

21 Patient management problems

Rob Butler & Brice Pitt

Assessment • Epidemiology • Delirium • Alzheimer's disease • Vascular dementia • Management of dementia • Depression • Mania • Anxiety disorder • Late paraphrenia • Alcohol dependence • Personality disorder • Imaging • Services • Liaison • Residential and nursing homes • Pharmacological treatments • Psychological treatments • Carers • Law • Research

Patient management problems are short descriptions of clinical situations, followed by a series of questions. They form part of the assessment for the MRCPsych Part 2 examination. In this chapter we have included a patient management problem for each chapter in the book. Fortunately, one of us has come across quite a few clinical situations over a long career in old age psychiatry. The answers are not intended to cover everything (the chapters are!) but are offered as a guide. Good answers tend to be systematic ones, which follow the time honoured order of gathering information; taking a history and mental state examination; performing a physical examination and investigations; involving the patient, relatives and carers (where possible and bearing in mind confidentiality); and offering social, psychological and biological interventions. We suggest that you attempt each problem after reading the relevant chapter.

Assessment

An elderly gentleman found wandering on the motorway last night, was brought to an accident and emergency department. The casualty officer says that he appears to be confused.

Q. What are the possible diagnoses?

A. Dementia, delirium, mania, depression, psychosis.

Q. How would you assess him?

A. This will involve a history, mental state and physical examination. Gain as detailed a history as possible. Speak to informants, such as the person who brought him in, the casualty officer and the nurses in casualty. Talk to the patient and see if he is carrying any information. Examine his appearance for signs of long-term dirtiness. Undertake a mental state examination, including a detailed cognitive

examination and a Mini-Mental State Examination (MMSE; Folstein *et al*, 1975). On physical examination record his temperature, pulse and respiration rate, and examine his level of consciousness, respiratory, cardiovascular and neurological systems, including signs of injury or intoxication. Investigations include routine blood tests, mid-stream urine chest X-ray and CT scan, if there is any evidence of a neurological lesion.

- Q. You find that the patient is unable to give a coherent history and has a MMSE of 13/30. There is no collateral history, no obvious physical signs and routine tests are negative. How would you manage him?*
- A. Try to find out more information. Ring the police and social services to see if they have a missing person matching his description. Consider acute admission to hospital, or emergency admission to respite care if the patient agrees. Also, an overnight ward may be suitable.
- Q. The patient is unwilling to be admitted. What are the possible management situations?*
- A. Letting a confused man leave the department would put him at risk and would not be advised. He may be reassured and gently persuaded to come into hospital by repeated calm explanations of the situation from a sympathetic member of staff. Otherwise he may need compulsory admission under the Mental Health Act 1983.

Epidemiology

- Q. Using the same, standard epidemiological techniques, researchers found a prevalence of dementia in the elderly of 4.2% in New York and 2.8% in London (Gurland *et al*, 1983). What factors could account for the difference?*
- A. 1. Interview or sampling biases such as different social class, age structures or proportion living in residential accommodation.
 2. The screening instrument favouring educational or cultural sub-groups.
 3. A true difference – attributable to possible risk factors such as exposure to ‘bath tub gin’ drink during prohibition in New York.

On closer inspection of the data, it becomes apparent that the difference extends over the whole range of cognitive scores, and not just to those below the cut-off score for dementia.

- Q. How does this affect the possible explanations?*
- A. It could still be explained by the use of a screening instrument which favoured London educationally or culturally. Alternatively, a real

difference may exist as the result of factors which generally lower cognition in New York.

Delirium

Mrs Fraser is a 75-year-old lady who fractured her neck of femur and had it pinned. She was grossly disturbed last night on the orthopaedic ward, keeping all the other patients awake. This morning she is shouting and refusing to take medication.

Q. What are the diagnostic possibilities?

A. Delirium, dementia, mania, schizophrenia.

Q. How would you establish the diagnosis of delirium?

A. From a full history (which includes information from the nursing staff), mental state and examination. You need to establish whether she was mentally well before the operation. She may have a fluctuating level of consciousness and cognitive impairment.

Q. What are the most likely causes of her delirium?

A. There may be an underlying cognitive impairment. Causes of delirium include anaesthesia, blood loss, pulmonary embolus, wound infection, chest infection, urinary tract infection, electrolyte disturbance, medication side-effects, post-operative analgesia, alcohol withdrawal, stroke, cardiac event and fat embolus.

