Challenges in managing dementia in a primary health care setting: A case report

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Abstract

Dementia is a condition that is frequently associated with ageing. However, many fail to recognise that dementia is a treatable condition if detected early. This case report illustrates a 64-year-old man who was initially presented in a primary health care (PHC) centre in Kuala Lumpur Malaysia, with gradual changes in his behaviour. Initial assessment concluded that he suffered from depression and he was treated accordingly. However, over time his condition deteriorated and the diagnosis was re-evaluated from depression to dementia when he developed poor cognitive and memory function. The patient defaulted on his follow-up appointments due to poor understanding of the illness and poor family support.

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Introduction

Dementia is commonly defined as "a progressive and largely irreversible clinical syndrome characterised by a widespread impairment of mental function".[1] Among its presenting features are memory and cognitive dysfunction, difficulties in performing activities of daily living, disorientation and self-neglect, and even psychiatric symptoms such as depression, apathy and psychosis. As there is an increase in the ageing population worldwide, this condition is becoming an important primary health care (PHC) problem. Hoffman et al reported in the 1990s that a general practitioner in a typical practice would see approximately 1.6 new cases of dementia in a year but this has increased to approximately ten cases on a monthly basis.[2] The prevalence of dementia in Malaysia also shows a similar trend, in which the ageing population is projected to doubly increase from 63.0/1 000 population in 2006 to 2050.[3] We report a case of a 64-yearold man who initially presented at a PHC clinic with atypical symptoms of dementia and gradually developed features suggesting dementia later in the course of his illness.

Case report

A 64-year-old retired policeman, accompanied by his wife, was seen at the Hulu Langat Health Clinic, a rural primary health clinic 40 km from the city of Kuala Lumpur, for the insidious onset of change in behaviour and personality of 18 months' duration. The changes were noted by his wife, who described him as easily agitated, disliking visitors and preferring to be alone. The patient also developed a strong suspicion that his wife was having extramarital affairs, causing him to verbally and physically abuse her. However, his sleep pattern and appetite were undisturbed. Premorbidly he was a loving and caring person. He was an ex-smoker, non-alcoholic and had no other medical illnesses. During the first consultation he appeared alert, orientated and was neatly dressed. Clinically his gait was normal with no focal neurological deficits. An examination of his visual field proved normal and there was no evidence of papilloedema. Examinations of his cardiovascular, respiratory and thyroid systems all proved normal. The Mini Mental State Examination (MMSE) score was 23/30, during which he was unable to perform the serial-7 calculations and failed to recall two out of three objects.

Initial screening investigations of full blood count and fasting blood sugar, fasting lipid profile, urine microscopy, renal profile, serum VDRL/RPR and thyroid function tests were all within normal levels. A provisional diagnosis of depression was made at this point and the patient was referred for psychiatric evaluation and follow-up appointments.

During the first consultation at the psychiatric clinic he reported talking to himself at home and having had an early morning awakening. Paranoid ideations of his wife having affairs persisted. The MMSE score remained 23/30. A CT brain scan showed brain atrophy with an absence of any space-occupying lesions. Antidepressant and antipsychotic medication were prescribed and the patient's symptoms improved. However, the patient defaulted on the subsequent follow-up appointments and treatment. He returned to the psychiatric clinic six months later, at which time he was increasingly aggressive with a history of wandering and losing his way home. His forgetfulness created conflict with his wife and he continued to be abusive. During consultation he became irritable and abusive, and the MMSE was therefore not completed. His orientation to place, five minute recall and drawing were impaired. A diagnosis of dementia was made and the patient was referred to the neurology clinic for further management.

He again defaulted on the neurology follow-up appointments and refused to answer telephone calls. After a home visit by a health clinic worker, it was reported that his condition had deteriorated and that he refused to come to the health clinic. The family members were also not

supportive of their father's condition and they felt more worried about the neighbours' perceptions of having an unsound family member at home. A year later, the patient became withdrawn and totally dependent on his wife for his daily activities. His wife, who is a diabetic, developed poor glycaemic control, succumbed to sepsis and passed away. The patient passed away six months later due to a chest infection.

