Dementia in the LMICs

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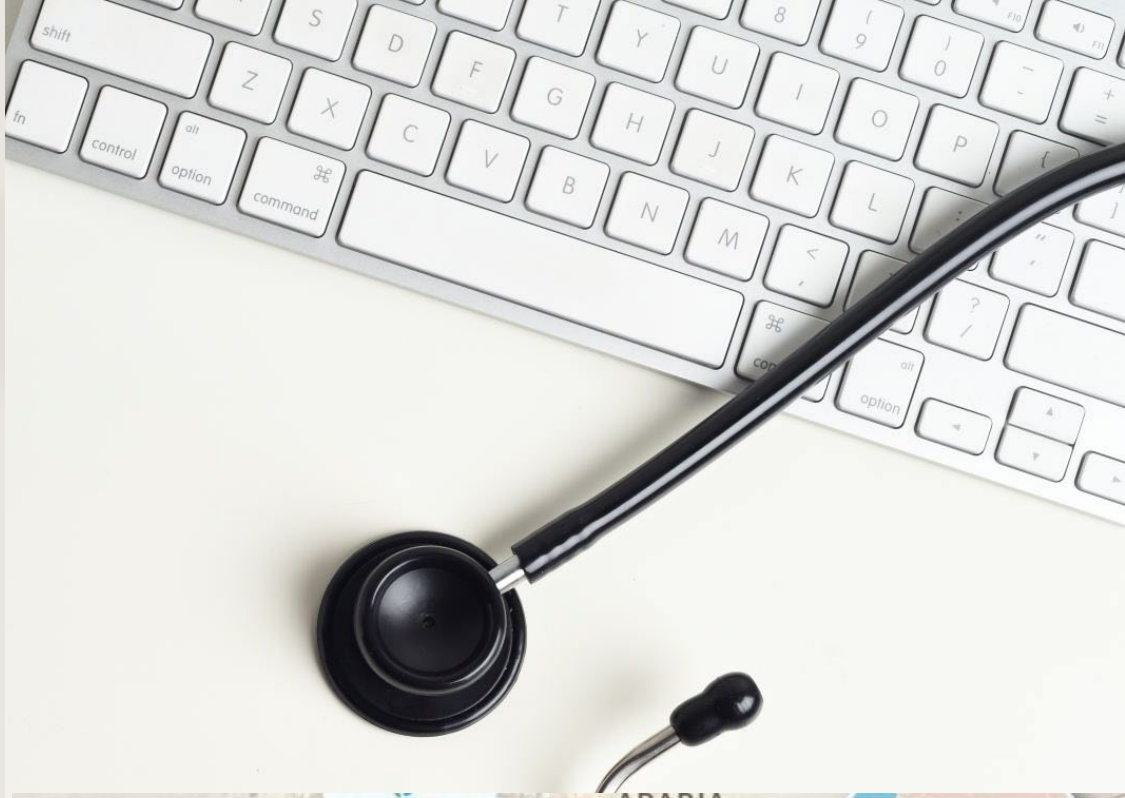
Case study: Dementia presentation and Care in Somaliland

- A 69 years old male, right-handed, married living with his family member. He has high school level education and is retired.
- He is a known local community leader and has history of controlled HTN.
- He came with his wife and his daughter to our psychiatry outpatient unit at Borama Hospital in Somaliland in June 2023.
- He presented with worsening memory impairment in the last 2 years.



- He was relatively stable up to two years ago. He had sleep difficulty, moments of low mood and anxiousness prior to this presentation. He went to a sheikh to help him.

- He **started to forget keys of the house** and his car.

- He lost from **home several times although he was active with his community as elder/leader**.

- He reported to have **forgotten key meetings and commitments. In the first six months it was becoming a that disturbing factor among his community circles.**

- He would have difficulty parking his car in the hotel parking slot where community meet or fail to get his car.

- In the last three months prior to the office visit, **he began to forget names of his colleagues and it progressed to his own family members.**

- He is observant Muslim and he forgot prayers, ways to do ambulation(Islamic ritual to prepare for prayers) and **ate food while it is Ramadan three months prior to the assessment** which alerted his family so clearly that memory problem was going on.

- He started to suspect people that they are attacking him. His wife reported that he **observes ghosts on the wall** that makes him frightened.

In the last month prior to assessment, he even forgot to go to washroom at times or have a bath. His wife and his children support him to do his basic activities.

His sleep got worse. He has difficulty falling sleep and he asks his wife to give him breakfast at 2 am and says he wants to go the market. They are forced to lock the house up now and he gets angry when family tell him it is late in the night.

He would feel very anxious and depressed in the last weeks.

