

SYSTEMATIC REVIEW AND META-ANALYSIS

Intima Media Thickness and Cognitive Function Among Adults: Meta-Analysis of Observational and Longitudinal Studies

Celia Álvarez-Bueno , PhD; Iván Cavero-Redondo , PhD; Rosa Maria Bruno , MD, PhD; Alicia Saz-Lara , MSc; Irene Sequí-Dominguez , MSc; Blanca Notario-Pacheco , PhD; Vicente Martínez-Vizcaino , MD, PhD

BACKGROUND: Carotid structural changes measured by intima media thickness (IMT) have been related to cognitive complaints during aging. Therefore, the aims of this meta-analysis were (1) to elucidate the relationship between vascular status, measured as IMT, and cognitive domains distinguishing between global cognition, executive functions, memory and attention; and (2) to explore whether demographic (ie, age and sex), clinical (ie, body mass index and IMT baseline values), and procedure characteristics influence this association.

METHODS AND RESULTS: We performed a systematic review of MEDLINE (via PubMed), Scopus, and Web of Science databases from their inception to June 2021. Studies meeting the following inclusion criteria were included: (1) the participants were adults; (2) the exposure was carotid IMT; (3) the outcome was cognitive function, including global cognition, executive function, memory, and attention measured using standardized tests; and (4) the study design was cross-sectional or longitudinal including unadjusted and adjusted analyses. A total of 19 cross-sectional and 15 longitudinal studies were included and demographic (age and sex), clinical (body mass index and baseline IMT values), and procedure characteristics were analyzed as potential mediator or moderators of the association.

CONCLUSIONS: Our data support negative associations between IMT and cognitive function in cross-sectional studies. The association between IMT and cognition lost significance in longitudinal studies and when controlling for covariates in cross-sectional studies. Finally, the strength of these associations seems not to be modified by age, sex, body mass index, and baseline IMT values. This systematic review and meta-analysis adds to the evidence supporting the use of IMT as a measure for identifying patients at risk of cognitive decline.

Key Words: aging ■ carotid intima-media thickness ■ cognition ■ cognitive impairment

According to World Health Organization estimates, by the end of 2020, the number of people aged >60 years might outnumber children younger than 5 years and reach 22% of the global population by 2050.¹ As population life expectancy continues growing worldwide, health systems, social systems, and governments have to face the aging-related burden of chronic diseases.² Among the needs of elderly people are changes in several physical and mental

health domains (eg, somatic diseases, physical function aging, and psychological and cognitive changes). In particular, cognitive complaints are among the most common reasons for consultation with older patients and their primary caregivers and have been described as a predictor of cognitive decline.³

To date, cognitive decline lacks effective treatment, and the search for approaches to prevent or delay its progression and the onset of cognitive impairment has

Correspondence to: Iván Cavero-Redondo, PhD, Health and Social Research Center, Universidad de Castilla-La Mancha, Cuenca, Spain. E-mail: ivan.cavero@uclm.es

Supplemental Material is available at <https://www.ahajournals.org/doi/suppl/10.1161/JAHA.121.021760>

For Sources of Funding and Disclosures, see page 16.

© 2022 The Authors. Published on behalf of the American Heart Association, Inc., by Wiley. This is an open access article under the terms of the Creative Commons Attribution-NonCommercial-NoDerivs License, which permits use and distribution in any medium, provided the original work is properly cited, the use is non-commercial and no modifications or adaptations are made.

JAHA is available at: www.ahajournals.org/journal/jaha

CLINICAL PERSPECTIVE

What Is New?

- A cross-sectional negative association between intima media thickness (IMT) and global cognition, executive functions, and memory has been identified.
- This association is not supported for longitudinal studies and when controlling for covariates in cross-sectional studies.
- In addition, variables including age, sex, body mass index, and baseline IMT values do not seem to modify the strength of this association.

What Are the Clinical Implications?

- The results of this systematic review and meta-analysis do not support a strong association between IMT and longitudinal change in cognitive function.
- Although IMT could be used as a measure for identifying patients at risk of cognitive decline, future work is needed to address the association of IMT with the onset of cognitive impairment.

Nonstandard Abbreviations and Acronyms

ES	effect size
IMT	intima media thickness

become an important clinical target.^{4,5} The concept of cognitive decline as a vascular disease is being increasingly accepted,⁶ together with the evidence that the early detection and treatment of classical cardiovascular risk factors could reduce the impact of cognitive decline.⁷⁻⁹ In this framework, the monitoring of subclinical cardiovascular risk markers may have an important role in detecting individuals at risk to develop cognitive impairment⁹ and in tracking changes induced by treatments.¹⁰ A number of structural alterations that are an expression of vascular aging, reflecting the integrated burden of known and unknown cardiovascular risk factors on the vasculature, such as large artery stiffness¹¹⁻¹³ and carotid structural changes,^{14,15} have been associated with a steeper cognitive decline. Among subclinical cardiovascular risk markers, carotid structural changes have been specifically associated with chronic cerebral hypoperfusion, silent micro- and macrocerebrovascular disease, and cortical atrophy, silent cerebral small vessel lesions,¹⁶⁻¹⁸ which in turn are associated with reduced cognitive function.

The utility of the measurement of carotid structural changes by intima media thickness (IMT) has been debated; these subclinical biomarkers of vascular

aging are currently not recommended in international guidelines for risk stratification,¹⁹ though recent meta-analyses demonstrate that the extent of intervention effects on carotid IMT predicted the degree of cardiovascular diseases reduction, thus supporting the usefulness of IMT as surrogate biomarkers in interventional trials.²⁰ Furthermore, a relationship between IMT and cognitive performance has been demonstrated in many cross-sectional and longitudinal studies.²¹⁻²³ Discrepancies among studies, including differences in the design and population characteristics and the measurement of a wide variety of cognitive domains, make the evidence of this relationship inconsistent. Furthermore, not every cognitive domain is equally affected during aging, because the brain does not age uniformly, and several factors could protect or damage specific cognitive functions.^{24,25}

Therefore, the aims of this meta-analysis were the following: (1) to elucidate the relationship between vascular status, measured as IMT, and cognitive domains distinguishing between global cognition, executive functions, memory, and attention; and (2) to explore whether demographic (ie, age and sex), clinical (ie, body mass index (BMI) and baseline IMT values), and procedure characteristics influence this association.

METHODS

This systematic review and meta-analysis was conducted following the Cochrane Collaboration Handbook²⁶ and was reported following the Preferred Reporting Items for Systematic Reviews and Meta-Analysis of Observational Studies in Epidemiology statement.²⁷ The protocol for this systematic review and meta-analysis was previously registered on PROSPERO. The methods used in the analysis, and materials used to conduct the research are available to other researchers upon request.

Data Sources and Searches

Studies on the association between carotid IMT and cognitive function in adults were searched on Medline (via PubMed), Web of Science, and Scopus from database inception to June 2021. The search strategy included the following terms: "endothelial function," "atherosclerosis," "IMT," "intima thickness," "intima media thickness," "carotid plaque," "cognition," "executive," "executive function," "cognitive control," "memory," "attention," "metacognition," "life skills," "goal setting," "problem solving," "self-regulation," "brain development," and "brain health". We completed the search by screening previous systematic reviews and meta-analyses in the field and checking the reference lists of the included studies.

Study Selection

This systematic review includes studies on the relationship between vascular status, measured by IMT, and cognitive function in adults. The inclusion criteria were as follows: (1) the participants were adults, (2) the exposure was carotid IMT, (3) the outcome was cognitive function, including global cognition, executive function, memory and attention, measured using standardized tests, and (4) the study design was cross-sectional or longitudinal including unadjusted and adjusted analyses.

Studies were excluded when they were (1) focused on children or adolescents, (2) focused on patients with dementia, or (3) written in languages other than English, French, Portuguese, or Spanish.

Data Extraction and Risk of Bias Assessment

The main characteristics of the included studies are summarized in Table 1 and Table S1, including information on (1) subject characteristics (sample size, percentage of women, mean age, BMI, systolic blood pressure, and diastolic blood pressure; (2) exposure (technique used to measure IMT); and (3) outcome information (test used to measure cognitive function and cognitive domain measured).

The Quality Assessment Tool for Observational Cohort and Cross-Sectional Studies was used to evaluate the risk of bias.⁵⁷ This tool evaluates 14 criteria for longitudinal studies. For cross-sectional designs, only 11 were applied. Each criterion could be scored as “yes” when the study achieves the criterion, “no” when the study does not achieve the criterion, and “not reported” when the studies do not clearly report the required information. Following this risk of bias tool, studies could be rated as good (ie, at least 11 criteria for longitudinal studies and 8 criteria for cross-sectional studies were met), fair (ie, from 6–10 criteria for longitudinal studies and 4–7 criteria for cross-sectional studies were met), or poor (ie, from 1–5 criteria for longitudinal studies and 1–3 criteria for cross-sectional studies were met).

The literature search (inter-rater agreement Kappa^{58,59} index 0.93 [95% CI, 0.99–0.95]), data extraction (inter-rater agreement Kappa index 0.89 [95% CI, 0.87–0.91]), and risk of bias assessment (inter-rater agreement Kappa index 0.92 [95% CI, 0.90–0.94]) were independently performed by 2 researchers (C.A.-B. and I.C.-R.), and disagreements were solved by consensus or involving a third researcher (V.M.V.).

Data Synthesis and Statistical Analysis

To perform the meta-analysis, 4 cognitive domains were considered: (1) global cognition, (2) executive

functions, (3) memory, and (4) attention. Separate analyses were conducted for unadjusted and adjusted estimations of cross-sectional and longitudinal associations. For cross-sectional associations, effect sizes (ESs) and 95% CIs were calculated for each observed correlation and regression coefficient using Cohen's *d* index. A pooled ES was estimated for each cognitive domain using a random-effects model based on the Der Simonian and Laird method.⁶⁰ Random effects models were used as they provide more conservative results than fixed effects models and assume that each sample comes from a different population and that the effects in these populations may also differ.^{61,62} The ES was interpreted following Cohen's suggestions; *d*=0.2 was considered a “small” ES, 0.5 represented a “medium” ES, and 0.8 a “large” ES. The Cochran's *Q* statistics were used to estimate the between-study heterogeneity in ES.⁶³ The proportion of the total variation across studies because of heterogeneity was assessed using the *I*² statistic, whose values were not important (0% to <30%), moderate (≥30% to <50%), substantial (≥50% to <75%), or considerable (≥75% to 100%).⁶³ Moreover, the corresponding *P* values were also considered.⁵⁸ Following similar procedures, we estimated the pooled ES for the longitudinal associations between the baseline IMT and the pre–post change in the cognitive domains. The *Z* scores and corresponding *P* values against the hypothesis that IMT has no effect on cognitive function were also reported.

The following methodological considerations for data collection and analysis should be noted. When longitudinal studies reported baseline associations between IMT and cognitive function, these reports were included in the cross-sectional pooled ES estimates. When studies provided ≥2 measurements for the same cognitive domain, these measurements were combined to calculate a single pooled ES for the corresponding domain. For unadjusted analyses, those associations including the shortest number of covariates were considered, and for the adjusted analyses, those associations including the largest number of covariates were considered. Finally, when studies reported mean value trends by groups or associations using regression models or correlation coefficients, ES values were calculated.

