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# Would doctors routinely asking older patients about their memory improve dementia outcomes?

The UK government wants general practitioners to check for dementia in all patients aged 75 and older.

**Jill Rasmussen** says that it will allow earlier support for patients with dementia, but **Margaret McCartney** says that industry has more to gain

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- Observations: There is no evidence base for proposed dementia screening (*BMJ* 2012;345:e8588)
- Research: Effectiveness of dementia follow-up care by memory clinics or general practitioners (*BMJ* 2012;344:e3086)

**Jill Rasmussen** general practitioner with special interest in mental health and learning disability, East Surrey, Clinical Commissioning Group, Caterham CR3 5QX, UK  
jill.Rasmussen@virgin.net

**YES** Earlier identification of dementia gives patients and their families and carers more opportunity to consider the implications of the diagnosis and to make decisions while the patient can actively participate. Although no preventive or curative treatments are available, we have pharmacological interventions such as cholinesterase inhibitors that can optimise a patient’s capabilities during early dementia, enabling them to play more active roles in society, spend quality time with “near and dear”; and enjoy a better quality of life.<sup>1</sup>

Many people attribute memory problems to old age. Unfortunately, many healthcare professionals are guilty of the same presumption when confronted with an older patient or concerned relative with memory complaints. Timely diagnosis in dementia gives the opportunity to maximise the benefits of current interventions.

**Need for better care**

The *Appraisal of Screening for Alzheimer’s Disease* 2009 concluded that “an evidence based routine screening programme for Alzheimer’s disease that will reduce mortality and morbidity is not yet a

**Margaret McCartney** general practitioner, Glasgow, UK  
margaret@margaretmccartney.com

**NO** We are already screening for dementia. Never mind the evidence based conclusion from the UK National Screening Committee that “screening should not be offered,”<sup>1</sup> our hospitals now receive financial incentives to do exactly that.

In early 2012 the Department of Health’s new Commissioning for Quality and Innovation (CQUIN) payments aimed to increase the rate of diagnosis of Alzheimer’s disease by asking everybody admitted to hospital over the age of 75 whether they have been more forgetful in the past 12 months to the extent that it has significantly affected their daily life.<sup>2</sup> The question has to be asked within 72 hours of admission, and hospitals must achieve 90% compliance over three consecutive months before payment. Patients answering “yes” must have a “diagnostic assessment.”

The CQUIN document says that this is “awareness raising rather than formal screening.” But what is screening if it is not looking for a condition that the patient did not complain of or demonstrate symptoms of? And importantly, evidence of benefit is lacking. We do not have clear data on the positive predictive value of the question in real life

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possibility.” The appraisal also highlights that the UK is in the bottom third of European performance for diagnosis and treatment of dementia, and that services and support for patients, families, and carers are inadequate.<sup>2</sup>

The challenges faced by those affected by dementia go beyond health and social care. An Alzheimer’s Society survey of people with early dementia in 2012 found that as many as 67% of the 306 respondents felt isolated from society and that communities fail to appreciate their problems or make reasonable adjustments to meet their needs.<sup>3</sup>

Since 2009 there have been important policy initiatives in the UK to increase awareness of dementia and to establish effective services for early diagnosis and intervention; ensure adequate support after diagnosis; and make our communities more dementia friendly.<sup>4</sup>

Guidelines from the National Institute for Health and Clinical Excellence in 2011 endorsed the use of cholinesterase inhibitors in mild to moderate Alzheimer’s disease.<sup>5</sup> Models of memory services have shown that diagnosis should be embedded more in the community, with general practitioners taking ownership and closer liaison with secondary services.<sup>6</sup> GPs’ concerns about

or knowledge of the amount of harm that will be caused through overinvestigation and the lack of consent for the process.

The same document claims that anxiety will be raised unnecessarily, “only if the process is done badly,” and justifies it by claiming that “doing nothing is not an option.” Nevertheless, it admits that, “There will never be enough old age psychiatry liaison teams to assess, diagnose, and manage people with dementia in the general hospital,” and that, “Help from organisations such as the Alzheimer’s Society will be important.” So there is resource to pay for non-evidence based screening, yet a seeming acceptance that the NHS cannot offer adequate specialist care, and that people will be directed to the third sector instead.

This is a disservice to people with life impairing dementia, but it is also disease mongering in people with mild or occasional memory problems who live well. Patients in the community are also to be screened—the Department of Health has said that the general practitioner contract will “reward practices” that screen patients at supposedly high risk of dementia.<sup>3</sup> We know the harms of screening have been insufficiently studied.<sup>4</sup> We know that it will often detect mild cognitive impairment and that this does not necessarily progress to dementia.<sup>5</sup>

cognitive assessment tools have been addressed in a toolkit published by the Alzheimer's Society.<sup>7</sup> We have made considerable progress since 2009 in ameliorating the effect of dementia.

### Opportunity to ask about memory problems

The 2012 report of the All Party Parliamentary Group on Dementia finds no justification for population screening but recommends opportunistic questioning about memory problems.<sup>8</sup> Advanced age is the predominant risk factor for dementia, and many people over the age of 65 will have at least one long term health problem. These patients usually attend primary care regularly for reviews or annual flu jabs. Such interactions give cost efficient opportunities to inquire about health concerns, including memory problems. Taking advantage of these contacts could improve early detection and might help overcome the impression that primary care has been a barrier to diagnosis rather than a portal to advice and services.

