**SUPPLEMENTARY MATERIAL**

*Supplementary Table 1. Main Search Strategy (performed on 5/2/21).*

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| **PUBMED** |  | Late-onset OR LOP OR VLOSLP OR very late-onset  |
|  | AND | Epidemiol\* OR case control OR cohort studies OR cohort analy\* OR follow up stud\* OR longitudinal OR retrospective OR prospective OR cross sectional |
|  | AND | Psychos\* OR Psychotic OR schizoaffective OR schizophreniform OR delusion\* OR hallucinat\* OR affective psychos\* OR schizophrenia-like psycho\* OR paranoi\* OR bipolar affective psycho\* OR bipolar psycho\* OR psychotic depression OR depressive psycho\* OR manic depressive psychos\* OR severe depression with psycho\* OR paraphrenia |
|  | AND | Dementia\* OR Alzheimer\* OR cognitive impair\* OR cognitive dysfunction OR cognitive decline OR cognition disorder\* OR frontotemporal lobar degeneration |
|  | Qualifier | Middle Aged: 45–64 years OR Aged: 65+ years |
| **PsycINFO** |  | “Late-onset” OR LOP or VLOSLP OR “very late-onset” |
|  | AND | Epidemiol\* OR “case control” OR “cohort studies” OR “cohort analy\*” OR “follow up stud\*” OR longitudinal OR retrospective OR prospective OR “cross sectional” |
|  | AND | Psychos\* OR Psychotic OR schizoaffective OR schizophreniform OR delusion\* OR hallucinat\* OR “affective psychos\*” OR “schizophrenia-like psycho\*” OR paranoi\* OR “bipolar affective psycho\*” OR “bipolar psycho\*” OR “psychotic depression” OR “depressive psycho\*” OR “manic depressive psychos\*” OR “severe depression with psycho\*” OR paraphrenia |
|  | AND | Dementia\* OR Alzheimer\* OR “cognitive impair\*” OR “cognitive dysfunction” OR “cognitive decline” OR “cognition disorder\*” OR “frontotemporal lobar degeneration” |
|  | Qualifier | Full text, Peer reviewed, subject: aged |
| **Web of Science**  | 1 | TS=(Late-onset OR LOP or VLOSLP OR very late-onset) |
|  | 2 | TS=(Epidemiol\* OR “case control” OR “cohort studies” OR “cohort analy\*” OR “follow up stud\*” OR longitudinal OR retrospective OR prospective OR “cross sectional”) |
|  | 3 | TS=(Psychos\* OR Psychotic OR schizoaffective OR schizophreniform OR delusion\* OR hallucinat\* OR “affective psychos\*” OR “schizophrenia-like psycho\*” OR paranoi\* OR “bipolar affective psycho\*” OR “bipolar psycho\*” OR “psychotic depression” OR “depressive psycho\*” OR “manic depressive psychos\*” OR “severe depression with psycho\*” OR paraphrenia) |
|  | 4 | TS=(Dementia\* OR Alzheimer\* OR “cognitive impair\*” OR “cognitive dysfunction” OR “cognitive decline” OR “cognition disorder\*” OR “frontotemporal lobar degeneration”) |
|  |  | (1 AND 2 AND 3 AND 4) |

*Supplementary Table 2. Quality Assessment using GRADE Criteria.*

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|  | Outcome | Baseline Rating  | Assessment Criteria | Quality of Evidence | Inclusion in review  |
| Risk of bias | Inconsistency | Indirectness | Imprecision | Publication Bias | Others  |
| **Cross-Sectional Studies** |
| Bentall, R. P., et al. (2009).  | Executive Function | ++ | 0 | 0 | 0 | – | 0 | 0 | + (Very Low) | Yes |
| Reasoning | ++ | 0 | 0 | 0 | 0 | 0 | 0 | ++ (Low) | Yes |
| Language | ++ | 0 | 0 | 0 | 0 | 0 | 0 | ++ (Low) | Yes |