Sensitivity analyses were performed excluding all the studies 1 at a time from the pooled estimates to evaluate whether any particular study modified the original summary estimate. Subgroup analyses were performed based on characteristics of the procedures to measure IMT, including (1) manual, automated, or not specified measurements; (2) right, left, or bilateral carotid artery measurement; and (3) frequency of the ultrasound (defined as a range, >7 or not specified). Additional subgroup analyses were performed based on the method used to measure cognitive function

Table 1. Characteristics of the Studies Included in the Systematic Review and Meta-Analysis on the Association Between Cognition Parameters and IMT

References	Subjects characteristics						Exposure		Outcome	
	n, female (%)	Age	BMI	SBP	DBP	Depressives (%)	IMT device	IMT average	Cognitive measurement	Cognitive construct
Al Hazzouri et al, 2015 ²⁸	2618 (57.1)	45.3 (3.6)	NR	NR	NR	16.2%	GE-Logiq-700	0.8 (0.1)	Rey AVLT Digit Symbol Substitution Stroop Interference	Delayed verbal memory Processing speed Executive function
Arntzen et al, 2012 ²³	4371 (51.5)	M: 58.6 (9.3) W: 59.5 (9.9)	M: 26.1 (3.1) W: 25.8 (4.2)	M: 143.1 (19.2) W: 142.4 (22.9)	NR	M: 2.1% W: 5.5%	High- resolution B-mode ultrasonography	M: 0.88 (0.18) W: 0.81 (0.16)	12-word memory Test Digit Symbol-Coding Test Finger tapping Test	Immediate free recall Psychomotor speed, attention, and mental flexibility. Psychomotor tempo
Casado-Naranjo et al, 2016 ²⁹	181 (45.9)	MCI: 77.5 (4.6) C: 75.3 (5.2)	NR	NR	NR	MCI: 18.1% C: 4.0%	Philips HD 11	MCI: 1.03 (0.27) C: 0.85 (0.32)	MMSE	Global cognitive
Cohen-Mannheim et al, 2016 ³⁰	507 (32.3)	49.9 (0.8)	24.7 (3.6)	112.0 (10.0)	68.0 (9.0)	Depressive symptoms score (HADS 0-21): 3.6 (2.9)	Philips IU22	0.63 (0.11)	Digit arithmetic problems Go-NoGo, Stroop and Catch Game Abstract spatial ability test Immediate and delayed memory tests	Global cognitive Attention Information processing speed Executive Visual spatial processing Memory
Cohen et al, 2009 ³¹	88 (NR)	72.2 (7.7)	NR	129.3 (19.5)	68.5 (10.1)	Exam Score Beck Depression Inventory: 4.2 (2.5)	Agilent 5500 machine	0.88 (0.13)	MMSE, Dementia Rating Scale BNT, Animals Block Design, Hooper Visual Organization, Rey Complex Figure Test- Copy California Verbal Learning delayed, Rey Complex Figure Test delayed, Brief Visual Memory Test-Revised Stroop, TMT A-B, controlled oral Word association, Letter search, Digit Symbol Coding, Digit Span and Pags-D	Global cognitive Language Visual-spatial Learning and memory functions Attention-executive- psychomotor functions
Del Brutto et al, 2020 ²⁴	561 (58)	57.8 (11.9)	NR	NR	NR	10%	Terason Smart 3300 NexGen	NR	MoCA	Global cognition

(Continued)

Table 1. Continued

References	Subjects characteristics						Exposure		Outcome	
	n, female (%)	Age	BMI	SBP	DBP	Depressives (%)	IMT device	IMT average	Cognitive measurement	Cognitive construct
Feinkohl et al, 2013 ³²	831 (48.3)	67.7 (4.2)	31.3 (5.6)	132.5 (15.9)	69.0 (8.9)	HADS Depression: 3 (1–5)	Sonoline Elegra Ultrasound Imaging System	1.0 (0.2)	Borkowski Verbal Fluency Test Logical Memory Faces Subtest TMT-B Digit Symbol Coding Letter-Number Sequencing Matrix Reasoning Mill Hill Vocabulary Scale MMSE	Executive function Immediate and delayed memory Nonverbal memory Mental flexibility and Executive function Speed of information processing Working memory Nonverbal reasoning Vocabulary abilities Global cognition
Frazier et al, 2014 ³³	251 (46.0)	78.0 (6.4)	NR	NR	NR	NR	High-resolution B-mode ultrasound	0.9 (0.1)	Dementia Rating Scale Initiation-perseveration subscale, Wechsler Memory Scale Memory Scale-Revised Digit and Visual Span backwards, COW-Fluency Task Word List Learning Test, short and long delayed recall	Executive function Verbal memory
Gardener et al, 2018 ³⁴	1166 (60.0)	70.0 (9.0)	28.0 (5.0)	NR	NR	NR	GE LogIQ 700	0.9 (0.1)	List-learning, Delayed Recall, Delayed Recognition Color Trail Test, Odd-man-out subtest Grooved Pegboard Task, Color Trial test, Visual-motor Integration BNT, Animal Naming, Phonetic fluency test	Episodic memory Executive function Processing speed Semantic memory
Gatto et al, 2009 ³⁵	504 (38.9)	60.8 (9.9)	28.1 (5.0)	129.6 (16.9)	80.8 (10.4)	7.3%	High-resolution B-mode ultrasound	0.75 (0.15)	Symbol Digit Modalities, Trial-B, Letter-Number Sequencing, Judgment of Line Orientation, Block design, Shipley Institute of Living Scale California Verbal Learning Test, immediate recall and delayed recall Paragraph recall- immediate recall and delayed recall Faces I and II Category fluency and BNT	Executive function Verbal learning Logical memory Visual memory Semantic memory Global cognitive
Geijselaers et al, 2016 ³⁶	722 (44.9)	60.0 (8.0)	27.2 (4.4)	137.0 (19.0)	77.0 (11.0)	3.9%	MyLab 70	0.85 (0.15)	Verbal Learning Test Stroop Colour/Word, Concept Shifting Test Part A and B, Letter-Digit Substitution Test Stroop Colour-Word, Concept Shifting	Immediate and delayed recall Processing speed Executive function and attention

(Continued)

Table 1. Continued

References	Subjects characteristics						Exposure		Outcome	
	n, female (%)	Age	BMI	SBP	DBP	Depressives (%)	IMT device	IMT average	Cognitive measurement	Cognitive construct
Haley et al, 2007 ³⁷	109 (43.0)	69.2 (7.43)	NR	NR	NR	NR	High-resolution B-mode ultrasonography	0.88 (0.13)	MMSE, Dementia Rating Scale BNT, Category Fluency for Animals HVOT, WAIS-III Block Design Subtest, CFT copy CVLT, CFT immediate recall, delayed recall, and recognition discrimination BVMIT-R, recognition discrimination TMT (A and B), Stroop Word/Color, COW-Association Test, Letter Search, WAIS-III Block Coding Subtest, WAIS-III Digit Span Subtest, Grooved Pegboard Dominant Hand	Global cognitive functioning Language Visual-spatial Memory Attention-executive- psychomotor
Imran et al, 2020 ³⁸	79 (NR)	55.5 (12.7)	NR	NR	NR	NR	Mindray Z6	0.81 (0.22)	RAVLT ROCFE	Memory function
Jiang et al, 2017 ³⁹	357 (65.0)	57.2 (9.3)	25.3 (3.3)	132.2 (16.6)	83.4 (9.3)	NR	Sequoia scanner	0.8 (0.2)	MoCA	Global cognition
Kemp et al, 2016 ⁴⁰	8114 (56.3)	51.2 (8.8)	NR	NR	NR	Depression severity: 8.0 (7.8)	Toshiba (Apilo XG)	0.8 (0.2)	TMT-B	Executive function
Komulainen et al, 2007 ⁴¹	91 (100)	63.8 (3.2)	27.6 (4.4)	NR	NR	Zung self-report 20-item scale: 36.4 (5.5)	Carotid ultrasonography	1.02 (0.26)	MMSE Word Recall Test Stroop test and Letter-Digit Substitution Test	Global cognition Memory Cognitive Speed
Lim et al, 2016 ⁴²	463 (43.2)	MP: 63.0 (6.1) NP: 64.2 (6.4)	MP: 25.0 (4.1) NP: 24.6 (3.5)	NR	NR	NR	High-resolution B-mode ultrasound	MP: 0.8 (0.5-1.8) NP: 0.7 (0.5-1.8)	MMSE Digit Span-Forward, Colour Trails Test Rev Auditory Verbal Learning Test, Story Memory and Recall BNT Brief Visuospatial Memory Test-Revised Digit Span- Backward, Block Design, Colour Trails Test 2 and Categorical Verbal Fluency (Animal Naming)	Global cognition Attention Verbal memory Language Visuospatial ability Executive function
Masley et al, 2014 ⁴³	536 (27.4)	48.0 (7.5)	27.4 (4.7)	117.7 (15.3)	75.7 (10.4)	NR	High-resolution B-mode ultrasound	0.7 (0.1)	Index score Verbal memory and visual memory components Symbol Digit Coding Stroop Test, Continuous Performance Test Finger Tapping Test, Stroop Test	Global cognition Memory Executive function Attention Motor speed

(Continued)

Table 1. Continued

References	Subjects characteristics						Exposure		Outcome	
	n, female (%)	Age	BMI	SBP	DBP	Depressives (%)	IMT device	IMT average	Cognitive measurement	Cognitive construct
Matsumoto et al, 2018 ²⁵	176 (55.7)	CI: 67.7 (12.3) Non-CI: 64.6 (9.6)		CI: 125.4 (20.9) Non-CI: 119.9 (16.1)	CI: 23.8 (2.8) Non-CI: 23.4 (3.4)	NR	Xario SSA-660A	CI: 2.0 (1.0) Non-CI: 1.7 (0.6)	MMSE, Hasegawa Dementia Scale-revised Logical Memory IA and IIA of the WMS-R Clock-drawing Test	Global cognition Immediate and delayed recall Visuo-constructional function, executive function and planning ability
Muela et al, 2018 ⁴⁴	211 (54.8)	NoHTA: 52.2 (13.9) HTA 1: 52.1 (13.0) HTA 2: 51.3 (10.1)		NoHTA: 121.9 (8.3) HTA 1: 135.0 (13.5) HTA 2: 147.5 (26.1)	NoHTA:26.7 (4.2) HTA 1: 28.5 (4.6) HTA 2: 30.1 (4.6)	NR	Wall Track System, Medical Systems (Arnhem)	NoHTA: 0.7 (0.1) HTA 1: 0.8 (0.1) HTA 2:0.8 (0.1)	MMSE, MoCA BNT RAVLT REY, Clock Drawing Test Semantic Verbal Fluency animal category, Phonological Verbal Fluency Forward and Backward Digit Span Tess, Trail Making Test, and Digit Symbols Substitution Test	Global cognition Language Memory Visuospatial abilities Attention and executive functions
Muller et al, 2007 ⁴⁵	396 (0.0)	N-CVD: 54.5 (10.3) S-CVD: 66.8 (8.1) P-CVD: 67.7 (8.8)	N-CVD: 25.9 (0.3) S-CVD: 26.5 (0.3) P-CVD: 27.3 (0.5)	N-CVD: 134.2 (1.3) S-CVD: 145.5 (1.7) P-CVD: 140.2 (2.5)	NR	NR	Acuson Aspen	N-CVD: 0.77 (0.01) S-CVD: 0.89 (0.01) P-CVD: 0.89 (0.02)	MMSE, Rey auditory verbal learning test, and door test Digit span, TMT-A TMT-B, Word fluency test Dutch adult reading test	Memory Processing/speed Executive function
Roberts et al, 2013 ⁴⁶	278 (54.3)	49.0–51.0	NR	NR	NR	NR	High-resolution B-mode ultrasound	NR	IQ test Moray House Tests 57 & 58, the English and Arithmetic tests and the Mill Hill and Raven's Progressive Matrices	IQ Language Arithmetic
Rogne et al, 2013 ⁴⁷	1577 (47.3)	57 (52–61)	25.6 (3.2)	138.0 (18.0)	NR	NR	High-resolution B-mode ultrasonography	0.78 (0.69–0.89)	Digit Symbol Test Finger tapping test 12-word test parts 1 and 2 test (modification of the CVL test) MMSE	Executive function Motor speed Verbal episodic memory Global cognition
Romero et al, 2009 ⁴⁸	1971 (53.0)	58.0 (10.0)	NR	126.0 (18.0)	NR	NR	Doppler spectral analyzer (Model SSH-140A)	NR	Wechsler Memory Scale Logical Memory, Paragraph A subtest, Immediate and Delayed Recall Halstead Reitan TMT (A and B) BNT, WAIS Similarities subtest, HVOT	Verbal memory Executive function Non-verbal memory
Schwerdtfeger et al, 2015 ⁴⁹	124 (49.0)	37.5 (7.9)	23.8 (4.0)	NR	NR	NR	High-resolution B-mode ultrasound	0.5 (0.1)	Mainz Coping Inventory	Cognitive avoidance

(Continued)

