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UPON TYPE, FREQUENCY AND SOME CLINICAL ASPECTS OF PSYCHOTIC SYMPTOMS IN ALZHEIMER'S DISEASE

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SUMMARY:

Various psychotic disorders develop often at different stages of the disease. A comprehensive approach of type, frequency and clinical aspects of the psychotic disorders patients with Alzheimer's disease (AD) can optimize management of these conditions in patients with dementia. We examined 120 patients with probable AD. The routine clinical examination and observation were used to delineate the most common psychotic symptoms. Delusions, found in the explored patients were predominantly paranoid. The delusions are often short lived and lack complexity of that seen in schizophrenia. In number of cases they are difficult to be distinguished from confabulations. Hallucinations were mostly verbal, visual and tactile. Misidentification syndromes were identified in a considerable number of patients. They are often disputable or have been classified as delusions or hallucinations, depending on interpretation of psychotic phenomena. We discuss different forms of misidentification. The presence of psychotic symptoms predicts the occurrence and frequency of different forms of aggression and destructive behavior.

Key words: Alzheimer's disease, psychotic symptoms, BPSD

INTRODUCTION:

Various psychotic disorders develop often at different stages of Alzheimer's disease (AD). Behavioral and Psychological Symptoms of Dementia (BPSD) are an integral part of the disease process. In Alzheimer's classic case description (1906) psychotic symptoms were among the prominent manifestations of the disease (2). It has been disputable about prevalence of different BPSD in demented patients (1, 16, 19). The rates of all the psychotic symptoms vary widely depending on how the phenomena are defined, patients' sample, stage of the disease, accurate data, investigator's skills, etc. A psychosis of Alzheimer's disease has been accepted since the 1999 conference of the International Psychogeriatric Association (IPA). Psychotic symptoms are among the most intrusive and difficult BPSD to cope with. Estimates of their frequency differ in a broad range (17, 20). A comprehensive approach of type, frequency and clinical aspects of the psychotic disorders in AD patients can optimize management of these conditions in patients with dementia.

AIM:

The aim of our study was to explore the type, frequency and clinical aspects of the psychotic disorders in AD patients.

SUBJECTS AND METHODS:

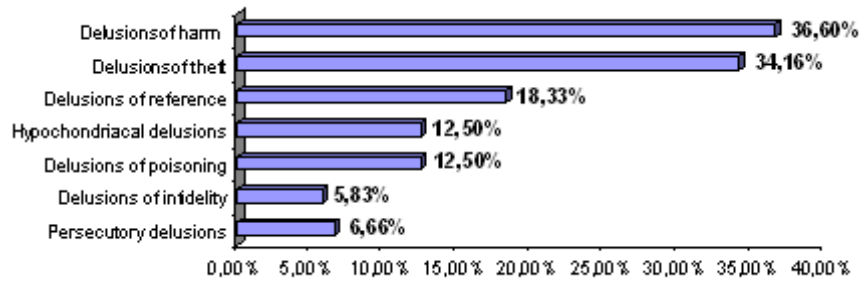
We examined 120 patients, admitted at the gerontopsychiatry department of Third psychiatric clinic at MHAT "St.Marina"-Varna. Patients were diagnosed according to the criteria of ICD-10, DSM-IV and NINCDS/ADRD criteria for probable AD. The routine clinical examination and observation were used to delineate the most common psychotic symptoms. The comprehensive clinical assessment included a longitudinal review of the current symptoms, psychiatric, medical and drug history, family history, observation of the psychotic phenomena in the course of the interview and during the stay at the department. An important information was taken from a reliable caregiver for a more precise and adequate assessment of cognitively impaired patients.

RESULTS:

We found out multiple coexsisting BPSD in the explored AD patients. This is in contrast with the relatively monosymptomatic clinical presentation of the classic psychiatric disorders. Psychosis in AD is represented by the occurrence of delusions and hallucinations that had their onset after the appearance of the dementia syndrome, a duration at least for a month, severe enough to impair patient's functioning, when other somatic, organic or psychotic disorders are excluded (17). According to Mendez et al. (1990), Cooper et al. (1991), Ballard et al. (1995), Gormly, Rizwan (1998), coexistence of delusions and hallucinations is in 40-65% of cases; delusions in- 30-50%; hallucinations- 10-20% (21, 8, 3, 13). The prevalence of delusions varies between 10% to about 73% depending on the study population (22, 25).

