key points

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Vascular dementia is the second most common type of dementia, after Alzheimer's disease, and accounts for 15% of cases. The core diagnostic features include cognitive impairment in at least two domains (orientation, attention, language, visuospatial function, executive function, motor control and praxis), which affect social or occupational function, together with evidence of cerebrovascular disease (focal neurological signs or neuroimaging). Crucially there should be a temporal relationship between cerebrovascular disease and the onset of cognitive changes.

Onset may occur following a single (major) stroke, a series of multiple small strokes (multi-infarct dementia) including silent strokes, small vessel disease, CADASIL, and also in combination with other dementias, particularly Alzheimer's disease, where the vascular component may exacerbate the symptoms.

Presentation may be very varied. The most common cognitive symptoms are changes in language (particularly nominal aphasia), executive function (planning) and visuospatial skills. Vascular dementia should be suspected if there is a decline in at least two cognitive domains over at least six months, particularly if there is a characteristic stepwise progression in symptoms.

A thorough clinical history and physical examination, together with collateral history is vital. Clinical cognitive assessment should include the use of a validated tool which rapidly assesses multiple cognitive domains. The MoCA is preferable as it has been developed particularly with stroke populations in mind and covers more domains of cognition.

In general, there should be a low threshold for referral to memory clinics for assessment for possible dementia. GPs should consider a referral if patients, their families, or other professionals have raised concerns, particularly if these are having an adverse impact on the patient's ability to live independently. As vascular dementia progresses, many patients will develop noncognitive and behavioural symptoms such as anxiety, psychosis, and agitation. If these symptoms cause concern then a referral (back) to specialist services should be made to assist with management.

There are currently no nationally recommended pharmacological treatments to improve cognitive function in vascular dementia. Patients should be offered treatment for comorbid anxiety or depression. If patients become severely distressed or a risk to themselves or others, they should be re-assessed to exclude any new physical symptoms (e.g. infection, pain, constipation). Diagnosing and treating comorbidities and risk factors is the mainstay of prevention and treatment strategies. Modifying cardiovascular risk factors in midlife will help reduce the risk of developing vascular dementia, and may slow progression of vascular dementia.