**Name of Journal:** *World Journal of Clinical Cases*

**Manuscript NO:** 73058

**Manuscript Type:** META-ANALYSIS

**Association of chronic obstructive pulmonary disease with mild cognitive impairment and dementia risk: A systematic review and meta-analysis**

Zhao LY *et al*. Association of COPD with MCI and dementia risk

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**Author contributions:** Zhao LY conceived and designed the study; Zhao LY and Zhou XL were involved in literature search and data collection; Zhao LY analyzed the data; Zhao LY and Zhou XL wrote the paper; Zhao LY edited the manuscript; all authors read and approved the final manuscript.

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**Received:** November 10, 2021

**Revised:** January 25, 2022

**Accepted:** February 23, 2022

**Published online:** April 16, 2022

**Abstract**

BACKGROUND

Chronic obstructive pulmonary disease (COPD) is a common public health issue that has been linked to cognitive dysfunction.

AIM

To investigate the relationship between COPD and a risk of mild cognitive impairment (MCI) and dementia.

METHODS

A comprehensive literature search of the PubMed, EMbase, Google Scholar, and Cochrane Library electronic databases was conducted. Pooled odds ratios (OR) and mean differences (MD) with 95% confidence intervals (CIs) were calculated using a random or fixed effects model. Studies that met the inclusion criteria were assessed for quality using the Newcastle Ottawa Scale.

RESULTS

Twenty-seven studies met all the inclusion criteria. Meta-analysis yielded a strong association between COPD and increased risk of MCI incidence (OR = 2.11, 95%CI: 1.32-3.38). It also revealed a borderline trend for an increased dementia risk in COPD patients (OR = 1.16, 95%CI: 0.98-1.37). Pooled hazard ratios (HR) using adjusted confounders also showed a higher incidence of MCI (HR = 1.22, 95%CI: -1.18 to -1.27) and dementia (HR = 1.32, 95%CI: -1.22 to -1.43) in COPD patients. A significant lower mini-mental state examination score in COPD patients was noted (MD = -1.68, 95%CI: -2.66 to -0.71).

CONCLUSION

Our findings revealed an elevated risk for the occurrence of MCI and dementia in COPD patients. Proper clinical management and attention are required to prevent and control MCI and dementia incidence in COPD patients.

**Key Words:** Mild cognitive impairment; Chronic obstructive pulmonary disease; Dementia; Meta-analysis

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**Citation:** Zhao LY, Zhou XL. Association of chronic obstructive pulmonary disease with mild cognitive impairment and dementia risk: A systematic review and meta-analysis. *World J Clin Cases* 2022; 10(11): 3449-3460

**URL:** <https://www.wjgnet.com/2307-8960/full/v10/i11/3449.htm>

**DOI:** https://dx.doi.org/10.12998/wjcc.v10.i11.3449

**Core Tip:** Chronic obstructive pulmonary disease (COPD) is a common public health issue that has been linked to cognitive dysfunction. The current meta-analysis was performed to investigate the relationship between COPD and mild cognitive impairment (MCI) and dementia risk. Twenty-seven studies met all the inclusion criteria. Meta-analysis yielded a strong association between COPD and an increased risk of MCI incidence (odds ratio = 2.11, 95% confidence interval: 1.32-3.38). Our findings revealed an elevated risk for the occurrence of MCI and dementia in COPD patients. Proper clinical management and attention are required to prevent and control MCI and dementia incidence in COPD patients.

**INTRODUCTION**

Chronic obstructive pulmonary disease (COPD) is a progressive multicomponent lung disease that occurs more commonly in the elderly[1]. It is characterised by a partially irreversible chronic obstruction of lung airflow resulting in an abnormal decrease in blood oxygen levels, potentially leading to cognitive dysfunction[2]. Various studies have estimated that the prevalence of cognitive impairment in COPD patients ranges from 16% to 57%[3,4]. A prior review of 17 individual studies by Yohannes *et al*[5] showed that 32% of COPD patients showed some signs of cognitive dysfunction, with no less than 25% of patients showing at least mild cognitive impairment (MCI).

Cognitive impairment in COPD patients may compromise their capability to self-care and adhere to treatment regimens, making the relationship between COPD and cognitive impairment important for devising therapeutic approaches for COPD[6,7]. Some studies have focused on the relationship between COPD and neurologic function, but with inconsistent conclusions[8]. Data based on the Atherosclerosis Risk in Communities study showed that reduced lung function was associated with poor cognitive performance and higher risk of dementia hospitalization[9]. Data based on Taiwanese National Health Insurance Research Database showed that COPD patients exhibited a 1.27-fold higher risk of developing dementia[10].

To our knowledge, there has only been one published meta-analysis investigating the statistical association of COPD with cognition dysfunction. Zhang *et al*[11] concluded that COPD patients had an elevated risk of cognitive dysfunction. Similarly, only one single meta-analysis has looked at the relationship between COPD and dementia. Pooling data from three studies, Wang *et al*[12] showed that COPD patients faced a higher risk of developing dementia. However, these important clinical questions have not been investigated in a more thorough and conclusive manner. As such, we conducted a comprehensive systematic review and meta-analysis to investigate the association between COPD and the risk of MCI and dementia.

**MATERIALS AND METHODS**

***Search strategy***

Our meta-analysis was performed according to the Preferred Reporting Items for Systematic Reviews and Meta-analysis (PRISMA) guidelines[13]. We conducted a comprehensive search using PubMed, EMbase, Google Scholar, and Cochrane Library online databases for articles published prior to March 31, 2021. The following key terms were used: “Chronic Obstructive Pulmonary Disease” OR “COPD” OR “Chronic Obstructive Airway Disease” OR “COAD” AND “Mild Cognitive impairment” OR “MCI” OR “Cognitive dysfunction” OR “Cognitive decline” AND “Dementia”. Studies cited by articles that met the inclusion criteria were manually searched to identify additional eligible studies. Study eligibility was not restricted based on language, sex, or publication year. Systematic reviews, conference abstracts, and editorials were excluded due to insufficient data presentation details.

