INFORMATION FOR PATIENTS AND CARERS

C	**Patients and carers should be offered information tailored to the patient's perceived needs.**
C C D	**Healthcare professionals should be aware that:** ▪ **many people with dementia can understand this diagnosis, receive information and be involved in decision making** ▪ **some people with dementia may not wish to know their diagnosis** ▪ **in some situations disclosure of a diagnosis of dementia may be inappropriate.**
☑	▪ The wishes of the person with dementia should be upheld at all times. ▪ The diagnosis of dementia should be given by a health care professional skilled in communication or counselling. ▪ Where diagnosis is not disclosed there should be a clear record of the reasons. ▪ Patients and carers should be provided with information about the services and interventions available to them at all stages of the patient's journey of care. ▪ Information should be offered to patients and carers in advance of the next stage of the illness.

SOURCES OF FURTHER INFORMATION

Alzheimer Scotland – Action on Dementia
22 Drumsheugh Gardens, Edinburgh EH3 7RN
Tel: 0131 243 1453 • 24 hour freephone helpline 0808 808 3000
Website: www.alzscot.org.uk

Age Concern Scotland
Causewayside House, 160 Causewayside, Edinburgh, EH9 1PR
Tel: 0845 833 0200 • Fax: 0845 833 0759
Email: enquiries@acscot.org.uk •
Website: www.ageconcernscotland.org.uk

Help the Aged in Scotland
11 Granton Square, Edinburgh, EH5 1HX
Tel: 0131 551 6331 • Email: infoscot@helptheaged.org.uk

Mental Health Foundation Scotland
5th Floor, Merchants House, 30 George Square, Glasgow, G2 1EG
Tel: 0141 572 0125
Email: Scotland@mhf.org.uk • Website: www.mentalhealth.org.uk

ABBREVIATIONS

DSM-IV	Diagnostic and Statistical Manual, 4th edition
MMSE	Mini-Mental State Examination
NINCDS-ADRDA	National Institute of Neurologic, Communicative Disorders and Stroke–AD and related Disorders Association
NINDS-AIRENS	National Institute of Neurological Disorders and Stroke Association Internationale pour la Recherche et l'Enseignement en Neurosciences
SPECT	single photon emission controlled tomography

This Quick Reference Guide provides a summary of the main recommendations in the SIGN guideline on **Management of patients with dementia.**

Recommendations are graded A B C D to indicate the strength of the supporting evidence.

Good practice points ☑ are provided where the guideline development group wishes to highlight specific aspects of accepted clinical practice.

Details of the evidence supporting these recommendations can be found in the full guideline, available on the SIGN website: **www.sign.ac.uk**

SIGN
Scottish Intercollegiate Guidelines Network

NHS Quality Improvement Scotland

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Quick Reference Guide

February 2006

COPIES OF ALL SIGN GUIDELINES ARE AVAILABLE ONLINE AT WWW.SIGN.AC.UK

DIAGNOSIS

B **DSM-IV or NINCDS-ADRDA criteria should be used for the diagnosis of Alzheimer's disease.**

B **The Hachinski Ischaemic Scale or NINDS-AIRENS criteria may be used to assist in the diagnosis of vascular dementia.**

C **Diagnostic criteria for dementia with Lewy bodies and fronto-temporal dementia should be considered in clinical assessment.**

INITIAL COGNITIVE TESTING

B **In individuals with suspected cognitive impairment, the MMSE should be used in the diagnosis of dementia.**

☑ Initial cognitive testing can be improved by the use of Addenbrooke's Cognitive Examination.

SCREENING FOR COMORBID CONDITIONS

☑ Physical investigations including laboratory tests should be selected on clinical grounds according to history and clinical circumstances.

B **As part of the assessment for suspected dementia, the presence of comorbid depression should be considered.**

THE USE OF IMAGING

C **Structural imaging should ideally form part of the diagnostic workup of patients with suspected dementia.**

C **SPECT may be used in combination with CT to aid the differential diagnosis of dementia when the diagnosis is in doubt.**

NEUROPSYCHOLOGICAL TESTING

B **Neuropsychological testing should be used in the diagnosis of dementia, especially in patients where dementia is not clinically obvious.**

NON-PHARMACOLOGICAL INTERVENTIONS

BEHAVIOUR MANAGEMENT

B **Behaviour management may be used to reduce depression in people with dementia.**

CAREGIVER INTERVENTION PROGRAMMES

B **Caregivers should receive comprehensive training on interventions that are effective for people with dementia.**

COGNITIVE STIMULATION

B **Cognitive stimulation should be offered to individuals with dementia.**

MULTISENSORY STIMULATION AND COMBINED THERAPIES

☑ For people with moderate dementia who can tolerate it, multisensory stimulation may be a clinically useful intervention.

☑
- Multisensory stimulation is not recommended for relief of neuropsychiatric symptoms in people with moderate to severe dementia.
- Bright light therapy is not recommended for the treatment of cognitive impairment, sleep disturbance or agitation in people with dementia.
- In people with dementia who show behavioural disturbance despite the use of psychotropic medication, aromatherapy may influence behaviour but cannot be recommended as a direct alternative to antipsychotic drugs, nor for the reduction of specific behavioural problems.
- The use of aromatherapy to reduce associated symptoms in people with dementia should be discussed with a qualified aromatherapist who can advise on contraindications.

RECREATIONAL AND PHYSICAL ACTIVITIES

B **Recreational activities should be introduced to people with dementia to enhance quality of life and well-being.**

☑ For people with dementia a combination of structured exercise and conversation may help maintain mobility.

REALITY ORIENTATION THERAPY

D **Reality orientation therapy should be used by a skilled practitioner, on an individualised basis, with people who are disorientated in time, place and person.**

PHARMACOLOGICAL INTERVENTIONS

CHOLINESTERASE INHIBITORS

B **Donepezil, at daily doses of 5 mg and above can be used:**
- **to treat cognitive decline in people with Alzheimer's disease**
- **for the management of associated symptoms in people with Alzheimer's disease**

B **Galantamine, at daily doses of 16 mg and above can be used:**
- **to treat cognitive decline in people with Alzheimer's disease and people with mixed dementias**
- **for the management of associated symptoms in people with Alzheimer's disease.**

B **Rivastigmine, at daily doses of 6mg and above can be used:**
- **to treat cognitive decline in people with Alzheimer's disease**
- **to treat cognitive decline in people with dementia with Lewy bodies**
- **for the management of associated symptoms in people with Alzheimer's disease and dementia with Lewy bodies**

ANTIPSYCHOTICS

A **If necessary, conventional antipsychotics may be used with caution, given their side effect profile, to treat the associated symptoms of dementia.**

☑
- An individualised approach to managing agitation in people with dementia is required.
- Atypical antipsychotics with reduced sedation and extrapyramidal side effects may be useful in practice, although the risk of serious adverse events such as stroke must be carefully evaluated.
- In patients who are stable antipsychotic withdrawal should be considered.
- Where antipsychotics are inappropriate cholinesterase inhibitors may be considered.

ANTIDEPRESSANTS

D **Antidepressants can be used for the treatment of comorbid depression in dementia providing their use is evaluated carefully.**

☑ Trazodone may be considered for patients with depressive symptoms and dementia associated agitation.

HERBAL MEDICINES

☑
- People with dementia who wish to use *Ginkgo biloba* should consult a qualified herbalist for advice and should be made aware of possible interactions with other prescribed drugs.
- People with dementia who wish to use *Salvia officinalis* should consult a qualified herbalist for advice.