

Early Detection of Cognitive Impairment Importance in Older Adults

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Abstract

New drug therapies for Alzheimer's disease (AD) are currently in late clinical development. Once approved, new healthcare infrastructure and services, including primary health care, will be required to meet the great demand for early and large-scale detection of AD. The need for assessment in this area was of great concern to adults. Early detection of cognitive impairment is further advanced by new technologies in the future. Identifying evidence is one of the most important steps in diagnosis to ensure that the correct diagnosis and procedure is needed. This review noted several different methods of cognitive impairment and early detection in the elderly, and the importance of having a positive attitude towards the family during discovery.

Introduction

There are many possible causes for cognitive impairment in the elderly, including side effects from medication. Metabolic and / or endocrine disorders; Delirium due to illness (eg, urinary tract or COVID-19 infection); Depression; Alzheimer's disease is the most common. Some causes, such as side effects of medications and depression, can be remedied or ameliorated by treatment. Others like Alzheimer's disease are irreversible, but symptoms can be managed for a period of time and, more importantly, the family can be prepared for predictable changes and addressed safety concerns. Many people who have or already have dementia are not diagnosed. According to one study, doctors were unaware of cognitive impairment in more than 40% of patients with cognitive impairment [1]. The problem of underdiagnosis is even more pronounced in under-served and under-educated people [2]. Another study found that more than half of patients with dementia did not receive a clinical cognitive assessment from their doctors [3]. Failure to assess memory and cognitive discomfort can interfere with the treatment of underlying and comorbidities and can pose safety concerns to patients and others [4, 5]. Cognitive problems often worsen over time [4, 6, 7]. Most people with memory, other cognitive or behavioral problems want a diagnosis to understand the nature of the problem and what to expect. Some people (or their families) are hesitant to raise such concerns because of the fear of being diagnosed with dementia and the associated future. In such cases, the family doctor can explain the benefits of finding the cause that is causing the person's health problems.

Early Detection and its Importance

Pharmacological treatment options for memory loss and other cognitive symptoms associated with Alzheimer's disease are limited and cannot stop or reverse the progression of the disease. However, there are several benefits to assessing and determining the cause of cognitive impairment, especially in the early stages.

New science shows that treatable signs of cognitive decline are the onset of full-blown dementia symptoms, as the pathology of Alzheimer's disease can begin up to 20 years before the onset of dementia symptoms. It shows that it starts long ago [8]. With this in mind, brain health should be viewed as heart health. Indicators such as blood pressure and cholesterol can be monitored regularly to provide clinical courses based on prevention and risk correction and to compare established baselines [9]. The best way to establish this baseline is through a system of cognitive screening and assessment. Many different short screening tests for cognitive impairment are available. Screening tests generally involve asking a patient to perform

a series of tasks that assess one or more areas of cognitive function. These tests are not intended to diagnose MCI or dementia. Positive screening test results lead to additional tests that may include blood tests, radiation tests, and medical and neuropsychological assessments to confirm the diagnosis of dementia and determine its subtypes. A well-researched screening tool is the Mini-Mental State Examination (MMSE). Other screening tools include clock drawing test (CDT), memory loss screen (MIS) / telephone MIS (MIS-T), mental state questionnaire (MSQ), minicog language fluency, and eight informant interviews. (AD8), features included. Activity Questionnaire (FAQ), 7 Minute Screening (7MS), Shortened Psychiatric Examination (AMT), Montreal Cognitive Assessment (MoCA), St. Louis University Mental Status Examination (SLUMS), Telephone Equipment for Cognitive Status (TICS) and Information Provision Questionnaire about cognitive decline (IQCODE) in the elderly. For more information on all screening tools reviewed by the USPSTF, see the full evidence review [10,11].

If the screening is negative: Concerns can be dispelled at least at this point. If the screening is positive and further evaluation is needed: Patients and physicians can take the following steps to identify the cause of the disorder (eg, anxiety, Alzheimer's disease, or associated dementia). This can lead to the following:

- Treatment of underlying illness or medical condition.
- More effective management of comorbidity.
- Prevention or treatment of potential security issues.
- Allow individuals to create or update living wills to plan long-term care.
- Make sure the person has support services and a care network to assist with medical, legal and financial issues.

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- Work with the person and their caregivers to develop strategies to improve quality of life, change their lifestyle, change home security, and manage emotions associated with dementia diagnosis.

- Referrals to behavioral medicine professionals who may be able to provide individuals with memory tools that can help individuals become more organized to better manage the symptoms of memory loss.

- Ensure that caregivers receive relevant information, advice, and support in coping with dementia diagnoses and coping with stress.

- Encourage participation in clinical research.

Positive screening results guarantee further evaluation. A combination of cognitive tests and information from people who come into frequent contact with the person. A spouse or other caregiver is the best way to assess cognitive impairment more comprehensively [12]. Your doctor can make an assessment or refer you to a specialist such as a geriatrician, neurologist, geriatric psychiatrist, or neuropsychologist. If possible, your local clinic or Alzheimer's disease Research Center may also accept referrals.

