

老年人的面談與 身心功能評估

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老年精神醫學會繼續教育

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Agenda Overview

- Psychiatric assessment of older people (Chap. 10)
- Physical assessment of older people (Chap.12)
- Clinical cognitive assessment (Chap.11)
- Psychometry in older persons (Chap.8)

Based on Oxford Textbook of Old Age Psychiatry by R. Jacoby et al and Clinical Geriatric Psychiatry by JP Hwang

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Complete psychiatric assessment: Aims

- Holistic approach to achieve overall understanding of patient's complete set of needs
- Identifying the range of issues which need further assessment
- Establishing rapport with p't and family for further assessment and care
- Patient identification

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Complete psychiatric assessment (I)

- Clinical diagnosis based on chief problems and history taking
- Eliciting symptoms/behavior not in diagnostic criteria (eg.BPSD)- to identify caregiver burden and need; for D/D of rare disorders
- Functional limitation: ADL, IADL, mobility
- Medical illness: thyroid problems and vascular factor (stroke, TIA, CAD, DM, hypertension, falls)

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Complete psychiatric assessment (II)

- Medication history:
 - polypharmacy,
 - recent medication change,
 - vitamins and OTC to give insight about pt's possible concerns
- Personal history and personality
- Social history
- Family history

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Complete psychiatric assessment (III)

- Mental state examination
- Physical assessment
- (optional) Capacity assessment
- Informant interview:
 - Note cognitive/emotional status of informants
 - Communication with foreign caregivers
 - Beware of conflict between family members

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Personal history: relevant issues

- Informal assessment of severity of memory impairment
- **Understanding the patient as a person**, eg, the degree of autonomy and responsibility before disease onset (in marriage and work)
- Premorbid personality
- **Coping with developmental tasks:**
 - Retirement, bereavement, serious illness, placement et al

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Social history: key areas

- Social activities
- Relationship with others
- Independency / Amount of care by others
- Current social support
- Financial safety
- Driving safety
- Disposition

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Physical assessment: caveats

- Nonspecific presentation of disease (social admission) generally have significant underlying pathology.
- Atypical presentation of diseases in old age generally reflect inadequate assessment.
- Elderly are prone to multiple pathologies, one positive findings should alert other contributory causes! eg. Parkinson D. + OA+ SMD of retina+ orthostatic BP
- Devastating function decline after physical illness is common.

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Geriatric syndromes

- delirium
- immobility
- falls
- incontinence
- frailty
- malnutrition and failure to thrive

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Comprehensive Geriatric Assessment (CGA)

- Visual impairment
- Hearing impairment
- Activity of daily living (ADL, IADL)
- Falls and impaired mobility
- Cognitive impairment
- Depression
- Body weight loss and malnutrition
- Urinary incontinence

(Simple screening as attached table) ¹¹

When/Who to do CGA ?

- Patients who have a living situation in transitions
- Recent development of physical or cognitive impairment
- Unmet need by fragmented specialty medical care (esp. geriatric syndromes)
- Evaluation of patient's competency with potential medico-legal issues

Palmer RM: Med Clin North Am 1999;83:1503-23 ¹²

Clinical Cognitive Assessment and Psychometry

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Clinical cognitive assessment

- General assessment
- Attention: serial 7 (MMSE), digit span, CPT
- Orientation: MMSE 10 items
- **Memory**: MMSE 3 objects recall
- **Language**: MMSE 5 domains
- **Executive and frontal lobe function**: backward digit span for working memory; trail B ; category fluency
- **Apraxia**: imitation, alternating hand movement
- Visuospatial ability and **agnosia**: pentagon drawing in MMSE, clock drawing test

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Measurement Issues of Cognitive Assessment Tools (I)

- Heterogeneity within age cohort: large inter-individual difference; what is “normal aging” ?
- High prevalence of sensory impairment and multiple co-morbidities: lack of validation for this “common” population
- High level of illiteracy and low educational level in the elderly: “education fair” test ?
Adjusting for education level ?

