FTD phenotypes, and to understand the rates and effects of more extensive repetitive head trauma (symptomatic and asymptomatic) in patients with FTD.

Categories: Neurodegenerative Disorders
Keyword 1: traumatic brain injury
Keyword 2: dementia - other cortical
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58 Highly Educated Professionals with Dementia: More than just Physicians

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Objective: Findings from cognitive screenings have resulted in lower-than-expected scores amongst late-career physicians (Moutier et al., 2013). Similar to healthy aging samples and those with mild cognitive impairment, inconsistencies in self-report and objective neuropsychological functioning have been noted in physicians (Nasreddine et al., 2005). Little research has focused on neuropsychological functioning of other highly educated groups, including PhD and JD degrees. We addressed a lack of normative cognitive performance data for populations with advanced degrees by exploring cognitive test scores in a mixed clinical sample of adults.
Participants and Methods: Archival data are from 208 neuropsychology clinic outpatients with 20 years of education (Mage=67.7, SDage=12.3; 25% female; 95% White). Academic degrees were PhD (35.6%), JD (28.4%), MD/DO (21.6%), and 6% other. Referrals sources were physicians (93.8%), licensing boards/employers (3.8%), self-referrals (1.4%), and attorneys (1.0%). Employment status was 55.3% employed and 44.7% not employed. Final DSM-5 neurocognitive diagnosis (NCD) status was: no NCD (45.2%), mild NCD (35.6%), and major NCD (19.2%). Etiologies were: possible Alzheimer's disease (41.2%), unspecified (13.2%), and possible vascular (12.3%). Chi-square tests denoted diagnostic status differences between degree type and employment status. ANOVAs denoted differences in global cognitive and intellectual functioning (on the Repeatable Battery for Neuropsychological Status [RBANS] Total Index, Weschler Adult Intelligence Scale-IV (WAIS-IV), Weschler Abbreviated Scale of Intelligence-II [WASI-II] FSIQ-4 and FSIQ-2) between degree types. Cumulative frequency rates for low scores in the entire sample on normally distributed tests of general intellectual and cognitive functioning were computed for -1.0, -1.5, -2.0, and -2.5 standard deviations (SDs) at or below the population mean.
Results: NCD diagnosis did not differ by degree ($\chi2[14]=8.73$, $p=.848$) but did differ by employment status ($\chi2[2]=40.98$, $p<.001$, $\varphi=0.44$). Employment rate was highest for the no NCD group (66.0%), followed by mild NCD (37.8%), and major NCD (7.5%). For cases below retirement age (<65 years), employment status did not significantly differ between NCD diagnostic groups ($\chi2[2]=5.97$, $p=.050$). Low scores on an FSIQ measure were: -1 SD (7.0%), -1.5 SD (2.6%), -2.0 SD (0.9%), and -2.5 SD (0.0%) compared to general cognitive test scores which demonstrated 42.5% at -1 SD, 30.5% at -1.5 SD, 19.0% at -2.0 SD, and 9.2% at -2.5 SD below the population mean.
Conclusions: The high-education literature is limited to medical degree samples. This sample included multiple degree types. Unsurprisingly, employment rates were higher for healthy versus impaired samples; however, employment rates were similar across these groups for people below retirement age. Our findings suggest that cognitively impaired people with 20 years of education often perform at or near the general population average on tests of general intellectual functioning but below the general population average on tests of general cognitive functioning. Future work should include base rates of low scores on a broader array of cognitive tests across diagnostic groups.

Categories: Neurodegenerative Disorders
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Keyword 2: memory disorders
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59 Effects of Cognitive Impairment, Geriatric Depression, and Anxiety on the Texas Functional Living Scale (TFLS) in a Memory Disorder Clinic

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