

# General practitioners should be conducting targeted screening for dementia in people aged 65 to 74

## YES

### The burden

Dementia, including Alzheimer's disease, is among the largest global public health challenges facing our generation. Today, over 35 million people worldwide live with the condition, and this number is expected to double by 2030, and more than triple by 2050 to 115 million.<sup>1</sup> Yet, in many countries, the majority of those with dementia have not been identified, with the mean rate of diagnosis in the UK at 48% (range 39% to 78%).<sup>2</sup>

Failure to diagnose dementia means people with the disorder, their families and carers are denied proper support. This results often in crises that were avoidable, including inappropriate hospital admissions and earlier nursing home placements. The outcome is not only higher personal costs, but also avoidable and substantially increased health and social care costs. In these times of financial constraint and austerity, this money would be better spent on improving services—especially those in primary and community care.<sup>3</sup>

### The stigma

Despite campaigns to increase awareness of dementia, the public are often reluctant to seek advice about their concerns.<sup>4</sup> People cite a lack of clarity of presenting symptoms, and often consider that cognitive impairment is a natural part of ageing; there is also considerable stigma and 'fear' associated with the diagnosis of dementia.<sup>5</sup>

Health professionals in primary care are in the privileged position of having access to a wealth of knowledge about an individual's health, family history and social circumstances, and can often identify 'change' that may indicate a health issue. Patients are more likely to voice concerns about themselves or a family member to someone they know, in an environment that is not stigmatised as a specific type of clinic.

### The diagnosis

Increasing age, especially from 70 years onward, is an important risk factor for dementia. However, longevity also brings with it risk for other long-term conditions. Most people with dementia have multiple physical comorbidities, and certain long-term conditions, such as diabetes and hypertension, are associated with increased risk of dementia. Cognitive impairment is frequently multifaceted and it is important to recognise cog-

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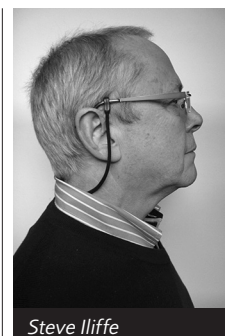
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While evidence can help inform best practice, it needs to be placed in context. There may be no evidence available or applicable for a specific patient with his or her own set of conditions, capabilities, beliefs, expectations and social circumstances. There are areas of uncertainty, ethics and aspects of care for which there is no one right answer. General practice is an art as well as a science. Quality of care also lies with the nature of the clinical relationship, with communication and with truly informed decision-making. The **BACK TO BACK** section stimulates debate, with two professionals presenting their opposing views regarding a clinical, ethical or political issue.



Jill Rasmussen



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BACK TO BACK this issue:

nitive impairment<sup>6</sup> and manage those potential causes of cognitive decline that are amenable to clinical management. Common treatable causes include physical illnesses, such as anaemia or thyroid dysfunction; mental illness, such as depression and the side effects of medications. It is important to reassure patients when their symptoms are not associated with dementia.

## Evidence supports how important early diagnosis is to most people with dementia, as it gives them time to make choices and plan for the future

One of the recommendations from the UK All Party Parliamentary Group report in 2012<sup>4</sup> was that:

Primary care workers and other health and social care professionals in contact with people in groups with an established risk of dementia should routinely ask questions to identify symptoms of dementia. The commitment in the Prime Minister's challenge on dementia for regular checks for the over-65s should be widened to include regular checks for all groups at risk of developing dementia.

The review of people with long-term conditions is standard practice in primary care. It is desirable and logical that such reviews also include evaluations relevant to dementia when patient age and medical history suggest risk of this disorder.

It is important that people with dementia have coordinated and holistic care that addresses all of their and their family and carers' health and social needs. General practitioners (GPs) are in the best position to identify and coordinate these needs and ensure that they are met.

