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Pharmacological management of visual hallucinations in dementia with Lewy body – A case presentation

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Introduction: Dementia with Lewy bodies(DLB) and Parkinson's disease dementia(PDD) make up for about 20% of dementia cases, with a significant overlap of clinical features. They are described as separate entities in the DSM-5 with an arbitrary delimitation based on the onset of cognitive decline in relation to parkinsonism.Visual hallucinations are a common clinical feature. Treatment consists of low dose antipsychotics, generally quetiapine or clozapine being used.
Objectives: Case presentation and reflection on pharmacological treatment
Methods: Review of the clinical file of a patient with DLB
Results: A 76 year old female was referred to our clinic with a recent history of complex visual hallucinations and delusional thoughts. The onset of parkinsonism was made 8 months prior to admission and treatment with IMAO-B Rasagiline and a combination of Levodopa was initiated. The patient had no psychiatric hospitalization history. Her comorbidities include hypertension, dyslipidemia and osteoporosis, for which she received specific treatment. The onset of complex visual hallucinations was one month prior to admission. A trial with small dose clozapine was initiated in an outpatient setting and dropped out due to intolerance.
During the hospitalization she was describing recurrent complex visual hallucinations in the form of people engaging in sexual activities in front of her and suspected her husband of involvement in these acts. She was also experiencing tactile and proprioceptive hallucinations, interpreting them as harmful laser beams resulting in skin marks (age spots were present). Sun downing syndrome was present, consisting of fluctuating cognition, worsening of temporospatial orientation, marked anxiety as the visual hallucinations became more vivid. CT scan showed moderate atrophy and psychological testing indicated moderate cognitive decline.
Treatment with Rasagiline was interrupted as it can worsen psychotic features, by raising dopamine levels. Levodopa was reduced to the minimum efficient dose for parkinsonism as it can cause agitation and worsening of visual hallucinations. Treatment with small dose quetiapine (100 mg per day) was initiated, the patient experiencing severe hypotension due to neuroleptic sensitivity. Quetiapine was continued for about 3 months, with the aggravation of the visual hallucinations and encapsulated delusional thinking. Small dose Clozapine (25 mg per day) was rechallenged, with favorable outcome. Some visual disturbances were still present but less bothersome. Lorazepam was used for the management of insomnia and psychomotor agitation and the cholinesterase inhibitor Rivastigmine for managing the behavioral symptoms and cognitive decline.
Conclusions: Visual hallucinations are often a bothersome clinical feature in DLB. Treatment and diagnosis is often challenging. Clozapine is a good option for managing visual hallucinations in DLB.

Disclosure of Interest: None Declared

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Cognitive disorders in the elderly persons and their psychometric markers

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Introduction: Population aging is accompanied by an increase in mental disorders of late age, cognitive impairment and dementia, which makes research on their diagnosis, prevention and therapy particularly relevant.
Objectives: In order to improve the diagnosis of cognitive disorders in elderly patients, a comparative characteristic of the MMSE and MoCA psychometric scales is presented. Due to the lack of differentiation of results in the MoCA - test according to the severity of cognitive disorders, ranking was carried out to determine the scoring levels of cognitive decline.
Methods: On the clinical basis of the scientific department of gerontopsychiatry of the Moscow Research Institute of Psychiatry - branch of the V. Serbsky National Medical Research Center for Psychiatry and Narcology, 46 people over 60 years old were examined. The identified mental disorders were coded under the ICD-10 F00-F09 rubric "Organic, including symptomatic mental disorders". Cognitive status assessment was carried out by psychometric scales MMSE and MoCA. Psychometric and statistical research methods were used. To compare MoCA and MMSE scores, an equal-percentage alignment method was used
Results: In patients examined by MMSE and MoCA, different point values were determined in assessing cognitive functions. In most observations, the MoCA- test indicators were lower than the MMSE values. The following correspondences of the score values of the scales were revealed: MOCA 23-30 - MMSE 28-30 points; MOCA 22-18 - MMSE 27-25; MOCA 17-12 – MMSE 23-20; MOCA 12-0 – MMSE 19-0.
Conclusions: Such features of the MMSE scale as insufficient sensitivity in assessing memory impairment and differentiation of non-dementia levels of cognitive impairment, regulatory functions of programming and goal-setting, lexical fluency were revealed. The advantages of the MoCA - test were the ability to assess visual-constructive and executive skills, praxis, a more accurate assessment of memory impairments, mobility of mental processes and the ability to switch, logical thinking, the possibility of topical diagnosis of brain damage. The disadvantages of the MoCA - test were the duration of its implementation, the fatigue of patients, the lack of tasks for assessing written speech and motor praxis.
The MoCA - test is a more sensitive method for detecting and differentiating cognitive impairment compared to the MMSE scale, which makes it possible to recommend it for widespread introduction into psychiatric practice. Relevant in further studies are the determination of indicators of moderate cognitive impairment as a threshold value between mild cognitive impairment (MCI) and incipient dementia, clarification of the point values of different levels of dementia.

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