

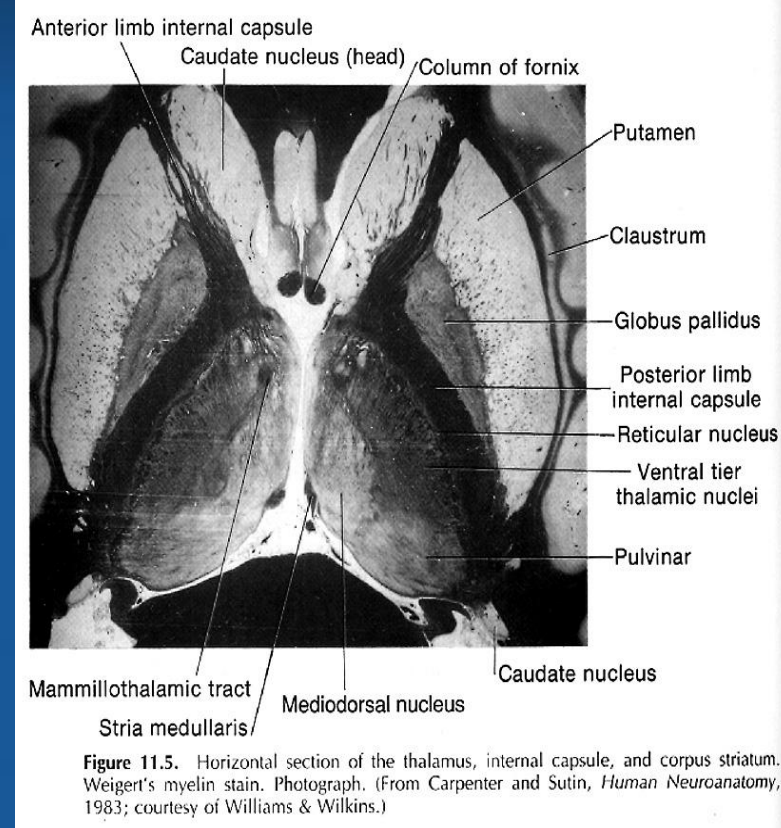
Movement Disorders and Dementia

Majed Habahbeh MBBS FRCP

Anatomy of The Basal Ganglia

The Basal Ganglia are “large subcortical nuclei derived from the telencephalon forming connections between the cortex and thalamus providing for the ease and quickness of human movement”

- Striatum
 - caudate
 - putamen
- Globus Pallidus
 - Externa/Interna
- Substantia Nigra
 - Pars compacta/reticulata
- Subthalamic Nucleus

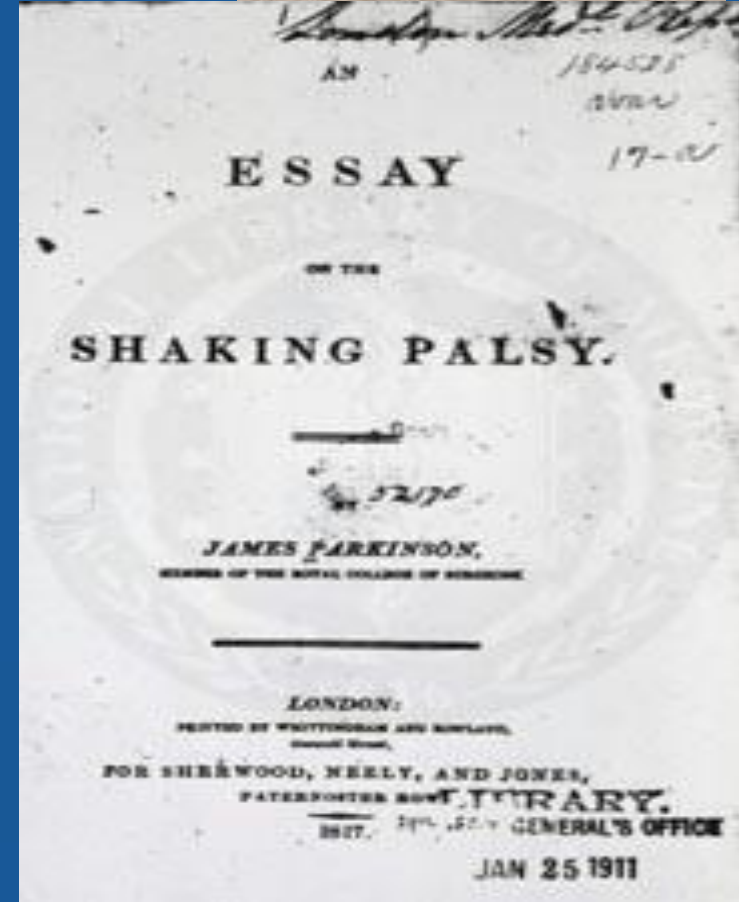


Phenomenological Classification of Movement Disorders

- Movement Disorders are classified broadly into two main groups:
 - HYPOKINETIC DISORDERS:** too little movement
bradykinesia (slowness of movements)
(Parkinson's Disease and other akinetic rigid syndromes)
 - HYPERKINETIC DISORDERS:** too much movement
dyskinesias- (different types of involuntary movements)

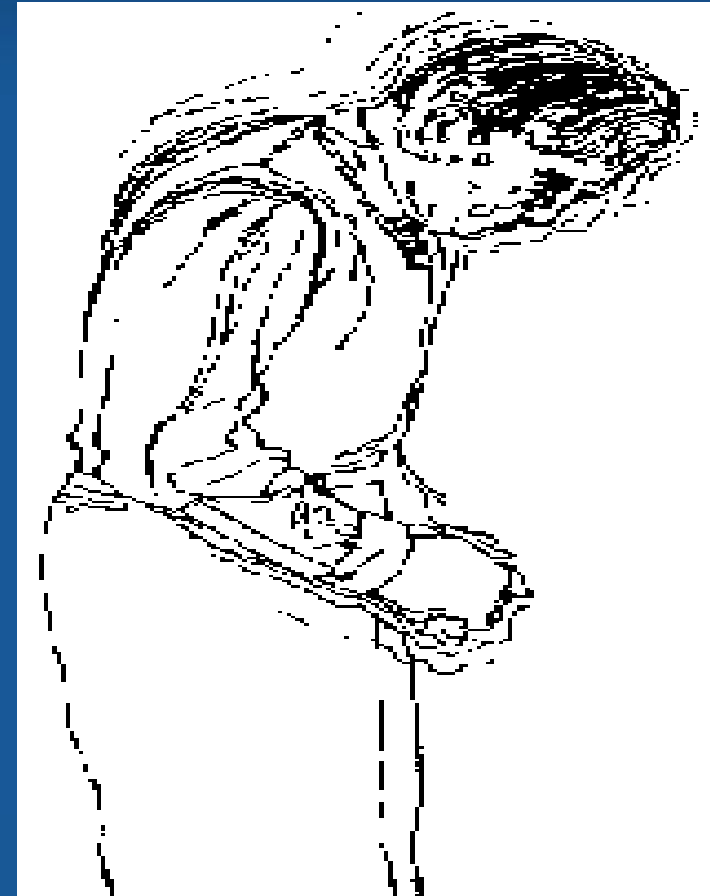
Parkinson's Disease

- **1776:** John Hunter, a British surgeon, describes patients with 'severe tremor on awakening who do not complain from tiredness in the muscles.'
- **1817:** James Parkinson (born 1755 near London) publishes the *Essay on the Shaking Palsy*/ paralysis agitans, the condition that subsequently comes to bear his name.
- **1872:** Jean-Martin Charcot added bradykinesia to the cardinal signs and coined the eponym *Parkinson's Disease*



Parkinson's Disease

- **Parkinson's disease is the second most common neurodegenerative disease after Alzheimer's Disease.**
- A clinical and neuropathological entity characterised by:
 - **Bradykinesia**
 - Rigidity
 - Tremor
- **Parkinsonism:**
 - Any bradykinetic-rigid syndrome



Pathology of Parkinson's Disease

Lewy bodies

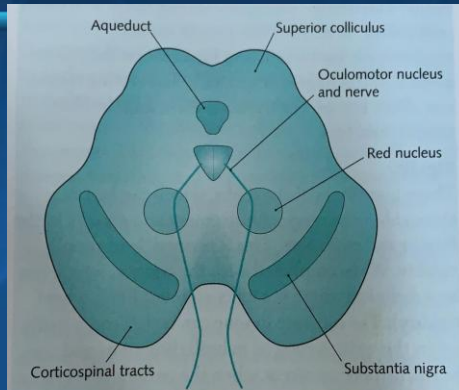
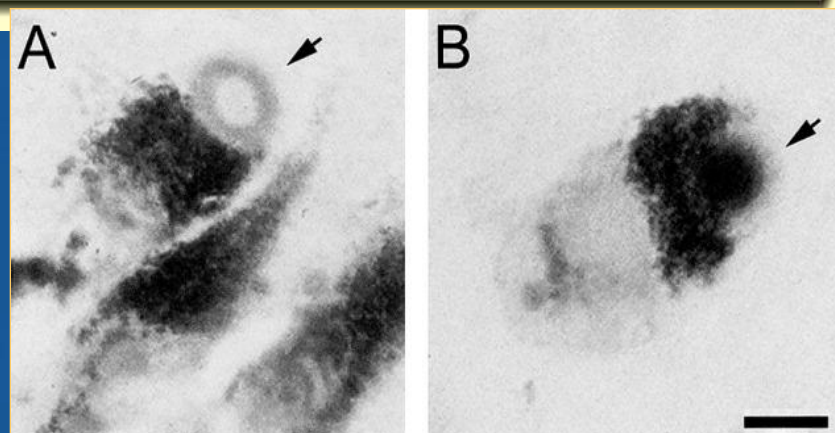
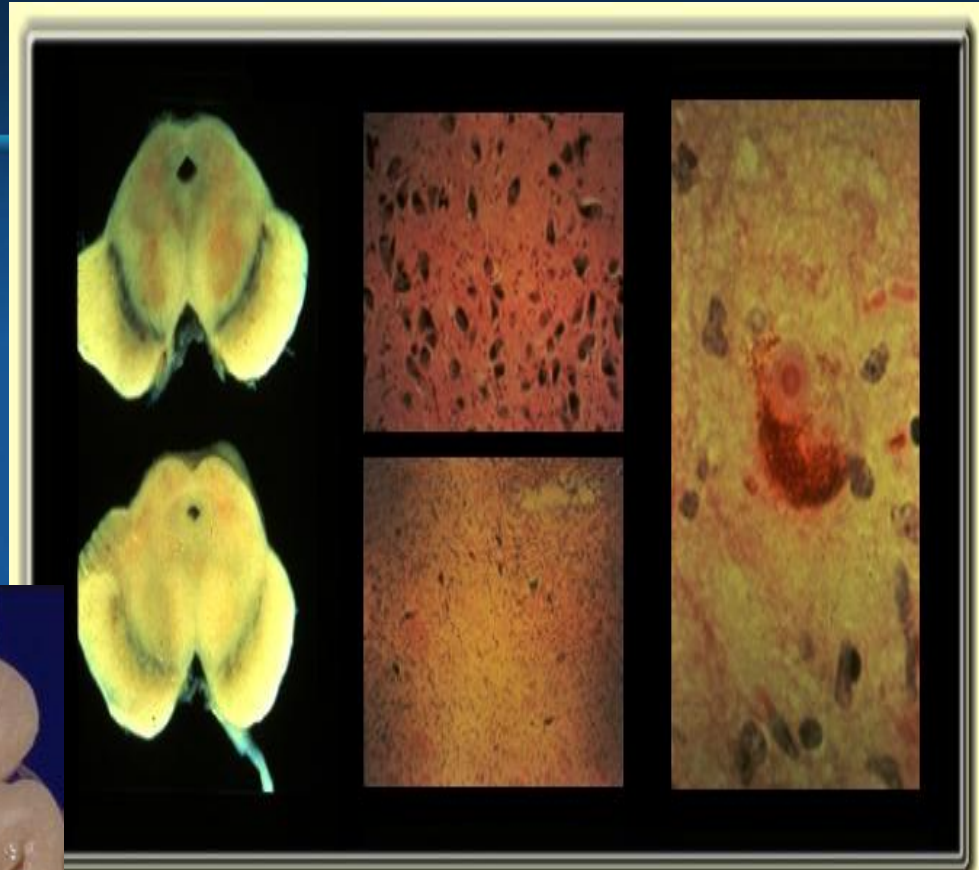


Fig. 18.1 Cross-section of the midbrain.



