



# Dementia End-of-Life Care

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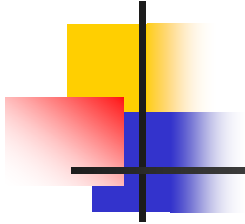
Dr. L. Badenhorst  
Riverview Health Centre  
*Behaviour Management*  
*Chronic Care*



# End-of-Life Care in Dementia

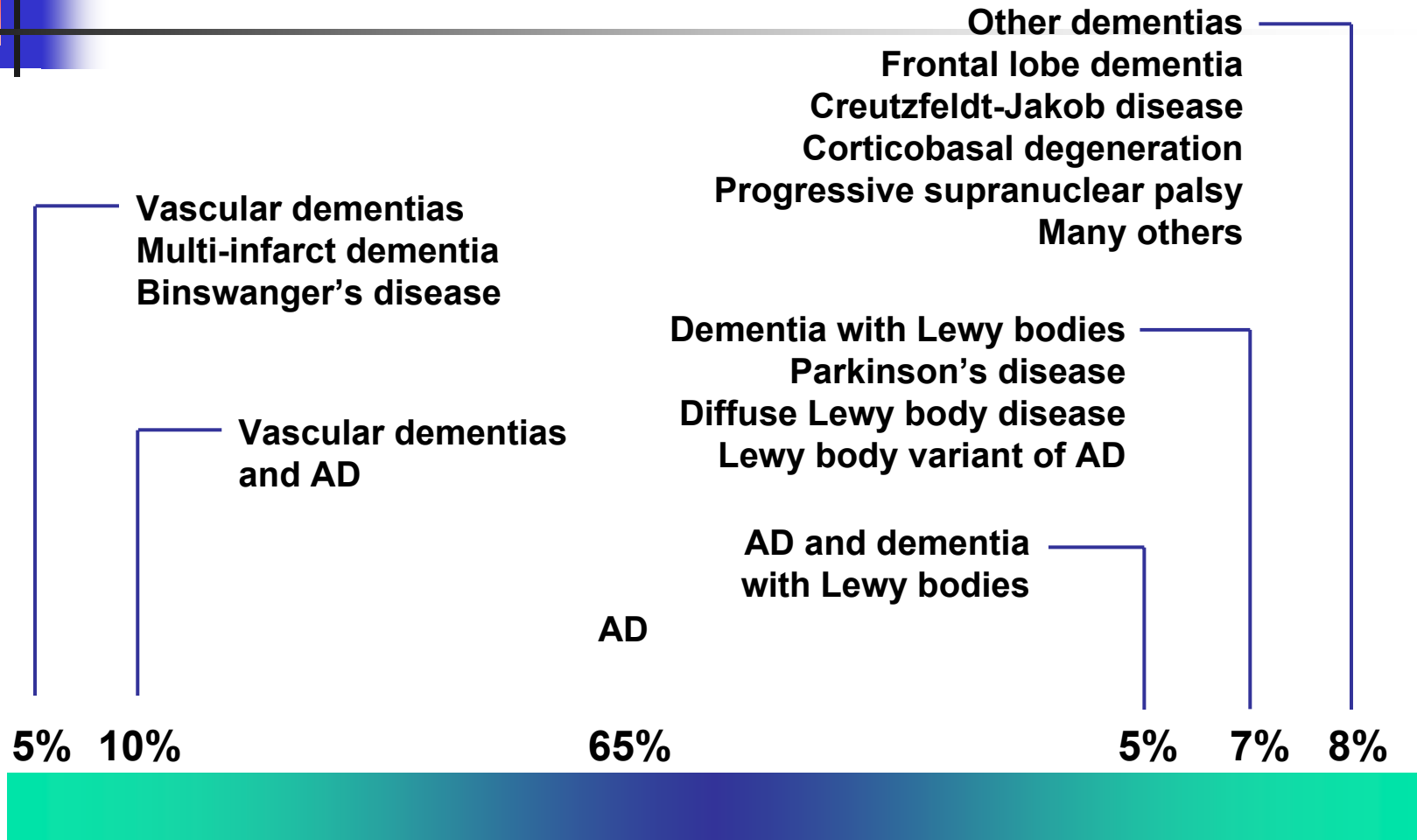
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- ⇒ Definitions
  - ⇒ Dementia
  - ⇒ Palliative Care
  - ⇒ End-of-Life care
- ⇒ Challenges
  - ⇒ Diagnosing End-Stage Dementia
  - ⇒ Managing End-Stage Dementia
- ⇒ Conclusions
- ⇒ Discussion



Dementia is a global impairment of every aspect of the intellect, memory and personality without alteration of consciousness.

