stipulate a broader policy change and enable us to transfer the risk for developing cognitive decline in later life by roughly 60%,
a cumulative preventive model is a logical consequence, and this logic gives a simple answer. So, when to start promoting physical activity and exercise for brain health? As early as possible. Lifelong brain health is a lifelong challenge.

References


Andreas Ströhle, MD
Department of Psychiatry and Psychotherapy
Campus Charité Mitte
Charité—Universitätsmedizin
Berlin, Germany

Michael A. Rapp, MD, PhD
Social and Preventive Medicine
Department of Sports and Health Sciences
University of Potsdam
Potsdam, Germany

http://dx.doi.org/10.1016/j.jamda.2016.02.030

Timely Diagnosis for Dementia: The Need for Specialists

To the Editor:

Dementia is recognized as a global health priority and has recently been identified as the single greatest cause of disability and the third leading cause of death in older Australians. Findings from a recent Australian Parliamentary Inquiry into early diagnosis and intervention in dementia highlighted that current care pathways for dementia diagnosis are not timely but instead complex and variable. This is not unique to Australia but common also in many developed countries. This has prompted a call within this journal for earlier diagnosis of cognitive impairment.1 However, in such a drive for earlier diagnosis of cognitive impairment for older people, we should acknowledge the potential harm of misdiagnosis and overdiagnosis,2 and that the evidence for screening for cognitive impairment is insufficient to recommend this strategy.3,4 Where screening is associated with high false-positive rates, lack of access to diagnostic services is likely to result in prolonged periods of living with uncertainty. Finally, making a diagnosis without the provision of support services and therapeutic solutions is detrimental.

We would argue that what is required is timely diagnosis, a diagnostic process initiated by either the older person or key informants immediately after cognitive complaints have been identified. This diagnostic process will also ensure that consumers with dementia and their carers are linked into support services and commenced on appropriate therapy. Too often cognitive complaints are dismissed as simply “growing old,” thus denying many to valuable treatment options. Many have argued that general practitioners (GPs) are the most appropriate clinicians to provide these assessments. However, decades of encouragement have not been able to overcome the significant barriers that GPs face in providing these assessments,5 not the least of which is the significant up-skilling of GPs for no more than on average 2 new patients with dementia per year. There is a need to provide specialist assessment services in shared care models so that GPs can encourage reporting of concerns by consumers with dementia or key informants as well as provide for advanced care planning and the ongoing continuing care of people with dementia and their considerable comorbidities. The diagnostic process itself should be undertaken by specialists who regularly assess several patients presenting with cognitive complaints on a weekly basis.

Recently, the Australian National Health and Medical Research Council released “Clinical Practice Guidelines for Dementia in Australia.”6 These guidelines recommend that all Australians with a possible diagnosis of dementia should be offered access to memory assessment services. Memory assessment services facilitate timely access to diagnosis and linking into relevant clinical and community care pathways to support enablement and improve quality of life for the person with dementia and family carers. Unfortunately, these memory assessment services are not standardized across Australia. These inefficiencies in service provision make it virtually impossible to identify consistent referral pathways and this is to the detriment of the person with dementia. Consumers (people with dementia, their carers and families) have called for a greater focus on access to restorative care to delay functional decline and for an increase in the availability of nonpharmacological treatments and clinical and community support care pathways after diagnosis that

http://dx.doi.org/10.1016/j.jamda.2016.02.030
focus on the promotion of functional independence, self-determination, and the enhancement of quality of life.

Memory clinics are frequently described as the means by which such services should be delivered. Unfortunately, there have been only 2 randomized trials conducted.[18] One trial[1] demonstrated that the psychosocial health-related quality of life for family carers improved as a result of attendance at a memory clinic. A more recent study conducted in the Netherlands[18] found no evidence that memory clinics were more costly than GPs with regard to the care of patients with dementia during the postdiagnostic period (follow-up to 12 months after diagnosis).

No evidence is currently available to determine the cost-effectiveness of memory assessment services or to determine their optimal configuration. This evidence gap is a major barrier to the funding and roll out of memory assessment services internationally, disadvantaging consumers greatly.

To progress in this area we need to do the following:

- Develop a greater understanding of the process and timing of dementia diagnosis and clinical and community care pathways experienced by people with dementia and family carers during the diagnostic and postdiagnostic period.
- Quantify the economic impact of memory assessment services in relation to resource use, costs, and clinical and quality of life outcomes.
- Determine the optimal configuration of memory assessment services by identifying which elements of the dementia diagnostic process and associated clinical and community care pathways generate the best outcomes and which are most cost-effective.

In the face of growing numbers of older people and their associated cognitive complaints, greater numbers of people are presenting for assessment. Rather than trying to identify more people with relatively minor cognitive complaints, we need to increase access to efficient and streamlined services for older people who need our care today. We must provide the necessary evidence to convince funders and policy makers that such vital services are necessary.

References


Leon Flicker, MBBS, PhD, FRACP
Western Australian Centre for Health and Ageing
Centre for Medical Research
School of Medicine and Pharmacology
University of Western Australia
Perth, Australia

Renuka Visvanathan, PhD, FRACP, MBBS
National Health and Medical Research Council Centre of Research Excellence: Frailty Trans-disciplinary Research To Achieve Health Aging
Adelaide Geriatrics Training and Research with Aged Care Centre
School of Medicine
University of Adelaide
Aged & Extended Care Services
The Queen Elizabeth Hospital
Central Adelaide Local Health Network
Adelaide, Australia

Julie Ratcliffe, PhD, MSc
School of Medicine
Flinders Centre for Clinical Change and Health Care Research
Flinders University
Adelaide, Australia

http://dx.doi.org/10.1016/j.jamda.2016.02.031