Risk Factors for PD

- Increased risk
 - Age
 - Family history
 - Exposure in early life to
 - Well water
 - Pesticides
 - Head injury
- Decreased risk
 - Caffeine
 - Cigarettes

Prevalence

- The prevalence of PD in industrialised countries is estimated at about 1% in individuals over 60 years of age.
- The age-adjusted prevalence :1.3 per 100,000 in persons under 45 years of age compared to 1200 per 100,000 in individuals aged 75–85.
- Jordan: 60/ 100,000

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Prevalence of Parkinson's disease in Northern Jordan

Ali Alrefai^{a,*}, Majed Hababbi^b, Mohammad Alkhawajah^c, Mohammad Darwish^d,
Waleed Batayha^d, Yousef Khader^e, Khalid El-Salem^a

^a Department of Neuroscience, Jordan University of Science and Technology, Irbid, Jordan

^b King Hussein Medical Center, Amman, Jordan

^c Department of Neuroscience, King Abdullah University Hospital, Jordan

^d Princess Basma Hospital, Irbid, Jordan

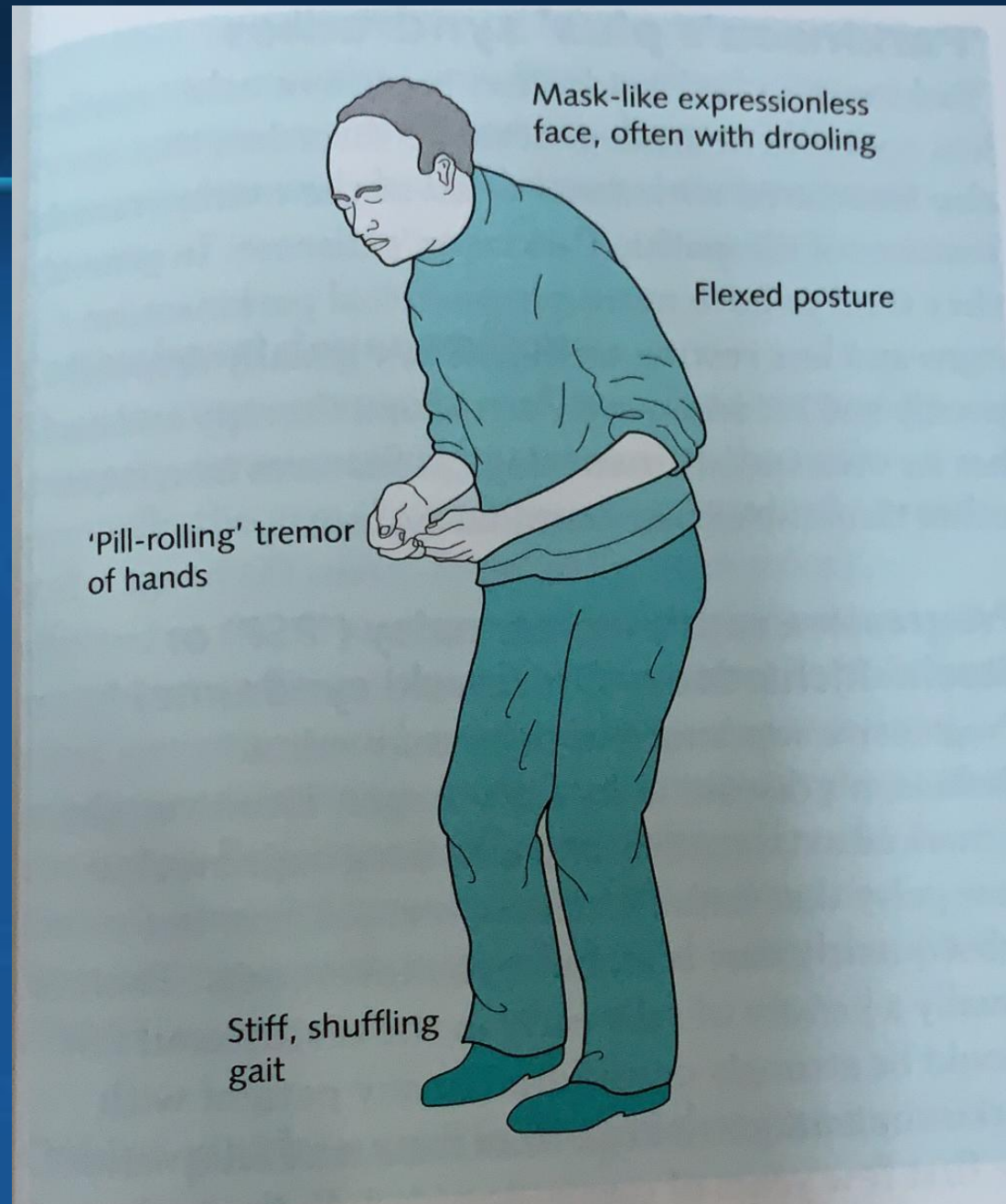
^e Department of Community Medicine and Public Health, Jordan University of Science and Technology, Irbid, Jordan

Main Biochemical Abnormality

- Marked striatal Dopamine (DA) depletion
- <50% DA loss is asymptomatic
- ~70% DA loss for symptom manifestations
- At death, DA loss > 90%

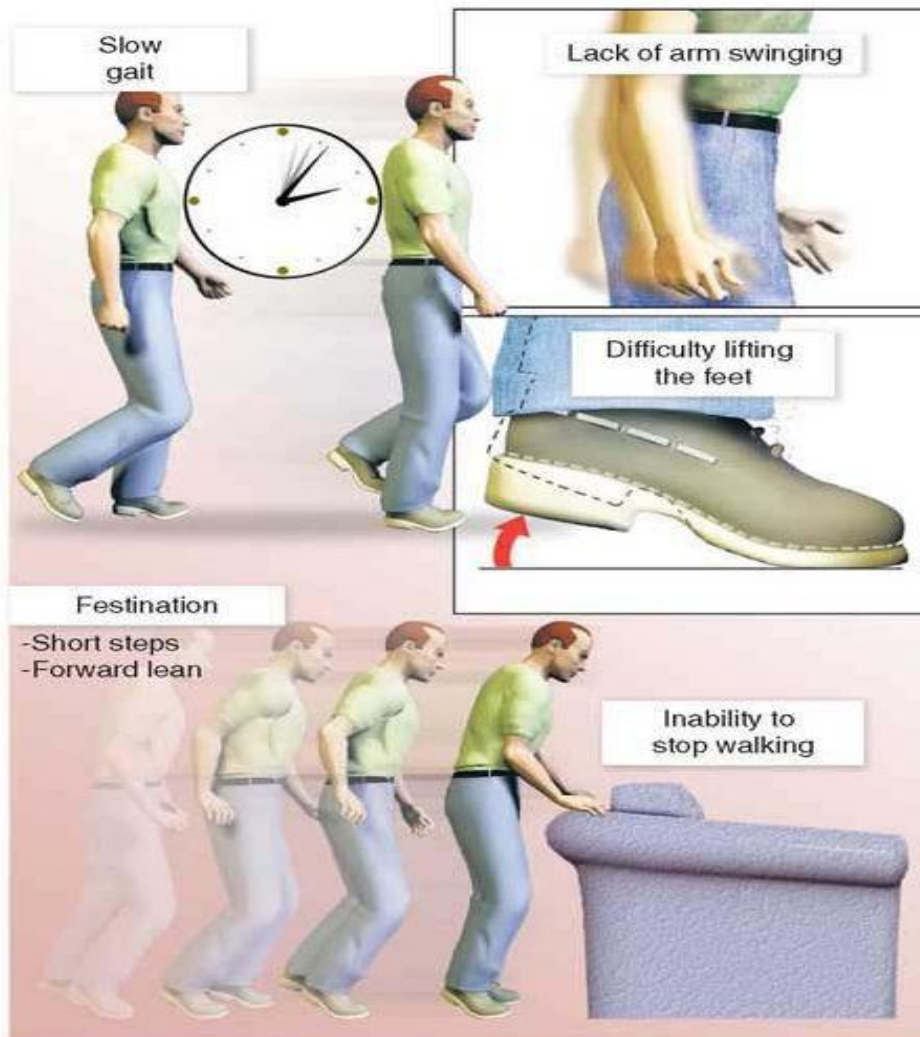
Diagnosis / differential diagnosis

- Tremor
- Rigidity
- Akinesia
- Postural Instability



Bradykinesia

Difficulty of movement ■



Bradykinesia includes such motor phenomena as delayed initiation, slow performance, low amplitude and intermittent arrests of voluntary movement.

Tremor in PD

Main symptoms: resting tremor ■



"Pill rolling" tremor

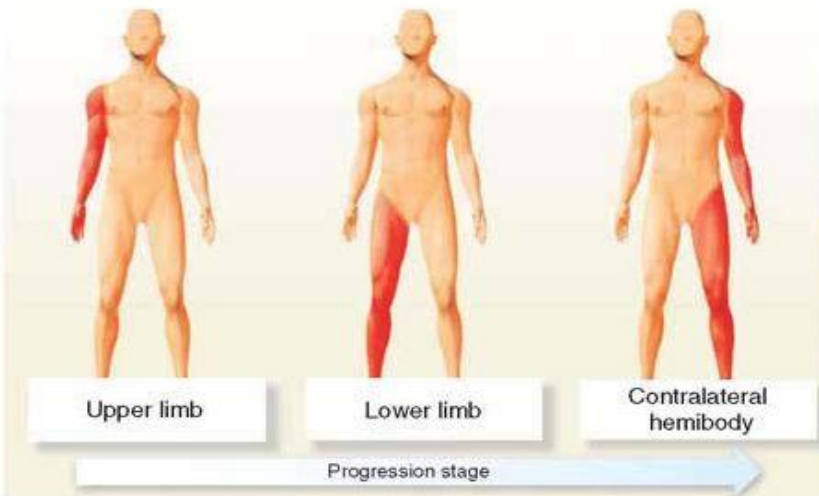


Resting tremor



Disappearance of tremor with movement

Chronology of tremor onset



The tremor of PD is seen at rest- frequency is typically 4-6 Hz.

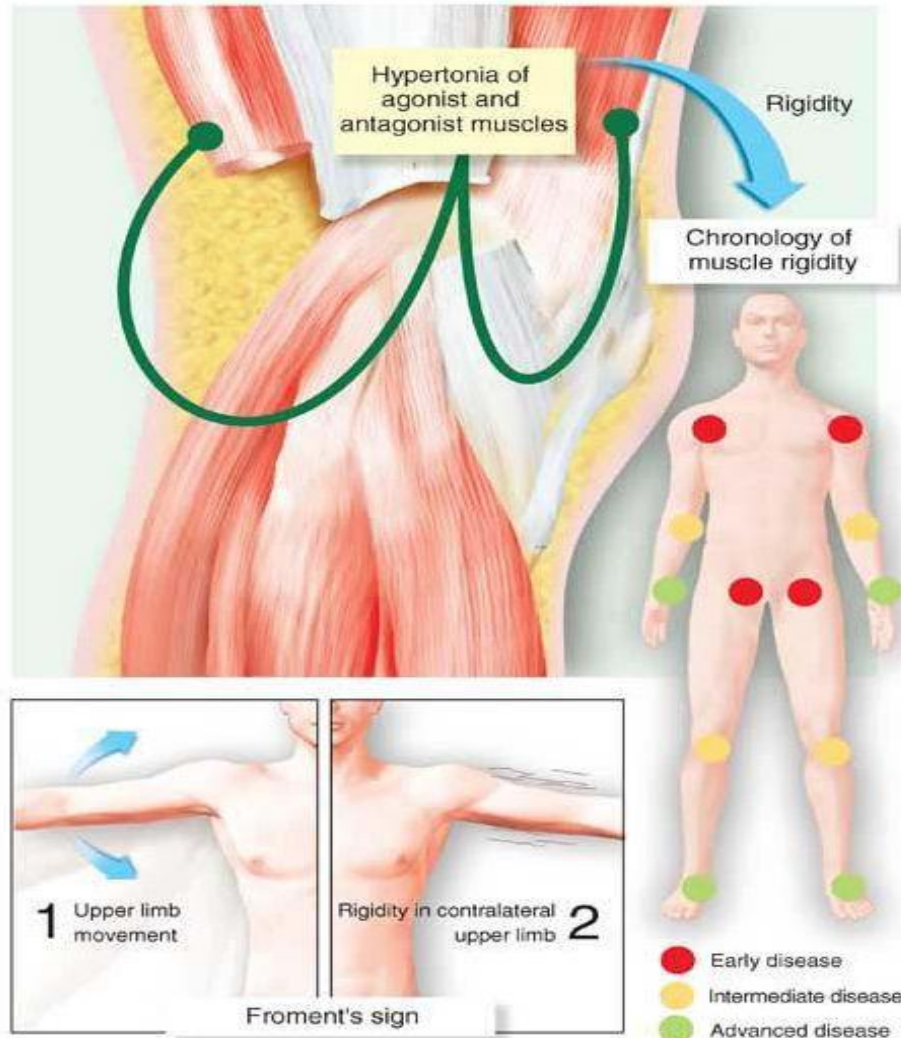
Involves Hand / leg / chin

No head tremor

Postural tremor is commonly seen, but is much less specific for the syndrome.

Rigidity

Main symptoms: rigidity ■



Rigidity describes increased resistance to passive range of motion in limbs or neck/trunk.

Rigidity is present in both flexor and extensor muscles.

