Complete Summary

GUIDELINE TITLE

Management of patients with dementia. A national clinical guideline.

BIBLIOGRAPHIC SOURCE(S)

Scottish Intercollegiate Guidelines Network (SIGN). Management of patients with dementia. A national clinical guideline. Edinburgh (Scotland): Scottish Intercollegiate Guidelines Network (SIGN); 2006 Feb. 53 p. (SIGN publication; no. 86). [183 references]

GUIDELINE STATUS

This is the current release of the guideline.

This guideline updates a previous version: Interventions in the management of behavioural and psychological aspects of dementia. A national clinical guideline recommended for use in Scotland by the Scottish Intercollegiate Guidelines Network. Edinburgh (Scotland): Scottish Intercollegiate Guidelines Network (SIGN); 1998 Feb. 26 p. (SIGN publication; no. 22).

Any amendments to the guideline in the interim period will be noted on Scottish Intercollegiate Guidelines Network (SIGN) Web site.

** REGULATORY ALERT **

FDA WARNING/REGULATORY ALERT

Note from the National Guideline Clearinghouse: This guideline references a drug(s) for which important revised regulatory and/or warning information has been released.

- On April 12, 2005, the U.S. Food and Drug Administration (FDA) issued a public health advisory to alert health care providers, patients, and patient caregivers to new safety information concerning an unapproved, "off-label" use of certain antipsychotic drugs approved for the treatment of schizophrenia and mania. FDA has determined that the treatment of behavioral disorders in elderly patients with dementia with atypical (second generation) antipsychotic medications is associated with increased mortality. Clinical studies of these drugs in this population have shown a higher death rate associated with their use compared to patients receiving a placebo. See the FDA Web site for more information.
- On July 1, 2005, in response to recent scientific publications that report the possibility of increased risk of suicidal behavior in adults treated with antidepressants, the U.S. Food and Drug Administration (FDA) issued a Public

Health Advisory to update patients and healthcare providers with the latest information on this subject. Even before the publication of these recent reports, FDA had already begun the process of reviewing available data to determine whether there is an increased risk of suicidal behavior in adults taking antidepressants. The Agency has asked manufacturers to provide information from their trials using an approach similar to that used in the evaluation of the risk of suicidal behavior in the pediatric population taking antidepressants. This effort will involve hundreds of clinical trials and may take more than a year to complete. See the FDA Web site for more information.

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SCOPE

DISEASE/CONDITION(S)

Dementia

Note: This guideline does not address mild cognitive impairment, palliative care in advanced disease, risk, or prevention.

GUIDELINE CATEGORY

Diagnosis
Evaluation
Treatment

CLINICAL SPECIALTY

Family Practice
Geriatrics
Internal Medicine
Neurology
Psychiatry
Psychology

INTENDED USERS

Advanced Practice Nurses
Nurses
Occupational Therapists
Physical Therapists
Physician Assistants
Physicians
Psychologists/Non-physician Behavioral Health Clinicians

GUIDELINE OBJECTIVE(S)

- To present evidence-based recommendations for the management of dementia
- To consider investigations and interventions in which direct benefit to the patient can be demonstrated

TARGET POPULATION

Patients with all stages of dementia excluding mild cognitive impairment

INTERVENTIONS AND PRACTICES CONSIDERED

Diagnosis

1. Detailed medical history including mode of onset, course of progression, pattern of cognitive impairment, presence of behavioural disturbances, hallucinations, and delusions
2. Diagnosis using Diagnostic and Statistical Manual, 4th edition (DSM-IV) and other scales for differential diagnosis of dementia
3. Cognitive testing using Mini-Mental State Examination (MMSE) and Adenbrooke's Cognitive Examination (ACE)
4. Screening for comorbid conditions
5. Imaging techniques such as computed tomography (CT) and single photon emission controlled tomography (SPECT)
6. Neuropsychological testing

Treatment

1. Non-pharmacological interventions including:
    - Behaviour management
    - Caregiver intervention programmes
    - Cognitive stimulation
    - Reality orientation therapy
    - Recreational activities

