

Transcript Details

This is a transcript of a continuing medical education (CME) activity. Additional media formats for the activity and full activity details (including sponsor and supporter, disclosures, and instructions for claiming credit) are available by visiting:

<https://reachmd.com/programs/cme/disparities-and-inequities-in-the-diagnosis-and-care-of-vulnerable-patient-populations/16057/>

Released: 09/08/2023

Valid until: 09/08/2024

Time needed to complete: 1h 04m

ReachMD

www.reachmd.com

info@reachmd.com

(866) 423-7849

Disparities and Inequities in the Diagnosis and Care of Vulnerable Patient Populations

Announcer:

Welcome to CME on ReachMD. This episode is part of our MinuteCE curriculum.

Prior to beginning the activity, please be sure to review the faculty and commercial support disclosure statements as well as the learning objectives.

Dr. Sabbagh:

Hello, I'm Marwan Sabbagh, Professor of Neurology at Barrow Neurological Institute. This is a case report or a case series, we're going to discuss Disparities and Inequities in the Diagnosis and Care of Vulnerable Patient Populations.

So today we're going to talk about a Latinx man, this is a - he's trying to navigate the healthcare system. He is a 66-year-old right-handed Latinx man with 9 years of formal education, who comes - who's complaining of memory issues for the past 6 months. He reports that he had changes starting with COVID-19 and describes them as having brain fog. He is now forgetting conversations, trouble tracking events or appointments. He is coming in with his daughter who accompanies him because he does not speak English. His Functional Assessment Staging scale is 3. He works in landscaping. He has been independent. He denies depression and anxiety. He has had some other concomitant medications and medical conditions. He does complain of migraines, low back pain, difficulty sleeping, and nocturia. They do not - his cognitive symptoms are neither improving nor are they progressing. His medical history significant for migraine, lumbago, obstructive sleep apnea, he is now using a CPAP machine, type 2 diabetes, and hyperlipidemia. He has a laminectomy. His medications include nortriptyline, baclofen, oxybutynin, Metformin, and atorvastatin. And he has a mother who has had Alzheimer's type dementia starting in her late 60s, passing at age 72. His review of systems is significant for daytime somnolence and fatigue. And of course, remember he has - this as a MoCA translated into Spanish. And his MoCA comes in at 14 out of 30. The rest of his physical and neurological exam are normal.

So our first impression is that we need to come up with a diagnosis. Is it normal mild cognitive impairment? Dementia? Or other? And so in this case, I might go with cognitive disorder not otherwise specified because it doesn't fit the typical progressive amnesic form of a mild cognitive impairment. He's not fully impaired, so it's not dementia. So also, you would consider the alternative to cognitive disorder NOS, which would be mild neurocognitive disorder, which is a DSM-5 criteria. And that way, you know that DSM-5 uses mild neurocognitive disorder is that basically they have 1 domain of impairment, you do not need to have 2 domains. The technical definition of mild cognitive impairment is a report of a member complaint, corroborated by his informant, objectively demonstrated with a functional impairment. So kind of sort of this might be mild cognitive impairment, but it's not clearly identified. And so the patient continues to be independent.

So what would we do next? What would be our next steps? And so take a second to think about this. Would we just wait and see? Would we stop offending medications? Understand he is on 3 medications that affect memory, nortriptyline, baclofen, and oxybutynin. Would you send to a sleep specialist to get the sleep apnea treated? Would you order neuro-psych testing? Would you get some labs and MRI? Or would you do all the above? And the answer, in my opinion, is do all of them except for the wait and see. So I would stop the nortriptyline, stop the baclofen, stop the oxybutynin, get the sleep under control, order the neuro-psych testing, order the labs, order the MRI.

Now here's the problem. The patient is in the system, he has Medicaid, and therefore the Medicaid gives me very, very limited options. Second thing we face is of course, that his English is not his first language. So I will tell you that I ordered a sleep study, and they're like, 'We don't take the patient's insurance.' So that was not available. They are not going to allow me to get a 16-lead polysomnogram. Neuro-psych testing, it turns out that in our - where I work, you know, the number of neuro-psych specialists that Spanish fluently enough to give neuro-psych testing is very, very limited down to 1 that I know of. And of course, we do the B12, TSH, MRI, and he has minimal white matter change with minimal atrophy on his MRI.

So, here we are. He feels a little bit less fatigued, off of his meds. He's thinking more clearly, his brain fog has improved. However, he continues to be forgetful. He got lost to a landscaping job he's been working for years on, his other workers are teasing him because he's repeating himself, his MoCA has not improved despite the meds and it continues to be a 14 out of 30 in Spanish. You are able to order a home sleep study because Medicaid will not pay for a 16-lead polysomnogram.

Here's where you start to see challenges in the system, right? The family is concerned that he will be laid off because he's more forgetful of work. He is not completing tasks at his job. You discuss Social Security Disability with him. This home sleep study revealed that he does have obstructive sleep apnea which is considered to be mild without the need for CPAP.

Given the family history, what would you do next? Would you get an apoE genotyping, which is not covered under a CNS code? Would you send him for a CSF testing? May or may not be covered under - Would you order amyloid PET? Would you order - give him an empiric trial of donepezil? As I said to you, neuro-psych testing is limited; very, very few neuropsychologists can do a translation into Spanish.

Let me just kind of walk you through where I would be. Number one is, we actually would consider doing amyloid PET under the new IDEAS program. It's a Medicare demonstration grant that allows us to order amyloid PET. Or we would get prior authorization to send them for CSF testing for the lumbar puncture. But that's a binary test. So amyloid PET and CSF testing is either you have Alzheimer changes, or you don't. It would not tell me anything else. And so the questions are, you know, could this patient have his differential diagnosis? So let's talk about differential diagnosis, brain fog related to residual effects of COVID, polypharmacy prodromal Alzheimer's, and Mood Disorder. Well, though, that is unlikely. We talked about the fact that we got him off the meds, his cognitive, his subjective complaints improved. We talked about the fact that he has sleep apnea, but it's minimal, and therefore is not considered significant to his general health or his cognitive complaints. So that means that prodromal Alzheimer's is still on the list. And we would need to explore that further. Given the fact that you do not have neuro-psych testing available, because of the Spanish language barrier, how would you go about addressing it next? We already know it's not a B12 deficiency. We know it's not a stroke, tumor, or hydrocephalus. We know it's not a thyroid disorder. Therefore, we have to figure out an objective way to determine in the differential if there's a prodromal Alzheimer's process. And that's why you would consider CSF testing or amyloid PET.

The fundamental question is, is that when you start to think about the new era of monoclonal antibodies, how are you going to test patients? How are you going to evaluate patients for drugs like lecanemab when they have challenges like these, and that is the take-home message here is that they're broad differential, you have to identify all the possibilities of what could be contributing to this, and figure out a way to differentiate things like COVID residual from sleep apnea from prodromal Alzheimer's disease.

I hope this was informative to you. Thank you.

Announcer:

You have been listening to CME on ReachMD. This activity is jointly provided by Global Learning Collaborative (GLC) and TotalCME, LLC. and is part of our MinuteCE curriculum.

To receive your free CME credit, or to download this activity, go to ReachMD.com/CME. Thank you for listening.