Black Country Partnership NHS
NHS Foundation Trust

NHS
Wolverhampton
Clinical Commissioning Group

Dementia Diagnosis Guidelines

Primary Care

Dementia Diagnosis – Primary Care Guidelines

Introduction

Dementia is a long term condition, which primarily affects people over the age of 65 (late on-set dementia) but can also occur in people under the age of 65 (young on-set dementia). The prevalence and incidence rises with age, such that up to 49.6% of people over the age of 90 have it some extent.

There is no single 'dementia test'. Cognitive decline, specifically memory loss alone, is not sufficient to diagnose dementia. There needs to be an impact on daily functioning related to a decline in the ability to judge, think, plan and organise. There is an associated change in behaviour such as emotional lability, irritability, apathy or coarsening of social skills.

There must be evidence of decline over time (months or years rather than days or weeks) to make a diagnosis of dementia – delirium and depression are the two most common conditions in the differential diagnosis.

'Timely' diagnosis is when the patient wants it **OR** when the carers need it.

Sub-typing dementia is important in guiding prescribing decisions. Most sub-typing can be arrived at by taking a careful history. Differentiating vascular dementia and Alzheimer's becomes more challenging in older patients and in terms of post diagnostic support may not significantly influence management. Sub-types include:

- Alzheimer's Disease – 50% of late on-set dementia cases
- Lewy Body Dementia (LBD) – second most common cause of late on-set. Often patients also have parkinsonian gait, fluctuating levels of cognitions, and can also suffer from visual hallucinations/
- Vascular Dementia (multi-infarct or arteriosclerotic) – 20% of late-onset dementia cases
- Amnesiac dementia or Korsakoff's dementia – secondary to excessive alcohol
- Mixed Alzheimer's/Vascular dementia
- Dementia in Parkinson's disease
- Dementia unspecified

Patients developing dementia often present with family, friends, carers, or neighbours reporting problems with activities of daily living, memory problems.

Sometimes patients present themselves having noticed memory problems. Health care professionals who have known the patient for a period of time may also notice that the patient's mental state is deteriorating.

Risk Factors

Non Modifiable	Modifiable
Age	Diabetes
Gender (♀>♂)	Hypertension
Genetic factors ○ Down's syndrome > 40 ○ Learning Disability > 50	Hypercholesterolemia
	Obesity
	Diet with less than 2 portions of fresh fruit or vegetables daily
	Smoking
	Alcohol
	Lack of exercise
	Lack of mental Stimulation

Symptoms

Most common symptoms are:

- Memory loss
- Loss of higher executive functions (mental arithmetic, identifying and forming patterns, ability to follow complex orders)
- Language impairment
- Sleep disturbance
- Mood disturbance
- Self-neglect
- Disinhibition

History

- How long has it been going on for?
- Is there a gradual deterioration or is it step-wise (stable, then drops, then stable)
- What problems have been noted
- Cognition, consciousness levels, hallucinations
- Any physical health problems? TIAs can contribute to vascular dementia, Parkinson's disease increases the risk of dementia, acute or sub-acute confusional state may be due to underlying infection. Malignancy is a rare but important cause of dementia-like symptoms
- Any suggestion of depression or anxiety?
- Any neurological features – seizures, dysphasia, myoclonus, etc

Diagnosis in Primary Care

People with moderate or advanced dementia who have scored poorly on whichever screening tool is used **(MMSE <20/30, GP-COG <9/15)** may be diagnosed in primary care by their GP without referral to specialist services.

GP diagnosis is suitable in the setting of moderate or advanced dementia and should be considered instead of specialist referral provided that:

- The patient and their carer/family member in attendance do not specifically request a specialist referral, despite counselling that this is not necessary;
- The GP feels confident about making the diagnosis.
- The 'default' diagnosis in this setting should be Alzheimer's Disease but Vascular Dementia or Mixed Dementia should be considered if:
    - Gait disturbance and frequent falls have occurred
    - Early unexplained urinary symptoms
    - Personality and/or mood changes, psychomotor retardation are present
    - A history (within past 3 months) or clinical evidence of past stroke

Who do we refer for brain imaging?