Discussion

This case illustrates the challenges in managing dementia in a PHC setting. The first challenge is the late recognition of dementia among patients seen in a PHC setting. Our patient was diagnosed with depression, as he initially presented with depressive symptoms. Literature reviews have outlined the role of PHC facilities as the appropriate point of reference for the early detection of dementia.[4,5] Doctors in PHC facilities are in a unique position to establish a diagnosis and provide longitudinal support for patients and their families. Working in a PHC practice enables the doctor to coordinate provision and support multidisciplinary management, such as social services and support groups, or even to coordinate multiple appointments of the patient at the hospital.[6] However, this does not appear to be translated into practice. A systematic review of the early diagnosis of dementia reported that 3.2 to 12% of the criteria for dementia were not documented in PHC practices.[7] It was also reported that most missed cases were those with mild to moderate dementia, with more than 70% being male patients who had cognitive or memory problems. In our case study, the patient was initially not diagnosed with dementia, as forgetfulness or cognitive impairment was not the initial presentation.

This presentation was in concordance with the findings from Lepeire et al, who explored the early signs of dementia presented by patients in the PHC setting.[8] Five most important early signs of dementia were reported as disturbed function at work, problems in recent memory, fixation on emotional events that lead to emotional distress, looking for partner's support and the carer taking over roles. Interestingly, triggers typically perceived as symptoms of dementia, such as disturbed long-term memory, cognitive impairment and an outsider noticing something is wrong, were not reported as the main triggers for early dementia in this study. It can be hypothesised that the absence of these typical symptoms of dementia could bring about the failure of early diagnosis of dementia. As many PHC doctors practise the 'hypothetico-deductive' method in their diagnostic processes, the vague presenting symptoms of people with dementia in PHC settings may lead to the failure of these doctors to identify trigger factors that are associated with dementia – hence failing to generate hypotheses for the diagnosis.9 This hypothesis was also apparent in this case, as our patient presented with atypical symptoms of dementia during the initial stage of his illness

Another challenge in managing this case is the lack of understanding of a shared-care approach in the management of dementia in a PHC setting. This case study demonstrated a lack of understanding by the patient and his family of the illness, and the need for a shared-care approach from various health care providers. This in turn led to miscommunication and a lack of compliance to the scheduled appointments. Malaysian clinical guidelines suggest a multidisciplinary approach in providing longitudinal management for people with dementia.[10] The elements of the multidisciplinary approach include the assessment of the carer's needs, managing co-morbid conditions and providing long-term intervention and appropriate support for patients and families, especially in the chronic stage of the condition.

The intention of this shared-care approach is to promote and maintain independence in the domains of mobility and function, adaptation of new skills and minimisation of needs for support of people with dementia.1 However, providing this approach remains a challenge. One of the obstacles to achieving this objective is a lack of definition of the roles of various practitioners, including neurologists, psychiatrists, geriatricians and PHC physicians, leading to miscommunication.[11,12] In addition, a delay in the diagnosis at the PHC setting often leads to actions taken at a later stage of the illness, hence limiting the role of multidisciplinary intervention. Lastly, the assumption that it is a natural part of ageing may lead to inadequate knowledge of practitioners regarding how best to approach dementia in daily practice. The lack of resources and avenues for training among health care practitioners may also contribute to the unmet needs of people with dementia in the community.[13]

In conclusion, this case highlights the increasing challenges in managing dementia in the PHC setting. Dementia should not be viewed as a normal part of ageing, but needs to be identified early for the management to commence, thereby giving the patient a chance to lead a better quality of life throughout the condition.

Conclusion

A rise in dementia cases is anticipated as the ageing population in Malaysia increases. However, due to its complexity and vague initial presentation, many cases can be missed. Doctors working in the PHC setting need to have a high index of suspicion and be aware of different presentations of dementia when consulting with the elderly.

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