Cognitive Difficulty in Older Men with concordant Mental Health Diagnoses
Case Reports from a Male Inpatient Ward

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Introduction

Older adult teams are generally reticent to take patients until they are graduated to Old age.
Mainly 50-year-old patients with cognitive deficits are treated on general adult wards and require more specialist older adult medical and psychiatric experience whilst also displaying challenges due to frailty and cognitive deficits. This can block 10-20% of beds on these wards.
We shall present 2 cases of patients (Patients X and Y) with cognitive difficulties that required initial treatment, discuss complexities with regards to diagnosis and treatment and inform you of the correct process for ensuring patients are correctly transferred effectively i.e. to external accommodation.

Discussion Points

- Frail patients likely to remain on a general adult ward which may require increased intervention/observations to ensure risks and falls are limited.
- Referral system for patients into accommodation and the processes involved
- Deciding on antipsychotic dosage
- Deciding on when to diagnose a dementia – Patient X has changes on the brain - although we are continuing to call this a cognitive disorder due to schizophrenia whilst awaiting further input. However if behaviours did not improve then this may have had to be reconsidered.
- Schizophrenia with cognitive disorder are limiting factors for obtaining placement.

Patient X

Patient X is a 55 year old Caucasian male who presented with psychotic symptoms and self-neglect. He was previously diagnosed with schizophrenia 20+ years previously treated with ECT. He had no further follow up from mental health service.

Presenting complaint
Patient X was brought to A&E by the Police after being found wandering and confused in the street. Patient X was living with his elderly mother with suspected undiagnosed dementia and who had carers four times a day. Concerns were raised about patient X and his mother's physical and mental health. He was sleeping in his mother's bed and had recently set fire to a package containing a knife.

Management
Patient X on admission was commenced on 10mg Olanzapine for his schizophrenia whilst also adding in chlordiazepoxide and thiamine due to excess use of alcohol. Initially he maintained a low profile on the ward. He was observed responding (talking to his girlfriend) in his room. Gradually over time his olanzapine was increased to 20mg leading to decreased responding
Showed improved interaction with staff/peers and partook in activities on the ward. There was an improvement in ACE assessment score from 25 to 47 which showed a improvement in his language and attention with minimal improvement to memory. Patient X had required referrals for OT, advocacy, homelessness, welfare rights, safeguarding and the Cerebral Function Unit

Discharge
It had taken considerable time to arrange accommodation for Patient X. Care homes were concerned that his cognitive difficulties may enhance his schizophrenia although this was considered highly unlikely given his presentation.
Although this gentleman's abilities did improve during the admission there were still noticeable difficulties present with ADLS which required support. Further to this although his ACE score improved, he still was significantly underperforming.
Once placement was agreed there had been a further delay with regards to obtaining funding.

Discussion
There are documented reports of patients with schizophrenia having cognitive issues. Indeed dementia medications have been used in PICU's and shown to improve cognition in small studies. It is difficult to consider this when patients may be presenting with negative symptoms of schizophrenia and are younger adults..
Treatment for cognitive issues has benefits for not only improving memory deficits but also improving mental states and behavioral symptoms. It therefore leaves a medical dilemma at times of when to treat or diagnose as history's may not be clear and are convoluted by mental health difficulties. Diagnoses must be carefully considered with regards to dementias; however we can still diagnose memory impairments. The difficulty then is whether one would chooses to medicate with dementia medications as off license. Further research is required within this area to consider these potentially helpful treatments for patients with obvious cognitive difficulty's. In this case we decided against current prescribing as there was improvement with alternative medications.

Patient Y

Patient Y is a 59 year old gentleman that has a long-standing diagnosis of Bipolar Affective Disorder and is resident in a nursing home due to his cognitive decline. He had also been treated for Korsakoff's syndrome secondary to excessive alcohol intake previously. He mobilises with a Zimmer frame.

Presenting Complaint
Patient Y presented to the hospital via ambulance due to increased confusion and agitation. He was psychotic on presentation where he was aggressive and within a manic phase of his bipolar affective disorder. Physical causes of delirium were ruled out in an acute ward. He was discharged to a care home where he was displaying signs of agitation, confusion, aggression and sexually inappropriate behaviour with the staff and other residents there. He was then transferred to the psychiatry ward as this was thought to be worsening of his mental state. At this point he was found to be displaying signs of grandiose delusions and therefore a decision had been made to admit Patient Y under Section 2.
Collateral history from his daughter had revealed that Patient Y had been sexually disinhibited for many years but this was in a verbal capacity and would not display physical sexual disinhibition when he was well.

Management
Patient Y was commenced on Memantine. His dose of quetiapine was increased and he was started on melatonin. He had already been taking sodium valproate. An ACE III assessment carried out showed a score of 67/100 with significant deficit in the memory and attention subsections. A CT head scan revealed general atrophy of the cerebral and cerebellum regions which were advanced for his age. Patient Y showed gradual improvement in the coming days where his agitation and confusion had become greatly reduced and he was able to communicate with staff appropriately, however there were still incidents of sexually inappropriate comments made to staff. At one point it, anti-libido drugs were considered but never commenced. His general demeanour was seen to be improved over the course of his stay.

Discharge
During Patient Y's admission, a professionals meeting consisting members of a multi-disciplinary team including members of community and inpatient services to discuss Patient Y's discharge placement. This resulted in a placement being sourced for Patient Y relatively speedily albeit still a couple of months.

Discussion
Patients with a known diagnosis of bipolar affective disorder along with cognitive impairments can initially be difficult to manage. This is because there can be difficulty determining if the presentation of psychosis and worsening mental health is due to their mental illness or due to organic causes.. There is a history of excessive alcohol intake resulting in Korsakoff's as well as a CT head scan which reveals significant cerebral and cerebellar atrophy advanced for his age. Patient Y's inappropriate behaviour was a significant cause for concern as well as his falls risk. Given this history and investigation it appeared more appropriate to start medicaiton for dementia than wait for further prolonged testing. Further to this there is research suggesting it is beneficial for treating difficult to manage behaviours of korsakoffs.

Conclusion

Patients of this dual diagnostic type normally remain on the ward for lengthier periods due to placement issues. We now plan for discharge from admission by having a professionals/discharge meeting within 7 days of admission. This has been very effective for patient Y as he was then allocated a care-coordinator relatively quickly. This did not occur with Patient X and his stay has been more prolonged . Units which have both nursing and residential home support would be able to accommodate early referrals however there are few placements where this is possible. There are then further issues with regards to whether they should graduate to older adult services. We have found that if discharge planning is not in place then 5-10% of beds on a general adult ward can be occupied for 3-6 months. This is a poor use of resources and further consideration of how to reduce this time needs to be considered for safety and cost effective purposes.
Diagnosing dementia on a general adult ward is somewhat difficult and can not be taken lightly as there are considerable implications. This has significant implications in a young adult. Patients in their 50 with cognitivie deficits and psychotic history's is an area that may be rising and further consideration on how this can be reviewed on general adult wards need to be considered to ensure effective treatment is available.