

early to evaluate the effect of this change on patient behaviour.

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### Assessment of cognitive impairment in the elderly

Sir,

The paper by Illiffe and colleagues, (January *Journal*, p.9) once again raises questions about our ability to detect cognitive impairment in elderly patients.

Using the mini-mental state examination, Illiffe and colleagues found the prevalence of cognitive impairment to be 4.6% in a sample of patients aged 75 years and over, with possible impairment in a further 10.5%. Of concern is the finding that only one of the four medical records of the patients with mini-mental state examination scores of less than 11 (which indicates severe impairment) contained a record of dementia. Also, dementia was noted in only four of the 239 patient records studied. Despite the low prevalence of dementia found on formal testing, the general practitioners had apparently still failed to detect most of the cognitively impaired patients.

This study seems to confirm the finding of previous studies of cognitive impairment in the elderly in the community which claim that formal testing of cognitive function would reveal many more cases of impaired function than doctors or nurses suspected.<sup>1,2</sup> However, more recent work has suggested that health care workers may not be failing to detect as many demented elderly persons as previously thought.<sup>3,4</sup>

A consensus seems to be emerging about which of the many short functional testing tools is most appropriate — most workers seem to feel that either the short portable mental status questionnaire or the mini-mental state examination are the best screening tools for busy general prac-

tioners to use.<sup>5,6</sup> However, the question of the number of impaired patients being missed is far from settled. A further complication is that prevalence rates are much affected by the cut-off points and diagnostic criteria used when administering the various tests for dementia.<sup>7</sup>

In a review of prevalence studies of elderly patients in the community I found rates ranging from 1.3%<sup>8</sup> to 33.0%<sup>9</sup>, because of the widely different methods used and the very different populations studied. Illiffe's result falls between these extremes. The only consensus seems to be that prevalence rates increase with age, with the rate doubling every five years.<sup>10</sup>

The clinic where I work has recently completed a survey of the cognitive function of all 233 persons aged 70 years and over living in our small rural Canadian community. The instrument used was the Canadian mental status questionnaire (a local version of the short portable mental status questionnaire). The prevalence of severe cognitive impairment was 2.1%, and moderate cognitive impairment 6.4%, giving a total impairment of 8.6%. When former members of the community who are now in institutions were also tested, the prevalence of severe or moderate dysfunction rose to 11.6%.

In our study, physicians had noted the presence of dementia in the charts of all five patients found to be severely impaired by the test instrument. However, of the 15 patients who were found to be moderately impaired on testing, nine had been noted as 'neurologically normal' at a regular medical check up, and two men had been certified fit to drive a motor vehicle. It seems that doctors have difficulty detecting moderate degrees of impairment, although severe impairment is easily found.

In the light of Illiffe's results, and those of my own study, I think there is a place for the use of short screening tests on our elderly patients; we can hardly afford not to evaluate them for dementia.

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### Which antidepressant?

Sir,

We write in response to the views expressed by Matthews and Eagles (March *Journal* p.123) on the choice of antidepressants in general practice. The article was entitled a 'discussion paper' but no opposing views were offered. Our recommendations would be quite different.

We would first point out that depressed patients treated by general practitioners show different features to those seen by psychiatrists.<sup>1</sup> The best evidence that antidepressants are effective in general practice patients comes from placebo-controlled trials of tricyclic antidepressants.<sup>2,3</sup> Second generation antidepressants have rarely been tested adequately in general practice samples, and for some, overall evidence of efficacy is not very good. In addition, like all other drugs, they produce side effects, and it can take several years before the full picture of these emerges. With drugs of new chemical and pharmacological classes particularly, careful and extensive evaluation is needed before their place can be secure.

In their concluding paragraph, Matthews and Eagles recommend the first line use of trazodone, mianserin, lofepramine, fluvoxamine and fluoxetine by general practitioners. Most of these produce considerable adverse effects. Priapism is a well documented effect of trazodone which contraindicates its use in men. Nausea and vomiting occur with fluvoxamine and fluoxetine. Matthews and Eagles provide a particularly detailed defence of the record of mianserin in producing blood dyscrasias without reference to the Committee on Safety of Medicines' recommen-