IRISH SOCIETY OF PHYSICIANS
IN GERIATRIC MEDICINE

HISTORY-TAKING IN THE PRESENCE OF COGNITIVE IMPAIRMENT

Recommended ISPGM supplement to Talley and O'Connor Section 1, The General Principles of History Taking and Physical Examination, to be inserted between section OBTAINING THE HISTORY and INTRODUCTORY QUESTIONS (pages 5-6 in Talley and O'Connor, 8th Edition)

Traditionally, much emphasis was made on directing students towards patients who gave "a good history". However, it is increasingly important that students recognise that a significant proportion – up to 30% of older people, proportionately the highest users of clinical services in developed countries - have a degree of memory impairment due to conditions such as delirium and/or dementia - which creates barriers to obtaining a crisp, sequential and accurate history. Therefore, one of the key skills for modern medical students is the recognition at an early stage of when the patient has some degree of cognitive impairment, and to understand that **the history should still be taken but that it is not complete until they have performed a formal cognitive screen, and taken a collateral/informant history from a relative or a friend**.

In the past such patients may have been described as 'poor historians', a dismissive, demeaning and pejorative term: we now recognize that it is the clinician who fails to detect cognitive impairment, perform a cognitive screen and collect a collateral history who is the 'poor historian'. If a patient had barriers to history taking such as not speaking the language of your country, or severe hearing loss, we would ensure presence of an interpreter, or seek hearing aids: with cognitive impairment the equivalent is adding a cognitive screen and collateral/informant history.

The elements which may make you consider that cognitive impairment is present include: vagueness about the presenting symptom, inconsistency of the narrative, uncertainty about age, day and date of the week, a sense that the patient's demeanour or contact with you does not match the gravity of the situation (nobody wants to be in hospital unnecessarily!), or the presence of either agitation or reduced engagement with taking the history.

As the history is the basis of the personal relationship with the patient, as well as the fact that long-term memory is better preserved than short term memory, you should continue with the history, mindful that it will need to be counter-checked with the collateral history, including past medical history, allergies and current medications. Remember that even with significant cognitive impairment, patients will also be able to signal pain and other discomforts.

There is a wide variety of **short cognitive screens** available to clinicians, including the Folstein Mini-Mental State Examination (MMSE) (30 questions), the Montreal Cognitive Assessment (MoCA) (30 questions), the Clock-Drawing Test, as well as shorter screens such as the Abbreviated Mental Test Score (AMT4) and the 4-AT[1]. The 4-AT includes a question

from a collateral/informant source which can be useful in terms of providing an opportunity to take a wider collateral/informant history: however, it may be challenging to attain an answer for this in the early hours of the morning in an emergency department, and may need to be taken the next day. The cut-off points for all of these scores are **suggestive** rather than indicative of cognitive status, as there are always small numbers of false positives and negatives with any simple screens, and almost certainly have higher predictive value in hospital settings than in community settings.

The **informant history** has six key elements[2], and should be taken with permission from the patient from the person they see as the one most likely to know them well. These elements are:

1) Do you think your friend/relative has a memory problem?
2) If so, how long has this been present?
3) Was the onset abrupt (eg, associated with a hospital admission/surgery/stroke..) or insidious?
4) Has the memory loss been progressive (suggestive dementia), and has there been a recent rapid deterioration (suggestive delirium)?
5) Has the memory loss contributed to loss of social or occupational function? Here ask about the highest functions – managing finances, household tasks, etc - prior to the onset of memory problems: loss of function is a key diagnostic element of the dementia syndrome. A useful aid here is the AD-8, a check-list on change of function and capabilities.
6) What are you concerns arising from the memory and associated issues?

The collateral/informant history is also useful for garnering information on gait and balance, continence and mood, as patients with cognitive impairment may also have impairments in these domains which they may not report accurately.

Although you may be at an early stage of your medical student training at this point, it is important that you seek guidance from the team with which you are attached as to how to combine the a) history despite its inconsistencies, b) cognitive screen, and c) collateral/informant history so as to formulate a diagnosis and management plan of the condition underlying any detected cognitive impairment.

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[1] O'Neill D. Brain stethoscopes: the use and abuse of brief mental status schedules. *Postgrad Med J* 1993;69(814):599-601. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2399697/pdf/postmedj00056-0004.pdf

[2] Briggs R, O'Neill D. The informant history: a neglected aspect of clinical education and practice. *QJM* 2016;109(5):301-2. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4888321/