Debate Continues Over Early Cognition Screening

BY ALICIA AULT
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WASHINGTON — Some Alzheimer's disease–related groups—but not all—are stepping up calls for earlier and more frequent cognition screening, citing an aging population increasingly at risk for dementia.

The disease affects 1 in 10 people older than age 65 years, and almost half of those older than age 85 years, according to the Alzheimer's Foundation of America. It is the seventh leading cause of death in the United States.

A cognition screen can establish a baseline, and be used to prompt referrals to clinicians who can pinpoint the cause of memory loss or loss of executive functioning, Eric J. Hall, CEO of the New York–based AFA, said in an interview.

Knowing of an Alzheimer's diagnosis early in the disease progression helps patients and families prepare, and early intervention can improve quality of life, he said.

The AFA has been seeking coverage of cognition screening as part of the "Welcome to Medicare" exam. The exam is offered during the first 6 months of Medicare Part B coverage; beneficiaries pay 20% of the cost, if they've met the deductible. If they have not met the deductible, they may be liable for the exam's entire cost.

To add cognition screening would require an act of Congress, according to a spokesperson at the Centers for Medicare and Medicaid Services.

The AFA's call for early screening and coverage was echoed by a group of experts convened by Pfizer Inc. and Eisai Inc., who issued a consensus statement in November. Pfizer and Eisai manufacture Aricept (donepezil), an Alzheimer's drug.

In the consensus document, the Alzheimer's Disease Screening Discussion Group urged all adults aged 65 years and older to seek cognition screening during a physical exam. Screening should be conducted on those with a strong family history of the disease or those who are concerned about memory problems, as well as on anyone admitted to an assisted-living or long-term care facility, said the seven-member panel.

Two of the panelists are paid speakers for Pfizer: Paul Solomon, Ph.D., who is clinical director of the memory clinic at Williams College, Williamstown, Mass., and Dr. Barry W. Rovner, who serves as director of clinical Alzheimer's disease research at Jefferson Medical College, Philadelphia.

At a briefing on the consensus document, Dr. Solomon said there are a number of validated cognition screening tools that can be used by practitioners, including the Mini-Mental State Examination, verbal fluency test, and clock-drawing test. "A delay in diagnosis can undermine Alzheimer's patients and their families in [their] ability to plan financially, socially, emotionally, and medically for the future," he said.

Dr. Rovner called for more training during medical school and residency on the importance of cognition screening, and for more education programs to target primary care physicians and the public.

Patients aren't talking with physicians about memory loss, according to an AFA survey of 1,902 people who participated in the organization's National Memory Screening Day in 2006. Of the survey respondents, 97% had never been given a memory test.

Of those surveyed, 80% said they had visited a primary care physician within the last 6 months, but fewer than 10% of those with self-identified memory problems had talked about them with their doctor.

The 2007 National Memory Screening Day was held in mid-November at 2,000 sites in 46 states, including 1,100 Kmart pharmacies. The AFA is supported by drug company grants and private donations. Memory Screening Day participants are given access to a special Web site that contains education materials and three cognition tests recommended by the AFA's Memory Screening Advisory Board.

The Chicago-based Alzheimer's Association does not see the wisdom of such health fair–type screening events, William Thies, Ph.D., vice president of medical and scientific relations, said in an interview. Patients may not get enough encouragement to talk with their physicians, and the tests used for screening are often not sensitive or specific enough, thus potentially leading to false-negative or false-positive results, he said.

"But we know it's a good thing for people to talk to their physicians about any memory concerns they have," Dr. Thies said, adding that the Alzheimer's Association encourages physicians to conduct more "cognitive surveillance."

Once a dialogue has started, physicians can determine whether the patient is just worried or if diagnostics are necessary, Dr. Thies said. ■

Auditory Training Program Leads to Improved Memory

BY SHERRY BOSCHERT
San Francisco Bureau

SAN FRANCISCO — An auditory training program designed to improve brain plasticity bestowed the side benefit of improved memory in a randomized, controlled, double-blind trial in 468 adults older than 65 years with normal cognition.

