To the Editor: In my actual and online support groups for caregivers of spouses with early- to moderate-stage Alzheimer’s disease (AD), one of the most difficult issues we discuss is driving. When caregivers suggest that their spouses with AD stop driving, they usually meet resistance that leads to emotional arguments. Sometimes, only a doctor will be able to convince an individual with AD that it is time to stop driving, yet too often doctors shy away from this responsibility.

The American Academy of Neurology (AAN) guideline issued in 2000 stated that patients should stop driving after a dementia diagnosis, but the revised 2010 guideline backs away from that categorical position. Noting that “giving up driving is associated with depression and increased awareness of mortality,” the new guideline calls for doctors to use the Clinical Dementia Rating Scale, which allows for input from the individual and caregiver, to help determine when people with dementia should stop driving. The 2010 guidelines state that “a recent history of collisions or moving violations,” among other signs, “may indicate increased risk for driving.”

I find the 2010 AAN guideline troubling. True, some people with mild dementia may be able to drive safely for a period of time, but the decline in skills and abilities of the person with AD are eventually going to make driving unsafe, so why wait until that decline causes property damage, physical injury, or death to the individual or innocent others?

A diagnosis of dementia or AD should automatically mandate removal of a driver’s license—if not immediately, then certainly within a period 3 to 6 months, at most, which would give the person and caregiver ample time to make other driving arrangements. The AAN had it right in 2000—a dementia diagnosis should signal an end to safe driving. By definition, when one is diagnosed with AD, one already has some degree of cognitive, perceptual, and memory impairment that makes driving unsafe. As the disease progresses, ability to drive safely will only get worse. There will be more-impaired judgment and reasoning skills, more-impaired depth perception, and less ability to interpret the many visual cues and factors affecting one’s ability to drive safely (e.g., assessing and reacting to road and weather conditions, traffic signals, safely turning across oncoming traffic lanes, safe braking distance).

In a handful of states, physicians must report names of patients diagnosed with AD to their Department of Motor Vehicles (DMV) for further assessment, but doctors know that, on any given day, a person with AD may do well on a written or occupational safety test, or even on a road evaluation. Such is the nature of AD.

In my support group, we always ask this question of new members facing the driving issue: “Do you feel comfortable with your grandchildren in the car while your AD spouse is driving?” Invariably, the caregiver says no, but adds something like, “I agree with you, but my spouse says that, since the doctor never said that he/she should stop driving, he/she can still drive safely.”

Please, doctors, at the time of a dementia or AD diagnosis, or very shortly thereafter, please assume responsibility for telling your patients that they must stop driving. Spouses and caregivers should not have to manage this highly emotional decision without your help. Yes, taking away the car keys also takes away independence from your patients, and yes, taking away the car keys may even lead to depression in some of your patients, and yes, some of your newly diagnosed patients could probably continue driving safely for quite some time. However, you also know that it is just a matter of time before your newly diagnosed patient loses the cognitive ability to drive safely—if that has not already happened—and your patient may not be scheduled to see you again before this
happens. So, why wait until after a preventable tragedy occurs? Let me put it one more way; imagine the lawsuit you and your patient could face if the estate of a mortally injured party sues, arguing that the doctor should have known better than to allow a person with diagnosed cognitive deficiencies to continue driving! So, doctors, please tell patients with AD not to drive!

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BETTER CHARACTERIZATION OF TRANSIENT ISCHEMIC ATTACK MIGHT IMPROVE THE BENEFIT: RISK PROFILE OF THROMBOLYSIS

To the Editor: In the management of ischemic stroke, diagnosis has to be accurate and timely in order to achieve the best outcome from thrombolysis.1 The diagnostic error to avoid is to mistake transient ischemic attack (TIA) for ischemic stroke, with consequent inappropriate thrombolysis. Universal adoption of the tissue-based definition of “TIAs are brief episodes of neurological dysfunction resulting from focal cerebral ischemia not associated with permanent cerebral infarction”2 might mitigate this risk of misdiagnosis. Magnetic resonance imaging (MRI) should be the imaging modality of choice, given the fact that it has a sensitivity of 88% to 100% and a specificity of 86% to 100% for identification of cerebral infarction. Diagnostic accuracy is lower for computed tomography (CT), which has a sensitivity of less than 60% and a specificity of 88%.3 The potential for MRI to distinguish between TIA and ischemic stroke would also benefit individuals with cerebral infarction who experience rapid symptomatic improvement that falls short of complete resolution of symptoms. Such individuals run the risk of being denied thrombolytic treatment solely because of mild or rapidly improving symptoms (which might lead to erroneous diagnosis of TIA), as was the case in 12,912 of 93,517 individuals arriving at the hospital within 2 hours of onset of focal neurological symptoms.4 As many as 26.7% of those 12,912 individuals subsequently deteriorated and were no longer independently mobile at the time of discharge. In addition to these 12,912 individuals with unresolved symptoms, 6,500 individuals were symptomatic on arrival in hospital but were eventually recategorized as having TIA. What was not specified was the time course of resolution of their symptoms and whether recategorization was on the basis of MRI. Major disadvantages of MRI are contraindications to the procedure in some individuals and the fact that it takes longer to obtain diagnostic images with MRI than with CT.5 Nevertheless, faster sequences and stronger and faster gradients have been developed, with ever-improving computing power.5

Some individuals with TIA who do not have an infarct in the neurological territory subserved by the incident focal neurological episode nevertheless have multiple clinically “silent” cerebral infarcts (detectable on MRI) in other vascular territories.6 Such infarcts might be compatible with cardioembolic cerebral embolism, mandating anticoagulation as the treatment strategy of choice, in preference to thrombolysis, especially because individuals with premorbid atrial fibrillation (a major risk factor for cardioembolic cerebral embolism) experience early recurrence of stroke in as many as 83.3% of instances, despite thrombolytic therapy for incident ischemic stroke.7

By excluding cerebral infarction, MRI might also mitigate the risk of inappropriate thrombolysis in individuals who present with TIA in the presence of cerebral amyloid angiopathy (CAA). Individuals with the latter disorder run the risk of thrombosis-related intracerebral hemorrhage, exemplified by a 60-year-old person who received recombinant TPA for treatment of myocardial infarction.8

Accordingly, the fact that thrombolysis has been proposed for ischemic stroke in patients aged 80 and older mandates heightened awareness that CAA may present with TIA,9 given that CAA has its highest prevalence in that age group.10

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REFERENCES