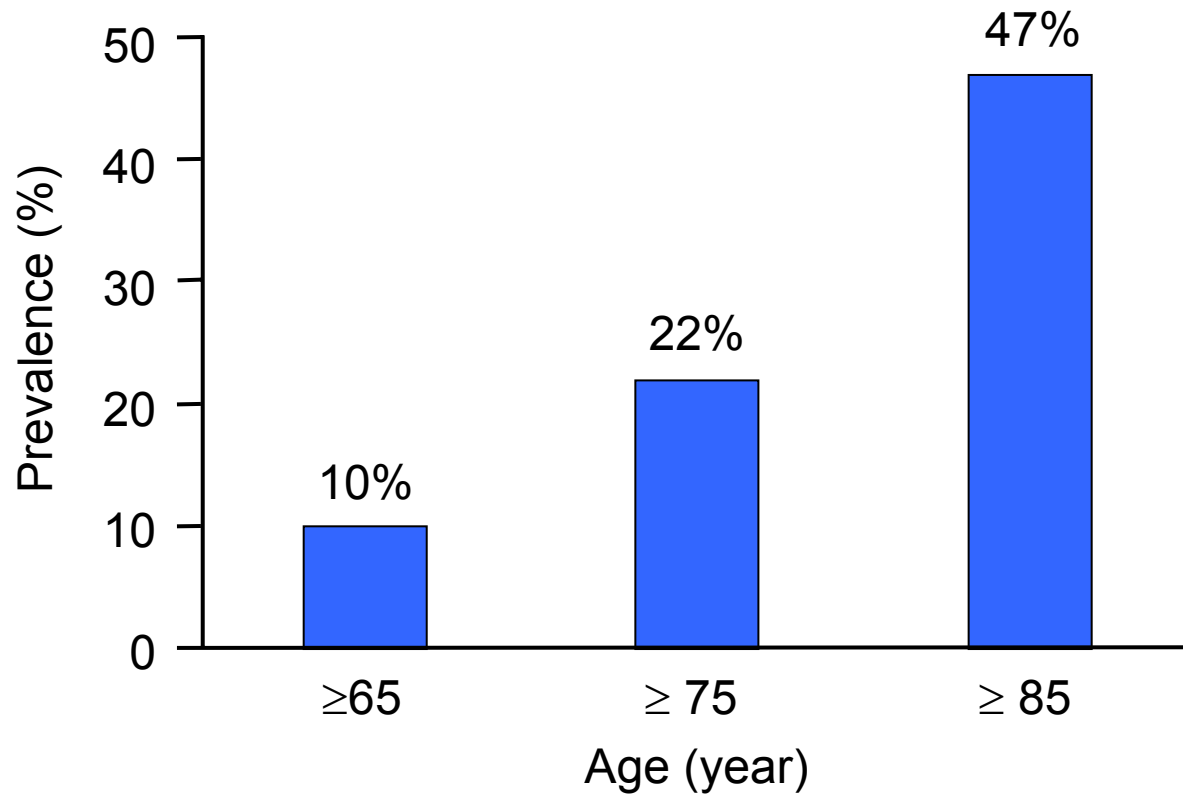
# Differential Diagnosis of Dementia



Small et al, 1997; APA, 1997; Morris, 1994.