    Note: The following non-pharmacological interventions are considered, but the evidence to support their use is mixed:

    - Aromatherapy
    - Environmental design
    - Light therapy
    - Multisensory stimulation

- Music therapy
- Physical activities
- Simulated presence
- Validation therapy

Note: The following non-pharmacological interventions were considered but not recommended:

- Memory books
- Reminiscence therapy

2. Pharmacological interventions including:
   - Antidepressants
   - Cholinesterase inhibitors (donepezil, galantamine, and rivastigmine)
   - Conventional antipsychotics (use with caution)

   Note: The following pharmacological interventions were considered but not recommended:

   - Anticonvulsants
   - Acetyl-L-camitine
   - Anti-inflammatories
   - Aspirin (with the exception of people with vascular dementia who have a history of vascular disease)
   - Benzodiazepines
   - Cerebrolysin
   - Ginkgo
   - Lecithin
   - Lithium
   - Melatonin
   - Memantine
   - Nicergoline
   - Oestrogen
   - Physostigmine
   - Salvia
   - Selegiline
   - Trazodone

MAJOR OUTCOMES CONSIDERED

- Accuracy of diagnostic testing
- Activities of daily living
- Symptoms of dementia including depression, behavioural disorders, and cognitive function
- Nursing home placement

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

The evidence base for this guideline was synthesized in accordance with Scottish Intercollegiate Guidelines Network (SIGN) methodology. A systematic review of the literature was carried out using an explicit search strategy devised by a SIGN Information Officer. Databases searched include Medline, Embase, Cinahl, PsychINFO, and the Cochrane Library. The year range covered was 1997-2004. Internet searches were carried out on various websites including the New Zealand Guidelines Programme, NELH Guidelines Finder, and the US National Guidelines Clearinghouse. The Medline version of the main search strategies can be found on the SIGN website, in the section covering supplementary guideline material. The main searches were supplemented by material identified by individual members of the development group.

NUMBER OF SOURCE DOCUMENTS

705

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Weighting According to a Rating Scheme (Scheme Given)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Levels of Evidence

1++: High quality meta-analyses, systematic reviews of randomised controlled trials (RCTs), or RCTs with a very low risk of bias

1+: Well-conducted meta-analyses, systematic reviews of RCTs, or RCTs with a low risk of bias

1-: Meta-analyses, systematic reviews of RCTs, or RCTs with a high risk of bias

2++: High quality systematic reviews of case control or cohort studies
High quality case control or cohort studies with a very low risk of confounding or bias and a high probability that the relationship is causal

2+: Well-conducted case control or cohort studies with a low risk of confounding or bias and a moderate probability that the relationship is causal

2-: Case control or cohort studies with a high risk of confounding or bias and a significant risk that the relationship is not causal

3: Non-analytic studies (e.g., case reports, case series)

4: Expert opinion

METHODS USED TO ANALYZE THE EVIDENCE

Review of Published Meta-Analyses
Systematic Review with Evidence Tables

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Once papers have been selected as potential sources of evidence, the methodology used in each study is assessed to ensure its validity. The result of this assessment will affect the level of evidence allocated to the paper, which will in turn influence the grade of recommendation that it supports.

The methodological assessment is based on a number of key questions that focus on those aspects of the study design that research has shown to have a significant influence on the validity of the results reported and conclusions drawn. These key questions differ between study types, and a range of checklists is used to bring a degree of consistency to the assessment process. Scottish Intercollegiate Guidelines Network (SIGN) has based its assessments on the MERGE (Method for Evaluating Research and Guideline Evidence) checklists developed by the New South Wales Department of Health, which have been subjected to wide consultation and evaluation. These checklists were subjected to detailed evaluation and adaptation to meet SIGN's requirements for a balance between methodological rigour and practicality of use.

The assessment process inevitably involves a degree of subjective judgment. The extent to which a study meets a particular criterion (e.g., an acceptable level of loss to follow up) and, more importantly, the likely impact of this on the reported results from the study will depend on the clinical context. To minimise any potential bias resulting from this, each study must be evaluated independently by at least two group members. Any differences in assessment should then be discussed by the full group. Where differences cannot be resolved, an independent reviewer or an experienced member of SIGN Executive staff will arbitrate to reach an agreed quality assessment.