***Eligibility criteria***

**Inclusion criteria:** We included studies that: (1) Investigated the association between COPD and a risk of MCI or dementia; (2) adopted a definite outcome of cognitive impairment or dementia in COPD and non-COPD subjects; (3) reported raw values necessary to calculate odds ratios (OR) or hazard ratios (HRs) for the incidence of cognitive impairment or dementia; (4) contained case controls, were prospective or retrospective-cohort, or had a cross-sectional design; and (5) compared the association between COPD and non-COPD patients.

**Exclusion criteria:** We excluded studies that: (1) Did not report relevant outcomes; or (2) were full-text inaccessible.

***Data collection and analysis***

All eligible studies were separately screened by two reviewers to determine whether they met the inclusion criteria. Screening was first conducted at the abstract content level, with relevant studies further investigated at the full-text level. Articles published in languages other than English were machine-translated using Google Translate, with the translated version reviewed. The following information was extracted from the included studies for summarization and analysis: Author, year, study design type, group investigated, sample size, diagnostic criteria for COPD, adjusted confounder for calculating pooled ratio, MCI prevalence, dementia prevalence, and scales used for cognitive assessment.

***Quality assessment***

Study quality was assessed independently by two separate reviewers using the Newcastle-Ottawa Scale (NOS)[14], which examined three components: Selection, comparability, and ascertainment of outcome. Disagreements were resolved through discussion.

***Publication bias***

Publication bias was assessed using Funnel plot analysis and Egger’s regression test[15,16].

***Statistical analysis***

Mean differences (MDs) with 95% confidence intervals (CIs) were calculated for continuous outcomes. For categorical outcomes, ORs and HRs with 95%CIs were calculated to estimate pooled findings. Heterogeneity between studies (measurable heterogeneity) was evaluated using *I*2 statistics. If *I*2 values > 50%, a random-effects model was applied, otherwise a fixed-effect model was applied. Statistical analyses were performed using Review Manager software (Version 5.3, Copenhagen: The Nordic Cochrane Centre, The Cochrane Collaboration 2014).

**RESULTS**

***Literature search***

Preliminary screening of PubMed, EMbase, Google Scholar, and Cochrane Library databases yielded 234 results (Figure 1). Review of article title and abstract resulted in 72 remaining studies. Full-text review further excluded 45, leaving 27 studies[3,4,10,17–40] that were ultimately included in the meta-analysis.

***Properties and characteristics of included studies***

Relevant study data, including the diagnostic criteria for COPD, sample size, and disease assessment scales for all the 27 included studies[3,4,10,17–40] are shown in Table 1. The included studies were published between 1996 and 2020, and study sample sizes ranged from 20 to 243420 subjects. Ten studies[17,19–22,28,29,34,35,39] were case-controlled, ten were cross-sectional[3,4,24–26,32,36–38,40], four were prospective-cohort[18,27,30,31], and three were retrospective-cohort[10,23,33]. Seventeen studies[4,17–22,25,31,32,34–40] reported cognitive impairment data based on the mini-mental state examination (MMSE) scoring system. Twenty-two studies used the GOLD criteria, three[10,23,33] reported the ICD-9 CM criteria, and two[3,26] followed the standardized guidelines for COPD diagnosis. The quality score was high in twelve studies, medium in seven, and low in six (Supplementary Table 1). The assessment criteria involving the NOS uses three broad criteria: Selection, comparability, and exposure, where the selection defines and analyses the cases and control subjects included in the study, comparability defines the matching or comparison of cases and control subjects for better empirical investigation, and exposure determines whether the study was conducted in a blinded or unbiased manner along with the response of the subjects.

***Association of COPD with MCI risk***

Ten studies[3,18,19,24,26–29,33,37] detailing 71174 COPD patients and 22082 control subjects investigated the association of COPD with MCI risk. Our meta-analysis indicated a strong association between COPD and an increased MCI incidence risk (OR = 2.11, 95%CI: 1.32-3.38). A significant degree of heterogeneity was observed (*I*2 = 99%). Using a random effects model, we demonstrated that COPD patients were 1.26 times more susceptible to MCI compared to non-COPD controls (Figure 2A).

***Adjusted HRs for MCI risk in COPD patients***

Pooling adjusted HRs from four studies[3,18,27,28] investigating the relationship between COPD and MCI incidence revealed a significant association (HR = 1.22, 95%CI: -1.18 to -1.27; *I*2 = 26%] (Figure 2B).

***Association of COPD with risk of dementia***

Seven studies[10,18,23,24,27,28,30] involving 108606 COPD patients and 347939 control subjects, investigated the relationship between COPD and dementia risk. Pooling these data showed a borderline trend for an increased dementia risk in COPD patients compared to non-COPD control patients (OR = 1.16, 95%CI: 0.98-1.37). A high degree of heterogeneity was observed (*I*2 = 94%). Our meta-analysis showed that COPD patients were more susceptible to dementia (Figure 3A).

***Adjusted HRs for dementia risk in COPD patients***

Pooling adjusted HRs from six studies[10,18,23,27,28,30] investigating the relationship between COPD and dementia incidence revealed a significant association (HR = 1.32, 95%CI: -1.22 to -1.43; I2: 99%) (Figure 3B).

***MMSE score in COPD and non-COPD patients***

Seventeen studies[4,17–22,32,35–40,25,31,34] involving 1392 COPD patients and 5097 control subjects, reported mean MMSE score data for both COPD and non-COPD patients. Pooling these results showed a significant lower MMSE score in COPD patients compared to controls (MD = -1.68, 95%CI: -2.66 to -0.71] (Figure 4). A high degree of heterogeneity among these seventeen studies was observed (*I*2 = 96%).