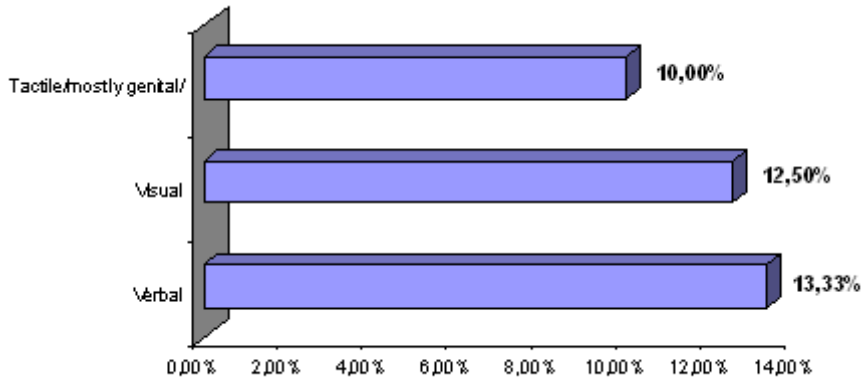
Delusions, found in our study were predominantly paranoid: delusions of harm in 44 (36.6%) patients, delusions of theft in 41 (34.16%); delusions of reference in 22 (18.33%); hypochondriacal delusions in 15 (12.5%); delusions of poisoning in 15 (12.55%), delusions of infidelity in 7 (5.83%) patients and persecutory delusions in 8 (6.66%). **(**Fig.1).

Fig.1. Paranoid delusions



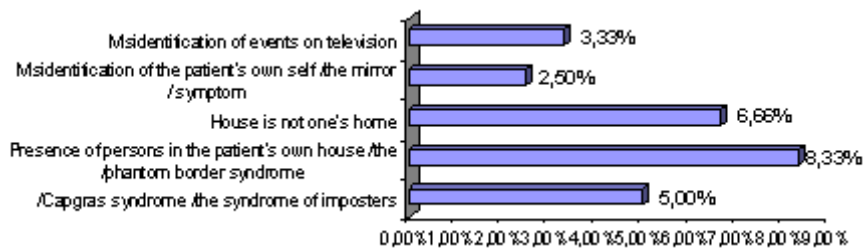
Regarding hallucinations, verbal were found in 13.33%; visual in 12.5% and tactile (mostly genital)- in 10% of the patients. Our results are in consistency with studies in clinical settings that have found prevalence rates for all hallucinations of 10% (4, 12, 20). (Fig. 2).

Fig. 2. Hallucinations



Misidentification syndromes were identified in 23 patients. Capgras syndrome (the misidentified person is accepted as looking exactly the same as their "double"), often called the syndrome of imposters (10) was present in 6 (5%) of all demented patients. Other presentation of misidentifications found: presence of persons in the patient´s own house (the phantom border syndrome) was registered in 10 (8. 33 %); house is not one's home in 8 (6.66%), misidentification of the patient's own self (mirror symptom) shared 3 (2.5%) and misidentification of events on television 4 (3. 33 %) of the patients (Fig.3).

Fig. 3. Misidentification syndromes



DISCUSSION

Delusions are false beliefs about external reality that are firmly held despite evidence. In endogeneous psychotic disorders such as schizophrenia, delusions are commonly accompanied by evidence of a thought disorder, neologisms and typical emotional disturbances. It is interesting that some authors classify BPSD in dementia as positive and negative symptoms, psychosis being among positive (7, 23). It is near the similar classification in schizophrenia where delusions and hallucinations are included in the positive register. The difference of psychotic symptoms in dementia is they, except the above mentioned characteristics, tend to lack the complexity and systematization of the delusions seen in schizophrenia. They are most probably connected with memory impairment in contrast with schizophrenic patients with similar delusions. Grandiose or bizarre delusions observed in patients with schizophrenia or mood disorders are unusual in demented patients. Cognitive impairment provokes most of the paranoid delusions. It is most obvious with the delusions of robbery. Due to their short life they may not be present at every examination. It is known, that BPSD emerge at any time in the course of the disease and fluctuate (9, 18). Other authors connect their short duration with difficulties to distinguish them from confabulations (15). Our patients were evaluated at their first hospitalization due to psychotic symptoms or behavioral problems. Wandering or agitation are the behavioral symptoms most often associated with the delusions of theft, harm, persecution, the family members or caregivers mostly suffering.

Concerning hallucinations, one has to have in mind, that visual are highly correlated with visual pathology (14) and verbal- with hard of hearing.

Misidentifications are often disputable or have been classified as delusions (delusional misidentification) or hallucinations, depending on interpretation of psychotic phenomena. Some authors find occurring in about 23-30% of sufferers at some time and about 19% during a single year (6, 24). Misidentifications in dementia are examples of disorders of perception (5). Unlike hallucinations, misidentifications are misperceptions of external stimuli and can be defined as misperceptions with an associated belief that is held with delusional intensity. Ellis et al. (1997) proposed that Capgras patients interpret the loss of affective response for familiar people in a paranoid suspicious way (11). In some instances anger or violence can be provoked towards perceived impostor. We should underline the difficulty to precise eliciting the phenomena in such patients as many factors have an influence- degree of dementia, collaboration of patients, adequate informants' data etc.

CONCLUSION

Alzheimer's disease is accompanied by a variety of psychotic symptoms. The key of accurate diagnosis of psychotic disorders lies in a careful and profound assessment of the patients, including informant input. Psychotic phenomena predict the occurrence and frequency of different forms of aggression and destructive behavior and present a great burden for the families and caregivers**.** The purpose of their more careful and profound research is to find adequate and optimal management..

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