Non-Cognitive Aspects of Alzheimer's Disease

Elie Stephan M.D
Fam. Med. /Geriatric medicine.
Chair of Geriatric program
Assistant Professor
in clinical medicine,
St George Hospital/
Balamand University

Driving

The proportion of older drivers with driving license is increasing in the general driving population and a growing number of the population show a decline of cognitive functions that are important for road safety.
Drivers over the age of 65 have the highest per mile traveled mortality rate (the highest is held by drivers aged 15-24 rate) even if they cross fewer miles per year than young drivers. (National Highway traffic safety Administration, 1994)
Current data suggest that car accidents of older people with cognitive impairment often occur due to failure to make the right decision at intersections.
Matthew Rizzo and al (Alzheimer Disease and Associated Disorders: 2001) conducted an experiment on 30 participants (18 Alzh + 12 Normal) on a virtual road in a scenario where the simulator, within 3.6 seconds of an intersection triggered an illegal incursion by another vehicle: The results showed that 6 of the 18 drivers with AD (33 %) did collide versus none of the 12 non-demented drivers of the same age
Johansson et al. 1997 analyzed at autopsy the brain of 98 older drivers who died in single and multi-vehicle collisions: 52 of 98 (53%) had sufficient neuritic plaques (20%) suggesting Alzheimer Disease. Yet not one of those drivers were known by their doctor or by family members to have a problem .This raises the possibility that the first manifestation of AD can sometimes be a fatal accident.

Because Alzheimer's disease decreases reasoning skills, caregivers fail to recognize when a loved one becomes a danger in driving. Warning signs of unsafe driving include:
Forgetting how to locate familiar places
Non -compliance with traffic lights
Making slow or poor decisions
Problems with changing lanes or making turns
Hit the pavement while driving
Lead to inappropriate speed
Becoming angry and confused while driving
Confusing the brake and the accelerator pedal

Eating

Eating disorders are a spectrum of problems in the 3 stages of dementia, going from the early stage where we encounter changes in preferences or forgetting to shop passing to the moderate stage when the patient suffers from agnosia, dyspraxia, keep food in the mouth, difficulty chewing enough with choking hazard, distractibility, impaired attention and concentration arriving then unto the advanced stage when the patient eats more slowly, refuses to open the mouth and food remains in the mouth, etc…
Malnutrition can lead to: decreased muscle strength, poor wound healing, increased pressure ulcers, increased risk of infection, increased post- operative complications.
The contributing external factors are also important like the restrictive diet, the adverse events of medications, lack of adequate number of staff and need for education

How to improve nutrition in demented patients?
For this purpose we should work on 3 axes at the same time:
Change in the environment: :Prepare the meal near the area of food, Good lighting, diffuse lighting, Avoid clutter and distractions, ,music, colored dishes and glasses (red/blue)
Change the attitude of caregiver: Educate family caregiver, small frequent meals, one course at a time, finger food. Sit down and feed up to the level of patients' eyes. Eye contact, stimulate the throat of patients to encourage swallowing, breakfast, lunch: biggest meal; educate caregivers to the desired behavior, additional vitamins, Stop the clock (time),Watch ritual handwashing / blessing. Keep food closest to original form.
Change of patients: Relearn eating behavior: guiding hand on hand, Dental prostheses in place, mouth care, soft diet, wear safety glasses / hearing aids, exercise.

