

Monitoring Patients for Driving Safety Is Critical

Drivers with dementia have a twofold increased risk of crashing, vs. their age-matched counterparts.

BY KERRI WACHTER
Senior Writer

SAN JUAN, P.R. — Not all older patients with dementia are dangerous drivers, making individual assessments of fitness to drive crucial for road safety, Dr. John C. Morris said at the annual meeting of the American Association for Geriatric Psychiatry.

It's no surprise that increasing dementia severity is a risk factor for unsafe driving. About 30% of demented people continue to drive. "We know that all demented drivers—at some point in the course of their dementia—will become unsafe," said Dr. Morris, professor of neurology at Washington University, St. Louis.

Demented drivers also have a twofold increased risk of crashing, compared with age-matched nondemented individuals. "In particular, they're at increased risk of fatal crashes," said Dr. Morris.

Despite the potential danger, few older adults with dementia want to stop driving. "It's no surprise that older adults do not want to relinquish driving," Dr. Morris said. Driving is a crucial means of transportation for many older adults—losing the ability to drive means losing autonomy. Without the ability to drive, older adults are at greater risk for social isolation and depression.

For many older adults, the issue of fairness also comes into play. They don't believe it is fair to have to give up their ability to drive when they have never had an accident.

"It's very important for older adults—

if they are safe to drive—to be able to continue to do so," Dr. Morris said. As a starting point, ask not only the patient but also family and caregivers about problematic driving behaviors whenever you evaluate an older adult. In particular, ask about the following unsafe behaviors that are typically exhibited by older adults with dementia:

- ▶ Failing to stay in their lane or to maintain proper distance.
- ▶ Driving at improper speeds (too fast or too slow).
- ▶ Ignoring or failing to comprehend road signs.
- ▶ Failing to signal, check traffic, or react to other drivers.
- ▶ Becoming lost.
- ▶ Having accidents (even "fender benders").
- ▶ Receiving citations.

Driving simulators provide a safe testing environment and can help determine whether a person with dementia is safe on the roads. Road tests, however, may be the standard by which other evaluation methods are measured, Dr. Morris said. These tests provide a reliable, direct measure of a person's driving ability but require special equipment and can be costly.

Finally, there is physician judgment based on information from the patient and family, cognitive measures, and physical examinations. Physicians actually do a fairly good job of evaluating a patient's ability to drive safely, Dr. Morris said. According to one study, physicians are accurate roughly three-quarters of the time in determining whether a person has



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the ability to drive safely (J. Am. Geriatr. Soc. 2005;53:94-8).

Age alone appears to be a risk factor for unsafe driving as well. Studies indicate that periodically monitoring older patients for driving ability is important. At-risk drivers should be reevaluated about every 6 months.

Here's the approach that Dr. Morris and his colleagues at Washington University's Alzheimer's disease research center use when dealing with the issue of dementia and driving:

- ▶ Routinely ask the patient and family if the patient is driving and, if so, about any problems or risks.

▶ Assess any comorbid factors, such as medications and visual impairment.

▶ If the patient with dementia wishes to drive and reportedly can do so safely, require confirmation with a road test.

▶ If the patient performs safely on the road test, allow continued driving until a follow-up road test is performed in 6-12 months.

▶ If the patient is determined to be an unsafe driver following a road test, initiate driving cessation.

"The most difficult part is, how do we get an older person to stop driving?" Dr. Morris asked. Appealing to the older driver's judgment usually does not work, but it is very important to maintain the patient's dignity during this process, he said. Going over with the patient and family the reasons why he or she should stop driving is sometimes helpful. "It has more weight coming from a physician," said Dr. Morris, who also gives his patients a written reminder—a prescription—that they may not drive.

The family has to be involved in enforcing the decision. It's also important that the family work to provide an alternative means of transportation for the patient. In extreme situations, when the patient is determined to continue driving, the family may have to consider simply selling the car. ■

Dr. Morris recommended the following Web sites for more information about older drivers or drivers with dementia:

- ▶ www.ama-assn.org/go/olderdrivers.
- ▶ www.alz.org.
- ▶ www.nhtsa.dot.gov.

Caution Urged in Using Experimental Tools to Evaluate MCI

BY PATRICE WENDLING
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ROSEMONT, ILL. — Experimental technologies for evaluating patients with suspected mild cognitive impairment hold great promise, but until their clinical relevance is well understood, they should not be used in routine practice, Dr. Paul B. Rosenberg said at a conference sponsored by the American Association for Geriatric Psychiatry.

Clinically, magnetic resonance imaging (MRI) is already useful for ruling out unusual causes of cognitive impairment such as a brain mass, occult subdural hematoma, and stroke, said Dr. Rosenberg, a neuropsychiatrist with Johns Hopkins University, Baltimore.

In the research arena, however, MRI is being taken to the next level. By visualizing hippocampal volume loss in patients, for example, the imaging technology is helping to define subtypes of mild cognitive impairment (MCI).

Likewise, genotyping is being used to identify carriers of the apolipoprotein ε4 (apo ε4) allele, which has been shown to be associated with an elevated risk of converting to Alzheimer's disease. But for many reasons, these experimental applications of available technologies should remain in the research setting for now, Dr. Rosenberg cautioned.

Magnetic resonance imaging and genotyping can be very useful, but these applications should remain in the research setting for now.

Genotyping for apo ε4 is particularly controversial. "Personally, I'd like to do it for my own curiosity, but ethically I don't. ... I'm worried about patients getting blackballed. The mere fact that a patient got tested [for apo ε4] may bar them from getting long-term care insurance," he said.

Clinicians may be tempted to perform genotyping because of a study in which the treatment effect of donepezil (Aricept) was more significant and lasting in patients who were apo ε4 positive (N. Engl. J. Med. 2005;352:2379-88). But the same investigation also showed that donepezil was no more effective than vitamin E or placebo in slowing progression to Alzheimer's at 36 months.

The results underscore the need for more effective interventions before routine genotyping would be practical, Dr. Rosenberg said.

Unlike Alzheimer's patients, who are often unaware of their cognitive decline, people with MCI will complain of memory problems when they present. "These are the most anxious patients I've ever worked with. ... They are absolutely terrified they have [gotten] that disease [Alzheimer's], and it's no less scary than thinking you've got cancer," he said.

The diagnostic work-up for MCI should include interviews, family and medical histories, functional assess-

ments, and psychiatric, cognitive, and neurologic exams.

During interviews, be alert to complaints about forgetting names, problems doing bills, repeating stories, and forgetting appointments. Getting lost in unfamiliar environments is frequently the first sign of MCI, he said.

MCI patients rarely present with complaints that they no longer remember how to do things such as drive a car, which is a well-ingrained skill that doesn't require much short-term recall.

Patients and family members should be interviewed separately to avoid prompting and to tease out difficult issues such as violence.

If a cognitive deficit isn't indicated in the patient history, it's unlikely it will be found on further examination, he noted.

Functional assessments should address topics such as activities of daily living, social life, and functioning on a job. But with retirement, cognitive impairment may be less apparent as patients face fewer cognitive challenges in their daily lives.

A past history or current symptoms of depression, anxiety, or irritability on a psychiatric exam are particularly noteworthy because they are risk factors for conversion to dementia.

Results from a prospective study indicated that a staggering 85% of MCI patients who were depressed went on to develop dementia at 3 years, compared with only 32% of nondepressed MCI patients (Arch. Neurol. 2004;61:1290-3). ■