Cancer and Dementia
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OVERVIEW

- Numbers/evidence
- Types of dementia and their impact on cancer diagnosis and treatment
- Clinical Challenges:
  - Capacity
  - Challenging behaviour
- Best practice for patients with dementia

NUMBERS

- Both cancer and dementia incidence increase with age
- However, rates of cancer seem to be lower in patients with dementia (Roe et al., 2010)
- Hypotheses –
  - Biological underpinnings –
    Neurodegeneration vs Cell proliferation
    Role of P53, Pin1, progranulin (PGRN)
  - Poor recognition and diagnosis?

POLICY

- 3 themes
  - Public and professional awareness
  - Early diagnosis
  - Improved care quality
  - 17 recommendations

POLICY

DIAGNOSING DEMENTIA

- General term
- Global and relentless progression
- Effects at least 2 domains –
  - Memory
  - Behavioural/ psychological functioning (language, personality, etc)
- ADLs (Activities of Daily Living)
CONSIDERATIONS TO EXCLUDE

- Depression
- Anxiety
- Hypothyroidism
- Nutritional deficiencies – thiamine, B12, folate
- Hyponatraemia and electrolyte imbalance
- Hypoxia – CCF/ arrhythmias

TYPES

- Alzheimer’s disease (62%)
- Vascular dementia (17%)
- Mixed Alzheimer’s and vascular (10%)
- Lewy Body dementia (4%)
- Frontotemporal dementia (2%)
- Dementia with Parkinson’s disease (2%)
- Other dementias (3%)

BEST PRACTICE

CASE EXAMPLE 1

RN, 76 yr old man admitted for NHL chemotherapy
Became forgetful and had marked word finding difficulty
Uncertainty about continuing chemotherapy
His wife wanted to stop treatment as it ‘gave him dementia’
Capacity assessment - ability to decide on treatment
Daughter reported concerns 6 months prior to cancer diagnosis

ASSESSING CAPACITY

- ALWAYS ASSUME THE PATIENT HAS CAPACITY
- STEPS:
  1) to UNDERSTAND (in preferred language and with explanation)
  the particular investigation, treatment or arrangements involve?
  2) to BELIEVE and RETAIN the information relevant to the decision
  (eg, common risks and benefits) long enough to reach a decision.
  3) to be able to WEIGH THE INFORMATION and options in the
  balance to ARRIVE AT THE DECISION.
  4) to COMMUNICATE the decision

INSIGHTS INTO ‘MAKING THE CALL’

- Always assume that the person has the ability to make a decision and work backwards
- Mild cognitive impairment does not necessarily progress to dementia (Mitchell et al, 2009)
- Many patients with early Alzheimer’s dementia are fit and well and not on any medication
- Patients with early Frontotemporal dementia can score 30/30 on the MMSE, be aware of executive function deficits

FRONTOTEMPORAL DEMENTIA

BEST PRACTICE

CASE EXAMPLE 2

CD, 69 yr old woman diagnosed with bowel cancer
Referred following successful hemicolectomy
Family concerned about patient’s ability to manage stoma bag
Concerns about progressive memory loss and neglect
Patient insisted on being discharged home
Distressed and tearful, refused to consider alternatives
PALLIATION

COMMUNICATION DIFFICULTIES IN ADVANCED DEMENTIA. CONSIDER:

PHYSICAL HEALTH:
- Pain or discomfort
- Side effects of medication
- Bowels and continence
- Sleep – wake pattern
- Hunger and diet

MENTAL HEALTH:
- Mental health
- Depression/anxiety
- Psychosis
- Boredom/ isolation
- Poor quality environment
- Wandering

ASSESSMENT TOOLS

ANTIPSYCHOTICS

CONCLUSIONS

- Early diagnosis can alter an entire care plan
- Dementia doesn’t mean lack of capacity

THANK YOU

References available on request
Questions/ comments:
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