A diagnosis of dementia is the condition most feared by people in their fifties. Through various initiatives in the last decade, such as the National Dementia Strategy and the Prime Minister’s Challenge on Dementia, there has been an increase in awareness of dementia and the value of a diagnosis. In parallel, primary care has been encouraged to review people at risk of dementia so that a diagnosis can be made earlier in the course of illness.

Differential diagnosis of cognitive impairment
The dissection of factors that contribute to cognitive impairment are frequently complex. In addition to the possibility of dementia they include age, cerebrovascular disease, depression, physical illness and side-effects of medication.

Having excluded non-psychiatric causes of cognitive impairment, making a diagnosis can be a challenge for the non-specialist who needs to determine whether cognitive impairment is associated with: • Likely dementia as the main problem with concerns (depression / anxiety symptoms) secondary. • Co-occurring dementia and depression. • Depression, with or without risk factors for dementia.

Where there is a concern about the impact of the impairment combined with difficulty in making a diagnosis it is understandable that a GP would seek advice from specialist colleagues. A memory assessment service (MAS) would not seem an unreasonable choice for referral.

In their audit of referrals of people aged under 65 years to a MAS, O’Kelly et al. found that 73% of people received a psychiatric diagnosis – dementia (19%), mild cognitive impairment (MCI, 10%), depression (30%) or ‘other’ diagnoses (14%) most of which were relevant for review by a psychiatrist.

All these diagnoses are likely to have had a component of cognitive impairment – the question is: ‘Is the MAS the best place for referral and, if not, what is the alternative?’

Memory service concept
Dementia is predominantly a disease of older people and the majority of memory assessment clinics were initially set up within old age mental health services that traditionally have usually only reviewed people aged over 65 years.

People with atypical presentations or Parkinson’s disease are likely to be referred to a neurologist and people with comorbid physical illnesses referred to a geriatrician. Those with learning disability are usually seen by a psychiatrist in the learning disability services. In the UK about 80% of people with concerns about their memory are seen by old age psychiatrists.

MAS are often reluctant to review certain subtypes of dementia – alcoholic, those associated with traumatic brain injury or neurological disorders. It would seem sensible to set up more comprehensive memory services that have the capability of evaluating the broad spectrum of people with memory impairment, whether a primary dementia or dementia associated with other conditions.

The future
Many new models of memory assessment service are evolving – primary care or secondary care-based – involving either psychiatrists or specialist GPs with and without direct links to neurologists and learning disability services. For long-term physical conditions, primary care nurses play a major role in assisting GPs with management. Primary care also has access to specialist nurses which provide a ‘bridge’ between primary and secondary care and can advise about case management and triage referrals to specialists. This model works very well, and makes best use of resources and expertise. Such a model should be considered as a template for memory assessment services.

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Review of under 65 years referrals to a memory clinic

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O’Kelly et al. (see p21) highlight some significant issues resulting from the increased emphasis on the importance of recognising dementia in people under 65 years of age and the impact this is having on memory assessment services that are run by old age mental health services who usually cater for people over the age of 65 years.