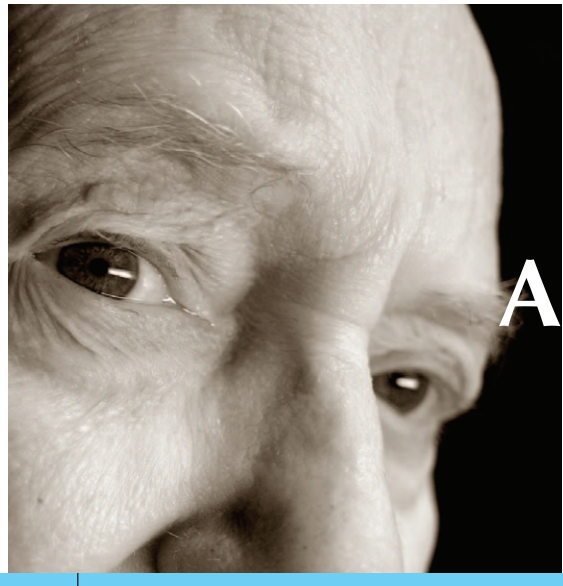

The Growing Challenge of Alzheimer Disease

Part 2

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Alzheimer disease is the fourth leading cause of death after heart disease, cancer, and stroke. The incidence is rapidly increasing as the population ages. Behavior management is the foundation of AD treatment. Effective ways to deal with a variety of behavior problems are summarized. Tremendous changes need to be made in health care policy if the education of providers and reimbursement regulations are to be adequate to care for these growing numbers of patients.

Currently, Alzheimer disease (AD) is the fourth leading cause of death in the United States. About 50% of patients older than 85 years has AD, and this segment of the population is growing the most rapidly. The number of patients with AD threatens to overwhelm our health care system. The system needs to make changes to be able to care for these patients adequately.
Research is being done on the cause of AD. Different theories provide theoretical treatments, which are being investigated. The benefits of most of this research remain to be realized; none are expected to be available in the near future.
Two classes of medications are now available for use in patients with AD. The acetylcholinesterase inhibitors are of use in early AD; the N-methyl-d-aspartate antagonist is useful in moderate to severe AD. Other medications are also somewhat useful in managing some symptoms. Part 1 of this series described the causation theories and drug treatment options in detail.[1] Behavioral management remains the mainstay of treatment for patients with AD. It is also clear that interdisciplinary care is essential if the patient's symptoms are to be appropriately managed as they progress over time. The focus of this article is on nonpharmacologic management.

INTERDISCIPLINARY CARE

Management of the patient with AD is complex and extends beyond normal medical care. The provider must take into account the demanding needs of both the patient and the caregiver. Caregivers will need help in finding appropriate information and services. The care team will often include physician, nurse practitioner (NP), nurse, social worker, physical therapist, occupational therapist, home health aide, nutritionist, clergy, financial planner, and lawyer. Resources commonly needed are respite care, institutional placement, transportation, and hospice care.

Traditionally, the physician is the leader of a patient's care team. However, in AD, the physician

often does not have the interest, knowledge, or time required to coordinate care. Depending on major needs, the NP, social worker, or nurse can assume the role of care coordinator. The team members often work independently. Demands on time often make communication limited with resultant overlaps or gaps in care.

Continuity of care is essential and improves when the various team members take the time to communicate well with each other. However, that is often a challenge when the patient moves from home to hospital to nursing facility to home. Often a different doctor takes care of the patient in each setting. They often do not obtain information from the other doctors. They are not aware of what other services are involved and may order duplicate or conflicting services. Observation suggests and research confirms that the patient is put at significant risk of errors, involving such things as medications, because of the lack of adequate communication among providers.

CARING FOR THE PATIENT WITH AD

Behavior management remains the cornerstone of therapy for patients with AD. The profound fact is that the patient cannot learn new behaviors. Thus, the patient's environment and caregivers' actions must be adapted to the patient's ability. The environment and actions must be constantly assessed and adaptations continually made as the patient slowly changes in functional ability. Many excellent books have been written on this topic that may be found on the website of the Alzheimer's Association.[2]

The purpose of behavior management in the patient with AD is to prevent problem behaviors. Common problem behaviors include emotional outbursts; agitation; aggression; refusal of care, eating, taking medications, oral hygiene; and wandering. Before trying to treat behavior problems, check to see whether a physical cause explains the behavior. Common causes for some of these behaviors include pain, urinary urgency, and fecal impaction. Also the patient may have delirium caused by a medication change, an infection (usually pneumonia or urinary tract), or other medical illness.

The physical environment must be adjusted to the individual patient. The amount of stimulation must be enough to keep patients alert but not enough to make them agitated. The physical environment must be simplified however possible. Continence can be maintained longer if the patient has easy access to a bathroom. Background noise makes it hard for patients with AD to concentrate, unless they are used to having a television on all the time. The patient with AD will have difficulty adjusting to any changes in the environment. Consistency is a key.

ADVICE FOR CAREGIVERS

The patient with AD is also sensitive to the emotional environment. If the caregiver is anxious, angry, or frustrated, the patient will sense this and become anxious. The caregiver must have a calm demeanor, even in the midst of extreme frustration. Some of the basic principles that the caregiver must be taught include:

1. Simplify everything.
2. Establish routines.
3. Slow down, both verbally and physically.
4. Use repetition.
5. Monitor behavior.
6. Back off, then simplify, if the patient starts to get agitated.

When talking to the patients, speak in simple sentences, pause between sentences, and give them simple choices when possible, with both choices being acceptable. Do not ask, "Do you want a bath?" Ask, "Do you want your bath before or after lunch?" Do not argue with them, do not try to correct their delusions, do not try to teach them new things, and do not get upset in front of them. Leave the room when you need to let off steam or express frustration.

Do not tell patients with AD more than they can handle. One must be careful here. Clinicians generally do not lie to patients, but it is usually prudent to avoid telling patients with AD upsetting things. They no longer have the ability to understand, so telling them upsetting information does not serve any purpose and just makes them suffer. Come up with a vague, simple explanation to their questions.

For example, a patient with AD is seen after she has had a fall. She is aware that she is beginning to have memory problems and is upset by them. She was told that her brain had been hurt as an explanation for her perceived memory problems. She believed that the fall had injured her brain and caused her memory problems. There was no reason to tell her "you have AD." She had already gotten upset when that possibility had been raised earlier, saying, "I do not have AD, there is nothing wrong with me." Insisting that she had AD would have only made her more upset and lessened the chances she would take her prescribed medicine, donepezil (Aricept).