| Hanssen, M., et al. (2015).  | Memory and Recall | ++ | – | 0 | 0 | 0 | 0 | 0 | + (Very Low) | Yes |
| Orientation | ++ | – | 0 | 0 | 0 | 0 | 0 | + (Very Low) | Yes |
| Language | ++ | – | 0 | 0 | 0 | 0 | 0 | + (Very Low) | Yes |
| Attention | ++ | – | 0 | 0 | 0 | 0 | 0 | + (Very Low) | Yes |
| Perception | ++ | – | 0 | 0 | 0 | 0 | 0 | + (Very Low) | Yes |
| Executive Function | ++ | – | 0 | 0 | 0 | 0 | 0 | + (Very Low) | Yes |
| Henderson, A. S., et al. (1998). | Memory and Recall | ++ | – | 0 | 0 | – | 0 | 0 | + (Very Low) | Yes |
| Orientation | ++ | – | 0 | 0 | – | 0 | 0 | + (Very Low) | Yes |
| Language | ++ | – | 0 | 0 | – | 0 | 0 | + (Very Low) | Yes |
| Registration | ++ | – | 0 | 0 | 0 | 0 | 0 | + (Very Low) | Yes |
| Attention | ++ | – | 0 | 0 | 0 | 0 | 0 | + (Very Low) | Yes |
| Moore, R., et al. (2006).  | Memory and Recall | ++ | 0 | 0 | 0 | 0 | 0 | 0 | ++ (Low) | Yes |
| Language | ++ | 0 | 0 | 0 | 0 | 0 | 0 | ++ (Low) | Yes |
| Perception | ++ | 0 | 0 | 0 | 0 | 0 | 0 | ++ (Low) | Yes |
| Naguib, M. and R. Levy (1987). | Memory and Recall | ++ | 0 | 0 | 0 | – | 0 | 0 | + (Very Low) | Yes |
| Orientation | ++ | 0 | 0 | 0 | – | 0 | 0 | + (Very Low) | Yes |
| Visuospatial ability | ++ | 0 | 0 | 0 | – | 0 | 0 | + (Very Low) | Yes |
| Psychomotor function | ++ | 0 | 0 | 0 | – | 0 | 0 | + (Very Low) | Yes |
| Rodriguez-Ferrera, S., et al. (2004). | Memory and Recall | ++ | – | 0 | 0 | 0 | 0 | 0 | + (Very Low) | Yes |
| Orientation | ++ | – | 0 | 0 | 0 | 0 | 0 | + (Very Low) | Yes |
| Registration | ++ | – | 0 | 0 | 0 | 0 | 0 | + (Very Low) | Yes |
| Attention | ++ | – | 0 | 0 | 0 | 0 | 0 | + (Very Low) | Yes |
| Language | ++ | – | 0 | 0 | 0 | 0 | 0 | + (Very Low) | Yes |
| Psychomotor function | ++ | – | 0 | 0 | 0 | 0 | 0 | + (Very Low) | Yes |
| Van Assche, L., et al. (2019). | Memory and Recall | ++ | 0 | – | 0 | 0 | 0 | 0 | + (Very Low) | Yes |
| Language | ++ | 0 | – | 0 | 0 | 0 | 0 | + (Very Low) | Yes |
| Registration | ++ | 0 | – | 0 | 0 | 0 | 0 | + (Very Low) | Yes |
| Attention | ++ | 0 | – | 0 | 0 | 0 | 0 | + (Very Low) | Yes |
| Executive Function | ++ | 0 | – | 0 | 0 | 0 | 0 | + (Very Low) | Yes |
| Perception | ++ | 0 | – | 0 | 0 | 0 | 0 | + (Very Low) | Yes |
| Visuospatial ability | ++ | 0 | – | 0 | 0 | 0 | 0 | + (Very Low) | Yes |
| **Longitudinal Studies** |
| Almeida, O. P., et al. (2019). | Rate of dementia diagnosis | ++ | 0 | 0 | – | 0 | 0 | 0 | + (Very Low)  | Yes |
| Holden, N. L. (1987).  | Rate of dementia diagnosis | ++ | 0 | 0 | 0 | 0 | 0 | 0 | ++ (Low) | Yes |
| Howard, R., et al. (1995).  | Memory and Recall | ++ | 0 | 0 | 0 | 0 | 0 | 0 | ++ (Low) | Yes |
| Orientation | ++ | 0 | 0 | 0 | 0 | 0 | 0 | ++ (Low) | Yes |
| Language | ++ | 0 | 0 | 0 | 0 | 0 | 0 | ++ (Low) | Yes |
| Registration | ++ | 0 | 0 | 0 | 0 | 0 | 0 | ++ (Low) | Yes |
| Attention | ++ | 0 | 0 | 0 | 0 | 0 | 0 | ++ (Low) | Yes |
| Executive Function | ++ | 0 | 0 | 0 | 0 | 0 | 0 | ++ (Low) | Yes |
| Hymas, N., et al. (1989).  | Memory and Recall | ++ | 0 | 0 | 0 | – | 0 | 0 | + (Very Low) | Yes |
| Orientation | ++ | 0 | 0 | 0 | – | 0 | 0 | + (Very Low) | Yes |
| Psychomotor function | ++ | 0 | 0 | 0 | – | 0 | 0 | + (Very Low) | Yes |