### Missed and misdiagnosis

Concerns have been raised that identifying dementia earlier in the course of the illness and having targets for diagnostic rates (as in the UK)

will be associated with higher rates of misdiagnosis. On the other hand, people with dementia, their families and carers have raised concerns about delays in the diagnostic process and the failure of GPs to recognise possible dementia (missed diagnosis). Factors that have contributed to the attitude of some GPs toward the diagnosis of dementia include inaccurate assessment tools, therapeutic nihilism and lack of post-diagnostic support.<sup>4</sup> The UK National Audit Office report in 2010 found evidence that the situation was improving, with 77% of GPs agreeing that early diagnosis would be beneficial compared with 66% in 2007.<sup>7</sup>

Improving diagnosis and care of patients with dementia has been prioritised by the Department of Health through the NHS Mandate and by NHS England through its planning guidance for Clinical Commissioning Groups.<sup>8</sup> This enhanced service is designed to encourage practices to take a proactive approach to the timely assessment of patients who may be at risk of dementia. Health professionals must also respect the fact that advice and screening may be offered to people at risk of a particular disorder, but some may decline the opportunity.

National dementia strategies and associated initiatives have focused minds on the need for better training and education of health and social care professionals about dementia, the need for improvements in assessment tools and models of integrated care, and the need for dementia services that address the delays in diagnosis and lack of support and poor coordination in post-diagnostic services.<sup>2</sup> Whilst highlighting the challenges that still need to be overcome, the latest 'State of the Nation' report in the UK describes the progress that has been made in dementia care.<sup>2</sup>

### Conclusion

Nobody wants to hear that they have an incurable illness, but evidence supports how important early diagnosis is to most people with dementia, as it gives them time to make choices and plan for the future.

#### COMPETING INTERESTS NHS, UK

Strategic Clinical Network  
South East Clinical  
Lead Dementia;  
East Surrey CCG  
Commissioning Lead for  
Mental Health, Learning  
Disability and Dementia;  
Co-developer of  
MoodHive (Depression  
Anxiety Pathway).

**Royal College of  
General Practitioners**  
Chair Learning Disability  
Special Interest Group;  
Clinical Champion  
Dementia.

**Consultancy/Advisory  
Boards/Speakers Bureau**  
Autism Therapeutics,  
Alzheimer's Society,  
Cerestim, Chronos, EDRIP,  
Lilly, Napp, Otsuka, Pfizer,  
Roche, Servier, Targacept.

The primary care environment is familiar to people with long-term conditions, as they are invited to attend regularly for review. For those at increased risk of dementia, this is a convenient, cost-effective and non-stigmatising environment to enquire about and/or identify concerns where the person, their family and carers can receive holistic consideration.

In these times of austerity, if the needs of the growing number of people with dementia, their families and carers are to be met, all those involved in the design and provision of dementia care must ensure the most efficient use of resources. Therefore, recognition of dementia earlier in the course of illness by targeting 'at risk' people aged 65 to 74 is necessary and entirely justified.

#### References

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# NO

Screening for dementia syndrome is not justified by available evidence, applying the Wilson and Jungner criteria for screening and the definition of screening on the UK Screening Portal.<sup>1</sup> Screening becomes appropriate and ethical when four sets of conditions—about the condition, its diagnosis, its treatment and the costs of treatment—are met.

### The condition

The condition must be important, with detectable risk factors and disease markers, a recognisable latent or early symptomatic stage and a clearly understood natural course. All cost-effective primary prevention interventions should have been implemented as far as practicable.

There is no doubt that dementia syndrome is important. It costs the health and social services more than cancer, heart disease and stroke combined, and its prevalence is rising. It is a syndrome of symptoms that includes a range of neurodegenerative disorders that share two common features: they are progressive, and no disease-modifying treatments are available for them despite decades of research. The survival time for most people who develop dementia is short, being 4.5–5 years from symptom onset<sup>2</sup> to 3.5 years from diagnosis,<sup>3</sup> making dementia a condition in need of palliation.

Risk factors for dementia are similar to those of cardiovascular disease, but with some evidence of genetic vulnerability, especially in those who acquire the syndrome relatively early in life. As yet, there are no disease markers available for population screening.

Mild cognitive impairment, the presumed prodromal state of dementia syndrome, is problematic

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