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The Implementation of Scenar Therapy in the clinical practice of a GERONTOLOGIST.

Chronic progressive diseases of the brain in the elderly and the senile.

In the present phase of medical development, in connection with the established ageing population trends in our country, one very real problem is in the impaired cognitive functions and the development of dementia in the elderly (61-75 years) and senile (76-90 years).

With the increase of life expectancy, the number of aged mentally ill people (AMIP), predominantly with chronic progressive diseases of the brain - depression and dementia steadily grows. In the age group 65 years and more senior, depression (10 %) and dementia (5 %), exceed 15 %. Symptoms of depression and dementia in patients of senile age mask each other, and it becomes difficult to separate them in precise nosological terms.

Some geronto-psychiatrists express the opinion, that the dissemination of dementia and other mental impairments of older people in their latter years take on the character of an epidemic, "a silent epidemic", and senile dementia in the near future will become the "disease of the century".

Dementia - the clinical syndrome manifests permanent multiple disturbances in cognitive functions and quite often transforms into a traumatic existence for both the patient and their family. The retardation of mental development (congenital dementia) can vary from high level intelligence diseases from resistive delusional disorders, to limited diverse syndromes such as aphasia and to simultaneous impairments of several cognitive functions.

Progressive consequences of chronic pathological processes are not only difficult to stop but also to slow down their progression. More than 50 % of elderly and senile persons display some expression of cognitive deficiency, with transitory or permanent cognitive impairment.

The fundamental cognitive structural components of intelligence comprise of various functions, socially age relevant:

- Attention,
- Memory,

- Perception,
- Sensory - motor activity,
- Analytical-synthetic processes.

The purpose of this research was to study the efficiency of SCENAR Therapy for the improvement of the functional condition of the brain and intellectual functions of older people.

In the first phase, a base group of 38 people (20 women and 18 men) of elderly and senile age (average age - 79.5 years) was taken from a branch of war veterans and invalids from the M.A. Podgorbynskovo MUS. GKB №3 who were examined by clinical and neuropsychological diagnostic methods.

All that were examined had no case histories of acute vascular disorders – myo-cardio infarction or strokes.

Psycho-organic syndromes by definition were absent according to the diagnosis of all patients.

Diagnosis: - insufficient blood circulation I-II degree and chronic ischemia of the brain II-III degree (established from initial clinical symptoms).

In the clinical picture, chronic ischemia of the brain dominated vestibulopathy atactic (100%) and pseudobulbar syndromes (78%). Other syndromes – akinetico-rigid, pyramidal cell insufficiency, astheno-depressive, and bulbar collectively accounted for no more than 28% (clinical expression of symptoms was not significant).

All patients were lead through a standard neuropsychological examination including:

- Brief investigation of mental condition (MMSE), in points (0 - 30)
- Battery of frontal lobe dysfunction (FAB), in points (0 - 18)
- Test of plotting hours, test for digital sequence (10 point scale)

Investigation Results:

All patients exhibited marked cognitive impairments in differing degrees of expressiveness.

Only in seven cases was there a lessening of comparative cognitive functions in relation to age changes. The remaining patients (33) examined were determined by cognitive impairment - slight (13) and moderate (20) degrees on the MMSE scale.

In the slight degree of cognitive impairment, 6 patients showed insignificant reduction on FAB and the test of plotting hours that presented in favour of Alzheimer type dementia, and the remaining (7) it was determined that a significant reduction on FAB and the test of plotting hours corresponding with frontal dementia was evident.

The test for digital sequence revealed a significant decrease in cognitive functions of all examined patients, confirming the presence of organic lesions of the brain, thus changes were not specific and did not rely on the expressions of cognitive impairment in other scales.

To clarify the understanding of the task, (AMIP) the patients were often not in a condition to comply with given instructions for their performance and experienced difficulties in independent execution of tasks.

The symptoms accompanying cognitive impairment included significant continuous movement, hyperactivity and impulsiveness: marked motor anxiety (sitting on a chair, turning, often rising from their place, inability to sit silently – and talkativeness). Their impulsiveness was aggravated by the complex adaptive and compensatory association: they interrupted each other, kept to their associates, had no appreciation of personal space, often answered before the completion of a question, and displayed marked forgetfulness and slight distractedness.

In the second stage - patients were divided into two groups (those receiving SCENAR therapy and those undertaking the normal treatment protocol). In the first group there were 16 persons, in the second 22 persons (the patients were grouped according to identical degrees of cognitive impairment, and divided into approximate age group and sex).

The control group received treatment against a background of common therapy (Nootropilum, campolon, Cavintonum, Aminalonum) and Tanakanum (an extract of ginkgo biloba EGB 761) in connection with a wide therapeutic range and with the absence of serious contra-indications and side effects.

