On the Frontlines with Alzheimer's Disease: Diagnosis & Management

Stephen M. Scheinthal, DO, DFACN, DFAPA
ACOFP FULL DISCLOSURE FOR CME ACTIVITIES

Please check where applicable and sign below. Provide additional pages as necessary.

Name of CME Activity: 2017 ACOFP Annual Convention & Scientific Seminars
Dates and Location of CME Activity: March 16 - 19, 2017, Gaylord Palms Resort and Convention Center, Kissimmee, FL, United

Name of Faculty/Moderator: Stephen M. Scheinthal, DO, DFACN, DFAPA

DISCLOSURE OF FINANCIAL RELATIONSHIPS WITHIN 12 MONTHS OF DATE OF THIS FORM

A. Neither I nor any member of my immediate family has a financial relationship or interest with any proprietary entity producing health care goods or services.

B. I have, or an immediate family member has, a financial relationship or interest with a proprietary entity producing health care goods or services. Please check the relationship(s) that applies.

- Research Grants
- Speakers' Bureaus*
- Stock/Bond Holdings (excluding mutual funds)
- Employment
- Ownership
- Partnership
- Consultant for Fee
- Others, please list:

Please indicate the name(s) of the organization(s) with which you have a financial relationship or interest, and the specific clinical area(s) that correspond to the relationship(s). If more than four relationships, please list on separate piece of paper:

<table>
<thead>
<tr>
<th>Organization With Which Relationship Exists</th>
<th>Clinical Area Involved</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>1.</td>
</tr>
<tr>
<td>2.</td>
<td>2.</td>
</tr>
<tr>
<td>3.</td>
<td>3.</td>
</tr>
<tr>
<td>4.</td>
<td>4.</td>
</tr>
</tbody>
</table>

*If you checked "Speakers' Bureaus" in item B, please continue:

- Did you participate in company-provided speaker training related to your proposed topic?  
  Yes:  
  No:
- Did you travel to participate in this training?  
  Yes:  
  No:
- Did the company provide you with slides of the presentation in which you were trained as a speaker?  
  Yes:  
  No:
- Did the company pay the travel/lodging/other expenses?  
  Yes:  
  No:
- Did you receive an honorarium or consulting fee for participating in this training?  
  Yes:  
  No:
- Have you received any other type of compensation from the company? Please specify:  
  Yes:  
  No:
- When serving as faculty for ACOFP, will you use slides provided by a proprietary entity for your presentation and/or lecture handout materials?  
  Yes:  
  No:
- Will your topic involve information or data obtained from commercial speaker training?  
  Yes:  
  No:

DISCLOSURE OF UNLABELED/INVESTIGATIONAL USES OF PRODUCTS

A. The content of my material(s)/presentation(s) in this CME activity will not include discussion of unapproved or investigational uses of products or devices.

B. The content of my material(s)/presentation(s) in this CME activity will include discussion of unapproved or investigational uses of products or devices as indicated below:

I have read the ACOFP policy on full disclosure. If I have indicated a financial relationship or interest, I understand that this information will be reviewed to determine whether a conflict of interest may exist, and I may be asked to provide additional information. I understand that failure or refusal to disclose, false disclosure, or inability to resolve conflicts will require the ACOFP to identify a replacement.

Signature: [Signature]
Date: 3/7/17

Please email this form to joank@acofp.org as soon as possible
Deadline: Thursday, February 23, 2017
On the Frontlines with Alzheimer’s Disease: Diagnosis & Management

www.osteopathic.org/research/alz

Faculty Bio

Stephen M. Scheinthal, DO

- Chair, Department of Psychiatry – Rowan University School of Osteopathic Medicine
- Doctor of Osteopathy degree from the University of Medicine and Dentistry of New Jersey-School of Osteopathic Medicine (UMDNJ-SOM) in Stratford, New Jersey
- Distinguished Fellow of the American College of Osteopathic Neurologists and Psychiatrists, American Psychiatric Association and the College of Physicians of Philadelphia
- Recipient of a Geriatric Academic Career Award from the Health Resources Service Administration and is a member of the first Costin Institute class
Purpose

Foster patient communication, and utilize physician resources to address dementia, with a focus on Alzheimer’s disease (AD).