Q. What are the most important principles of management for a delirium?

A. 1. Treat the underlying cause or causes.
2. Maintain adequate hydration and nutrition.
3. Rest, reassurance and reorientation.
4. Nurse in the same room, with the same staff (if possible), and have relatives or friends present.
5. Neuroleptics such as haloperidol or thioridazine may be prescribed acutely, in small doses to reduce agitation. Alternatives include benzodiazepines and chlormethiazole.

Alzheimer's disease

A general practitioner (GP) rings you to say he has a deputation from a local housing estate complaining that Mrs Smith, 85, living alone, is in a state of serious neglect, and is causing considerable nuisance by wandering out at night, getting lost and banging on doors. The GP thinks she is suffering from dementia and would like her to be admitted to hospital urgently on a section.

Q. How would you manage the situation?

A. Gather information from her GP and other sources, including details of her past medical and psychiatric history. Speak to others involved in the situation including her relatives, friends, carers and the head of the deputation. Make a joint home visit with her GP, someone who knows her, or alone.

Q. How could you prepare yourself for a home visit if you felt she may be reluctant to see you?

A. Telephone her first, being as pleasant as possible and offering a time to suit her. Her next of kin, neighbour or social worker may be able to offer advice on the best approaches to visiting her, or agree to come with you.

She allows you in. There is a faint smell of urine. The dwelling is cluttered and there is clothing close to electric fires. The milk is off. She scores 21 out of 30 on the MMSE. Although she is polite, she says she does not want any interventions, such as meals on wheels or home help.

Q. What action would you take?

A. Her GP may want to investigate a possible urinary tract infection. Call a case conference, convened by a social worker, involving next of kin, other family members, neighbours, her GP and any other involved professionals. Discuss how to achieve a balance between her rights and the risks she faces. Consider using the Mental Health Act 1983, but only use it if alternatives fail, and she is considered a danger to herself. A community psychiatric nurse (CPN) or another person may develop a relationship with her and be able to encourage her to accept services. You will need to follow-up her situation and place her on a dementia register if there is one locally.

Vascular dementia

Mr Milford, a retired solicitor aged 82, is reported by his wife to have become cantankerous and confused over the last few months, especially at night. He was always been irritable but is now said to be abusive, raising his fists and swearing at the slightest prevarication.

Q. What diagnostic possibilities occur to you?

A. Dementia, alcohol misuse, marital tension, depression, delirium.

You are asked to see Mr Milford at his home after a bad night; his wife says she is at her wit's end and something must be done. You find him to be pleasant, courteous, smartly dressed, clean shaven and able to converse. He

has no recollection of the alleged disturbance, but implies that his wife has become rather pernickety of late. His MMSE score is 24 out of 30.

Q. How would you seek to clarify the diagnosis?

A. From a history, mental state and physical examination. Interview Mr Milford and his wife, assessing their relationship and their mental states. Consider admitting Mr Milford to day hospital for a more thorough assessment and observation over a period of time. Look for risk factors for vascular dementia such as smoking, a family history of heart disease or a history of myocardial infarct, diabetes mellitus or transient ischaemic attacks. Repeat cognitive assessments at different times of day to pick-up 'sundowning'. Physically examine Mr Milford, looking for signs of cerebrovascular disease, such as hypertension and peripheral vascular disease. On neurological examination test for frontal lobe signs including the putting and grasp reflexes. Arrange for investigations and a CT brain scan.

Q. The diagnosis is vascular dementia. What are the principles of management for these aggressive outbursts?

A. 1. Suggest he has activities during the day, such as attending a day centre. Ask occupational therapy for ideas to employ his residual cognition as fully as possible.
2. Support and offer help and advice to his wife, including marital counselling if necessary.
3. A neuroleptic such as haloperidol 0.5 mg once a day increased up to four times daily may reduce his level of agitation, but you must monitor for side-effects.

Management of dementia

Mr Green, 78, a widower, former grocer and councillor, lives alone. Children in the neighbourhood report that he has been exposing himself from his front room window. He strenuously denies this. Cognitive assessment shows no gross abnormality, but his flies are open and he tells rather inappropriate dirty jokes.

Q. What is the differential diagnosis?

A. Frontal lobe dementia, alcohol dependence, hypomania.

Q. What would be the management?

A. Take a full history, mental state and physical examination. The assessment would include gathering information from his GP, hospital notes and forensic history. A programme of assessment and supervision might include help with his dressing, such as an *aide*-

mémoire “have you done up your flies?”. If he has difficulty in fastening buttons or pulling a zip, velcro might be used to fasten the flies. A fuller structured day might keep him occupied and relieve boredom. Attendance at a day centre or hospital, complemented by visits from community staff would help. If he is able to acknowledge a sexual drive behind his self-exposure, counselling, or in an extreme situation, anti-androgens or benperidol could be considered.

