

PSEUDODEMENTIA: AN INSURABLE CONDITION?



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For a life underwriter, the word *dementia* on a physician's report or a prescription for an anti-dementia drug or drugs, absent a dementia diagnosis, can immediately send up a host of red flags.

Whether the coverage is for life, long-term care or disability, any indication of dementia in an applicant's medical paperwork means more investigation and more research in order to arrive at the insurability determination, which is almost always a declination (or, at the very least, a high substandard rating).

If, however, an examining doctor uses the word *pseudodementia*, the application must be analyzed in a different light. The underwriter still has to dig deeper, but the insurability determination could be far more positive (depending, of course, on the type of coverage for which the application was submitted).

Consider, for example, this recent life case: The applicant, a 69-year-old female nonsmoker, had no concerning factors from her history, application or phone interview. Her cognitive interview, senior assessment test results and EEG also showed no particular red flags. However, her attending physician's report mentioned both pseudodementia and dementia, as she had been experiencing some mild forgetfulness, and her prescription database check showed that for the past 3 years she had been taking Venlafaxine, which was consistent with the diagnoses of fibromyalgia and dysthymic disorder (depression) in her medical history, and she was also taking Donepezil, a drug commonly prescribed for dementia. However, there was no specific detail as to why Donepezil had been prescribed.

Clearly, additional investigation was, and is, needed about the mentions of both dementia and pseudodementia. Is there a real difference between the two? And, could an applicant with pseudodementia be insurable?

Executive Summary *Pseudodementia is a term that describes specific types of reversible dementias. It is primarily associated with depression, but can be due to other causes as well. This article distinguishes pseudodementia from true dementia, discusses pseudodementia's causes, characteristic signs and symptoms, diagnosis and treatments, and covers its most important mortality concerns.*

Pseudodementia and True Dementia

Dementia, in medical literature, is an umbrella term covering diagnoses of progressive neurological conditions that exhibit symptoms such as memory loss, confusion, declining problem-solving skills and judgments, and language deficits.

Dementias fall into two categories: irreversible (true dementia) and reversible (pseudodementia). True or irreversible dementias include:

- Alzheimer's disease.
- Spongiform encephalopathies such as Creutzfeldt-Jakob disease and variant Creutzfeldt-Jakob disease (the human form of mad cow disease).
- Fronto-temporal conditions such as Pick's disease, Huntington's disease, Korsakoff's syndrome and Lewy body disease (also known as Lewy body dementia).
- Multi-infarct or vascular dementias that can occur with diseases such as Parkinson's and multiple sclerosis.
- AIDS dementia complex (ADC). ADC, which results directly from advanced stages of acquired immune deficiency syndrome (AIDS), is unique in that it is not caused by an opportunistic virus, but rather directly by the human immunodeficiency virus.

Pseudodementia is a term used to describe a variety of conditions and disorders that mimic true dementia. This disorder is generally caused by depression or other functional condition(s). Once the condition

causing the pseudodementia can be determined and diagnosed, it can be treated, and is almost always fully or partially reversible.

Pseudodementia Causes

Since the late 1800s physicians have been aware of the group of clinical symptoms that today are referred to as pseudodementia. However, the actual term was not coined until 1961, the year British psychiatrist Leslie Gordon Kiloh published a paper titled "Pseudodementia" in the journal *Acta Psychiatrica Scandinavica*. The article did not provide objective or explicit diagnostic criteria for the condition, which for a time sparked disagreement over whether it was an actual condition or just a variant on depression.

Physicians today agree that pseudodementia is an actual condition, distinct from true dementia. According to a 1983 *British Medical Journal* paper on pseudodementia by Tom Arie, Emeritus Professor of Health Care of the Elderly at University of Nottingham (UK) and considered to be one of the founding fathers of old-age psychiatry, "The term 'pseudodementia' is used to describe disorders which present with the features of dementia but which, on closer study or because of their subsequent course, turn out to be of different origin – and in old people, the underlying disorder is most often depression."

Although Professor Arie recommended confining the term pseudodementia only to dementia-like presentations of depressive illnesses, the condition can stem from a range of psychological and physiological disorders, from schizophrenia, bipolar disorder and dissociative disorders to conversion disorders, malnutrition and metabolic disorders.

Both schizophrenia and bipolar disorder can present with cognitive symptoms like those of depression (indeed, schizophrenia was once known as "dementia praecox"). Because the symptoms will reverse upon treatment, the cause in these two conditions is generally deemed pseudodementia. Dissociative disorders develop primarily in response to unpleasant/stressful situations and head injuries, and frequently present in men between the ages of 15 and 40. Patients with conversion disorders (where anxiety converts to physical symptoms) will often exhibit dementia-like cognitive impairments without any organic evidence of dementia. These individuals, most of whom are in late-middle or early-old ages, frequently exhibit age regression as well as increasing physical dependency.

Pseudodementia can also result from endocrine conditions such as impaired thyroid, adrenal and gonadal function, from normal pressure hydrocephalus (also

known as symptomatic hydrocephalus or "water on the brain"), from anemia, from a brain tumor (or tumors) and from metabolic disorders such as diabetes.