Learning Objectives:

- Incorporate the osteopathic approach and provide quality care to patients suffering from Dementia/Alzheimer’s Disease (AD)
- Recognize how the pathophysiology of AD starts earlier than the manifestation of AD symptoms
- Explain the need for starting the conversation early with patients and caregivers
- Identify the steps to take in screening and diagnosing patients
- Choose resources (tools and services) available to enhance the ability to diagnose and manage the disease for patients
Alzheimer’s Disease (AD) and the Importance of Early Detection

• What is Dementia?
• What is AD?
• Epidemiology
• Risk Factors
• Screening for cognitive impairment

PART 1.

What is Dementia and how is it related to AD?

• Dementia is not a specific disease - it is a collection of symptoms that can be caused by a number of disorders/diseases that affect the brain.
• It is not a normal part of the aging process.
• Memory loss is a common symptom of dementia, but by itself does not mean that a person has dementia.
• With dementia there is:
  • Significantly impaired intellectual functioning that interferes with normal activities and relationships.
  • Loss of ability to solve problems and maintain emotional control.
  • A possibility of personality changes and behavioral problems, (e.g., agitation, delusions, and hallucinations).
• Alzheimer’s disease (AD) is the most common cause of dementia in people age 65 and older.

http://www.ninds.nih.gov/disorders/dementias/dementia.htm
What is Alzheimer’s Disease (AD)?

- Irreversible, degenerative brain disorder
- Gradual loss of memory and thinking skills
- Eventual loss of the ability to carry out simple tasks
- Accounts for 60 to 80 percent of dementia cases
- Some treatments can help manage symptoms No known cure

Alois Alzheimer (1864-1915)

The earlier the detection the more effective the treatments!
Key Histopathological Features of AD

• 3 characteristic findings\(^1\)\(^-\)\(^5\)
  ✓ β-amylloid neuritic plaques
  ✓ Neurofibrillary tangles
  ✓ Degeneration with loss of neurons and synapses

• Definitive diagnosis is with histopathology

Click for Video (Pathophysiology)


Progression of Alzheimer’s Disease

Source: National Institutes of Health, National Institute of Aging
**Non-Modifiable Risk Factors**

| Age | • Strongest risk factor  
• Incidence of AD approximately doubles every 10 years after the age of 60 years |
| Genetic Factors | • Early-onset AD;  
• Amyloid precursor protein — APP gene  
• Presenilin 1 — PSEN1 gene  
• Presenilin 2 — PSEN2 gene  
• Trisomy 21 — (Down syndrome)  
• Late-onset AD;  
• Apolipoprotein E — APOE gene (APOE epsilon 4 (ε4) allele) |
| Mild Cognitive Impairment (MCI) | • May be a precursor to a dementia state |

---

**Modifiable Risk Factors**

![Diagram showing increases and decreases in risk factors for dementia](image_url)

*Fig. 2. Strength of evidence on risk*

M. Baumgart et al. / Alzheimer's & Dementia 11 (2015) 718-726
Need for Early Detection of AD

- Longer time for patient’s independence of activities of daily living
- Better control of concomitant medical issues (e.g., Diabetes Mellitus, Hypertension)
- Opportunity to plan for future and limit financial impact
- Delay long-term care placement

Signs that a Physician Needs to Screen a Patient

[Diagram showing symptoms of Alzheimer's disease, including:
- Memory loss/
changes in memory
- Forgetting words or
substituting inappropriate words
- Problems in
speaking, reading,
writing and
understanding
- Disorientation to
time and place
- Poor or decreased
judgment
- Problems with
abstract thinking
- Misplacing things in inappropriate places
- Drastic changes in personality
- Difficulty performing familiar tasks/routine chores]
Understand Normal vs Abnormal Aging