***Publication bias***

Egger’s tests did not show any significant publication bias for the examined comparisons. Figure 5 shows the funnel plot of the studies included in each comparison. However, no significant publication biases were observed for the association of COPD with risk of MCI and dementia, MCI risk in COPD patients, dementia risk in COPD patients, and comparison of MMSE score between the COPD and control groups.

**DISCUSSION**

This study is the first systematic review and meta-analysis examining the association between COPD and the risk of MCI and dementia. We found that patients with COPD are 2.11 times more susceptible to MCI and 1.16 times more susceptible to dementia. Moreover, lower MMSE scores were observed in COPD patients, indicating greater cognitive impairment.

COPD-associated neurological impairment and dementia put a great burden on the patients and the healthcare system. In particular, declining cognition leads to COPD patients requiring more assistance for daily activities[41]. Our analysis was performed based on the reported adjustments within individual studies for confounding factors such as age, sex, smoking, body mass index, education level, diabetes mellitus, and previous history of stroke or cardiovascular disease[10,23,27,28,30]. Studies by Thakur *et al*[33], Singh *et al*[26], and Martinez *et al*[24] reported data as ORs for adjusted confounders and therefore were not included in the calculations for pooled incidence for MCI or dementia.

From a clinical approach, COPD can lead to pulmonary encephalopathy, hypoxemia, and inflammation, all of which may impact brain function[42]. Indeed, COPD patients exhibit a unique neurophysiological profile stemming from neurotoxicity featuring deficits of attention, motor, memory, and cognitive domain executive function[4]. Interestingly, the relationship between COPD and dementia persists even after accounting for the presence of vascular disease, suggesting that COPD is an independent predictor of dementia.

Our findings are consistent with the previous literature[5,11,12,42,43]. However, the available literature on the relationship between dementia and COPD remains limited, as only seven studies were found for this meta-analysis. Our study also had several other limitations. The included studies had different designs, which may be one of the leading causes of heterogeneity. Additional sources of heterogeneity may include different geographical population, variation in the diagnostic criteria of COPD, and diversity in the factors undertaken for the multivariate analysis of each included studies. The included studies also lacked long-term follow-up data, as well as data that would facilitate subgroup analysis based on co-morbidities, age, and gender. Finally, different studies varied on how they assessed and diagnosed COPD and cognitive impairment.

**CONCLUSION**

Our meta-analysis revealed an elevated risk for MCI and dementia in COPD patients. Proper clinical management and attention are necessary to prevent or mitigate the incidence of MCI and dementia in COPD patients.

**ARTICLE HIGHLIGHTS**

***Research background***

Chronic obstructive pulmonary disease (COPD) is a common public health issue that has been linked to cognitive dysfunction. No clear evidence is available for the relationship between COPD and mild cognitive impairment (MCI) and dementia risk.

***Research motivation***

To our knowledge, there has only been one published meta-analysis with limited number studies investigating the statistical association of COPD with cognition dysfunction.

***Research objectives***

The current meta-analysis was performed to investigate the relationship between COPD and MCI and dementia risk.

***Research methods***

A comprehensive search was performed using PubMed, EMbase, Google Scholar, and Cochrane Library online databases for articles published prior to March 31, 2021.

***Research results***

Twenty-seven studies met all the inclusion criteria. Meta-analysis yielded a strong association between COPD and an increased risk of MCI incidence. It also revealed a borderline trend for an increased dementia risk in COPD patients. A significant lower MMSE score in COPD patients was noted.

***Research conclusions***

Our findings revealed an elevated risk for the occurrence of MCI and dementia in COPD patients. Proper clinical management and attention are required to prevent and control MCI and dementia incidence in COPD patients.

***Research perspectives***

Further large prospective observational studies are needed to strengthen the evidence on this important subject.

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**Footnotes**

**Conflict-of-interest statement:** The authors deny any conflict of interest for this article.

**PRISMA 2009 Checklist statement:** The authors have read the PRISMA 2009 Checklist, and manuscript was prepared and revised according to the PRISMA 2009 Checklist.

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**Provenance and peer review:** Unsolicited article; Externally peer reviewed.