Table 1. Continued

References	Subjects characteristics						Exposure			Outcome	
	n, female (%)	Age	BMI	SBP	DBP	Depressives (%)	IMT device	IMT average	Cognitive measurement	Cognitive construct	
Singh-Manoux et al, 2008 ⁵⁰	3896 (27.9)	H-SES-M: 62.3 (5.6) H-SES-W: 59.8 (5.5) I-SES-M: 60.0 (5.8) I-SES-W: 60.1 (5.9)	H-SES-M: 26.2 (3.7) H-SES-W: 25.6 (5.1) I-SES-M: 26.5 (3.8) I-SES-W: 26.4 (5.3)	H-SES-M: 127.9 (15.5) H-SES-W: 122.8 (17.7) I-SES-M: 127.2 (15.2) I-SES-W: 124.7 (16.9)	H-SES-M: 74.2 (10.3) H-SES-W: 71.9 (10.3) I-SES-M: 74.3 (10.1) I-SES-W: 72.6 (10.4)	NR	Aloka 5500	H-SES-M: 0.8 (0.2) H-SES-W: 0.8 (0.1) I-SES-M: 0.8 (0.2) I-SES-W: 0.8 (0.1)	20-word Free Recall Test Alice Heim 4-1 Mill Hill Vocabulary Test "S" words and "animal" words MMSE	Short term verbal memory Inductive reasoning Verbal meaning and Encompasses Phonetic and Semantic fluency Global cognition	
Smith et al, 2011 ⁵¹	124 (63.7)	52.3 (9.6)	32.8 (3.8)	138.3 (8.4)	86.1 (6.5)	8%	High- resolution B-mode ultrasonography	0.70 (0.14)	TMT (A and B), Stroop Test, Verbal Paired Associates test, COW-Association Test, Digit Span Test, Animal Naming Ruff 2 & 7 Test, Digit Symbol Substitution Test	Executive Function Psychomotor Speed	
Suemoto et al, 2015 ⁵²	8208 (55.9)	49.6 (7.3)	26.6 (4.5)	NR	NR	4.0%	Toshiba ultrasound machine	0.7 (0.2)	CERAD Delayed Word Recall test Category Fluency Test TMT-B	Verbal learning and recent memory Language and executive function Executive function, speed of processing, and attention	
Wang et al, 2016 ⁵³	3227 (43.4)	57.9 (10.9)	24.9 (3.3)	130.8 (19.9)	82.6 (11.0)	NR	Philips iU-22 ultra- sound system	NR	MMSE	Global cognition	

(Continued)

Table 1. Continued

References	Subjects characteristics							Exposure		Outcome	
	n, female (%)	Age	BMI	SBP	DBP	Depressives (%)	IMT device	IMT average	Cognitive measurement	Cognitive construct	
Wendell et al, 2009 ¹⁵	538 (60.2)	54.9 (14.0)	26.3 (4.5)	NR	NR	CES-D: 6.6 (9.6)	Ultramark 9 HDI	0.5 (0.1)	Blessed Information-Memory-Concentration (I-M-C) Test, MMSE Digits Forward, Digits Backward CVL learning slope CVL immediate, short-delay and long-delay free recall BVRT, RCFT immediate and long-delay recall TMT (A and B) Letter Fluency Category Fluency BNT RCFT copy Card Rotations Test	Attention and concentration Verbal learning Memory Nonverbal memory Attention, perceptuomotor speed, visuomotor scanning, and mental flexibility Phonemic fluency Semantic fluency Language Visuospatial constructional ability Visuospatial function	
Wendell et al, 2016 ⁵⁴	1712 (55.1)	46.9 (9.3)	29.4 (7.4)	119.5 (17.2)	NR	CES-D: 14.0 (10.8)	Acuson CV 70	0.7 (0.1)	MMSE Benton Visual Retention Test CVL Animal fluency Brief Test of Attention Digit Span subtest of the Wechsler Adult Intelligence Scale-Revised TMT (A and B)	Global cognition Visuospatial memory Verbal learning and memory Language and semantic association fluency Auditory divided attention memory Attention, visual scanning, psychomotor speed, and mental flexibility	
Yue et al, 2016 ⁵⁵	1826 (35.2)	63.2 (11.9)	NR	Cint: 147.2 (22.4) Cimp: 149.0 (22.7)	Cint: 85.5 (12.5) Cimp: 84.0 (13.6)	NR	High-resolution B-mode ultrasonography	1.4 (0.7)	MMSE	Global cognition	
Zhong et al, 2011 ⁵⁶	2794 (54.0)	49.0 (9.8)	NR	NR	NR	NR	Biosound AU4	0.65 (0.15)	TMT (A and B) Grooved Pegboard Test MMSE	Executive, attention and psychomotor function Executive, and psychomotor function General cognitive function	

(Continued)

Table 1. Continued

References	Subjects characteristics						Exposure		Outcome	
	n, female (%)	Age	BMI	SBP	DBP	Depressives (%)	IMT device	IMT average	Cognitive measurement	Cognitive construct
Zhong et al, 2012 ²²	1651 (59.2)	66.8 (NR)	30.1 (5.9)	NR	NR	NR	Biosound AU4	0.86 (0.21)	MMSE TMT (A and B) Digit-Symbol Substitution Test AVLT Verbal Fluency Test (VFT)	Executive function, attention and speed Psychomotor speed and sustained attention Memory Spontaneous production of words

ADAS-cog indicates Alzheimer Disease Assessment Scale-cognitive subscale; AVLT, Rey Auditory Verbal Learning Test; BNT, Boston naming test; BVM-T-R, Brief Visual Memory Test-Revised; COWAT, Controlled Oral Word Association Test; CVLT, California Verbal Learning Test; HVOT, Hooper Visual Organization Test; M, men; MMSE, Mini-Mental State Examination; MoCA, Montreal cognitive assessment; NR, not reported; RAVLT, Osterrieth Auditory Verbal Learning Test; ROCFT, Rey-Osterrieth Complex Figure Test; TMT, Trail Making Test; W, women; WAIS, Wechsler Adult Intelligence Scale; and WMS-R, Wechsler Memory Scale Revised.

(global test of cognition or domain-specific assessments). Random effect meta-regressions were calculated based on sample characteristics: percentage of women, mean age, BMI, and baseline IMT values. Finally, publication bias was estimated using Egger's test.⁶⁴ All the statistical analyses were performed using STATA 15 (StataCorp) software.

RESULTS

Systematic Review

The literature search retrieved 6879 studies, of which 19 cross-sectional and 15 longitudinal studies were included in this systematic review and meta-analysis^{15,22-25,28-56} (Figure S1). The studies included a total of 50 779 participants aged 45.3 to 78.0 years. Table 1 and Table S1 summarize the characteristics of included studies. Table S2 summarizes the covariates used in the analyses of the included studies.

Risk of Bias Assessment

Cross-sectional studies scored between 5 and 11 points, and longitudinal studies scored between 8 and 12 points. The 4 criteria in which most articles lacked information were sample size justification, power description, variance, and outcome blinding of the assessors to the participants' exposure status (Table S3).

Meta-Analysis

The pooled ES for the unadjusted cross-sectional association between carotid IMT and cognitive function was small for global cognition (−0.25 [95% CI, −0.36 to −0.14]; Q: 134.40; I²: 89.6%), for executive function (−0.18 [95% CI, −0.29 to −0.07]; Q: 37.15; 81.2%), for memory (−0.14 [95% CI, −0.25 to −0.04]; Q: 151.33; 90.1%), and for attention (−0.12 [95% CI, −0.29 to 0.04]; Q: 54.16; 87.1%). Considering the adjusted cross-sectional data, the pooled ES was small for global cognition (−0.15 [95% CI, −0.24 to −0.07]; Q: 78.08; I²: 82.1%), for executive function (−0.12 [95% CI, −0.21 to −0.03]; Q: 27.04; 74.1%), for memory (−0.09 [95% CI, −0.15 to −0.03]; Q: 33.88; I²: 55.7%), and for attention (−0.13 [95% CI, −0.26 to 0.01]; Q: 32.46; 78.4%) (Figures 1 and 2).

Additionally, for the longitudinal associations, the pooled ES for the unadjusted longitudinal association between IMT and cognitive function was small for global cognition (−0.21 [95% CI, −0.38 to −0.04]; Q: 16.37; I²: 81.7%), for executive function (−0.14 [95% CI, −0.29 to 0.01]; Q: 50.25; I²: 90.0%), for memory (−0.15 [95% CI, −0.30 to 0.00]; Q: 255.80; I²: 96.5%), and for attention (−0.23 [95% CI, −0.62 to 0.17]; Q: 215.95; 98.6%). Considering the adjusted longitudinal data, the pooled ES was small for global cognition (−0.09 [95% CI, −0.20 to 0.02]; Q: 7.30; I²: 58.9%), for executive function (−0.04 [95% CI, −0.12 to 0.04]; Q: 12.78;

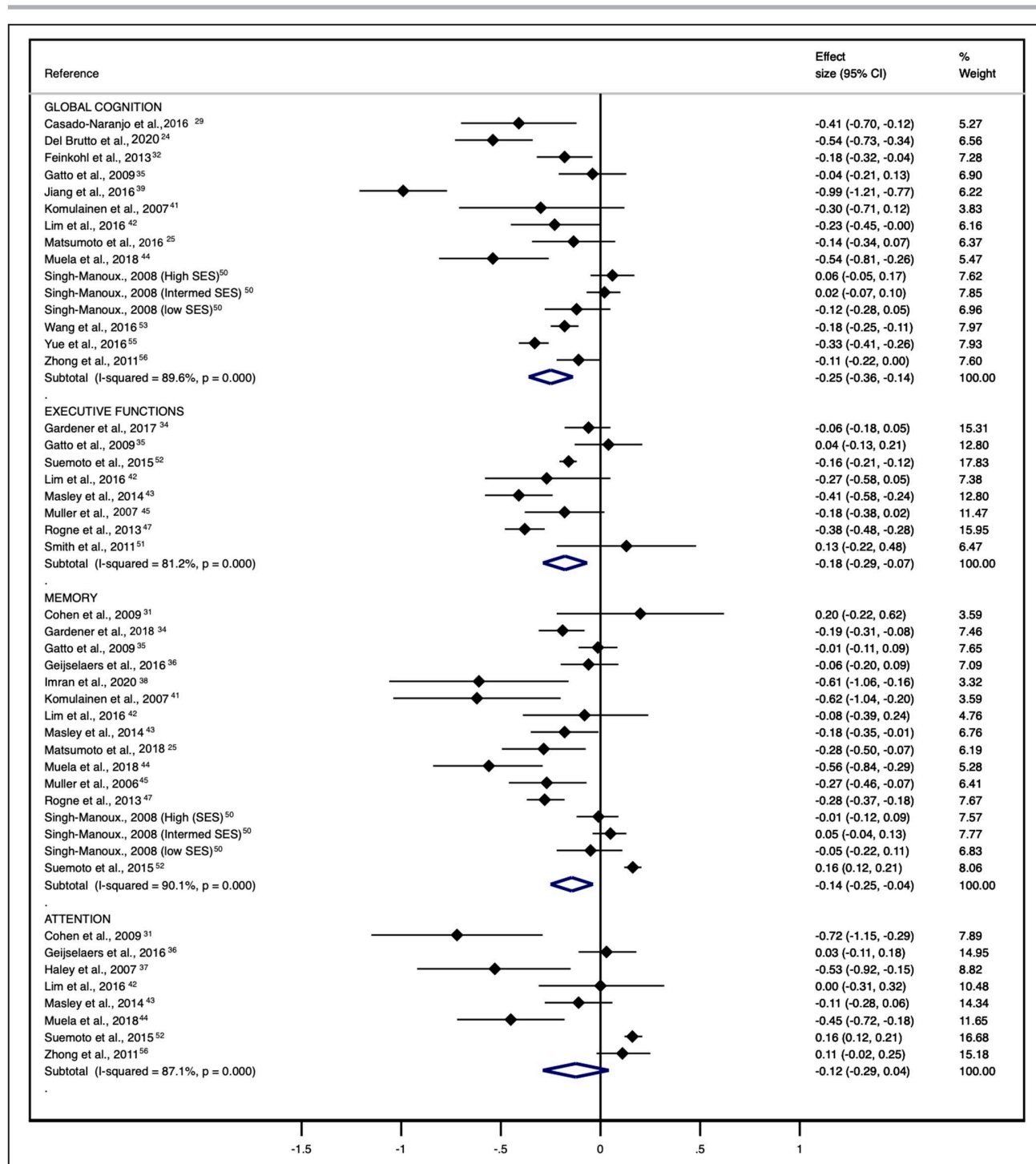


Figure 1. Forest plot for the unadjusted cross-sectional association between intima media thickness and cognitive function domains.
 SES indicates socioeconomic status.

I^2 : 60.9%), for memory (-0.00 [95% CI, -0.05 to 0.04]; Q : 23.32; I^2 : 61.4%); and for attention (-0.04 [95% CI, -0.09 to 0.01]; Q : 3.81; 21.3%) (Figures 3 and 4).

The Z scores and corresponding P values against the hypothesis that IMT has no effect on cognitive function are reported in Table S4.