Past psychiatric history

No past psychiatric history

No previous history of suicide or homicide

No past psychotherapy or medications

No prior psych hospitalizations

Medication history

- Imipramine 10mg po od nocte, by his PCP/potentially MDD for insomnia
- Simvastatin 20mg po od nocte
- No known allergies
- No other medical side-effects

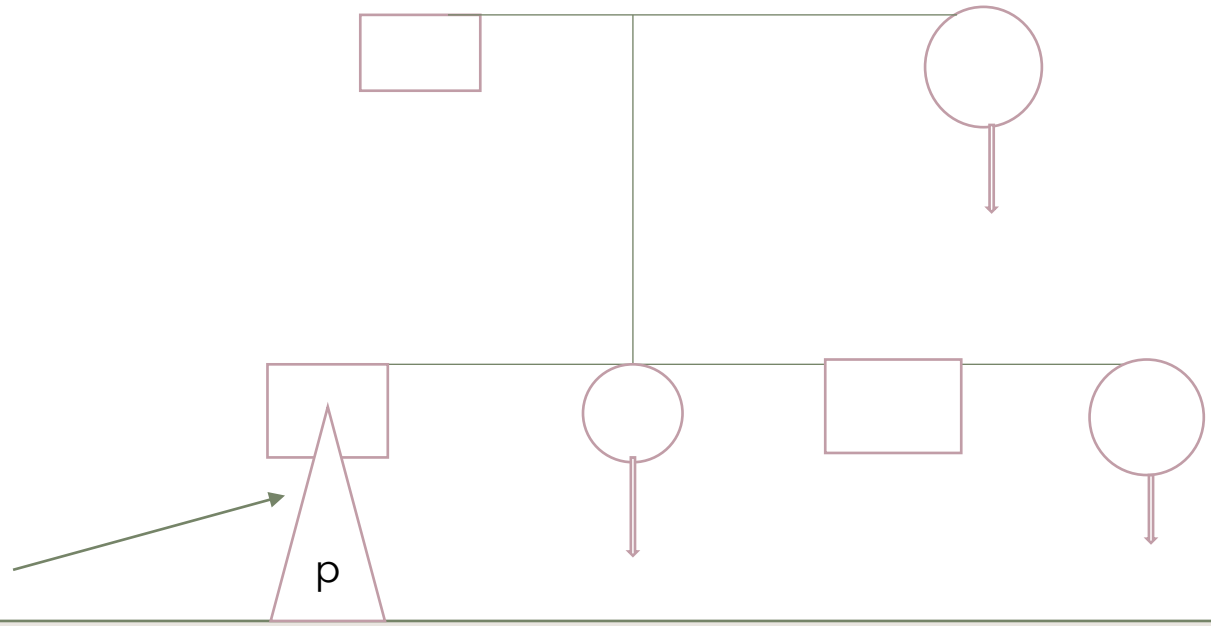
Past medical history

- HTN
- Dyslipidemia
- No known previous surgeries or med conditions

Family History

No known family history of dementia, mental illness, suicide.

No med conditions



Personal and social history

He was born in a rural setting. He went to school and had to leave high school to earn a job. He worked in manual workforce.

He had no known traumatic life experiences

He is married for over 4 decades. He has children and grandkids.

He is economically supported by family, stable socio-economic condition.

Pre-morbid personality

No known personality change

MSE

Appearance and behavior: well-dressed, poor eye contact

Speech: normal rate but with low tone

Mood: He expressed as fine

Affect: looked to be mood congruent.

Perception: visual hallucinations

Thought form: coherent

Thought content: paranoid delusions, no suicidal/homicidal ideation

Sensorium and Cognition: He seemed to be disoriented to time, place and person

Insight: intact

MMSE

Orientation: 5/5 lost points for year, month, state, season and floor

Registration: 2/3

Attention and Calculation: 2/5

Recall: 0/3

Language: 4/9 lost points for 3 stage command, read/command and drawing a pentagon.

Total: 13/30

Patient was alert

Work up

CBC, UA, LFT, RFT, TFT, RBG, Lipid profile, VDRL, HIV, Vitamin B12(Unremarkable).

MRI not available at the site of assessment, the patient had to travel to a city 120km away.

It showed diffuse brain atrophy.

Management plan

- Donepezil 5mg po od nocte
- Quetiapine 5mg po od nocte
- Caregiver education and dealing with neuropsychological symptoms of dementia
- No community or social worker link for dementia

DDX

Alzheimer's Disorder

Lewy body disease

Probable diagnosis: Major neurocognitive disorder due to AD

Limitations

- No social workers/nurses to work on BPSD in Somaliland
- No many MRI/No biomarkers etc.
- No neuropsychologists/neuropathologists
- No many psychiatrists or neurologists
- Primary care physicians and nurses are available as family medicine residency is the only specialist training now there.
- Community health workers exist in other primary psych disorders but not for dementia

Caregiver perspective: The son of the patient discusses his dad's status of living with dementia