

The Brain Trust Podcast | Episode #11 Detecting early signs, symptoms, and behaviors in neurocognitive disorders

Transcript

Speaker 1: Kate Rowland, MD

Welcome to the Brain Trust, A Physician's Guide to Diagnosing Alzheimer's Disease and Related Dementias. Brought to you from the Illinois Academy of Family Physicians. I'm Dr. Kate Rowland, family physician, member of the IAFP and faculty at Rush University. Funding for this podcast series was provided by a grant from the Illinois Department of Public Health. The goal of the Brain trust in this podcast series is to educate and empower the primary care clinician in the early detection, diagnosis and management of Alzheimer's disease and related dementias.

Clinical resources, Free CME and other educational materials are available online at theBrainTrustProject.com. CME Credit is available for each podcast. The Illinois Academy of Family Physicians is accredited by the Accreditation Council of Continuing Medical Education to provide continuing medical education for physicians. Information on how to receive credit can be found on the Brain Trust Project website.

Thank you for joining us. As we empower each other and provide training on the early detection of Alzheimer's disease and related dementias. And now today's episode.

Host: Eukesh Ranjit, MD

Hello, everyone, and welcome to our podcast. Today, I have a special guest with me who is joining me at SIU all the way from California who would be talking with me today about early signs and symptoms of neurocognitive disorder, as well as who would help us in describing the degenerative cognitive syndromes which can manifest with behavioral changes.

My host today is Dr. Dennis File. She is the director of Geriatric psychiatry Training and education at Greater Los Angeles VA Health Care System. She is also a health science clinical professor at UCLA and the program director of UCLA Geriatric Psychiatric Fellowship at David Geffen School of Medicine at UCLA. Dr. Phil actually received her medical degree from McGill University in 1995 and has been in practice for 24 years.

She's bilingual in French and English and specializes in dementia, diagnosis and treatment, and conducts research on health services and health behavior. Let's welcome Dr. Feil. Welcome to our podcast.

Guest: Denise Feil, MD, MPH

Thank you. It's very nice to be here. It's great to be virtually in Illinois. Rural Midwest is very familiar to me, having grown up in the rural countryside of the Midwest.

Host: Eukesh Ranjit, MD

That is great to hear. Dr. Feil, tell us something about working with a primary care provider.

Guest: Denise Feil, MD, MPH

Well, that's really much of what I do in my health care setting. Actually, we have an integrative clinic, whereas geriatric medicine in which we're able to address all of the behavioral cognitive issues in addition to all of the medical problems. And really it's difficult to treat and isolate out the cognitive issues from all of the underlying medical problems.

And so that's been enriching setting for me over the last 20 years to help me understand the medical side, meaning the primary medical problems, as well as the neurocognitive issues and how they work together in terms of addressing and treating.

Host: Eukesh Ranjit, MD

For my listeners, any tip that you'd like to share, you know, that could improve the communication between primary care providers and between, you know, the patients and the caregiver?

Guest: Denise Feil, MD, MPH

Right. So that can be complicated by what the health care system looks like and how many opportunities there are to work together. But taking advantage of any of those, maybe adding a psychiatrist or cognitive specialist or a geriatric medicine physician like Dr. Eukesh available to assist you with some of those questions that you may have, I think that can be quite helpful.

I know as a geriatric psychiatrist, I am contacting primary care and geriatric medicine on a daily basis.

Host: Eukesh Ranjit, MD

Could you please give us some examples of how in a primary care providers can attain greater level of comfort with what they're already doing, you know, helping geriatricians, helping psychiatrists and other subspecialists?

Guest: Denise Feil, MD, MPH

Sure. Maybe it helps to even start with a case that I had just this this week, which is a complex issue with how we kind of split up our divisions of labor. And in this case, we were able to work together very well, and it helped us understand and treat this patient in a way that's quite unusual. But I think we often it's probably more common than we know. So this this is a 75 year old man, and he came in to our memory clinic complaining of quite a number of issues.