Rigidity is not velocity dependent (Unlike spasticity)

Non-Motor Symptoms of Parkinson's Disease

Neuropsychiatric symptoms

Depression, apathy, anxiety
Anhedonia
Attention deficit
Hallucinations, illusions, delusions
Dementia
Obsessional behaviour (can be drug-induced)
and repetitive behaviour
Confusion
Delirium (could be drug-induced)
Panic attacks

Sleep disorders

Restless legs and periodic limb movements
Rapid eye movement (REM) sleep behaviour
disorder and REM loss of atonia
Non-REM sleep-related movement disorders
Excessive daytime somnolence
Vivid dreaming
Insomnia
Sleep-disordered breathing

Autonomic symptoms

Bladder disturbances
Urgency
Nocturia
Frequency
Sweating
Orthostatic hypotension
Falls related to orthostatic hypotension
Coat-hanger pain
Sexual dysfunction
Hypersexuality (likely to be drug-
induced)
Erectile impotence
Dry eyes

Classification of Parkinsonian Syndromes

- Primary (Degenerative)
- Secondary

Degenerative PS

- Parkinson's disease

- Sporadic
- Hereditary forms

Atypical Parkinsonism

- Multiple system atrophy
- Dementia with Lewy Bodies.
- Progressive supranuclear palsy
- Corticobasal degeneration

Atypical Parkinsonism

Key Features of Atypical Parkinsonian Disorders

	PSP	CBD	MSA	DLB	Vascular
Early Falls	++++	+/-	+/-	+/-	++
Gaze palsy	+++	++	+/-	+/-	+/-
Dementia	+/-	+/-	+/-	+++	+/-
Psychosis	-	-	-	+/-	-
RBD	-	-	+++	++	-
Pathology	Tau	Tau	GCI	LB	vascular

PSP= progressive supranuclear palsy; CBD= corticobasal degeneration; MSA= multiple system atrophy; DLB= dementia with Lewy bodies; RBD= REM sleep behavior disorder; tau= microtubule associated protein tau; GCI= alpha-synuclein glial cytoplasmic inclusions; LB- Lewy bodies (alpha-synuclein, ubiquitin)



Brainstem silhouettes in Parkinson and Parkinson-plus syndromes



Normal probands &
Idiopathic Parkinson
disease

Progressive
Supranuclear
Palsy

Multiple
System Atrophy
(cerebellar type)

@theneuroradguy

Secondary Parkinsonism

- Post-encephalitic
- Post-traumatic
- Vascular/SDH
- Metabolic: Wilson's disease, Hypo/hyper- parathyroidism
- Hydrocephalus and Space-occupying lesion
- Toxic
 - Manganese
 - MPTP
 - Carbon monoxide
 - Cyanide
 - Carbon disulfide
- **Drug-induced**
 - DA-receptor blockers
 - Antipsychotics
 - Anti-emetics
 - Ca-channel blockers
 - Anticonvulsants
 - Phenytoin
 - Valproic acid
 - Others
 - Lithium

Hereditary PD

10-15 % of cases of PD



Hereditary PD

		locus	protein
PARK1	AD	4q21-23	α -synuclein
PARK2	AR	6q25.2-27	Parkin
PARK3	AD	2p13	?
PARK4	AD	4p15	?
PARK5	AD	4p14	UCH-L1
PARK6	AR	1p35-36	PINK1
PARK7	AR	1p36	DJ-1
PARK8	AD	12q12	LRRK2
PARK9 Kufor-Rakeb	AR	1p36	?
PARK 10	AD	1p32	?
PARK11	AD	2q36-37	?



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Pallido-pyramidal degeneration,
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Kufor-Rakeb syndrome

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A. S. Najim Al-Din¹, A. Wriekat²,
A. Mubaidin², M. Dasouki¹, M. Hiari²
¹Jordan University Hospital, ²King Hussein
Medical Centre, Amman, Jordan

Parkinsonian Syndromes in a Community

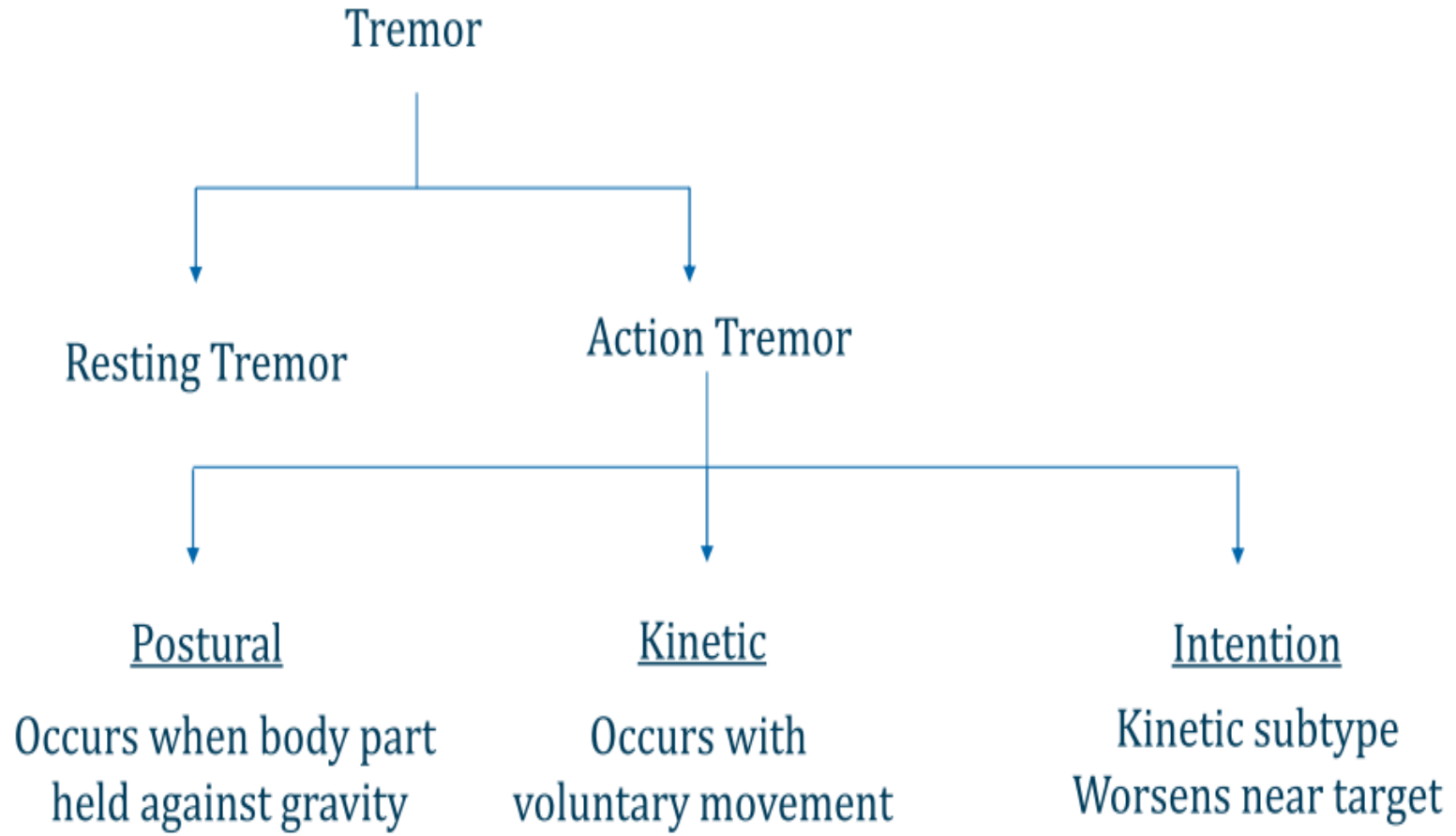
- Idiopathic PD ~ 85% of all PS cases
- Drug-induced parkinsonism (DIP) 7% - 9%
- MSA ~ 2.5%
- PSP and CBD ~ 1.5%
- Vascular Parkinsonism ~ 3%
- PS due to MPTP, CO, Mn, recurrent head trauma is rare
- No definite new cases of encephalitic lethargica since 1960s



Important mimics not to miss

- Essential Tremor.
- Normal pressure Hydrocephalus.
- Cerebrovascular Disease/ vascular Parkinsonism
- Chronic subdural hematoma.
- Elderly patients with slowness and tremor/ staggering gait of the elderly

Tremor



Tremor

- **Definition:** Rhythmic oscillation of a body part.
- Tremors can be classified as:
 - *Rest*: occurs when affected body part is at rest
 - *Postural*: occurs when arms are outstretched
 - *Kinetic*: occurs during movement of body part.

Tremor

Resting tremor:

- Parkinson's disease and other parkinsonian disorders, dystonic tremor, one component of rubral tremor, severe ET,

Postural:

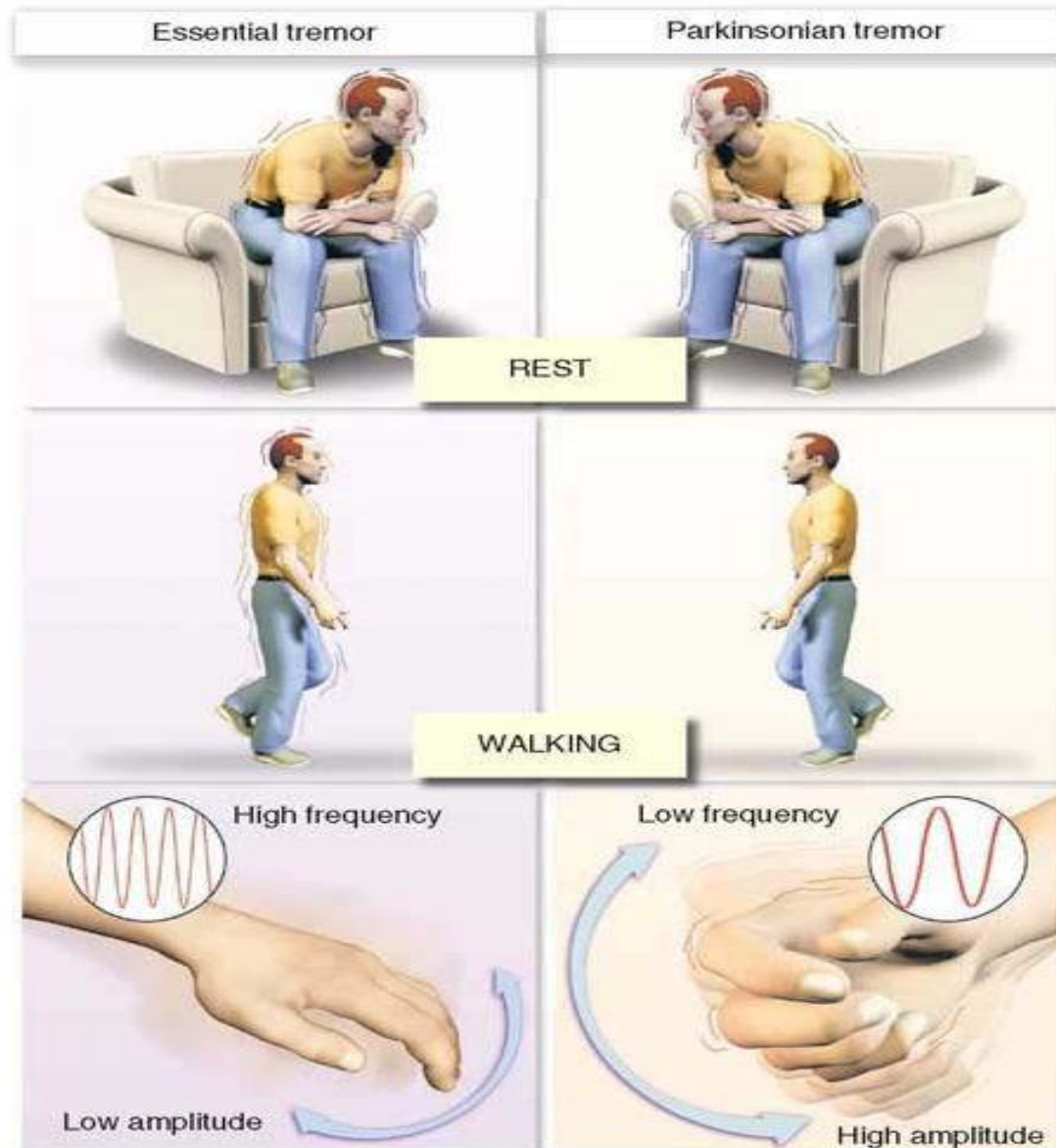
- Essential tremor, Physiological
- PD, Dystonic tremor etc

Kinetic:

- Cerebellar disorders

Other types of tremor: differential diagnosis ■

from Parkinson's disease

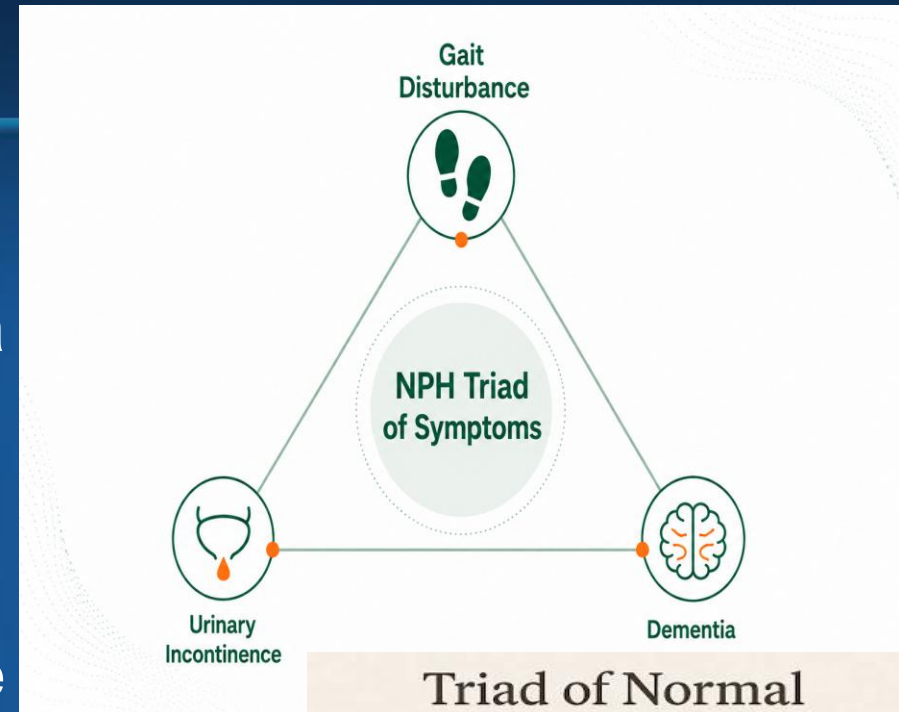


Essential Tremor

- Essential tremor is an action tremor characterised by rhythmic shaking of the arms in almost every case; it may also involve tremor of the head, tongue, lower limbs, voice and face.
- Essential tremor is commonly autosomal dominant, so a family history is important.
- Enhanced physiological tremor is commonly misdiagnosed as essential tremor.
- First-line agents for the treatment of essential tremor include propranolol and primidone. DBS (Vim nucleus of thalamus) for severe cases

Normal Pressure Hydrocephalus

- NPH is an uncommon disorder, but its reversibility, by means of a CSF shunt, justifies increased awareness among clinicians.
- Dilated ventricles, impaired balance, and gait disturbance are the cardinal features. Mental impairment and/or urinary symptoms may also occur.
- 70–80% of patients operated on with a CSF shunt improve postoperatively



Triad of Normal Pressure Hydrocephalus (NPH)



Wet – Urinary incontinence

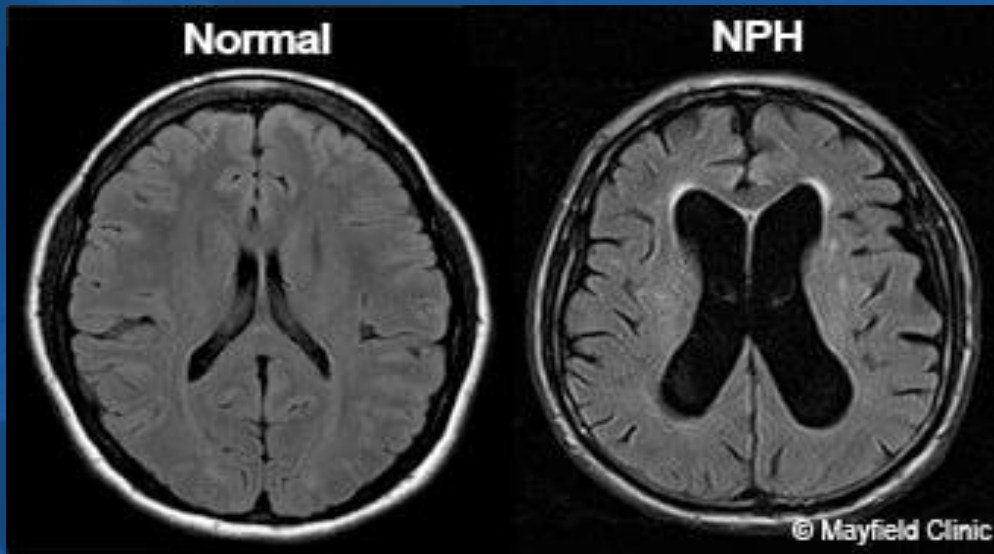
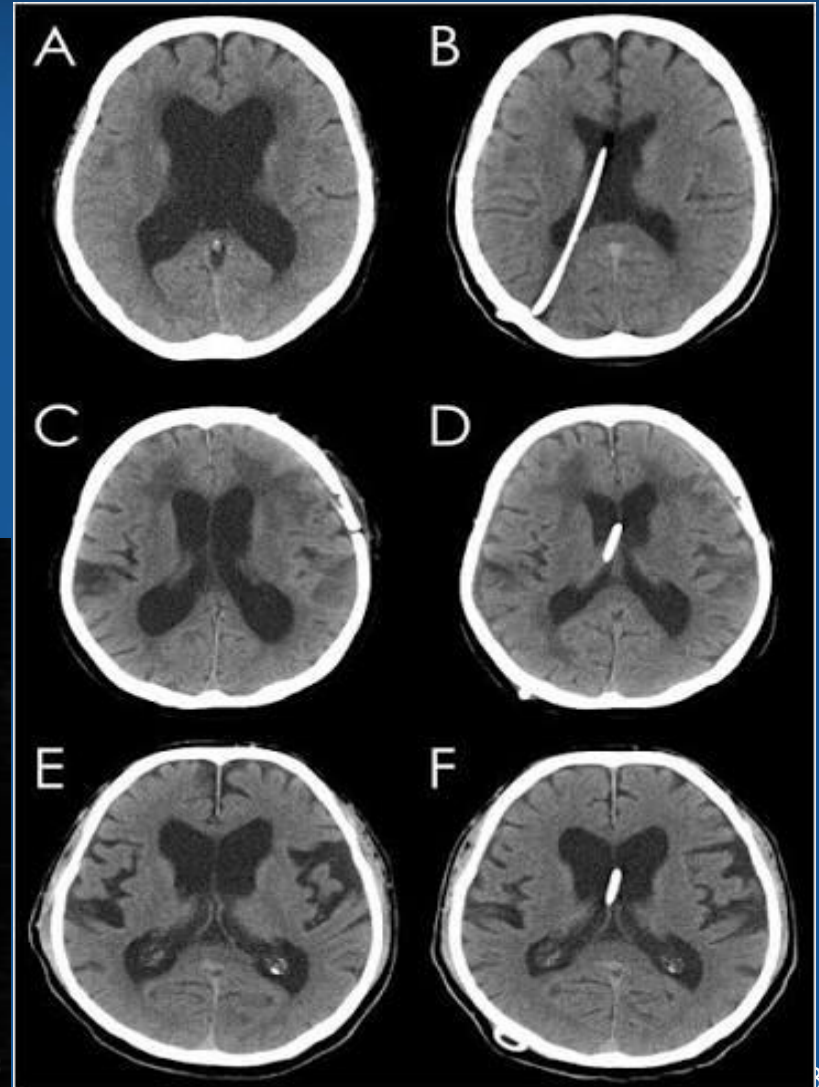


Wobbly – Gait disturbance (magnetic gait)



Wacky – Cognitive impairment

NPH – Imaging



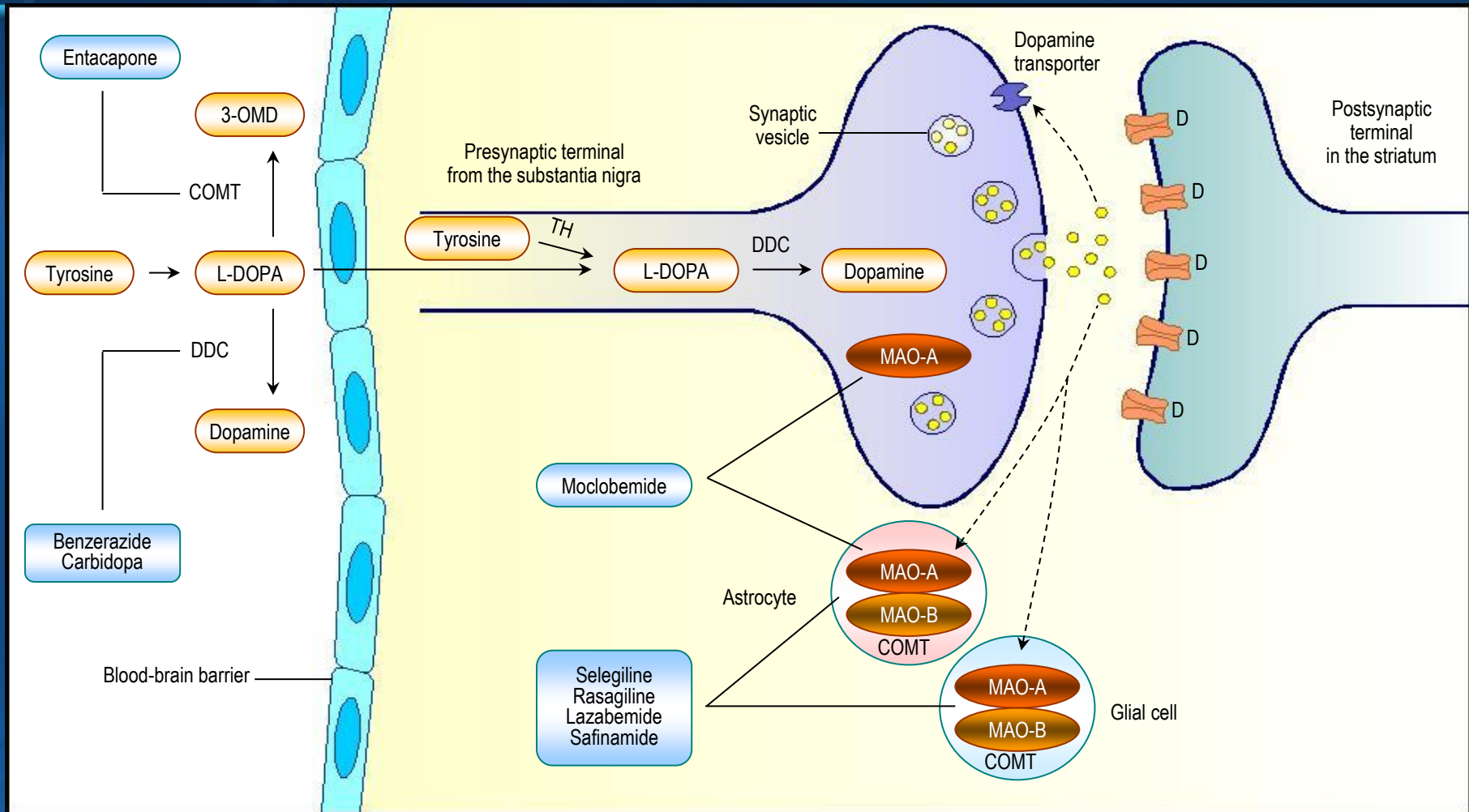
Video 1 -NPH patient before treatment

Video 2 -NPH patient before treatment

Video 3 -NPH patient after treatment

Drug Therapy in PD

The Basis for Symptomatic Drug Therapy of Motor Symptoms in Parkinson's Disease



Abbreviations: DDC, dopa decarboxylase; TH, tyrosine hydroxylase; L-DOPA, levodopa; MAO-A, monoamine oxidase A; MAO-B, monoamine oxidase B; COMT, catechol-O-methyltransferase; D, dopamine receptors; 3-OMD, 3-O-methyldopa

Drug Therapy – Symptomatic Treatment of Motor Symptoms-Dopaminergic agents

– Levodopa

- Levodopa + carbidopa
- Levodopa + benserazide
- COMT inhibitors (entacapone, tolcapone)

– Selective MAO-B inhibitors

- Selegiline
- Rasagiline
- Saffinamide

– Dopamine agonists

• Non-ergot

- Pramipexole
- Ropinirole
- Rotigotine
- Piribedil

• Ergot

- Bromocriptine
- Pergolide
- Cabergoline
- Dihydroergocryptine
- Lisuride

Non-dopaminergic agents

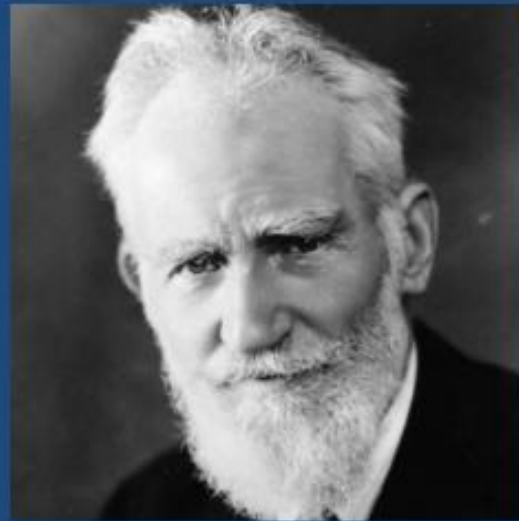
- Anticholinergic agents:
 - Trihexyphenidyl
 - Benztropine
- NMDA antagonists
 - Amantadine

