some form of cognitive impairment, including mild cognitive impairment and Alzheimer disease. For China, it is reported that there were 9.19 million cases of any cognitive impairment in mainland China alone in 2010 and the numbers are expected to rise in the coming decades. Obviously, cognitive impairment will be a new epidemic in the future unless major public health policies and preventive measures target brain health.

The International Association of Gerontology and Geriatrics (IAGG) Consensus article has put forward the need for screening and case finding of cognitive impairment. It is paramount that cognitive impairment should be screened for and recognized early. However, the lack of recognition of cognitive impairment by medical staff has been documented. The general underrecognition of dementia has serious consequences, such as not seeking medical help in a timely manner, inappropriate prevention, not planning for legal and financial affairs in advance, and insufficient training for caregivers. These factors create a negative consequence and significant financial burden on society. Also, it is upsetting for the individual and the individual’s family.

Considering the huge population base, we have to say that dementia screening for every elderly person in China is a big challenge. With the emphasis that “screening instruments should take less than 3 to 7 minutes to administer,” the IAGG consensus article has recommended some screening tools, such as MiniCog, the 5 Words, Rapid Cognitive Screen (RCS), St Louis University Mental Status Examination (SLUMS), and Mini-Mental Status Exam (MMS). In this sense, MiniCog, the 5 Words, RCS, and SLUMS fulfill our requirements. In particular, SLUMS is a popular screening scale for cognitive impairment, which has been studied in the Chinese population in 2012. In this study, we compared consistency of the SLUMS with the Chinese version of Mini-Mental Status Examination (CMMSE) and the Beijing version of Montreal Cognitive Assessment (MoCA-B). The results showed that the scores of SLUMS are fairly consistent with MoCA-B and CMMSE in Chinese elderly. Spearman correlation coefficient between scores of the scales were 0.747 (SLUMS vs CMMSE, \( P < .001 \)), 0.839 (SLUMS vs MoCA-B, \( P < .001 \)), and 0.773 (CMMSE vs MoCA-B, \( P < .001 \)).

Financial input into senior care has increased from last year in China. By way of illustration, I will refer to the example of Chengdu city. Chengdu is the capital of Sichuan Province, covering a total land area of 12,400 square kilometers. Chengdu has direct jurisdiction over 10 districts, 4 county-level cities, and 5 counties. By the end of 2013, the population of Chengdu had reached 14.17 million. Up to now, the Chengdu Civil Affairs Bureau has set up hundreds of community health service settings for senior people. Each elder person in the community will receive a quick screening for cognitive function by recalling 3 words. If there is any problem for recalling 3 words, further assessment of SLUMS should be carried out by trained assessors. In addition to cognitive assessments, we also evaluate other geriatric syndromes, including depression, pain, falls, and nutrition status. The elderly who received geriatric assessments at entry were followed up annually. In this way, we can track the elderly continually. These data will be further collected and the outcome will be released in the future.

### References


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Brain Health: Case Finding of Cognitive Impairment in Primary Care by Using a Risk Score and 2-Pronged Performance-based and Informant-based Assessment Approach

To the Editor:

Recently, the International Association of Gerontology and Geriatrics (IAGG) consensus recommended case finding for cognitive impairment in adults 70 years or older as a fundamental step to enhance brain health worldwide. Although case finding for cognitive impairment targeting at-risk populations at the primary care setting is considered necessary for early detection of cognitive impairment, its implementation is challenging due to (1) the lack of an effective approach to improve the detection of patients with cognitive impairment, and (2) the lack of cognitive instruments validated for a primary care population with good discriminant indices, such as sensitivity, specificity, and, more importantly, positive and negative predictive values (PPV and NPV).

The IAGG consensus proposed an optimal case-finding strategy for cognitive impairment, that is, a 2-pronged approach with both performance-based and informant-based assessments. This approach may be suitable for case finding for cognitive impairment in primary care but requires empirical evidence for implementation. In response to this, we have operationalized a composite total risk score (TRS) to identify cognitive impairment in at-risk patients attending a primary care center. Among sociodemographic and vascular risk factors reported previously, we have delineated significant risk factors associated with cognitive impairment: advanced age (>70 years), diabetes, history of stroke, female sex, and presence of subjective cognitive complaints. These significant risk factors were operationalized into a composite risk score, the TRS, which can predict cognitive performance (global cognition) determined by a gold standard form neuropsychological evaluation. The TRS has a total score of 8 and is a good risk-stratification measure to predict individuals with cognitive impairment. Its cutoff point at ≥3 has a good sensitivity (0.82) for detecting cognitive impairment. Additionally, brief cognitive tests, such as the AD8,