Dementia With A Twist

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Geriatric Update for the Primary Care Provider
November 17th, 2016
79 y/o woman originally from Greece

- CC: paranoia, abulia and mutism
- Accompanied by daughter and grandson
- Onset: 8 months ago
  - Progressively worsening symptoms
- Previously normal, robust
  - Living alone in her own home in Indiana
  - No need for assistance with ADLs
79 y/o woman with paranoia, abulia and mutism

- Abrupt lightheadedness, confusion and disorientation
  - February 16th, 2016
  - No inciting events

- Paranoid delusions of the television “recording” her

- Physical aggression towards family members.
• Increasingly hypo-verbal and ultimately mute

• Abulia

• Rapidly decreasing oral intake felt secondary to poor volition
• PMH:
  • Hypertension
  • Diabetes mellitus Type 2, last HbA1C 7.2%
  • Hyperlipidemia
  • No prior psychiatric history

• Medications:
  • Fenofibrate
  • Ezetimibe
  • Linagliptin
  • Lisinopril
  • Cyanocobalamin
  • Vitamin D
• Family History:
  • Negative for psychiatric, neurologic or autoimmune conditions

• Social History:
  • No prior tobacco, EtOH or drug use
• Physical Exam:
  • Alert, cooperative, nonverbal
  • No evidence of hallucinations
  • Questionable masked facies
  • Able to follow one-step commands
  • CN exam normal
  • Bradykinetic, but essentially normal gait
  • No weakness. **Rigidity** present in bilateral upper extremities.
  • Reflexes normal with bilateral flexor toe responses.
Evaluation

• CT-A, MRI head, EEG, and extensive laboratory testing including paraneoplastic panel negative

• PET MRI: patchy bilateral cortical hypometabolism notable in anterior frontal and temporal lobes
  - Depression or frontotemporal dementia?
  - Venlafaxine x 5 weeks without improvement
  - Risperidone aggravated sx – paradoxical effect
  - Olanzapine without improvement
Evaluation

• Autoimmune panel: borderline positive rheumatoid factor and ANA
  • Follow up autoantibody panel negative.
  • Empiric course of IV steroids
    • No improvement

• Low Vitamin B12
  • Supplemented without improvement
Psychiatric Evaluation

• Physical examination:
  • Essentially mute, use of one word phrases with repetition
  • Indecisiveness with yes/no questions
  • Staring, wooden facial expressions
  • Waxy flexibility

Diagnosis: Catatonia
Definition of Catatonia

• DSM V: *specifier* of other conditions:
  1. Catatonia due to general medical condition
  2. Schizophrenia with catatonia
  3. Major depression with catatonia
  4. Bipolar disorder with catatonia
  5. Catatonic disorder NOS
Diagnosis

- Requires 3 or more of the following...
- **waxy flexibility**

Not a Zebra

• Prevalence in 65+ y/o inpatient referrals: 5-9%
• 35% had no prior psychiatric history
• 92% had vascular risk factor(s)
• Common sx:
  • Staring
  • Immobility
  • Withdrawal
  • Mutism

Treatment

- Avoid antipsychotics!
- Psychiatry referral
- Benzodiazepine challenge
  - 1 mg IV lorazepam
  - Up to 5 mg per day
  - +/- maintenance therapy
Treatment

• Electroconvulsive Therapy
  • 6-10 treatments
  • Efficacy: 80 - ~100\% in catatonia
  • Indications: major depression, bipolar, schizophrenia, refractory PD
  • No absolute contraindications
  • Safer in the elderly?
  • Effect on cognition?

• Kerner et al. “Current electroconvulsive therapy practice and research in the geriatric population” Neuropsychiatry. 2014.
Post-ECT course

• After 2 treatments → speaking in short sentences; more interactive with family and staff.

• After 4 treatments → returned to her pre-morbid baseline, was capable of conversing, eating well, and wished to return home to her regular activities.
Case Resolution

• Greek MoCA: 11/30
  • persistent neurocognitive disorder

• Dx: Probable frontotemporal dementia with catatonia
  • Psychosis
  • Hypometabolism of frontotemporal regions

• PT/OT evaluation: requires 24 hour supervision.

• Dismissed to home with family providing supervision
Catatonia and Frontotemporal Dementia

- Frontalstriatal dysfunction
- mutism, verbigeration $\leftrightarrow$ aphasia

- Catatonia
  - Waxing and waning
  - Responds to treatment

- FTD
  - Progressive decline
Clinical Pearls

• Catatonia is more common than we realize… so look for it!
• Common symptoms in the elderly are staring, immobility, mutism and withdrawal
• Highly responsive to treatment
  • *High impact on function and avoidance of institutionalization*
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