Curbside Consultation

Peer to peer consultations facilitated by dementia care experts

Alberta Health Services

Seniors Health Strategic Clinical Network

Frontotemporal Dementia & Responsive Behaviours

Case study

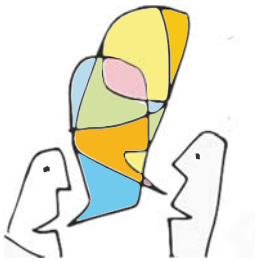
An 87 year old female has diagnoses of frontotemporal dementia (FTD), arthritis, anxiety disorder, constipation and depressive episodes. She has lower leg edema and red, cold, painful-looking feet, but refuses to wear compression stockings. She eats well at meals and has 1-2 bowel movements per day. She experienced hallucinations for 1-3 months after moving into the care home, but those seem to have resolved. She grew up on a farm, married, had 4 children and is now widowed. She enjoyed music and watching dancing.

She moved into her current care home after a fractured hip. While in hospital she was started on Seroquel “for agitation”. She currently suffers from severe anxiety with major escalations of yelling, crying and shaking that last many hours or an entire day. Ativan and antipsychotics have had varied or temporary success. This is her third trial on Seroquel since admission. Her neighbours are increasingly frustrated with the noise. Recently she developed a small open area on her buttocks, due to her severely impaired circulation and not letting staff touch her when in an “episode”.

Attempted strategies

She needs to be the first person to the dining room, they re-arrange the dining table setting so she can put it the way she wants it. A table is set up as her office in her neighborhood; this helps her to have a place to call her own. She attends very minimal recreation, typically only live music and with the encouragement of her regular HCA’s.

Some staff members had success when they treated the episodes like a tantrum. They accompanied her to her bedroom and stayed until she was calm and felt safe.



Frontotemporal Dementia & Responsive Behaviours … *continued*

What would the care team ask that the participants focus on?

We're looking for strategies to help this resident when she is upset and anxious.

Medications

Medication	Class of medication and why prescribed	Possible side effects related to responsive behaviours	Anti-cholinergic
Voltaren 1.16% to right knee at bedtime	Topical anti-inflammatory for joint pain	Chest pain, slurred speech, vision or balance problems, GI bleeding, swelling or rapid weight gain, pale or yellowed skin, dark coloured urine, urinating less than usual, confusion, bruising, numbness, pain, tingling, muscle weakness, skin irritation	
Acetaminophen 650mg QID	Analgesic for mild to moderate pain	Dizziness, ringing in the ears. Bitter taste when crushed.	
Zopiclone 7.5mg at bedtime	Central nervous system depressant for insomnia	Confusion, falls, agitation, dizziness, trembling, tingling/burning sensation, rapid heart rate, nausea, dry mouth, bitter taste in mouth, appetite changes	yes
Citalopram 10 mg in a.m.	Antidepressant	Dry mouth, nausea, vomiting, headache, dizziness, insomnia or somnolence, agitation, anxiety fatigue, tremor, upper respiratory infection, rhinitis, sinusitis	yes
Sennosides 17.2mg in a.m.	Laxative for constipation	Cramping, loose or urgent BMs	
Vitamin D 1000u with supper	Vitamin for bone strength, muscle mass, cognition		
Statex(Morphine) 2.5mg TID and PRN	Narcotic analgesic for pain control	Abdominal pain, chest pain, anxiety, confusion, dizziness, orthostatic hypotension, fainting, irregular/rapid/slow heartbeat, headache, nausea or vomiting, nervousness, pounding in the ears, constipation, shakiness, sweating or chills, sleepiness/trouble sleeping, weight loss, depression, dry mouth, muscle tightness.	yes
Peg-a-lax 17g in a.m.	Stool softener for constipation	Cramping, loose or urgent BMs	
Seroquel 25mg at 1400hrs daily	Atypical antipsychotic (pharm. restraint)	Agitation, dizziness, drowsiness, fatigue, upset stomach, sore throat, muscle stiffness, tremors, insomnia	yes
Gabapentin 200mg QID (recently increased)	Anticonvulsant that also treats nerve pain	Dizziness, drowsiness, fatigue, weakness, double vision, tremor, vision problems, fever, GI bleeding, unusual bruising, sores in the mouth, depression or mood changes, cough, confusion.	

