

Mild Cognitive Impairment

Key Facts and Recommendations for Management

This document outlines the key facts about mild cognitive impairment (MCI) and recommendations for management by clinicians. This document has collated information from a number of sources and has the consensus of the National Team. It can be used by commissioners and clinicians to support the identification and management of MCI.

The recommendations are for people who have received a diagnosis of MCI after referral to a memory assessment service or equivalent e.g. neurologist, learning disability services.

Key Facts:

Everyone with MCI is likely to be worried that they have, or are developing, Alzheimer's disease or another subtype of dementia.

MCI is different from normal ageing - people have objective evidence of difficulty with memory- they may drop one or two points on the GP Cog.

MCI differs from dementia because dementia affects a person's everyday activities and is more than just memory loss.

MCI finds you - you do not have to look for it. People will complain of memory difficulties and it is NOT uncommon for family members to bring it to your attention. The reverse is true for dementia.

It is important to recognise MCI because it occupies a position between normal ageing and dementia, similar to an abnormal glucose tolerance test for diabetes. By diagnosing it positively, or excluding other causes, it gives people who wish it, reassurance and certainty.

MCI is a heterogeneous group affecting up to 20% of people over 65. About a third of people may get better (showing the symptoms were due to a transient physical or emotional illness). Others stay the same whilst the remaining third go on to develop dementia (15 times more likely than the general population).

Following people up is the only way at present to distinguish those people who are getting worse. This is also a great opportunity to talk about dementia risk reduction / prevention "**What's good for your heart's good for your head**". It is also a good opportunity to encourage people to take part in research.

For every person with a diagnosis of MCI advise about the importance of healthy lifestyle (exercise, alcohol within recommended limits, no smoking), nutrition, keeping your brain active (puzzles, cross words, suduko).

Recommendations

1. **All patients with MCI should be coded on Primary Care Systems** using the following codes: **Read Code Eu057 or CTv3 code X00RS**
2. **MCI should be included on the “Problem Page” or equivalent of the patient record so it is apparent whenever the patient attends an appointment.**
3. **Patients with a diagnosis of MCI should be reviewed in Primary Care at least Annually.**

They should be asked two simple questions about their memory and / or how they are managing (see below).

Examples of two questions:

- Do you remember being referred to a specialist clinic last year to investigate how well you remember things? How are things now – better, the same or are you concerned?
- How are you coping with every day things e.g. bills, remembering family events, driving

Attending Primary Care:

The majority of these patients will be over 65 and likely to have one or more LT conditions for which they should have an annual review. Other people may be attending a primary care clinic for a flu jab. Such interactions with health professionals offer an opportunity to ask the above two simple questions.

These patients may be well known to health professionals who see them regularly and any deterioration in physical or mental health may be obvious.

Not attending Primary Care:

A member of the Primary Health care team should contact the patient by telephone or to ask them for a face-to-face conversation to determine their response to the above two questions.

4. Outcome of MCI review

Concerns about deterioration in memory of functioning

The person should be re-evaluated using the usual dementia screening process:

- Blood tests, screening for depression, history from pt and carer / family
- Dementia screening tool – GP-cog 6-CIT

to determine the differential diagnosis of their cognitive impairment i.e. exclude physical illness, depression, side-effects of medication before considering dementia and re-referral to the MAS. Remember there may be more than one cause for the impairment.

No Concerns about deterioration in memory of functioning

If there are NO concerns about functioning and memory – review again in 12 months.

5. Patients with MCI diagnosed as borderline dementia Atypical / Young Age

Refer to MAS or other secondary care specialist (neurologist, learning disability services) for review at least annually.

References

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www.alzheimers.org.uk/download/downloads/id/1773/factsheet_what_is_mild_cognitive_impairment_mci.pdf.What is Mild Cognitive Impairment (MCI).
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3. Mitchell AJ et al. Rate of progression of mild cognitive impairment to dementia – meta-analysis of 41 robust inception cohort studies. *Acta Psychiatr Scand* 2009; 119:252-265.
4. Public Health England. Blackfriars Consensus on promoting brain health: Reducing risks for dementia in the population. April 2014. http://nhfshare.heartforum.org.uk/RMAssets/Dementia/Blackfriars%20consensus%20%20_V19c.pdf