The active properties of Tanakanum are based on its positive influence on rheological properties of blood, antioxidant and neuro-protective effect. Neuro-protective properties EGb 761 are caused by the antioxidatic activity of flavonol glycoside, which is its ability to block free radicals and inhibit protein kinasis. Its other component - ginkgolide V – constitutes an antagonistic factor of platelet activation, production of which reinforce the condition of cerebral ischemia, that further damage rheological properties of blood and the release of free radicals. The given mechanisms also provide the opportunity to administer Tanakanum for hypoxic correction, ischemic and neurodegenerative damage of brain cells. In a number of clinical studies the efficiency of Tanakanum has been demonstrated in the treatment of AAlzheimer type dementia, vascular and compound dementia.

In turn, the group of patients receiving Scenar Therapy was divided into two groups.

10 persons received treatment under the following protocol:

Treatment in the individually-dosed out mode, according to SCENAR rules of the principle "HIGHER", zones - «Three paths and six points», «Collar zone» (alternating treatment in the subjective-dosed out and individually-dosed out modes), after one day;

And treatment of the zone of the frontal projection of the liver in the subjective-dosed out mode (Fm, SW), twice a week.

6 persons received a special treatment protocol:

Cyclically repeating influence on five positions (a technique «Penetrating monad», - alternating modes of modulations and positions of an electrode, according to a schemata), for two days; Special treatment of six and nine points on the person's face according to the schemata (a technique « 6 + 9 »), each third day.

On the first and last procedures the zone treatment of «Three paths and six points » was undertaken, in the individually-dosed out mode.

Research Results:

1. Positive changes detected in cognitive impairment in patients of the control group in the first week of treatment was not revealed, only in the fourth week was there a noted tendency towards positive shifts in hyperactivity and impulsiveness: the motor anxiety had decreased, they ceased to cling to their associates. The patients began to carry out the tasks better, and their attention and visual memory had improved.

2. The patients who received SCENAR Therapy, the most significant changes were noted in the second half of the treatment protocol (in the second week of therapy). It was evident in the dynamics of cognitive functions, characterized by the volume and accurate imprinting of visual information, logical thinking, and an increase in fixed attentiveness, and stabilization of the fundamental cortical processes.

3. With SCENAR Therapy memory of immediate events was authentically improved, social activity (patients again began to communicate actively within their group), they started to collaborate, and they found it is easier to carry out mathematical operations already after the first week of investigative - treatment.

4. It is necessary to separate the results of the treatment under the second schemata. It was observed, that all the patients experienced faster changes in their cognitive status. Most noticeable was the increase in social activity. Logical thinking allowed them to solve problems and to increase points in the repeated testing of all variants. It demonstrated the reduction of organic changes in the brain.

5. The given results were kept after the termination of the treatment protocol and the achieved effects were sufficiently stable (the control group of 20 persons was tracked for over a month). Further tests were conducted. Results in the group receiving the general therapy and Tanakanum had not changed considerably.

CONCLUSIONS

SCENAR Therapy demonstrates a positive influence on the activity of the cortex of the brain, which leads to the improvement in the quality of cerebration (mental activity).

The efficacy of SCENAR Therapy was already evident in the second half of the treatment protocol (6-8 session), in comparison with the control.

It would be appropriate to introduce SCENAR Therapy with the purpose of correction and preventive maintenance in the cognitive disorders of the elderly.

Scientific research is still continuing in this field.

The Literature

1. Gavrilova S.I. Concept of mild cognitive depression. // The illness Alzheimer and ageing: Materials of III Russian conference, devoted to the 100 anniversary from the date of a birth Prof. E.Y.Shterneberg: 2003. - P.9-20.
2. Gavrilova S.I. Pharmaco-therapy of the Alzheimer illness. - M: Pulse, 2003 – p.320.
3. Zakharov V.V. The application of tanakanum and the Neurodegenerative Specialist. // Neurologic magazine. - 1997, №5. - P.42-49.

