

Dementia: Differentiation and Rehabilitation Strategies

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The APTA conference is coming to our neighborhood this June. It will be a conference to remember. But we both face it with excitement and some trepidation. Being a specialist in geriatrics has a down side at national meetings, at times. We see our peers in sports medicine and manual therapy projecting a veneer of being the “best“ in the profession.

When we encounter them after many years and we are asked our specialty there is an uncomfortable somewhat condescending moment. We feel like our specialty is not as rigorous or deserving of praise. This is a bad feeling. When we reflect on the complexity of our patients, their multiple co-morbidities and medications as well as challenging functional levels we wonder why anyone would not think we are the brightest and hardest working of the profession ? On top of that our patients may be in need of cognitive support and treatment modifications to achieve functional improvement.

Below is an introduction to just a few of the important facts about working with patients with dementia, a highly skilled area of physical therapy.

Rehabilitation of the patient with dementia requires specific evaluation, treatment, communication, and approach strategies for successful outcomes. Current literature has shown that physical therapy is effective with this population. For example, a study by Claire Toullotte et al in *Age and Aging* 2003, demonstrated significant improvements in walking, mobility, flexibility and balance of frail, elderly patients with dementia after receiving physical training. The challenge is finding appropriate techniques that connect with the patient with dementia and enable them to reach their maximum functional potential. Historically, Medicare intermediaries automatically denied rehabilitation services when ICD-9 codes for dementia were used. This unethical and unfair practice was overturned on September 25th, 2001 and we are now reimbursed for this patient population if adequate functional progress is made and it is clearly demonstrated that the skills of a professional were required to provide the services.

Evaluation of the patient with dementia requires differentiation of the specific type of dementia due to different medical managements, specific patient presentations, differing rates of decline, and the overall prognosis. The differentiation of dementia is often overlooked, with the patient being diagnosed as confused (which is like being diagnosed as having pain) or the patient may be diagnosed as having Alzheimer’s disease without an appropriate medical and psychiatric evaluation to rule out other causes.

The Physical Therapist can play an important role in the interdisciplinary assessment of the type of dementia through careful assessment of symptoms, onset, and patient risk factors that can lead to a fairly certain differentiation of the type of dementia. First and foremost, it is critical to determine if the patient is experiencing an acute or chronic disorder of dementia. This is critical secondary to acute disorders of dementia may be reversible if detected and treated promptly. The three most common types of acute disorders of dementia are delirium, depression, and normal pressure hydrocephalus.

Delirium is an abrupt change in mental status with global, fluctuating, cognitive impairment, alterations in consciousness (hyper or hypo alert), disorientation to time, and occasional periods of lucidity. Studies show that the incidence of delirium is particularly high with patients after a hip fracture repair at 50%.

Depression is often called the pseudodementia due to the cognitive symptoms that may appear to be dementia, such as poor concentration, memory problems, and apathy. Depression affects 25-50% of the elderly and can significantly decrease motivation and participation in the rehabilitation process. There are valid and reliable screening tools for delirium and depression that the Physical Therapist can use to accurately assess for the presence of delirium or depression. Nearly 50% of delirium cases and 70% of depression cases go undetected and therefore untreated. The patient with dementia is at high risk for delirium and depression and need to be monitored carefully for abrupt changes in their baseline cognition.

Normal pressure hydrocephalus is recognizable by the abrupt onset and clinical triad of an acute cognitive change, unsteady shuffling gait, and urinary incontinence. It is treatable with placement of a shunt or repair of a malfunctioning shunt. If untreated, the cognitive changes will become irreversible.

The differentiation of a chronic disorder of dementia by the Physical Therapist can assist in knowing the probable rate of decline, typical symptoms, and aide in working with the interdisciplinary team on appropriate medical management. The three most common types of chronic disorders of dementia are Alzheimer's disease, dementia with Lewy bodies, and vascular dementia. Alzheimer's disease accounts for 50% of the cases of dementia and has a slow onset, with the early symptoms being STM problems and word finding problems. Gait changes usually occur in the middle to late stages of the disease process. The life expectancy is from 8-20 years once being diagnosed with Alzheimer's disease.

Dementia with Lewy bodies is often misdiagnosed as Alzheimer's disease or Parkinson's disease and accounts for 20% of all dementias. The early symptoms of dementia with Lewy bodies are impairments with attention, logical thinking, and spatial and time perceptions. Memory problems are not a typical early symptom as seen in Alzheimer's disease. Within the first year of onset of dementia with Lewy bodies the patient usually presents with parkinsonian motor problems and visual hallucinations. Gait changes usually occur within the first year of the disease due to the parkinsonian motor problems and sensory deficits. Dementia with Lewy bodies is also recognized by fluctuations in memory and cognition that are not seen in other types of dementia. Life expectancy is 5-7 years after the onset of dementia with Lewy bodies.

Vascular dementia accounts for 10-20% of the cases of dementia and is recognizable by the presence of focal neurological signs and a step-wise progression of symptoms. Once risk factors are managed medically, such as HTN or CAD, the progression of this form of dementia may be dramatically slowed or stopped. Early gait changes at onset, with a history of multiple CVA's are signs that may assist in differentiating this type of dementia.

Rehabilitation strategies for the patient with dementia include specific communication and approach strategies that enable the physical therapist or assistant to connect with the patient and use our traditional interventions. Communication strategies include increased use of nonverbal communication, to speak more slowly in simple phrases, with increased time given for processing, the use of multi-sensory cues, minimizing environmental distractions, the use of reassuring touch, and listening to the emotions behind what a patient is saying. I find it helpful to visit with the patient for a few minutes, talking about their life story and forming a rapport, prior to initiating the evaluation or treatment process.

Approach strategies include use of the patient's life story to connect and reassure if they are fearful, increased use of familiar function oriented tasks, and asking the patient to help you do something. For example, instead of having a patient walk up the hallway and back to perform gait training, have them help you bring something to someone or help you look for something. The use of function oriented tasks greatly improves a patient with dementia's ability to participate in the task. For example, if I want a patient with dementia to perform repeated transfers for strengthening and balance, I will ask if they need to use the toilet or look for the most comfortable chair. The patient with dementia is very sensitive to being rushed or hurried and can accurately read your nonverbal language. Approaching the patient with dementia with caring, patience, and respect as an elder in an unhurried manner will go a long way. It is imperative that we continue to improve our skills in working effectively with the patient with dementia as the population is rapidly growing and requiring our services.

Armed with good information and high skill level in treating our complex patients with dementia we will show are peers that we are an important and highly skilled specialty in the profession. As we greet our friends this June with confidence this will be a conference to remember.

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