And he had a word binding saying he was feeling like in his brain he had kind of a traffic jam, but he also had a lot of significant medical problems and he had a history of traumatic brain injury. He had untreated obstructive sleep apnea. His primary care physician had attempted to treat that, but the CPAP wasn't working. He also had a new device that he was using that made him claustrophobic related to his PTSD, post-traumatic stress disorder, and he just wasn't sure if it was helping him at all.

So he stopped using it. He also had somewhat uncontrolled diabetes. He had a lot of pain that was affecting his ability to kind of process information. He was scheduled for a hip surgery in a few months, but the pain was really getting him down. So just this last week, we saw him in clinic. It had been a follow up period of about five months.

And meanwhile, he actually had a successful left total hip arthroplasty and was dealing much better. His pain was mostly resolved. He also had this kind of severe osteoarthritis and was getting proper treatment for that. That was not affecting his mentation. And then for this obstructive sleep apnea, where we're really at a bit of a crossroads with that because he has claustrophobia issues related to this PTSD.

And so we sent him back to sleep clinic and they actually gave him a mandibular advancement device instead, which was working well for him. And we care so much about that in our cognitive setting, because with the lack of oxygen to the brain, you know, there's really an increased risk of dementia. There's also a concern over just general lack of well-being from not getting oxygenation during the night.

And then we also referred him for psychotherapy. He never received psychotherapy for some of the worst PTSD I've seen. And there was some associated depression with that. So his therapist and psychiatrist actually added Duloxetine for him. He titrated up on the deluxe setting to about 60 milligrams and also was getting some psychotherapy and some support for a lot of these preoccupations that he was having.

And so we actually graduated. We were able to graduate him from our memory clinic. This is a relatively rare occurrence but had a huge impact to see that actually somebody who really was we were thinking he had at least mild cognitive impairment, if not emergent dementia. Actually, his memory issues completely resolved. And so that's kind of why we care so much because of the potential for misdiagnosing, giving somebody a bad diagnosis and prognosis when actually there's all these medical problems that can be treated and can help to really improve their cognition and their well-being.

Host: Eukesh Ranjit, MD

That is an amazing case. Thank you so much for sharing that and also the case it highly illustrates the multifaceted problems that could all lead to a possible decline in cognition in a patient. Then how as primary care provider, we can ordinate care as well as take care of the small issues that we do not otherwise think of as affecting memory, things like osteoarthritis where, you know, pain management can affect cognition, obstructive sleep apnea and so on.

With regards to primary care providers detecting or sensing changes in cognition, are there any said that we should be looking for early on? You know, are some pearls of wisdom that that you could share with us that would help us take care of these cognitive problems early on?

Guest: Denise Feil, MD, MPH

That's a good question. And Dr. Eukesh, you probably see more of this than I do.

You are at least we see equal equal percentages of this conundrum in our patients. So how do we kind of break that down a bit when we have someone coming in to our practice and either we ask specialists or primary care providers kind of feel like there's something not quite right, but the families not aware or the patient is not aware.

So that's one scenario. Another one is how the family member comes in and or makes a cold call and basically says, I know there's something going on with my father, my mother, my grandparents or my my spouse. They're having trouble with their driving. They're tending to get lost. You know, things are just changing. Sometimes he gets really irritable, sometimes she maybe makes decisions that I would make, and this is kind of new.

So that's kind of often we'll hear something like that. And, you know, in a conundrum about how to how to address that when it's, you know, a family member reporting it. And then also we we never really know for sure what's what's happening initially when a patient comes in. So maybe we can break that down for our listeners today.

And just to make one note of something that we often aren't aware of outside of, you know, our specialties, and that is that part of the disease process in Alzheimer's in particular, is that there's a lack of insight. We even have a special name for that and a signature, and that is typical a lot of a lot of brain syndromes.