Depression

Mr Montgomery, 84, was admitted to a psychiatric ward from his sheltered flat because he cut his wrist with a safety razor blade. There was not much blood loss, but he had severed a tendon.

Q. How would you assess his suicide risk?

A. Take a full history and mental state examination. This would include collateral information from his warden and GP. Ask Mr Montgomery why he did it and whether anything had changed. Find out if he had left a note, how soon before it came to light and had he told anyone. Ask about a family history of psychiatric illness, or past psychiatric history including deliberate self-harm. Find out how he views his present life situation and what his intentions are for the future. Does he have a mental illness such as depression, alcohol dependence, schizophrenia or dementia?

Q. You decide that this was a failed attempt at suicide in the presence of an agitated depression and he still wants to die. What management would you offer?

A. You would want to keep him in hospital, even if this involved using the Mental Health Act 1983. On the ward he would initially have close observations. A full assessment would include finding what management has been successful in the past. On the ward, a more sedative antidepressant such as lofepramine would be prescribed, as well as a small dose of a neuroleptic such as thioridazine to reduce his agitation. Electroconvulsive therapy would be considered if his depression was psychotic, he remained a high suicidal risk or if he failed to eat or drink.

Mania

Mrs Luke, 71, is a new arrival at the Everest Old People’s Home on a one-month trial. She has been placed there by the social services, as an emergency, because of confused behaviour and self-neglect. The manager

complained that she is noisy, talks nineteen to the dozen, is rude, disinhibited, flirtatious, greedy, takes her nightie off in the living room and is up all night.

Q. What is the differential diagnosis?

A. Mania, delirium, dementia, drug misuse.

Q. What features of the history are consistent with hypomania?

A. Pressure of speech, disinhibition, poor sleep and over-activity.

Q. The GP tells you she has a history of depressive illness. How would you manage her?

A. Make a full assessment including history, mental state and physical examination. Admission to hospital will depend upon how well the home can manage her. Day hospital attendance is an alternative. If her diagnosis is mania, then consider prescribing a neuroleptic such as thioridazine. Lithium may be appropriate for prophylaxis, although it can also be prescribed for acute episodes. Explain to the staff the implications of Mrs Luke's diagnosis, emphasising that it is a treatable condition which explains her behaviour and that you will follow-up.

Anxiety disorder

Mr Evans, 69, never married, has not left his sheltered flat since he had a heart attack three years ago. His new GP does not want to continue prescribing the lorazepam 1 mg three times daily, which he has been taking for three years.

Q. What is the differential diagnosis?

A. Anxiety disorder, depressive illness, agoraphobia, anxious personality disorder, benzodiazepine dependence, physical illness such as angina.

Q. You have reached the diagnosis of a late-onset agoraphobia. Are there any benefits to stopping the benzodiazepines?

A. Apart from tolerance and dependence, benzodiazepines may have interactions and side-effects such as unsteadiness and falls, which may be more problematic in older age. Most older people can withdraw from benzodiazepines successfully.

Q. He would like to stop taking the lorazepam, and you agree. How would you do this?

A. Alter the lorazepam to an equivalent dose of a long-acting benzodiazepine, such as diazepam. Reduce the dose gradually over

several weeks, based upon regular reviews. Offer help for any underlying problems. Support includes day hospital admission, individual or group psychotherapy, relaxation therapy and monitoring by a CPN or psychologist.

Late paraphrenia

The housing welfare officer has been told by Miss Jones that she hears her neighbours talking to her through the radio and what they say distresses her.

Q. What possible diagnosis occurs to you?

A. Late paraphrenia, schizophrenia, depression, dementia, poor hearing, no mental illness – she is being persecuted by the person next door.

Q. How would you assess her?

A. With a history, mental state and physical examination. Speak to her housing officer, GP and other involved individuals to gain as full a history as possible. Visit her at home with her GP, someone who knows her or alone.

Q. What special features might you notice in her flat?

A. Lots of locks and precautions against voices such as loudspeakers. She may whisper and insist you only talk in another part of the flat.