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Measurement Issues of Cognitive Assessment Tools (II)

- High rate of institutionalization in the elderly: MMSE drop 4 points on institutionalization (Ward 1990); poor differentiation between “ability” and “performance”
- Some tests developed for adults: content not suitable for the elderly; overreliance on “rote memory”, not precis recall (summary in the text) (better in the elderly)

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智能評估工具的用途

- 失智症的篩檢工具
- 失智症診斷準則或鑑別診斷的一部份 (eg. NINCDS-ADRDA)
- 整體認知功能缺損程度的量化指標
- 失智症嚴重度分級之依據 ?

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Cognitive Screening Instruments

- Brief mental state examination
- Abbreviated neuropsychological assessment of specific cognitive functions
- Informant tests to estimate the degree of cognitive decline

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臺灣常用之簡短智能評估 (I)

- **MMSE** (Mini-mental state examination): Folstein 1975, 郭乃文 1988, 葉英 / 胡海國 1984, 葉炳強 1992, 劉秀枝 1994, 劉景寬 1996, 李朝雄 / 蘇哲能 1997, 行為神經學組共識版 1999-健保局與公勞農保鑑定必備
- **SPMSQ** (Short Portable Mental Status Questionnaire): Pfeiffer 1975, 李明濱 1989, 劉景寬 1996-- 長照中心與老人健檢使用

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臺灣常用之簡短智能評估 (II)

- **HDS** (Hasegawa Dementia Scale) and **HDS-R** (revised HDS): Hasegawa 1974, Katoh 1991, 林信男 1984, 張景瑞 1998, 早期研究使用, 中風過或低教育水準影響較少
- **CDT** (Clock Drawing Test): sensitive to cognitive decline, Lin KN 2003, 計分系統複雜

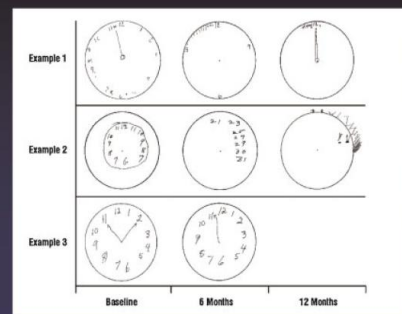
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Mini-Mental State Examination (MMSE) 的缺點

- attention and calculation items (5/30): poorly operationalized
- language items (8/30): insensitive
- lack of frontal lobe sensitive task
- strong influence of educational level:
17/18 for illiterate, 24/25 for > 6 y (Shanghai study); 19 for 0-4y, 27 for 9-12y (ECA, USA)

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Sensitivity to Deterioration in Dementia



6 Months 12 Months 18 Months

Abbreviated neuropsychological assessment of specific cognitive functions

- **CASI** (Cognitive Ability Screening Instrument) : Teng 1994, 張景瑞 1993, 劉秀枝 1994, 陳振宇 1996, 劉景寬 1998
- **MoCA** (Montreal Cognitive Assessment): Nasreddine 2005, 蔡佳芬 2008, Cut-off < 26/30, better differentiation for MCI and dementia

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Psychometric features of CASI

- cut-off score ≤ 86 , Sen. 96%, Spe. 92%
 ≤ 81 , Sen. 82%, Spe.99% (Graves et al., 1992)
- cut-off score ≤ 50 , Sen. 88%, Spe. 94%, mean 73 (38-98) in non-demented Chinese (Liu et al., 1994)
- total score significantly associated with age and education, the Ed. effect more on the oldest-old (3 pts in 65-69Y, 7 pts in 90-95)
- ceiling effects limit the use of subscale pattern

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MONTREAL COGNITIVE ASSESSMENT (MOCA)

NAME: _____ Education: _____ Date of birth: _____
 Sex: _____ (Draw CLOCK (Ten past eleven) (3 points))