Frontotemporal Dementia & Responsive Behaviours … *continued*

Ideas suggested by Alberta LTC teams

Resident assessment/evaluation

- Review of medications: This is not a form of dementia that responds well to medications. Consider what medications can be discontinued to see if this reduces her anxiety:
  - Citalopram: How long has she been on this? Is it causing agitation? If tapering and discontinuing it doesn't improve symptoms, might another antidepressant work better?
  - Seroquel: This is her third time on an antipsychotic without much benefit. Gradual dose reduction and discontinuation may be appropriate.
  - Senokot: not recommended for use on a daily basis.
  - Zopiclone: the dose is double the standard dose for the elderly. Insufficient evidence of benefit long term/in the elderly.
- Pain assessment: perhaps she would do better on a long acting analgesic? Assess for the possibility of a nerve block to control her pain. Consider a palliative consultation for pain control.
- Consider geriatric psychiatry assessment regarding her anxiety and depression.
- Is there a possibility of PTSD?
- Assessment and treatment by a foot care nurse, wound care nurse or podiatrist for her feet.

Person Centered strategies

Modifying the environment to avoid triggers is usually helpful in FTD:

1. Shift change does cause problems; we think it is the noise level that sets her off.
   - Consider what changes staff can make to reduce the noise of shift change (e.g. meet and report in different places)
   - Ask her family to visit and keep her busy over the shift change from days to evenings; Ask a day shift staff member to introduce her to an evening shift staff member before they leave for the day. Breathe and relax before you approach her. Use a very calm approach
   - Provide an activity in her room during shift change such as folding baby clothes, doll therapy, sorting, rolling balls of yarn, videos of old musicals, old TV shows like I Love Lucy, singing, music therapy, 1:1 activities
2. Not being first into the dining room will set her off - staff make sure she's the first one in.
3. Having her place setting organized at the table upsets her – staff mix up the dishes and cutlery so she can arrange them the way she likes them.
4. Other residents can be triggers – it's not possible to control other dementia residents; staff bring her to her room and stay with her until she feels calm and safe.

Frontotemporal Dementia & Responsive Behaviours … *continued*

Other Considerations for Frontotemporal Dementia

- FTD is very stressful for family members, staff and other patients/residents. Symptoms include antisocial behaviors, reactive aggression, lack of empathy and lack of insight.
- Persons may become withdrawn or disinhibited (they lose ability to control or restrain their actions).
- It may be difficult to diagnose because it is not always associated with memory loss. It can be young onset, and can be mistaken for criminal behavior or mental illness. Persons with FTD often alienate family members and lose jobs and benefits before a diagnosis is made.
- In late stages, special care units may need to segregate FTD residents from other dementia patients; higher staff-patient ratios may be required for patient/resident safety.

Staff education and resources

- AUA toolkit Meaningful Activities
- Music & Memory http://musicandmemory.org
- Alzheimer Society of Canada: http://www.alzheimer.ca
  - Frontotemporal dementia
- BrainXChange: http://brainxchange.ca
  - Frontotemporal Dementia: Facing the Challenges for Patients, Family Members, and Clinicians (00:00 to 23:00)
- Vancouver Coastal Health Geropsychiatric Education Program http://geropsychiatriceducation.vch.ca
  - Fact Sheet: Frontotemporal Lobe Dementia

Curbside Consultation info

The Appropriate Use of Antipsychotics (AUA) team hosts monthly peer to peer call-in meetings to discuss specific challenges related to care of persons with dementia. A case study is prepared in advance and sent out to care teams on our contact list. During a call on the third Wednesday of each month, care teams share their expertise. The case study and suggested strategies are summarized and shared or later used for staff education.

If you have a topic or resident case study you'd like help with, or would like to be on our e-mail list, contact: AUA@ahs.ca