The study is one of the first to show generalized benefits—beyond improvements in the skills trained directly—from an intervention aiming to improve cognition or memory, Elizabeth M. Zelinski, Ph.D., and her associates reported in a poster presentation at the annual meeting of the Gerontological Society of America.

The overall memory composite score rose from 97.1 to 101.4 in the intervention group.

DR. ZELINSKI

They asked the 232 participants in the intervention group to spend an hour a day, 5 days a week for 10 weeks doing six adaptive, computerized listening exercises meant to increase the speed and accuracy of aural information processing and the production of neuromodulators associated with learning and memory.

The 236 participants in the control group were asked to spend the same amount of time using a DVD-based educational training program on a computer and taking written quizzes that probed memory and content comprehension. The control activities were modeled on physicians' usual treatments for memory complaints and were matched for novelty level and intensity to the study intervention.

At the end of the study, people in the intervention group were significantly more likely to say that they perceived improvements in their everyday cognitive function; objective measures supported their reports in intention-to-treat analyses of the results, said Dr. Zelinski of the University of Southern California, Los Angeles. She receives per diem honoraria from the company that markets the brain fitness program, Posit Science Corp., which also funded the study.

Clinicians who were blinded to randomization performed neuropsychological evaluations to measure the results. Scores in both groups improved on most measures, but they improved significantly more in the intervention group.

For the primary outcome, scores in the intervention group on the Repeatable Battery for the Assessment of Neuropsychological Status (RBANS) global auditory memory score improved significantly from 95.4 to 99.2, compared with a change from 95.6 to 98.3 in the control group, Dr. Zelinski said. The RBANS global auditory memory score was derived from stub tests on list learning, story memory, digit span forward, delayed free list recall, delayed list recognition, and delayed free story recall.

Secondary outcome measures included the Rey Auditory Verbal Learning Test (RAVLT), the Wechsler Memory Scale (WMS-III), and the Rivermead Behavioral Memory Test (RBMT). Significantly greater improvements were seen in the intervention group on RAVLT and WMS-III measures, but not on the RBMT. The overall memory composite score increased from 97.1 to 101.4 in the intervention group, which was significantly more than the control group's improvement from 96.9 to 97.9, she said.

Scores on the RAVLT for trials 1-5 increased from 39.3 to 40.6 in the intervention group and declined from 40.1 to 39.2 in the control group. Scores on the RAVLT delayed recall test improved from 6.3 to 6.9 in the intervention group and held steady at 6.6 in the control group.

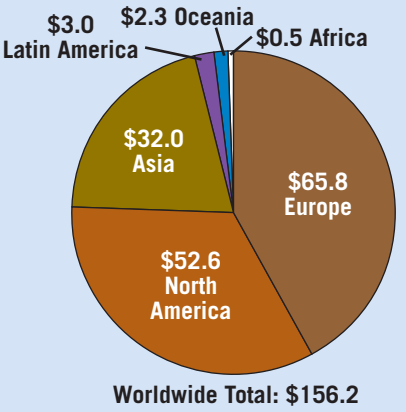
On the WMS-III, scores on the digit span backward test increased from 7.3 to 7.9 in the intervention group and from 7.1 to 7.3 in the control group. Scores on the WMS-III letter-number sequencing test improved from 9.5 to 10.2 in the intervention group and from 9.4 to 9.5 in the control group.

The study recruited participants through direct mail, radio, newspaper ads, flyers, and presentations. Participants were older than 65 years, had Mini-Mental State Examination (MMSE) scores greater than 26, and could read 14-point type and hear adequately. During the study, 8% of those in the intervention group and 12% of those in the control group withdrew prematurely. The intervention group had significantly fewer men (42%) than did the control group (53%), but the groups did not differ in age, education level, MMSE scores, or other factors. The mean age was 75 years.

Many interventions claim to improve cognition and memory in people with normal age-related cognitive decline, there is little empiric evidence of the efficacy of such interventions. The current study is the largest on aging and cognitive training to use available products, she said. ■

DATA WATCH

Estimated Direct Costs of Dementia Highest in Europe
(in billions of dollars)



Note: Based on 2003 epidemiologic and cost data.
Source: Dement. Geriatr. Cogn. Disord. 2006;21:175-81

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