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VANTAGE POINT

Alzheimer's disease – helpful guidelines for a general practitioner

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Alzheimer's disease, a progressive, degenerative disease affecting all areas of functioning, is best treated holistically by a multi-professional team. Most often the patients and family members present to the general practitioner or community clinic. This practical article serves to assist the general practitioner with helpful guidelines to best manage the patient and their family from diagnosis to death.

Keywords: Alzheimer's disease, mini-mental state examination (MMSE); Montreal Cognitive Assessment (MoCA)

Background

There is undoubtedly an increase in the number of people diagnosed with dementia worldwide and caring for persons living with Alzheimer's disease and their loved ones is a multi-professional task that most often starts with a visit to the family general practitioner or the local clinic. Drawing from practical experience, to assist in this time-consuming, multifaceted medical process, a framework has been compiled to assist the general practitioner cover the bases required for effective management from intake.

Diagnosis

A good clinical interview is essential at the outset. This is time-consuming but important to listen to the patient and ideally also a family member and to hear what symptoms are being presented for collateral information.

The early diagnostic process includes:

- A detailed history
- Physical examination
- Blood tests (e.g. thyroid, vitamin deficiency, cholesterol)
- Brain scan (if possible)
- Neuropsychology assessment (if possible)
- Screening test: mini-mental state examination/Montreal Cognitive Assessment (MMSE/MoCA)

Alzheimer's disease can be difficult to diagnose, and a true diagnosis is still only possible after an autopsy. In making a diagnosis, it is important to exclude the following symptoms of confusion and memory loss, for example, constipation, urinary tract infections, high temperature, pneumonia, very low blood pressure, dehydration, stroke, low folic acid levels, vitamin deficiencies, brain tumour, stress and trauma.

The checklist given in Table I provides information on the most commonly observed signs and symptoms of Alzheimer's disease.

Table I: Typical signs of Alzheimer's disease

	Yes	No
Memory loss that disrupts daily life		
Challenges in planning and problem solving		
Misplacing things and losing the ability to retrace steps		
New problems with words in speaking and writing		
Poor short-term memory, repeating themselves		
Trouble understanding usual images and spatial relationships		
Inability to look after themselves and perform activities of daily living (ADLs)		
Changes in mood and personality		
Withdrawal from work and social activities		
Decreased or poor judgement		
Disorientation in time/place/person		

Should the general practitioner feel there is sufficient medical evidence to diagnose Alzheimer's, it is very important to be able to communicate this to the person and family. Most people battle to understand the difference between 'Dementia' and 'Alzheimer's' and value a clear understanding of the terminology. Persons living with Alzheimer's disease and their families are usually keen to know how far progressed the disease is. Whereas some literature refers to a number of different 'stages', in the writer's experience, 'mild', 'moderate', 'severe' and 'terminal' are more helpful terminology. The score of the MMSE/MoCA, as well as the intensity of the signs and symptoms (Table II), help a practitioner gauge this stage.

Management

Depending on the progression of the disease, a memory enhancer is experienced to be helpful to prescribe as it can slow down the progression of the disease. When the disease reaches later moderate or severe stages, it appears that this medication is of little value. As the disease progresses, medication to manage

Table II: Signs/symptoms in the stages of the disease

Mild	Moderate	Severe
Stress	Restless	Fragmented memory
Depression	Wandering	Impaired word finding
Forgetfulness	Loss of previous skills	Agitation
Erratic behaviour	Forgetfulness	Sleep disturbances
Poor concentration	Disorientation	Whimpering/screaming/difficulty moving/bedridden
Withdrawal	Repeating themselves	Can't recognise familiar people
Irritability	Bewildered	Battles to speak
Anxiety	Aggressive	Completely dependent
Denial	Volatile	
Compensation	Defensive	
Rationalisation	Resisting grooming	
Getting lost in familiar places	Disjointed conversations	
Loss of competency	Hoarding	
Long-term memory intact	Short-term memory impaired	
	Needs help with most/all ADLs	

Table III: Referrals for person with Alzheimer's/family

Mild stage	Moderate stage	Severe stage	Terminal
	Carer/care facility	Carer/care facility	Bereavement counselling
Medical and exclusion of alternatives and medication	Assistance with ADLs	Support group counselling for carers/family	
		Legal – curatorship	Legal – estate
Counselling	Legal – curatorship		
Psychological education/support group	Support group for family/carers		
Legal – management of finances	Respite for carers/family		
Occupational therapy	Medication		

behaviour – like restlessness and aggression – is known to be very helpful. Medication to relieve anxiety and depression is also helpful for some patients living with Alzheimer's disease. As previously noted by the author, the management of Alzheimer's disease, as well as other dementias, is a multi-professional process and a holistic approach is advocated.

The referrals in Table III are helpful for the general practitioner to make in the various stages.

From experience, after diagnosis, referral to a psychiatrist is generally more helpful than a neurologist as the focus is more on the management of the symptomatic behaviour of the disease. Regarding the referral to a care facility or choosing a home-based carer, this is believed to be a personal choice. Unless there are specific nursing considerations that are best met in a care facility, the psychosocial circumstances of the family usually direct the choice. A person living with Alzheimer's disease can be cared for in either context.

As the disease progresses, due to the nature of the disease, the focus changes to the carer/family of the patient, as long as the person living with Alzheimer's disease is well managed. The carer/family is often physically exhausted and emotionally struggling with the changed roles (e.g. from spouse to carer or child to carer) and the emotional loss of who the person/patient used to be. This will very likely be the focus of help that the general practitioner needs to manage.

In conclusion, sadly this disease is very neglected by our society, probably largely because it cannot be 'cured' and is a time-consuming intervention. However, this disease can be well managed, and limited but helpful resources are available. Alzheimer's South Africa is represented in all provinces of South Africa. Dementia SA is also a very resourceful organisation, to name but two aged care organisations.

Resources

1. Alzheimer's South Africa – 011 792 2511 / info@alzheimersa.org
2. Dementia SA – 021 421 0077 / assistance@dementiasa.org

Reference

Alzheimer's South Africa Training Manual.