Cognitive symptoms and referral to neurology: Advice for primary care

Dept Clinical Neurosciences, NHS Lothian. 2025

We are often asked to see people with cognitive symptoms, typically memory issues. Many such people are concerned about dementia but have other explanations for their symptoms for which a neurology assessment is not required. We have written this for primary care and patients who are receiving a letter of advice back from neurology rather than an appointment. Typically, this information is about people under the age of 65, although it may also apply to older people.

What types of cognitive symptoms can be managed in primary care without seeing a neurologist?

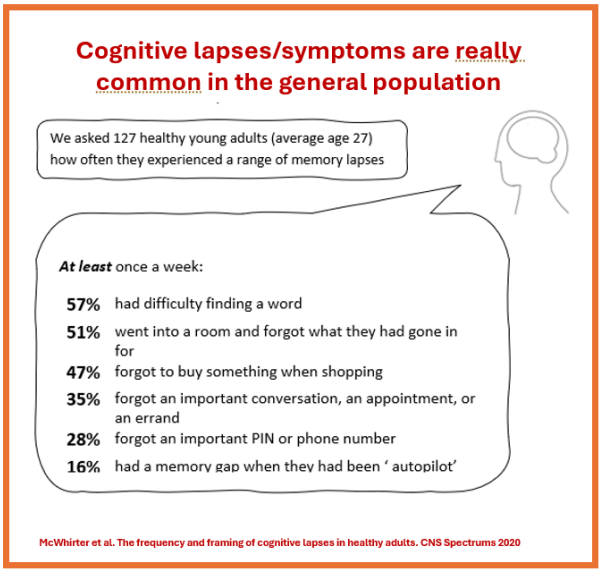
People who experience cognitive symptoms are often understandably concerned that they may be developing a dementia such as Alzheimer's disease. However, these conditions only account for a minority of patients seen in memory clinics that focus on younger people and neurology clinics.

There are many common causes of cognitive symptoms which are NOT dementia and cognitive symptoms are very common in the general population (*see below*). So, any decision about seeing a neurologist needs to consider firstly – **is there a cause ALREADY present which may explain the symptoms?** and **are the symptoms out of the ordinary compared to the general population**? Research in Edinburgh shows how common symptoms are, such as forgetting conversations, losing things, or having word finding difficulty in HEALTHY people in their twenties (figure).

Common causes of Cognitive symptoms that are NOT dementia

Anxiety/ Depression/ PTSD
Sleep Apnoea
Chronic pain – especially fibromyalgia / chronic migraine
Persistent fatigue/stress
Sleep deprivation
Medication – especially opiates/gabapentinoids
Functional Cognitive Symptoms*
Alcohol/Substance misuse
Other known neurological conditions (eg MS, Epilepsy)
Traumatic Brain Injury**

* Evidence that someone has marked cognitive symptoms at times in contrast to good cognitive function at others (eg able to follow complex drama/fulfil work obligations), able to report memory lapses in detail. Not better explained by other conditions on this list
** If minor, then direct symptoms from head injury usually last no more than 3 months



What investigations can be done in primary care?

Look for the common causes listed above and some of the 'red flags' below. If someone can carry out complex cognitive tasks sometimes but performs badly at others, this often suggests one of the causes above. Some blood tests, including FBC, U&E, Ca, LFTs, TFTs, B12, HIV/Syphilis serology are often reasonable. Cognitive testing has some role (e.g. Montreal Cognitive assessment or 6CIT); if normal, that can be helpful but people with functional cognitive symptoms may score poorly on such tests. A detailed clinical history is usually most helpful in sorting out the diagnosis.

'Red flags' for referral to neurology/psychiatry for the elderly (if over 65)?

- Someone who is NOT concerned about their memory or concentration, but others are.
- Cognitive symptoms that interfere with ability to manage their finances.
- Objective evidence of poor performance at work related to cognitive symptoms.
- Getting lost in familiar places or difficulty driving
- Focal neurological symptoms or signs
- Family history of early onset dementia or MND

What treatments can be given in primary care?

- Treat any causes found, eg anxiety, depression, PTSD, sleep apnoea
- Reduce sedating medication, especially opiates and gabapentinoids
- headinjurysymptoms.org has information about cognitive symptoms in the context of mild traumatic brain injury.

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