| Kodesh, A., et al. (2020) | Rate of dementia diagnosis | ++ | 0 | 0 | 0 | 0 | 0 | + (Large magnitude of effect) | +++ (Moderate) | Yes |
| Kørner, A., et al. (2008).  | Rate of dementia diagnosis | ++ | 0 | 0 | 0 | 0 | 0 | + (Large magnitude of effect),+ (Plausible confounding would reduce effect) | ++++ (High) | Yes |
| Kørner, A., et al. (2009).  | Rate of dementia diagnosis | ++ | 0 | 0 | 0 | 0 | 0 | 0 | ++ (Low) | Yes |
| Mazeh, D., et al. (2005).  | Decline in cognitive function | ++ | 0 | 0 | 0 | – | 0 | 0 | + (Very Low) | Yes |
| Ostling, S., et al. (2007).  | Rate of dementia diagnosis | ++ | – | 0 | 0 | 0 | 0 | 0 | + (Very Low) | Yes |
| Talaslahti, T., et al. (2015).  | Mortality from dementia | ++ | 0 | 0 | – | 0 | 0 | 0 | + (Very Low) | Yes |

Note. “+” under “Baseline Rating” and “Quality of Evidence” denotes a quality rating of Very Low, “++” of Low, “+++” of Moderate, and “++++” of High. A baseline rating of Low was applied to all outcomes derived from observational studies in accordance with guidelines for using the GRADE system of quality rating (Ryan and Hill, 2016). Studies were then evaluated according to assessment criteria, upgraded or downgraded accordingly. “0” denotes no change to rating, “–” denotes a downgrade, and “+” denotes an upgrade. Final quality rating is reflected under the “Quality of Evidence” column.

*Supplementary Table 3. Summary of Results of Cross-Sectional Studies.*

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| **Cross-Sectional Studies** |
| Study | Participants | Age (years) | Outcome Measures | Findings |
| Bentall, R. P., et al. (2009). | (Inpatients and outpatients)VLOSLP (n = 27) andVLODD (n = 2)Healthy aged controls (n = 31) | During study 76.90 (SD±5.99)At disease onsetM: 72.38SD: 6.87During studyM: 75.6SD: 5.54 | WASI, DS Bw, BiaJ, ToMD | VLOSLP/VLODD patients scored significantly lower on a multidimensional model of cognitive performance analysed using the WASI IQ, DS Bw, BiaJ and ToMD tests compared to healthy aged controls. WASI IQVLOSLP/VLODD: 93.10 (14.13)Controls: 104.97 (16.21)WASI VerbalVLOSLP/VLODD: 45.21 (10.86)Controls: 53.29 (9.85)WASI Matrix Reasoning VLOSLP/VLODD: 45.76 (10.60)Controls: 51.90 (11.89)Backwards digit spanVLOSLP/VLODD: 5.14 (2.41)Controls: 7.26 (2.46)BiaJVLOSLP/VLODD: 3.73 (±4.13)Controls: 4.88 (±4.44)BiaJ social taskVLOSLP/VLODD: 3.52 (4.46)Controls: 4.62 (5.24)ToMD (first-order)VLOSLP/VLODD: 79.76 (29.17)Controls: 96.77 (10.02)ToMD (second-order)VLOSLP/VLODD: 28.57 (29.70)Controls: 55.91 (34.84) |
| Hanssen, M., et al. (2015). | (Inpatients and outpatients)VLOSLP (n = 28)Healthy controls (n = 290)LOP (n = 24)EOP (n = 24) | During studyM:75.68Range: 72.56–78.80At onsetM: 72.39 SD: 7.72During studyM:37.55Range: 35.50–39.59During studyM:58.13Range: 53.02–63.23At onsetM: 49.13 SD: 5.54During study M:27.3 Range: 26.47–28.24At onset M: 22.19 SD: 6.49 | CAMCOG, GWLT, CPT, RST, abbreviated WAIS-III, RSPM  | Patients with VLOSLP performed marginally better on the CAMCOG (when adjusted) and RST compared to LOS patients. There were no significant differences in performance between VLOP, LOP and EOP on the WAIS/Raven IQ, GWLT, or CPT