Q. You have made a diagnosis of late paraphrenia. How would you manage her?

A. Following a full assessment you may consider doing little more than excluding treatable conditions, such as ear wax, and improving her social isolation as much possible. Sometimes a cure for paraphrenia can be worse than the condition in its milder forms. She should be offered medication but she may well refuse it. She may be more willing to take it if she develops a good relationship with her GP, yourself, a CPN or staff at the day hospital. Hospital admission should be considered, especially if she is neglecting herself, not eating adequately, threatening her neighbours, or putting herself at risk of eviction or criminal charges.

Alcohol dependence

Mr Evans, 72, unmarried, has lived in sheltered accommodation since a stroke six months after his retirement at 65. He is reported to be abusive, uncooperative, complaining all the time about his home help, bathing

attendants, wardens and social worker. At a domiciliary visit he is smelling of alcohol. There are bottles of beer and whisky under his bed.

Q. What is the likeliest diagnosis and how would you manage the situation?

A. The likeliest diagnosis is alcohol dependence. The management would include finding out how much he is drinking, how he is supplied and the cost (if he is unable to leave his home alone, how does he obtain his alcohol?). He will need a full assessment, including physical examination and investigations looking for alcohol damage. If he acknowledges his problem with alcohol he may agree to a programme of detoxification, followed by support. Should he be admitted to a residential home he may have less access to alcohol.

Personality disorder

The housing authority has been approached by Miss Dawson's neighbours, because Miss Dawson, aged 68, causes a nuisance through her persistent feeding of pigeons. She was contacted by the housing authority and told that she would face eviction if this behaviour continues. One week later she is feeding the birds as before. The housing officer wants a psychiatric assessment, with a view to finding an alternative to eviction. Miss Dawson has agreed to see a psychiatrist at her home.

Q. What possible diagnosis do you entertain as you go to see her?

A. No mental illness (non-conformity or eccentricity), dementia, personality disorder.

Q. An assessment reveals no evidence of a mental illness. How would you manage her?

A. A realistic appraisal may conclude that what cannot be cured, must be endured. However, a further appeal should be made to her to avoid eviction. Inform the housing officer that you have found no evidence of mental disorder, and although she is unlikely to change her behaviour, an eviction order will simply move the problem to another area. A home help or other sympathetic worker may be able to develop a relationship with her and influence her behaviour that way. She may agree to attend a day centre.

Imaging

Mr Brotherton, 84, living in Torquay, has been in the habit of going for a swim with his widowed daughter every day. She reports that in the last three months he has been unsteady as he emerged from the water, and

occasionally incontinent of urine during their car drive back to his home. He is also becoming mentally slow and forgetful.

Q. What possible diagnoses do these symptoms suggest?

A. Normal pressure hydrocephalous, vascular dementia, stroke, tumour.

Q. How would you confirm the diagnosis? What treatments might be available?

A. A full assessment including mental state, history and physical examination. The typical triad for normal pressure hydrocephalous is dementia, incontinence and ataxia. A CT scan will show enlarged ventricles in hydrocephalous or may reveal a tumour. Both conditions may be amenable to surgery. Hydrocephalous is treatable, with a shunt from the ventricle into the vena cava or the peritoneal cavity.

Services

Mr Jones, 86, suffering from moderate dementia, is looked after by his wife who needs to have a cataract operation. Two days before the operation, a caring geriatrician admits him to his ward as a social admission, but the next morning Mr Jones is extremely agitated, searching for his wife, and insisting they have not been separated in more than 50 years. He demands that he is allowed home.

Q. You are asked to transfer him to a psychogeriatric ward for containment. What are your options?

A. Assess him on the geriatric ward and try to persuade him to stay. Find out how long his wife will be in hospital, what support he needs at home and whether alternative arrangements can be made, such as staying with relatives. His wife's operation may need to be postponed. An assessment for Section 2 of the Mental Health Act 1983 and sedation should be avoided if possible.

You visit Mr George on the ward, and confirm he is confused, agitated and very keen to return to his wife. He scores 15 out of 30 on the MMSE. You are unable to persuade him to stay while his wife has the operation. You therefore arrange for him to return home to his wife, and the operation to be delayed. He rapidly settles, but she still needs the operation.

Q. What better arrangements might be made?

A. Day surgery may be possible, but the couple would need support. A full domiciliary assessment, including activities of daily living and social worker assessment, will establish what support is required at

home. He may be gradually introduced to other sources of support such as home help, a day centre or a home carer. It may be necessary to provide full domiciliary care including a live-in carer during his wife's hospital admission.

