The Brain Trust Podcast | Episode 3: Diagnosing, Documenting, & Screening
Hosts: Raj Shah, MD & Eukesh Ranjit, MD, MBBS, CAQGM, FAAFP
Transcript

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Welcome to the Brain Trust, A Physician's Guide to Diagnosing Alzheimer's Disease and Related Dementias. Brought to you from the Illinois Academy of Family Physicians. I'm Dr. Kate Rowland, family physician, member of the IAFP and faculty at Rush University. Funding for this podcast series was provided by a grant from the Illinois Department of Public Health. The goal of the Brain trust in this podcast series is to educate and empower the primary care clinician in the early detection, diagnosis and management of Alzheimer's disease and related dementias.

Clinical resources, Free CME and other educational materials are available online at thebraintrustproject.com. CME Credit is available for each podcast. The Illinois Academy of Family Physicians is accredited by the Accreditation Council of Continuing Medical Education to provide continuing medical education for physicians. Information on how to receive credit can be found on the Brain Trust Project website.

Thank you for joining us as we empower each other and provide training on the early detection of Alzheimer's disease and related dementias. And now today's episode.

Raj Shah, MD

Welcome again to our podcast for the Brain Trust. Today, we're going to spend a little bit more time on the area of diagnosis. This is again, Raj Shah, geriatrician, and professor at Rush University Medical Center. And I'm back on the road to make another trip to see and Springfield, Illinois, to visit my friend Dr. Eukesh Ranjit, where we'll discuss some of the issues that go on around how do we objectively document that somebody is having a cognitive issue and why that is important?

So, you guys, really great to see you again today. How are you?

Eukesh Ranjit, MD

Hey, Raj, I'm doing good. How are you?

Raj Shah, MD

I'm doing okay. Thank you. By the way, a great suggestion. Last time around, the coffee place to stop at happy.

Eukesh Ranjit, MD

Loved it that.

Raj Shah, MD

Oh, yeah. So today you guys were talking about a really important issue and sort of the diagnostic aspect that I know a lot of family physicians have a little bit of anxiety about and questions about. And one of

the things that's important as we talked about, about what a dementia is, is dementia is a chronic thinking problem that affects people's day to day activities.

And it's how do we document the thinking? And sometimes is it really important that I have to document objectively how somebody is having thinking problems in my notes? So what are your thoughts about why is it important in your practice that we document objectively that somebody is having troubles with their cognition? And what does objective mean in that sense?

Eukesh Ranjit, MD

Oh, that's a really good question. It is very important to basically have an objective documentation of what is happening with the patient with dementia. I know, as we recall, dementia is a very big umbrella topic. Basically, there are patients with dementia. We still have some degree of functionality and there are people in the dementia spectrum who have a lot of loss of their functionality.

So just having the term dementia in the chart does not give a provider a good idea of what is going on with the patient. Also, there are some faculties which might be in pack and there are some other faculties or domains of cognition. This might be affected more so for these reasons to help the patients basically with their daily functioning.

It is very important to document as objectively as possible about the domains that are involved, about the facets of their life, rather that is involved and affected by dementia.

Raj Shah, MD

Yeah, And I guess, you know, you can say what I've heard sometimes or sometimes family physicians will tell me as well, isn't it enough? Just if I document that the person is expressing their having thinking problems and I just write that or I write their caregiver is noticing that they're having difficulties. So, the symptoms. Right. And they're noticing they're having troubles organizing their day to day activities or they're having troubles with remembering what they did yesterday.

And that's becoming more frustrating to them. So things that we commonly put in the note around sort the subjective of what people are telling us and what are the signs, Why isn't that just enough? Why do we have to then move on into sort of like something with our physical exam to objectively state what is happening with their cognition?

Eukesh Ranjit, MD

Basically, objective assessment provides us with a way to see, you know, where the patient is at the moment and see if there is any further decline in as the time progresses. By that, It is something that we could do with patients with dementia, for example, the patient or the family members are saying singing problem does not give us enough information about how it is affecting their life.