<table>
<thead>
<tr>
<th>Normal Aging</th>
<th>Abnormal Aging</th>
</tr>
</thead>
<tbody>
<tr>
<td>Making bad decision once in a while</td>
<td>Poor judgment and decision making</td>
</tr>
<tr>
<td>Missing a monthly payment</td>
<td>Inability to manage a budget</td>
</tr>
<tr>
<td>Forgetting which day it is and remembering later</td>
<td>Losing track of the date or the season</td>
</tr>
<tr>
<td>Sometimes forgetting which word to use</td>
<td>Difficulty having a conversation</td>
</tr>
<tr>
<td>Losing things from time to time</td>
<td>Misplacing things and being unable to retrace steps to find them</td>
</tr>
</tbody>
</table>

Source: https://www.alz.org/national/documents/aa_brochure_10warnsigns.pdf

Things Physicians Should be Aware of...

- Avoid cognitive screening solely on the basis of age
- Screen vulnerable elderly patients at their initial visit and annually thereafter
- Ensure that all patients who undergo cognitive screening are tested for depression
- Family/caregivers' information is integral to this process
Common Screening Tools for the Provider

<table>
<thead>
<tr>
<th>Cognitive Assessment Test</th>
<th>Administration Time</th>
<th>Scale (pts.)</th>
<th>MCI Sensitivity</th>
<th>Dementia Sensitivity</th>
<th>Dementia Specificity</th>
</tr>
</thead>
<tbody>
<tr>
<td>MiniCog</td>
<td>1-3 min</td>
<td>5</td>
<td>NA</td>
<td>76%</td>
<td>89%</td>
</tr>
<tr>
<td>MMSE</td>
<td>7 min</td>
<td>30</td>
<td>18%</td>
<td>78%</td>
<td>88-100%</td>
</tr>
<tr>
<td>SLUMS</td>
<td>10 min</td>
<td>30</td>
<td>92%</td>
<td>100%</td>
<td>81%</td>
</tr>
<tr>
<td>MoCA</td>
<td>12 min</td>
<td>30</td>
<td>90%</td>
<td>100%</td>
<td>87%</td>
</tr>
</tbody>
</table>

- MMSE – Mini Mental State Examination
- SLUMS - St. Louis University Mental Status Exam
- MoCA - Montreal Cognitive Assessment

Factors that may affect the results of screening...

- Patient gives up too quickly
- Allowing patient’s family to be in the room (at clinician’s discretion)
- Allowing family to help answer questions
- Physicians offer clues or multiple choice
- Biased scoring by coaching

Take the first answer given by a patient!
So, you have finished the screening process... what are the next steps?

Part 2.

The Osteopathic Approach to Diagnosing, Treating and Managing AD
# Steps to Take

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 1</td>
<td>• Recognize the osteopathic approach</td>
</tr>
<tr>
<td>Step 2</td>
<td>• Rule out other causes of cognitive impairment</td>
</tr>
<tr>
<td>Step 3</td>
<td>• Differentiate among degenerative dementias</td>
</tr>
<tr>
<td>Step 4</td>
<td>• Consider need for advanced diagnostics</td>
</tr>
<tr>
<td>Step 5</td>
<td>• Reach a clinical diagnosis</td>
</tr>
<tr>
<td>Step 6</td>
<td>• Talk to patient &amp; family - sharing results</td>
</tr>
<tr>
<td>Step 7</td>
<td>• Decide on pharmacological therapies and non-pharmacological approaches</td>
</tr>
</tbody>
</table>

1. **Recognize the osteopathic approach specifically encourages...**
   - The accurate geriatric assessment for dementia is bio/psycho/social by nature.
   - Detailed history and listening to the patient and their family.
   - Looking at the environment, medications, psychiatric issues, and social stressors.
   - Assessment of vision, hearing, nutrition.
   - Assessment of pain.
   - Review the patients medications and eliminate unnecessary medications.

