210 - General diagnostic requirements for dementia

General diagnostic requirements for dementia

Clinical Descriptions and Diagnostic Requirements for ICD-11 Mental, Behavioural or Neurodevelopmental Disorders This section begins by providing the general diagnostic requirements for dementia, which are applicable to all forms of dementia. Next, additional information is provided about the diagnostic requirements for each of the specific types of dementia. Each of the dementia categories may be described as mild, moderate or severe. The general CDDR for dementia also provide guidance on applying each level of the severity specifier: XS5W Mild XS0T Moderate XS25 Severe Specifiers are also provided for behavioural or psychological disturbances in dementia that may be used when these are severe enough to represent a focus of clinical intervention. These specifiers are also described below as part of the general CDDR for dementia. As many behavioural or psychological disturbances specifiers may be applied as necessary to describe the current clinical picture. These specifiers may be applied to all dementia categories. They include: 6D86.0 Psychotic symptoms in dementia 6D86.1 Mood symptoms in dementia 6D86.2 Anxiety symptoms in dementia 6D86.3 Apathy in dementia 6D86.4 Agitation or aggression in dementia 6D86.5 Disinhibition in dementia 6D86.6 Wandering in dementia 6D86.Y Other specified behavioural or psychological disturbance in dementia 6D86.Z Behavioural or psychological disturbance in dementia, unspecified. General diagnostic requirements for dementia Essential (required) features • Marked impairment in two or more cognitive domains relative to the level expected given the individual’s age and general premorbid level of neurocognitive functioning, which represents a decline from the individual’s previous level of functioning, is required for diagnosis. • Memory impairment is present in most forms of dementia, but neurocognitive impairment is not restricted to memory and may be present in other cognitive domains such as executive functioning, attention, language, social cognition and judgement, psychomotor speed, and visuoperceptual or visuospatial functioning. • Evidence of neurocognitive impairment is based on: • information obtained from the individual, an informant or clinical observation; • substantial impairment in neurocognitive performance as demonstrated by standardized neuropsychological/cognitive testing or, in its absence, another quantified clinical assessment. • Behavioural changes (e.g. changes in personality, disinhibition, agitation, irritability) may also be present and, in some forms of dementia, may be the presenting symptom.

619 Neurocognitive disorders Additional clinical features for dementia • Symptom course may provide information about the etiology of dementia (see the descriptions below of dementia due to specific etiologies). Most dementias are progressive (e.g. dementia due to Alzheimer disease, dementia due to Lewy body disease, frontotemporal dementia), whereas other forms are reversible (e.g. dementia related to nutritional or metabolic abnormalities), stable (e.g. some cases of dementia due to cerebrovascular disease) or rapidly progressing (e.g. dementia due to prion disease). Boundary with normality (threshold) for dementia • Normal ageing is typically associated with some degree of cognitive change. Dementia is differentiated from normal ageing by the severity or magnitude of neurocognitive impairment relative to expectations for age, and by functional impairment in everyday skills and tasks. Deviation from normal ageing can be determined by standardized assessment using appropriately normed measures. When cognitive difficulties consistent with normal ageing are present and clinically relevant, the symptom code MB21.0 Age-associated cognitive decline may be used. Course features for dementia • Onset and course of symptoms varies considerably by dementia etiology. (See additional information below regarding symptom onset and course for dementia due to specific etiologies.) Developmental presentations for dementia • Dementia in children or young adults is rare, and often caused by neuronal ceroid lipofuscinoses, a group of lysosomal storage disorders. • Dementia due to Down syndrome occurs in about 50% or more of individuals with Down syndrome, and typically emerges after the fourth decade of life. • Risk of dementia increases in older adulthood. Neurocognitive disorders | Dementia

Clinical Descriptions and Diagnostic Requirements for ICD-11 Mental, Behavioural or Neurodevelopmental Disorders Culture-related features for dementia • Performance during clinical assessment may vary according to cultural and/or linguistic factors. When assessing impairment in neurocognitive functioning and activities of daily living, cultural and linguistic factors should be considered and accounted for when possible. • When standardized neuropsychological/cognitive testing is utilized for determination of neurocognitive impairment, performance should be measured with appropriately normed, standardized tests. In situations where appropriately normed and standardized tests are not available, assessment of neurocognitive functioning requires greater reliance on clinical judgement. (See the section on general cultural considerations for neurocognitive disorders above for additional information and examples.) Boundaries with other disorders and conditions (differential diagnosis) for dementia Boundary with delirium Delirium is differentiated from dementia in that delirium is characterized by global neurocognitive impairment and confusion that have a precipitous onset, are transient, and fluctuate depending on the underlying causal condition or etiology. Dementia is more typically characterized by impairment in specific cognitive skills, and is often progressive and more gradual in onset. Individuals with dementia are at increased risk of delirium, and those who develop acute disturbances in attention, orientation and awareness should be assigned an additional diagnosis of delirium and evaluated to determine its specific etiology. Boundary with mild neurocognitive disorder Dementia is characterized by marked impairment in two or more cognitive domains that is severe enough to cause significant impairment in personal, family, social, educational, occupational or other important areas of functioning. Neurocognitive deficits in mild neurocognitive disorder may be in similar cognitive domains, but are not severe enough to cause significant impairment in functioning. Boundary with amnestic disorder Amnestic disorder is characterized by prominent memory impairment relative to expectations for age and general level of premorbid neurocognitive

functioning, in the absence of other significant neurocognitive impairment. In contrast, dementia is characterized by impairment in two or more cognitive domains, which often but not invariably include memory. Boundary with disorders of intellectual development Disorders of intellectual development are characterized by significant limitations in both intellectual functioning and adaptive behaviour, with onset during the developmental period. By convention, cases that meet the diagnostic requirements for disorders of intellectual development are diagnosed as such unless the neurocognitive impairments are known to be caused by an etiology that is specifically associated with dementia, in which case the dementia diagnosis Neurocognitive disorders | Dementia

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