**Peer-review model:** Single blind

**Peer-review started:** November 10, 2021

**First decision:** January 11, 2022

**Article in press:** February 23, 2022

**Specialty type:** Medicine, research and experimental

**Country/Territory of origin:** China

**Peer-review report’s scientific quality classification**

Grade A (Excellent): 0

Grade B (Very good): B, B

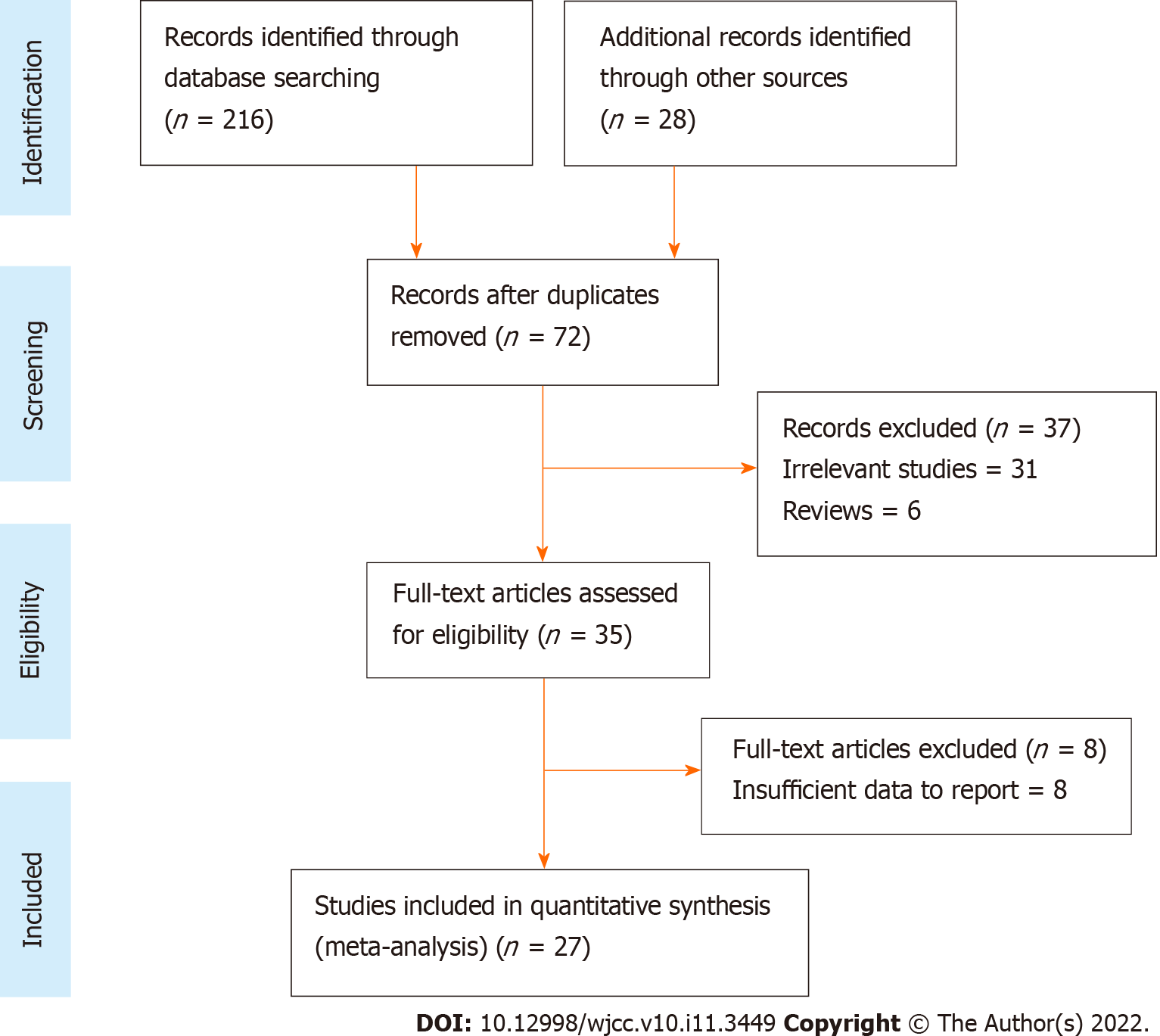
Grade C (Good): 0

Grade D (Fair): 0

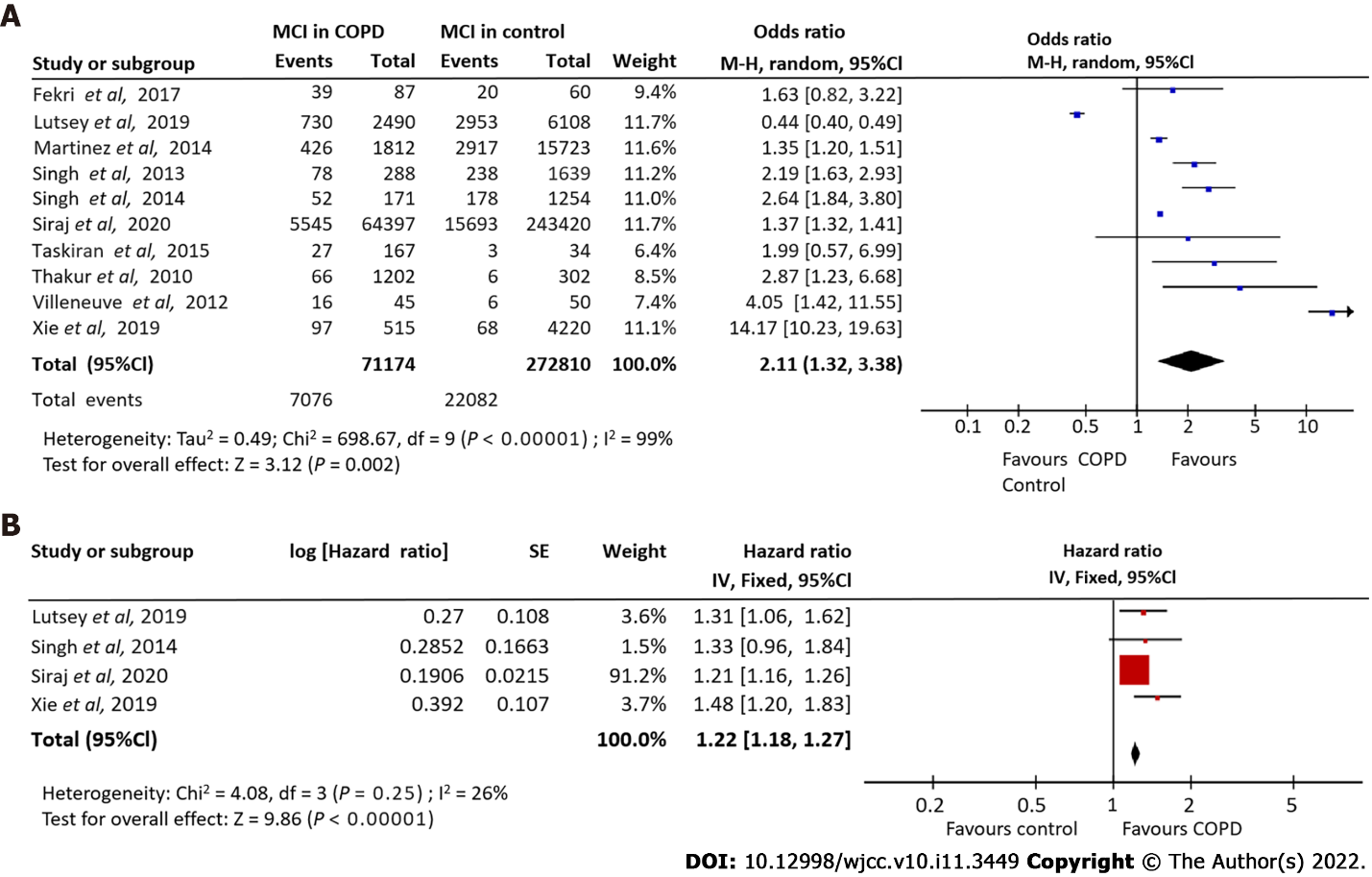
Grade E (Poor): 0

**P-Reviewer:** Biondi A, Byeon H **S-Editor:** Fan JR **L-Editor:** Wang TQ **P-Editor:** Yu HG

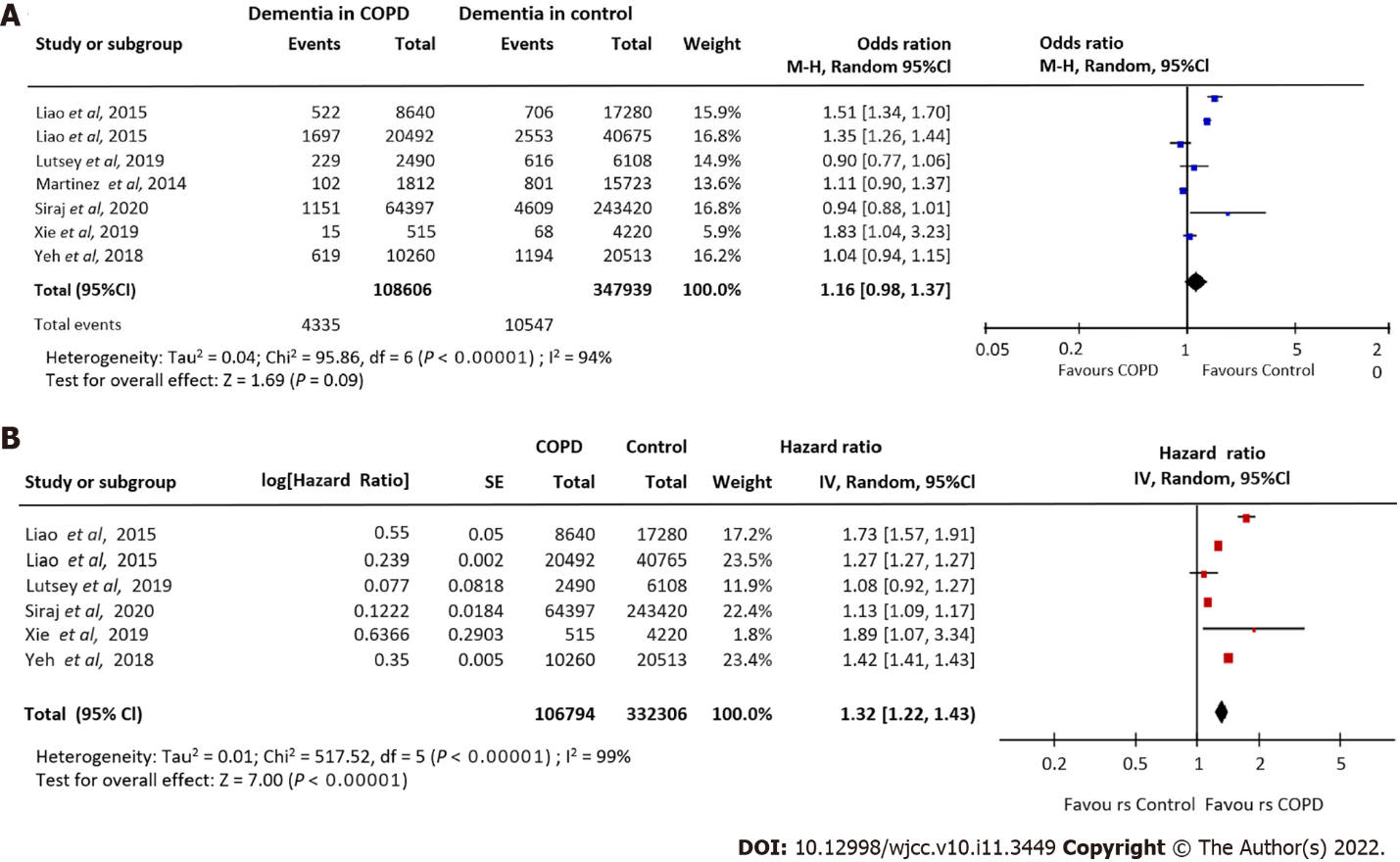
