

# Diving Into Dementia

## Overcoming the Barriers to Dementia Diagnosis

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**D**ementia has been called both an “epidemic” and “a public health crisis”; yet, the number of people with dementia is rising and projected to continue to rise.<sup>1</sup> Despite this, Alzheimer's disease (AD) and related dementing disorders remain underrecognized, undetected, and underdiagnosed. Indeed, dementia remains stigmatized and marginalized by both providers and the public. I wonder, how can this be?

Over the past half-century, there has been increased recognition by both providers and the public that memory loss is not a normal part of aging. In my clinical practice, I have seen firsthand a significant decline in the severity of cognitive impairment at which patients present for initial evaluation. Yet, there continues to be a general failure to recognize and detect both early cognitive impairment and signs of dementia among primary care providers and specialty practitioners.

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Reportedly, only 35% of Medicare beneficiaries with a diagnosed dementia, or their caregivers, were aware of the diagnosis.<sup>2</sup> Like other medical conditions, one has to be willing to either look for it, but there are few incentives for providers to do so. Subtle cognitive impairment—the very early signs of what may manifest to be a dementia—are easily dismissed or overlooked by busy providers, the person experiencing the change, and their family. However, a dementing illness, wherein cognitive and functional decline are present, should be easily detected by astute clinicians, regardless of specialty. It seems apparent, to paraphrase Rodney Dangerfield, that AD “gets no respect.”

While on the one hand I am perplexed by this persistent failure to recognize and diagnose, on the other I find it understandable and, at some level, quite rational. Because

there is no cure and providers are limited in how much we can help manage symptoms and progressive decline, some may ask, “Would you want to know?” and, “What is the benefit of early detection?” But such phrases indicate a nihilistic view point that is shared by too many providers, patients, and families. My answer to the first question is a resounding “Yes, yes, yes!” both for myself and for my family; why should cognitive decline be treated different from any other illness (eg, hypertension, diabetes, cancer) wherein early symptom recognition is promoted as important to optimal care and treatment?

At the core of the medical education is learning to take down a medical history, and the first step of a medical history is the “chief complaint.” Why do medical providers minimize or discount complaints of memory or thinking problems by patients or families? What makes these complaints less legitimate than a complaint of headache, chest pain, or shortness of breath? Patients and family members too frequently tell me that, when they first mentioned to their medical provider a concern about memory loss or a change in thinking, their complaint was dismissed or minimized, often with a response along the lines of: “Oh, that’s just what happens when you are X years old.” My response to that provider would be: “So, when *you* are X years old, do you expect to have problems with your memory?”

The barriers to detection and diagnosis are real, especially in busy primary care practices. Cognitive and functional decline with age occurs insidiously and are frequently unrecognized by the individual experiencing the change, attributed to aging or to other medical conditions. In addition, there is no single clinical algorithm for detecting patients who may have mild cognitive impairment or dementia; thus, clinical practice continues to rely on others, largely family members, to report concerns. The inclusion of a cognitive screen as a mandatory component of the annual Medicare Wellness Examination was supposed to help improve early detection, as well as provide a baseline.<sup>3</sup> However, its implementation has been uneven, there is no standardized method or agreed upon tool for accomplishing this evaluation, and there is no data thus far to indicate it has had any significant impact.

The consequences of delayed recognition and diagnosis can be detrimental to patients’ health. People who show

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signs of dementia but are undiagnosed are more likely to participate in unsafe activities and have problems with money and medication management.<sup>4</sup> Earlier recognition and earlier diagnosis can also allow patients the opportunity to be involved in decisions for ongoing and future care needs; family members can also become educated so that they are prepared to meet the growing needs of their loved one. Early detection of cognitive change can improve patient outcomes by helping providers to better manage a patient's coexisting medical problems and avoid complications, such as delirium, that are all too common among individuals with cognitive impairment.

Just how frequently a dementia diagnosis is missed or delayed is unknown, but the literature and my experience suggest it is not an uncommon occurrence. Until screening for cognitive impairment or dementia is incorporated into routine care, either by requiring it as an element for billing or quality assurance, the true prevalence and extent of the consequences of missed diagnoses will remain unknown; and the challenges presented to patients, families, and providers in preventable events will continue. Further, without

early detection, advances toward a potentially viable pharmacologic treatment may be hindered or delayed, as clinical trials currently are focused almost exclusively on those with very early/mild cognitive decline.

I know I may be “preaching to the choir” here, but I want to strongly encourage all clinicians working with older adults to promote among colleagues, in both primary and specialty care, the need to take off the blinders, raise the bar of suspicion, actively look for signs and symptoms of cognitive decline among the aging patient population, and take complaints of memory loss and other thinking problems seriously. ♦

## References

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