Basically. So there are various parameters that are taken into consideration, which gives us in many cases, a number which we could use as a yardstick to see where the patient is at the moment who was the patient would be in future, you know, and the change in those objective values gives us a much more greater information to us about how dementia is progressing and what we can do to help them as the disease progresses.

Also, a number of times the subjective documentation, you know, it does not provide a very profound like information about patient oftentimes, you know, and an objective assessment helps us with that as well.

Raj Shah, MD

Yeah, that's definitely one thing I've noticed. I think as I've mentioned to you, I've been involved for the last ten years in this large clinical trial by the NIH or the National Institute on Aging that followed older people, about 20,000 of them in the United States and Australia, to look whether Aspirin, low dose exposure could help in preventing dementia from developing.

And one of the important things in the study is that we had to I chair a committee called an adjudication committee, where we had to review the charts of everybody that seemed to be having difficulty with our cognition to see if they met the criteria for dementia. And I would say one of the hardest things we had is we would find in the notes somebody writing in a primary care note that they would say, oh, the family is saying this person's having troubles with their thinking, but we would have no objective test.

That said, I gave them three words to remember, and they were unable, after 5 minutes to recall any of those three words which would tell me as somebody who's reviewing it, that the person is having troubles with what we call episodic memory. Right. Short term memory, that the. Yes. For that memory. And remember it 5 minutes later.

Eukesh Ranjit, MD

Yeah.

Raj Shah, MD

And so, I think it's really important because it's not just a note for you, right? It's a note for they're the families and the patient so they can follow and track what's going on now that we have open notes policies and it's a note for your other providers like if you are out, you cash right. And you didn't have that information and that person is now seeing another clinician in your office, they wouldn't know where to start.

Right. And was a move from three out of three recall to zero three recall in six months. That means a lot more than saying they moved from one out of three on recall in 5 minutes to zero out of three.

Eukesh Ranjit, MD

And then not just them by itself. It's a note for you yourself as well. You know, you might see a patient after six months or a year. And, you know if we do not have anything, object to talk demented. Sometimes it's hard to figure out what the patient had been previously and whether the patient is now and the other way it helps, just like with insurance is number of times, you know, if you're ordering an imaging or if you're ordering a test, ask some kind.

And if you do not have a proper documentation, it may not be done or may not be done in time. So it is immensely important to have this object to documentation as a clinician, and it's not that hard to do. Like you said, Raj, you know, some of these tests are the tests are very simple and you know, we can just get it done in our brief visit with the patient.

Raj Shah, MD

And I think that is one of the concerns I hear a lot, right? Like there's a lot of anxiety in a family physician and in their office to say, well, you know, in my training I didn't learn all those neuropsychological testing. And you know what? It ends up showing that, you know, what is episodic memory, what is semantic memory, what is working memory?

The terms are not things. I spend a lot of time in my education because unfortunately, in most of our medical schools, we may only spend an hour giving a lecture around dementia, even though it's the fifth leading cause of death in most absolutely right. So, people are usually like, well, if I don't know how to do this and it takes a long time, you know, I don't have time to do this in my office.

So should I just send everybody that I get with subject of memory problems to see a neuropsychologist? You can spend the 3 hours or 8 hours doing all this test and then get this report. Should we do that for the million people, you know, that are over age 65 in Illinois so that every one of them is required to get a neuropsychology examination to document objectively how they're doing with their cognition.

What do you think?

Eukesh Ranjit, MD

I think it would be an overkill. First of all, not everyone needs, you know, cognitive, a detailed neurocognitive evaluation. You know, not everyone needs to go through the TR test with a neurocognitive specialist here. There are things that we could do in our clinic by itself, which would help us assess a patient's cognition. And these tests are very short tests.

The other thing is we do not have that many, you know, for people specializing in neurocognitive tests and in our state basically here in central Illinois and southern Illinois, we can literally count enhance number of people who are specialized in those tests. If we send each and every one of our patients for those tests, it would take them up to months and years for them to even get evaluated.

And a patient might have a significant decline In the meantime. And there are other things that we could have provided those patients and in the meantime that the patient would miss out on. So I think it would be a better idea if we as primary care providers did some of the preliminary testing and then sit the patient down.