Main Mechanisms of Action of Therapeutic Interventions in Parkinson's Disease

	Action			
Drugs	Promote dopamine synthesis	Activate specific receptors	Prolong dopamine availability	Prolong levodopa bioavailability
Dopaminergic	Levodopa	DAs	MAO-B inhibitors	COMT inhibitors
Antiglutamatergic	Amantadine*			
Anticholinergic†		Trihexyphenidyl Benztropine		
Surgery	Lesion Thalamotomy Pallidotomy Subthalamic nucleotomy	DBS Thalamus Pallidum Subthalamic nucleus	Transplantation‡ Foetal mesencephalic cells	
Rehabilitation procedures	Physical therapy Occupational therapy Speech therapy			

Science never solves a problem without
creating ten more

George Bernard Shaw



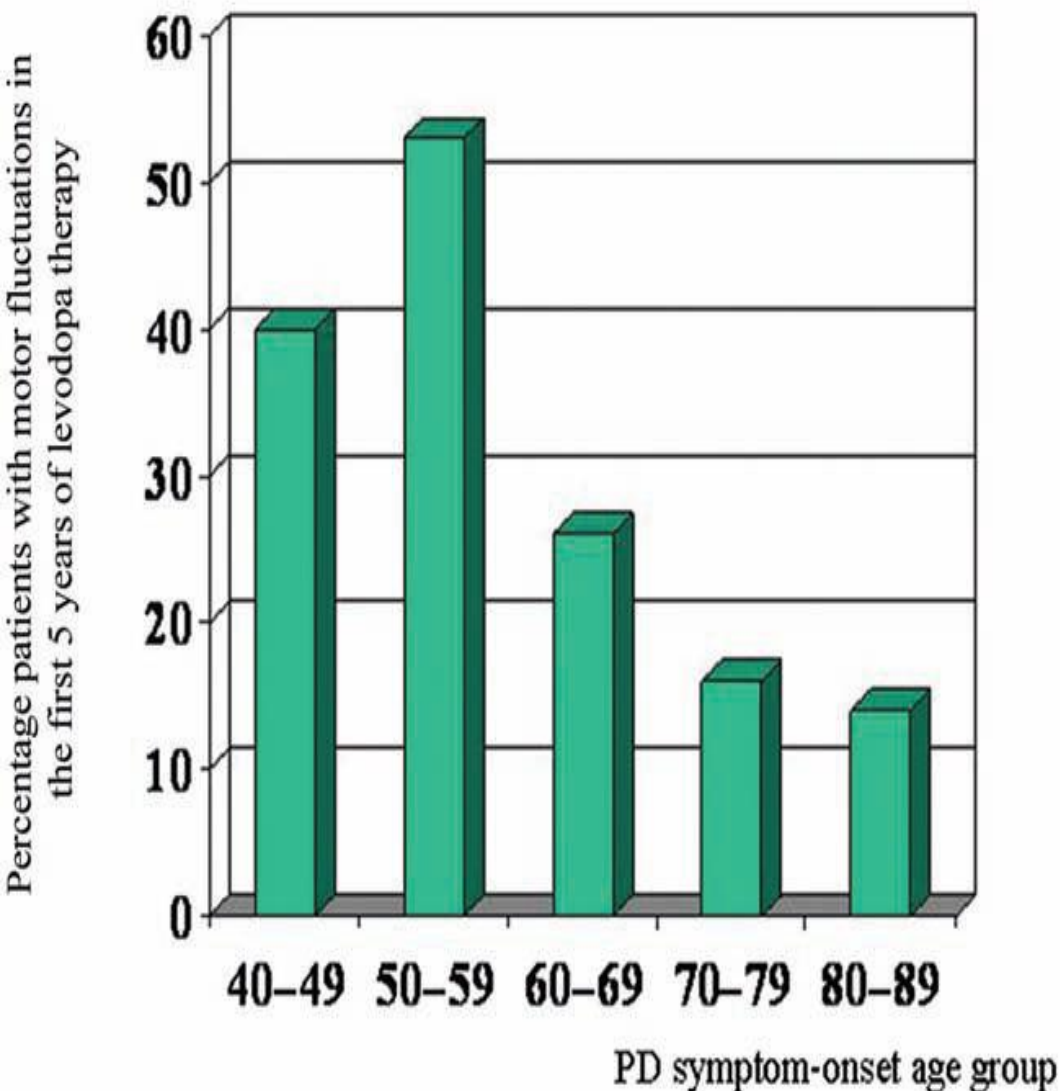
Levodopa in the Management of Parkinson's Disease

- First of the dopaminergic drugs
 - Used since late 1960s
- Highly effective drug
 - Relatively rapid relief of bradykinesia, rigidity and associated pain
 - Reduces tremor in many patients

Levodopa improves quality of life and life expectancy in patients with PD



Levodopa induces motor complications



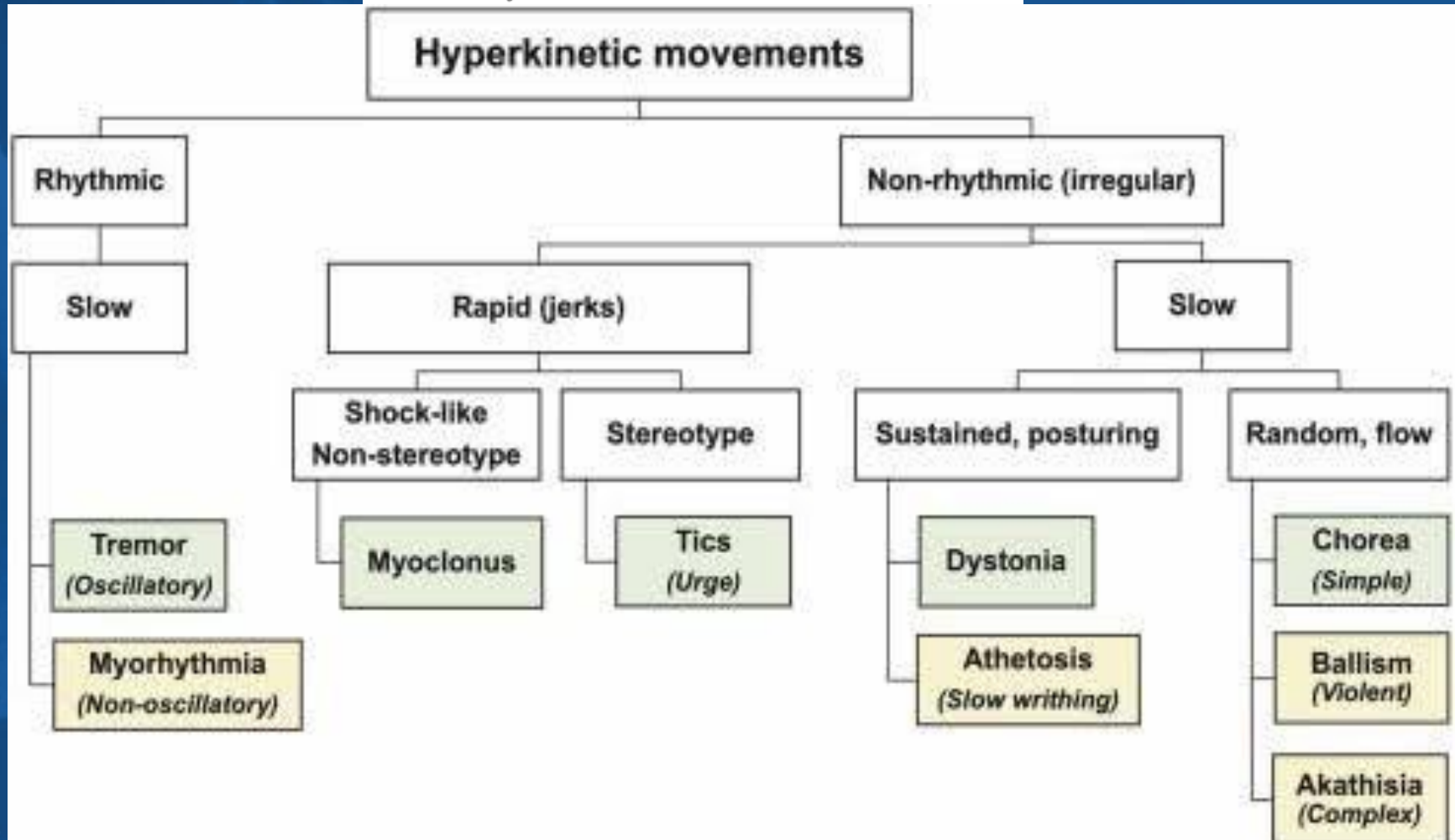
- Up to 80% of PD patients suffer from motor fluctuations and dyskinesias after approximately 5 to 10 years of treatment with levodopa
- 50 to 75% of patients develop motor fluctuations 3 to 6 years after initiating therapy
- 70% of young-onset PD patients develop motor complications after 3 years

Definition of motor complications

- **Motor complications**: The dyskinesias and motor fluctuations which occur during the long term management of patients with Parkinson's disease
- **Motor fluctuations**:
 - (1) Predictable wearing *OFF*
 - (2) unpredictable ON–OFF fluctuations
 - (3) sudden OFF periods
- **Dyskinesias**:
 - (1) Peak dose dyskinesias
 - (2) diphasic dyskinesias
 - (3) OFF period dystonia

Hyperkinetic Disorders

- Five main types:
 - Tremor
 - Tics
 - Chorea
 - Myoclonus
 - Dystonia



Chorea

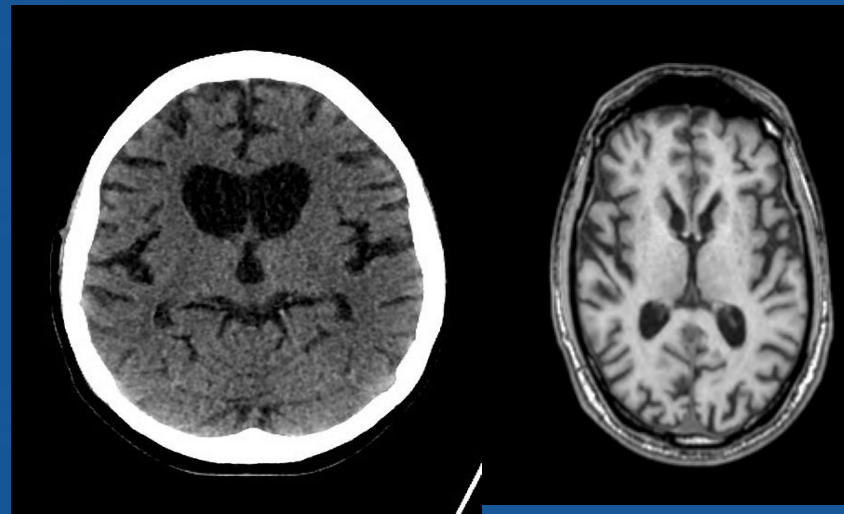
- Chorea is characterized by brief, nonstereotyped, rapid movements that travel randomly among body parts often giving the patient a “fidgety” appearance.
- When it travels in a flowing manner between body parts, as opposed to jumping, it is referred to as choreoathetosis.
- In its extreme form, with large amplitude, proximal, flinging movement, it is called ballismus.

Many causes: Acquired and inherited

- Drugs/ Oral contraceptives
- Basal ganglia lesions
- Sydenham's chorea
- Antiphospholipid antibody syndrome
- Huntington's disease/ HD like diseases
- Neuroacanthocytosis

Huntington's Disease

- An AD trinucleotide (CAG) repeat expansion disorder with the cardinal manifestations of chorea, psychiatric disease and cognitive decline.
- Chorea involves limbs ,head and face
- Motor impersistence (of grip, tongue protrusion or gaze fixation) is a classic feature
- Caudate atrophy on imaging



Tics

- Brief, repetitive and stereotyped movements or vocalisations.
- Tics are usually suppressible for a short period of time, but at the expense of mounting inner tension.
- Very common: 3-4% of the population are affected at some time in their lives, almost always starting in childhood.

Motor:

- eye blinking
- head jerks
- arm/leg jerks
- complex sequence

Vocal:

- sniffing
- grunting
- snorting

Gilles de la Tourette Syndrome

- Typically, onset of persistent multiple motor and vocal tics, often with associated psychiatric disturbance [Attention deficit hyperactivity syndrome (ADHD); Obsessive compulsive disorder (OCD); copropraxia; coprolalia]

Myoclonus

- Myoclonus refers to brief, shock-like muscle jerks.
- The major categories of myoclonus include physiologic, epileptic, essential, and symptomatic
- Myoclonus can also be classified anatomically as cortical, subcortical, brainstem, spinal , or peripheral.

Dystonia

- Involuntary muscle spasms leading to abnormal posturing of limbs and writhing movements (athetosis).
- *Primary dystonia*: without any structural damage often inherited
- *Secondary dystonia*: Due to variety of environmental or hereditary degenerative causes with structural damage to the CNS
- *Paroxysmal dystonia*: brief episodes of dystonia/dyskinesia

- Focal
- Segmental
- Generalized

Three features unique to dystonia

- **Task-specificity:** selective activation of involuntary movements by specific tasks (e.g. writing, using a computer mouse, playing a musical instrument).
- **Geste antagoniste:** a sensory trick that improves the dystonic phenotype while it is applied (touching the chin, touching the eyes, holding an object between the teeth).
- **State function:** variation in severity of dystonia with specific actions (walking backwards but not forwards, speaking but not eating).

