

How to talk to patients and their family after a diagnosis of mild cognitive impairment

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Mild cognitive impairment (MCI) is a transitional clinical stage between normal aging and dementia. Together with aging, it is considered the most significant risk factor for developing dementia, often the Alzheimer's type.¹

MCI is a challenging neuropsychiatric diagnosis to discuss with patients and their family because it is characterized by overlapping features of normal aging and because of its heterogeneity of etiology, clinical presentation, and outcome.^{2,3} The evolution to dementia and the lack of effective treatments for preventing or forestalling this outcome can be difficult to address—particularly when the patient is in good health and has been leading a productive life.

Successful communication is key

You can take steps to communicate in a helpful way, build a strong treatment alliance, and reduce the potential for the iatrogenic effects of disclosing this diagnosis and its prognostic implications.

Clarify that your findings are consistent with the patient's or family's report of sustained and concerning change in cognition and, depending on the patient, concurrent alterations in affect, behavior, or both. Emphasize that these changes are disproportionately severe relative to expectations for the patient's age and are not caused by psychiatric or clear-cut medical factors.

Highlight contexts in which the patient's symptoms are likely to become more disruptive and impaired, and situations in

which the patient can be expected to function more effectively.

Provide evidence-based support for the rate of progression of symptoms and functional impairment.³

Emphasize that major lifestyle adjustments usually are unnecessary in the absence of progression, especially for patients who are retired or not involved in endeavors that involve significant cognitive and executive functioning demands.

Discuss the role that cognition-enhancing medications might play in managing symptoms.⁴

Address indications for additional services, including formal psychiatric care for patients who have concomitant affective or behavioral symptoms and who are highly distressed by the diagnosis. Pair these services with longitudinal monitoring for possible exacerbation of symptoms.

Identify psychiatric, medical, and lifestyle factors that can increase the risk of dementia. Depending on the patient's history, this might include diabetes, hypertension, elevated lipid levels, obesity, smoking, head trauma, depression, physical inactivity, and lack of intellectual stimulation.

Review compensatory strategies. In MCI predominantly amnesic type, for example, having the patient make systematic lists for shopping and other activities of daily living, as well as establishing rou-

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tines for organization, can bolster successful coping.

If psychometric testing was not utilized to establish the diagnosis, discussion can include the value of performing such an assessment for a more finely tuned profile of preserved and impaired neurobehavioral functions. Such a profile can include test patterns that 1) have prognostic value with regard to the likelihood of progression to dementia and 2) establish a baseline against which you can assess stability or progression over time.⁵

References

1. Albert MS, DeKosky ST, Dickson D, et al. The diagnosis of mild cognitive impairment due to Alzheimer's disease: recommendations from the National Institute on Aging-Alzheimer's Association workgroups on diagnostic guidelines for Alzheimer's disease. *Alzheimers Dement*. 2011;7(3):270-279.
2. Ellison JM, Harper DG, Berlow Y, et al. Beyond the "C" in MCI: noncognitive symptoms in amnesic and non-amnesic mild cognitive impairment. *CNS Spectr*. 2008;13(1):66-72.
3. Goveas JS, Dixon-Holbrook M, Kerwin D, et al. Mild cognitive impairment: how can you be sure? *Current Psychiatry*. 2008;7(4):36-40, 46-50.
4. Doody RS, Ferris SH, Salloway S, et al. Donepezil treatment of patients with MCI: a 48-week randomized, placebo-controlled trial. *Neurology*. 2009;72(18):1555-1561.
5. Summers MJ, Saunders NL. Neuropsychological measures predict decline to Alzheimer's dementia from mild cognitive impairment. *Neuropsychology*. 2012;26(4):498-508.