Liaison

Mr George, 75, is unpopular on the geriatric ward where has been admitted for treatment for a chronic leg ulcer, diabetes and vascular disease. His wife says she cannot deal with him as he is demanding, intolerant of pain and stubborn about not using crutches. There is a strong feeling on the ward that he is attention-seeking. On questioning him, you find he was a pilot in the Second World War involved in the Dresden raid. Subsequently he was a teacher, until he retired 10 years ago. In 1965, he had an agitated depression and was suicidal. His depression responded well, on that occasion, to electroconvulsive therapy and amitriptyline.

Q. What is the differential diagnosis?

A. Agitated depression, anxiety disorder, dementia, cerebrovascular disease, frontal lobe personality change, post-traumatic stress disorder.

Q. He has a depressive illness. What information and advice would you offer the ward to facilitate his management?

A. Explain to the staff that he is depressed, and that his behaviour is not attention-seeking but is a part of a treatable illness. Explain that sympathetic listening and reassurance from the staff will play a vital part in his therapy. They should also monitor important indicators of the mental state including appetite, weight and sleep. Prescribe an antidepressant such as lofepramine and explain the effect this will have. Arrange for Mr George to be reviewed regularly by the old age psychiatric team, with a member of the nursing staff present, until he recovers.

Residential and nursing homes

Mr Simon, a widower of 86, has mild dementia and moved to sheltered housing because he wandered at night. After four months he still wanders and occasionally goes into the rooms of other residents, sometimes climbing into their beds. Their complaints have made the social worker suggest he moves to a residential home. His son, however, who visits at least once a week, feels that his father is happy there and has not had time to settle in.

- Q. Give one advantage and one disadvantage of Mr Simon remaining where he is, for himself, his son, and his social worker.*
- A. Advantage for Mr Simon – he is spared another move. Disadvantage for Mr Simon – his wandering puts him at risk. Advantage for his son – he feels his father is happier living where he is. Disadvantage for his son – he will remain under pressure from other residents and their families. Advantage for his social worker – he does not have to seek more costly care. Disadvantage for his social worker – he remains under pressure from the sheltered accommodation staff.
- Q. What measures would help him to remain in the sheltered flat?*
- A. Treat any underlying medical or psychiatric problems. A CPN may be able to advise staff on how to avoid confrontation with Mr Simon, while accepting an element of risk for him. A programme of activities could be arranged within the housing development and at a day centre. A neuroleptic, such as thioridazine or haloperidol, may be helpful for agitation, but should not be used to damp down his overall activity.

Pharmacological treatments

Mrs Forsyth, aged 77, has a history of variable confusion for the past seven months. She also experiences visual hallucinations and intermittent clouding of consciousness.

- Q. What is the differential diagnosis?*
- A. Lewy body dementia, subdural haematoma, alcohol misuse, brain tumour.

She has been visited by the GP who prescribed thioridazine 50 mg twice daily. She is now in a state of being barely able to walk because of extreme muscular stiffness and shaking. She can barely speak, and drools.

- Q. Which of your diagnoses does this favour and what are the main features of this condition?*
- A. Lewy Body dementia. Visual hallucinations, dementia, clouding of consciousness, sensitivity to neuroleptics and Parkinsonian symptoms.

Psychological treatments

Mrs Jenkins has a history of bipolar affective illness. In recent years she has been almost constantly unhappy, dissatisfied, negative and self-critical.

Her physical health is good for her 82 years, but she complains of inertia and fatigue, and spends much of the day in bed. She is financially well off, has a pleasant home and a generally cheerful, long suffering husband. She has been treated with tricyclics and monoamine oxidase inhibitors, and is now taking paroxetine 40 mg daily and lithium carbonate with a serum level of 0.7 mmol/l.

Q. Her GP refers her to the old age psychiatry department, with a view to her having psychotherapy for her refractory depression. What forms of psychological treatment might be available?

A. Counselling and support, brief dynamic psychotherapy, marital therapy, cognitive-behavioural therapy or analytical psychotherapy.

Q. You feel that counselling would be insufficient. You can identify no dynamic or marital stresses amenable to therapy, but you are struck by her persistent pessimism and self-criticism (although of less than delusional intensity). Along what lines would you offer cognitive-behavioural therapy?

A. The therapist needs to be trained in cognitive-behavioural therapy and able to offer the time for treatment. It may be yourself or one of your colleagues, such as a psychologist or CPN. Mrs Jenkins should be willing to have the therapy. The therapy is explained to her and a series of appointments made. She will need to complete a diary, and her 'home work' will involve prioritising her negative thoughts, with examples from her daily thinking and behaviour, and exploring and challenging them with her therapist.