Brain scans are not essential for a clinical diagnosis of dementia. If a scan is justified, detailed clinical information is crucial for the radiologist.

However brain imaging is likely to be helpful in order to:

- Exclude other intracranial causes of cognitive decline or symptoms;
- Support a diagnosis of Vascular dementia

Complex Diagnosis – Referral to Specialist Dementia Services

The following subtypes of dementia should prompt specialist referral even if the dementia is moderate or advanced.

Dementia with Lewy Bodies (DLB)	Parkinsons Disease Dementia (PDD)	Fronto-temporal (inc Picks Disease, FTD *)
✓ **Parkinsonian features** ✓ **Visual hallucinations** ✓ **'Funny turns'/falls prominent in history** ✓ **Nocturnal agitation and daytime somnolence** ✓ **DLB features from International Consensus Consortium**	✓ History of Parkinson's Disease ✓ Loss of emotional control ✓ Visual hallucinations	✓ Personality change, unusual aggression ✓ Lacking insight in social situations, loss of inhibitions ✓ Development of compulsive rituals ✓ Language difficulties, word-finding problems and circumlocution ✓ Earlier onset with memory loss a late feature ✓ * FTD features from Lund-Manchester Criteria

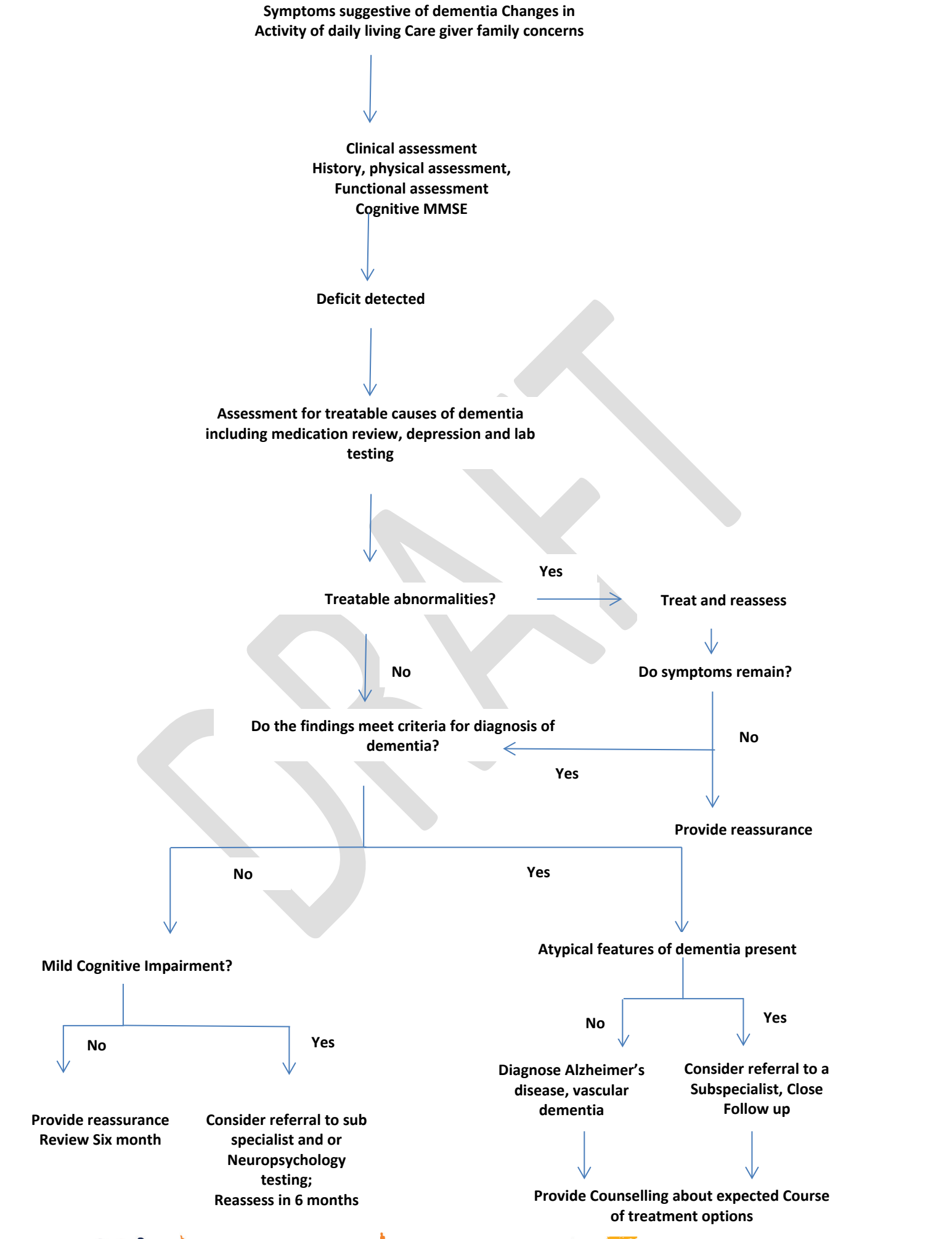
Referral in these circumstances is important

