SmartPaper - Psychological v NEUROLOGICAL [– Background –, Concomitant, Cognitive, *Scores*]

 26 January 2018. **These guidelines need to be considered in the context of clinical, imaging and laboratory findings.**

<table>
<tr><td>Psychological - Clinical Features
Prefers that you do not speak to partner</td><td rowspan="2">Indifference to cognitive limitations (in the absence of major frontal pathology). Confabulations that consist of boasting. Refuses to do tests.</td><td>Complains of jumbled, speeded, or slowed thinking. focused on minutiae of symptoms to an obsessional degree. Presents a written list of symptoms.</td><td>Patient is more concerned about cognitive symptoms than partner</td><td>Symptoms related to poor concentration - e.g. put milk in cupboard, not know what went into room for, wash clean plate, lose glasses, leave tap on, leave key in front door</td><td rowspan="2">Recalls well items such as drug regime, names of clinical staff, journey to hospital, recent visit to restaurant, how spent last birthday/Xmas, etc (verify). Can give detailed medical history, including names of professionals seen; day, time, content and duration of appointment; scans. Can give detailed account of when memory last failed.</td><td>Cognitive symptoms occur in parallel with mood state, tiredness, pain or other physical symptoms</td></tr>
<tr><td>Difficulty getting off to sleep, wakes up in the middle of the night or early in the morning, mainly due to preoccupation with worries</td><td>Anxiety-related behaviour during interview (e.g. poor eye contact)
Sensitive to noise and crowds. Overwhelmed by visitors.</td><td colspan="2">Patient reports concentration worse than memory, or there is evidence that memory difficulties are due to poor concentration. Memory varies with interest in item. Cognitive symptoms variable with completely normal functioning on some days.</td><td>Cognitive decline parallels specific life events, with sudden onset related to specific emotional precipitant</td></tr>
<tr><td>Perfectionist/sets self very high standards
Slow and lacking confidence when making decisions</td><td colspan="3">Evidence of depression/anxiety - e.g. early morning waking, negative self-image, tearfulness, night sweats, weight loss/gain, change in urinary/bowel habits. feelings of worthlessness. Preoccupation with death. Reduction in libido. 'Life is a struggle'. Sleep disturbed. Change in eating/drinking habits due to mood. fatigue. Apathy. Suicidal ideation.</td><td>Dense autobiographical amnesia that includes loss of childhood memories. Admits to 'blanks' in past memories. Selective loss of emotionally traumatic memories.</td><td>Complains of memory problems but – understands and follows films/plays/ soap operas; can easily learn tasks that involve assimilating new information/new instructions or rules.</td><td>Loss of personal semantic memory (e.g. name, d.o.b., signature, name of spouse, long-standing facts – e.g. address)</td></tr>
<tr><td>Multiple somatic symptoms - tiredness, syncope, headache, backache, stomach ache, dizziness</td><td colspan="3">Functional v Malingering. Personal more than public memories affected in hysteria – personally familiar faces, personal rather than matched public events. In malingering, more contrast with ADL adjustment. Lower cognitive test scores in malingering. If low test scores in hysteria, due to poor attention secondary to preoccupation with symptoms. Hysterics more cooperative in interview/testing. Somatoform hysterics have thicker case note files!</td><td>Cognitive symptoms worse in the morning in depression
Cannot recognise as familiar faces of family members</td><td></td><td>Loss of ability to perform well-established 'everyday skills' – e.g. brushing teeth, 'forgets how to breathe'.</td></tr>
<tr><td>Easily suggestible to plausible symptoms – e.g. sees flashing coloured shapes on awakening</td><td colspan="4"></td><td>Psychological - Test Performance</td></tr>
<tr><td>Psychotic symptoms –intrusive thoughts, people know what you are thinking/doing, auditory hallucinations</td><td colspan="4"></td><td>Shows discrepancy between performance on cognitively similar tests.</td></tr>
<tr><td>Anxiety due to family history of brain illness. Become more introspective or self-critical recently</td><td colspan="4"></td><td rowspan="2">Chance or below-chance performance on recognition memory tests.