Geste Antagoniste



What is this sign/disease



Kayser-Fleischer Rings of Wilson Disease



Two potentially treatable causes of dystonia to consider in every patient

- Wilson's disease
- Dopa-responsive dystonia (DRD)

Wilson's disease

- Wilson's disease is a monogenic, autosomal recessive condition. The causative gene, ATP7B, encodes a copper-transporting P-type ATPase
- Cu deposition in many organs

Wilson's disease

Clinical Presentation

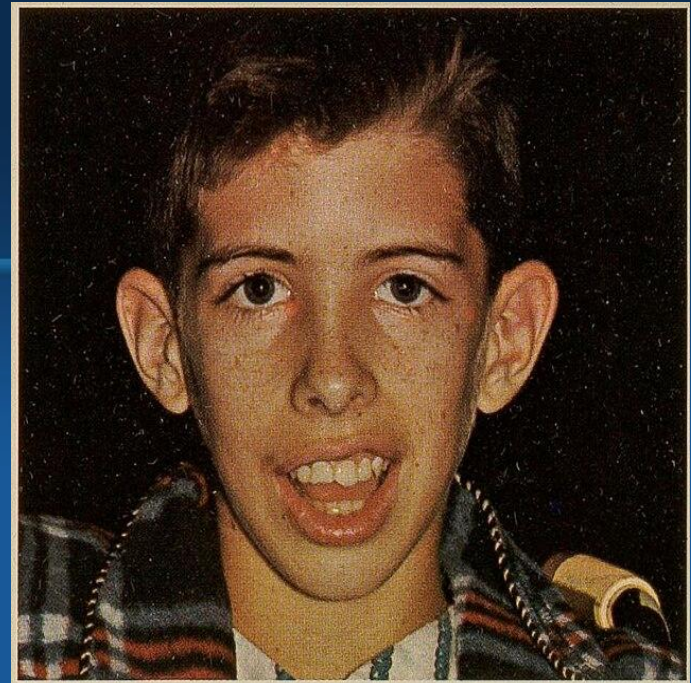
- Younger patients often develop hepatic manifestations
- Older patients with WD -neurological issues
- 20-30% of the patients have prominent psychiatric and behavioral issues
- Movement Disorders –often in combination
 - dystonia
 - parkinsonism
 - tremor
 - ataxia
 - dysarthria
 - rarely chorea

Dysphagia and drooling may occur

Wilsonian face/smile



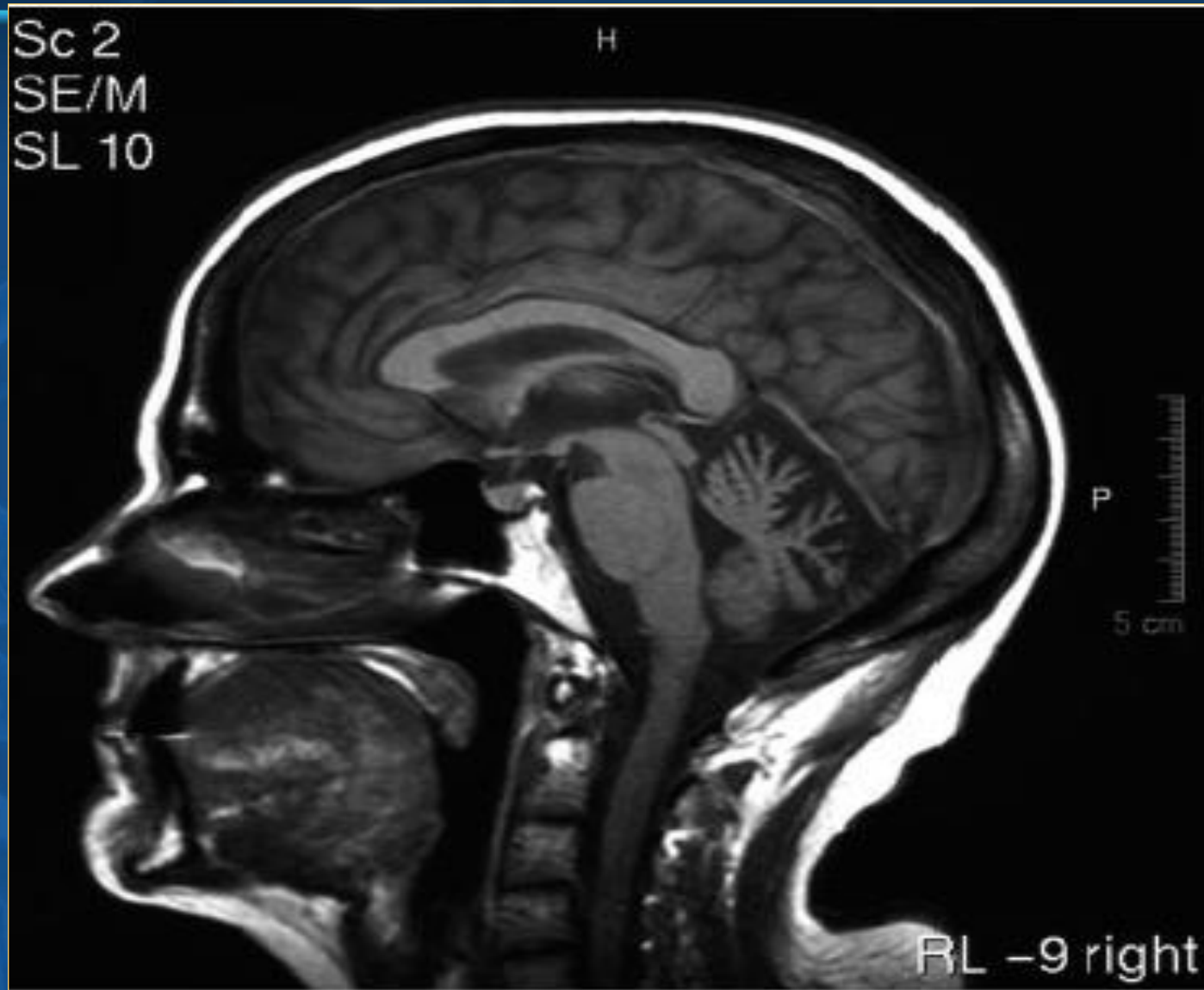
Fig. 1 : Showing typical orofacial dystonia and carpopedal spasm



Dopa Responsive dystonia

- An inherited condition characterised by early onset dystonia and parkinsonism.
- Responds very well to small doses of levodopa, and response lasts for life.
- Many people with DRD are misdiagnosed as having other conditions e.g cerebral palsy.
- *Therefore, levodopa should be considered in all patients with dystonia, particularly those with young onset.*

Ataxias



Definition

- ❖ Ataxia (Gk. Taxis = Order; means lack of order)
- ❖ Ataxia denotes a syndrome of imbalance and incoordination involving gait, limbs, and speech and usually results from the disorder of the cerebellum or its connections
- ❖ It is characterized by dyssynergia, dysmetria, dysdiadochokinesia
- ❖ It is a disorder of rate, range, direction and force of movements

Examination

- ❖ Neck tilt and titubation
- ❖ Nystagmus and other ocular movement abnormalities
- ❖ Dysarthria
- ❖ Intention tremor
- ❖ Hypotonia
- ❖ Past pointing
- ❖ Rebound phenomenon
- ❖ Macrographia
- ❖ Stance
- ❖ Ataxic Gait
- ❖ Pendular knee jerk

TABLE 1. TYPES OF ATAXIAS

Type (presentation)	Mechanisms
Acquired (acute or subacute)	Vascular and structural lesions
	Infectious, parainfectious (eg, acute cerebellitis, inflammatory, or immune-mediated)
	Substrate deficiency (vitamin B ₁ , B ₁₂ , E or A)
	Toxin or drug induced
Genetic (hereditary; chronic, slowly progressive)	Autosomal dominant spinocerebellar ataxia (SCA) 1-49
	Autosomal recessive cerebellar ataxia (ARCA)
	Episodic ataxia
	Mitochondrial ataxia
	X-linked ataxia
Sporadic (subacute or chronic)	Idiopathic late-onset cerebellar ataxia
	Multiple system atrophy

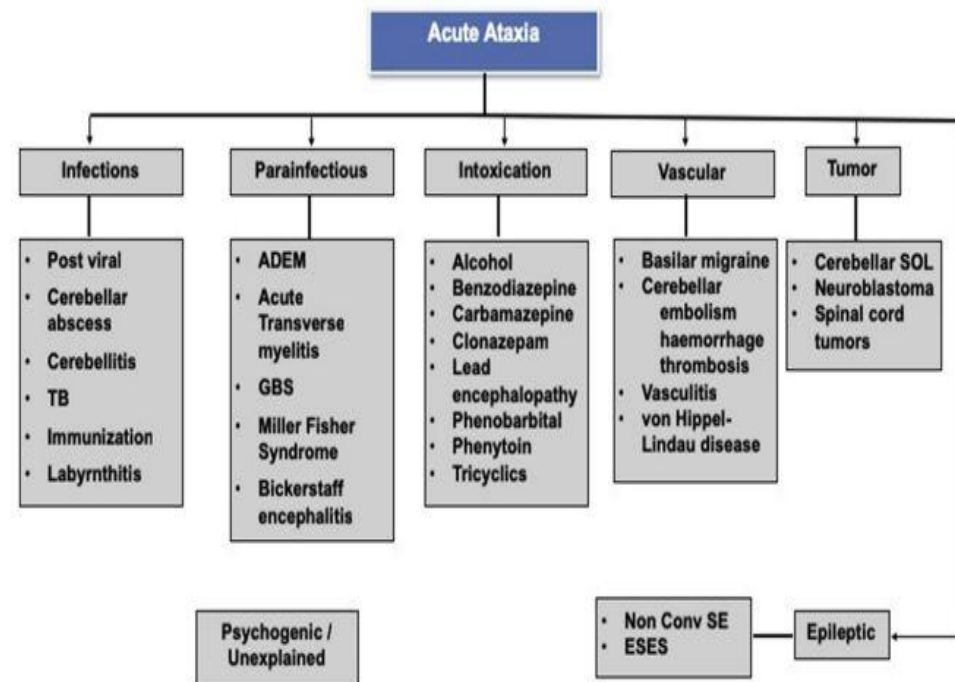


Figure 2 Causes of acute ataxia.

Differentiation of sensory and cerebellar ataxia

- ❖ Sensory ataxia is due to severe sensory neuropathy, ganglionopathy or lesions of the posterior columns of the spinal cord : DM , Sjogren's syndrome, chemotherapy , paraneoplastic disorders, B12 deficiency (SACD), tertiary syphilis (tabes dorsalis)

<u>Cerebellar ataxia</u>	<u>Sensory ataxia</u>
Scanning speech	Normal speech
Nystagmus and other ocular signs	Absent
Sensory exam normal, Romberg test negative	Sensory loss, Romberg's test positive
Pendular reflexes	Hypo to areflexia
Reeling, ataxic gait	Stamping gait

Dementia Made Easy !!

Clinical Definition of Dementia

- An acquired disorder of established mental function, defined as deterioration in more than one cognitive domain (Usually memory impairment) below the pre-morbid level, **severe enough to impair normal daily functioning** (DSM IV).
- Key principles
 - Patient has experienced a decline from some previous higher level of functioning, in contrast to developmental disorders of mental function in which normal mental function had never been achieved.
 - The dementia “significantly interferes with work or usual social activities”

Cognitive Domains

- Deficits apparent in > 1 Cognitive Domain
 - **Recent memory** – ability to learn, retain, and retrieve newly acquired information
 - **Language** – ability to comprehend and express verbal information
 - **Visuospatial function** – ability to manipulate and synthesize nonverbal, geographic, or graphic information
 - **Executive function** – ability to perform abstract reasoning, solve problems, plan for future events, mentally manipulate more than one idea at a time, maintain mental focus in the face of distraction, or shift mental effort easily

NORMAL AGING

VS

DEMENTIA

NORMAL AGING

Occasional trouble recalling people or places

Forgetting appointments or events occasionally

Taking longer to process information

Sometimes losing track of a conversation

Occasionally forgetting where an item is

DEMENTIA

Not remembering the names of close friends or relatives

Frequently forgetting appointments and events

Trouble verbalizing thoughts, frequent pauses in conversations and substituting common words