Sensitivity Analysis

Sensitivity analyses were performed excluding all the studies 1 at a time from the pooled estimates to evaluate whether any particular study modified the original summary estimate. The sensitivity analyses for the cross-sectional estimates showed that the adjusted

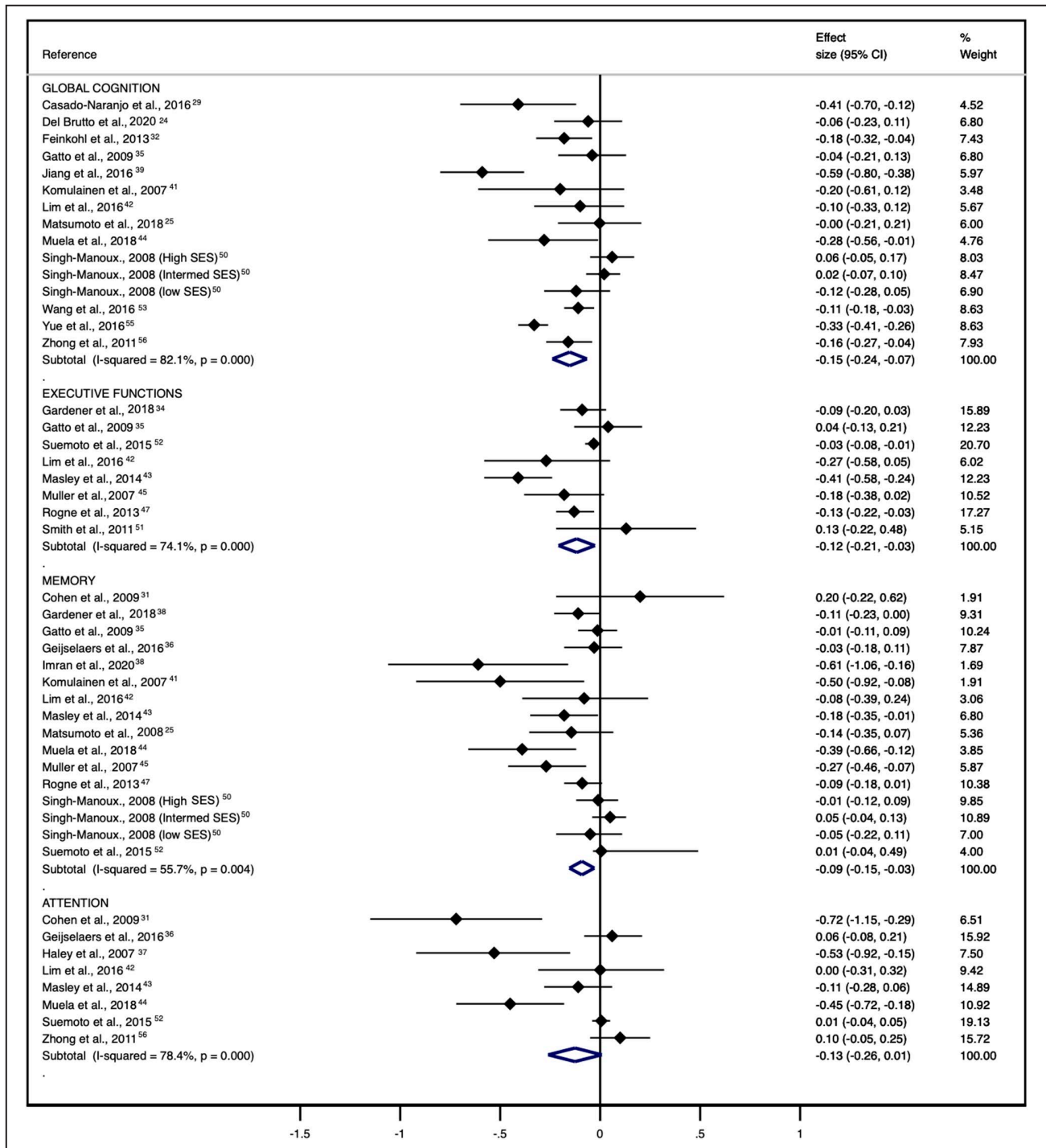


Figure 2. Forest plot for the adjusted cross-sectional association between intima media thickness and cognitive function domains. SES indicates socioeconomic status.

association between IMT and attention became significant after excluding the studies performed by Geijselaers et al and Zhong et al.

The sensitivity analyses for the longitudinal estimates showed that the unadjusted association between IMT and cognitive function became significant

after excluding the studies performed by (1) Cohen-Manheim et al, Del Brutto et al, and Feinkohl et al, for global cognition; (2) Gardener et al, and Romero et al, for executive functions; and (3) Gardener et al, Romero et al, Wendell et al, and Zhong et al, for memory (Tables S5–S8).

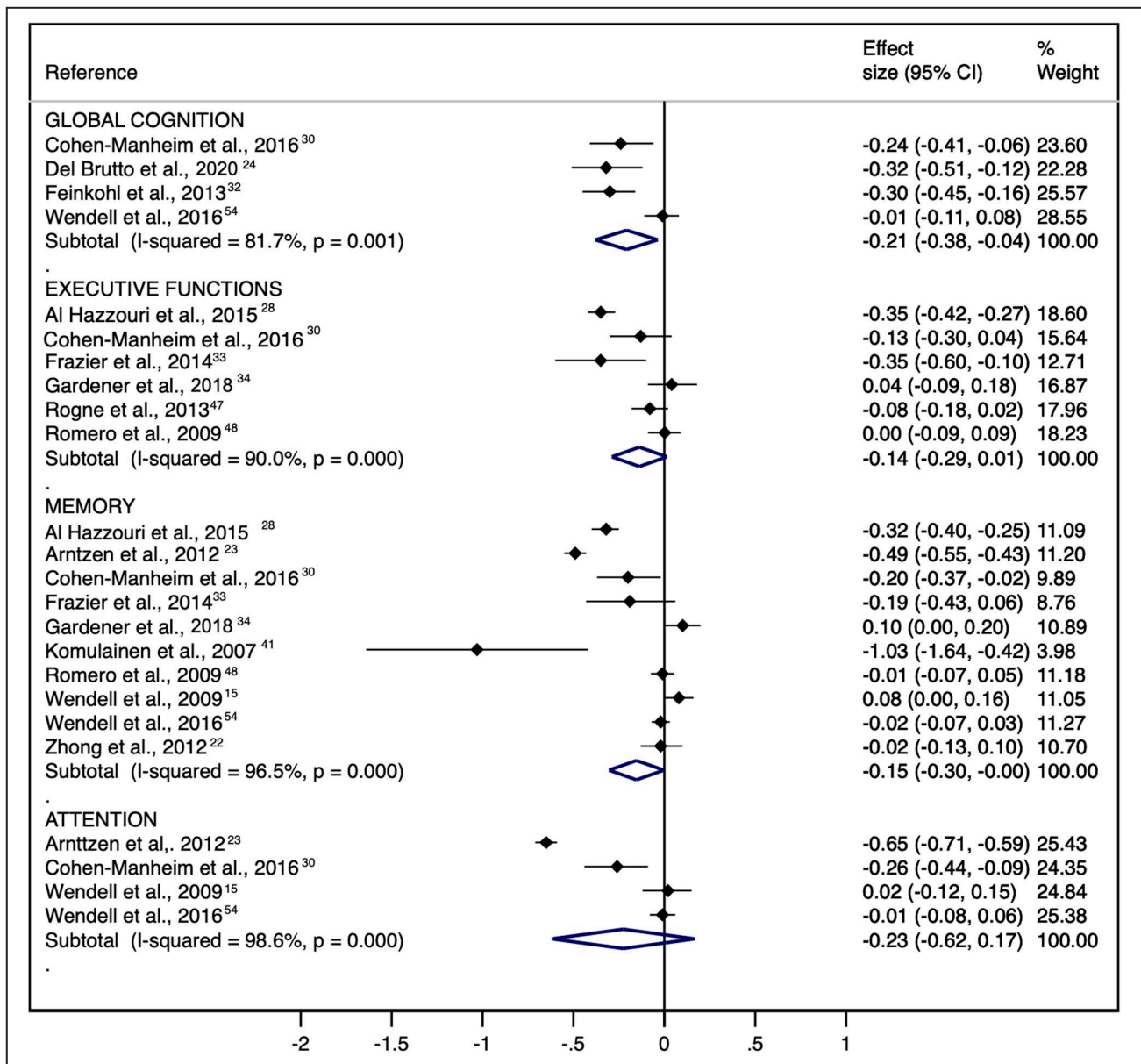


Figure 3. Forest plot for the unadjusted longitudinal association between intima media thickness and cognitive function domains.

SES indicates socioeconomic status.

Meta-Regressions and Subgroup Analyses

Meta-regressions showed that none of the considered variables (ie, % females, age, BMI, and baseline IMT values) influenced the relationship between IMT and cognitive function for the cross-sectional or longitudinal models (Table S9). Additionally, when considering the procedure characteristics, the ESs for the subgroup analyses were similar to the pooled ESs when (1) automated and not specified measurements of IMT were used for cross-sectional studies reporting on global cognition and memory; (2) bilateral carotid artery measurement was used for cross-sectional and

longitudinal studies reporting on global cognition, executive functions, and memory; (3) >7 frequency of the ultrasound was used for cross-sectional studies reporting on global cognition, memory, and attention; and (4) domain-specific assessments to measure cognitive function were used for cross-sectional studies reporting on global cognition and memory (Table S10).

Publication Bias

As evaluated by Egger's test and funnel plot asymmetry, publication bias was found for (1) global cognition in the unadjusted longitudinal analysis; (2) memory in the unadjusted and adjusted cross-sectional analyses;

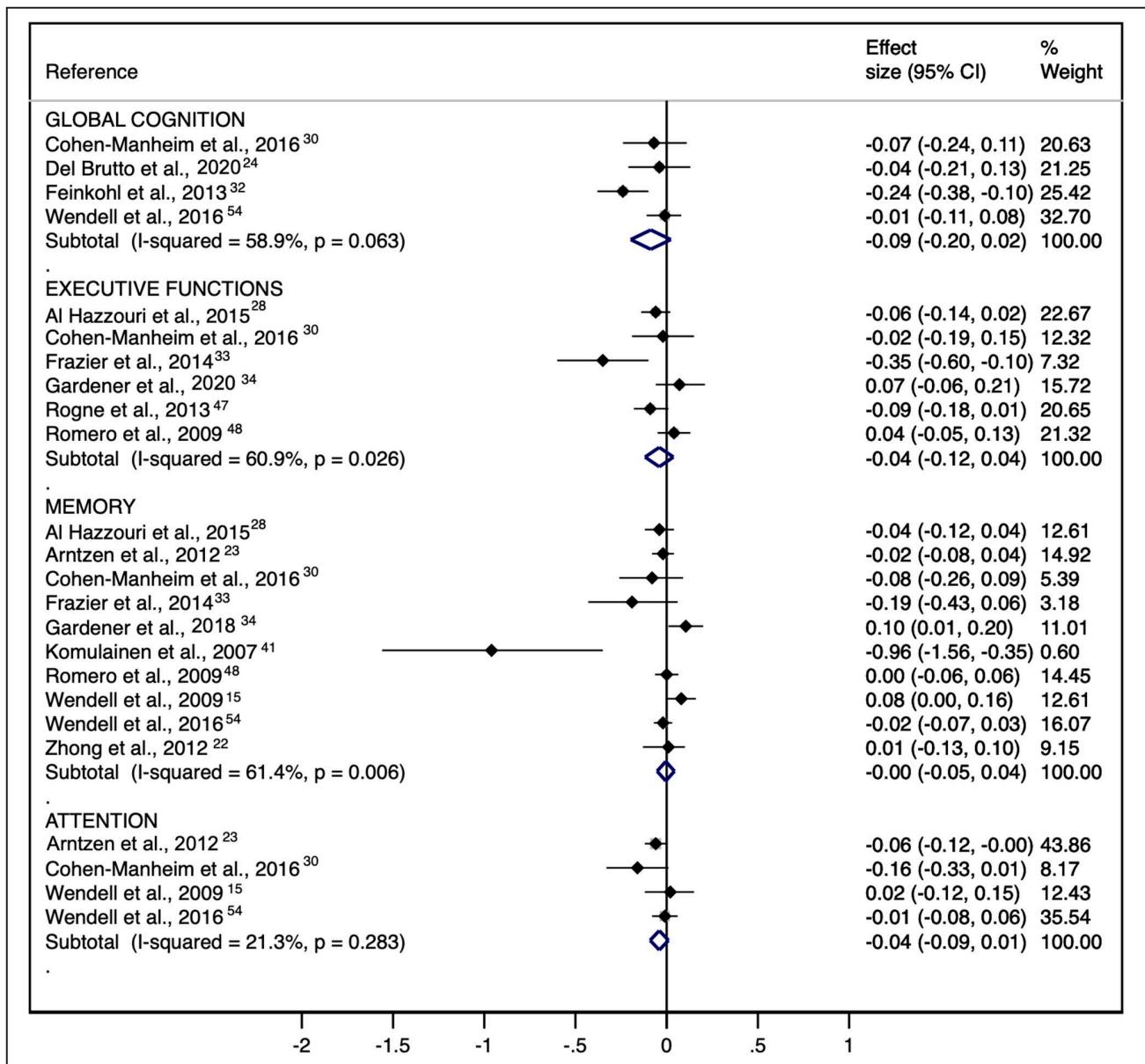


Figure 4. Forest plot for the adjusted longitudinal association between intima media thickness and cognitive function domains.

and (3) attention in the unadjusted cross-sectional analysis (Table S11 and Figures S2–S9).