*Evaluating the patient from multiple perspectives angles gives a more complete picture.*

*Dementia remains a diagnosis of exclusion.*
1) Obtain History
Detailed history from the family is essential
Work closely with family to understand what has changed
Medical history - Family & Patient

2) Conduct physical and neurological exam

3) Order lab tests and diagnostic imaging tests
Helps rule out other causes of dementia-like symptoms

Note: Yield of screening for reversible causes of dementia is very low, but is still necessary

Differentiating AD From Other Causes of Cognitive Impairment Is Challenging

- Mild cognitive impairment (MCI) can be confused with normal aging
- Symptoms of AD dementia frequently overlap with those of other conditions
- Differentiating degenerative or vascular etiologies from reversible ones is important
- Patients often present with multiple comorbidities, which can contribute to confusion about their diagnoses
- About 1 in 5 AD dementia diagnoses by experts do not have AD

Causes of cognitive impairment include
- Depression
- Delirium
- Thyroid dysfunction
- B12 deficiency
- Vascular dementia
- Parkinson’s disease
- Lewy body dementia
- Frontotemporal dementia
- Alzheimer’s disease
- Normal pressure hydrocephalus
- Substance or alcohol abuse
- Tumor
- Stroke
- Infection
- Sleep deprivation/ disorder

References:
Differentiate among degenerative dementias

- Alzheimer’s disease is the most common cause of dementia, accounting for 50% to 60% of all cases.
- The 4 most common non-AD types of dementia:
  - Vascular dementia (VaD)
  - Dementia with Lewy bodies (DLB)
  - Parkinson’s disease dementia (PDD)
  - Frontotemporal dementia (FTD); also called frontotemporal lobar degeneration (FTLD)
- Cases of mixed dementia also occur (e.g., AD comorbid with VaD or DLB)

Types of Dementia

<table>
<thead>
<tr>
<th>Disease</th>
<th>First Symptom</th>
<th>Mental Status</th>
<th>Neuro-psychiatry</th>
<th>Neurology</th>
<th>MRI Imaging</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alzheimer’s disease</td>
<td>Memory loss</td>
<td>Episodic memory loss</td>
<td>Initially normal</td>
<td>Initially normal</td>
<td>Entorhinal cortex and hippocampal atrophy</td>
</tr>
<tr>
<td>Dementia with Lewy bodies</td>
<td>Visual hallucinations, REM sleep disorder, delirium, Capgras’ syndrome, parkinsonism</td>
<td>Drawing and frontal/executive; spares memory; delirium prone</td>
<td>Visual hallucinations, depression, sleep disorder, delusions</td>
<td>Parkinsonism</td>
<td>Posterior parietal atrophy; hippocampi larger than in AD</td>
</tr>
<tr>
<td>Vascular</td>
<td>Often but not always sudden; variable; apathy, falls, focal weakness</td>
<td>Frontal/executive, cognitive slowing; can spare memory</td>
<td>Apathy, delusions, anxiety</td>
<td>Usually motor slowing, spasticity; can be normal</td>
<td>Cortical and/or subcortical infarctions, confluent white matter disease</td>
</tr>
<tr>
<td>Frontotemporal dementia</td>
<td>Apathy; poor judgment/insight, speech/language; hyperorality</td>
<td>Frontal/executive, language; spares drawing</td>
<td>Apathy, disinhibition, hyperorality, euphoria, depression</td>
<td>May have vertical gaze palsy, axial rigidity, dystonia, alien hand, or Motor Neuron Disease</td>
<td>Frontal, insular, and/or temporal atrophy; spares posterior parietal lobe</td>
</tr>
</tbody>
</table>

Testing to consider when diagnosis remains unclear or atypical clinical presentation:

- Formal neuropsychological testing
- Advanced MRI (volumetric, DTI)
- PET neuroimaging (amyloid, FDG)
- CSF analysis (Aβ, tau)
- Dopamine transporter SPECT scan
- Genetic testing

**Cognitive Domains Neuropsychologists Test**

**Purpose:** Looking for the strengths and weaknesses of function in the different parts of the brain.

**Neurocognitive domains**

- **Perceptual–motor function**
  - Visual perception
  - Visuconstructional reasoning
  - Perceptual–motor coordination

- **Language**
  - Object naming
  - Word finding
  - Fluency
  - Grammar and syntax
  - Receptive language

- **Executive function**
  - Planning
  - Decision-making
  - Working memory
  - Responding to feedback
  - Inhibition
  - Flexibility

- **Learning and memory**
  - Free recall
  - Cued recall
  - Recognition memory
  - Semantic and autobiographical long-term memory
  - Implicit learning

- **Complex attention**
  - Sustained attention
  - Divided attention
  - Selective attention
  - Processing speed

- **Social cognition**
  - Recognition of emotions
  - Theory of mind
  - Insight

Core Criteria for Diagnosis of All-Cause Dementia (NIA-AA)

Cognitive or neuropsychiatric symptoms that
1. Interfere with the ability to function at work or at usual activities
2. Represent a decline in patient's level of functioning
3. Cannot be explained by delirium or major psychiatric disorder
4. (cont. on next slide)

Reaching a clinical diagnosis

4. Involve a minimum of 2 of the following domains
   - Ability to acquire and remember new information
     Misplacing items, forgetting appointments, getting lost on a familiar route
   - Reasoning and handling of complex tasks, and judgment
     Poor decision-making ability, poor understanding of safety risks
   - Visuospatial abilities
     Inability to recognize faces or objects, inability to orient clothing to body
   - Language functions
     Difficulty thinking of common words while speaking; speech, spelling, and writing errors
   - Changes in personality, behavior
     Uncharacteristic mood fluctuations, apathy, social withdrawal, socially unacceptable behaviors

Cognitive impairment is detected and diagnosed through a combination of (1) history-taking from the patient and a knowledgeable informant and (2) an objective cognitive assessment

NIA/AA Core Clinical Criteria of Alzheimer’s Disease Diagnosis

According to the 2011 National Institute of Aging/Alzheimer’s Association (NIA/AA) guidelines, Alzheimer’s disease diagnosis requires core criteria be met \(^1\,^2\):

1. Report of cognitive concern by patient, caregiver or clinician
2. Gradual onset over months to years
3. Evidence of longitudinal cognitive decline
4. Differential diagnosis that rules out vascular, traumatic and medical causes of cognitive decline

Objective evidence of impairment in \(>1\) cognitive domains and maintains independence

Objective evidence of impairment in \(>2\) cognitive domains and unable to function at work or usual activities

MCI due to AD

Dementia due to AD

Possible AD: Atypical course or etiologically mixed presentation

Probable AD: Insidious onset, history of progressive worsening, & no evidence of CVD, DLB, FTD or aphasia

Proven AD: Meets widely accepted neuropathology criteria at autopsy


The Talk - Sharing Results

- The patient should typically not be excluded from being told the diagnosis
- Try to include all important family members
- Use the words Alzheimer’s disease (if applicable)
- Be sure to assess for the patient’s capacity for insight when disclosing the diagnosis, and maintain a sensitive approach to the patient and family members regarding what and how much information they are able to hear and absorb
Practical Explanation of the Diagnosis

• Define It – Dementia involves difficulty with memory or thinking and the most common form of dementia is AD

• Give the Facts – It is a clinical diagnosis supported by the work up

• Give Rationalization – Patients that fit the clinical diagnosis have symptoms seen in patients studied pre- and post-mortem who all had the same changes in the brain

• Emphasize Importance of Diagnosis – Treating the disease as early as possible

Decide on pharmacological therapies and non-pharmacological approaches

Pharmacological Therapies

Treatments for AD:

