### Question 6

What further information was gained from this interview?

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#### **Feedback**

Dr George was able to ascertain many more important pieces of information that included; Carer concern; Carers take a large burden of responsibility and distress in dementia. The daughter was able to express her concerns and discuss possible reasons.

Cognitive decline; the daughter clearly stated a gradual onset of worsening memory over time. She also voiced further evidence of functional decline; less bridge playing, social isolation, reduced care in dressing/clothes. Lastly, she described a lack of insight which is a common finding in Dementia and highlights the need for a collaborative history.

Dr George also asked the daughter what she thought was going on? This provided an opportunity to gauge her level of concern, and to raise the possibility of Dementia as a possible cause.

#### Question 7

Which inclusion criteria have been demonstrated?

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#### **Feedback**

##### **Four Inclusion Criteria:**

1. Gradual onset of poor memory – **confirmed as gradual onset memory loss as opposed to a sudden loss that might be seen from a different cause like a CVA**
2. Worsening of memory problem – **increasingly forgetful, getting worse**

3. Failure of function – **She is no longer gardening at all - “abandoned her garden”. This suggests a cause beyond lack of physical capacity. She is losing care in her meticulous personal presentation - dressing and clothes. She is no longer playing Bridge as often which indicates as a change in function too, most likely related to decrease in cognitive function. All of this is leading to been more socially isolated, also a sign of reduced function.**
4. Cortical dysfunction – **dysphasia, agnosia, dyspraxia need to be tested for at a later stage by Dr George, or via a cognitive assessment tool.**

#### Question 8

What do you now think might be going on for Anna?

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#### **Feedback**

The personal and collaborative history are now emphasizing the strong possibility of dementia as a cause for her initial concern of memory loss.

#### Question 9

What are your next steps?

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#### **Feedback**

Follow up needs to be arranged to complete the full assessment. This includes completing an appropriate cognitive assessment tool based on the patients cultural and education levels. Completing appropriate investigations to exclude other causes for cognitive decline and a review of her medication, OTC tablets and to exclude AOD use. She also needs to be screened for depression or other relevant psychiatric diagnoses.

#### Part 4

Dr George arranges investigations for Anna as per his local HealthPathway. The investigations rule out any exclusion criteria. Anna is not depressed. Her MMSE score is 23.

Anna returns to see Dr George for results. He is confident that Anna's most likely diagnosis is Alzheimer's dementia.

#### Question 10

Describe how you would approach offering a diagnosis of dementia to a patient like Anna?

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#### Feedback

Giving a diagnosis of dementia uses the same concepts for providing challenging news for any new diagnosis. Three important principals include;

1. Maintain Hope and dispel myths
2. Patient centred – listen to what the patient wants. Address any immediate questions today
3. Create a Holistic approach – Social, Emotional, Physical and Carer needs – that may take multiple visits to complete

Watch the [video of Dr George offering the diagnosis of dementia to Anna](#)

#### Question 11

What do you think Dr George did well?

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#### Feedback

Dr George did many things well

1. He was direct and used easy to understand language in giving the diagnosis – important to use the "Dementia" word

2. He provided space for the patient and daughter to respond
3. He checked with them what prior knowledge they have about dementia
4. He answered their questions and stated clear goals
5. He started to address issues around Advanced Care Directive, Power Of Attorney and Guardianship
6. He stressed he would be providing help to both the patient and the daughter

Question 12

Reflecting on your response to question 10, how might you change your approach to offering a diagnosis of dementia?

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