DISCUSSION

The purpose of this meta-analysis was to identify associations between IMT and cognitive function in cross-sectional and longitudinal studies. Our data support a small negative association between IMT and cognitive function in cross-sectional studies, especially for global cognition, executive functions, and memory. The association between IMT and cognition lost significance in the longitudinal studies and after controlling for covariates in cross-sectional studies. Finally, our data suggest

that demographic (age and sex), clinical (BMI and baseline IMT values), and procedure characteristics do not influence the strength of this association.

Data from cross-sectional studies suggest an association between IMT and cognition, indicating that cognition is reduced in people with increased IMT. The association was not significant when ESs of longitudinal studies were pooled; therefore, the pooled results did not support that IMT level predicted cognitive performance over time. This asymptomatic carotid atherosclerosis could be the image of the arterial remodeling that occurs during the natural process of vascular aging.⁶⁵ In addition, several covariates could negatively impact vascular aging, including age, sex,

diabetes, hypertension, and patient education, resulting in atherosclerosis as a maladaptive process of vascular remodeling.⁶⁶

Significant heterogeneity was observed in the pooled analyses and explored by subgroup analyses and meta-regressions based on demographic, clinical, and procedure characteristics. Although sex, age, and BMI have been proposed to be factors affecting IMT, the results of the meta-regressions do not suggest that the relationship between IMT and cognitive functions could be influenced by these factors.⁶⁷ In addition, the different effects of hemodynamic and biochemical changes on the left and right IMT could be sources of heterogeneity; data from the subgroup analyses suggest that the bilateral IMT measurement is the most reported and reproducible method when assessing the relationship between IMT and cognitive functions.⁶⁸ The influence of other procedure characteristics including the method used to measure IMT (automated or manual methods) and cognitive functions (domain-specific assessment or global test of cognition), and the mHz applied could not be confirmed because of the lack of studies to draw conclusions.⁶⁹

Different mechanisms have been proposed to explain the effect of IMT on cognitive function. Blood support to neural cells could be compromised as a result of 2 interrelated events: (1) the thickening of the arterial wall, which could reduce the vessel lumen and produce chronic cerebral hypoperfusion; and (2) the promotion of endothelial dysfunction by the increased wall stress.⁷⁰ Additionally, the increased wall stress has been related to an increased risk of plaque fissuring,⁷¹ increasing the subsequent risk of neural ischemia. Atherosclerosis and embolization of the vascular microcirculation and subsequent chronic inflammation^{65,72} have been suggested to precipitate cerebral small vessel disease.⁷³ Furthermore, the local thickening of the arterial wall could produce a microturbulent flow, reducing the supply of blood and nutrients and leading to neuronal dysfunction and cell death.

The results of this systematic review and meta-analysis should be cautiously considered, as some limitations should be mentioned. In addition to the specific limitations of the meta-analysis design, other sources of bias could be that (1) we did not use the original data but the data as reported by the studies to estimate the pooled ES; (2) substantial heterogeneity was found when pooled ESs were estimated, and diverse methods and tools were used to measure cognitive function across the included studies; (3) publication bias was found in some of the analyses; (4) language restrictions may have limited the number of included studies; and (5) our data might be limited by the use of 3 databases, and additional studies may have been found by checking other databases.

In conclusion, the pooled analysis of cross-sectional studies suggests a negative association between IMT and global cognition, executive functions, and memory. The association between IMT and cognition lost significance in longitudinal studies and when controlling for covariates in cross-sectional studies. Finally, age, sex, BMI, and baseline IMT values do not seem to modify the strength of this association. The results of this systematic review and meta-analysis do not support a strong association between IMT and longitudinal change in cognitive function, and future work is needed to address this association with the onset of cognitive impairment.

ARTICLE INFORMATION

Received March 23, 2021; accepted November 24, 2021.

Affiliations

Health and Social Research Center, Universidad de Castilla-La Mancha, Cuenca, Spain (C.Á., I.C., A.S., I.S., B.N., V.M.); Universidad Politécnica y Artística del Paraguay, Asunción, Paraguay (C.Á.); Rehabilitation in Health Research Center (CIRES), Universidad de las Américas, Santiago, Chile (I.C.); Department of Clinical and Experimental Medicine, University of Pisa, Italy (R.M.B.); INSERM U970 and Université de Paris, Paris, France (R.M.B.); and Facultad de Ciencias de la Salud, Universidad Autónoma de Chile, Talca, Chile (V.M.).

Sources of Funding

This study was funded by European Regional Development Fund.

Disclosures

None.

Supplemental Material

Tables S1–S11
Figures S1–S9

REFERENCES

1. WHO. Ageing and health [Internet]. World Health Association. Available at: <https://www.WHO.int/news-room/fact-sheets/detail/ageing-and-health>. Accessed January 20, 2021.
2. Jaul E, Barron J. Age-related diseases and clinical and public health implications for the 85 years old and over population. *Front Public Health*. 2017;5:335.
3. Numbers K, Crawford JD, Kochan NA, Draper B, Sachdev PS, Brodaty H. Participant and informant memory-specific cognitive complaints predict future decline and incident dementia: findings from the Sydney Memory and Ageing Study. *PLoS One*. 2020;15:e0232961. doi: 10.1371/journal.pone.0232961
4. Kivipelto M, Mangialasche F, Ngandu T. Lifestyle interventions to prevent cognitive impairment, dementia and Alzheimer disease. *Nat Rev Neurol*. 2018;14:653–666. doi: 10.1038/s41582-018-0070-3
5. Rosenberg A, Mangialasche F, Ngandu T, Solomon A, Kivipelto M. Multidomain interventions to prevent cognitive impairment, Alzheimer's disease, and dementia: from FINGER to world-wide FINGERS. *J Prev Alzheimers Dis*. 2020;7:29–36.
6. Picano E, Bruno RM, Ferrari GF, Bonuccelli U. Cognitive impairment and cardiovascular disease: so near, so far. *Int J Cardiol*. 2014;175:21–29. doi: 10.1016/j.ijcard.2014.05.004
7. Larsson SC, Hugh SM. Does treating vascular risk factors prevent dementia and Alzheimer's disease? A systematic review and meta-analysis. *J Alzheimers Dis*. 2018;64(2):657–668. doi: 10.3233/JAD-180288
8. Rosenberg A, Ngandu T, Rusanen M, Antikainen R, Bäckman L, Havulinna S, Hänninen T, Laatikainen T, Lehtisalo J, Levälahti E, et al. Multidomain lifestyle intervention benefits a large elderly population at risk for cognitive decline and dementia regardless of baseline

- characteristics: the FINGER trial. *Alzheimers Dement*. 2018;14:263–270. doi: 10.1016/j.jalz.2017.09.006
9. Vintimilla R, Balasubramanian K, Hall J, Johnson L, O'Bryant S. Cardiovascular risk factors, cognitive dysfunction, and mild cognitive impairment. *Dement Geriatr Cogn Dis Extra*. 2020;10:154–162. doi: 10.1159/000511103
 10. Bruno RM, Stea F, Sicari R, Ghiadoni L, Taddei S, Ungar A, Bonuccelli U, Tognoni G, Cintoli S, Del Turco S, et al. Vascular function is improved after an environmental enrichment program: the train the brain-mind the vessel study. *Hypertension*. 2018;71:1218–1225. doi: 10.1161/HYPERTENSIONAHA.117.10066
 11. Waldstein SR, Rice SC, Thayer JF, Najjar SS, Scuteri A, Zonderman AB. Pulse pressure and pulse wave velocity are related to cognitive decline in the Baltimore Longitudinal Study of Aging. *Hypertension*. 2008;51:99–104. doi: 10.1161/HYPERTENSIONAHA.107.093674
 12. Mitchell GF, van Buchem MA, Sigurdsson S, Gotlib JD, Jonsdottir MK, Kjartansson Ó, Garcia M, Aspelund T, Harris TB, Gudnason V, et al. Arterial stiffness, pressure and flow pulsatility and brain structure and function: the Age, Gene/Environment Susceptibility–Reykjavik study. *Brain*. 2011;134:3398–3407. doi: 10.1093/brain/awr253
 13. Poels MM, van Oijen M, Mattace-Raso FU, Hofman A, Koudstaal PJ, Witteman JC, Breteler MM. Arterial stiffness, cognitive decline, and risk of dementia: the Rotterdam Study. *Stroke*. 2007;38:888–892. doi: 10.1161/01.STR.0000257998.33768.87
 14. Hofman A, Ott A, Breteler MM, Bots ML, Slooter AJ, van Harskamp F, van Duijn CN, Van Broeckhoven C, Grobbee DE. Atherosclerosis, apolipoprotein E, and prevalence of dementia and Alzheimer's disease in the Rotterdam Study. *Lancet*. 1997;349:151–154. doi: 10.1016/S0140-6736(96)09328-2
 15. Wendell CR, Zonderman AB, Metter EJ, Najjar SS, Waldstein SR. Carotid intimal medial thickness predicts cognitive decline among adults without clinical vascular disease. *Stroke*. 2009;40:3180–3185. doi: 10.1161/STROKEAHA.109.557280
 16. Bots ML, Breteler M, Hofman A, Grobbee DE, van Swieten JC, van Gijn J, van Swieten JC, de Jong P. Cerebral white matter lesions and atherosclerosis in the Rotterdam Study. *Lancet*. 1993;341:1232–1237. doi: 10.1016/0140-6736(93)91144-B
 17. Manolio TA, Burke GL, O'Leary DH, Evans G, Beauchamp N, Knepper L, Ward B. Relationships of cerebral MRI findings to ultrasonographic carotid atherosclerosis in older adults: the Cardiovascular Health Study. *Arterioscler Thromb Vasc Biol*. 1999;19:356–365. doi: 10.1161/01.ATV.19.2.356
 18. Matsumoto M, Inoue K, Moriki A. Associations of brachial-ankle pulse wave velocity and carotid atherosclerotic lesions with silent cerebral lesions. *Hypertens Res*. 2007;30:767–773. doi: 10.1291/hyres.30.767
 19. Goff DC, Lloyd-Jones DM, Bennett G, Coady S, D'Agostino RB, Gibbons R, Greenland P, Lackland DT, Levy D, O'Donnell CJ, et al. 2013 ACC/AHA guideline on the assessment of cardiovascular risk: a report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines. *Circulation*. 2014;63:2935–2959.
 20. Willeit P, Tschiderer L, Allara E, Reuber K, Seekircher L, Gao LU, Liao X, Lonn E, Gerstein HC, Yusuf S, et al. Carotid intima-media thickness progression as surrogate marker for cardiovascular risk: meta-analysis of 119 clinical trials involving 100 667 patients. *Circulation*. 2020;142:621–642. doi: 10.1161/CIRCULATIONAHA.120.046361
 21. Wadström BN, Engström G, Nilsson PM. Exploring and comparing definitions of healthy vascular ageing in the population: characteristics and prospective cardiovascular risk. *J Hum Hypertens*. 2020;35:428–436.
 22. Zhong W, Cruickshanks KJ, Schubert CR, Acher CW, Carlsson CM, Klein BE, Klein R, Chappell RJ. Carotid atherosclerosis and 10-year changes in cognitive function. *Atherosclerosis*. 2012;224:506–510. doi: 10.1016/j.atherosclerosis.2012.07.024
 23. Arntzen KA, Schirmer H, Johnsen SH, Wilsaard T, Mathiesen EB. Carotid atherosclerosis predicts lower cognitive test results: a 7-year follow-up study of 4,371 stroke-free subjects—the Tromsø study. *Cerebrovasc Dis*. 2012;33:159–165. doi: 10.1159/000334182
 24. Del Brutto OH, Mera RM, Recalde BY, Del Brutto VJ. Carotid intima-media thickness, cognitive performance and cognitive decline in stroke-free middle-aged and older adults. The Atahualpa Project. *J Stroke Cerebrovasc Dis*. 2020;29:104576. doi: 10.1016/j.jstrokecerebrovasdis.2019.104576
 25. Matsumoto L, Suzuki K, Mizuno Y, Ohike Y, Ozeki A, Ono S, Takashi M, Sawaki D, Suzuki T, Yamazaki T, et al. Association of subclinical carotid atherosclerosis with immediate memory and other cognitive functions. *Geriatr Gerontol Int*. 2018;18:65–71. doi: 10.1111/ggi.13142
 26. Chandler J, Cumpston M, Thomas J, Higgins JPT, Deeks JJ, Clarke MJ. Chapter 1: introduction. In: Higgins JPT, Thomas J, Chandler J, Cumpston M, Li T, Page MJ, Welch VA, eds. *Cochrane Handbook for Systematic Reviews of Interventions Version 6.1 (updated September 2020)*. Cochrane; 2020. Available at: www.training.cochrane.org/handbook. Accessed November 28, 2020.
 27. Stroup DF, Berlin JA, Morton SC, Olkin I, Williamson GD, Rennie D, Moher D, Becker BJ, Sipe TA, Thecker SB; for the Meta-analysis Of Observational Studies in Epidemiology (MOOSE) Group. Meta-analysis of observational studies in epidemiology: a proposal for reporting. *JAMA*. 2008;283:2008–2012.
 28. Al Hazzouri AZ, Vittinghoff E, Sidney S, Reis JP, Jacobs DR Jr, Yaffe K. Intima-media thickness and cognitive function in stroke-free middle-aged adults: findings from the Coronary Artery Risk Development in Young Adults Study. *Stroke*. 2015;46:2190–2196. doi: 10.1161/STROKEAHA.115.008994
 29. Casado-Naranjo IRSR, Romero Sevilla R, Portilla Cuenca JC, de San D, Juan B, Calle Escobar ML, Fernández Pereira L, Fuentes JM, Ramírez-Moreno JM. Association between subclinical carotid atherosclerosis, hyperhomocysteinaemia and mild cognitive impairment. *Acta Neurol Scand*. 2016;134:154–159. doi: 10.1111/ane.12525
 30. Cohen-Manheim I, Pinchas-Mizrachi R, Doniger GM, Simon ES, Sinnreich R, Kark JD. Measures of carotid atherosclerosis and cognitive function in midlife: the Jerusalem ARC longitudinal study. *Intelligence*. 2016;57:73–80. doi: 10.1016/j.intell.2016.05.003
 31. Cohen RA, Poppas A, Forman DE, Hoth KF, Haley AP, Gunstad J, Jefferson AL, Tate DF, Paul RH, Sweet LH, et al. Vascular and cognitive functions associated with cardiovascular disease in the elderly. *J Clin Exp Neuropsychol*. 2009;31:96–110. doi: 10.1080/13803390802014594
 32. Feinkohl I, Keller M, Robertson CM, Morling JR, Williamson RM, Nee LD, McLachlan S, Sattar N, Welsh P, Reynolds RM, et al. Clinical and subclinical macrovascular disease as predictors of cognitive decline in older patients with type 2 diabetes: the Edinburgh Type 2 Diabetes Study. *Diabetes Care*. 2013;36:2779–2786. doi: 10.2337/dc12-2241
 33. Frazier DT, Seider T, Bettcher BM, Mack WJ, Jastrab L, Chao L, Weiner MW, DeCarli C, Reed BR, Mungas D, et al. The role of carotid intima-media thickness in predicting longitudinal cognitive function in an older adult cohort. *Cerebrovasc Dis*. 2014;38:441–447. doi: 10.1159/000366469
 34. Gardener H, Caunca MR, Dong C, Cheung YK, Elkind MS, Sacco RL, Rundek T, Wright CB. Ultrasound markers of carotid atherosclerosis and cognition: the Northern Manhattan Study. *Stroke*. 2017;48:1855–1861. doi: 10.1161/STROKEAHA.117.016921
 35. Gatto NM, Henderson VW, St. John JA, McCleary C, Detrano R, Hodis HN, Mack WJ. Subclinical atherosclerosis is weakly associated with lower cognitive function in healthy hyperhomocysteinemic adults without clinical cardiovascular disease. *Int J Geriatr Psychiatry*. 2009;24:390–399. doi: 10.1002/gps.2134
 36. Geijselaers SLC, Sep SJS, Schram MT, van Bortel MPJ, van Sloten TT, op het Roodt J, Henry RMA, Reesink KD, Schaper NC, Dagnelie PC, et al. Carotid circumferential wall stress is not associated with cognitive performance among individuals in late middle age: the Maastricht Study. *Atherosclerosis*. 2018;276:15–22. doi: 10.1016/j.atherosclerosis.2018.07.003
 37. Haley AP, Forman DE, Poppas A, Hoth KF, Gunstad J, Jefferson AL, Paul RH, Ler ASH, Sweet LH, Cohen RA. Carotid artery intima-media thickness and cognition in cardiovascular disease. *Int J Cardiol*. 2007;121:148–154. doi: 10.1016/j.ijcard.2006.10.032
 38. Imran Y, Prawiroharjo P, Mawi M, Pratama P. Carotid intima media thickness correlates with memory function in productive age population. *Age*. 2020;55:1699–1702.
 39. Jiang X, Zhao X, Chen R, Jiang Q, Zhou B. Plasma soluble CD36, carotid intima-media thickness and cognitive function in patients with type 2 diabetes. *Arch Med Sci*. 2017;13:1031. doi: 10.5114/aoms.2016.60821
 40. Kemp AH, López SF, Passos VMA, Bittencourt MS, Dantas EM, Mill JG, Ribeiro ALP, Thayer JF, Bensenor IM, Lotufo PA, et al. Insulin resistance and carotid intima-media thickness mediate the association between resting-state heart rate variability and executive function: a path modelling study. *Biol Psychol*. 2016;117:216–224. doi: 10.1016/j.biopsycho.2016.04.006
 41. Komulainen P, Kivipelto M, Lakka TA, Hassinen M, Helkala E-L, Patja K, Nissinen A, Rauramaa R. Carotid intima-media thickness and cognitive function in elderly women: a population-based study. *Neuroepidemiology*. 2007;28:207–213. doi: 10.1159/000108112

