Neuropsychiatric symptoms (NPS) in patients with pure vascular dementia (VaD) and mixed dementia (MD) from a memory outpatient clinic in Southeast Brazil

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ABSTRACT. Vascular Dementia (VaD) and Vascular Cognitive Impairment (VCI) are increasingly common worldwide. Nevertheless, the clinical-neuropsychiatric profile of these patients at presentation is still poorly characterized in developing countries. Objective: We aimed to characterize the prevalence of neuropsychiatric symptoms, as well as the clinical and cognitive profile of patients with VaD and VCI in our tertiary University outpatient cognitive clinic. Methods: We reviewed data on 253 patients diagnosed with VaD or VCI at our center between January 1996 and December 2005, located in an industrial region of the state of São Paulo, southeast Brazil. We excluded 19 patients who did not meet the clinical or neuroimaging criteria for vascular dementia. We collected socio-demographic data, educational level, vascular risk factors, behavioral and neuropsychological symptoms and cognitive complaints at presentation. Results: Two hundred and thirty-four cases were included in this analysis. The mean age was 67.77±10.35 years; 72% were males and 82% had less than four years of education (average 2.84±2.96 years). The initial Clinical Dementia Rating score was 2 & 3 in 68%. A total of 185 patients had neuropsychiatric symptoms distributed in main categories as follows: psychosis (52.6%), hallucinations (23.5%), psychomotor agitation (22.5%), depression (17.5%) and apathy (17.5%). Hypertension and previous stroke were the most prevalent risk factors. Conclusion: We found a high prevalence of neuropsychiatric symptoms. The clinical-neuropsychiatric profile of patients presenting to cognitive clinics in developing countries may differ greatly to that of more developed nations. These characteristics may have implications for public health strategies.

Key words: vascular dementia, neuropsychiatric symptoms, vascular risk factors, developing countries.
INTRODUCTION

Vascular Dementia (VaD) is increasingly common in cognitive clinics worldwide. This type of Dementia is probably the second-most-common cause of dementia after Alzheimer’s disease. Prevalence rates of post-stroke dementia (PSD), one of the most frequent subtypes of VaD, range from 12.2% to 31.8% in the first year after stroke and VaD is estimated at between 20% and 40%. Mixed dementia seems to be more prevalent than the pure form of VaD. Some community and hospital-based studies in Brazil have suggested a prevalence ranging from 9.3% to 24.9% for VaD. In the last few years, the term Vascular Dementia has been partially substituted, now more commonly referred to as VCI (Vascular Cognitive Impairment). Nevertheless, in this paper we have used VaD because the vast majority of our patients had dementia.

The most used group of criteria for diagnosing VaD includes: ICD-10, DSM-IV, NINDS-AIREN, and ADDTC (State of California Alzheimer’s Disease Diagnostic and Treatment Centers). The NINDS-AIREN (National Institute of Neurological Disorders and Stroke and Association Internationale pour la Recherche et l’Enseignement en Neuroscience) criteria is used preferentially in controlled assays because it is very specific, but less sensitive. The Hachinski Score is easily applied, sensitive, but less specific for subcortical dementia and does not include imaging. At present, a better group of criteria is not available (DSM-IV, ICD-10, ADDTC and NINDS-AIREN).

Neuropsychiatric symptoms are mainly classified into mood, psychotic disorders, and frontal manifestations. Paranoid delusions were the most common psychotic symptom reported in Alzheimer’s dementia, particularly at late stages. The prevalence of Behavioral and Psychological Symptoms of Dementia (BPSD) attains 90% during the course of illness in subjects with Alzheimer’s disease, but there are scant references to this profile in VaD for Brazilian patients. With the exception of Psychosis and Depression in AD, there are few consensus diagnostic criteria for BPSD in dementia.

The aim of this study was to determine the prevalence of BPSD at the 1st consultation and characterize the profile of BPSD of patients with VaD and VCI at our public tertiary university outpatient cognitive clinic located in Ribeirao Preto city, Sao Paulo, Brazil.

METHODS

Subjects. This was a retrospective study involving two-hundred fifty-three consecutive patients with a diagnosis of either Vascular Dementia or VCI followed at the Memory Clinic at the University Hospital, Ribeirao Preto - Southeast - Brazil. This is a regional tertiary clinic which is part of the Sao Paulo Health Care System. A thorough review of all medical records of the patients seen at this service from January 1996 to December 2005 was carried out. This study was approved by our Institutional review board.

Diagnosis of vascular dementia. Two hundred thirty-four patients with a diagnosis of vascular dementia according to the Diagnostic and Statistical Manual IV (American Psychiatric Association, 1994) criteria were included. Patients who did not complete the medical investigation or who did not meet the clinical or neuroimaging criteria for vascular dementia were excluded (N=19).

Medical investigation. The dementia work-up included: complete medical history, sociodemographic variables, risk factors, clinical examination, neurological examination, screening questionnaires and scales for cognitive disorders and brain MRI or CT-Scan. Other neuroimaging studies, such as SPECT, MRI angiography, carotid duplex scan, and conventional angiography, completed the investigation in selected cases. Routine laboratory tests for dementia were performed, which included: complete blood count, renal and liver function tests, glucose, cholesterol total and fractions, calcium and phosphate levels, serum vitamin B12, serum folic acid, thyroid function tests, HIV serology and VDRL, and transthoracic echocardiogram. Other blood tests for Chagas disease, thrombophilic state, auto-immune...
diseases, hematologic diseases and cardiac tests (holter, transesophageal echocardiogram and coronarography) were also performed electively.