# Dementia

## Prevalence Increases with Age



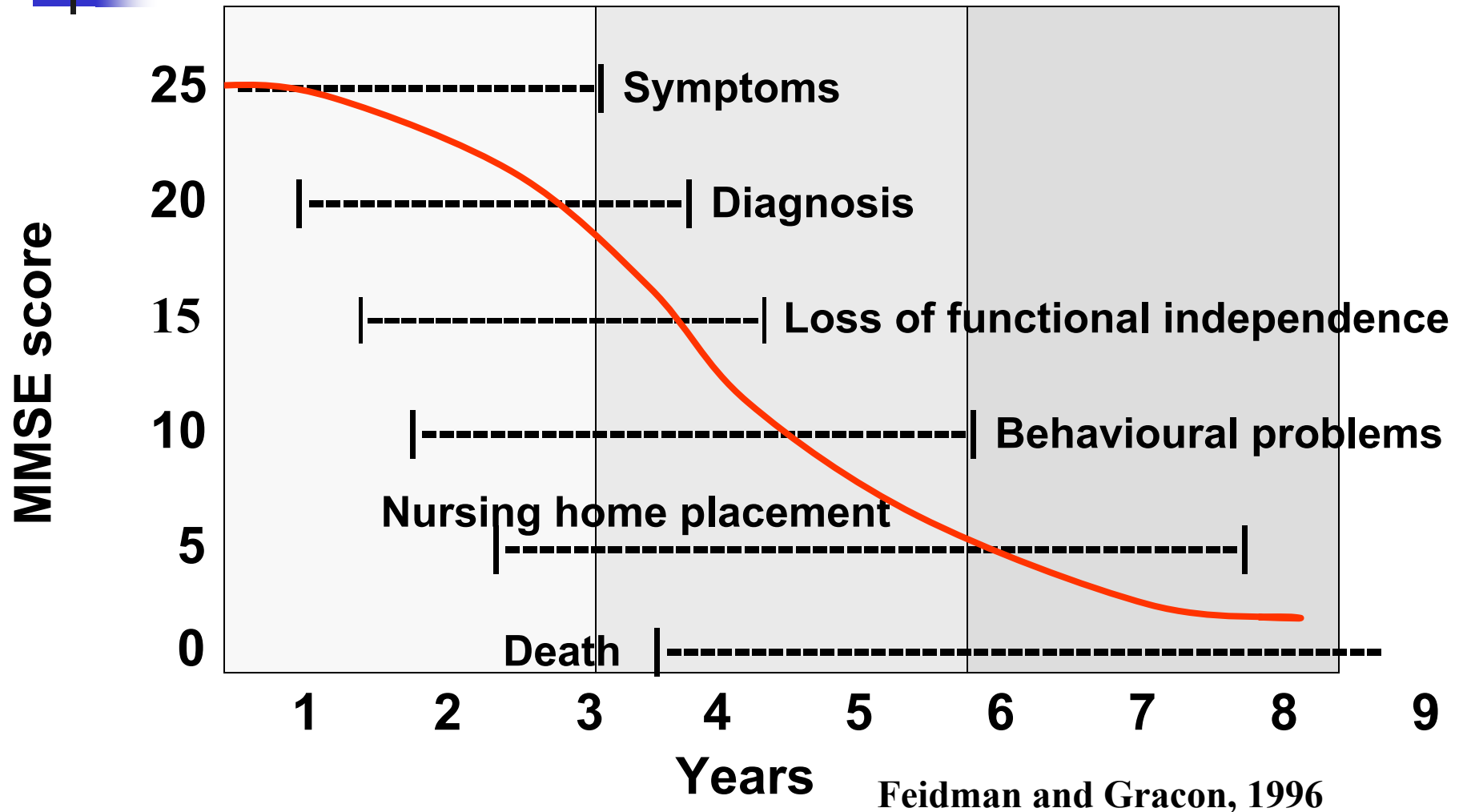


# Alzheimers: Overview

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- Progressive, degenerative CNS disorder
- Characterised by memory impairment plus one or more additional cognitive disturbances
- Gradual decline in three key symptom domains
  - Activities of daily living (ADL)
  - Behaviour and personality
  - Cognition

# Alzheimers: Progression





# Alzheimers: Burden

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- Caregivers of persons with AD or related disorders require
  - 46% more physician visits
  - 71% more prescribed medications
  - Higher diastolic blood pressure
  - Hypercoagulable state
  - Higher plasma norepinephrine

Haley WE, Levine EG, Brown SL, et al. Am J Geriatr Soc. 1987(May);35(5):405-411; Shaw et al., J Psychosom Res 2003; 54:293-302; vonKanel et al., Am J of Cardiol 2001(June);87:1405-1408; Grant I, Psychosom Med 1999; 61:420-423



# Hospice Palliative Care

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## Definition:

- ⇒ Relief of suffering and improved quality of life for persons who are dying or are bereaved.
- ⇒ Comfort, dignity and best quality of life for both the person and family.
- ⇒ Physical, psychological, social, cultural, and spiritual needs.