VISOSPATIAL / EXECUTIVE Copy cube (3 points) **POINTS**

Trail (E) (A) (B) (2) (3) (4) (C) (D) (1) **/5**

NAMING **POINTS**

FACE VELVET CHURCH DAISSY RED **/5**

MEMORY Read list of words, subject must repeat them. Do a recall after 5 minutes. **/5**

ATTENTION Read list of digits (5 digit/ sec). Subject has to repeat them in the forward order. **/5**

Head list of letters. The subject must tap with his hand at each letter A. No points if a error. **/1**

Serial 7 subtraction starting at 100 **/5**

LANGUAGE Repeat: I only know that follows in the line to help today. **/5**

Phonemy / Name maximum number of words in one minute that begin with the letter P. **/5**

ABSTRACTION Similarity between e.g. banana - orange - fruit. **/5**

DELAYED RECALL Has to reach words write adjective. **/5**

ORIENTATION Date Month Year Day Place City **/6**

© J. Macintosh MD. Version November 7, 2004. www.mocatest.org. Normal 0 00 / 00. TOTAL Add 1 point if 6-10 yr edu. /30

Informant tests to estimate the degree of cognitive decline

- MMSE 與家屬報告 (IQCODE, Informant Questionnaire on Cognitive Decline in the Elderly, Jorm 1989) 併用比單獨使用更能篩檢出個案 (Mackinnon et al, 1998)
- IQCODE: 不受教育程度與病前能力影響, 評估10年來的改變, 而非目前功能狀態,
- 中文版: 傅中玲 1995

Diagnostic Instruments

- CAMDEX (Cambridge Exam for Mental Disorders): Roth 1988
- GMS (Geriatric Mental State Schedule) and AGE CAT : based on PSE, Copeland 1976, 曾憲洋, 劉珣瑛
- SCAN (Schedules for Clinical Assessment in Neuropsychiatry) : based on PSE 10, Wing 1990, WHO 1994, 鄭泰安/張景瑞 2001

Other Cognitive Assessment

- Monitor progress of therapy: ADAS-cog (Alzheimer's Disease Assessment Scale, cognitive and non-cognitive sections): Rosen 1984, 李眉 1998
- Function assessment: Barthel index (巴氏量表), ADL, IADL, ICF framework (未來的殘障鑑定工具)
- BPSD scales
- Staging and severity assessment

BPSD常用量表(I)

- Global scales
- BEHAVE-AD (Behavioral symptoms in Alzheimer's disease) : Reisberg 1987
 - NPI (Neuropsychiatric Inventory): Cummings 1994, 傅中玲 2001
 - RMBPC (Revised Memory and Behavior Problems Checklist): Teri 1992, 傅中玲 1999

BPSD常用量表(II)

- 特殊量表
- CMAI (Cohen-Mansfield Agitation Inventory): Cohen-Mansfield 1986
 - OAS (Overt Aggression Scale): Yudofsky 1986

非認知症狀量表的問題

- 各症狀定義不夠明確, 彼此之間不易區分
- 與認知症狀和 ADL 間不易區分
- 許多工具之 psychometric properties 研究不足
- 長期追蹤對變化不夠敏感
- 目前的量表均需依賴照顧者報告: informant bias

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Staging and Severity of Dementia

- CDR (Clinical Dementia Rating): Hughes 1982, difficult algorithm
- GDS (Global Deterioration Scale) and FAST (Functional Assessment Staging): Reisberg 1982, 1988, 7 major stages with 16 successive substage, especially useful for staging of severe AD

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老年精神醫學訓練有關評估應加強者

- Physical assessment and drug review
- Neuropsychology
- Image study
- 不同 setting 的個案, 如正常社區老年人, 安養院的院民接觸機會太少
- 缺乏 comprehensive evaluation unit, 如 memory clinic, geriatric psychiatric ward

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Thank You For Your Attention!

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