And we often think of the patient as being in denial or trying to hide it, that sort of thing. And that can happen. But for the most part, this part of the brain that makes us aware of the disease itself that's happening in our brain is sometimes not working well and gets affected by the disease itself. And so that's probably one of the most complicating factors in treating the cognitive disorders.

Anything else that you can think of, Doctor you Eukesh

Host: Eukesh Ranjit, MD

There are changes in some of the activities of daily living, you know, especially the instrumental activities of daily living. And for me in my practice, I do tend to ask them about their ability to take medications, for example. Sometimes I get notes from the pharmacy saying the patient has not refilled their prescription and then it's about time.

Oftentimes, there are some subtle changes in their ability to take care of their finances so their loved one, generally the husband or the wife takes over those responsibilities. Driving has been something that becomes problematic, either having an accident or, you know, running over a stop sign, red light or just pulling over just to think, you know, where they're headed, even while driving in places, you know, where they are most familiar with.

They are some of the problems that I see as well. So one of the things that I wanted to touch base with you today was that with regards to the behavioral disturbances that are associated with dementia, when we talk about dementia, we are always focused primarily on the cognitive aspect. Even in the primary cognitive aspect, we are focused more on the memory much more than the other domains of cognition.

Could you please tell us something more about some of the common behavioral disturbances or behavioral changes that can be noticed in dementia?

Guest: Denise Feil, MD, MPH

Oh, such a good question. And in terms of how that plays in with the different kind of diagnoses that we might be seeing in primary care practice. So sometimes even early on, you know, you mentioned some of the daily activities that can be affected, but also there can be some associated behavioral changes even early on.

And one of the most common ones is apathy or a lack of motivation. And this is seen in pretty much all of the dementias that we'll talk about Alzheimer's disease, vascular dementia, Lewy body dementia being the three most common ones. So apathy is something that, you know, where there's just kind of a lack of motivation, lack of initiation, even of motor movements that can be seen really early on in some of the dementias.

And then also there can be some early depression we see that's pretty typical in Alzheimer's disease. So there can be a lot of depression even a few years, you know, a near depression, sometimes associated anxiety, irritability can occur, but that's often more in the you know, we're more into a mild to moderate stage. Again, if it's a different type of dementia like frontotemporal dementia, we might see irritability and personality change very early on and then brain behavior disorder and some of these sleep disorders that often fall into the end of the purview of geriatric medicine and primary care, you treat constantly treating one type of sleep disorder or another. Those can occur early on here.

So again, Lewy body dementia, we can see REM behavior disorder in, you know, maybe even 12 to 15 years prior to the onset of the actual Lewy body disorder. We care about those things. We care about getting sleep studies. And we it does capture our attention when we are informed about some of these types of changes that are would be considered emotional or behavioral.

Host: Eukesh Ranjit, MD

So if we see these changes, you know, what should we do? You know, prior to making a referral or, you know, what are the most common indications for a referral and what role can primary care providers play during those referrals?

Guest: Denise Feil, MD, MPH

You know, I think I might actually punt this about to you. What type of brief screener are you using or that you think might be helpful to primary care providers when they have, you know, 5 to 10 medical problems that they're trying to address, making sure that their diabetes is okay, their blood pressure?

These are really key, key issues and actually can affect their cognition by being vascular risk factors. So what you're addressing all of those medical problems that can contribute to what we're seeing here. But

in addition to that, what kind of a screener or what kind of questions do you tend to ask when you have just 5 minutes after you Dr. Eukesh?

Host: Eukesh Ranjit, MD

It is always a challenge, you know, because we have so many problems that that patient present to us with either tend to go with their history and see if there's any family history of Alzheimer's, Parkinsonism or some dementia, as in the family physical examination wise, you know, if they have any tremor, if they are falling down, you know, I often attempts to do a timed up and go test, which is also called drug test to see, you know, if they have a slower gait and, you know, a neurological examination would be something that I would do.