# Palliative Care Delivery

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**Primary Care**

**Secondary  
Care**

**3<sup>0</sup>  
Care**



# Curative vs. Palliative Care

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**Curative  
Care**

**Palliative  
Care**

**Diagnosis**

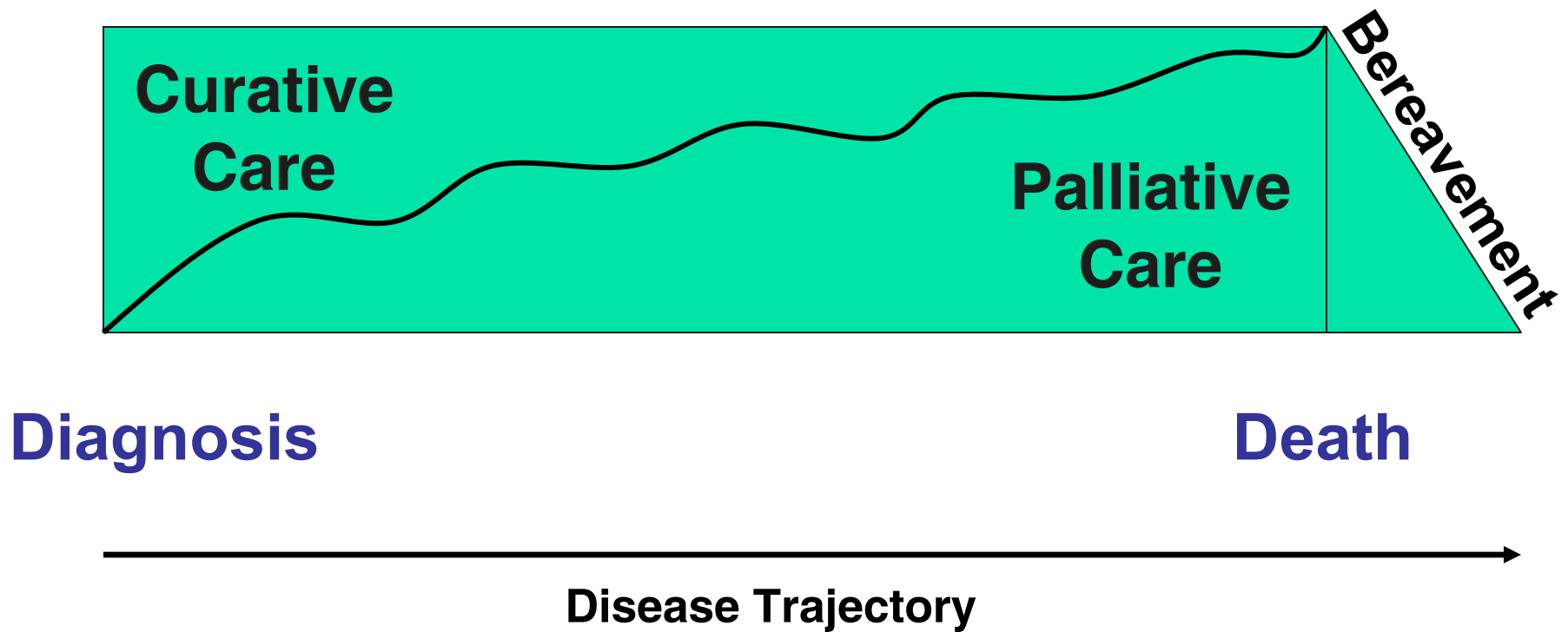
**Death**

**Disease Trajectory**





# Curative vs. Palliative Care





# End-of-Life Care for Seniors

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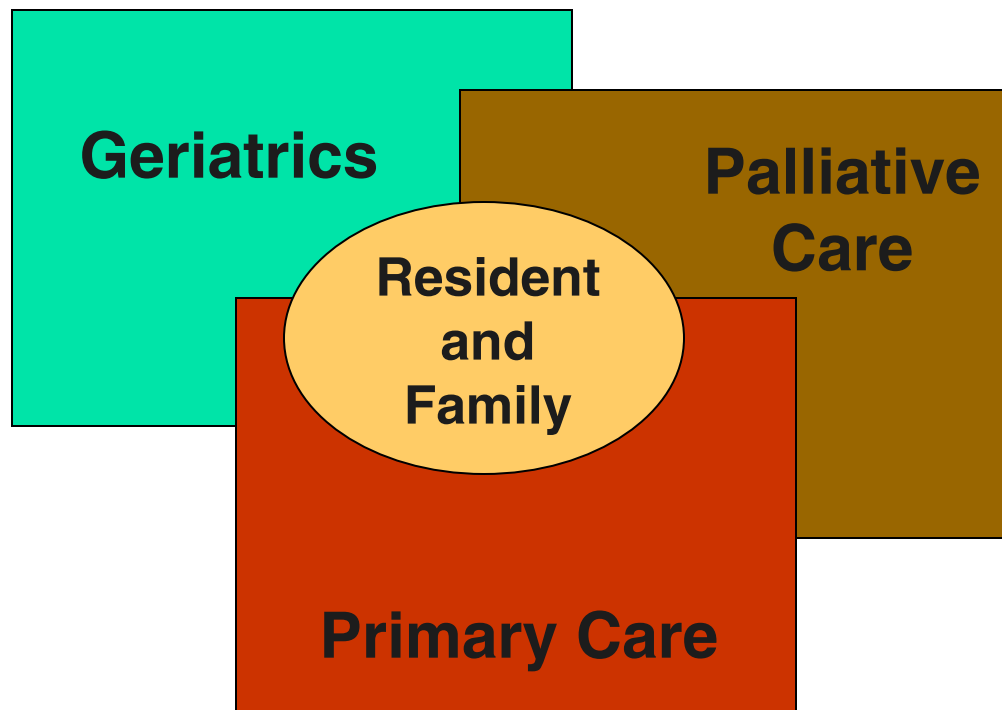
- requires an active, compassionate approach that treats, comforts and supports older individuals who are living with, or dying from, progressive or chronic life-threatening conditions.
- is sensitive to personal, cultural and spiritual values, beliefs and practices.
- encompasses support for families and friends up to and including the period of bereavement.



# End-of-Life Care for Seniors

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Delivery Model:





# Successful Ageing?

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- The success in ageing has led to viewing these aged individuals (successful in their efforts) as a “burden” to society
- This is especially the case for frail elders suffering from dementia



# Implications of Ageing

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- Clinical- what interventions achieve what goals: multiple, chronic medical problems