42. Lim SL, Gao QI, Nyunt MSZ, Gong L, Lunaria JB, Lim ML, Ling A, Lam C-P, Richards AM, Ling LH, et al. Vascular health indices and cognitive domain function: Singapore longitudinal ageing studies. *J Alzheimers Dis*. 2016;50:27–40. doi: 10.3233/JAD-150516
43. Masley SC, Masley LV, Guatieri CT. Cardiovascular biomarkers and carotid IMT scores as predictors of cognitive function. *J Am Coll Nutr*. 2014;33:63–69. doi: 10.1080/07315724.2014.870010
44. Muela HCS, Costa-Hong VA, Yassuda MS, Moraes NC, Memória CM, Machado MF, Bor-Seng-Shu E, Nogueira RC, Mansur AJ, Massaro AR, et al. Higher arterial stiffness is associated with lower cognitive performance in patients with hypertension. *J Clin Hypertens*. 2018;20:22–30. doi: 10.1111/jch.13129
45. Muller M, Grobbee DE, Aleman A, Bots M, Van der Schouw YT. Cardiovascular disease and cognitive performance in middle-aged and elderly men. *Atherosclerosis*. 2007;190:143–149. doi: 10.1016/j.atherosclerosis.2006.01.005
46. Roberts BA, Batty GD, Gale CR, Deary IJ, Parker L, Pearce MS. IQ in childhood and atherosclerosis in middle-age: 40 year follow-up of the Newcastle Thousand Families Cohort Study. *Atherosclerosis*. 2013;231:234–237. doi: 10.1016/j.atherosclerosis.2013.09.018
47. Rogne SO, Solbu MD, Arntzen KA, Herder M, Mathiesen EB, Schirmer H. Albuminuria and carotid atherosclerosis as predictors of cognitive function in a general population. *Eur Neurol*. 2013;70:340–348. doi: 10.1159/000353701
48. Romero JR, Beiser A, Seshadri S, Benjamin EJ, Polak JF, Vasan RS, Au R, DeCarli C, Wolf PA. Carotid artery atherosclerosis, MRI indices of brain ischemia, aging, and cognitive impairment: the Framingham study. *Stroke*. 2009;40:1590–1596. doi: 10.1161/STROKEAHA.108.535245
49. Schwedtfeger AR, Scharnagl H, Stojakovic T, Rathner EM. Cognitive avoidant coping is associated with higher carotid intima media thickness among middle-aged adults. *Int J Behav Med*. 2015;22:597–604. doi: 10.1007/s12529-014-9457-8
50. Singh-Manoux A, Britton A, Kivimaki M, Guéguen A, Halcov J, Marmot M. Socioeconomic status moderates the association between carotid intima-media thickness and cognition in midlife: evidence from the Whitehall II study. *Atherosclerosis*. 2008;197:541–548. doi: 10.1016/j.atherosclerosis.2007.08.010
51. Smith PJ, Blumenthal JA, Babyak MA, Hinderliter A, Sherwood A. Association of vascular health and neurocognitive performance in overweight adults with high blood pressure. *J Clin Exp Neuropsychol*. 2011;33:559–566. doi: 10.1080/13803395.2010.537648
52. Suemoto CK, Santos IS, Bittencourt MS, Pereira AC, Goulart AC, Rundek T, Passos VM, Lotufo P, Benseñor IM. Subclinical carotid artery atherosclerosis and performance on cognitive tests in middle-aged adults: baseline results from the ELSA-Brasil. *Atherosclerosis*. 2015;243:510–515. doi: 10.1016/j.atherosclerosis.2015.10.008
53. Wang A, Chen G, Su Z, Liu X, Yuan X, Jiang R, Cao Y, Chen S, Luo Y, Guo X, et al. Carotid intima-media thickness and cognitive function in a middle-aged and older adult community: a cross-sectional study. *J Neurol*. 2016;263:2097–2104.
54. Wendell CR, Waldstein SR, Evans MK, Zonderman AB. Subclinical carotid atherosclerosis and neurocognitive function in an urban population. *Atherosclerosis*. 2016;249:125–131. doi: 10.1016/j.atherosclerosis.2016.04.009
55. Yue W, Wang A, Liang H, Hu F, Zhang Y, Deng M, Li T, Hu X, Ye Z, Shen Y, et al. Association between carotid intima-media thickness and cognitive impairment in a Chinese stroke population: a cross-sectional study. *Sci Rep*. 2016;6:1–6. doi: 10.1038/srep19556
56. Zhong W, Cruickshanks KJ, Huang GH, Klein BE, Klein R, Nieto FJ, Pankow JS, Schubert CR. Carotid atherosclerosis and cognitive function in midlife: the Beaver Dam Offspring Study. *Atherosclerosis*. 2011;219:330–333. doi: 10.1016/j.atherosclerosis.2011.07.013
57. National Heart, Lung, and Blood Institute. Quality assessment tool for observational cohort and cross-sectional studies. Available at: <https://www.nhlbi.nih.gov/health-topics/study-quality-assessment-tools>. Accessed November 28, 2020.
58. Cohen J. A coefficient of agreement for nominal scales. *Educ Psychol Meas*. 1960;20:37–46. doi: 10.1177/001316446002000104
59. Altman DG. *Practical Statistics for Medical Research*. Chapman and Hall; 1991.
60. DerSimonian R, Kacker R. Random-effects model for meta-analysis of clinical trials: an update. *Contemp Clin Trials*. 2007;28:105–114. doi: 10.1016/j.cct.2006.04.004
61. Jackson D, White IR, Thompson SG. Extending Der Simonian and Laird's methodology to perform multivariate random effects meta-analyses. *Stat Med*. 2010;29:1282–1297. doi: 10.1002/sim.3602
62. Tak LM, Meijer A, Manoharan A, de Jonge P, Rosmalen JG. More than the sum of its parts: meta-analysis and its potential to discover sources of heterogeneity in psychosomatic medicine. *Psychosom Med*. 2010;72:253–265. doi: 10.1097/PSY.0b013e3181d714e1
63. Higgins JPT, Thompson SG. Quantifying heterogeneity in a meta-analysis. *Stat Med*. 2002;21:1539–1558. doi: 10.1002/sim.1186
64. Sterne JA, Egger M, Smith GD. Systematic reviews in health care: investigating and dealing with publication and other biases in meta-analysis. *BMJ*. 2001;323:101–105. doi: 10.1136/bmj.323.7304.101
65. Ward MR, Pasterkamp G, Yeung AC, Borst C. Arterial remodeling, mechanisms and clinical implications. *Circulation*. 2000;102:1186–1191. doi: 10.1161/01.CIR.102.10.1186
66. Zhang Y, Fang X, Hua Y, Tang Z, Guan S, Wu X, Liu H, Liu B, Wang C, Zhang Z, et al. Carotid artery plaques, carotid intima-media thickness, and risk of cardiovascular events and all-cause death in older adults: a 5-year prospective, community-based study. *Angiology*. 2018;69:120–129. doi: 10.1177/0003319717716842
67. Łoboz-Rudnicka M, Jaroch J, Bociąga Z, Rzyckowska B, Uchmanowicz I, Polański J, Dudek K, Szuba A, Łoboz-Grudzień K. Impact of cardiovascular risk factors on carotid intima-media thickness: sex differences. *Clin Interv Aging*. 2016;11:721–731. doi: 10.2147/CIA.S103521
68. Touboul PJ, Grobbee DE, Ruitjer H. Assessment of subclinical atherosclerosis by carotid intima media thickness: technical issues. *Eur J Prev Cardiol*. 2012;19:18–24. doi: 10.1177/2047487312448990
69. Freire CMV, Ribeiro ALP, Barbosa FBL, Nogueira AI, de Almeida MCC, Barbosa MM, Quintão Lana AM, Simões e Silva AC, Ribeiro-Oliveira Jr A. Comparison between automated and manual measurements of carotid intima-media thickness in clinical practice. *Vasc Health Risk Manag*. 2009;5:811–817.
70. Richardson PD, Davies MJ, Born GVR. Influence of plaque configuration and stress distribution on fissuring of coronary atherosclerotic plaques. *Lancet*. 1989;334:941–944. doi: 10.1016/S0140-6736(89)90953-7
71. Cheng GC, Loree HM, Kamm RD, Fishbein MC, Lee RT. Distribution of circumferential stress in ruptured and stable atherosclerotic lesions. A structural analysis with histopathological correlation. *Circulation*. 1993;87:1179–1187. doi: 10.1161/01.CIR.87.4.1179
72. Henry RM, Kostense PJ, Dekker JM, Nijpels G, Heine RJ, Kamp O, Bouter LM, Stehouwer CDA. Carotid arterial remodeling: a maladaptive phenomenon in type 2 diabetes but not in impaired glucose metabolism: the Hoorn study. *Stroke*. 2004;35:671–676. doi: 10.1161/01.STR.0000115752.58601.0B
73. Wardlaw JM. Blood-brain barrier and cerebral small vessel disease. *J Neurol Sci*. 2010;299:66–71. doi: 10.1016/j.jns.2010.08.042