Regularly repeating statement or questions

Consistently misplacing items



OTHER DEMENTIA SYMPTOMS



Frequent confusion or an inability to focus



Becoming lost in familiar places

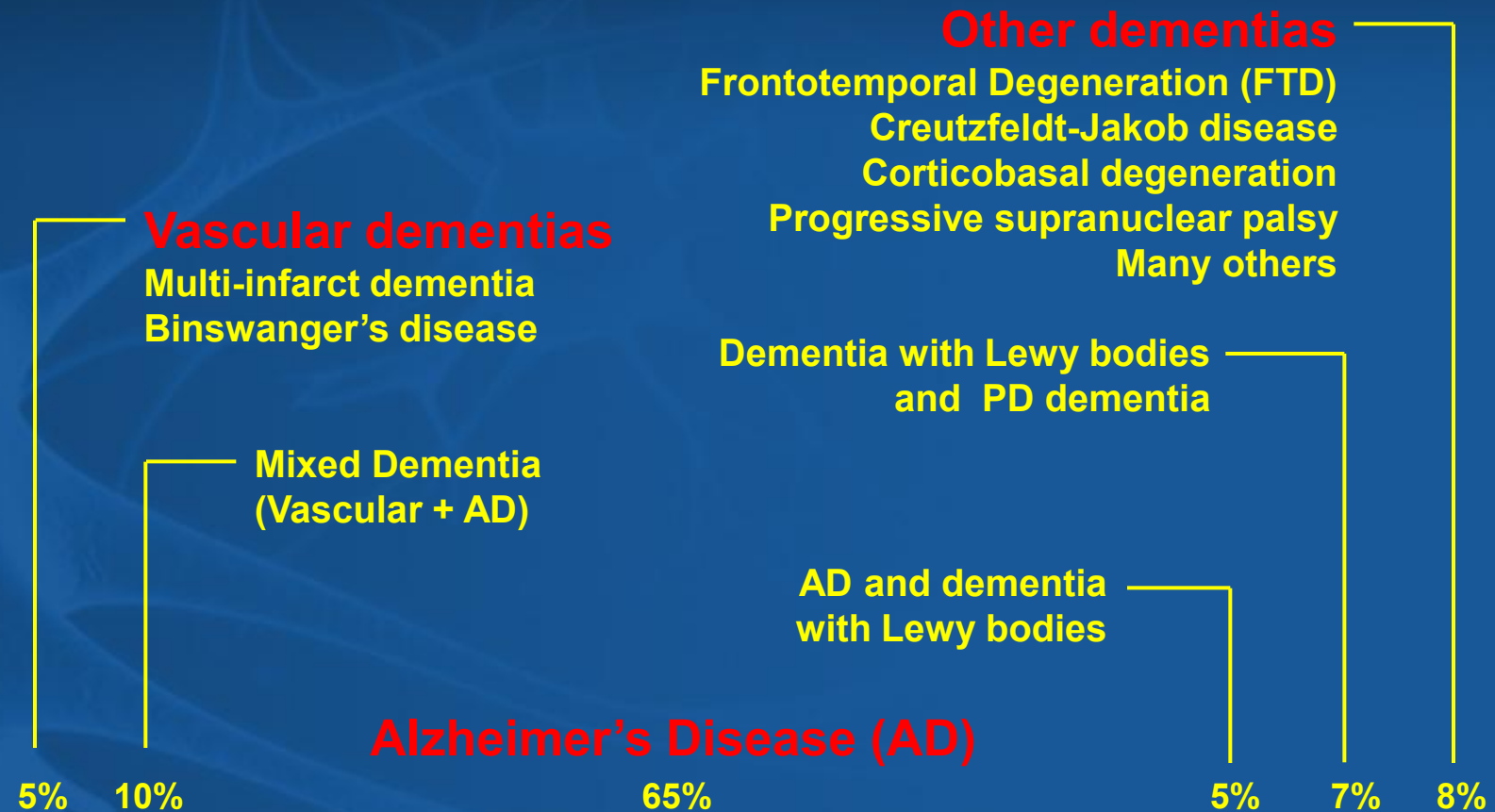


Mood changes



THE BRIELLE
— AT SEAVIEW —

The common Dementias



Classification of Dementias

- **Primary degenerative** dementias including pure dementia (AD , FTD) and dementia-plus syndromes (DLB ...)
- **Secondary forms** of dementia such as vascular dementia, Infections, demyelination, Trauma , tumors, Subdural hematoma , hydrocephalus, Inborn errors of metabolism, metabolic-nutritional conditions, endocrine, toxic, and immune-mediated disorders – **some of them may be reversible**

Rapidly Progressive Dementias

- **Potentially reversible conditions**

- Autoimmune encephalopathies.
- CNS vasculitis.
- Toxic
 - Medication misuse, overuse, adverse effects
 - Alcohol related
- Metabolic disturbances
 - Thyroid, vitamin B12, electrolyte, hepatic, renal and calcium-based disturbances
- Encephalitis

- **Fatal, irreversible conditions**

- Creutzfeldt-Jakob Disease

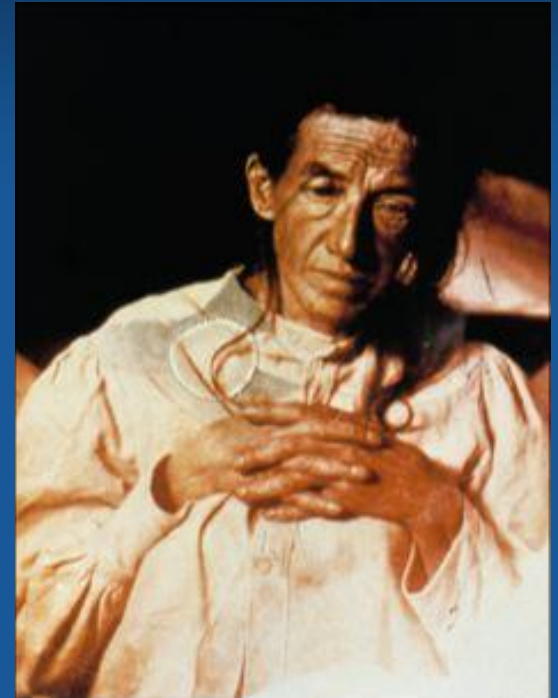
Alzheimer's Disease



Dr Alois Alzheimer
1864 - 1915

German
neuropathologist
& psychiatrist.

In a 1906
lecture he first
described the
disease which
now carries his
name.



Auguste D.

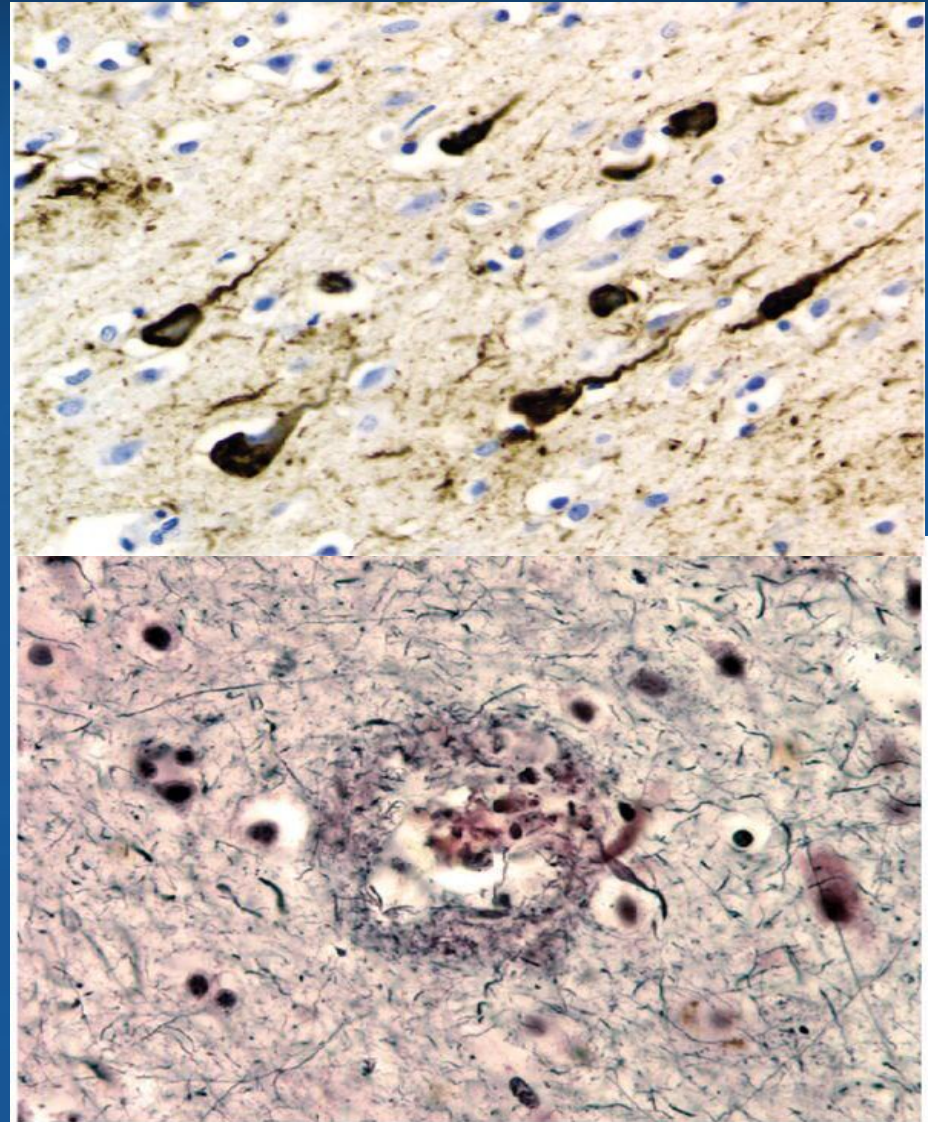
*First seen by Dr Alzheimer in
1901 when she was in her early
50s with:*

- Memory impairment
- Hallucinations
- Executive dysfunction

Pathology of Alzheimer's Disease (AD)

Extracellular Amyloid Plaques and Intraneuronal Neurofibrillary Tangles

- In patients with AD, atrophy starts in the entorhinal cortex and hippocampus, and as the illness worsens clinically, loss of brain volume increases and spreads more globally to involve most areas of the cortex.



Warning signs of AD

1. Memory loss that affects job skills
2. Difficulty performing familiar tasks
3. Problems with language
4. Disorientation to time and place
5. Poor or decreased judgment
6. Problems with abstract thinking
7. Misplacing things
8. Changes in mood or behavior
9. Changes in personality
10. Loss of initiative

Mini-Mental State Examination (MMSE)

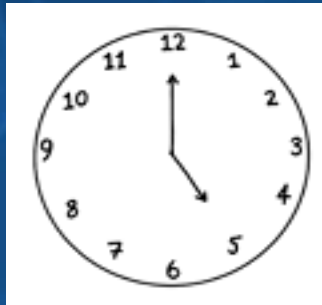
Mini-Mental State Examination (MMSE)

Patient's Name: _____ Date: _____

Instructions: Score one point for each correct response within each question or activity.

Maximum Score	Patient's Score	Questions
5		"What is the year? Season? Date? Day? Month?"
5		"Where are we now? State? County? Town/city? Hospital? Floor?"
3		The examiner names three unrelated objects clearly and slowly, then the instructor asks the patient to name all three of them. The patient's response is used for scoring. The examiner repeats them until patient learns all of them, if possible.
5		"I would like you to count backward from 100 by sevens." (93, 86, 79, 72, 65, ...) Alternative: "Spell WORLD backwards." (D-L-R-O-W)
3		"Earlier I told you the names of three things. Can you tell me what those were?"
2		Show the patient two simple objects, such as a wristwatch and a pencil, and ask the patient to name them.
1		"Repeat the phrase: 'No ifs, ands, or buts.'"
3		"Take the paper in your right hand, fold it in half, and put it on the floor." (The examiner gives the patient a piece of blank paper.)
1		"Please read this and do what it says." (Written instruction is "Close your eyes.")
1		"Make up and write a sentence about anything." (This sentence must contain a noun and a verb.)
1		"Please copy this picture." (The examiner gives the patient a blank piece of paper and asks him/her to draw the symbol below. All 10 angles must be present and two must intersect.) 
30		TOTAL

The Clock Draw Test



Time: 5.00
Score: 7 (normal)



Time: .10.30
Score: 3 (demented)



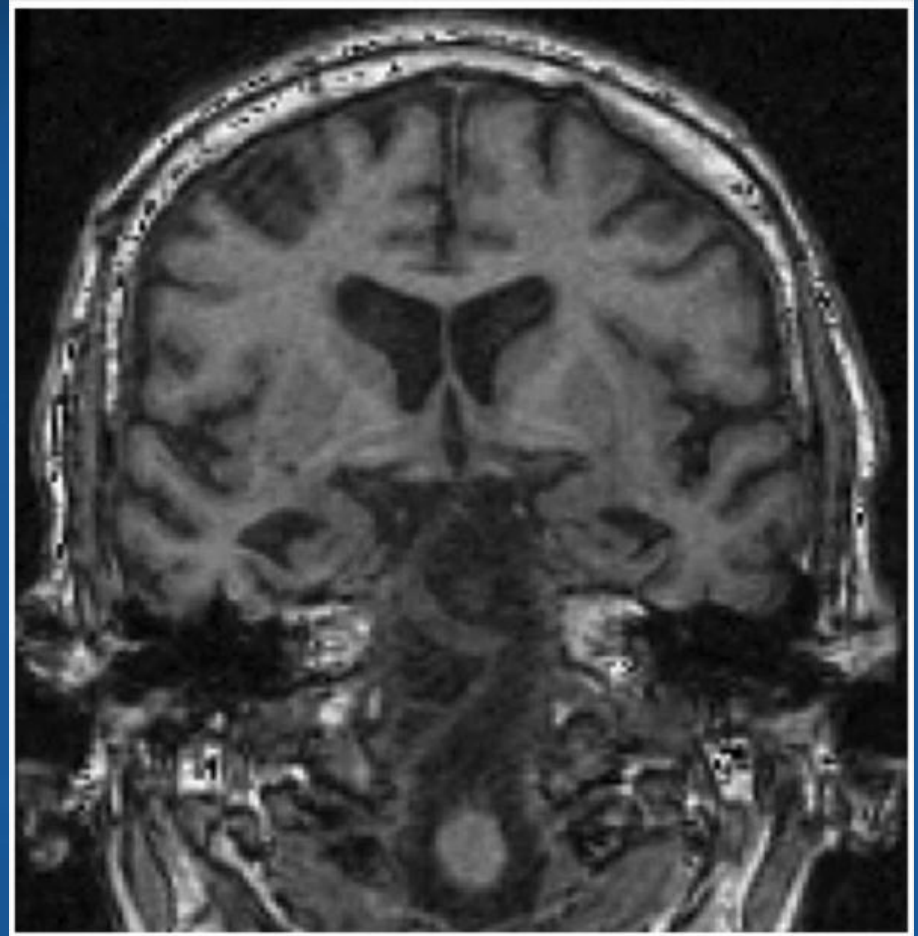
Time: 'no real time'
Score: 2 (demented)