**Figure Legends**



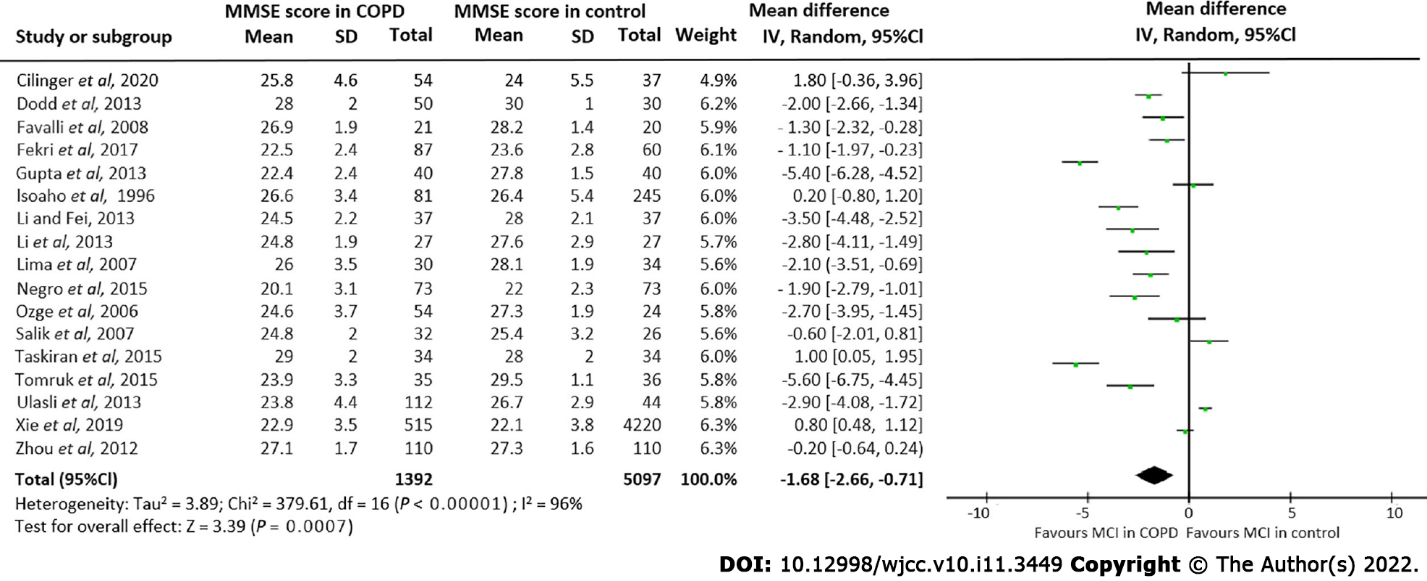
**Figure 1** **Flow diagram for study selection.**



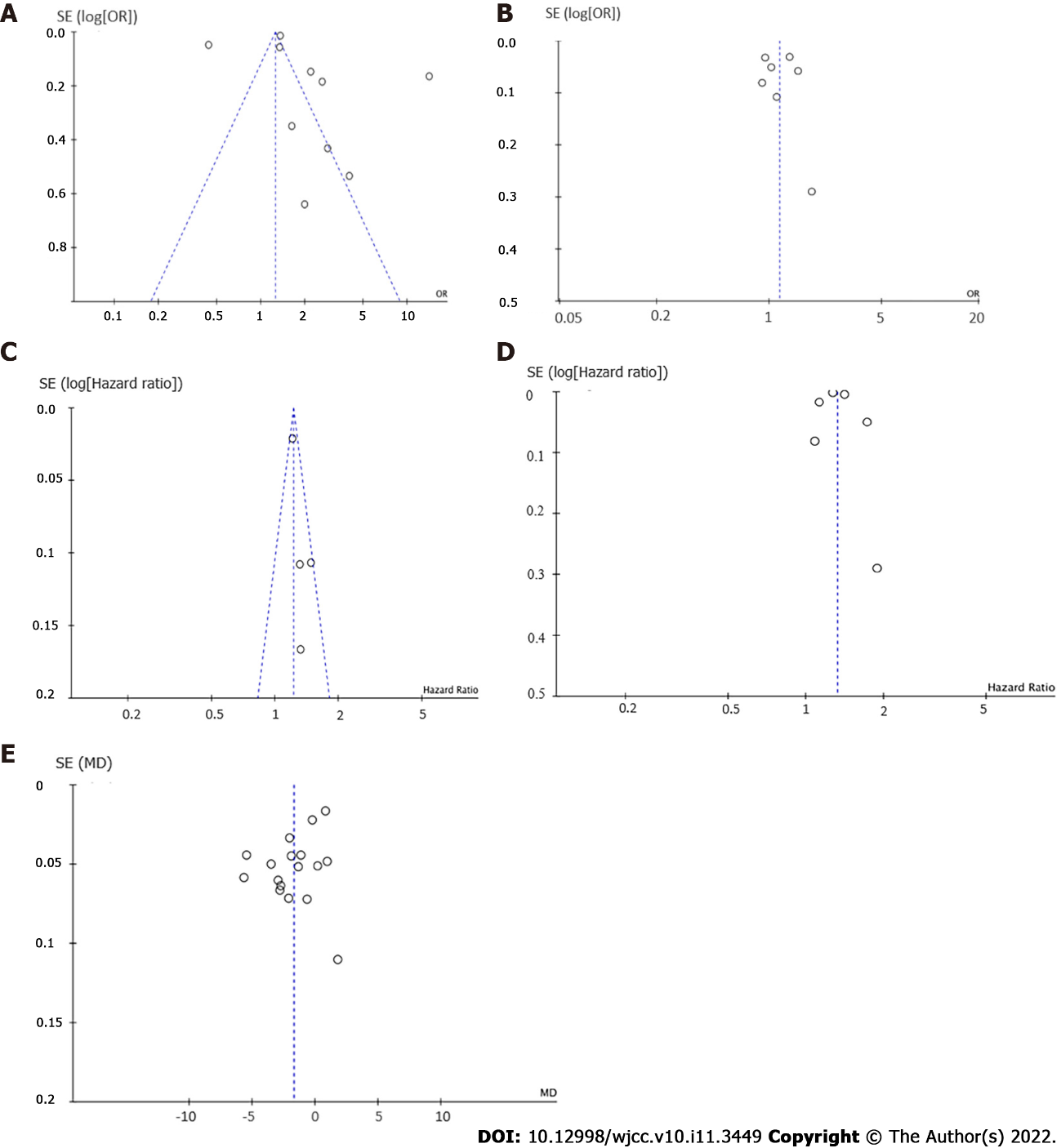
**Figure 2** **Forest plot examining the association of chronic obstructive pulmonary disease with mild cognitive impairment risk.** A: Odds ratios; B: Hazard ratios.