Carers

Mr Stevens, aged 78, a former bus driver, suffered a right hemiplegia 10 months ago. He is now ambulant but emotional, irritable, erratic and forgetful. His wife of 44 years is mentally alert, but stressed by his bad tempers, his wandering (he sometimes has to be brought back by the police) and his turning on the gas without igniting it. She says that she must have a break.

Q. What help could you offer her?

A. Counselling and support. Relative support group and information from the local Alzheimer's Disease Society. Respite care from a day carer, day centre, day hospital, residential home or hospital.

Q. You decide that she needs respite, and social services find him a place in a nursing home for two weeks. Ten days after his admission you are asked to see her again because she is in a state of great distress.

Her husband is with her, she removed him from the home after six days. Why might this be?

- A. 1. Her husband missed her greatly, clamoured to come home and was eventually allowed to do so.
2. She had not realised that she would have to make a financial contribution and felt she could not afford it.
3. Mr Stevens settled into the home, but his wife was distressed by the inactivity of the residents, and the excessive prevalence of senility. She could not bear to leave her husband there.
4. After two days, she found that she missed him dreadfully, felt very anxious alone, so bought him back for her own comfort.
- Q. You decide that support should be provided at home and that she needs expert counselling. What should the counsellor seek to address?*
- A. The counsellor needs to be able to offer her the chance to express her feelings in a safe environment. Particular issues may include those of attachment, dependency, guilt and ambivalence. She may need to be guided through the loss of her husband as she knew him.

Law

Mrs Lockwood, aged 87, was admitted to the geriatric ward suffering from pneumonia and a heel ulcer. Her Mental Test Score (MTS; Hodkinson, 1972) on admission was four out of 10. You are told that she wants to alter her will in favour of her nephew, who visits frequently. The geriatricians are concerned and want your advice.

Q. What would your assessment take into consideration?

- A. Her cognitive functioning may have improved as her pneumonia got better and needs to be reassessed. You need to establish her testamentary capacity (i.e. that she knows the extent of her estate and which people have reasonable expectations from her will). You should establish if her reasoning for changing her will is affected by mental illness or by pressure from her nephew. Undue influence may invalidate a will.

Q. She tells you she has been looked after very nicely by the ward and she wants to leave £1000 for a new music centre. Does this change your position?

- A. No. Accepting a large donation to the ward would only be considered if she could afford it, and she was fully aware of the nature of the donation and the repercussions to her own finances. Mania needs to be excluded as a possible diagnosis.

Research

Mrs Granger, aged 67, complains of a failing memory. This is confirmed by her husband, who has made her an appointment at the memory clinic. You make a diagnosis of early Alzheimer's disease and inform her husband. He asks for this information to be withheld from his wife, but wants her to be considered for a drug trial of a new anti-dementia drug.

Q. Should you tell her, and can she enter the drug trial?

A. Yes and no. Mrs Granger has the right to know her diagnosis and cannot give informed consent to participate in a drug trial unless she is fully aware of her diagnosis, and its implications. When and how to tell someone their diagnosis is a sensitive issue and should take into account the cultural and family feelings.

Q. How might you tell her diagnosis?

A. Explain the situation to her husband and gain his support. Break the news to her in a sympathetic and unhurried manner, offering plenty of time for questions. Confirm to her that she has an impaired memory and this goes beyond what is normal for her age. Explain that the likeliest cause is Alzheimer's disease, although the diagnosis can only be confirmed with the passage of time. Say that with Alzheimer's disease, progress can be slow, with a plateau. Offer further counselling and support, including details of the Alzheimer's Disease Society. Inform her that there is medication that may delay the disorder and that research is likely to yield other medications. She will be able to plan her own future including establishing a power of attorney and making a will. If she drives she is obliged to inform the Driver and Vehicle Licencing Agency of her diagnosis.

References

- Folstein, M., Folstein, S. & McHugh, P. (1975) Mini-Mental State. A practical method for grading the cognitive state of patients for the clinician. *Journal of Psychiatric Research*, **12**, 189–198.
- Gurland, B., Copeland, J., Kuriansky, J., *et al* (1983) *The Mind and Mood of Aging: Mental Health Problems in the Community Elderly in New York and London*. New York: Haworth Press.
- Hodkinson, H. (1972) Evaluation of a mental test score for assessment of mental impairment in the elderly. *Age and Aging*, **1**, 233–238.