

## Should Family Physicians Routinely Screen Patients for Cognitive Impairment?

### Yes: Screening Is the First Step Toward Improving Care

J. RILEY McCARTEN, MD, *Minneapolis Veterans Affairs Health Care System and University of Minnesota, Minneapolis, Minnesota*

SOO BORSON, MD, *University of Washington School of Medicine, Seattle, Washington*

Dementia in older adults is a common,<sup>1</sup> costly,<sup>2</sup> and rapidly growing<sup>3</sup> health care problem. It is almost invariably the result of chronic, progressive, and ultimately terminal brain disease, most often Alzheimer disease.<sup>4</sup> Little can be done to alter the course of the underlying brain pathology. Determining whether to assess patients for dementia is not based on halting or reversing disease; rather, it is based on whether recognizing dementia when it is present will improve decisions made by the physician, the patient, or the patient's family.

Good medical decisions depend on good information. When a physician knows that a patient's ability to provide a history may be limited by cognitive impairment, he or she can arrange to gather additional information from someone who knows the patient well. Knowing that dementia interferes with self-management, the physician also can involve the patient's family members early as partners in care.

Patients with dementia often are unaware of the extent or impact of their cognitive deficits, so they may not talk about or acknowledge them.<sup>5</sup> This makes dementia an occult disease appropriate for screening. Even patients with preserved insight may fear the diagnosis and minimize symptoms; this is common with many disorders. Persons with dementia of mild or even moderate severity typically look and act healthy—the *Diagnostic and Statistical Manual of Mental Disorders*, 5th ed., describes persons with dementia as



This is one in a series of pro/con editorials discussing controversial issues in family medicine.

▶ See related editorial on page 864.

having preserved social cognition and procedural memory.<sup>6</sup> Cognitive impairment that is not severe cannot be recognized reliably without testing. Even patients with normal results on cognitive tests are at significantly increased risk of dementia if they have ever had symptoms of incipient dementia (mild cognitive impairment).<sup>7</sup> When evaluating older adults, physicians must remain vigilant for cognitive impairment.

The diagnosis of any serious disease is a life-changing event for patients and families. What a patient and his or her family do with the information is deeply personal, yet essential to clinical interactions. For the person with dementia, the ability to think about the future and make informed decisions progressively fades, usually well before a terminal event. Early diagnosis not only provides patients with the opportunity to enjoy their best function while they still can, but it gives them more time to consider and express their wishes for a future in which they will not be able to make decisions for themselves. It also potentially gives family members extra time to gradually take on new roles, in parallel with progression of the patient's impairment.

The U.S. Preventive Services Task Force (USPSTF) recommendations on screening for cognitive impairment in older adults indicate that brief screening instruments can adequately detect dementia, but that there is a lack of empirical evidence that early detection improves outcomes. However, the USPSTF recognizes that early detection may

be beneficial for many reasons, including optimizing medical management of coexisting conditions that could worsen cognition, planning for the future when decision making is still relatively intact, and providing education about symptoms and access to services.<sup>8</sup>

Because dementia is associated with potentially preventable excess morbidity, it is a ready target for interventions in primary care. Older persons with dementia have more hospitalizations, often potentially preventable ones, than those without dementia.<sup>9</sup> Once admitted, they require more hours of care, have longer stays, and are at increased risk of delayed discharge and functional decline during admission.<sup>10</sup> They are more likely than patients without dementia to develop delirium, which is itself associated with long-term functional and cognitive decline, and increased institutionalization, rehospitalization, and mortality.<sup>11,12</sup> One prospective study found that more than 40% of hospitalized patients older than 70 years had dementia, but only one-half had been previously diagnosed. It also found that the mortality rates in the patients with dementia were markedly higher.<sup>13</sup> These data suggest the need for enhanced case-finding in older inpatients,<sup>14</sup> with the goal of intervening as early as possible to reduce complications.