And I do agree, I mean, like the words, the terminology, the word that are used in some of these neurocognitive evaluations, they sound like Greek and Latin, and they know the sound very far into us. And I do remember as just having one lecture in med school and just a few assessments, you know, in my residency. But we don't have to master all of these tests if we just know a few tests, you know, that that could help us a lot in our clinical practice by itself.

Raj Shah, MD

Yeah, and definitely I think some of it is we are using it in a different way, right? Like we're not necessarily how we're trying to use it as in our diagnostic capability is to say that this person has a thinking problem. So, we just have to be able to at least document that they're having a problem in a particular area.

So are they having problems with remembering three words back right? Absolutely. Are they having troubles with repeating phrases, which is a language function? Right. Are they having difficulties with withdrawing a figure or a clock which can tell me a lot about their visuospatial abilities? Exactly. They have problems organizing a three step command, which tells me about their executive function, and we just have to at least document one or two of those, right to be able to say that this person is going to meet criteria for a thinking problem.

Eukesh Ranjit, MD

Yes. And there are a few tests that that are fairly simple ones like mini-COG. You know, it's a simple test in which we ask the patient to remember three words. Then we ask them to draw a clock and set time on the clock. And after 5 minutes we ask them to recall the three words that we had asked them earlier and basically, depending on how well they do and what they did, there's a total score of five is asking them to do two tasks and they know it can be done in about 5 minutes time.

And the sensitivity and specificity of even these simple tests are very high, and it's just something which we could do in our clinic by itself. It's good for documentation and it's good to see, you know, how the patient progresses over time. And it provides us with an object of documentation that would be helpful for us, for other providers, for researchers, and for insurance purposes as well.

Raj Shah, MD

Yeah, And I think, you know, I'm glad you were able to share with me an article that you had written about sort of these cognitive tests that can be used in an office setting in primary care. And we'll put that as one of our resources on the website for the brain trust. So that people can have access to that if they want to use it in their own learning or in the learning and teaching of other students or residents, that could be really helpful.

So, thank you for sharing that. And I think that's been part of the there's a little bit of confusion right around these cognitive tests because many of them were created with this concept of screening, right? They call them screening cognitive test, which was meant to be. I take everybody in the population and I do this test, and by doing this test, I can figure out if some people score at a certain level that they are more likely to have a dementia.

So it's taking asymptomatic people, people that aren't telling us they're having problems with their memory is giving this test. And by saying that we've given the screening test, that then we have to do more because we think that they're probably qualified for having a dementia. But here we're not really talking about using them as screening tests, these short tests, we're talking about them being used to help us in documenting and evaluating that somebody has a problem in early detection.

Absolutely. So can you talk a little bit about that difference? I mean, it's always a little tricky when you use a test that's designed for something else. And everybody is saying like, wait, it's a screening test. But the US Preventive Services Task Force is saying we shouldn't be screening, so why am I spending my time in my clinic doing a screening test?

But here we're saying something slightly different, right?

Eukesh Ranjit, MD

Absolutely. So when these tests were developed, you know, we didn't have as much of a good Grasp of dementia as we do now. And it's a still a knowledge that is in evolution. And we're learning new things as the days go by. Back in the days that there was a drive to screen everyone for dementia, United States Preventive services Task Force, as of now, they say that there is insufficient evidence that it is helpful.

Things may change down the line, basically where, you know, might have one tool which we might use in everyone. But as of now, it's a Grade II, which means there's insufficient evidence to screen everyone, basically. And the other thing about these tools that we have to be mindful of as primary care providers are, is that these are screening tools.

Now, the tools that we use in our clinic, they are not diagnostic tools, meaning if someone has a particular score, we cannot indiscriminately say you have dementia. No, we have to correlate to the information that we get from these screening tools with the clinical features and with the level of functioning of the patient. So the way in which we are using it now, coming back to your point raised is, is that we are trying to detect dementia early on, basically patients that may not have a severe life altering change in their activities, daily living, meaning they might be functioning relatively well, but there are some decline in cognition that can be detected by these object tests. And the key is to find it early on so that we can help patients basically get adjusted with their disease as it progresses and help them through each and every stage of declining cognition.

