ECHO Idaho: Alzheimer's Disease and Related Dementias
CASE RECOMMENDATION FORM

ECHO Session Date: 6/10/25

Thank you for presenting your patient at ECHO Idaho –Alzheimer's Disease and Related Dementias session.

Summary:
Mr. A is a 73-year-old man with a 14-year history of Parkinson's disease and a two-year history of progressive cognitive decline, presenting with behavioral symptoms including aggression, inappropriate sexual behavior, visual hallucinations, and emotional lability. His symptoms worsened after discontinuing rivastigmine, which was later restarted with partial improvement. He struggles with IADLs, has experienced personality changes, and recently became suicidal and aggressive toward his wife after sexual rejection. He has no substance use history, a MoCA score of 23/30, and is currently on medications for Parkinson's, depression, and cognitive symptoms. His family seeks help managing his sexual behaviors and associated emotional distress.

After reviewing the case presentation and discussion of this patient's case among the ECHO Community of Practice, the following suggestions have been made:

Medical Management

- Adjust Parkinson's medications: Consider tapering or adjusting carbidopa/levodopa with close neurologist oversight to manage side effects like impulsivity and hallucinations.
- Reevaluate cholinesterase inhibitors: Oral rivastigmine helped but caused side effects. A return to the transdermal patch may be beneficial with fewer side effects.
- Address antidepressant use: Switching from sertraline to venlafaxine is noted. There's also a suggestion to increase antidepressant dosage or trial a different one.
- Manage insomnia: Review clonazepam use; it may contribute to cognitive impairment and disinhibition. A different sleep aid (e.g., temazepam) may be safer.
- Antipsychotic consideration: If hallucinations persist or risk to self/others increases, antipsychotics like quetiapine, pimavanserin, or clozapine may be appropriate (as a last resort).

Safety Interventions

- Address urgent safety risks, including access to firearms, driving accidents, and suicidal ideation.
- Ensure a thorough risk assessment is completed and consider inpatient psychiatric admission if risk escalates.

Caregiver and Family Support

- Support for caregiver (the wife) is essential, particularly regarding emotional strain, safety concerns, and managing inappropriate sexual behavior.

- Educate caregivers on communication strategies like the “yes, and…” technique for redirection and emotional validation.
- Provide tools to reframe inappropriate behaviors through understanding misinterpretation and disinhibition in dementia.

Occupational Therapy and Functional Support

- Refer to OT to help focusing on preserved abilities—helping with difficult tasks only when frustration occurs, and providing cognitive cues to preserve autonomy.
- Encourage the use of Big and Loud therapy for Parkinson’s (OT/PT/SLP interventions to address motor and speech symptoms).

Healthy Sexuality and Intimacy

- Reframe sexuality in dementia as a basic activity of daily living (ADL).
- Promote healthy intimacy, including touch, affection, and connection that do not involve sexual intercourse, especially when consent or discomfort is an issue.
- Educate staff and families on therapeutic touch to reduce agitation and support human connection in dementia care.