Test performance discordant with clinical history and ADL.</td></tr>
<tr><td>– Long history of cognitive symptoms (many years) without any major effects on everyday adjustment –</td><td colspan="4"></td></tr>
<tr><td>– Stress in marriage or relationship with children. Recent bereavement –</td><td colspan="4"></td><td rowspan="2">Performs well on difficult memory tests, and on timed perceptual-motor tests (Digit-Symbol, Trail-Making Test, etc).</td></tr>
<tr><td rowspan="2">– Secondary gain for neuropsychological disability. Family history of psychiatric illness –</td><td colspan="4"></td></tr>
<tr><td colspan="4"></td><td>Poor immediate recall with better delayed recall</td></tr>
<tr><td>– < 55 years of age in ? dementia cases –</td><td colspan="4"></td><td>Better at recall than recognition memory tests</td></tr>
<tr><td>– Excessive work-load/multi-tasking since onset of cognitive symptoms –</td><td colspan="4"></td><td>Discrepancy between test profile and brain imaging findings</td></tr>
<tr><td rowspan="2">– History of psychiatric consultations, psychotropic medication, stressful life events, crime, drug/alcohol abuse –</td><td colspan="4"></td><td rowspan="2">Low forward digit span. Impaired on dot counting with no major posterior pathology.</td></tr>
<tr><td colspan="4"></td></tr>
<tr><td>NEUROLOGICAL - Clinical Features</td><td colspan="4"></td><td><u>NEUROLOGICAL - Test Performance</u></td></tr>
<tr><td>Concern from family/work-colleagues.</td><td colspan="4"></td><td><u>Cannot give correct day, month, year, age, PM.</u></td></tr>
<tr><td>Difficulty in following plots in films/soaps.</td><td colspan="4"></td><td><u>Hayling, Backward span, Trails & Fluency down more in FTD-F cfd to psy.</u></td></tr>
<tr><td rowspan="2">Difficulty in assimilating what is read – keeping track of characters, plot. Cannot name title/author of book currently being read.</td><td colspan="4"></td><td><u>Evidence of aphasia, apraxia or agnosia</u></td></tr>
<tr><td colspan="4"></td><td><u>Impaired on 'stress free' cognitive tasks (e.g. draw a clock, picture recognition memory)</u></td></tr>
<tr><td>Difficulty navigating familiar routes. Has recently had car accidents.
Difficulty learning new routes after several journeys.</td><td colspan="4"></td><td><u>Shows impaired performance on several recognition memory tests. Major discrepancy in semantic v letter fluency.</u></td></tr>
<tr><td rowspan="2">Cannot recollect major autobiographical events from the last few years (e.g. holidays, hospital treatments, family events), even after being provided with cues. May watch film twice with no earlier recall.</td><td colspan="4"></td><td rowspan="2"><u>Marked drop from immediate to delayed recall. Recall not helped by cues. Zero immediate recall – giving a further presentation trial and test trial does little to improve performance.</u></td></tr>
<tr><td colspan="4"></td></tr>
<tr><td rowspan="3">In hotel, difficulty learning location of dining room, way back to hotel. Cannot recall where items are kept in supermarket, where items belong at home – e.g. where things go in the kitchen.</td><td colspan="4"></td><td rowspan="3"><u>Impaired on Luria 3-step command and alternating sequence command</u></td></tr>
<tr><td colspan="4">If patient is unaccompanied to clinic, and partner is available on phone, get permission to ring partner, perhaps during break in testing. Slight atrophy on scan not helpful…in focal dementia, SPECT scan may be informative if other scans equivocal.</td></tr>
<tr><td colspan="4">When making judgment about simulation, note 6 components of Cognitive Effort – [Encoding] 1. I can't pay attention. 2. I don't care about paying attention. 3. I will deliberately not pay attention/misinterpret. [Retrieval] 4. I can't concentrate on responding. 5. I don't care how I respond. 6. I am deliberately going to perform in a suboptimal fashion.</td></tr>
<tr><td>No knowledge of births / marriages / deaths of famous personalities, or of close relatives/friends.</td><td colspan="2">Assuming that there are no other reasons for so doing, repeats same story or frequently asks same question. May also apply to actions, such as buying things, eating a meal again.</td><td colspan="2">Cooking for several people is more difficult than before, omits ingredients from recipes, leave kitchen equipment on, etc.</td><td>Utilisation behaviour, frontal lobe reflexes, perseveration, echolalia; visual hallucinations, incontinence, ataxia, micrographia</td><td>Impaired in organizing holidays, birthdays parties, sending Xmas cards.</td></tr>
<tr><td>Perseveration & impulsivity. Difficulty in following / retaining test instructions.</td><td colspan="2">Difficulty in following conversations, losing thread of own or others' comments. Remarks inappropriate to context of conversation. Impaired word/sentence comprehension.</td><td>Word substitution errors in speech. Significant drop in premorbid spelling ability.</td><td rowspan="2">Out-of-character behaviour - apathy; social/£/ sexual disinhibition; loss of insight; marked change in eating habits; swearing; reduced empathy; stereotyped-repetitive behaviour.</td><td colspan="2">Slower or makes mistakes in DIY tasks that were once easy. More difficulty than expected in using mobile or landline phone.</td></tr>
<tr><td>Difficulties in situations that involve learning to operate new gadgets or equipment.</td><td colspan="2">Gets agitated/depressed due to frustrations at inability to do things that could do before. Family/spouse take over more and more responsibilities that the patient used to perform in the past. Cannot readily give names and ages of children or grandchildren, and may frequently confuse one with another.</td><td>Patient looks bewildered, turns to partner for answers. Difficulty with 2-part questions, forgets the second question.</td><td colspan="2">Cognitive symptoms do not improve with anti-depressant medication, time off work, etc. Presence of apathy rather than depression more suggestive of neurological basis.</td></tr>
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