Raj Shah, MD

Great. Yeah. And I think one of the difficulties, right, is there's more than one of these tests out there, and they've been developed since the 1970s or even before. And, you know, should I be using the mini mental state exam or the message, should I be using this MOCA exam or the Montreal cognitive assessment form? Should I be using the Slums tool?

You know, there's about ten of these things out there and everybody has their own favorite and I guess, I mean, what is your thought about, you know, is one tool really better than the others? Or how do I pick which tool is best for me to use in my primary care practice?

Eukesh Ranjit, MD

Well, this is a question that I get very often and that there's a reason why I wrote the article that I know about selecting the cognitive tools. Basically, there are four primary care purposes that they're all fairly similar. You know, a neurocognitive, you know, scientist might find them to be different in their domain. But for us as a primary care provider, they're all pretty similar with the similar sensitivity.

So the specificity is the simplest tool that we can use as a by far mini cog, because, you know, it has two things that we're testing their word recall abilities and their ability to draw a clock. And it takes a very short period of time to do that test.

Raj Shah, MD

Can I just ask a follow up there? Yes, that's right. There's the mini cog. Right. So, I'm assessing two things, right? Like, I'm assessing how can they remember these three words and delay. And then I'm

asking them to draw a clock, which can tell me about how can they organize the clock, which is executive function and also how they draw.

It tells me something about their visual spatial. So, I get like three pieces of information about on that test in a relatively short amount of time. Right. Like about 5 minutes or so. The question becomes in my mind is, well, if somebody is telling me that they're having troubles with their memory and I do this test and they pass it with flying colors, right, Like they they're able to remember those three words again and they're able to remember is you just say, like automatically like, no, they don't have a dementia.

Eukesh Ranjit, MD

No, these are the screening tools. These are not diagnostic tools. So, we use these rules to screen someone with memory issues. And since these are not diagnostic tools, we cannot diagnose someone as having dementia are not using these tools. So if you are confused off of that, like, you know, if someone has thinking issues, you do a screening evaluation, a patient does well, our patient does not do as well as you would have expected them to do.

Those patients should be evaluated for them. And those are the cases where a detailed neurocognitive evaluation might be more helpful.

Yeah, and I think it's just recognizing that, right? Like because I'm like a mini cog and only address like three of multiple domains. Right. And I just need one or two domains to be affected. And I just might not have examined those domains. So we can't absolutely say like, oh, they passed this with flying colors. So, there's nothing wrong with their memory, even though they're telling right.

Okay. So that's why I think your idea of we have to do something more right. Like they have to maybe test another area of memory or Absolutely. Send them to get some more detailed testing. So that we can really understand why this disconnect between them telling me that they're not having trouble, they're having trouble with their memory, and I'm not seeing it on objective tests.

Right.

Eukesh Ranjit, MD

So in our practice, what we do is like the primary care physicians. They most of the times do a mini carga and they know if they find something that is concerning a concerning score or if they're patient, has issues that are more concerning. But the patient passes a mini call with flying colors, they send them to geriatricians and we do a slightly detailed evaluation of the patient's cognition, our patients activities of daily living.

And since geriatrics visits are slightly longer than primary care visits, we assess them and see where they are at, and it notices that there's a requirement for a detailed neurocognitive evaluation that is taken care of as well.

Raj Shah, MD

You know, that's great to have that tiered approach, right? Like, yeah, I'll do my best with the simple tool I can do in my office, but I'm going to just keep in the back of my mind if it's not matching, I may have to get some more help here. Perhaps that's the way that we can triage those resources where there's not as many geriatricians and now they can focus on the things that are more important.

You've done some of the initial work and now they can build on it and really explore it. But also tell me something about you were kind of getting to this and I want to spend a little bit more time on that is that even if somebody is having troubles on the test, say they score a little bit lower, like a common test people use out of 30 points.

Is this mini mental score, right? And somebody scores a 22 on the mini mental. So in general, you would say, oh, there's an impairment because it's less than like 26 and I have to be concerned about this and this matches maybe their story. But what happens if somebody has, say, a low education level or a low literacy level or a language barrier?

