



## ORIGINAL ARTICLE

# Behavioural and psychiatric symptoms in cognitive neurology<sup>☆</sup>



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### KEYWORDS

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**Abstract** Behavioural and psychiatric symptoms (BPS) are frequent in neurological patients, contribute to disability, and decrease quality of life. We recorded BPS prevalence and type, as well as any associations with specific diagnoses, brain regions, and treatments, in consecutive outpatients examined in a cognitive neurology clinic.

**Method:** A retrospective analysis of 843 consecutive patients was performed, including a review of BPS, diagnosis, sensory impairment, lesion topography (neuroimaging), and treatment. The total sample was considered, and the cognitive impairment (CI) group ( $n = 607$ ) was compared to the non-CI group.

**Results:** BPS was present in 59.9% of the patients (61.3% in the CI group, 56.4% in the non-CI group). One BPS was present in 31.1%, two in 17.4%, and three or more in 11.4%. BPS, especially depression and anxiety, are more frequent in women than in men. Psychotic and behavioural symptoms predominate in subjects aged 65 and older, and anxiety in those younger than 65. Psychotic symptoms appear more often in patients with sensory impairment. Psychotic and behavioural symptoms are more prevalent in patients with degenerative dementia; depression and anxiety in those who suffer a psychiatric disease or adverse effects of substances; emotional lability in individuals with a metabolic or hormonal disorder; hypochondria in those with a pain syndrome; and irritability in subjects with chronic hypoxia. Behavioural symptoms are more frequent in patients with anomalies in the frontal or right temporal or parietal lobes, and antipsychotics constitute the first line of treatment. Leaving standard treatments aside, associations were observed between dysthymia and opioid analgesics, betahistine and statins, and between psychotic symptoms and levodopa, piracetam, and vasodilators.

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**PALABRAS CLAVE**

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**Síntomas conductuales y psiquiátricos en neurología cognitiva**

**Resumen** Los síntomas conductuales y psiquiátricos (SCP) son frecuentes en el enfermo neurológico, contribuyen a producir discapacidad y reducen la calidad de vida. Se ha observado, en pacientes de neurología cognitiva, la prevalencia y tipo de SCP y su asociación con diagnósticos, regiones cerebrales o tratamientos específicos.

**Método:** Análisis retrospectivo de 843 pacientes consecutivos de neurología cognitiva, revisando SCP, diagnóstico, alteración sensorial, topografía lesional en neuroimagen y tratamiento. Se contempló el total y se comparó el grupo de pacientes con deterioro cognitivo objetivo (n = 607) y sin deterioro.

**Resultados:** Hubo SCP en el 59,9% de los pacientes (61,3% en los deteriorados y 56,4% en el resto). Un 31,1% tenía un SCP, 17,4% dos y 11,4% más de dos. Los SCP son más frecuentes en mujeres, sobre todo depresión y ansiedad. En los mayores de 64 años predominan los síntomas psicóticos y conductuales, y en los menores de 65 la ansiedad. Las personas con alteración sensorial tienen más síntomas psicóticos. Se aprecian más síntomas conductuales y psicóticos en personas con demencia degenerativa, depresión y ansiedad en las que tienen enfermedad psiquiátrica o efecto nocivo de sustancias, labilidad emocional en relación con trastorno metabólico u hormonal, hipocondría en los síndromes dolorosos e irritabilidad en la hipoxia crónica. Hay más alteraciones de la conducta en pacientes con anomalía en lóbulos frontales o temporal o parietal derechos, y se tratan preferentemente con antipsicóticos. Aparte de los tratamientos estándar, se observó asociación de distimia con opioides, betahistina y estatinas, y síntomas psicóticos con levodopa, piracetam y vasodilatadores.

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**Introduction**

Cognitive neurology clinics evaluate and treat declining intellectual function. Furthermore, this decline is often associated with behaviour disorders and other typical symptoms of psychiatric diseases. These associated symptoms may indicate a psychological reaction to the self-perceived cognitive disorder, which may also be accompanied by other neurological and/or systemic manifestations. This perception can lead to different degrees of worry or alarm, depending on the patient's personality and intensity of symptoms; alarm may manifest in the form of behavioural changes and such psychiatric symptoms as depression and anxiety. In other cases, behavioural and psychiatric symptoms (BPS) are part of the array of changes arising from the dysfunction of neuronal circuits that also elicit the cognitive dysfunction. At times, both the primary and the reactive mechanisms contribute to these symptoms in varying degrees.

This is a transcendent matter because the prevalence of BPS is high in patients with neurological disease<sup>1-4</sup> and because these clinical manifestations increase disability,<sup>5</sup> lessen quality of life,<sup>6,7</sup> and are very stressful for those living with the patient.<sup>6,8</sup>

The purpose of this study is to observe BPS frequency in a sample of patients seen at a cognitive neurology clinic. We also examine the association between these symptoms and specific diagnoses, or with structural changes in precise regions of the brain.

**Patients and methods**

We performed a transversal retrospective analysis of a register of 857 patients examined in a cognitive neurology clinic. Records lacking any of the essential data for this study were excluded. Patients were categorised in 2 groups. Those in group 1 had a syndromic diagnosis of mild cognitive impairment or dementia. In group 2, which served as a control, cognitive function was not considered pathological.

We recorded age, sex, aetiological diagnosis, and the presence and type of BPS. If BPS were detected, we examined neuroimaging studies when available. To assess their potential influence on outcomes, we checked for presence or absence of sensory alterations (visual or auditory) and recorded the type of treatment for each patient.

In a later stage, we estimated prevalence of BPS and examined the association between these symptoms and different aetiological diagnoses (disease types). We examined the possibility of a link between BPS and neuroimaging anomalies in specific regions (disease topography). We also compared results from groups 1 and 2.

BPS occurring during sleep, such as somnambulism or REM sleep behaviour disorders, were not included. BPS recognised in this study were limited to those relevant to the diagnosis, affecting family life, or requiring treatment or modifying treatment. We did not examine sporadic or mild symptoms with no significance and no repercussions on treatment decisions.

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