reaction time. VLOP patients had impaired CPT accuracy scores compared to LOP and EOP patients.CAMCOGVLOP: 1.88 (0.24)LOP: 1.75 (0.33)p = 0.020 (when adjusted for sex, education level, negative symptoms and remission state)RSTVLOP: 0.44 (1.28)LOP: –0.36 (1.3)EOP: –0.20 (1.32)CPT-AccuracyVLOP: 0.16 (1.51)LOP: 0.6 (0.89)VLOP < LOP, p = 0.047EOP: 0.4 (0.84)WAIS/Raven IQVLOP: –1.18 (1.58)LOP: –1.18 (1.5)EOP: –0.93 (1.12)GWLT-Immediate RecallVLOP: –0.72 (1.11)LOP: –0.81 (1.5)EOP: –1.02 (1.24)GWLT-Delayed RecallVLOP: –0.53 (1.17)LOP: –0.74 (1.06)EOP: –0.85 (1.17)CPT-Reaction TimeVLOP: 1.43 (0.22)LOP: 1.48 (0.24)EOP: 1.45 (0.24)  |
| Henderson, A. S., et al. (1998).   | (Nursing homes)VLOSLP (n = 40)Healthy aged controls (n = 771) | During studyM: 78.9SD: 6.5During studyM: 76.7SD: 5.1 | MMSE, SLMT, EMT, NART | MMSE, EMT and NART scores were not significantly different in psychotic and non-psychotic elderly. SLMT scores were significantly higher in non-psychotic elderly.SLMT Psychotic: 91.1Non-psychotic: 99.8t=3.2, df=701, p=0.001 |
| Moore, R., et al. (2006).  | (Inpatients and outpatients)VLOSLP (n = 29)Healthy aged controls (n = 30) | During studyM:76.90SD: 5.99During studyM:75.73SD: 5.59 | WASI IQ, DS Bw, Mentalising task (Snowden et al., unpublished), BiaJ | VLOSLP patients performed significantly worse on the WASI IQ test, mentalising task (deception) and digit span backwards test. There was no significant difference in performance between VLOSLP patients and controls on mentalising task (false belief) and the Beads in a jar test.WASI IQVLOSLP: 93.10 (14.13)Controls: 104.00 (15.63)p = 0.01DS BwVLOSLP: 5.14 (2.42)Controls: 7.17 (2.45)p <0.01Mentalising task (first-order deception)VLOSLP: 79.76 (29.17)Controls: 96.67 (10.17)p < 0.01Mentalising task (second-order deception)VLOSLP: 28.57 (29.70)Controls: 55.56 (35.75)p < 0.01Mentalising task (first-order false belief)VLOSLP: 85.06 (21.06)Controls: 95.56 (14.47)Mentalising task (second-order false belief)VLOSLP: 68.97 (30.77)Controls: 92.22 (14.34)BiaJVLOSLP: 3.73 (4.13)Controls: 4.90 (4.52) |
| Naguib, M. and R. Levy (1987).  | (Inpatients and outpatients)Late Paraphrenia (n = 43)Healthy aged controls (n = 40) | During studyM:75.27SD: 6.29During studyM:75.85SD: 8.64 | MTS, DCT, DSST | Patients with paraphrenia performed worse on the MTS and DCT compared to controls. There was no significant difference in performance on the DSST.MTSParaphrenia: 28.48 (4.03)Controls: 31.72 (3.08)p < 0.001DCTParaphrenia: 59.62 (32.96)Controls: 93.59 (30.86)p < 0.002DSSTParaphrenia: 9.93 (7.03)Controls: 11.52 (3.22) |
| Rodriguez-Ferrera, S., et al. (2004).  | (Inpatients and outpatients)VLOP (n =26)EOP (n = 46) | During studyM: 72SD: 7.16During studyM: 36SD: 11.3 | MMSE, TDRS | VLOP patients had significantly lower TDRS scores compared to AOP patients. No significant difference in MMSE performance was found between VLOP and AOP patients. TDRSVLOP: 35.12 (23% scored above 34, p = 0.003)AOP: 37.82 (61% scored above 34)p = 0.003MMSEVLOP: 26.52 AOP: 27.02 |