The cognitive screening battery included the Mini-Mental State Examination (MMSE), and CDR (Clinical Dementia Rating) was performed in all cases. The Neuropsychiatric Inventory (NPI), HIS (Hachinski Ischemic Score), Pfeffer Functional Index, Geriatric Depression Scale were not performed routinely during the time of the study. The NINDS-AIREN and ADDTC criteria for VD were also not applied. Formal complete neuropsychological evaluation was carried out in only a few cases, precluding consistent analysis.

The majority of the patients were studied with Brain MRI (1.5 Tesla). After collection of all clinical and neuroimaging data we discussed the findings in a consensus discussion with the members of our team, including 03 cognitive neurologists and an experienced neuroradiologist for classification ascertainment. The following parameters were evaluated on imaging: [1] White matter changes, [2] Multiple cortical infarcts, [3] Subcortical Infarcts, [4] Strategically located Infarcts, [5] Hemorrhagic Lesions, [6] Ventricular dilatation, [7] Cerebral Atrophy, [8] Symmetric Temporal Atrophy (not proportional to age). Fazekas grade was applied to measure the burden of white matter changes as a cut-off point to evaluate subcortical lesions.

Neuropsychiatric symptoms. The classification of psychiatric symptoms was obtained from chart review based on the structured admission interview questionnaire of our memory clinic. The protocol includes questions about all major neuropsychiatric domains. The symptoms of psychotic and mood behavior were also registered.

Statistical analysis. The analyses were undertaken with the aid of the Statistical Package for the Social Sciences software package (SPSS). The data were described through frequency distributions of categorical variables, mean values and standard (mean±SD) deviations for continuous variables with a normal distribution. Continuous data were compared using the Chi-square test (p<0.05) when normally distributed or with the Mann-Whitney U-test if non-normally distributed (univariate analysis), while categorical variables were compared by cross-tabulation.

RESULTS

Demographic and clinical variables. The study population exhibited a Male : Female ratio of 1:0.6. All two hundred thirty-four patients had their educational profile documented. A total of 34.62% of subjects were illiterate and only 4.7% had university level education or higher. Socio-demographic variables are given in Table 1.

Non-cognitive complaints at presentation. The prevalence of non-cognitive complaints at the admission consultation is shown in Figure 1.

Major clinical findings. At the first inquiry, the mean time elapsed from the first complaint to clinical attendance at our memory clinic was 2.69±2.50 years (range 0-20). Two hundred and twenty-nine individuals met the DSM

Table 1. Socio-demographic variables (N=234)

<table>
<thead>
<tr>
<th>Variable</th>
<th>Global</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (mean±SD)</td>
<td>67.77±10.35</td>
<td>66.97±10.18</td>
<td>69.09±10.56</td>
</tr>
<tr>
<td>Female gender (%)</td>
<td>38.03</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Education Years (Mean±SD)</td>
<td>2.84±2.96</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 2. Major clinical findings observed at first interview.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial MMSE (Mean±SD)</td>
<td>13.22±7.00</td>
</tr>
<tr>
<td>CDR 0.5&amp;1 (%)</td>
<td>32.05</td>
</tr>
<tr>
<td>CDR 2 &amp; 3 (%)</td>
<td>67.95</td>
</tr>
<tr>
<td>Delay in attendance¹ (Mean±SD)</td>
<td>2.69±2.50</td>
</tr>
<tr>
<td>DSM-IV criteria for VD (%)</td>
<td>97.86</td>
</tr>
<tr>
<td>Vascular cognitive impairment (%)</td>
<td>2.14</td>
</tr>
<tr>
<td>Previous stroke (%)</td>
<td>23.93</td>
</tr>
<tr>
<td>Psychotropic drug Use (%)</td>
<td>79.91</td>
</tr>
<tr>
<td>Cholinesterase inhibitor use (%)</td>
<td>19.66</td>
</tr>
</tbody>
</table>

CDR: Clinical Dementia Rating; SD: Standard Deviation; MMSE: Mini-Mental State Examination; VD: Vascular Dementia. ¹Time elapsed from perception of chief complaint to seeking treatment at our memory clinic, expressed in years.
IV criteria for dementia while only five patients (2.14%) presented vascular cognitive impairment (VCI). Our series had a greater prevalence of isolated VaD, with 123 cases, versus 111 cases of mixed dementia. Other clinical findings are described in Table 2.

**Overview of comorbidities and vascular risk factors.** All patients had comorbidities documented, where hypertension was present in 80.80% and previous stroke in 42.70%, with significance difference in gender for the latter condition. This data can be found in Table 3.

**Characteristics of behavioral disturbances in dementia patients.** The most common presenting behavioral abnormality was hallucination (23.50%), followed by agitation (22.20%) and depression (17.50%). Figure 2 summarizes the psychiatric abnormalities in patients with behavioral complaints or detected symptoms.

**DISCUSSION**

The high prevalence and clinical significance of psychiatric disturbances in dementia are now receiving increased attention. Most of the series available estimate the prevalence of neuropsychiatric signs and symptoms in dementia of the Alzheimer type, and a broad range of rates from 60% to 90% has been reported.²⁻⁵,²⁴⁻²⁸ In our series, we observed a prevalence at first consultation of 79%, similar to the upper limit cited. This may indicate that in our clinics, the vascular burden may contribute in the form of presentation of dementia.

Particularly noteworthy is the extremely high prevalence of low educational level in our sample. Most series in developed countries have reported an average of 12 years of study or more.²⁻⁵,¹⁷⁻¹⁹,²⁵ The review by Kalaria NJ et al.² on vascular dementia in developing countries, showed similar results to those found in our series. The substantial impact of educational level on understand-
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