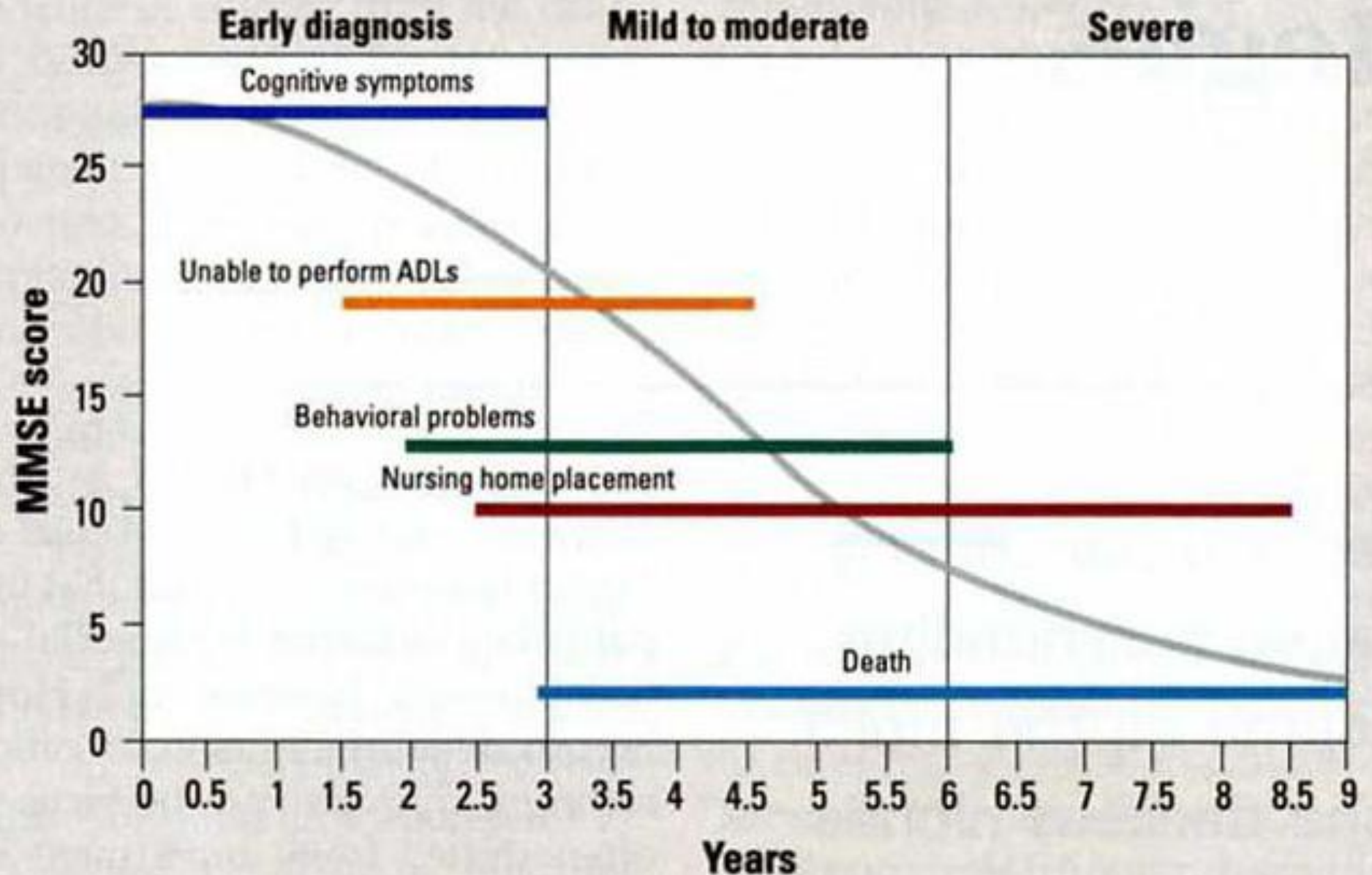
Time: 1/4 past 25
Score: 3 (demented)

MRI changes

- MRI study with coronal view through the hippocampal region illustrating moderately severe medial temporal atrophy and milder global atrophy typical for Alzheimer's disease



Alzheimer's Disease Progression



Management



- Died in 2004 @ 93 yrs of age

Treatment of AD-Symptomatic therapy

Cholinesterase Inhibitors

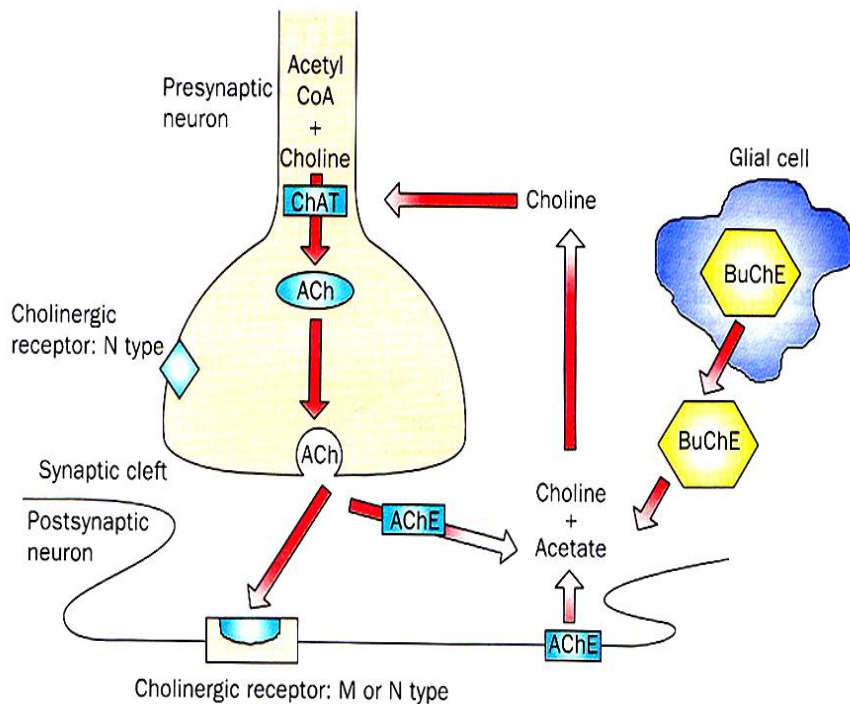


Figure 2. Functional features of the cholinergic system. ACh=acetylcholine; AChE=acetylcholinesterase; BuChE=butyrylcholinesterase; ChAT=choline acetyltransferase; CoA = coenzyme A.

Characteristic	Donepezil	Rivastigmine	Galantamine	Memantine
Chemical class	Piperidine	Carbamate	Phenanthrene alkaloid	Similar to amantadine
Primary mechanism	AChE-I	AChE-I	AChE-I	NMDA receptor antagonist
Other mechanism	None	BuChE-I	Nicotine modulator	HT3 receptor antagonist
Half-life	70 h	90 min	7 h	70 h
Metabolism	Hepatic CYP450 2D6 and 3A4	Synaptic, renal clearance	Hepatic	Partial hepatic

AChE-I = acetylcholinesterase inhibitor; BuChE-I = butyrylcholinesterase inhibitor; NMDA = N-methyl-D-aspartate.

Disease-Modifying Therapy

- **New Anti-Amyloid Therapies**

Treatment for Behavioral and psychiatric symptoms

Behavioral

Wandering

Physical
aggression

Restlessness

Agitation

Pacing

Screaming

Disinhibition
and social
inappropriateness

Psychiatric

Delusions

Hallucinations

Anxiety

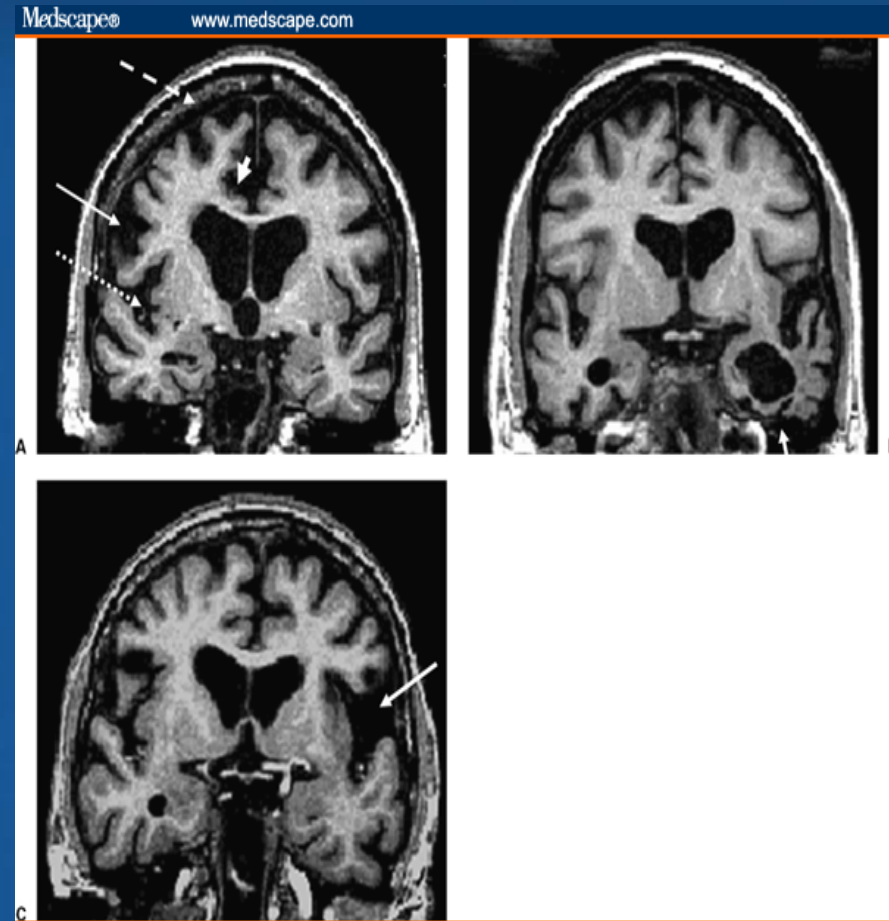
Depression

Sleep
disturbances

Misidentifications

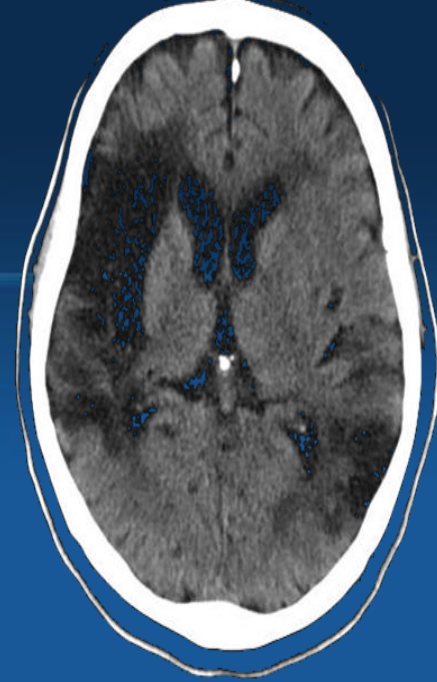
Frontotemporal Dementias

- Uncommon
- Initially may be misdiagnosed as a psychiatric disorder
- Principal manifestations are changes in:
 - Personality
 - Behavior
 - Judgment
 - Impaired reasoning or impaired handling of complex tasks out of proportion to impairments of recent memory or to spatial abilities



Source: Semin Neurol © 2008 Thieme Medical Publishers

Vascular Dementia (VaD)



- Infarctions may be silent
 - More commonly non-dominant hemisphere
 - Lacunar infarctions
 - Severe white matter disease
- 1 in 10 to 1 in 5 patients with dementia have a VaD component
- Initial cognitive symptoms depend on location of infarction