Dementia & Cognitive Impairment

Exclude delirium, depression and drugs first · what comes FIRST names the subtype · and the subtype decides what is safe to prescribe

Never diagnose *during acute illness*

BEFORE THE LABEL *three exclusions, and the reversible cause is usually in the chart*

⚠ DELIRIUM

Acute onset, fluctuating, inattention. Cognitive testing during acute illness measures the delirium, not a baseline. **Labeling a delirious inpatient as demented stops the search for the cause and follows them in the chart forever.** Get collateral about pre-admission function, treat the illness, **re-test weeks after recovery** (delirium does predict cognitive vulnerability, so arrange the follow-up).

DEPRESSION

"Pseudodementia": **poor effort and "I don't know" answers** rather than confabulation, prominent low mood, subacute course. It is treatable, so it must be actively sought rather than assumed absent.

⚠ MEDICATIONS

Anticholinergics (oxybutynin, diphenhydramine, TCAs), benzodiazepines, opioids, sedative-hypnotics. Review the list *before* ordering the MRI: **the reversible contributor is more often in the medication list than on the scan.**

SUBTYPE: WHAT COMES FIRST *sequence discriminates better than the later picture, because all subtypes converge*

Type	Recognize it by	What changes
Alzheimer *~60-70%*	**Episodic memory first**: repeating questions, recent events lost. Gradual over years, then language and visuospatial decline	Cholinesterase inhibitor ± memantine; anti-amyloid therapy only in early disease with confirmed amyloid
Vascular	**Stepwise decline** or clear link to strokes; **early executive dysfunction and gait disturbance**, focal signs, vascular burden on imaging	**Vascular risk factor control IS the treatment**: BP, lipids, diabetes, antiplatelet, smoking cessation. Preventing the next infarct is the therapy
⚠ Lewy body	**Fluctuating cognition, well-formed visual hallucinations, spontaneous parkinsonism, REM sleep behavior disorder.** Dementia within 1 year of motor symptoms (vs Parkinson disease dementia, motor first)	**Severe neuroleptic sensitivity: antipsychotics can cause life-threatening rigidity and autonomic instability.** Cholinesterase inhibitors work particularly well. Quetiapine, clozapine or pimavanserin only if unavoidable
Frontotemporal	**Younger (45-65), personality, behavior or language change BEFORE memory**: disinhibition, apathy, loss of empathy, hyperorality	**Cholinesterase inhibitors do not help and may worsen behavior**; memantine ineffective. SSRIs for behavior; genetic counseling
NPH	**Gait apraxia FIRST** ("magnetic"), then incontinence, then cognitive slowing. Ventriculomegaly out of proportion to atrophy	**Potentially reversible with shunting**; large-volume LP with gait testing before and after predicts response. Gait improves most, cognition least

WORKUP *targeted, not a shotgun*

Step	Detail
History and function	**Collateral history beats any office test** (finances, medications, driving, cooking), since impaired insight means patients under-report. **MoCA** is more sensitive than MMSE for MCI; **a score is a data point, not a diagnosis**, and a highly educated patient can decline substantially while still scoring "normal"
Labs and imaging	**CBC, CMP, TSH, B12 in everyone**; selective HIV and syphilis serology for young onset, risk factors or rapid course. **Structural imaging once at diagnosis** (MRI preferred) to exclude subdural hematoma, tumor, NPH and strokes. **Amyloid PET and CSF are NOT routine**: reserved for uncertainty, young or atypical presentations, and mandatory before anti-amyloid therapy
⚠ Red flags	**Rapid progression over weeks to months** (Creutzfeldt-Jakob, autoimmune encephalitis, malignancy) is a workup that cannot wait. Also onset before 65, early falls, early hallucinations, focal signs, or **gait change preceding cognition**

MANAGEMENT *the care plan outweighs the prescription*

DRUGS, HONESTLY FRAMED

Cholinesterase inhibitors and memantine slow decline modestly; they do not restore function, and families deserve that said rather than expecting recovery. Watch bradycardia and syncope. **Anti-amyloid therapy is narrow**: MCI or mild Alzheimer only, **amyloid confirmed by PET or CSF**, screening MRI (non-MRI-capable patients ineligible), and **APOE genotyping, since ε4 carriers and especially homozygotes have higher ARIA risk**. Surveillance MRIs are part of the therapy.

⚠ BEHAVIORAL SYMPTOMS

Agitation is usually communication. Look for pain (often the answer in a patient who cannot report it), infection, constipation, retention, fear or a new drug *before* prescribing; environmental and caregiver approaches beat antipsychotics on evidence. **Antipsychotics carry a boxed warning for increased mortality in dementia**: reserve for severe agitation or psychosis with risk of harm, lowest dose, documented risk discussion, **and a scheduled stop date**. Avoid benzodiazepines and anticholinergics.

Priority	Why it matters more than the prescription
Caregiver support	**The highest-yield intervention**: education, respite, support groups, and screening the caregiver for depression and burnout. **Caregiver collapse usually precipitates institutionalization**, not the patient's decline
Plan early, deprescribe broadly	Proxy, goals of care, feeding and hospitalization preferences **while the patient can still participate**: waiting until capacity is gone is the commonest failure in dementia care. Address driving, medication supervision, wandering and firearms, and **deprescribe drugs whose benefit accrues over a longer horizon than the patient has** (primary-prevention statins, tight glycemic targets, bisphosphonates)
⚠ Advanced disease	**Feeding tubes do not help advanced dementia**: no prevention of aspiration, no survival benefit, no pressure ulcer healing, while adding restraints and agitation. **Careful hand feeding is the evidence-based alternative.** Consider hospice with FAST stage 7, full ADL dependence or recurrent infections

PEARLS & PITFALLS

- **Memory first = Alzheimer. Behavior first = frontotemporal. Hallucinations and fluctuation first = Lewy body. Gait first = NPH or vascular.** Ask what changed first, not what is worst now.
- **Dementia is defined by lost independence, MCI by preserved independence:** ~10-15% of MCI progresses per year and some reverts, so it is monitored rather than treated as early dementia.
- **The visual hallucinations of Lewy body disease invite exactly the wrong drug.** The subtype is a safety decision, not an academic one.
- **Deprescribing often beats prescribing at the first visit:** oxybutynin and diphenhydramine can account for a surprising share of the deficit.

References: Alzheimer's Association appropriate use recommendations for amyloid-targeting therapy · AAN guidance on mild cognitive impairment · DSM-5 neurocognitive disorder criteria · consensus criteria for dementia with Lewy bodies and frontotemporal dementia.

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