How should I be careful about interpreting a low score and not automatically saying that, yes, this person has an impairment?

Eukesh Ranjit, MD

Absolutely. And for all our listeners who are not very familiar with the scoring tests like and there are various kinds of scoring tests that we can use, MSI was the traditional test that has been used for a long period of time. And I think that was a previous question actually. I skipped over that and went on to a different answer altogether.

There is a MSI minimum distance exam amount with Cognitive Assessment or MOCA, Louis University Mental status Exam Slumps, and this one from Australia called Roland. It's called Rude Ask. It's they're all on university dementia assessment scale. So there are different kinds of tests that are there. Most of them are scored in a total score of 30 basically, and a score somewhere between 25 to 26 is considered a more a score.

More than 35 to 26 is generally considered as normal. This is for those of us who are not very familiar with these tests. There are various factors which can affect these scores, like the level of education is definitely one of those factors. You know, people who are highly educated, who have a college education, university education tend to score higher compared to people who did not finished high schools, people who are involved in jobs that have more cognitive tasks like doctors, lawyers and engineers that tend to score better than people who are not involved in day to day activities.

That involves a lot of cognitive skills. There's also a question of language and cultural barriers which come into play. If someone's first language is not English, for example, they do tend to score lower than if someone's first language is English. And cultural factors as well do come into play oftentimes, basically because not all questions are universal and not all questions are questions which relate to daily activities of people all around the world.

Basically, under was the United States of being a country of immigrants. You know, we have people coming from different parts of the world and they're not even related questions that have been formed. Basically, some of the tests take some of these factors into consideration. For example, that when I was doing the study on the article, I found that the true test was actually just loves to serve people with culturally and linguistically diverse communities and sounds.

The tests like a MOCA does have a different scoring system for like if a patient does not have a higher level of education, they know that there's one point that you can substitute for. For them, there are

different score interpretation and tests like slums, where if someone has high school education, their normal is different than someone who has less than high school education.

But regardless of all of these, that these are not perfect systems yet. And this is a screening tool. So the score by themselves should be interpreted with the patient's clinical features so that with the patient's performance of activities of daily living as well as the patient's other factors, for example, like, you know, if a patient has anxiety, depression, has sleep issues, you know, has hypothyroidism, they do tend to score lower.

So, we have to make sure that the patient do not have any of these other factors that are going on. And we need to take the whole picture into consideration rather than just one objective score by itself.

Raj Shah, MD

So I know we've covered a lot and sometimes this is good for us to kind of summarize where we're at and what's been going on with our podcast today. So I think the key here is we started by thinking about this concept of diagnosis and then we asked ourselves, why is it important to show that there's a thinking problem and that we should document objectively in our assessment that there's some area that's being affected Now, we don't have to send everybody to get that objective measure of cognition to a neuropsychologist that just impractical.

We can do things in our office setting and what can we do in our office setting is we can use any of the tools that are currently available. They were just kind of screening, but we're really not using them for screening purposes. We're using them to document that there's an area of concern or difficulty that matches what the person is telling us is happening, and we have to just interpret those tests with a bit of caution because they're not complete, they're imperfect, but they do help us.

And I think that's all really been good, relevant information into the day to day practice of what family physicians and other primary care providers have to face in busy times. But it highlights again that we can do so much in our office by taking a few steps and just remembering if we can objectively document what we are hearing from our patients and their caregivers.

It will become really useful as information to help us monitor, guide them, support them with our team approach that we take. So Utkarsh as we wrap up our session today and you have to get back to the clinic and spend some time seeing people. So again, we wanted to thank our audience for partaking in the conversation. Thank you Utkarsh, for spending some time in your busy schedule to share your input on sort of how we approach objectively documenting, thinking problems and primary care.

And I'm looking forward to us hitting the road again and seeing what else we can learn from other physicians across the state on this really important puzzle and picture of how primary care physician family physicians play a huge role in our ecosystem for supporting dementia capability for the state of Illinois so that there is no wrong door when somebody is having troubles and they get the support from anybody they interact with.

So thanks again, everybody, for joining us on today's session. And we'll be back with another podcast soon.

Kate Rowland, MD

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