4. Zakharov V.V. Moderate cognitive impairment. Diagnostics and treatment. // Russian medical magazine. - 2006, T.14, №9 (261). - P.685-688.
5. Zakharov V.V., Yakhno N.N. Cognitive impairment of the elderly and the senile age.- , 2005. – P. 71.
6. Yakhno N.N., Zakharov V.V. Cognition and its' emotional-affective infringements on dis-circulatory encephalopathies // Russian medical magazine. - 2002. - T.10, № 12-13. - P. 531-551.
7. Petersen R.C., Smith G.E., Waring S.C. et al. Mild cognitive impairment: Clinical characterization and outcome. // Arch Neurol. - 1999. - V.56. - P.303-308.
8. Petersen R.C., Stevens J.C., Ganguli M. et al. Practice parameter: early detection of dementia: mild cognitive impairment (an evidence-based review): report of the Quality Standards Subcommittee of the American Academy of Neurology. // Neurology.-2001. - V.56. - P.1133-1142.
9. Ritchie K., Artero S., Touchon J. Classification criteria for mild cognitive impairment: a population-based validation study. // Neurology. - 2001, V.56. - P.37-42.
10. Schroeder J., Kratz B., Pantel J. et al. Prevalence of mild cognitive impairment in an elderly community sample. // J Neural Transm Suppl.-1998, V. 54. - P.51-59.
11. Lopez O., Jagust W., DeKosky S., et al. Prevalence and classification of mild cognitive impairment in the cardiovascular health study cognition study. // Arch Neurol. - 2003.-V.60, N.10. - P.1385-1389.
12. Graham J.E., Rockwood K., Beattie E.L. Prevalence and severity of cognitive impairment with and without dementia in an elderly population. // Lancet. - 1997. - V.349. - P.1793-1796.
13. Tschanz J., Welsh-Bohmer K., Lyketsos C., et al. Conversion to dementia from mild cognitive disorder. The Cache County Study // Neurology. - 2006. - V.67. - P.229-234.
14. Morris J.C., Storandt M., Miller J.P., et al. Mild cognitive impairment represents early-stage Alzheimer disease. // Arch Neurol. - 2001. - V.58. - P.397-405.
15. Kramer J.H., Nelson A., Johnson J.K., et al. Multiple cognitive deficits in amnesic mild cognitive impairment. // Dement Geriatr Cogn Disord. - 2006. - V.22, N.4. - P.306-311.
16. Loewenstein D.A., Acevedo A., Agron J., et al. Cognitive profiles in Alzheimer's disease and in mild cognitive impairment of different etiologies // Dement Geriatr Cogn Disord.-2006. - V21, N.5-6. - P.309-315.
17. Petersen R., Touchon J. Consensus on mild cognitive impairment. // Research and practice in AD. EADS-ADCS joint meeting. - 2005.-Vol.10. - P.24-32.
18. Nordlund A., Rolstad S., Hellstrom P. et al. The Goteborg MCI study: mild cognitive impairment is a heterogeneous condition. // J. of Neurology, Neurosurgery, and Psychiatry. - 2005. - V.76. - P.1485-1490.
19. Portet F., Ousset P., Visser P., et al. Mild cognitive impairment (MCI) in medical practice: a critical review of the concept and new diagnostic procedure. Report of the MCI Working Group of the European Consortium on Alzheimer's Disease // J. of Neurology, Neurosurgery, and Psychiatry. - 2006. - V.77. - P.714-718.
20. Petersen R., Doody R., Kurz A. et al. Current Concepts in Mild Cognitive Impairment. // Arch Neurol.-2001. V.58, N.12. - P.1985-1992.
21. Rasquin S.M., Lodder J., Visser P.J. et al. Predictive accuracy of MCI subtypes for Alzheimer's disease and vascular dementia in subjects with mild cognitive impairment:

- a 2-year follow-up study. // *Dement Geriatr Cogn Disord.* - 2005. - V.19, N. 2-3. - P.113-9.
22. Meyer J., Xu C., Thornby J. et al. Is mild cognitive impairment prodromal for vascular dementia like Alzheimer's disease? // *Stroke.*-2002. - V.33. - P.1981.
23. Doody R. S., Stevens J.C., Beck C. et al. Practice parameter: Management of dementia (an evidence-based review). Report of the Quality Standards Subcommittee of the American Academy of Neurology. // *Neurology.*-2001.-N.56.-P.1154-1166.
24. Kanowski S., Herrmann W., Stephan K. et al. Proof of efficacy of the ginkgo biloba special extract EGb 761 in outpatients suffering from mild to moderate primary degenerative dementia of the Alzheimer type or multi-infarct dementia // *Pharmacopsychiatry.*-1996. N.29.-P.47-56.
25. Kanowski S., Hoerr R. Ginkgo biloba extract EGb 761 in dementia: intent-to-treat analyses of a 24-week, multi-center, double-blind, placebo-controlled, randomized trial. // *Pharmacopsychiatry.*-2003.V.36,N.6.-P.297-303.
26. Wesnes I.L., Simmons D., Rook M., et al. A double-blind placebo-controlled trial of Tanaken in the treatment of idiopathic cognitive impairment in the elderly. // *Hum Psychopharmacol.*-1987.-V.2.-P.159.
27. LeBars P.L., Katz M.M., Berman N., et al. A placebo-controlled, double-blind, randomized trial of an extract of Ginkgo biloba for dementia. // *JAMA.*-1997 V.278. - P.1327-1332.
28. Birks J., Grimley E.V., Van Dongen M. Ginkgo biloba for cognitive impairment and dementia. // *Cochrane Database Syst Rev.* - 2002. - V.4.