



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

ECHO Session Date: 6-2-26

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

Summary:

73-year-old man with a history of alcoholism (largely in remission), prior traumatic brain injury with arm amputation, and mild mood disorder, who now presents with concerns about attention and memory, requesting treatment for presumed longstanding ADHD diagnosed decades ago but never treated. Recently, family members have noted forgetfulness and difficulty focusing, and during a hospitalization for neurologic symptoms (e.g., headache, intermittent ataxia), he scored 18/30 on a SLUMS exam with deficits in memory, attention, and executive function. Extensive imaging and lab work have been largely unremarkable aside from mild vertebral artery stenosis and transient hyponatremia. While the patient attributes his symptoms to ADHD and is dismissive of cognitive impairment, clinicians are concerned about possible mild cognitive impairment or early dementia, and neuropsychological testing has been completed but results are pending, raising the question of how to differentiate late-life ADHD symptoms from emerging neurocognitive disorder and guide further management.

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

Patient-Centered Decision Making

- First ask the patient if they want diagnostic clarity (e.g., Alzheimer’s testing):
 - If yes, pursue biomarkers/imaging
 - If no, proceed with watchful waiting and safety planning
- Even without a definitive diagnosis, continue to monitor function over time and provide supportive care and planning
- Incorporate patient preference but balance with safety and potential impaired insight; as much as possible, involve family/caregivers in decision-making early

Clinical Evaluation & Cognitive Workup

- Repeat cognitive screening (SLUMS or MoCA) in the outpatient setting when the patient is at baseline (avoid relying on inpatient results due to delirium risk).
- Proceed to neuropsychological testing if screening remains abnormal to differentiate:
 - Mild cognitive impairment
 - Major neurocognitive disorder
 - vs. other causes such as ADHD
- Use history, exam, and MRI to help rule out different types of dementia (vascular, Lewy body, frontotemporal).
- Explore clinical negative effects from 129 sodium. This could contribute to cognitive impairment and be a modifiable factor.



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Advanced Diagnostics (if needed and aligned with patient goals)

- Consider blood-based biomarkers for Alzheimer's disease (e.g., p-tau 217) if the patient wants diagnostic clarity.
- Consider FDG-PET scan to differentiate Alzheimer's vs. frontotemporal dementia when uncertainty remains.
- Explore volumetric MRI (e.g., NeuroQuant) to assess brain volume changes (e.g., hippocampal atrophy), though:
 - Availability may be limited
 - May require specific imaging protocols or repeat MRI
 - May involve out-of-pocket cost
- Consider evaluation for cerebellar atrophy (particularly given alcohol history).

Functional Assessment

- Assess functional abilities over time, especially for the following:
 - Driving
 - Medication management
 - Financial management
- Obtain information from a secondary historian (family, roommate, etc.) for reliable functional decline history.
- Ask about technology use changes (passwords, voicemail, finances) as early indicators of decline.

Medication & Adherence Review

- Perform a "deep dive" into medication refill history:
 - Look for delayed refills or excess medication accumulation
 - Contact the pharmacist directly for adherence concerns
- Watch for medications that impair cognition, especially:
 - Diphenhydramine (sleep aids, allergy meds)

Occupational Therapy & Functional Tools

- Use OT functional assessments (not just paper-based tests), such as:
 - KELS (Kohlman Evaluation of Living Skills)
 - DLOTCA
 - Kettle Test
 - Grocery Shopping Skills Test
- The Allen Cognitive Level Screen score of 4.6 indicates daily supervision to weekly supervision is recommended for safety for effective problem solving for more complex tasks such as multi step activities or novel tasks.
- Consider using the [OT-Innovations caregiver guide](#) that provides caregiver information for each level of the ACLS and is wonderful at breaking down the safety implications but also ways to support independence by providing cognitive cues to promote function and safety at each level.

Broader Medical & Risk Factor Assessment

- Evaluate for the following:
 - History of traumatic brain injury
 - Alcohol use impact
 - Diabetes control over time
- Review MRI for small vessel disease or other chronic changes



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Safety & Monitoring

- Carefully evaluate driving safety (especially if cognitive scores <5 on ACLS).
- Provide anticipatory guidance:
 - Medication supervision
 - Financial oversight
 - Driving reassessment
- Continue longitudinal monitoring if diagnostic certainty is not pursued.

Additional Practical Considerations

- Ask about caffeine/energy drink intake (can affect cognition, sleep).