Table S1. Characteristics of the IMT Measurement Procedures of the Studies Included in the Systematic Review and Meta-Analysis on the Association Between Cognition Parameters and IMT.

References	Manual/automated	Common carotid	mHz	Uni o bilateral	Mean or maximal	Global test of cognition or Domain specific assessments
Al Hazzouri et al., 2015 ²⁸	Manual	Yes	13	Bilateral	Maximal IMT of the near and far wall of the CCA	Global test of cognition
Arntzen et al., 2012 ²³	Automated	Yes	7.5	Right	Far and near wall of the CCA and the far wall of the bulb. Included plaque	Domain specific assessments
Casado-Naranjo et al., 2016 ²⁹	NE	Yes	3-12	Bilateral	CCA at 1.5 cm proximal to the flow divider	Domain specific assessments
Cohen-Manheim et al., 2016 ³⁰	Automated	Yes	7.5	Left	far wall of the left CCA, 1 cm proximal to the carotid bulb	Global test of cognition
Cohen et al., 2009 ³¹	Manual	Yes	7-17	Bilateral	CCA, bifurcation, and internal carotid artery, in three views (lateral, anterior, and posterior oblique) Included plaque	Global test of cognition
Del Brutto et al., 2020 ³⁴	NE	Yes	4-15	Bilateral	Near wall and far wall of the: 1) segment extending from 1-2cm proximal to the tip of the flow divider into the CCA; (2) carotid bifurcation beginning at the tip of the flow divider and extending 1cm proximal to the flow divider tip; and (3) proximal 1cm of the internal carotid artery	Domain specific assessments
Feinkohl et al., 2013 ³²	NE	Yes	NE	Bilateral (use of the higher value)	CCA, 1 to 2 cm below the bifurcation Free of plaque	Domain specific assessments
Frazier et al., 2014 ³³	Automated	Yes	NE	Bilateral	Far wall far wall of the right and left distal CCA, a 1 cm length, just distal to the carotid artery bulb	Domain specific assessments
Gardener et al., 2018 ³⁴	Automated	Yes	9-13	Bilateral	Near and far walls of the common carotid artery, bifurcation, and internal carotid artery Free of plaque	Domain specific assessments
Gatto et al., 2009 ³⁵	Automated	Yes	NE	Right	Distal CCA far wall along a 1-cm length just distal to the carotid artery bulb.	Global test of cognition
Geijselaers et al., 2016 ³⁶	NE	Yes	7.5	Left	Left CCA, 1 cm proximal to the carotid bulb. Free of plaque	Global test of cognition
Haley et al., 2007 ³⁷	Automated	Yes	7.5	Left	Far wall of the left CCA, 1 cm proximal to the carotid bulb	Global test of cognition
Imran et al., 2020 ³⁸	Manual	Yes	10	Bilateral	Near-and the far-wall of the distal part of CCA, on the 1-cm long segment from the carotid bulb	Domain specific assessments
Jiang et al., 2017 ³⁹	Automated	Yes	NE	Bilateral	Far wall of the CCA, the 1 cm segment proximal to the bifurcation	Domain specific assessments
Kemp et al., 2016 ⁴⁰	Automated	Yes	7.5	Bilateral	Outer wall, 1 cm in length from 1 cm below carotid bifurcation	Domain specific assessments
Komulainen et al., 2007 ⁴¹	Automated	NE	10	Bilateral	Far wall of the left and right bifurcation	Domain specific assessments
Lim et al., 2016 ⁴²	NE	Yes	10.5	Bilateral	The CCA was scanned in anterior, posterior and lateral at 1cm proximal to the carotid bulb Free of plaque	Global test of cognition
Masley et al., 2014 ⁴³	NE	Yes	5-10	Bilateral	Far wall of the right and left distal 1 cm of the CCA	Global test of cognition
Matsumoto et al., 2018 ²⁵	NE	Yes	NE	Bilateral	The maximum value among the bilateral common and internal carotid artery in the far arterial walls	Domain specific assessments
Muela et al., 2018 ⁴⁴	Automated	Yes	7.5	Left	Left CCA, 1 cm below the bifurcation at the site of the distal Free of plaque	Domain specific assessments
Muller et al., 2007 ⁴	NE	Yes	7.5	Bilateral	left and right distal CCA	Domain specific assessments
Roberts et al., 2013 ⁴⁶	NE	Yes	7	Bilateral	Three locations in the common and internal carotid arteries	Global test of cognition
Rogne et al., 2013 ⁴⁷	Semi-automated	Yes	7.5-12	Right	1cm segments of the far and near wall of the CCA, and in the most proximal 1cm segment of the bulb. Included plaque	Domain specific assessments
Romero et al., 2009 ⁴⁸	NE	Yes	7.5	Bilateral	Near and far walls of CCA, carotid bulb and ICA	Global test of cognition
Schwerdtfeger et al., 2015 ⁴⁹	Automated	NE	5-13	Bilateral	1 cm from carotid bifurcation from the far wall of the arteria carotid at a length of 1 cm	Domain specific assessments
Singh-Manoux et al., 2008 ⁵⁰	NE	Yes	7.5	Bilateral	Right and left CCA, thickest part 1 cm proximal to the bifurcation	Domain specific assessments
Smith et al., 2011 ⁵¹	Automated	Yes	10	Bilateral	Far wall of the left and right CCA	Global test of cognition
Suemoto et al., 2015 ⁵²	NE	Yes	7.5	Bilateral	Left and right CCA, within an area of 1 cm in length, 1 cm below the carotid bifurcation	Domain specific assessments
Wang et al., 2016 ⁵³	Manual	Yes	5-12	Bilateral	Far wall of the CCA proximal to the bifurcation, along a plaque-free segment of 1cm	Domain specific assessments
Wendell et al., 2009 ¹⁵	NE	Yes	5-10	Right	1.5 cm proximal to the carotid bifurcation, of the far arterial wall of the right CCA	Domain specific assessments
Wendell et al., 2016 ⁵⁴	NE	Yes	NE	Left	Far all of the left CCA, 1.5 cm proximal to the carotid bifurcation was identified. Free of plaque	Domain specific assessments
Yue et al., 2016 ⁵⁵	NE	Yes	7.5	Bilateral	Near and far walls of the right and left CCA Included plaque	Domain specific assessments
Zhong et al., 2011 ⁵⁶	NE	Yes	7.5	Bilateral	Left and right sides of the near and far walls of the CCA, the bifurcation and the internal carotid artery Included plaque	Domain specific assessments
Zhong et al., 2012 ²²	NE	Yes	7.5	Bilateral	Left and right sides of the near and far walls of the CCA, the bifurcation and the internal carotid artery Included plaque	Domain specific assessments

Table S2. List of covariates used in the analyses of the included studies.

References	Unadjusted	Adjusted
Al Hazzouri et al., 2015 ³⁸	None.	Age, sex, race, and education, smoking, physical activity, elevated depressive symptoms, body mass index, type 2 diabetes mellitus, hypertension, cystatin C–based estimated glomerular filtration rate and antihypertensive medication use.
Arntzen et al., 2012 ²³	None.	Sex, age and education, physical activity, smoking, systolic blood pressure, total cholesterol, HDL cholesterol, body mass index, diabetes, coronary heart disease and depression.
Casado-Naranjo et al., 2016 ²⁹	Education, smoking, hypertension, folate, B12, creatinine and others as covariates.	Education, smoking, hypertension, folate, B12, creatinine and others as covariates.
Cohen-Manheim et al., 2016 ³⁰	Sex.	Sex, age, education, childhood socioeconomic status (ICBS-based), adult socioeconomic status (ICBS-based), and cigarette pack–years, BMI, plasma cholesterol, fasting plasma glucose, and systolic and diastolic blood pressure measured at ages 28–32.
Cohen et al., 2009 ³¹	None.	None.
Del Brutto et al., 2020 ²⁴	None.	Demographics, cardiovascular risk factors, severe edentulism, and symptoms of depression
Feinkohl et al., 2013 ³²	Age and sex.	baseline vascular risk factors (total cholesterol, brachial blood pressure, cigarette smoking.
Frazier et al., 2014 ³³	Age at baseline, sex, education, CDR score, and hypertension.	Age at baseline, sex, education, CDR score, and hypertension, cerebrovascular risk factors (LDL, diabetes) and WHR.
Gardener et al., 2018 ³⁴	Age at neuropsychological examination, education (y), time from baseline to ultrasound, and time from ultrasound to neuropsychological examination.	Age at neuropsychological examination, education (y), time from baseline to ultrasound, time from ultrasound to neuropsychological examination, sex, race/ethnicity, medicaid/no insurance status, physical activity, alcohol use, smoking, body mass index, diabetes mellitus, hypercholesterolemia, and hypertension, and brain MRI markers (WMHV, brain volume, and SBI)
Gatto et al., 2009 ³⁵	Age, gender, race/ethnicity, education, income, CES-D score, Hcy, SBP, LDL-C, smoking status.	Age, gender, race/ethnicity, education, income, CES-D score, Hcy, SBP, LDL-C, smoking status.
Geijselaers et al., 2016 ³⁶	Age, sex, and educational level.	Age, sex, educational level, body mass index, total/high density lipoprotein-cholesterol ratio, triglycerides, use of lipid-modifying medication, hypertension, presence of type 2 diabetes, estimated glomerular filtration rate, smoking behaviour, alcohol consumption, history of cardiovascular disease(s) and presence of a current depression.
Haley et al., 2007 ³⁷	Age, education, sex, cardiovascular risk factors, and current systolic blood pressure.	Age, education, sex, cardiovascular risk factors, and current systolic blood pressure.
Imran et al., 2020 ³⁸	None.	None.
Jiang et al., 2017 ³⁹	None.	Age, gender, and education level, duration of DM, and hypertension
Komulainen et al., 2007 ⁴¹	None.	Age, education, depression, diabetes, LDL cholesterol, systolic blood pressure, cardiovascular disease (coronary heart disease, cardiac insufficiency), hormone replacement therapy at the time of IMT measures, physical activity, alcohol consumption and smoking.
Lim et al., 2016 ⁴²	None.	Age, gender, education, hypertension, diabetes, dyslipidemia, smoking, body mass index, and APOE 4 status.
Masley et al., 2014 ⁴³	None.	None.
Matsumoto et al., 2018 ²⁵	None.	Sex, age and years of education, body mass index, Brinkman index, systolic blood pressure, low-density lipoprotein cholesterol, high-density lipoprotein cholesterol, hemoglobin A1c, uric acid, bone density, and grade of deep and subcortical white matter hyperintensity.
Muela et al., 2018 ⁴⁴	None.	All independent variables with P<.01 in the bivariate analysis.
Muller et al., 2007 ⁴⁵	Age and education.	Age and education.
Rogne et al., 2013 ⁴⁷	None.	Cardiovascular risk factors and other factors known to influence cognition.
Romero et al., 2009 ⁴⁸	Age and sex.	Age, sex, time to MRI/Neuropsychological testing, diabetes, smoking, hypertension treatment, systolic blood pressure and cardiovascular disease.
Singh-Manoux et al., 2008 ⁵⁰	Age and sex.	Age and sex.
Smith et al., 2011 ⁵¹	Background characteristics, CVRF, and intima medial thickness.	Background characteristics, CVRF, and intima medial thickness.
Suemoto et al., 2015 ⁵²	None.	Age, sex, race, marital status, education, income, hypertension, diabetes, coronary artery disease, heart failure, smoking, heart failure, smoking, heart failure, physical activity, body mass index, depression, and thyroid function status.

