

28/06/2024  
Dr Harold Judelman  
Unit 19/100 King St  
RANDWICK NSW 2031

Dear Harold,

RE: Julie Chipman DOB: 09/10/1950  
Drayton House, 4-6 Cranbrook Rd, ROSE BAY NSW 2029

Many thanks for referring Julie for assessment, which was conducted at Drayton House on June 20th in the company of her daughter, Kylie and Kylie's partner, Zoe. Julie is 73 and was widowed six years ago. She and her husband had tragically only moved to a retirement setting a couple of weeks before he was diagnosed with a brain tumour. Julie was already showing signs of dementia at that point and transitioned to live independently remarkably well, although with increasing supports over the years since. Late last year, it became apparent that even with overnight supports, Julie was struggling to be alone for any length of time and she moved to residential aged care in February. Julie had stopped driving in late 2022. Julie has three children with a son in the US and a daughter in Melbourne. Kylie and her stepsister are Julie's appointed enduring powers of attorney and guardians and communicate well about her care.

Julie has had a slowly progressive course with her Alzheimer's dementia, with a positive response to both donepezil and a supplement regime prescribed by integrative doctor, Dr Cosford. She continued her nutritional programme until her move to residential care. She was also well supported by the social network in her retirement village and attended exercise regularly. By late last year nutrition was starting to drop and Julie was tending to only eat processed meats. She was having trouble managing basic household tasks and increasingly nervous being on her own. She initially settled in extremely well at Drayton House, although unfortunately developed COVID, which required a period of isolation and then had a herpes ophthalmicus reactivation in her left eye last month. All of this saw a marked increase in her anxiety and much more confusion. There have probably not been hallucinations but fluctuation has been observed and I do feel this is consistent with a likely delirium.

Fortunately Julie remains good on her feet. She does have urinary frequency at times, but a normal MSU late last month. She put on a little weight when she moved into residential care. Sleep had been good, although the last few nights, she has been more restless and nursing staff have commenced a sleep chart.

**Background health history** includes:

1. Alzheimer's dementia with onset of symptoms around 2015.
2. Irritable bowel syndrome in the past, managed well with nutritional approaches and no current symptoms.
3. Right-sided hearing loss.
4. Osteopenia, stable on bone mineral density last year.
5. Hysterectomy.
6. Zoster ophthalmicus, left eye.

Kylie mentioned later that I am also seeing Julie's sister who has also developed a neurodegenerative disease

**Current medications** are donepezil 10 mg daily, Melatonin 3 mg daily, valcyclovir BD, and supplements now include vitamin D, chewable B12, and Souvenaid.

**On examination**, Julie looked systemically well, although expressed being frightened about being left alone and was very focused on worries that she did not have enough money, being hard to distract from the latter. Her blood pressure was 160/90 and pulse was regular at 80 beats per minute. Her heart sounds were dual and her chest was clear. Gait was normal and she had no tremor or cogwheeling rigidity. Reflexes were symmetrical. Julie did not wish to undergo cognitive testing on the day I visited.



Thank you for sending in **bloods from March** which included GFR of 89, normal sodium, ALT of 33 and LD 359 with albumin 48 and globulins 20. Cholesterol was 6.5, LDL 4.0, vitamin D 152, ferritin 105, haemoglobin A1c 5.5%, TSH 0.85, B12 elevated on supplements, folate normal and full blood count normal. MSU late last month was normal. **CT brain in 2017** was normal for age.

#### **Summary and Management Suggestions:**

Julie has a history consistent with a **delirium triggered by COVID infection and the distress of isolation on a background of anxiety and Alzheimer's dementia**. Her **zoster** recurrence has added to her delirium. There was no real sign of this delirium settling when I saw her although her daughter was in touch by email 3 days later to say Julie has started to improve so I hope this has continued. We discussed measures to support recovery from delirium, and her dementia more broadly.