Hospitalized patients may do poorly on cognitive tests for many reasons; to improve care over the long term, a better approach would be to assess cognition as part of the routine care of older outpatients. When physicians are aware that a patient has cognitive impairment, they are also alerted to the patient's risk of poor outcomes in both the hospital and ambulatory care settings. Physicians can then take steps to mitigate these risks, including having an informed discussion with the patient, family, and staff; establishing a monitoring plan; and considering the benefit vs. risk of interventions, including hospitalization.

Although proof that early diagnosis and intervention improve outcomes for older adults with dementia is not yet established, being able to anticipate and mitigate the potentially adverse outcomes of hospitalization in these patients should be reason

enough to screen for cognitive impairment in the primary care setting.

Address correspondence to J. Riley McCarten, MD, at [mccar034@umn.edu](mailto:mccar034@umn.edu). Reprints are not available from the authors.

Author disclosure: No relevant financial affiliations.

## REFERENCES

1. Plassman BL, Langa KM, Fisher GG, et al. Prevalence of dementia in the United States: the aging, demographics, and memory study. *Neuroepidemiology*. 2007; 29(1-2):125-132.
2. Hurd MD, Martorell P, Delavande A, Mullen KJ, Langa KM. Monetary costs of dementia in the United States. *N Engl J Med*. 2013;368(14):1326-1334.
3. Ziegler-Graham K, Brookmeyer R, Johnson E, Arrighi HM. Worldwide variation in the doubling time of Alzheimer's disease incidence rates. *Alzheimers Dement*. 2008;4(5):316-323.
4. Hebert LE, Scherr PA, Bienias JL, Bennett DA, Evans DA. Alzheimer disease in the US population: prevalence estimates using the 2000 census. *Arch Neurol*. 2003;60(8):1119-1122.
5. Galvin JE, Sadowsky CH; NINCDS-ADRDA. Practical guidelines for the recognition and diagnosis of dementia. *J Am Board Fam Med*. 2012;25(3):367-382.
6. Neurocognitive disorders. In: American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*. 5th ed. Washington, DC: American Psychiatric Association; 2013:591-643.
7. Roberts RO, Knopman DS, Mielke MM, et al. Higher risk of progression to dementia in mild cognitive impairment cases who revert to normal. *Neurology*. 2014;82(4):317-325.
8. Lin JS, O'Connor E, Rossom RC, Perdue LA, Eckstrom E. Screening for cognitive impairment in older adults: a systematic review for the U.S. Preventive Services Task Force [published correction appears in *Ann Intern Med*. 2014;160(1):72]. *Ann Intern Med*. 2013; 159(9):601-612.
9. Phelan EA, Borson S, Grothaus L, Balch S, Larson EB. Association of incident dementia with hospitalizations. *JAMA*. 2012;307(2):165-172.
10. Mukadam N, Sampson EL. A systematic review of the prevalence, associations and outcomes of dementia in older general hospital inpatients. *Int Psychogeriatr*. 2011;23(3):344-355.
11. Fick DM, Agostini JV, Inouye SK. Delirium superimposed on dementia: a systematic review. *J Am Geriatr Soc*. 2002;50(10):1723-1732.
12. Witlox J, Eurelings LS, de Jonghe JF, Kalisvaart KJ, Eikelenboom P, van Gool WA. Delirium in elderly patients and the risk of postdischarge mortality, institutionalization, and dementia: a meta-analysis. *JAMA*. 2010;304(4):443-451.
13. Sampson EL, Blanchard MR, Jones L, Tookman A, King M. Dementia in the acute hospital: prospective cohort study of prevalence and mortality [published correction appears in *Br J Psychiatry*. 2013;202:156]. *Br J Psychiatry*. 2009;195(1):61-66.
14. Shenkin SD, Russ TC, Ryan TM, MacLulich AM. Screening for dementia and other causes of cognitive impairment in general hospital in-patients. *Age Ageing*. 2014;43(2):166-168. ■