

Case study of mrs. c – dementia

Health & Medicine, Disease



Profile and presenting symptoms:

The patient is Mrs. C, an 83-year-old widowed Caucasian female. She lives alone in her apartment. Means of income come from her husband's retirement income as well as her social security. She had no formal occupational training but formerly worked as a hairdresser at a theatre. Her 72-year-old brother brought her to a psycho-geriatric psychiatrist clinic for assessment and evaluation as she had been noted to be extremely forgetful, incapable of paying attention to simple chores and has difficulty finding words lately. Physical examination results showed good but deficits were confirmed on her mental status. Current diagnoses include osteoporosis and osteoarthritis and she had been solitary since the death of her husband of sixty years since two years ago. No history of major illness or injury as well as no prior psychiatric history. Current medications include Estrogen, Calcium with vitamin D and Multivitamins.

Full description of mental health problem:

MMSE score is 24/30. The patient was reported to be very forgetful. Reported by her brother that she had forgotten to lock her door and turn off the stove burner when he visited her. She admitted that she felt confused with episodes of not remembering things from one moment to another. She could not remember how long has this been going on and thinks of it as things attributable to normal ageing. She admitted having difficulty sleeping. Her brother reported that she had lost weight though she describes her appetite as "so-so." She sees herself as a worthless woman who is just a burden to her family. Added to the psychiatrist that she would be happy not to be in this world. She has a 52-year-old daughter who is married and has three children

but lives on another state. Next of kin nearby is her brother and his daughter.

Mental State Examination:

Mrs. C appeared somewhat untidy with uncombed hair, wore wrinkled dress and used strong perfume. She is a cooperative lady. LOC is alert and oriented to person and place (knows the year but is unsure of the month and date). Denied having any illusions and hallucinations but was found to be delusional that her brother wanted to get rid of her. She was noted to have difficulty concentrating, easily distracted and has loose associations but can be easily redirected. Presented labile moods, superficial, irritable and intermittently very anxious. Mrs. C was noted minimizing her cognitive defects by concealing them thru confabulating, circumstantialities as well as hiding them by perseverating. She has little insight of her current situation.

Risk Assessment for Mrs. C.

The psycho-geriatric specialist should appreciate that they are attempting to predict a heterogeneous group of disease condition. As a consequence to this, there is a possibility that emergence of some risk factors may predispose to some types of dementia while having little influence on predicting the onset of other types. Physicians should also be aware that most types of dementia are preceded by an identifiable phase of mild cognitive decline. They should also be knowledgeable with the concepts of mild cognitive impairment, cognitive impairment and their differences with dementia (Chertkow et al, 2008). An accurate diagnosis is very important in diagnosing the correct subtype of dementia that is essential in the potent

development of successful treatment regimen (Focht, 2009). Genetic aspects followed by vascular, lifestyle and socio-demographic risk factors should be considered.

Genetic risk factors

It is crucial to obtain an accurate family history revealing as much information as possible about the diagnosis of dementia as well as the age of its onset in all reportedly affected family members. Verification of diagnosis by reviewing clinical reports and neuropathologic findings will be a very good viable report in the confirmation of relatives' diagnosis. Although this may be unavailable as patient's parents' medical history may be unknown due to distance, life circumstance like divorce or death from other causes. In Mrs. C's case, it is helpful that her brother will be able to provide the doctor with information regarding their family history.

Vascular risk factors

Incidence of dementia may be reduced with the reduced risk of stroke. It is important that patient's blood pressure should be kept in good control. A target systolic blood pressure should be maintained ≤ 140 mmHg (Patterson et al, 2008). ASA and statin therapy following MI, antithrombotic therapy for nonvalvular atrial fibrillation and correction of carotid artery stenosis also reduces the risk of dementia.

Lifestyle risk factors

Although there is no available sufficient evidence for a firm results as yet, physicians recommended the following lifestyle modifications in order to reduce the risk of developing dementia: reduce the risk of serious head

injuries; use of appropriate protective clothing when dealing with pesticides, fumigants, fertilizers and defoliants; ensure appropriate levels of education and strategies to retain students in appropriate learning environments as well as education on living a healthy lifestyle; lastly, the increased consumption of fish, decreased consumption of dietary fat and moderate consumption of wine (Patterson et al, 2008).

Care plan for Mrs. C:

Problems:

Alteration of cognition level due to diagnosis of dementia.

Potential safety risks and harming self due to memory problems.

Potential risk of imbalanced nutrition due to impaired mental ability to take sufficient nutrients to meet metabolic needs.

Interventions and Rationals

Mrs. C should be given a caregiver to assist her activities of daily living once further assessment and evaluation proved the diagnosis (dementia). Transferring her to a dementia/ Alzheimer's unit in a long-term care facility could also be arranged.

All her daily routines should be kept consistent as much as possible in order for her not to get confused.

Questions need to be addressed in a yes/no type to determine her needs. It is important to use plain, simple and concrete language in order to reduce any confusion.

Due to memory problems brought about by her dementia, her safety is at risk if left alone to take care of her. Care providers should be with Mrs. C to

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ensure she is safe at all times. Mrs. C should be refrained from given any matches and she should be supervised when she's cooking. Care providers should also make sure that she locks her door for her own safety.

As a result of decreased mental ability regarding the right and sufficient food intake, it is best that Mrs. C should follow a diet regimen prescribed by a dietician. Her weight loss is a sign that Mrs. C is not capable of taking care of herself anymore. Care providers should ensure that Mrs. C is eating the right food for her.

Expected outcomes:

Mrs. C will remain oriented x 3 months.

She will make basic needs known on a daily basis x 3 months.

Mrs. C will remain safe from potential harm i. e. fire in the house x 3 months.

There will be no incidence of burglary in Mrs. C's house x 3 months.

Mrs. C's will have no further weight loss and will remain physically healthy x 3 months.

Although there is no method of curing or arresting dementia, early diagnosis is very crucial for a number of reasons. Early diagnosis will allow the patient and their family to be able to prepare, arrange and plan for the future. Identification of outside resources that will be helpful for the provision of help and assistance will also be done. Being alert for cognitive functional decline is the wisest way in recognizing dementia in its early stage (Santacruz and Swagerty, 2001).

The psycho-geriatric psychiatrist decided to admit her in the Older Adult Mental Health Unit for further assessment and investigation after the initial assessment. She was also started on Aricept 10mg mane, Mirtazapine 15mg nocte and Lorazepam 0.25mg prn. Aricept is an acetylcholine that is important for the processes of memory, thinking and processes. This medication is used in treating mild to moderate dementia. Mirtazapine is an antidepressant that influenced the chemicals in the brain that may cause depression. Lorazepam, on the other hand, is a benzodiazepine that is used to treat and manage anxiety.

It is best to start the medications with the lowest dose possible. In the case of Mrs. C, the psychiatrist prescribed her the combination of scheduled Aricept and Mirtazapine as well as a prn order of Lorazepam. Mrs. C is only taking Estrogen, Calcium with Vitamin D and Multivitamins so there is no adverse effects of drug-to-drug interactions. It is imperative that the physician will be notified of all the medications the patient is taking even if it's only OTC drugs. The three major types of drugs used to treat and control agitation and anxiety are antianxiety, antipsychotic and antidepressant medications. Once the patient is diagnosed with dementia, the medications prescribed are used to treat the symptoms of dementia and not the dementia per se (Hay, 1999).

References:

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