Review of:
*Dementia diagnosis and management: A brief pragmatic resource for general practitioners* (NHS England, Jan 2015)

Reviewed by:
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Up until very recently, the consensus was that when general practitioners (GPs) suspect dementia in a patient, they immediately refer to secondary care. The formal diagnosis is then made by an old age psychiatrist or care of the elderly physician. But can GPs confidently diagnose and manage more people with dementia themselves? And can they do more to reach patients who are unlikely to ever be seen in a memory clinic?

**Summary of the ‘brief pragmatic resource’**
This document, created by NHS England, is for use by GPs. Its aim is to support GPs to identify and manage dementia in primary care. NHS England states that there is room for GPs to make diagnoses more often than they currently do. The document shows how GPs can diagnose and manage dementia more effectively.

It begins by taking an overview of another recent document, *Dementia revealed – what primary care needs to know* (see elsewhere, this issue) which highlights what a practitioner should do to diagnose and manage dementia. Dementia is defined as a syndrome of chronic brain failure. It is mentioned that the diagnosis is clinical and CT or MRI imaging is not essential. The fact that delirium is more common in dementia and can worsen dementia is highlighted, as well as alcohol problems which are under reported. Being aware of the needs of carers is important in the wider care of people with dementia and this is briefly focused on. The role of organisations such as the Alzheimer’s Society in helping carers of people with dementia is mentioned. This then feeds into a section on long term care funding, adult safeguarding and lasting power of attorney for protection over financial and care decisions once mental capacity is lost.

In the section called ‘Ask the expert,’ the expert is Professor Alistair Burns, NHS England’s National Clinical Director for Dementia. The impact of memory deficit on activities of daily life is a key diagnostic indicator mentioned by Professor Burns and can be asked quickly by GPs. We can all appreciate that cognitive assessments sometimes take up to twenty minutes to do and many GPs simply do not have the time to go through them. Professor Burns recommends that GPs do assessments based on the time they have available. He states that frail and elderly patients whose long term care needs can be directed from a primary care setting are suitable for GP management, as well as those reluctant to engage with specialist services.

There is advice for GPs on diagnosing Lewy Body Dementia and what to be aware of when prescribing acetylcholinesterase inhibitors for Alzheimer’s disease. There are useful case
vignettes, which give examples of situations where a GP should refer to secondary care. The first person described has Alzheimer’s disease developing in the context of living with Down’s syndrome. The second person is relatively young, has speech and movement dysfunction which make diagnosing Alzheimer’s difficult, and suggest the possibility of fronto-temporal dementia. The third person has possible symptoms of Lewy Body Dementia. Two other scenarios show when GPs can diagnose dementia. The first one is a person with Alzheimer’s and the second has mixed vascular/Alzheimer’s dementia. The key features are that the symptoms of Alzheimer’s are very clear in people who are at an age where the risk is high.

There is a mention of dementia care enhanced services to promote GP diagnosis of dementia, and use of specialised software, a ‘dementia data quality toolkit,’ to screen for potential patients in their practice, then using the data as part of a quality improvement activity.

The two step process of diagnosis is described. The first step is to eliminate other potential causes as possible diagnoses of cognitive impairment e.g. depression, drugs, delirium. The second step is to determine the underlying cause of the dementia. If the diagnosis is unclear then the individual can be referred to a specialist.

There is also specific guidance for coding of dementia to help address the issue of inaccurate coding being linked to apparently low diagnostic rates in some places.

Opinion

This is a useful document explaining how GPs can explore symptom of cognitive impairment when they have little time available. It is explained well that diagnosis may not be possible in a single consultation but may be made over a period of time. GPs diagnosing more dementias would be cost effective for the NHS. It would reduce waiting lists for secondary care review and achieve earlier diagnosis. The burden on secondary care memory clinics may be reduced as result, and allow for more intensive assessment and management of complicated cases.

From the case scenarios one can conclude that GPs should be able to diagnose Alzheimer’s, vascular and mixed Alzheimer’s/vascular dementia, in typical presentations. If the symptoms suggest a rarer diagnosis such as Lewy Body Dementia, occur in a young patient or there is a relevant comorbidity, the individual should be referred to secondary care for diagnostic clarification.

These seem to be fair recommendations. The authors request feedback and give the email address of Dr Paul Twomey (Medical Director of North Yorkshire and Humber, paul.twomey@nhs.net) as a point of contact.