Genetic testing, neuroimaging, and biomarker testing are currently recommended for limited clinical applications [6, 13]. These tests are performed primarily in a research environment and have complex ethical, legal, and social implications to consider and may require consultation with a healthcare provider, counselor, family or caregiver. Interviews to assess memory, behavior, mood, and functional status (especially complex behaviors such as driving and money handling [14] should be conducted solely by the patient so that family members and attendants cannot encourage individuals. Collecting information from the behavior of people when they arrive at the clinic and their interactions with staff can also be analyzed. Keep in mind that people with only mild disabilities may be good at covering cognitive deficits and may hesitate to deal with the problem. In some cases, patients may not have insight into cognitive and functional problems due to the nature of their illness. Family members and close friends can also be good sources of information. Inviting them to speak personally allows for more open discussions. In accordance with HIPAA rules, patients must provide their consent in advance. Another option is to invite a family member or close associate to the office during the interview and provide additional information after the person speaks.

In most cases, the assessment or diagnosis of cognitive impairment is based on concerns or symptoms reported by the patient or caregiver, or suspicion by the physician. 29% to 76% of people with dementia go unnoticed in primary care [15-17]. In 2011, Medicare added detection of cognitive impairment to its annual wellness visit. The Centers for Medicare & Medicaid Services recommends assessing a patient's cognitive function through direct observation. Consider information and concerns reported by patients, family, friends, caregivers, etc. And when it seems appropriate, use short, validated, structured cognitive assessment tools [18].

Conclusion

Further research is needed on the impact of screening and early detection of cognitive impairment (MCI and mild to moderate dementia) on important patient, caregiver, and social outcomes such

as decision making, positive planning, and caregiver outcomes. The set of evidence for cognitive impairment screening and intervention benefits from more consistent definitions and reporting of results, enabling comparisons between studies, especially those with long-term follow-up.

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Conflict of Interest

None

References

1. Chodosh J, Petitti DB, Elliott M, Hays RD, Crooks CV, et al. (2004) Physician recognition of cognitive impairment: evaluating the need for improvement. *J Am Geriatr Soc* 52: 1051-1059.
2. Amjad H, Roth DL, Sheehan OC, Lyketsos CG, Wolff JL, et al. (2018) Underdiagnosis of Dementia: an Observational Study of Patterns in Diagnosis and Awareness in US Older Adults. *J Gen Intern Med* 33: 1131-1138.
3. Kotagal V, Langa KM, Plassman BL, Fisher GG, Giodani BJ, et al. (2015) Factors associated with cognitive evaluations in the United States. *Neurology* 84: 64-71.
4. McPherson S, Schoephoester G (2012) Screening for dementia in a primary care practice. *Minn Med* 95: 36-40.
5. Bradford A, Kunik M, Schulz P, Willaims SP, Singh (2009) Missed and delayed diagnosis of dementia in primary care: prevalence and contributing factors. *Alzheimer Dis Assoc Disord* 23: 306-313.
6. Galvin JE, Sadowsky CH (2012) Practical guidelines for the recognition and diagnosis of dementia. *J Am Board Family Med* 25:367-382.
7. Boustani M, Peterson B, Hanson L, Harris R, Lohr KN, et al. (2003) Screening for dementia in primary care: a summary of the evidence for the U.S. Preventive Services Task Force. *Ann Intern Med* 138: 927-937.
8. Beason-Held LL, Goh JO, Yang AN, Kraut MA, O'Brien RJ, et al. (2013) Changes in Brain Function Occur Years before the Onset of Cognitive Impairment. *J Neurosci* 33: 18008-18014.
9. <https://www.helpguide.org/articles/alzheimers-dementia-aging/preventing-alzheimers-disease.htm>
10. Holsinger T, Deveau J, Boustani M, Williams JW (2007) Does this patient have dementia? *JAMA* 297: 2391-2404.
11. <https://www.ncbi.nlm.nih.gov/books/NBK554654/>
12. <https://jamanetwork.com/journals/jama/fullarticle/2761650>
13. McKhann GM, Knopman DS, Chertkow H, Hyman BT, Jack CR, et al. (2011) The diagnosis of dementia due to Alzheimer's disease: recommendations from the National Institute on Aging-Alzheimer's Association workgroups on diagnostic guidelines for Alzheimer's disease. *Alzheimers Dement* 7: 263-269.
14. Marson DC (2013) Clinical and ethical aspects of financial capacity in dementia: a commentary. *Am J Geriatr Psychiatry* 21: 382-390.
15. Chodosh J, Petitti DB, Elliott M, Hays RD, Crooks VC, et al. (2004) Physician recognition of cognitive impairment: evaluating the need for improvement. *J Am Geriatr Soc* 52:1051-1059.
16. Olafsdóttir M, Skoog I, Marcusson J (2000) Detection of dementia in primary care: the Linköping study. *Dement Geriatr Cogn Disord* 11:223-229.
17. Valcour VG, Masaki KH, Curb JD, Blanchette PL (2000) The detection of dementia in the primary care setting. *Arch Intern Med* 160: 2964-2968.
18. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/AWV_Chart_ICN905706.pdf