Again, I would not be doing all of these tests. At the same time. I would do a certain number of tests initially and then have the patient come back for a follow up at a later date. Once I've done a detailed history and physical examination, if I am in a crunch of time, I tend to use mini cog basically because I would just be asking the questions to a patient to remember three words, ask them to draw a clock and then, you know, recite those three words back.

And it's it's a very time effective. If I have a longer time period like like, let's say, for example, if I'm calling a patient back for just memory assessment and I'm not addressing any other issues, there are a few tools that I use. Mulcahy is one of those tools and MSI, slums. And if a patient comes from a diverse background where English is not necessarily their primary language, and if we do not have a form main in their native language, so, you know, because oftentimes using a translator to do a mauka is almost impossible, then I use radars.

So those are some of the tools that I use for cognitive assessment. Then to assess their function, I tend to use assessment of basic activities of daily living and instrumental activities of daily living. Are those fairly standard things that you see on a regular basis Dr. Feil?

Guest: Denise Feil, MD, MPH

Absolutely. And you know, the acronyms may or may not be helpful to you.

And I'm trying to remember myself then, because we use them so commonly. But the MOCA is the Montreal Orientation and Montreal Cognitive Assessment. That is correct. Yes. And and that, you know, some of those it's hard to get a hold of those. They do take probably 15 to 20 minutes. But I really like your idea of just doing this.

Three words to have them repeat, because we get repetition that way. The clock is so helpful. If it's abnormal in any way, that should be a concern. And then the recall, you know, after they complete the clock. So you got the distraction of the clock and then, you know, to see whether they can recall those. So I agree.

If that's not abnormal for a primary care provider, I would be concerned. And to me, you know, we do hour and a half long batteries. And I feel like that is just a really excellent screener for a primary care provider. If that was something that a primary care provider would want to specialize in a little bit more than, you know.

I think the other ones that you mentioned are very, very helpful as well. But that takes away time from the things that we really care about, right, For cognition. It takes the time away from addressing that obstructive sleep apnea for treating the vascular risk factors for it. Also, maybe a quick screener on depression. We don't want to take away a primary care providers time from these real key, important risk factors for their brain.

And so I vote for this short screener. And then you can also, you know, as a primary care provider, you can look up you can just Google abnormal clocks have done and you can get an idea of, you know, what this one might look like or how you you know, it's fun. So you might actually enjoy looking at the abnormal clocks and seeing how it compares with what you're getting in their practice.

Host: Eukesh Ranjit, MD

Absolutely. And could you please tell us something about the most common causes of dementia? Because I know when you're in med school or in our training, we talk about all the different causes of dementia and things like risk failure. KOLBER type of dementia would not be something that we see on a regular basis. Could you please shed some light on this?

Guest: Denise Feil, MD, MPH

Oh yes. Everyone knows about Alzheimer's disease and there's a good reason for it. It is very common. It really does make up most of, I would imagine, what you see in a primary care practice. More than 50% of the cognitive disorders that primary care faces should be Alzheimer's, like. And so how do we capture that early? Well, the amnesic memory, meaning you can't remember and even with prompts, you can't recall it like basically your memory and log is erased.

So that's really typical of what we see in Alzheimer's. It's we call it amnesia and amnesic memory deficit and vascular or multi-infarct dementia. So there you know, we have both of them. Vascular dementia is really the umbrella that should be probably make up, you know, maybe 25 to 30% of the practice because we see vascular dementia mixed in with Alzheimer's a lot.

There's a lot of overlap. And so that, you know, that's where imaging can be quite helpful. Actually, all of imaging is helpful for Alzheimer's as well. It's just with the vascular dementia, we can the picture is somewhat better in Alzheimer's. We might just see a little bit of atrophy. Maybe, maybe not. And then with vascular dementia, we see the white matter in the brain, which means there sclerosis and those micro vascular networks that cause some of these cognitive changes.

