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Helping Patients After Diagnosisng Mild Cognitive Impairment

TREATMENT FOR MILD COGNITIVE IMPAIRMENT

Mild cognitive impairment occurs in up to 29% of our geriatric patients, what should we be doing after the diagnosis is made.

Welcome to The Clinician's Roundtable. I am Dr. Leslie Lundt, your host, and with me today is Dr. Joe Goveas, assistant professor in the Department of Psychiatry and Behavioral Medicine at the Medical College of Wisconsin in Milwaukee.

DR. LESLIE LUNDT:

Welcome to ReachMD.

DR. JOE GOVEAS:

Happy to be here, Dr. Lundt.

DR. LESLIE LUNDT:

Please review for us the statistics for mild cognitive impairment, who gets it and how often.

DR. JOE GOVEAS:

Mild cognitive impairment or MCI is present in an estimated 8 million individuals in the United States. It's a syndrome that is seen in roughly 30% of individuals above age 85 and one in five individuals between 65 and 85 has this condition as well so it's a very common syndrome and is thought to be in many cases a prodromal state of Alzheimer's or non-Alzheimer dementias.

DR. LESLIE LUNDT:

What should we be doing after we make the diagnosis of mild cognitive impairment?

DR. JOE GOVEAS:

If the person who is making the diagnosis is a primary physician or the person who is suspecting the MCI diagnosis is a non-expert in the field of memory disorders, then it will be reasonable to at least entertain the need to refer this individual with possible or probable MCI to an expert in the field. The experts could be a geriatric psychiatrist. It also could be a behavioral neurologist or a dementia specialist, a geriatrician, and also this person should be referred to formal neuropsychological testing if that is available. Objective formal testing that is more than what's used in an office based screening should be considered if a suspicion of MCI is entertained.

DR. LESLIE LUNDT:

Is there a place for neuroprotection in our management of these folks?

DR. JOE GOVEAS:

That's an excellent question. Yes there is and there are several. To start with, we need to keep in mind that there is no approved treatment for MCI, so neuroprotection and nonpharmacological approaches have a huge role in caring for a patient with MCI. One of the issues that we commonly see in our practice is in individuals, who comes with a possible MCI diagnosis is that they are on several medications as we all know most of our elderly are on at least half a dozen medications, if not more. Many of these medications may have anticholinergic effects so if possible eliminating drugs that are significantly anticholinergics would be a place to start and primary physicians should be keeping this in mind. Some of the drugs that are anticholinergic and are commonly used include the tricyclic antidepressants like Elavil or amitriptyline that many a times we see primary physicians prescribe for chronic persistent pain or sleep difficulties. Also, you see these drugs prescribed for depression as well. I am not a huge fan of these medications especially in individuals, who have cognitive impairment. Conventional and certain newer generation antipsychotics are also problematic, antihistamine drugs over-the-counter Benadryl that many of our elderly patients use, Tylenol PM can all be affecting that person's cognition. Drugs used for urinary incontinence like oxybutynin and Detrol are quite anticholinergics. Muscle relaxants, certain antiparkinsonian drugs are drugs that, if possible, should be eliminated. There is also an issue about under-diagnosis of alcohol misuse or alcohol abuse in our elderly population and the patients should be carefully reviewing history of alcoholism after the current abuse of alcohol in the cognitively impaired individuals. If possible, the physician should also try to eliminate drugs that are sedatives like benzodiazepines. On several occasions, we all come across patients who are prescribed Valium or diazepam, lorazepam, and alprazolam and these drugs could also affect cognition and should be avoided. Opioid analgesics should also be limited and may be even eliminated if possible. The other way to protect the nerve cells is by controlling cerebrovascular risk factors like hyperlipidemia, diabetes, hypertension, and obesity as well as metabolic syndrome trying to aggressively treat these is very important. Depression in elderly is also thought to be a risk factor for subsequent incident dementia as well as mild cognitive impairment, so aggressively treating depression may also delay the progression from MCI to dementia as well. There are several other ways to protect the nerve cells including having a healthy lifestyle. It's something that we all should be educating our patients about regardless of their cognitive status that includes good nutrition as you may be aware of a lot of our elderly have poor dietary intake that may also result in vitamin B12 deficiencies, so a good nutrition is important for getting enough vitamin and mineral resources to the brain, drinking sufficient amount of water, keeping themselves hydrated unless a physician is limiting liquid intake in a particular individual is important. Daily physical exercise, something that is talked about quite often, but never carried out, is moderate exercise at least 30 minutes per session a minimum of three times a week, if possible, at least 5 times a week would be excellent. Daily brain exercise whether that is doing crossword puzzles, reading, discussing with the significant other or friends the reading material, visiting with friends, doing tasks, working on enjoyable projects, developing leisure activities, trying to learn something new every day, playing a musical instrument if someone has interest in that, listening to music, taking photographs, looking into photo albums, reminiscing about their past experiences could all be very helpful. There are certain drugs and also certain herbs or over-the-counter drugs that may not be very good for the brain and should be inquired, about eating foods that is rich in antioxidants, whole grains, food that is rich in omega-3 fatty acids using green leafy vegetables, asparagus, and other diet that is rich in vitamin E, eating cold water, fish which I personally like,

