

# Screening for Dementia: Recommendation and Rationale

U.S. Preventive Services Task Force\*

This statement summarizes the U.S. Preventive Services Task Force (USPSTF) recommendations on screening for dementia and the supporting scientific evidence and updates the 1996 recommendations on this topic. The complete USPSTF recommendation and rationale statement on this topic, which includes a brief review of the supporting evidence, is available through the USPSTF Web site ([www.preventiveservices.ahrq.gov](http://www.preventiveservices.ahrq.gov)) and the National Guideline Clearinghouse ([www.guideline.gov](http://www.guideline.gov)) and in print by subscribing to the *Guide to Clinical Preventive Services, Third Edition: Periodic Updates*. The cost of this subscription is \$60, and it can be ordered through the Agency for Healthcare Research and Quality (AHRQ) Publications Clearinghouse (call 1-800-358-9295 or

e-mail [ahrqpubs@ahrq.gov](mailto:ahrqpubs@ahrq.gov)). The complete information on which this statement is based, including evidence tables and references, is available in the accompanying article in this issue and in the summary of the evidence and systematic evidence review on the Web sites already mentioned. The summary of the evidence is also available in print through the AHRQ Publications Clearinghouse.

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[www.annals.org](http://www.annals.org)

\* For a list of the members of the U.S. Preventive Services Task Force, see the Appendix.

See related article on pp 927-937.

## SUMMARY OF THE RECOMMENDATION

The U.S. Preventive Services Task Force (USPSTF) concludes that the evidence is insufficient to recommend for or against routine screening for dementia in older adults. This is a **grade I recommendation**. (See **Appendix Table 1** for a description of the USPSTF classification of recommendations.)

*The USPSTF found good evidence that some screening tests have good sensitivity but only fair specificity in detecting cognitive impairment and dementia. (See Appendix Table 2 for a description of the USPSTF classification of levels of evidence.) There is fair to good evidence that several drug therapies have a beneficial effect on cognitive function (equivalent to delaying the natural progression of Alzheimer disease from 2 to 7 months), but the evidence of their beneficial effects on instrumental activities of daily living is mixed, with the benefit being small at best. There is insufficient evidence to determine whether the benefits observed in drug trials are generalizable to patients whose disease would be detected by screening in primary care settings. The accuracy of diagnosis, the feasibility of screening and treatment in routine clinical practice, and the potential harms of screening (for example, labeling effects) are also unknown. The Task Force therefore could not determine whether the benefits of screening for dementia outweigh the harms.*

## CLINICAL CONSIDERATIONS

The Mini-Mental Status Examination (MMSE) is the best-studied instrument for screening for cognitive impairment. When the MMSE is used to screen unselected patients, the predictive value of a positive result is only fair. The accuracy of the MMSE depends on a person's age and educational level: Using an arbitrary cut-point may potentially lead to more false-positives among older people with lower educational levels, and more false-negatives among younger people with higher educational levels. Tests that assess functional limitations rather than cognitive impair-

ment, such as the Functional Activities Questionnaire (FAQ), can detect dementia with sensitivity and specificity comparable to those of the MMSE.

Early recognition of cognitive impairment, in addition to helping make diagnostic and treatment decisions, allows clinicians to anticipate problems the patient may have in understanding and adhering to recommended therapy. This information may also be useful to the patient's caregivers and family members in helping to anticipate and plan for future problems that may develop as a result of progression of cognitive impairment.

Although current evidence does not support routine screening of patients in whom cognitive impairment is not otherwise suspected, clinicians should assess cognitive function whenever cognitive impairment or deterioration is suspected on the basis of direct observation; patient report; or concerns raised by family members, friends, or caretakers.

The brief review of the evidence and other sections that are normally included in USPSTF recommendation statements are available in the complete recommendation and rationale statement on the USPSTF Web site ([www.preventiveservices.ahrq.gov](http://www.preventiveservices.ahrq.gov)).

## RECOMMENDATIONS OF OTHERS

No formal recommendations for routine screening for dementia are available. The American Academy of Neurology (1) and the Canadian Task Force on Preventive Health Care (2) conclude that there is insufficient evidence to recommend cognitive screening in asymptomatic individuals. The American Medical Association (3) and the American Academy of Family Physicians (4) recommend that physicians be alert for cognitive and functional decline in elderly patients for recognition of dementia in its early stages.

**Appendix Table 1. U.S. Preventive Services Task Force Grades and Recommendations\***

Grade	Recommendation
A	The USPSTF strongly recommends that clinicians routinely provide [the service] to eligible patients. <i>The USPSTF found good evidence that [the service] improves important health outcomes and concludes that benefits substantially outweigh harms.</i>
B	The USPSTF recommends that clinicians routinely provide [the service] to eligible patients. <i>The USPSTF found at least fair evidence that [the service] improves important health outcomes and concludes that benefits outweigh harms.</i>
C	The USPSTF makes no recommendation for or against routine provision of [the service]. <i>The USPSTF found at least fair evidence that [the service] can improve health outcomes but concludes that the balance of benefits and harms is too close to justify a general recommendation.</i>
D	The USPSTF recommends against routinely providing [the service] to asymptomatic patients. <i>The USPSTF found at least fair evidence that [the service] is ineffective or that harms outweigh benefits.</i>
I	The USPSTF concludes that the evidence is insufficient to recommend for or against routinely providing [the service]. <i>Evidence that the [service] is effective is lacking, of poor quality, or conflicting, and the balance of benefits and harms cannot be determined.</i>

\* The U.S. Preventive Services Task Force (USPSTF) grades its recommendations according to one of five classifications (A, B, C, D, I) reflecting the strength of evidence and magnitude of net benefit (benefits minus harms).

**Appendix Table 2. U.S. Preventive Services Task Force Grades for Strength of Overall Evidence\***

Grade	Definition
Good	Evidence includes consistent results from well-designed, well-conducted studies in representative populations that directly assess effects on health outcomes
Fair	Evidence is sufficient to determine effects on health outcomes, but the strength of the evidence is limited by the number, quality, or consistency of the individual studies; generalizability to routine practice; or indirect nature of the evidence on health outcomes
Poor	Evidence is insufficient to assess the effects on health outcomes because of limited number or power of studies, important flaws in their design or conduct, gaps in the chain of evidence, or lack of information on important health outcomes

\* The U.S. Preventive Services Task Force (USPSTF) grades the quality of the overall evidence for a service on a three-point scale (good, fair, poor).

## APPENDIX

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\* Members of the Task Force at the time this recommendation was finalized.

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## References

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