Evidence Tables

Evidence tables are compiled by SIGN executive staff based on the quality assessments of individual studies provided by guideline development group members. The tables summarise all the validated studies identified from the systematic literature review relating to each key question. They are presented in a standard format to make it easier to compare results across studies, and will present separately the evidence for each outcome measure used in the published studies. These evidence tables form an essential part of the guideline development record and ensure that the basis of the guideline development group's recommendations is transparent.

Additional details can be found in the companion document titled "An Introduction to the SIGN Methodology for the Development of Evidence-based Clinical

Guidelines." (Edinburgh [UK]: Scottish Intercollegiate Guidelines Network. [SIGN publication; no. 50]). Available from the SIGN Web site.

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

Synthesising the Evidence

Guideline recommendations are graded to differentiate between those based on strong evidence and those based on weak evidence. This judgment is made on the basis of an (objective) assessment of the design and quality of each study and a (perhaps more subjective) judgment on the consistency, clinical relevance and external validity of the whole body of evidence. The aim is to produce a recommendation that is evidence-based, but which is relevant to the way in which health care is delivered in Scotland and is therefore implementable.

It is important to emphasise that the grading does not relate to the importance of the recommendation, but to the strength of the supporting evidence and, in particular, to the predictive power of the study designs from which that data was obtained. Thus, the grading assigned to a recommendation indicates to users the likelihood that, if that recommendation is implemented, the predicted outcome will be achieved.

Considered Judgment

It is rare for the evidence to show clearly and unambiguously what course of action should be recommended for any given question. Consequently, it is not always clear to those who were not involved in the decision making process how guideline developers were able to arrive at their recommendations, given the evidence they had to base them on. In order to address this problem, the Scottish Intercollegiate Guidelines Network (SIGN) has introduced the concept of considered judgement.

Under the heading of considered judgement, guideline development groups are expected to summarise their view of the total body of evidence covered by each evidence table. This summary view is expected to cover the following aspects:

- Quantity, quality, and consistency of evidence
- Generalisability of study findings
- Directness of application to the target population of the guideline
- Clinical impact (i.e., the extent of the impact on the target patient population, and the resources need to treat them.)
- Implementability (i.e., how practical it would be for the NHS in Scotland to implement the recommendation.)

Guideline development groups are provided with a pro forma in which to record the main points from their considered judgement. Once they have considered

these issues, the group is asked to summarise their view of the evidence and assign a level of evidence to it, before going on to derive a graded recommendation.

Additional detail about SIGN's process for formulating guideline recommendations is provided in Section 6 of the companion document titled "SIGN 50: A Guideline Developers' Handbook." (Edinburgh [UK]: Scottish Intercollegiate Guidelines Network. [SIGN publication; no. 50], available from the SIGN Web site.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Grades of Recommendations

Note: The grade of recommendation relates to the strength of the evidence on which the recommendation is based. It does not reflect the clinical importance of the recommendation.

Grade A: At least one meta-analysis, systematic review of randomized controlled trials (RCTs), or RCT rated as 1++ and directly applicable to the target population; or

A body of evidence consisting principally of studies rated as 1+, directly applicable to the target population, and demonstrating overall consistency of results

Grade B: A body of evidence including studies rated as 2++, directly applicable to the target population, and demonstrating overall consistency of results; or

Extrapolated evidence from studies rated as 1++ or 1+

Grade C: A body of evidence including studies rated as 2+, directly applicable to the target population and demonstrating overall consistency of results; or

Extrapolated evidence from studies rated as 2++

Grade D: Evidence level 3 or 4; or

Extrapolated evidence from studies rated as 2+

Good Practice Points: Recommended best practice based on the clinical experience of the guideline development group.

COST ANALYSIS

The guideline developer reviewed one study that noted a cost savings of delay to institutionalisation as a result of caregiver training.