- The person with dementia is likely to need more detailed tests to help confirm the diagnosis
- The person with dementia and their carer will need different counseling and education over the likely future effects of their diagnosis
- Some drugs should not be used: acetyl cholinesterase inhibitors in FTD (risk of worsening condition, increased aggression), and antipsychotics in DLB (worsening condition).

Referral Information Required

Information to include when referring to the local Memory Clinic in the referral proforma

- Cognitive test score
- Confirmation that blood tests have been undertaken (no need to attach results)
- Confirmation that a physical examination has been done
- Any pertinent social factors including the name and contact number of a close family member or carer
- That depression and/or anxiety have been checked for and treated where necessary
- That the possibility of dementia has been discussed with the patient and carer/family member where possible


Symptoms suggestive of dementia Changes in Activity of daily living Care giver family concerns
Clinical assessment History, physical assessment, Functional assessment Cognitive MMSE
Deficit detected
Assessment for treatable causes of dementia including medication review, depression and lab testing
Treatable abnormalities?
Yes
Treat and reassess
Do symptoms remain?
No
Do the findings meet criteria for diagnosis of dementia?
No
Yes
Provide reassurance
No
Yes
Mild Cognitive Impairment?
No
Yes
Provide reassurance Review Six month
Consider referral to sub specialist and or Neuropsychology testing; Reassess in 6 months
Atypical features of dementia present
No
Yes
Diagnose Alzheimer's disease, vascular dementia
Consider referral to a Subspecialist, Close Follow up
Provide Counselling about expected Course of treatment options

Referral to: Memory Clinic Brooklands Health Centre **Date:**

Patient consent to referral: **Yes** **No** **Unable - Best Interests**

Patient Details			**GP Details**
Title:			**GP Name:**
Name:			
DOB:	**Sex: M ☐ F ☐**		**Address:**
NHS Number:			
Address:			
			Postcode:
Postcode:			
Preferred Tel Number:			
Ethnicity:			
Religion:			**Tel Number:**
Interpreter required:	**Yes**	**No**	**Fax Number:**
Do they live alone?	**Yes**	**No**	

PLEASE SEND NOK OR CARER DETAILS

NOK aware of referral:	**Yes**	**No**
NOK Name:		**NOK relationship:**
Address:		
Postcode:		
Tel Number:		

Reason for Referral/ History

Allergies: (please state if no allergies)

Please attach a copy of patient's medical summary and medication (Summary Care Record)

Investigations – Please request. (No need to wait for reports before referring)

Bloods (as per NICE CG42) *FBC / B12 & Folate / U&E / Ca / LFT / Glucose / TFT / Lipids* ☐

MRI/CT (please attach result if recently completed) ☐ **ECG** (please attach copy) ☐

Please attach cognitive test (sMMSE, 6CIT or GPCOG)

Please send or fax referrals to:

The Memory Clinic, Brooklands Health Centre, Brooklands Parade, Wolverhampton, WV1 2ND

Tel: 01902 442 391 **Fax: 01902 444 730**