SmartPaper

Alzheimer, Frontotemporal and Vascular Dementias

A.D. CLINICAL FEATURES

Difficulties in learning that involves new instructions

1-2 yr history of progressive deterioration in memory. Early-onset AD (EOAD) may have visuospatial, language and exec deficits. Late-onset AD (LOAD) will more likely have pure amnesia. EOAD declines faster than LOAD.

Difficulty in following conversations. May make remarks that are not appropriate to the context of the conversation. Loses track of what he/she or others have said.

Frequent difficulty in remembering names of children or grandchildren, compared to earlier intact ability. Cannot interact or play games with children / grandchildren as before.

Patient looks bewildered. Turns to partner for answers to questions.

Difficulty in planning events or activities – e.g. holidays, parties

Frequently repeats himself/herself – several times within a few hours rather than just occasionally. May repeatedly ask the day of the week.

Difficulty in following plots in films/soap operas - may see film again without realising having seen it before

Frequent difficulty in finding parked car. Difficulty in navigating around familiar supermarket. Forgets where items are located in the house/kitchen.

Gets agitated/depressed due to frustrations at inability to do things that he/she could do before, rather than mood state occurring in isolation

Forgets that family members/close friends are no longer alive, have recently been married / divorced, had children, etc.

Impaired performance in work/domestic settings. If person is living alone, consider 'fridge test' – fridge is full of duplicate or out-of-date items.

Forgets major personally experienced events from the last few years (e.g. holidays, hospital treatments)

Difficulty in assimilating what is read. May read something again without realising having read it before.

Navigational difficulties in settings that were previously easy. Thus, difficulty in navigating to familiar places, or in learning a new route after several journeys.

Impoverished knowledge of recent news events such as deaths of leading personalities.

VASCULAR DEMENTIA

Clinical - Vascular risk factors, history of TIA. More common in CVD than AD to have slowing down, fluctuations in cognition, behavioural/mood disturbance, nocturnal confusion, gait or urinary problems. News events memory autobiographical memory & orientation for time better in CVD than AD.

Cognitive - Delayed recall worse, and silhouette naming better, in AD compared to subcortical vascular dementia. Cues help recall in CVD more than in AD. AD patients without language impairment better on verbal fluency and worse on recognition memory than CVD patients. Timed attention and executive dysfunction worse in subcortical CVD. More marked & more generalised anterograde memory impairment in AD.

A.D. COGNITIVE TEST PROFILE

Significant drop from immediate to delayed recall.

Disoriented for time (day, month, year)

Impaired semantic verbal fluency

Impairment on some visual tests with a switching or problem-solving component.

Impaired performance on recognition memory tests

Impairment on WAIS Block Design, copy of complex figure or overlapping pentagons (MMSE). Clock drawing.

Remote memory deficits on knowledge and autobiographical memory tests

FTD-semantic (SD) Words or names no longer familiar or do not mean a lot. Gets stuck for words. Hypersensitive to pain, food fads, repetitive behaviour, clock watching, stick to rigid routine, excessive worrying, needs to do things immediately. Poor at picture naming & recognition, and at reading irregular words. Impaired word comprehension and verbal fluency. Poor verbal memory. WAIS Vocabulary and Similarities subtests, and Pyramids & Palm Trees Test impaired.

FTD-behavioural (bvFTD) Disinhibition, general loss of interest, gluttony, sweet food preference, eats if food present, crams food, wandering, pacing, loss of insight.

Family history of bvFTD more likely in bvFTD than SD or AD.

Test Scores – Compared to AD, more impairment in executive function tests. Less impairment on anterograde memory tests & visuospatial deficits. Compared to psychiatrically-similar cases, Hayling, Backward span, Trails & Fluency are low.

CEREBRAL AMYLOID ANGIOPATHY Usually presents with haemorrhagic strokes. Location of vascular lesions may contribute to profile, though reduced perceptual speed and impaired episodic memory have been reported.

FTD v AD, Rate of Decline – Although there is considerable variability within conditions, and decline may be specific to tests used, FTD-behavioural appears to progress faster, followed by LA & PNFA, then FTD-semantic and then Alzheimer's Disease (medial-temporal lobe variant)

FTD v AD, Clinical – Perseverations & concrete responses more common in FTD-behav. In drawing, spatial errors more in AD, organization errors more in FTD-behav. Everyday memory and recent autobiographical memory better in FTD than in AD. Navigation skills better in FTD.

POSTERIOR CORTICAL ATROPHY Symptoms - reading, driving / crossing road, going up/down stairs, faces identification, dressing, identifying coins. See things piece-meal, e.g. difficulty describing a complex scene; Navon letters (large letters made from small letters – only small letters seen). Poor copy of figures, clock drawing; WAIS Digit Symbol subtest down. Often young, 50-65 years of age.

PROGRESSIVE NONFLUENT APHASIA (PNFA) (left inferior frontal / left perisylvian fissure) Effortful and poorly articulated speech. Agrammatic (few pronouns, verbs). Lack of prosody (intonation lost). Impaired repetition for short & long items. Syntactic comprehension impaired. Buccofacial apraxia.

LOGOPENIC APHASIA (LA) (left parietal, posterior temporal) Word finding & naming difficulties. Pauses & phonemic errors. Impaired repetition for longer items. Speech largely grammatic, though sentence comprehension may be down. Milder than PNFA at first presentation.

These guidelines need to be considered in the context of clinical, imaging and laboratory findings