- Economic - what is society prepared to spend on the care of the elderly- and who will pay for what?
- Ethical- what is the impact on society's fabric of the decisions that are made?



# Challenges in End-of Life Care

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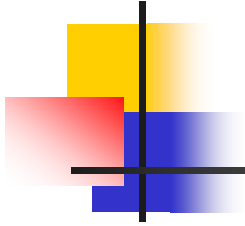
- Co-morbidities
- Cultural issues
- Directives for care
- Effects of aging
- Grief and Loss



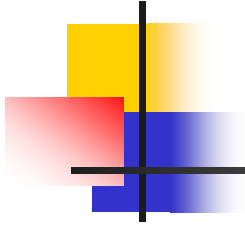
# PCH scenario

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- Changing patient population
  - Multiple pathology
  - Increased frequency of dementia,
  - Reduced length of stay
- No change in staffing
- Non-adaptive environments

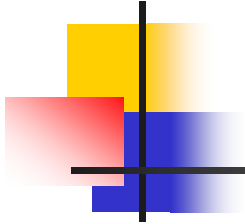


If you were dying, would  
you choose to die in  
your institution?

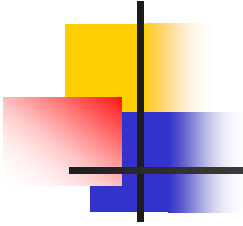


If your mother was dying,  
would you want her to die  
in your institution?

Your partner?

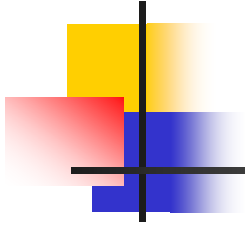


If your mother or partner had dementia, would you want him or her to die in your institution?



The dying need the friendship of the heart . . . its qualities of care, acceptance, vulnerability; but they also need the skills of the mind - the most sophisticated treatment medicine has to offer.

