Case Presentation- Geriatric Behavioral Conference 2021.

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Disclosure

- I have no financial relationships to disclose.

Objectives

- Discuss challenges encountered when managing patients with Neurocognitive disorder.
- Recognize the role of physical exam in mental health.
- Identify treatment options for Lewy body dementia.

Identifying data

- 78 YOM, Caucasian male, never married, retired from law enforcement, was born and raised in Nebraska , living alone . Hx of PTSD, Depression, alcohol abuse and hearing loss
- Poor historian, Chart review and collateral Hx obtained from Sibling and patients neighbor/friend.

- CC
  - Refusing to take medications,
  - locking himself up in his apartment.
  - Refusing care from home health.
  - Suicidal ideations/ concerning statements.

HPI

- Referral from PCP for evaluation concerns of suicidal ideations, negative thoughts, medication non compliance, declining self care
- Patient had stopped taking his medications including diabetic medications.
- He had decreased oral intake, required assistance from the neighbor to help with some ADL.
- The neighbor noted piling up of newspapers in the front door as he spent most of the time indoors and had lost interest in reading newspapers.

- “sudden change of behavior”, - squeezing air out of a small dog and claimed that the dog attacked him.
- He was more irritable and negative, increased hopelessness. Intermittent suicidal ideations that were not very clear.
- Patient had also told the neighbor that his PCP had informed him that he did not have long time to live. He started arranging for his funeral. He contacted a cremation company and paid all the necessary fees.
- Hx of worsening depression, was started Fluoxetine which was stopped due to confusion and visual changes, ? Visual hallucinations.
- No known particular social stressors apart from multiple medical conditions and unconfirmed hx of being told that he had a short time to live.

- Patients cognition had significantly worsened in the last six months.
- Last SLUMS score of 25/30. He was more forgetful. Its reported that he once forgot his apartment while driving and his drivers license had been revoked on unclear circumstance.
- Patient continued to drive without a license. mostly drove to the liquor store.
- During initial evaluation patient was very random with his ans. He said " I have no power, I have no answers to your questions"
- ED evaluation was consistent with sepsis and anion gap metabolic acidosis. Patient was admitted to medical unit for further evaluation and stabilization.
- Review of system was limited due to patient being a poor historian. Neighbor reported worsening paranoia.

PHX

- Patient did not have known previous psychiatric hospitalization.
- He had a psychiatrist and was supposed to be on some meds. He was non compliant. He had a diagnosis of Depression, PTSD and Dementia,
- Medication trials , Fluoxetine, mirtazapine, Seroquel,
- History of Recurrent falls, bruises but was not seeking treatment. Difficulties with ambulation with unsteady gait.
- Hx of alcohol abuse,

- PMHx significant for CAD, s/p CABG, chronic low back pain, hypothyroid, BPH, HLP, HTN, DM2,

Psychosocial

- Born and raised – Lincoln Nebraska
- Had no issues when growing up. Raised by 2 parents no trauma
- Patient had 2 siblings living out of state. His older sibling (2yrs older) has MNCD in memory care and the other is ok living in Colorado.
- Drafted to Vietnam war after high school
- He retired from military had some college education and later joined local Sheriff department.
- Never married , No children
- Described to be isolative, secretive and not very close with his siblings. More solitary life in last 3-4yrs.
- Hobbies used to like hunting but stopped a couple of years ago.

- Only patients sister with MNCD,
- no other known mental illness in the family.
- Hx of Alcohol use in family.

MSE

- Appearance: 78 yo male who appears stated age. Sitting throughout interview. Decreased grooming. Abrasion noted along face and arms. Prominent abrasion on tip of the nose.
- Behavior: Calm .
- Psychomotor Activity; Globally slowed
- Speech: Random
- Mood: "depressed and confused "
- Affect: Constricted
- Thought Process: Loosening of association
- Thought Content: No AVH, Nihilistic
- Sensorium: Awake and alert
- Cognition: impaired
- Insight: Impaired
- Judgment: Impaired
- Suicidal: SI no specific,