| Van Assche, L., et al. (2019) | (Inpatients and outpatients)VLOSLP (n = 57)(77.2% F, 22.8% M)DLB (n = 49)(32.7% F, 67.3% M)AD+P (n = 35)(62.9% F, 37.1% M) | During studyM: 79.25SD: 7.484During studyM: 76.20SD: 6.955During studyM: 78.80SD: 6.286 | MMSE, Stroop, DS Fw, DS Bw, RAVLT, BNT, Letter VF, AVF, VOSP, COTESS | VLOSLP patients had significantly higher scores on the RAVLT tasks compared to the DLB and AD+P groups, and the COTESS tasks compared to the DLB group.No significant difference in performance on the Stroop, DS Fw and Bw, BNT, AVF and VOSP was found between VLOSLP, DLB and AD+P patients. RAVLT Trial 1VLOSLP (n = 54): 3.94 (2.023)DLB (n = 46): 2.65 (1.609)AD+P (n = 35): 2.34 (1.259)VLOSLP > DLB *t*(87) = 4.598, *P* 0.002VLOSLP > AD+P *t*(98) = 3.549, *P* <0.001RAVLT sum of Trial 1–5VLOSLP (n = 54): 31.09 (11.653)DLB (n = 46): 23.72 (8.007)AD+P (n = 35): 19.06 (7.182)VLOSLP > DLB *t*(98) = 3.728, *P* 0.001VLOSLP > AD+P *t*(87) = 6.024, *P* <0.001DLB > AD+P *t*(79) = 2.752, *P* 0.020RAVLT delayed recallVLOSLP (n = 54): 5.28 (3.858)DLB (n = 46): 3.39 (2.832)AD+P (n = 35): 1.49 (2.035)VLOSLP > DLB t(98) = 2.817, P 0.016VLOSLP > AD+P t(87) = 6.038, P <0.001DLB > AD+P t(79) = 3.512, P 0.002RAVLT retention/trial 5VLOSLP (n = 54): 0.62 (0.344)DLB (n = 46): 0.51 (0.380)AD+P (n = 35): 0.27 (0.311)VLOSLP > AD+P t(87) = 5.028, P <0.001DLB > AD+P t(79) = 3.118, P 0.007RAVLT recognition (items correctly recognised/false identification)VLOSLP (n = 54): 9.11 (4.777)DLB (n = 46): 9.54 (3.067)AD+P (n = 35): 5.11 (5.593)VLOSLP > AD+Pt(87) = 3.486, P <0.001DLB > AD+Pt(79) = 4.227, P <0.001House (COTESS)VLOSLP (n = 45): 3.89 (1.541)DLB (n = 12): 2.50 (1.977)AD+P (n = 13): 2.77 (1.922)VLOSLP > DLB *t*(55) = 2.259, *P* 0.030House copy (COTESS)VLOSLP (n = 45): 4.80 (1.392)DLB (n = 14): 2.43 (1.910)AD+P (n = 13): 4.15 (0.987)VLOSLP > DLB t(57) = 4.301, P 0.001AD+P > DLB t(25) = 2.969, P 0.020Stroop IVLOSLP (n = 48): 85.29 (54.457)DLB (n = 34): 74.79 (29.432)AD+P (n = 27): 67.15 (18.106)Stroop IFVLOSLP (n = 46): 121.370 (72.933)DLB (n = 29): 178.69 (157.328)AD+P (n = 25): 142.720 (107.523)DS FwVLOSLP (n = 55): 4.69 (0.998)DLB (n = 46): 4.74 (0.976)AD+P (n = 33): 4.64 (0.859)DS BwVLOSLP (n = 55): 3.25 (0.966)DLB (n = 46): 3.17 (0.709)AD+P (n = 33): 3.30 (0.810)BNTVLOSLP (n = 53): 43.60 (9.153)DLB (n = 45): 40.80 (10.683)AD+P (n = 33): 38.58 (8.675)AVFVLOSLP (n = 56): 13.62 (4.363)DLB (n = 48): 11.73 (3.774)AD+P (n = 35): 11.54 (3.202)Letter VFVLOSLP (n = 55): 17.29 (10.168)DLB (n = 48): 17.60 (8.274)AD+P (n = 35): 16.51 (7.126)Object decision (VOSP)VLOSLP (n = 45): 14.58 (3.121)DLB (n = 21): 12.82 (3.924)AD+P (n = 16): 14.56 (3.203)Number location (VOSP)VLOSLP (n = 45): 8.36 (2.278)DLB (n = 21): 7.29 (2.704)AD+P (n = 16): 7.56 (2.683)Cube analysis (VOSP)VLOSLP (n = 45): 8.04 (2.067)DLB (n = 20): 6.65 (7.50)AD+P (n = 16): 7.50 (2.556) |

*Note. VLODD, Very Late-Onset Delusional Disorder; WASI, Wechsler Abbreviated Scale of Intelligence; DS Bw, Digit Span Backward; BiaJ, Beads in a Jar; ToMD, Theory of Mind Deception; CAMCOG, Cambridge Cognitive assessment battery; GWLT, Groningen Word Learning Test; CPT, Continuous Performance Test; RST, Response Shifting Task; WAIS-R, Wechsler Adult Intelligence Scale-Revised; LOP, Late-Onset Psychosis; EOP, Early-Onset Psychosis; RSPM, (Raven Standard) Progressive Matrices; MMSE, Mini