Dementia-related Q & A from American Brain Foundation eNews “Ask a Neurologist”*

Q. If you have different kinds of seizures, does this increase your chance of having early onset dementia?

A. It is important to keep in mind that the biggest risk factor, by far, for developing dementia is age. All of us are at increased risk as we move into the later decades of our life. It is true that concussive injuries and TBI may increase dementia risk to some extent although it is not clear the degree to which this results in “premature” symptoms. While there is a somewhat increased risk, it is important to keep in mind that many people with concussive and minor head traumas do not develop dementia. Seizures or epilepsy are not traditionally thought of as specific risk factors for dementia.

When thinking about dementia risk, it is useful to keep in mind that there are many factors that seem to influence our overall risk and that most of us have some of these, such as first-degree relative with the disease, high blood pressure, diabetes, etc. Most importantly, there are a number of lifestyle factors that can help reduce our risk. In particular, exercise appears to slow down age-associated cognitive decline and there are a number of convincing studies suggesting enhancements in attention and memory with increased aerobic exercise. Social and mental stimulation also appear to be of benefit, so maintaining an active and engaged lifestyle is important. Finally, modifiable risk factors for cardiovascular health, such as high cholesterol, high blood pressure, poor diet, also increase risk of dementia and can be addressed with your primary care physician.

Q. Is there any way that once dementia is established, the memory can improve? What about Parkinson’s dementia? Parkinson’s is not fatal by itself, but what if the patient develops dementia, could the Parkinson’s dementia be fatal or lead to an earlier death than just Parkinson’s alone?

A. Generally, dementia is associated with progressive, but slow, decline in memory and other aspects of cognition, such as language, visuospatial function, and attention. There are several medicines approved for Alzheimer’s disease that also may be of benefit in other forms of dementia, including related to Parkinson’s disease. These medicines may provide a modest benefit in memory and thinking, but the effects may be relatively subtle. However, there are some instances in which individuals feel that they are particularly beneficial. Memory can also be enhanced in dementia by reducing or eliminating other factors that can contribute to poor memory, such as sleep apnea, depression, anxiety, and some medicines, particularly those with anti-cholinergic side effects like Benadryl. For example, poor sleep at night may exacerbate the memory issues associated with dementia and improving quality and length of sleep may actually enhance memory.

Unfortunately, dementia associated with Parkinson’s disease, like all dementias, probably reduces longevity. For the most part, death is usually due to conditions related to the inactivity and general decline in health associated with dementia, such as aspiration pneumonia, rather than directly due to the dementia.
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Q. If you have Alzheimer's disease, is it normal to not have long or short term memory?

A. As Alzheimer’s progresses, it often involves both shorter and longer-term memories. Early in the disease, memory for recent events, such as what one had for breakfast or a conversation that occurred the prior day, is impaired. Alternatively, more remote information, such as where one went to college or even a family trip from 30 years ago, is spared. In addition, fact knowledge, such as who was the first U.S. President or what a “spoon” is used for, tends to be spared early in the disease. We call this form of memory, semantic memory. The reason that short-term memory is affected early in the disease while long-term/semantic memory is spared is that these forms of memory use different parts of the brain. Short-term memory is dependent on a part of the brain called the medial temporal lobe and it is associated with Alzheimer pathology very early in the disease course. As the disease spreads into other parts of the brain, long-term/semantic memory becomes affected as well.

Q. Is it possible for high levels of stress to trigger dementia and movement disorders?

A. Chronic stress is a risk factor for dementia. However, it is not likely to “trigger” dementia on its own and is only one of many risk factors. Alternatively, stress, anxiety, and low mood can affect people’s memory and thinking. For example, if someone is ruminating about something, this can be distracting and reduces attention to events, conversations, etc., which, in turn, reduces memory for them. Occasionally, this can be so significant that the individual appears to have dementia, so-called pseudo-dementia. It is important to determine if this is the case, as these conditions are treatable and the cognitive symptoms are potentially reversible. While stress and anxiety do not generally cause a movement disorder, they can certainly worsen an existing one. For example, anxiety is well known to increase the severity of a tremor. Again, treatment of anxiety may reduce motor symptoms in these individuals.

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