**Figure 3 Forest plot examining the association of chronic obstructive pulmonary disease with dementia risk.** A: Odds ratios; B: Hazard ratios.



**Figure 4** **Forest plot examining mini-mental state examination score differences between chronic obstructive pulmonary disease and control groups.**



**Figure 5 Funnel plot.** A: Mild cognitive impairment (MCI); B: Dementia; C: MCI risk in chronic obstructive pulmonary disease (COPD) patients; D: Dementia risk in COPD patients; E: Comparison of mini-mental state examination score between COPD and control groups.

**Table 1 Baseline and clinical characteristics of included studies**

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **No.** | **Ref.** | **Country or region** | **Study design** | **Groups investigated** | **Age** | **Diagnostic criteria** | **Assessment scales** | **Adjusted variables** | **MCI (%)** | **Dementia (%)** | **NOS quality score** |
| 1 | Mermit Çilingir *et al*[17], 2020 | Turkey | Case Control | COPD-E (*n* = 30); COPD-S (*n* = 54); Control (*n* = 37) | COPD-E-71.8 ± 12.3; COPD-S- 62 ± 10.2; Control-65.9 ± 12.8 | GOLD | MMSE; RCS | NA | NA | NA | 7 |
| 2 | Xie *et al*[18], 2019 | China | Prospective Cohort | COPD (*n* = 515); No COPD (*n* = 4220) | COPD-82.9 ± 9.7 | GOLD | MMSE | Age, gender, marital status, education level, alcohol drinking, current exercise, BMI, baseline prevalence of HTN, DM, and stroke | 18.8; 14.6 | 2.9; 1.6 | 8 |
| 3 | Samareh Fekri *et al*[19], 2017 | Iran | Case Control | COPD (*n* = 87); Control (*n* = 60) | COPD-60.4 ± 9.8; Control-58.1 ± 9.8 | GOLD | MMSE | Age and sex | 51.7; 36.6 | NA | 7 |
| 4 | Gupta *et al*[20], 2013 | India | Case Control | COPD-(*n* = 40); Control (*n* = 40) | COPD-57.2 ± 9.1; Control-56.9 ± 9.2 | GOLD | MMSE | Age | NA | NA | 5 |
| 5 | Li *et al*[21], 2013 | China | Case Control | Mild COPD-(*n* = 27); Severe COPD-(*n* = 35); Control (*n* = 27) | Mild COPD-70.4 ± 7.7; Severe COPD-68.2 ± 7.8; Control-66.2 ± 7.1 | GOLD | MMSE | Age, sex, education level, BMI, smoking status, and CVD | NA | NA | 6 |
| 6 | Li *et al*[22], 2013 | China | Case Control | Mild COPD-(*n* = 37); Severe COPD-(*n* = 48); Control (*n* = 37) | Mild COPD-69.2 ± 8.1; Severe COPD-67.6 ± 7.6; Control-66.5 ± 6.9 | GOLD | MMSE | Age, sex, education level, BMI, smoking status, and CVD | NA | NA | 8 |
| 7 | Liao *et al*[23], 2015 | Taiwan | Retrospective Cohort | COPD (*n* = 20492); No COPD (*n* = 40765) | COPD-68.2 ± 12.4; No COPD-67 ± 12.5 | ICD-9CM | NA | Age and sex | NA | 13.2  9.11 | **7** |
| 8 | Martinez *et al*[24], 2014 | Michigan | Cross-sectional | COPD (*n* = 1812); No COPD (*n* = 15723) | COPD-70.3 ± 9.0; No COPD-68.7 ± 9.9 | GOLD | ADL | Baseline cognition | 16.5; 12.4 | 3.9; 3.1 | 8 |
| 9 | Dal Negro *et al*[25], 2015 | Italy | Cross-sectional | COPD with LTOT (*n* = 73); COPD without LTOT (*n* = 73) | COPD with LTOT-70.9 ± 8.9; No COPD with LTOT-71.2 ± 9.1 | GOLD | MMSE  MRC; CAT | Age, gender, smoking history, BMI, dyspnoea score, ABG, and lung function | 32.8 | NA | 6 |
| 10 | Singh *et al*[26], 2013 | United States | Cross-sectional | COPD (*n* = 288); No COPD (*n* = 1639) | MCI-82.7 ± 11.2; Normal Cognition-79.7 ± 12.5 | Standard criteria | BDI; CDR | BDI-II Depression, history of stroke, APOEe4 genotype, DM, HTN, CAD, and BMI | 14.6; 27.1 | NA | 7 |
| 11 | Singh *et al*[3], 2014 | United States | Cross-sectional | Total COPD (*n* = 1425); COPD (*n* = 171); No COPD (*n* = 1254) | COPD-80.8 ± 7.5; No COPD-79.1 ± 7.5 | Standard criteria | BDI | BDI-II depression, history of stroke, APOEe4 genotype, smoking, DM, HTN, CAD, z-scores, and BMI | NA | NA | 7 |
| 12 | Lutsey *et al*[27], 2019 | United States | Prospective Cohort | COPD (*n* = 2490); No COPD (*n* = 6108) | COPD-55.1 ± 5.8; No COPD-53.9 ± 5.7 | GOLD | NA | Age, sex, education level, race, center, cigarette smoking and pack-years of smoking, physical activity, BMI, systolic BP, BP medication use, diabetes, HDL, LDL lipid-lowering medications, CAD, heart failure, stroke, apolipoprotein E genotype, and fibrinogen | NA | NA | 6 |