Mental State Examination; SLMT, Symbol Letter Modalities Test; EMT, Episodic Memory Test; NART, National Adult Reading Test; MTS, Mental Test Score; DCT, Digit Copying Test; DSST, Digit Symbol Substitution Test; VLOP, Very Late-Onset Psychosis; TDRS, Tardive Dyskinesia Rating Scale; Stroop I, Stroop Colour Word Interference Task Card I; Stroop IF, Stroop Colour Word Interference Task Interference Factor; DS Fw, Digit Span Forward; DLB, Dementia with Lewy-Bodies; AD+P, Alzheimer’s type Dementia with Psychosis; RAVLT, Rey Auditory Verbal Learning Test; BNT, Boston Naming Test; AVF, Animal Verbal Fluency; VOSP, Visual Object and Space Perception Battery; COTESS, Cognitieve Testbatterij voor Senioren (Cognitive Test for Seniors).*

*Supplementary Table 4. Summary of Results of Longitudinal Studies.*

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| **Longitudinal Studies** |
| Study | Participants | Duration of follow-up | Age | Outcome Measures | Findings |
| Almeida, O. P., et al. (2019)  | (Treatment context not stated)VLOSLP (sample size not reported) (men)Psychosis onset <65 years (sample size not reported) (men)Age-matched controls without psychosis at baseline(n = 37364) (men)  | 17.7 years | At baseline assessment65–85 | WADLSDementia from any cause, as coded by the International Classification of Diseases 9 & 10, was the primary outcome of interest. | At follow-up, VLOSLP patients were found to have a significantly higher rate of dementia compared to patients without a psychotic disorder at baseline.No significant difference was found between VLOSLP patients and age-matched EOS/LOS patients.Adjusted hazard ratioVLOSLP: 2.22 (1.74–2.84)Psychosis onset <65 years: 2.73 (2.34–3.18)Adjusted sub-hazard ratio (death used as competing risk)VLOSLP: 2.46 (1.89–3.19)Psychosis onset <65 years: 2.54 (2.14–3.00) |
| Holden, N. L. (1987).  | (Hospitalised at baseline assessment)VLOP (n = 37) | 10 years | Did not progress to dementiaM: 68.5Range: 60–79Progressed to dementiaM: 72.5Range: 60–82 | GWQ | At follow-up after 10 years, 13 (35%) cases were diagnosed as “organic psychosis” which progressed to dementia; 65% were not diagnosed with dementia. Patients who progressed to dementia had significantly lower GWQ scores at baseline assessment.  |
| Howard, R., et al. (1995).  | (Inpatients and outpatients)VLOSLP (n = 23)(20 F, 3 M) | 2 years | M: 79.91 | MMSE | At baseline assessment, all patients scored above 24 on the MMSE.At follow-up assessment, 3 of 23 (13%) patients scored below 24 on the MMSE. |
| Hymas, N., et al. (1989).  | (Inpatients and outpatients)Late Paraphrenia (n = 42)Healthy aged controls at baseline (n = 40)(31 F, 9 M)Healthy aged controls at follow-up(n = 23)(18 F, 5 M) | M: 3.7 yearsRange: 2.8–5.3 M: 3.7 yearsRange: 3.4–4.3  | Patients at baseline assessmentM: 75.27SD: 6.29Controls at baselineM: 75.9SD: 8.6Controls at follow-upM: 77.9SD: 9 | MTS | On both initial assessment and follow-up assessment, patients with paraphrenia performed significantly worse on the MTS than healthy controls. Patients with paraphrenia also showed a significantly greater decline in MTS scores, with 14 of 42 rated as “cognitively impaired” (33%) at follow-up.MTS–InitialParaphrenia (mean): 28.8 SD: 3.3Controls (mean): 32.4 SD: 2.2MTS–Follow-upParaphrenia (mean): 26.8 SD: 6.5Controls (mean): 30.8 SD: 5.1Change in MTSParaphrenia: Significant, p = 0.005Controls: Significant, p = 0.025 |