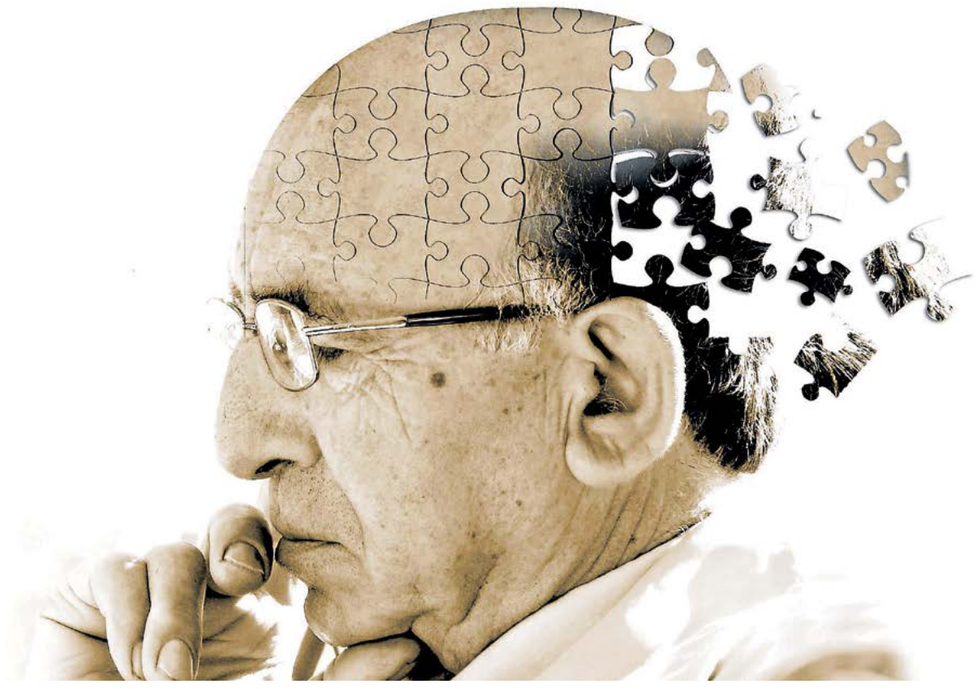
Falls

Why do people with dementia fall? Cognitive deficits increase the likelihood of falls.
Forgetting to avoid dangers in their environment, to get out of bed slowly to minimize orthostatic hypotension; elderly people with dementia are twice as likely to experience a fall compared to cognitively intact, similar elderly.
If Falls are repeated they can lead to a decrease in quality of life, a decrease of the activity, Depression and social isolation, Can cause functional decline; Do not forget fractures.
Home assessment for risk of falls: Environmental hazards, bad lighting, carpets, rugs, chairs , tables, furniture, floors, cabinets, bathrooms, stairs…
Orthostatic hypotension.
Urinary frequency and falls

Sexuality in dementia

Many people, have difficulty accepting that older adults or those who have serious illnesses still have sexual needs and the right to express them.
Alzheimer's disease is a devastating process that attacks many areas of the brain producing:
Memory loss and impaired thinking,
Daunting changes in behavior and personality:
In some cases, it brings about unwelcome sexual -- or seemingly sexual -- behaviors.
For spouses and loved ones, such changes underscore the impact of the disease on even the most intimate of relationships. It is vital, though, to remember that this behavior is not an intentional choice of the individual.

Impact of Sexual disturbance And Diagnosis of Alzheimer's disease
Some people find that when they, or their partner, are



diagnosed with dementia, this answers some questions about puzzling changes in their sex lives. Once dementia has been diagnosed, you can at least feel assured that these changes are not a reflection on either of you, and you may find it easier to understand what is happening.

Diminished Inhibitions, Disconcerting Behavior

Individuals with Alzheimer's may experience reduced sexual interest or less often -- sharply increased sexual interest or acting out, known as hypersexuality. Problem behavior can include jealous accusations that a spouse is having an affair, sexual overtures to a non-spouse, masturbation in public.

Other inappropriate behaviors, such as use of vulgar or obscene language, exposing oneself or undressing in public (collectively termed "disinhibition"), may not be sexual at all but can be construed as such by others.

Managing Behavior Without Drugs

People with Alzheimer's increasingly communicate through behavior instead of speech
The disease deprives them of cultural norms and personal history, their behavior can become unusual.

Advices for family and friends of individuals with Alzheimer's Disease:

- Avoid becoming angry at, arguing with or embarrassing the person; try to be gentle and patient.
- Seek a reason for the behavior; for example, someone who disrobes in public may simply be hot or tired or may find their clothing uncomfortable.
- Gently but firmly remind the individual that the behavior is inappropriate.
- Try distracting or redirecting the person's attention, or, if necessary, take him or her someplace private.
- Try increasing the level of appropriate physical attention, hugs, stroking the hair, massage, etc.; sexual advances may reflect a need for reassuring contact.
- Consider practical solutions; for inappropriate disrobing, try putting trousers or dresses on backward or carrying extra (more comfortable) clothing with you during outings.
- Keep in mind the possibility of depression, medication side effects or interactions, which can reduce interest in sex or trigger inappropriate behavior.
- Consult a specialist in Alzheimer's or dementia or a geriatric psychologist.

Long Term Care Facilities

Sexual needs can endure even after people no longer recognize their spouses or remember that they are married. This results in extramarital nursing-home relationships which can raise awkward issues.

Concerns

Avoiding any sexual exploitation
Avoiding abuse or assault
Determining the individuals' ability to give meaningful consent.
Ability to consent
Alzheimer's disease ultimately destroys the ability to consent.
A partner faces difficult ethical questions and may decide to forget sex altogether -- or seek it outside the relationship.
On the other hand, caregivers may experience a loss of desire.
Guilt about placing one's spouse in a nursing home can also dampen sexual desire.
Sometimes what appears to be sexual is actually an indication of something quite different, such as:
needing to use the toilet
discomfort caused by itchy or tight clothes or feeling too hot
boredom or agitation
expressing a need to be touched, or for affection
misunderstanding other people's needs or behaviour
mistaking someone for their current (or previous) partner.

Care Givers Burden Alzheimer's: The Devastating Impact

Family/spouse fears, concerns and frustrations:

- Gradual loss of their loved one
- Loss of companionship/sexuality
- Regrets about broken plans
- Concerns about changes in behaviour, increased dependence, care giving needs
- Behaviour causing embarrassment and/or frustration
- The mortality of their loved one
- Own mortality, leaving loved one on their own
- Sleep disturbances
- Restriction of caregiver's social life
- Financial burden