METHOD OF GUIDELINE VALIDATION

External Peer Review
Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

The national open meeting is the main consultative phase of the Scottish Intercollegiate Guidelines Network (SIGN) guideline development, at which the guideline development group presents its draft recommendations for the first time. The national open meeting for this guideline was held on 2 February 2004 and was attended by representatives of all the key specialties relevant to the guideline. The draft guideline was also available on the SIGN website for a limited period at this stage to allow those unable to attend the meeting to contribute to the development of the guideline.

This guideline was also reviewed in draft form by the independent expert referees, who were asked to comment primarily on the comprehensiveness and accuracy of interpretation of the evidence base supporting the recommendations in the guideline.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Note from the Scottish Intercollegiate Guidelines Network (SIGN) and National Guideline Clearinghouse (NGC): In addition to these evidence-based recommendations, the guideline development group also identifies points of best clinical practice in the full-text guideline document.

The strength of recommendation grading (A-D) and level of evidence (1++, 1+, 1, 2++, 2+, 2-, 3, 4) are defined at the end of the "Major Recommendations" field.

Diagnosis

History Taking and Differential Diagnosis

B - Diagnostic and Statistical Manual, 4th edition (DSM-IV) or National Institute of Neurologic, Communicative Disorders and Stroke-Alzheimer's disease and related Disorders Association (NINCDS-ADRDA) criteria should be used for the diagnosis of Alzheimer's disease.

B - The Hachinski Ischaemic Scale or National Institute of Neurological Disorders and Stroke

Association Internationale pour la Recherche et l'Enseignement en Neurosciences (NINDS-AIRENS) criteria may be used to assist in the diagnosis of vascular dementia.

C - Diagnostic criteria for dementia with Lewy bodies and fronto-temporal dementia should be considered in clinical assessment.

Initial Cognitive Testing

B - In individuals with suspected cognitive impairment, the Mini-Mental State Examination (MMSE) should be used in the diagnosis of dementia.

Screening for Comorbid Conditions

B - As part of the assessment for suspected dementia, the presence of comorbid depression should be considered.

The Use of Imaging

C - Structural imaging should ideally form part of the diagnostic workup of patients with suspected dementia.

C - Single photon emission controlled tomography (SPECT) may be used in combination with computed tomography (CT) to aid the differential diagnosis of dementia when the diagnosis is in doubt.

The Role of Cerebrospinal Fluid and Electroencephalography

B - Cerebrospinal fluid (CSF) and Electroencephalography (EEG) examinations are not recommended as routine investigations for dementia.

Neuropsychological Testing

B - Neuropsychological testing should be used in the diagnosis of dementia, especially in patients where dementia is not clinically obvious.

Non-Pharmacological Interventions

Behaviour Management

B - Behaviour management may be used to reduce depression in people with dementia.

Caregiver Intervention Programmes

B - Caregivers should receive comprehensive training on interventions that are effective for people with dementia.

Cognitive Stimulation

B - Cognitive stimulation should be offered to individuals with dementia.

Reality Orientation Therapy

D - Reality orientation therapy should be used by a skilled practitioner, on an individualised basis, with people who are disorientated in time, place and person.

Recreational Activities

B - Recreational activities should be introduced to people with dementia to enhance quality of life and well-being.

Pharmacological Interventions

Cholinesterase Inhibitors

Donepezil

B - Donepezil, at daily doses of 5 mg and above, can be used to treat cognitive decline in people with Alzheimer's disease.

B - Donepezil, at daily doses of 5 mg and above, can be used for the management of associated symptoms in people with Alzheimer's disease.

Galantamine

B - Galantamine, at daily doses of 16 mg and above, can be used to treat cognitive decline in people with Alzheimer's disease and people with mixed dementias.

B - Galantamine, at daily doses of 16 mg and above, can be used for the management of associated symptoms in people with Alzheimer's disease.

Rivastigmine

B - Rivastigmine, at daily doses of 6 mg and above, can be used to treat cognitive decline in people with Alzheimer's disease.

B - Rivastigmine, at daily doses of 6 mg and above, can be used to treat cognitive decline in people with dementia with Lewy bodies.

B - Rivastigmine, at daily doses of 6 mg and above, can be used for the management of associated symptoms in people with Alzheimer's disease and dementia with Lewy bodies.