- Acetyl-cholinesterase Inhibitors (ACHEI)
  - Donepezil (Aricept)
  - Galantamine (Razadyne)
  - Rivastigmine (Exelon)
- NMDA Receptor Antagonist
  - Memantine (Namenda)
- Combination of the ACHEI & NMDA Receptor Antagonist
  - Memantine + Donepezil (Namzaric)
**Currently available medications -**

**Treat symptoms but cannot stop damage to brain cells**

**Acetylcholinesterase Inhibitors (ACHEI):**
- Prevent breakdown of acetylcholine
- Delay symptom worsening for 6 to 12 months, on average, in 50% of patients
- Side effects can lead to prescribing cascades
  - Agitation
  - Insomnia
  - Nausea and vomiting
  - Anorexia
  - Agitation/Pacing/Restlessness
  - Bradycardia/Syncope

**NMDA Receptor Antagonist:**
- Regulates activity of glutamate
- Delays symptom worsening for some temporarily
- Can cause side effects
  - Constipation
  - Confusion
  - Dizziness
  - Restlessness
  - Hyper-vocalization
  - Agitation

**IMPORTANT !!!**
- Recognize the side effects before adding additional medication.
- If you feel there is a side effect from one of these products decrease or stop the offending drug rather than adding a new drug.

---

**Alternative Approaches**

<table>
<thead>
<tr>
<th>Interventional Agent</th>
<th>Effects of Agent on AD (conclusive results still pending)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Curcumin</td>
<td>Binds and destroys beta-amyloid plaques,</td>
</tr>
<tr>
<td></td>
<td>Delays degradation of neurons, metal-chelation, anti-inflammatory, antioxidant</td>
</tr>
<tr>
<td></td>
<td>Decreases microglia formation which may improve the overall memory in patients.</td>
</tr>
<tr>
<td>Genistein</td>
<td>An isoflavone that has antioxidant and neuroprotective effects on AD.</td>
</tr>
<tr>
<td>S-Equol</td>
<td>May increase mitochondrial activity for AD patients.</td>
</tr>
<tr>
<td></td>
<td>(Phase I Clinical Trial)</td>
</tr>
<tr>
<td>Glycosaminoglycans</td>
<td>May play a critical role in the binding to amyloid beta proteins and amyloid fibril formation.</td>
</tr>
<tr>
<td>Alpha-GPC</td>
<td>A parasympathomimetic acetylcholine precursor which is being used in Europe</td>
</tr>
<tr>
<td>Caprylidene (Axona)</td>
<td>A medical food that is metabolized into ketone bodies, which the brain can use for energy even when its ability to process glucose is impaired.</td>
</tr>
</tbody>
</table>

Sources: (Stankowska et al., 2015; Tiwari-Woodruff et al., 2007; Tiwari-Woodruff et al., 2007; Ariga et al., 2010; Clinical Trials.gov)
Non-Pharmacological Approaches

- **Cognitive behavioral therapy (CBT)** - Explores relationships among a person's thoughts, feelings and behaviors, and developing constructive ways of thinking that will produce healthier behaviors and beliefs (*used primarily for treatment of co-morbidities such as anxiety*)

- **Cognitive stimulation training (CST)** – Aims to improve cognitive skills and quality of life through activities such as categorization, word association and discussion of current affairs.

**Remember…** *nutrition/diet and exercise may serve as protective factors and can be adopted in the management of AD*

Drugs to Avoid

**Beers List:**

- Avoid anticholinergic drugs
- Avoid tricyclic anti-depressants, especially Amitriptyline (Elavil)

Beyond Beers:

Antipsychotics

- Neuroleptic Malignant Syndrome
- Extrapyramidal Symptoms
- Cerebral Adverse Events
- Falls
- Sedation
- QTc Prolongation
- Sudden Death

Benzodiazepines

- Depression
- Confusion
- Stroke/Cerebral Adverse Events
- Falls/Fractures
- Sleep Disturbance
- Delirium

Behavioral Symptoms - To Treat or Not to Treat

- Behaviors in dementia require careful analysis
  - Agitation
  - Increased confusion
  - Ask yourself, is this behavior related to something else?
    - Pain
    - Hunger
    - Boredom
    - Communication
    - Acute infection
    - Side effects from another medication
    - Pseudobulbar affect (PBA)

- For most dementia related behaviors there is no pill to treat the behavior.
- If patient is on a medication and it is not working, STOP THE MEDICATION!
Part 3.

