Diagnosing dementia in primary care

SIR—The findings of Löpönen et al. [1] that mild and potentially reversible dementia is perhaps unrecognised in primary care is not surprising since we note that evaluation of dementia in the earlier stages is not straightforward and is often best supported by specialist services [2]. In contrast to Löpönen et al. [1] in our research using a sample of 1003 community dwelling people aged ≥65 years and over, recruited by 24 GPs, with exclusion of known dementia cases, only 1.6% were undocumented dementia cases [3]. These contrasting findings could be explained by inter-country variation in GP practice, but may actually lie in differences in data collection between the two studies, i.e. retrospective medical data file observation [1] versus direct interview data from the GP [3]. Indeed, our interview data indicated that GPs were aware that patients had cognitive problems but they chose to not document these [2]. GPs are very reluctant to write down the diagnosis before it has been confirmed. This may be because reaching a diagnosis of mild dementia can take time with the difficult consequences acting as an obstacle for GP documentation. Availability of specialised services is also important [2].

In our study the referral rate to specialist diagnostic services was 50%, albeit within a group of volunteer GPs. It is unclear what the reason for this lack of referral may be, but we have evidence of the effect of factors other than GPs’ decisions and attitudes [3]. The obstacles and facilitators of timely recognition of dementia in primary care have been recently documented in a pan European pilot study of 8 EU states [2, 4].

Change is the core issue in dementia care, with multiple pathways of change that need to be understood at clinical and organisational levels. Practitioners and people with dementia are engaged in managing emotional, social and physical risks, making explicit risk management a potentially important component of dementia care. It is also important that the boundary between generalist and specialist services for both diagnosis and support is better understood in studies of early diagnosis of dementia, if the nihilism due to the stigma and ageism (which are variably distributed phenomena both within and among countries) is to be overcome.

DOI: 10.1093/ageing/afh067

Re: Estimating total Barthel scores from just three items

SIR—Measures of functional independence are fundamental to the characterisation of patient status following stroke. Historically, the Barthel Index (BI) [1] has probably been employed most widely to quantify independence in physical functioning. In an effort to reduce the administrative burden of the BI, subsets of its 10 items have been proposed. Specifically, 5- and 3-item subsets have been described and examined [2, 3]. In this journal, Ellul et al. portrayed a 3-item subset (incorporating the BI’s urinary continence, bed-chair transfer, and mobility items) as sufficient for estimating the total BI score [3]. They presented the following predictive equation: Total BI score = 0.14 + 2.39 × total BI score [3]. They reported that the predicted and actual BI scores were within 1 point in 79% of cases and within 2 points in 95% of cases.

Desiring to reduce the burden of outcomes measurement within our own setting, we tested the applicability of Ellul et al.’s 1998 findings to data gathered in 2001 and 2002 in our American stroke centre. We used self-report data obtained after hospital admission from 251 primarily elderly patients with stroke. The mean score for the sum of their 3 BI items was 4.0; the mean score for their total BI was 9.4. The mean score predicted using the equation of Ellul et al. [3] was 9.6. The total BI scores predicted by the Ellul et al. equation were within 1 point of the actual BI scores in 47.8% of the cases, within 2 points in 72.9% of the cases, and within 3 points in 91.6% of the cases. The best predictive

DOI: 10.1093/ageing/afh068