Screening for dementia
My father’s favorite axiom is alive and well

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Confronted with a 77-year-old female patient with hypertension, type 2 diabetes mellitus, congestive heart failure, osteoporosis, and osteoarthritis of the knees, the furthest thing from my mind was whether she had early dementia or mild cognitive impairment. I had already spent 15 minutes dealing with her written list of new symptoms, managing her five chronic illnesses, reviewing and renewing her 10 medications, and examining her. I was running late and my father’s favorite axiom, “Time is money,” kept running through my head.

Just as I was preparing to leave the exam room, my office receptionist knocked on the door and gave me a note from the patient’s daughter that read: “Mom is not taking her medications correctly and the bank called me yesterday to tell me that she withdrew $5,000. Is she getting early Alzheimer’s? What about this ‘MCI’ problem that I read about in the local newspaper? Please call me.”

So, should I do a mental status evaluation on this patient? Absolutely! Principal reason: Her daughter’s complaints about two important impairments of her instrumental activities of daily living (IADL)—the responsibility for taking correct medicines at correct times (medication management) and the ability to handle finances independently (money management)—have been shown to correlate with the presence of dementia.¹ This case makes the point that a mental status evaluation should be performed when the older adult or an informant complains to you about any of four specific IADL impairments:

1. Medication management
2. Money/financial management
3. Telephone management
4. Transportation management.

(Easy to remember: 2 M’s and 2 T’s.)

Would I do a mental status evaluation on the same patient if her daughter did not inform me of her IADL impairments? Absolutely—because the prevalence of dementia in her age range is about 10%, two to three times the prevalence for those age 65 to 74. I would definitely screen for dementia in this older patient despite the lack of any well-designed, randomized, controlled trials of dementia screening with health outcomes.² I would also screen this patient because any impairment in cognitive function is critical for care management and goal setting. Not knowing about cognitive status is tantamount to managing an obstetrics case without knowing the date of last menstrual period or prescribing medication to a woman of child-bearing age without knowing if she could be pregnant.

Would I use the Mini-Mental Status Examination (MMSE) as a screen for...
dementia in this patient? Probably not, as the MMSE takes 7 to 10 minutes to administer (remember my father’s axiom?), has only adequate sensitivity, and suffers from both educational and cultural biases.

Rather, I would use a shorter screen—the Mini-COG, which combines two tests:

1. recalling three unrelated words; and
2. a clock drawing test.

The Mini-COG takes, at most, three minutes to administer, and requires minimal training. Because the Mini-COG has high sensitivity and specificity and appears to be less affected by language, culture, and educational biases than the MMSE, I have started to use it, instead of the MMSE, as a screening tool. In fact, Geriatrics at your Fingertips (GAYF), an evidence-based, pocket guide published annually by the American Geriatrics Society, includes only a copy of the Mini-COG under its “Assessment Instruments” section. For unclear reasons, GAYF stopped including a copy of the MMSE beginning with its 2001 edition.

To understand the challenges of clinician and informant screening for dementia, the value of the Mini-COG, and the time you can save by using it, read our featured article, Should we screen for Alzheimer’s disease?, by Solomon and Murphy (page 26).

References