Antidepressants

D - Antidepressants can be used for the treatment of comorbid depression in dementia providing their use is evaluated carefully for each patient.

Antipsychotics

A - If necessary, conventional antipsychotics may be used with caution, given their side effect profile, to treat the associated symptoms of dementia.

Clinically Ineffective Interventions

Anti-Inflammatories

A - Anti-inflammatories are not recommended for treatment of cognitive decline in people with Alzheimer's disease.

B - Hydroxychloroquine is not recommended for the treatment of associated symptoms in people with dementia.

A - Prednisolone is not recommended for the treatment of associated symptoms in people with Alzheimer's disease.

Oestrogen

B - Oestrogen is not recommended for the treatment of associated symptoms in women with dementia.

Selegiline

A - Selegiline is not recommended for the treatment of core or associated symptoms in people with Alzheimer's disease.

Interventions Lacking Evidence of Clinical Effectiveness

Anticonvulsants

A - Valproate is not recommended for the treatment of behavioural symptoms associated with dementia.

Information for Discussion with Patients and Carers

Supportive Information for Patients and Carers

C - Patients and carers should be offered information tailored to the patient's perceived needs.

Disclosure of Diagnosis

C - Healthcare professionals should be aware that many people with dementia can understand their diagnosis, receive information and be involved in decision making.

C - Healthcare professionals should be aware that some people with dementia may not wish to know their diagnosis.

D - Healthcare professionals should be aware that in some situations disclosure of a diagnosis of dementia may be inappropriate.

Definitions:

Grades of Recommendations

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Grade C: A body of evidence including studies rated as 2+, directly applicable to the target population and demonstrating overall consistency of results; or

Extrapolated evidence from studies rated as 2++

Grade D: Evidence level 3 or 4; or

Extrapolated evidence from studies rated as 2+

Levels of Evidence

1++: High quality meta-analyses, systematic reviews of randomised controlled trials (RCTs), or RCTs with a very low risk of bias

1+: Well-conducted meta-analyses, systematic reviews of RCTs, or RCTs with a low risk of bias

1-: Meta-analyses, systematic reviews of RCTs, or RCTs with a high risk of bias

2++: High quality systematic reviews of case control or cohort studies
High quality case control or cohort studies with a very low risk of confounding or bias and a high probability that the relationship is causal

2+: Well-conducted case control or cohort studies with a low risk of confounding or bias and a moderate probability that the relationship is causal

2-: Case control or cohort studies with a high risk of confounding or bias and a significant risk that the relationship is not causal

3: Non-analytic studies (e.g., case reports, case series)

4: Expert opinion

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is identified and graded for each recommendation (see "Major Recommendations").

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Appropriate diagnosis and management of patients with behavioural and psychological aspects of dementia

POTENTIAL HARMS

- Side effects of antipsychotics such as sedation, movement disorder and increased confusion are all recognised. Concern has been expressed that the use of these drugs accelerates decline in Alzheimer's disease but a causal effect has not been established.
- Although evidence supports the use of olanzapine and risperidone in the management of behavioural and psychological symptoms of dementias (BPSD), particularly psychosis and aggression, these drugs are not currently recommended by the Medicines and Healthcare products Regulatory Agency (MHRA) due to concerns about serious adverse events, particularly stroke.

Subgroups Most Likely to be Harmed

Practitioners should be aware that up to 60% of patients with dementia with Lewy bodies suffer adverse reactions to antipsychotic drugs.

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

This guideline is not intended to be construed or to serve as a standard of medical care. Standards of medical care are determined on the basis of all clinical data available for an individual case and are subject to change as scientific knowledge and technology advance and patterns of care evolve. Adherence to guideline recommendations will not ensure a successful outcome in every case, nor should they be construed as including all proper methods of care or excluding other acceptable methods of care aimed at the same results. The ultimate judgment must be made by the appropriate healthcare professional(s) responsible for clinical decisions regarding a particular clinical procedure or treatment plan. This judgement should only be arrived at following discussion of the options with the patient, family and carers, covering the diagnostic and treatment choices available. It is advised, however, that significant departures from the national guideline or any local guidelines derived from it should be fully documented in the patient's case notes at the time the relevant decision is taken.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