In this environment of routine visits, general queries about health, including memory problems, can be raised without causing undue anxiety. It therefore seems sensible to explore possible memory and cognitive deficits in these patients. Equally, health professionals must be alert to other groups at higher risk of dementia—for example, those with Parkinson's disease or learning disability, especially Down's syndrome.

### Industry influence

So who will benefit from possible "pre-disease" being diagnosed? The obvious answer is the pharmaceutical industry, which could see its market grow from increasing numbers of people being diagnosed with mild cognitive impairment.

Industry has taken a position at many high tables. The Alzheimer's Society has a policy of accepting drug company funding to a maximum of 5% of its total,<sup>6</sup> and Andrew Chidgey, its director of external affairs, said on Twitter on 14 December 2012 that he meets "on and off" with the industry, including "looking round Eli Lilly to get an update on their research." Jeremy Hunt, health secretary, tweeted on 20 December, "Feeling optimistic about progress in dementia research. Thanks @Lillypad for great visit."

Eli Lilly recently published press notices about phase III clinical trials of solanezumab, a monoclonal antibody that it says shows "slowing of cognitive decline in patients with mild Alzheimer's disease." However, there was no significant change in the cognitive and functional outcomes used as primary endpoints, and only a prespecified secondary analysis showed benefit; to date neither the data nor any information about whether the

### Cost of failure to identify dementia

Evidence shows that failure to recognise dementia results in greater financial and personal costs and crisis in management. This results in inappropriate hospital admissions, earlier need for nursing home placement, and poorer quality of life for patients and their near and dear.<sup>8</sup> Dementia is the greatest health concern among people over 55.<sup>9</sup> Physical, psychiatric, and psychological clinical outcomes are better for everyone when crisis care is avoided and care follows a preventive model.

Failure to identify dementia deprives everyone involved—especially patients—of valuable time when the short and long term future can be discussed before events become critical. Early identification of disease, including dementia, improves treatment options and allows everyone to be better prepared to face the future. Important medicolegal issues should be discussed, such as lasting power of attorney, and personal decisions should be made while the patient can participate.

Some healthcare professionals see no value in diagnosing dementia because there is no cure. But most patients with dementia will live with the disease for years, and there is much that can be done to help them along the journey. Evidence is increasing that improvements in lifestyle (exercise, diet), combating obesity, and optimising control of comorbidities (hypertension, diabetes, cerebrovascular disease) can delay the

benefit was clinically useful have been published.<sup>7</sup>

In December the Social Market Foundation published a report on dementia diagnosis, *A Future State of Mind*, sponsored by Lilly, which railed against GPs, saying, "Early diagnosis is obstructed principally by problems in primary care associated with the capability of GPs, time constraints and physician perceptions of the benefits of diagnosis."<sup>8</sup> The document makes proposals to "improve early diagnosis," but does not include assessments of the harms of screening or overdiagnosis.

Other industries also stand to benefit from more "early" diagnosis. Adverts on bmj.com have included those for a nutritional product "designed specifically for people living with early Alzheimer's disease."<sup>9</sup> The claims of effectiveness are based on trials over six months that showed only small overall differences and used memory test outcomes rather than functional performance.<sup>10</sup>

Cambridge Cognition, a technology company, recently announced government support for trials of its high tech early dementia assessment service that could "reduce time to diagnosis from 18 months to 3 months." The service uses a diagnostic tool on a tablet computer that it claims, "in less

onset and slow the progression of dementia."<sup>10</sup> When impairment results from causes other than dementia, it is imperative to identify and treat these and to reassure patients.

Some patients will not want to pursue investigation of any memory problems, and their decision must be respected. We currently have no cure for dementia, but there is agreement that early detection benefits patients.<sup>11 12</sup>

We have interventions, such as cognitive stimulation,<sup>13</sup> that can help preserve competence for as long as possible. There is increasing provision of services within health, social care, and the voluntary sectors to support people with dementia, their families, and carers. We must ensure that such services and support are available to everyone with dementia.

Earlier diagnosis will not alter the ultimate outcome, but the better informed and prepared we all are, the better equipped we will be to tackle the challenges that dementia presents.

**Competing interests:** I am the clinical lead for mental health, learning disability and dementia for East Surrey CCG; co-developer of MoodHive (Depression Anxiety Pathway); chair of the Learning Disability Special Interest Group and Clinical Champion for Dementia at the Royal College of General Practitioners; as a director of Psi-napse, an independent consultancy I have advised pharmaceutical companies, venture capital banks, and organisations such as the Wellcome Trust about new therapeutics for psychiatric and neurological disorders.

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than 10 minutes, differentiates between patients with normal and abnormal memory."<sup>11</sup> However, the company cites a specificity of 92%, which will result in many false positive diagnoses.<sup>12</sup>

### Direct resources where most needed

The rush to "early" diagnosis has missed crucial dialogue. Earlier than what? Why? We should aim for timely, consensual diagnoses as part of a dialogue, not a test foisted on a patient who seeks healthcare with other priorities and lacks the choice and chance to consent, or not. A negative dementia screening result does not mean people do not have to plan for their future. This political drive will overdiagnose and overtreat many people with minor memory changes, who cannot benefit from screening and may only be harmed by it. Instead of shiny gadgets and incentives for hospital doctors to fill out admission questionnaires, we should turn our attention to the low tech, hard graft of supporting people with severe symptoms and their families with the front line care they need—and whose voices are scarcely heard.

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