

key points

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Approximately 10% of patients with mild cognitive

impairment progress to dementia each year. The most common type is Alzheimer's disease (AD), accounting for 60-80% of all cases. Other common types of dementia are vascular, frontotemporal (FTD), Lewy body (DLB), Parkinson's and mixed type dementia, where features of different dementias are present. There is evidence to suggest that dementia pathology is established before the onset of symptoms, and therefore mild cognitive impairment can be considered as a pre-dementia stage.

Early-onset AD is caused by mutations of genes

involved in amyloid processing, the late-onset form is attributed to ageing and the interaction between genetic predisposition and environmental factors, such as diet, smoking, alcohol, education and little physical exercise.

NICE guidance suggests examination of: attention,

concentration, short- and long-term memory, praxis, language and executive function. Particular attention should be paid to any signs of neglect, state of dress, agitation or poor attention. Dysphasia and difficulty in naming objects is often present. Mood symptoms (including suicidal ideation) may be primary or comorbid. Abnormal thoughts and perceptions should be probed for, as psychotic symptoms are common.

Primary care options for cognitive testing include the

General Practitioner Assessment of Cognition (GPCOG) or the Abbreviated Mental Test Score. Physical examination should include observation of gait, inspection for tremor; examination for rigidity, bradykinesia, frontal release signs, upper motor neurone lesions, pulse and blood pressure.

Structural brain imaging can improve diagnostic

accuracy, exclude other pathologies and act as a prognostic marker of dementia progression but the overlap in structural changes between the dementias makes imaging alone insufficient for diagnostic purposes.

NICE guidelines recommend referral to a memory

clinic for patients with mild cognitive impairment, those at high risk of dementia, such as patients with learning disabilities, Parkinson's disease, or patients who have had several strokes. Secondary prevention focuses on targeting smoking and alcohol intake, diabetes, obesity, high blood pressure and hyperlipidaemia.

Pharmacological management of cognitive and

behavioural symptoms in mild to moderate AD and DLB include acetylcholinesterase inhibitors: donepezil, rivastigmine, and galantamine. Antipsychotic drugs and benzodiazepines can be used to manage agitation, aggression or violence, after obvious causes have been excluded and if behavioural interventions prove ineffective, but they should be given at the lowest therapeutic dose, and the patient should be monitored for dystonia and extrapyramidal side effects.