Resources & Support

Once the diagnosis is made patient and family need to discuss and put into place advance directives if not already done.

- Medical Planning
- Legal Issues
- Living Arrangements
- Driving Privileges

All of this should be done before competency issues arise!!!

Medical Planning

- Health & Long Term Care Insurance

Legal Arrangements

- Power of Attorney, Living Wills, & Physician Orders for Life-Sustaining Treatment (POLST)

Living Arrangements

- Independent Senior Apartment, Assisted Living Facility and Long Term Care
Patient & Caregiver Support

Working with the Family -

• Family members play an increasingly important part in the patient’s care

• Behavioral problems or mood disorders determine caregiver burden, depression and mental health which may affect patient care (van der Lee et al., 2014; Norton et al., 2013)

• Caregivers need interventions that promote positive care management and ways to react to caregiving challenges

• Counseling and support for the caregiver can help keep patients from premature institutionalization (Gaugler, Reese & Mittelman, 2013)

Phases of Patients & Caregivers – How Physicians can help

Patient & Family

• Coping with symptoms
• Establishing working relationships with health care team
• Grieving loss of “normal life” before illness
• Gradually accepting illness as long term
• Pulling together as a family
• Developing flexibility toward future goals.

Physician (Clinician)

• Family unit is vulnerable at this phase
• Health care professionals have enormous influence over a family’s sense of competence
• “Frame the event” when disclosing diagnosis

Phases of Patients & Caregivers – How Physicians can help

Patient & Family
- Coming to grips with long-term changes
- Devising an ongoing coping strategy
- Maintaining semblance of a normal life during heightened uncertainty

Physician (Clinician)
- Help families develop new priorities within a “new normal”
- Help families maintain sense of autonomy
- Normalize emotions of ambivalence and loss to reduce feelings of blame, shame and guilt


“Thank you, but I’m doing fine”
Caregivers Need Support too!!!!!!

- Stress the importance of self-care
- Advise them to get emotional support
  - ***Support Groups***
- Individual Therapy
- Employee Assistance Programs (EAP)
- Informal Support
- Caregiver / Disease Associations
- From other family and friends
Network of Support

- Alzheimer’s Association (http://www.alz.org)
- Act on Alzheimer’s (http://www.actonalz.org/)
- ADEAR - Alzheimer Disease Education and Research Center - National Institute on Aging (http://www.nia.nih.gov/alzheimers)
- Association for Frontotemporal Degeneration (AFTD) (http://www.theaftd.org/)
- CurePSP: Foundation for PSP CBD and related Brain Diseases (http://www.psp.org/)
- Local agencies on Aging (http://Eldercare.gov)
- Lewy-Body Dementia Association (https://www.lbda.org/category/3437/what-is-lbd.htm)

***Check and see what resources are available to patients in your community.***

Other Resources
Key Messages:

• AD is the leading cause of dementia in the US, but is not the only type

• The pathophysiology of AD starts earlier than the manifestation of AD symptoms

• The PCP is paramount in early detection, accurate diagnosis and treatment of AD and other dementia disorders

• Use the Osteopathic holistic approach which involves treating the patient and assisting caregivers

• Help patient and caregivers access the resources they need to treat and manage AD and other dementia disorders

Link to Online Toolkit:
www.osteopathic.org/research/alz

Please complete the Post-Survey & Evaluation

Thank you!!!