Implementation of national clinical guidelines is the responsibility of local National Health Service (NHS) organizations and is an essential part of clinical governance. It is acknowledged that not every guideline can be implemented immediately on publication, but mechanisms should be in place to ensure that the care provided is reviewed against the guideline recommendations and the reasons for any differences assessed and, where appropriate, addressed. These discussions should involve both clinical staff and management. Local arrangements may then be made to implement the national guideline in individual hospitals, units and practices, and to monitor compliance. This may be done by a variety of means including patient-specific reminders, continuing education and training, and clinical audit.

Key areas to be considered for implementation are:

- The recognition of comorbid depression in dementia by primary care which will require significant training input
- The routine use of structural imaging which will require more access to imaging facilities given thenature of dementia and the prospect of treatment
- Widespread availability of information for patients and carers. This needs to extend beyond general practitioners' (GPs)' surgeries and appear in areas where older people go, such as libraries, post offices or supermarkets
- Clear strategies by NHS boards for the funding of cholinesterase inhibitors and associated infrastructure development of caregiver training programmes.

Key points for audit are identified in the original guideline document.

IMPLEMENTATION TOOLS

Audit Criteria/Indicators
Quick Reference Guides/Physician Guides

For information about availability, see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Living with Illness

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

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ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

1998 Feb (revised 2006 Feb)

GUIDELINE DEVELOPER(S)

Scottish Intercollegiate Guidelines Network - National Government Agency [Non-U.S.]

SOURCE(S) OF FUNDING

Scottish Executive Health Department

GUIDELINE COMMITTEE

Not stated

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

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FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Declarations of interests were made by all members of the guideline development group. Further details are available from the Scottish Intercollegiate Guidelines Network (SIGN) Executive.

GUIDELINE STATUS

This is the current release of the guideline.

This guideline updates a previous version: Interventions in the management of behavioural and psychological aspects of dementia. A national clinical guideline recommended for use in Scotland by the Scottish Intercollegiate Guidelines Network. Edinburgh (Scotland): Scottish Intercollegiate Guidelines Network (SIGN); 1998 Feb. 26 p. (SIGN publication; no. 22).

Any amendments to the guideline in the interim period will be noted on Scottish Intercollegiate Guidelines Network (SIGN) Web site.

GUIDELINE AVAILABILITY

Electronic copies: Available in Portable Document Format (PDF) from the Scottish Intercollegiate Guidelines Network (SIGN) Web site.

AVAILABILITY OF COMPANION DOCUMENTS

The following are available:

- Quick reference guide: Management of patients with dementia. Edinburgh (UK): Scottish Intercollegiate Guidelines Network, 2006 Feb. 2 p. Available in Portable Document Format (PDF) from the Scottish Intercollegiate Guidelines Network (SIGN) Web site.
- SIGN 50: A guideline developer's handbook. Edinburgh (Scotland): Scottish Intercollegiate Guidelines Network, 2001 Feb. (SIGN publication; no. 50). Electronic copies available from the SIGN Web site.
- Appraising the quality of clinical guidelines. The SIGN guide to the AGREE (Appraisal of Guidelines Research & Evaluation) guideline appraisal instrument. Edinburgh (Scotland): Scottish Intercollegiate Guidelines Network, 2001. Available from the SIGN Web site.
- A background paper on the legal implications of guidelines. Edinburgh (Scotland): Scottish Intercollegiate Guidelines Network.
- A sample Mini-Mental State Examination and Addenbrooke's Cognitive Examination can be found in Annex 7 of the original guideline document.
- A sample Short Form of the Informant Questionnaire on Cognitive Decline in the Elderly (Short IQCODE) can be found in Annex 8 of the original guideline document.

PATIENT RESOURCES

None available

NGC STATUS

This summary was completed by ECRI on February 6, 2002. The information was verified by the guideline developer as of April 9, 2002. This summary was updated by ECRI on April 7, 2006. The updated information was verified by the guideline developer on May 1, 2006.

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