Mackerel or Salmon or certain Tuna would all be very rich in omega-3 fatty acids and can promote nerve cells and healthy body and mind.

DR. LESLIE LUNDT:

If you're new to our channel, your listening to ReachMD XM 157, The Channel for Medical Professionals. I am Dr. Leslie Lundt, your host, and with me today is Dr. Joe Goveas. We are discussing possible interventions for mild cognitive impairment.

Okay, Dr. Goveas in our last few minutes the big question is, do we medicate with the dementia drugs or not?

DR. JOE GOVEAS:

Well, that's a question that I am asked always after I make a diagnosis of MCI, the families are very eager to know this, actually more than the patient is, because this diagnosis is, as one might imagine, is discomforting to both the patient and the family. So the goal with treatment, if there is one, is to either improve that individual's cogitation to the normal cognitive functions or at least delay the progression from MCI, or even better, prevent the progression of MCI to dementia, so the goal is to expand and preserve the brain cell connection and increase the chance of brain functioning better and longer. Unfortunately, the medications that are commonly used, the cholinesterase inhibitors, the donepezil or Aricept, galantamine, pyridostigmine, or Exelon as well as vitamin E has not found to prevent progression from MCI to Alzheimer disease. However, there is a little ray of hope and this comes from just one study that used donepezil or Aricept and showed possible short-term benefits when this medication was used in preventing the progression from MCI to Alzheimer disease. At least for one year, there was some benefit, but after that year, there was no significant differences between the various groups, the groups that were included in the studies or the patients were randomized too included an arm in which individuals received Aricept, another group that received vitamin E and another group that received a placebo, and after one year there were no significant differences between these groups, so there were some short-term benefits, but the long-term benefits were not seen and there were various reasons why this may not have been seen and that's beyond the discussion here, but there might be some ray of hope. What's more important is that there are several disease modifying agents that are currently in phase II and phase III trials that may, if it gets FDA approval and is available, may end up being helpful in someone, who has mild cognitive impairment so currently there is no recommended medications to be used in someone with MCI, but there are sometimes some patients, most of the time I see now that patients find comfort in getting some extra time to make decisions about advanced directives, attend to their will, and to optimize relationships while they still only have mild cognitive deficits and many a times when the evidence is presented, a significant minority of individuals do end up being on a cognitive enhancing medication that belongs to the cholinesterase group.

DR. LESLIE LUNDT:

Well, thank you so much for being on our show today.

DR. JOE GOVEAS:

You are most welcome.

DR. LESLIE LUNDT:

We've been speaking with Dr. Joe Goveas about the treatment of mild cognitive impairment.

I am Dr. Leslie Lundt. You've been listening to The Clinician's Roundtable on ReachMD XM 157, The Channel for Medical Professionals.

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This is Dr. Jennifer Shu. This week we will be speaking with Dr. Rob Lambert, Board Certified Internist and Pediatrician and author of the popular blog called Musings of a Distractible Mind. We will be talking about golden rules for physicians.

This is Dr. Jason Birnholz. Join me this week on Advances In Medical Imaging with Dr. Brian Garra of the University of Vermont. We'll be discussing ultrasonic strain imaging.

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