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Factors predicting mortality at the memory clinic at Siriraj Hospital: The Thai cohort

Individuals who registered at the MC during 2005 to mid of 2017 (n = 1,284) were included. 307 had died (mortality prevalence 23.9%, 95% CI 21.6 – 26.3). Only 815 subjects had neuroimaging at Siriraj Hospital were analyzed looking for mortality risks. Age, gender, medical comorbidities, vascular risk factors, cognition, and function were among parameters looking for mortality risks. Mean, median, standard deviation, chi-square test, hazard ratio, and survival analysis were utilized in this study.

Results: Diagnoses of our cohort were AD(433,53.1%), VaD(73,9%), mixed AD & VaD(42,5.2%), FTD(29,3.6%), PDD(16,2%), DLB(21,2.6%), reversible dementia(17,2.1%), and NPH(16.2%). 168(20.6%) had MCI. Of the 815, 74 died (9.08%, 95%CI 7.2-11.3). The mean(SD) age of those who were alive and dead was 71.31(9.65), and 73.22(8.71) (p=0.103). TMSE scores of those who were alive and dead was 21.33(5.92) and 19.26(6.13)(p=0.02). Patients, who died, were more likely to be older at onset, and have higher dementia severity at baseline. Other mortality risks in this study were history of valvular heart disease at baseline, and use of diuretics or angiotensin converting enzyme inhibitor (ACEI) antihypertensive drugs at the entry of the MC. Regarding the dementia type, we found that Alzheimer disease with cerebrovascular disease had the highest mortality rate (30.8%). The mean duration of symptoms

before entering the MC was significantly longer in the deceased group (11.8 years VS 9.5 years, p < 0.001). There was no difference in daily function, FAQ scores, PCA scores, CMBs amount, number of neuropsychiatric symptoms at baseline between those who had died and those who were alive. Being female (p=0.02,LR=5.38, having CAD(p=0.01,LR=6.51) and hyperlipidemia(p=0.035,LR=4.74) at baseline increased a risk of death later. ARWMC scores of those who were alive and dead was 7.36(5.57) and 10.40(6.02) p<0.001, OR=2.56(<9 vs >=9). The mean(SD,SE) number of lacuna infarction of those who were alive and dead was 1.15(2.33,0.09) and 2.29(3.03,0.36) (p=0.002,OR=3.21(0 vs >=1),OR=2.47(<2 vs >=2). Mean Rt & Lt MTA scores of those who were alive and dead was 1.25(0.95) and 1.63(0.91)(p=0.002,OR=2.58(0-1vs >=2). Those with 1 or more CMBs had increased mortality risk (p<0.001, OR=2.26). GCA scores of those who were alive and dead was 1.10(0.70) and 1.43(0.62)(p<0.001, OR=4.05(0 vs >=1).

Conclusion: We found that age, dementia severity, and vascular risk namely valvular heart disease and antihypertensive use were among clinical mortality risk factors. Having high WML burden, high MTA scores, more lacunar infarctions, having one or more CMBs, were all a risk for mortality in this study.

Biography

Vorapun Senanarong is trained in general medicine, neurology, and geriatric medicine as senior house officer, registrar, and fellow from Newcastle Upon Tyne, UK and UCLA, LA USA. She is one of the experts for WHO on the ICD11 Classification of Neurocognitive disorders. Her research areas are focused in dementia, geriatric neuropsychiatry and behavioral neurology. She has received grants from the National Research Council of Thailand, the Thailand Research Fund, Mahidol University Research Fund, and FIRCA(NIH). She is currently an Associate Professor, Head of Division of Neurology, Department of Medicine, Faculty of Medicine Siriraj Hospital, also the Vice President of the Dementia Association of Thailand and a member of the executive committee of the Neurological Society of Thailand, and of Asian Society against Dementia.

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