Assessment

- 78 yo male with hx of depression and dementia who presented with deterioration of self care, isolative, poor appetite, refusing to take medications, refusing assistance from home care, locking self up, increased agitation, worsening feelings of depression and intermittent suicidal ideations,
- PCP has been concerned with cognitive decline for the last 6 months. Last SLUMS exam was 25/30. Etiology of symptoms were unclear in the setting of sepsis and metabolic derangements. The differentials included:
- Major NCD, with behavioral disturbance – Genetic
- Unspecified depression, VS MDD
- Delirium
- Alcohol Abuse

Plan

- Started Mirtazapine 7.5mg for appetite
- CIWA Protocal. Vitamins replacement
- Fluoxetine was held due to previous " confusion and visual changes? Hallucinations"
- Neuropsychiatric eval was recommended
- Admit to geriatric unit when bed Avail/ patient stable .
- Noted; Elevated Beta-hydroxybutyrate, elevated lactic acid, elevated troponin and low sodium , B12, folate, TSH wnl

Progress

- Day 2-3 Confusion with agitation , Seroquel was started 12.5 mg BID ,
- Day 4-5; Eating poorly, hypoglycemic episodes,
- Day 5-6; Reported feelings hopelessness, eating poorly, Mirtazapine increased to 15mg. Continued Seroquel.
- Day 6-7 Slums 18/25 , Aricept 5mg, Namenda 5mg initiated , Seroquel was identified as a barrier to placement to SNF. Patient was less agitated this medication was stopped.
- Day 7- 8, nihilistic, poor appetite, mirtazapine increased 30mg.
- Day 10; Still depressed, 0.25mgRisperidone was started for mood augmentation, agitation and paranoia.

- Day 11-12, poor appetite, hypoglycemic episode , somnolent , poverty of speech, Stopped as needed Melatonin, Hold Mirtazipine due to hypersomnolence.
- Day 12-13 , increased agitation, waking up several times at night, non redirectable, messing up with the computer in the room, raising voice to staff, lifted walker as if wanted to throw it to staff. Was given Haldol and Ativan , Sitter at bedside, more somnolent during the day
- Day 13-14 Started Melatonin 3mg PRN for sleep cycle, increased risperidone to 0.5mg BID
- Day 14 -15, worsening feelings of depression started Setraline, increased nemanda to 10mg.

- Day 15-16, increased Setraline to 100mg, well tolerated
- Day 18 ; Increased somnolence, poor participation in interviews , nuchal rigidity discontinued melatonin, medical team was informed, neurology was consulted, UA – positive for UTI , was started on Rocephin.
- EEG was perfomed wnl. LP and CSF unremarkable. CT scan- no acute findings
- Day 20 ; Nuchal rigidity persisted, Cog wheeling noticed in upper extremity, patient was hypersomnolent, Discontinued Risperidone 0.5 mg bid,
- Day 22-23 Afterwards, Nuchal rigidty improved, cog wheeling resolved, decreased hypersomnolence, poor appetite persisted,

- Patient was transferred to geriatric unit
- Mirtazapine was reinitiated
- Appetite improved
- Discharged to SNF on Setraline 150mg, mirtazapine 15mg, Aricept 5 mg , nemanda 10mg.
- Discharge dx MNCD Probable lewy Body,

  MDD

Neurocognitive disorder with Lewy body – discussion

- Core
  - Fluctuating; cognition, attention, alertness
  - Recurrent well formed visual hallucinations
  - Parkinsonian symptoms After cognitive decline
- Suggestive
  - REM sleep behavior disorder
  - Severe neuroleptic sensitivity

Probable >2 core features or 1 core / 1 suggestive

Possible: 1 core feature

RX Lewy body dementia

- Non pharmacologic interventions, meds , treat delirium, infections,
- Cholinesterase inhibitors, Denepezil/ Aricept, rivastigimine , no guidelines on the period of treatment, six months
- Antipsychotics; Quietipine – well tolerated in PD

  Clozapine PD psychosis – indirect support, (monitoring)

  Pimavanserin - clinical trial , FDA approved in PD psychosis
- SSRI
- Avoid Benzodiazepines,

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