| Kodesh, A., et al. (2020) | (Treatment context not stated)VLOS (n = 329) (62.6% F, 37.4% M)Age-matched controls (n = 93791)(53.5% F, 46.5% M) | 4.8 years | At baselineM: 68.9SD: 7.1 | Meuhedet dementia registryDementia was defined based on the International Classification of Diseases 9 & 10. | VLOS patients had a significantly higher rate of developing dementia (n = 64, 19.52%) compared to non-VLOS patients (n = 5962, 6.4%), p < 0.001. |
| Kørner, A., et al. (2008).  | (Treatment context not stated)VLODD (n = 1437)(77.5% F)Controls: OA: 7302 (63.6% F) | Median: 1.87 yearsQuartiles: 0.69, 3.64Median: 4.40 yearsQuartiles: 2.28, 6.28 | At first dischargeMedian: 79.4Quartiles: 72.6, 85.8At first dischargeMedian: 71.3Quartiles: 65.8, 76.7 | DPCR, DNHR Dementia was defined as main diagnosis of AD/VaD/unspecified dementia based on the International Classification of Diseases 10. | A significantly higher proportion of patients with VLODD were later diagnosed with dementia (15.2%) compared to patients with OA (2.1%), p < 0.0001.VLODD patients had a higher relative risk (number) of developing dementia in the first 6 months after diagnosis compared to OA patients. Male VLODD patients had a higher relative risk than women. Relative riskWomen: 20.8 (10.27, 42.19)Men: 119.5 (16.08, 887.6) |
| Kørner, A., et al. (2009).  | (Treatment context not stated)VLOSLP(n = 409) (64.3% F)OA(n = 7303)(63.6% F) | Median: 3.00Quartiles: 1.25, 4.78Median: 4.41Quartiles:2.28, 6.29 | At first discharge Median: 71.19Quartiles: 64.88, 77.89At first dischargeMedian: 71.19Quartiles: 65.78, 76.74 | DPCR, DNHRDementia was defined as main diagnosis of AD/VaD/unspecified dementia based on the International Classification of Diseases 10. | VLOSLP patients had a significantly higher rate of being subsequently diagnosed with dementia (4.4%) compared to healthy controls (2.15%), p < 0.0001. The relative risk of developing dementia in VLOSLP compared to OA: 3.15 (1.93, 5.14) |
| Mazeh, D., et al. (2005).  | (Inpatients and outpatients)Primary caregivers of VLOSLP patients (n = 21)(Patients: 15 F, 6 M)(Inpatients) Primary caregivers of elderly EOS patients (n = 21)(Patients: 15 F, 6 M) | 6–30 months | >70 | Telephone interviews with primary carers | 13 of 16 living VLOSLP patients appeared cognitively intact at follow-up, 3 (18.8%) showed decline.16 of 19 living EOS patients appeared cognitively intact at follow up, 3 (15.8%) showed decline. |
| Ostling, S., et al. (2007).  | 15(Inpatients and outpatients)VLOSLP (n = 18)Age-matched controls(n = 349) | 1515 years | At baseline assessment 70At follow-up85 | DSM-III-R criteria | Among non-demented70-year-olds at baseline, 349 were free from previousor current psychotic symptoms or paranoid ideation aslong as they were non-demented during the entire20-year study period and 88 (25%) of those developeddementia. Among the 18 individuals who developedfirst-onset psychotic symptoms during the follow-up,8 (44%) developed dementia. A Cox regressionanalyse based on person-years at risk showed thatthe Hazard Ratio (HR) was 3.5 (95% CI 1.7–7.3,p¼0.00) for developing dementia after first-onsetpsychotic symptoms (Table 5). The risk of developingdementia among individual with first-onset ofpsychotic symptoms between ages 70–80 (HR 2.2,(95% CI 0.5–9.1) and ages 80–90 (HR 3.1, 95% CI0.4–22.9) was equal ly distributed. The mean intervalbetween first onset of psychotic symptoms anddevelopment of dementia was 5.0 year s (SD 4.7).Among non-demented70-year-olds at baseline, 349 were free from previousor current psychotic symptoms or paranoid ideation aslong as they were non-demented during the entire20-year study period and 88 (25%) of those developeddementia. Among the 18 individuals who developedfirst-onset psychotic symptoms during the follow-up,8 (44%) developed dementia. A Cox regressionanalyse based on person-years at risk showed thatthe Hazard Ratio (HR) was 3.5 (95% CI 1.7–7.3,p¼0.00) for developing dementia after first-onsetpsychotic symptoms (Table 5). The risk of developingdementia among individual with first-onset ofpsychotic symptoms between ages 70–80 (HR 2.2,(95% CI 0.5–9.1) and ages 80–90 (HR 3.1, 95% CI0.4–22.9) was equal ly distributed. The mean intervalbetween first onset of psychotic symptoms anddevelopment of dementia was 5.0 year s (SD 4.7).Among non-demented70-year-olds at baseline, 349 were free from previousor current psychotic symptoms or paranoid ideation aslong as they were non-demented during the entire20-year study period and 88 (25%) of those developeddementia. Among the 18 individuals who developedfirst-onset psychotic symptoms during the follow-up,8 (44%) developed dementia. A Cox regressionanalyse based on person-years at risk showed thatthe Hazard Ratio (HR) was 3.5 (95% CI 1.7–7.3,p¼0.00) for developing dementia after first-onsetpsychotic symptoms (Table 5). The risk of developingdementia among individual with first-onset ofpsychotic symptoms between ages 70–80 (HR 2.2,(95% CI 0.5–9.1) and ages 80–90 (HR 3.1, 95% CI0.4–22.9) was equal ly distributed. The mean intervalbetween first onset of psychotic symptoms anddevelopment of dementia was 5.0 year s (SD 4.7).5A significantly higher proportion of VLOSLP patients (44.4%) developed dementia compared to controls (25.2%), p < 0.01. |
| Talaslahti, T., et al. (2015).  | (Treatment context not stated)VLOSLP(n = 918)EOS/LOS(n = 6142) | 10 years | At baseline assessment >65 | FHDR, NCDRSF | SMR from dementia was found to be significantly higher in VLOSLP patients than in elderly patients with early or late-onset schizophrenia.SMR VLOSLP: 8.57 (6.69, 10.81)EOS/LOS: 3.03 (2.62–3.49)p < 0.001 |

*Note. WADLS, Western Australia Data Linkage System; VLOP, Very Late-Onset Psychosis; GWQ, Gresham Ward Questionnaire; VLOS, Very Late-Onset Schizophrenia; VLODD, Very Late-Onset Delusional Disorder; OA, Osteoarthritis; DPCR, Danish Psychiatric Central Register; DNHR, Danish National Hospital Register; AD, Alzheimer’s Disease; VaD, vascular dementia; FDHR, Finnish Hospital Discharge Register; NCDRSF, National Causes of Death Register of Statistics Finland; SMR, Standard Mortality Ratio*