An additional condition, fibromyalgia, is also emerging as a cause of pseudodementia. This condition is characterized by a collection of symptoms including long-term body-wide pain and tenderness, fatigue, sleep problems, headache, depression and anxiety. Fibromyalgia sufferers experience confusion, lapses in memory and difficulty concentrating – a group of conditions known as "fibro-fog" – which frequently render them no longer able to work.

Other conditions that can cause pseudodementia include malnutrition resulting in nutrient and/or enzyme deficiencies, specifically of co-enzyme Q10, folic acid, B12, B6 and B1; dehydration; bacterial infections such as bartonella and mycoplasma; and inflammatory conditions such as Lyme disease.

Medication and/or drug interactions can also cause pseudodementia. Sedatives, hypnotics and medications that treat high blood pressure and arthritis are the most common agents, especially among older adults, as their bodies metabolize medications less efficiently. A wrong medication, an incorrect dose of the correct medication, or unforeseen interactions between medications currently being taken can also be culprits.

Signs/Symptoms

Pseudodementia symptoms in older, depressed individuals often mimic true dementia. These symptoms will include anxiety, early-morning awakening, reduced libido, delusions, self-neglect, social withdrawal, and feelings of guilt or suicidality. The individuals will also many times present physical symptoms consistent with dementia, such as motor retardation and disturbances in sleep or appetite.

These symptoms will be more exaggerated in pseudodementia than in true dementia. According to some research studies, approximately 10% to 20% of patients referred for further investigation of dementia will turn out to have pseudodementia caused by another disorder. Another study found that up to 15% of patients with dementia had one of the reversible types, and that depression accounted for about half of the reversible dementias.

Older individuals experiencing memory loss along with slowed movements and/or speech are sometimes misdiagnosed with dementia. However, cognitive impairments for depressed elderly individuals are generally not as severe as those in true dementia, and

will involve fewer areas of cognition.

Depressed elderly persons who don't have true dementia will usually not show disturbances in language, nor will they have difficulty with the Visual Association Test, used to detect dementia of the Alzheimer type. Their histories may show recent life events, such as loss of a close relative or friend; a family history of depression; or depressive-type illnesses. These individuals are often verbal about their memory defects and relatively clear on their current and past medical histories. They have poor attention spans, can often become distressed, and do not make a great effort to do even simple tasks.

The most impaired functions for individuals with pseudodementia will be attention, motor speed, spontaneous elaboration and analysis of details. Cognitive tests will show reading comprehension, name recollection, verbal delayed recall, calculations and psychomotor speed will be relatively preserved. These patients will often say they don't know answers to questions posed and may become emotional, upset or distressed when questioned.

Keep in mind that older depressed individuals can present with true dementia. These patients will respond to cognitive tests differently from pseudodementia patients. True dementia patients do not recall their past histories, give wrong answers to questions, make current complaints, show poor attention and concentration, appear indifferent or unconcerned, but generally try to do their best when given a task to complete.

Diagnosis and Treatment

As with most medical conditions, the outcome of pseudodementia is determined by the final diagnosis and, ultimately, the patient's response to the treatment.

If the cognitive impairments exhibited are caused by depression, drug therapy and counseling will often reverse the memory loss and mental status test scores will improve. Where pseudodementia is due to organic conditions, the symptoms can be reversed via treatment targeted to the particular organic condition. Where mismedication is the culprit, cognitive dementia symptoms will usually reverse as soon as the problem is corrected. The symptoms, however, might take several weeks of treatment to show a noticeable decrease.

Some physicians believe patients with depression who are experiencing cognitive changes may be at greater risk for dementia than individuals of the same age

without depression, and that the pseudodementia might be an early sign of true dementia.

Let's go back to the case study cited earlier in this article. Interestingly, no mental status exams had been performed by the examining physician. The applicant, when asked by the underwriter about her cognitive issues, said her only complaints were not remembering details of previous days, which she attributed to the deaths of her husband and sister in the same year. She also said she had been the primary caregiver for her husband, who was completely disabled for years prior to his death.

When asked about her Donepezil prescription, she said she had asked her physician to prescribe Donepezil for her moderate-to-severe fibromyalgia. Little clinical proof is yet available about Donepezil's efficacy in this usage, but circumstantial evidence on fibromyalgia blogs mention frequently that Donepezil can provide some relief from "fibro-fog" symptoms.

Underwriting the Risk

Pseudodementia poses a challenge for underwriters when determining insurability. Underwriters need to be alert to medications prescribed, symptoms exhibited, and the cognitive tests and treatments

administered or recommended. This information should give some insight into the underlying cause or causes of the pseudodementia.

Pay close attention to your company's underwriting requirements, including the prescription database check. Be sure to check whether the applicant has visited physicians other than his main one, whether the applicant is taking prescriptions not listed in the APS, and the results of cognitive exams and screenings.

Favorable features in applicants with pseudodementia will include normal brain imaging, good neuropsychiatric testing, pre-existing depression, sustained improvement in cognitive changes, and favorable biomarker studies including cerebrospinal fluid studies, amyloid testing and imaging studies.

Though a challenge to underwrite, an applicant showing cognitive stability and/or improvement, as well as some of the other favorable elements listed above, may turn out to be an insurable risk.

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