Dame Cicely Saunders



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Dementia  
is a  
Terminal Illness



# Diagnosing Terminal Dementia

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- Denial of terminal illness
- Inability to predict the time of death
- Health care financial incentives



# End-Stage Dementia: Diagnosis

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- A. Cognition
- B. Function
- C. Behaviours



## *A. Cognition*

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- Amnesia
- Agnosia
- Aphasia
- Apraxia
- Loss of executive function



## *B. Function*

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- IADL & ADL
- Nutrition
- Continence
- Sleep



## *C. Behaviour (BPSD)*

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- Biological triggers
  - neuro-chemical
  - delirium
- Psychosocial triggers
  - Premorbid personality
  - Prior psychiatric illness
  - Change in social milieu



# Meds associated with BPSD

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- Antipsychotics
- Paxil
- TCAs
- Steroids
- Stimulants
- Anticonvulsants
- Anti-histamines
- Anti-parkinsons
- Narcotics
- Alcohol



# Meds associated with BPSD

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- Diuretics
  - Furosemide
  - HCT
  - Triamterene
- Digoxin
- Theophylline
- H2 blockers
  - Ranitidine
- Isordil
- Nifedipine
- Warfarin



# Management of End-Stage Dementia

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- Accommodate *Cognition*
- Optimise *Function*
- Modify *Behaviour*



# Environmental Interventions

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- Calm consistent environment
- Emphasize cognitive strengths
- Music / Light / Pets
- Occupational planning
- Programming
- Safe environment for wandering



# Clinical Interventions

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- Treat pain
- Manage constipation
- Correct sensory impairment
- Pharmacotherapy



## Some Specific Attributes...

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- Resistance with personal care
- Wandering, pacing and exit-seeking (including door pounding)
- Inappropriate sexuality
- Inappropriate voiding
- Inappropriate verbalising (calling out, screaming, foul language, repetitive questions)



## Other Symptoms

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- Aggression
- Anxiety
- Depression
- Insomnia
- Pain/physical discomfort



# Pharmacotherapy in Dementia

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- **START LOW, GO SLOW and CHECK OFTEN!**
- Combine with non-pharmacologic assessment and management
- Tolerability to agents is often different depending on age, body mass, gender and diagnosis
- **REVIEW and REDUCE!**



## Medications...

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- Anti-psychotics
- Anti-depressants
- Benzodiazepines
- Anti-convulsants
- Others



## Anti-psychotics...

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- Good evidence for their use
- Atypicals less risk of TD
- Fewer side effects/more tolerable
- Examples:
  - Risperidone 0.25 to 1.0 mg per day
  - Olanzapine 2.5 to 5 mg per day
  - Quetiapine 25 to 300 mg per day



## Anti-psychotics...

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- Typicals have higher risk of TD
- More side effects
- Examples:
  - Haldol 0.5 mg to 5 mg per day
  - Nozinan 5 mg to 100 mg per day
  - Loxapine 5 to 50 mg per day
  - Chorpromazine 25 to 100 mg per day



## Anti-depressants...

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- Evidence for treatment of comorbid depression, anxiety, obsessions, and some irritability
- SSRI's are first line
- Choice vs side-effects



## Benzodiazepines...

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- Good for short term relief and anxiety
- Some evidence for restless legs, myoclonus
- Problems:
  - Tolerance to effects
  - Worsens cognitive status
  - Paradoxical agitation
  - FALLS!!!



## Anti-convulsants...

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- Good evidence for treatment of mood lability, aggression, agitation
  - Carbamazapine 50 to 600 mg per day
  - Valproate 125 to 750 mg per day
  - Gabapentin 300 to 1800 mg per day
- Multiple Interactions



## Others...

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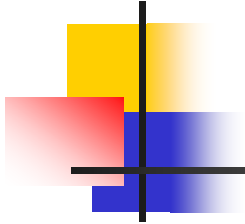
- ACEI's
  - Not usually initiated in terminal dementia
- Hormones
  - Provera 150 mg weekly or monthly
- Trazadone
  - 25 to 100 mg as sedative



# Food for Thought

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- Ageing is the 20th century success story
- Goal: increase quality of life not just life expectancy
- Individuals with dementia present a special challenge



“the life span of any civilization can be measured by the respect and care that is given to its elderly citizens and those societies which treat the elderly with contempt have the seeds of their own destruction within them”.

*Arnold Toynbee*