| 13 | Siraj *et al*[28], 2020 | United Kingdom | Case Control | COPD (*n* = 64397); No COPD (*n* = 243420) | COPD-66.4 ± 10.9; No COPD-65.7 ± 11 | Standard criteria | NA | Age, sex, GP, BMI, smoking status, modified CCI, CV disease, corticosteroid use, and socioeconomic class | NA | NA | 7 |
| 14 | Villeneuve *et al*[29], 2012 | Canada | Case Control | Total COPD (*n* = 45); Control (*n* = 50) | COPD-68.4 ± 8.7; Control-67.4 ± 8.7 | GOLD | MMSE; MoCA | Age and education | 36.0; 12.0 | NA | 5 |
| 15 | Yeh *et al*[30], 2018 | Taiwan | Prospective Cohort | COPD (*n* = 10260); No COPD (*n* = 20513) | COPD-65.6 ± 11.8; No COPD-65.5 ± 11.9 | GOLD | NA | Age, sex, each comorbidity, inhaled corticosteroid, and oral steroids | NA | 11.1; 8.81 | 4 |
| 16 | Ozge *et al*[31], 2006 | Turkey | Prospective cohort | COPD (*n* = 54); Control (*n* = 24) | COPD-64.6 ± 8.5; Control-62.4 ± 8.4 | GOLD | MMSE,BDS, CDR, IADL | Age and sex | NA | NA | 6 |
| 17 | Favalli *et al*[32], 2008 | Turkey | Cross-sectional | COPD (*n* = 21); Control (*n* = 20) | COPD-74.6 ± 5.4; Control-73.7 ± 4.5 | GOLD | MMSE; GDS | NA | NA | NA | 5 |
| 18 | Liao *et al*[10], 2015 | Taiwan | Retrospective Cohort | COPD (*n* = 8640); No COPD (*n* = 17280) | COPD-68.7 ± 10.7; No COPD-68.7 ± 10.7 | ICD-9CM | Self-administered questionnaire | Age and sex | NA | 5.22; 7.06 | 6 |
| 19 | Thakur *et al*[33], 2010 | United States | Retrospective Cohort | COPD (*n* = 1202); Control (*n* = 302) | COPD-58.2 ± 6.2; Control-58.5 ± 6.2 | ICD-9CM | MRC; BODE index; MMSE | Age, sex, race, educational attainment, and smoking history | 5.5; 2.0 | NA | 7 |
| 20 | Zhou *et al*[34], 2012 | China | Case Control | COPD (*n* = 110); Control (*n* = 110) | COPD-80.9 ± 1.7; Control-80.8 ± 1.5 | GOLD | CDR; MMSE | Age and education | NA | NA | 6 |
| 21 | Dodd *et al*[4], 2013 | United Kingdom | Cross-sectional | COPD-E (*n* = 30); COPD-S (*n* = 50); Control (*n* = 30) | COPD-E-70 ± 11; COPD-S-69 ± 8; Control-65 ± 8 | GOLD | MMSE | Age | NA | NA | 7 |
| 22 | Isoaho *et al*[35], 1996 | Finland | Case Control | COPD (*n* = 81); Control (*n* = 245) | COPD-70.4 ± 4.8; Control-71.3 ± 5.9 | GOLD | MMSE | Age and sex | 17.0; 13.0 | 7.1; 3.2 | 6 |
| 23 | Lima *et al*[36], 2007 | Brazil | Cross-sectional | COPD (*n* = 30); Control (*n* = 34) | COPD-65 ± 8; Control-66 ± 8 | GOLD | MMSE; DSM-IV | NA | NA | NA | 5 |
| 24 | Ozyemisci-Taskiran *et al*[37], 2015 | Turkey | Cross-sectional | COPD-E (*n* = 133); COPD-S (*n* = 34); Control (*n* = 34) | COPD-E-69.3 ± 8.9; COPD-S-67.5 ± 8.9; Control-68.3 ± 8.8 | GOLD | MMSE; HAD; BODE | Age and sex | 22.6 | NA | 6 |
| 25 | Salik *et al*[38], 2007 | Turkey | Cross-sectional | COPD (*n* = 32); Control (*n* = 26) | COPD-66.7 ± 2.5; Control-65.7 ± 7.3 | GOLD | MMSE; MCS | NA | NA | NA | 5 |
| 26 | Sarınç Ulaşlı *et al*[39], 2013 | Turkey | Case Control | COPD (*n* = 112); Control (*n* = 44) | COPD-65 ± 7.6; Control-64 ± 9 | GOLD | MMSE | Age and sex | NA | NA | 5 |
| 27 | Tomruk *et al*[40], 2015 | Turkey | Cross-sectional | COPD (*n* = 35); Control (*n* = 36) | COPD-62.9 ± 6.3; Control-60.8 ± 6.2 | GOLD | MMSE | Age | NA | NA | 4 |

COPD: Chronic obstructive pulmonary disease; S: Stable; E: Exacerbation; GOLD: Global Initiative for Chronic Obstructive Lung Disease; CAT: COPD Assessment Test; MMSE: Mini-Mental State Examination; COPD: Chronic obstructive pulmonary disease; LTOT: Long-term oxygen treatment; HAD: Hospital Anxiety and Depression; BODE: (B) BMI, (O) the severity of airflow obstruction (FEV1), (D) severity of dyspnea (modified Medical Research Council Dyspnea Scale), (E) exercise capacity; ICD-9CM: International Classification of Diseases, Ninth Revision, Clinical Modification; BDI: Beck Depression Inventory; IADL: Instrumental activities of daily living scale; CDR: Clinical dementia rating; BMI: Body mass index; CVD: Cardiovascular Disease; GP: General practice; DM: Diabetes mellitus; ABG: Arterial blood gas; HTN: Hypertension; CAD: Coronary artery disease; HDL: High Density lipoprotein; LDL: Low density lipoprotein; NA: Not applied.



Published by **Baishideng Publishing Group Inc**

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