I provided a request form for an **EUC and full blood count** given her current symptoms are more recent than her last blood tests. If strategies outlined below do not seem to be leading to resolution of Julie's delirium, it may be necessary to consider a CT brain. It has been some years since any cerebral imaging was done although the progression of her dementia has been typical for her diagnosis and imaging is not likely to change management otherwise.

We discussed mostly non-pharmacological measures to address her current distress. Julie **responds best to individualised attention at the moment** and minimising her anxiety in this way will hopefully bring about a quicker recovery. Privately funded extra support staff is one option to consider with directions that this time is to be spent on engaging closely with Julie to support her in her distress and find activities that are soothing for her. There is some low back stiffness at times and massage could be helpful. Tracey Stewart is a yoga teacher/Feldenkrais practitioner who could be helpful and may be able to provide a home visit.

**Regular walks outside and other forms of exercise** are encouraged. **Active support for good hydration** with prompting regularly through the day may be very helpful also as Julie is tending not to drink much and dehydration can exacerbate delirium.

Activities such as folding towels or sorting items may be calming for Julie as she has generally liked to keep busy. At the moment she is not liking the television, although was able to demonstrate use of the remote control effectively. Avoiding news and prioritising more relaxing, neutral, and familiar programmes may be helpful. She has **always tended to have hypersensitive hearing** so this needs to be considered in activities and interactions as it may be worse when she is more anxious or unwell. She has some music she enjoys, such as Andre Rieu, but may need help to use her CDs at the moment.

If **sleep issues are persisting** on the sleep chart, then a low dose of **mirtazapine could be considered** if her sodium is normal, 3.75 mg may be enough, or 7.5 mg if not. The dose could then be increased if needed, although as delirium resolves, Julie may not need anything. Further discussion with Kylie over time will be helpful in determining this as history suggested there may have been some well compensated longer term anxieties and as dementia progresses these can be harder to self-regulate. While it is true that antidepressants are not generally as effective in dementia I think it is important to consider this on a case by case basis and work closely with family and staff to decide on efficacy of anything trialled. Delirium can lead to anxiety and depression so this should also be considered.

**Dementia Support Australia** could assist with establishing a management plan for Julie's anxiety to soothe and/or distract. I am hopeful there will be recovery from this delirium, although a DSA plan will be helpful going forward to keep her activity levels and cognitive stimulation within her abilities. **Cognitive Stimulation** is an important, and evidence based, part of management and a well designed and supported programme may support Julie remaining in the room she is currently comfortable in longer, noting she is not in the fully supported dementia ward.

**Increasing her dose of donepezil to 15 mg** may be worth trying given she had a good response to this medication and may benefit further. This is best left till there is a more complete recovery from her current delirium and if there is no benefit noted after a couple of months on the higher dose then it should be reduced to minimise risk of adverse effects (bradycardia will need monitoring along with her bladder and bowel). Once efficacy is established or donepezil has been weaned back to 10mg, we **could also add memantine** at 5 mg mane for one week, 5 mg BD in the second week, 5 mg mane and 10 mg nocte in the third week and 10 mg BD in the fourth week before going on to 20 mg maintenance daily.

Julie **could reduce her B12** given her high levels to once or twice weekly and I suggested Kylie could perhaps discuss Julie's previous multiple **supplements** with Dr Cosford to decide if it would be worth **prioritising a small number of these being reintroduced**. Julie had always been keen on this approach, finding a benefit, and respecting her approach to her health remains appropriate. Ability to take large numbers of supplements will be increasingly difficult however so Kylie will work to determine which to prioritise and discuss with you and nursing staff further.

It would be my pleasure to review Julie again if I can be of any further assistance in monitoring and guiding management.

Kind Regards,



Dr Catriona Ireland  
Geriatrician and Cognitive Disorders Physician

cc:

Care Manager Drayton House, 1 Cranbrook Road, ROSE BAY NSW 2029  
Julie Chipman, Drayton House, 4-6 Cranbrook Rd, ROSE BAY NSW 2029

Healthlink EDI: inhousec  
Signed Digitally by Dr Ireland