Sometimes we see a stroke or we see a lot of lacuna, small infarcts in the brain. And that's again under that, that really it's primary care that is going to be addressing this. So it is, you know, getting that image can be very helpful. We tend to do MRI's with T two weighted images and the reason we do that is because we want to see that white matter that helps us understand what role the vasculature is playing in the cognitive presentation.

So that's really the bulk of what I think primary Care sees something that is a little more complex that will definitely come into primary care too, and that is something that you mentioned. Dr. Eukesh, about

the Parkinsonism. So Parkinson's disorders include Lewy body dementia, Lewy body dementia is this Lewy body depositions in the brain. Parkinson's disease is a Lewy body deposition disorder, too.

So we'll see something where we see a little bit of slowness, stiffness, maybe a little bit of tremor and Lewy body dementia, it presents a little bit differently. So there might be just a little bit of stiffness. We may not see tremor, but we see the cognitive changes and the cognitive changes are very different. This is hard for us to pick up.

It's going to be hard, even more difficult for primary care. But if you do that quick motor exam, it takes you like 10 seconds or 15 seconds. You look at their gait when they walk in, you look and see if that looks stiff. What's that arm swing like? You could just do a quick check for tone in one arm, the other arm.

You're good. And then as you're interviewing them, you see if there's a little tremor that's maybe suggestive of either some kind of underlying Parkinsonian disorder or the dementias, We would be concerned about a Lewy body dementia if there are also changes and mentation. Again, it's tricky. That's why I might harp on it a little bit. And because I don't always present with a memory issue, there's more of like a confusion there, you know, a little bit like they're in a few state or like a little bit in a fog.

That's kind of the sense that I get when I have one of these patients in the early. I've missed it many times myself. It's not easy to detect. There's not a whole lot we can do about it. But they have a lot of their behavioral issues, they have a lot of depression. They have their own behavior disorder, which can occur, like I said, up to 12 years before the onset of these symptoms.

It's really important to understand what that is, because if they do have a MBK bee disorder, then the likelihood of them developing a Parkinsonian disorder is about 90 to 95% over the course of the next 10 to 12 years. So what is REM behavior disorder? It's basically when they're acting out their dreams. Now that can sometimes happen if obstructive sleep apnea isn't treated well, you know, so that I would think about obstructive sleep apnea, get in treatment and see if those REM dreams go away.

But they're acting out there. Maybe if they're kicking their bed partner, they're falling out of bed, waking up on the floor, sometimes sleep. There's a little bit of sleepwalking, but mostly it's the kicking thrashing. And so we care a lot about that. That's probably one of my pearls of wisdom for Lewy Body Dementia is having a clear picture of that.

And then just a tiny percentage, maybe two or three times in your practice, you might see frontal lobe dementia. This is really much earlier onset. So that's in sometimes in the early fifties there can be and this is really where all those behavioral disturbances come in, really, they primarily present with personality change, apathy, impulsivity, and some of these kinds of odd behaviors.

They tend to be referred to psychiatry. And that is okay.

Host: Eukesh Ranjit, MD

Thank you so much, Dr. Father, for sharing all the information. That was the time that we had today for our conversation. Thank you listeners for listening to our podcast today. I hope all of you have a great day.

Speaker 1: Kate Rowland, MD

Thank you to our expert faculty and to you, our listeners, for tuning in to this episode. If you have any comments, questions, or ideas for future topics, please contact us at [podcast at the Brain Trust dot com](mailto:podcast@thebraintrustproject.com). For more episodes of the Brain Trust, please visit our website. [The Brain Trust Project dot com](http://TheBrainTrustProject.com) You'll find transcripts, speaker disclosures, instructions to claim CME Credit and other Alzheimer's resources as well. Subscribe to this podcast series on Health Care Now Radio, Spotify, Apple, Google Play for any major podcast platform. Thank you again and we hope you tune in to the next episode of The Brain Trust.