Table S2. List of covariates used in the analyses of the included studies. (continue)

References	Unadjusted	Adjusted
Wang et al., 2016 ⁵³	None.	Age, sex, education, income level, body mass index, physical exercise, systolic blood pressure, diastolic blood pressure, high-density lipoprotein cholesterol, hypertension, diabetes mellitus, <u>dyslipidemia, smoking, and drinking</u>
Wendell et al., 2009 ¹⁵	Age, years of education, MAP, BMI, total cholesterol, and depressive symptoms were treated as continuous covariates, and gender, race, smoking, and cardiovascular medications.	Age, years of education, MAP, BMI, total cholesterol, and depressive symptoms were treated as continuous covariates, and gender, race, smoking, and cardiovascular medications.
Wendell et al., 2016 ⁵⁴	Age, sex, race, poverty status, education, substance use, depressive symptoms, systolic blood pressure, total cholesterol, body mass index, antihypertensive use, lipid-lowering medication use, cardiovascular disease, and diabetes.	Age, sex, race, poverty status, education, substance use, depressive symptoms, systolic blood pressure, total cholesterol, body mass index, antihypertensive use, lipid-lowering medication use, cardiovascular disease, and diabetes.
Yue et al., 2016 ⁵⁵	None.	None.
Zhong et al., 2011 ⁵⁶	Age, sex, and education	Age, sex, education, marital status, family income, hypertension, CVD, diabetes, smoking and heavy drinking status, regular exercise, SF-36 mental score, HDL cholesterol, anti-hypertensive medications and use of statins.
Zhong et al., 2012 ²²	Age, sex and education	Hemoglobin A1C, SF-36 mental score, antihypertensive medications, body mass index, heavy drinking, HDL cholesterol and smoking.

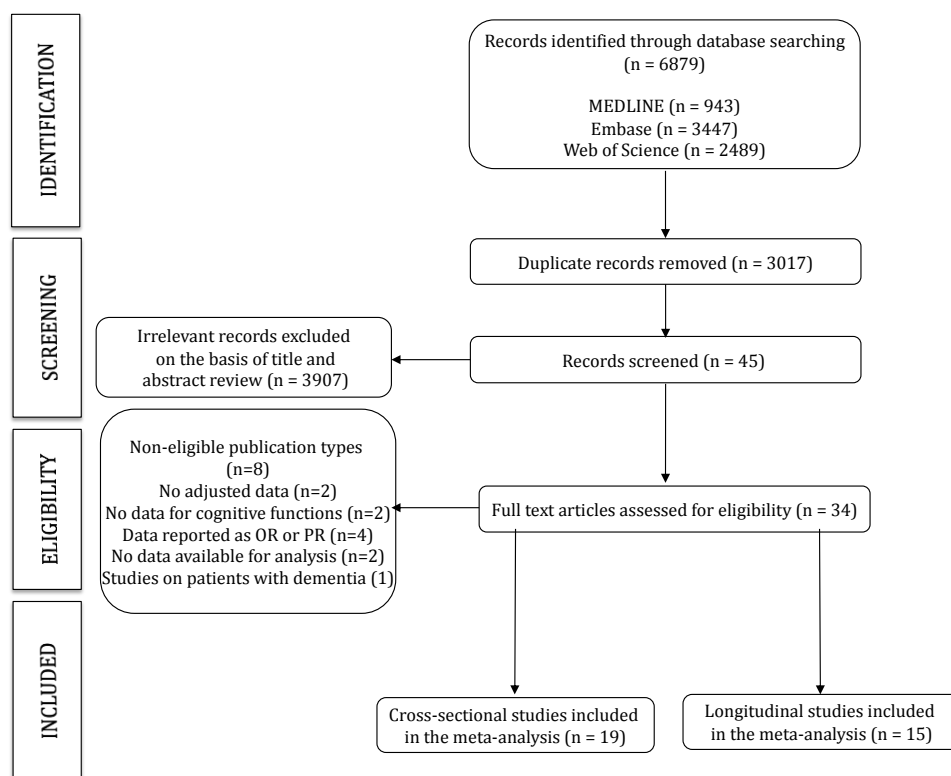


Figure S1. Preferred Reporting Items for Systematic Reviews flowchart.

Table S3. Risk of bias of cross-sectional and longitudinal included studies. Numbers representing the questions included in the The Quality Assessment Tool for Observational Cohort and Cross-Sectional Studies.

References	1	2	3	4	5	6	7	8	9	10	11	12	13	14	Total
Al Hazzouri et al., 2015 ²⁸	Y	Y	Y	Y	NR	Y	Y	Y	Y	Y	Y	Y	Y	Y	12
Arntzen et al., 2012 ²³	Y	Y	Y	Y	NR	NR	Y	Y	Y	NR	Y	Y	Y	Y	11
Casado-Naranjo et al., 2016 ²⁹	Y	Y	Y	Y	NR	-	-	Y	Y	-	Y	Y	-	Y	9
Cohen-Manheim et al., 2016 ³⁰	Y	Y	Y	Y	NR	NR	Y	Y	Y	Y	Y	NR	Y	Y	11
Cohen et al., 2009 ³¹	Y	Y	Y	Y	NR	-	-	Y	Y	-	Y	Y	-	N	8
Del Brutto et al., 2020 ²⁴	Y	Y	Y	Y	NR	Y	Y	Y	Y	NR	Y	Y	Y	Y	12
Feinkohl et al., 2013 ³²	Y	Y	N	Y	NR	Y	Y	Y	Y	Y	Y	NR	Y	Y	11
Frazier et al., 2014 ³³	Y	Y	Y	Y	NR	NR	Y	Y	Y	Y	Y	Y	Y	N	11
Gardener et al., 2018 ³⁴	Y	Y	Y	Y	NR	Y	Y	N	Y	Y	Y	NR	Y	Y	12
Gatto et al., 2009 ³⁵	Y	Y	N	Y	NR	-	-	Y	Y	-	Y	NR	-	Y	7
Geijselaers et al., 2016 ³⁶	Y	Y	Y	Y	NR	-	-	Y	Y	-	Y	NR	-	Y	8
Haley et al., 2007 ³⁷	Y	Y	Y	Y	NR	-	-	Y	Y	-	Y	NR	-	Y	8
Imran et al., 2020 ³⁸	Y	Y	Y	Y	NR	-	-	N	Y	-	Y	NR	-	N	6
Jiang et al., 2017 ³⁹	Y	Y	Y	Y	NR	-	-	Y	Y	-	Y	NR	-	Y	8
Kemp et al., 2016 ⁴⁰	Y	Y	Y	Y	NR	-	-	Y	Y	-	Y	NR	-	N	7
Komulainen et al., 2007 ⁴¹	Y	Y	Y	Y	NR	Y	Y	N	Y	Y	Y	NR	N	Y	10
Lim et al., 2016 ⁴²	Y	Y	NR	Y	NR	-	-	N	Y	-	Y	NR	-	Y	6
Masley et al., 2014 ⁴³	Y	Y	NR	Y	NR	-	-	N	Y	-	Y	NR	-	N	5
Matsumoto et al., 2018 ²⁵	Y	Y	NR	Y	NR	-	-	Y	Y	-	Y	Y	-	Y	7
Muela et al., 2018 ⁴⁴	Y	Y	NR	Y	NR	NR	-	Y	Y	-	Y	Y	-	Y	8
Muller et al., 2007 ⁴	Y	Y	N	Y	NR	NR	-	Y	Y	-	Y	NR	-	Y	7
Roberts et al., 2013 ⁴⁶	Y	Y	Y	Y	NR	Y	Y	Y	Y	Y	Y	NR	-	Y	11
Rogne et al., 2013 ⁴⁷	Y	Y	Y	Y	NR	Y	Y	Y	Y	Y	Y	NR	N	Y	11
Romero et al., 2009 ⁴⁸	Y	Y	Y	Y	NR	Y	Y	Y	Y	Y	Y	Y	N	Y	12
Schwerdtfeger et al., 2015 ⁴⁹	Y	Y	NR	Y	NR	-	-	Y	Y	-	Y	NR	-	Y	7
Singh-Manoux et al., 2008 ⁵⁰	Y	Y	N	Y	NR	-	-	Y	Y	-	Y	Y	-	Y	7
Smith et al., 2011 ⁵¹	Y	Y	Y	Y	NR	-	-	N	Y	-	Y	NR	-	Y	7
Suemoto et al., 2015 ⁵²	Y	Y	Y	Y	NR	-	-	Y	Y	-	Y	NR	-	Y	8
Wang et al., 2016 ⁵³	Y	Y	N	Y	NR	-	-	Y	Y	-	Y	NR	-	Y	7
Wendell et al., 2009 ¹⁵	Y	Y	NR	Y	NR	NR	Y	Y	Y	Y	Y	NR	NR	Y	9
Wendell et al., 2016 ⁵⁴	Y	Y	N	Y	NR	NR	Y	Y	Y	Y	Y	NR	N	Y	8
Yue et al., 2016 ⁵⁵	Y	Y	N	Y	NR	-	-	Y	Y	-	Y	NR	-	Y	7
Zhong et al., 2011 ⁵⁶	Y	Y	N	Y	NR	-	-	N	Y	-	Y	NR	-	Y	6
Zhong et al., 2012 ²²	Y	Y	NR	Y	NR	NR	Y	N	Y	Y	Y	NR	NR	Y	8

Y: yes; N: no; NR: not reported

Table S4: Heterogeneity, inconsistency estimations for DerSimonian and random effects methods and z scores and corresponding p-values against the hypothesis that IMT has no effect on cognitive function.

	Hypothesis values		Inconsistence	Heterogeneity		
	Q	p		I ²	z	p
Cross-sectional Unadjusted						
Global cognition	134.40	0.000	0.039	89.6	4.40	0.000
Executive function	37.15	0.000	0.012	81.2	3.15	0.002
Memory	151.33	0.000	0.036	90.1	2.65	0.008
Attention	54.16	0.000	0.042	87.1	1.47	0.142
Cross-sectional Adjusted						
Global cognition	78.08	0.000	0.021	82.1	3.46	0.001
Executive function	27.04	0.000	0.010	74.1	2.51	0.012
Memory	33.88	0.000	0.007	55.7	2.86	0.004
Attention	32.46	0.000	0.024	78.4	1.83	0.067
Longitudinal Unadjusted						
Global cognition	16.37	0.001	0.025	81.7	2.37	0.018
Executive function	50.25	0.000	0.031	90.0	1.78	0.075
Memory	255.80	0.000	0.052	96.5	2.00	0.046
Attention	215.95	0.000	0.157	98.6	1.13	0.259
Longitudinal Adjusted						
Global cognition	7.30	0.063	0.007	58.9	1.56	0.120
Executive function	12.78	0.026	0.005	60.9	1.03	0.305
Memory	23.32	0.006	0.003	61.4	0.20	0.843
Attention	3.81	0.283	0.000	21.3	1.57	0.116

Table S5. Sensitivity analyses by removing studies one by one from the pooled unadjusted cross-sectional analysis. The effect size and 95% interval confidence (95%IC) represents the pooled estimations after excluding from the analysis the corresponding reference.

Global cognition			
Reference	ES	LL	UL
Casado-Naranjo et al., 2016	-0.241	-0.355	-0.126
Del Brutto et al., 2020	-0.228	-0.339	-0.116
Feinkohl et al., 2013	-0.256	-0.375	-0.137
Gatto et al., 2009	-0.265	-0.382	-0.149
Jiang et al., 2016	-0.193	-0.285	-0.101
Komulainen et al., 2007	-0.247	-0.361	-0.134
Lim et al., 2016	-0.251	-0.367	-0.135
Matsumoto et al., 2018	-0.258	-0.374	-0.141
Muela et al., 2018	-0.232	-0.345	-0.119
Singh-Manoux., 2008 (High SES)	-0.274	-0.387	-0.161
Singh-Manoux., 2008 (Intermed SES)	-0.272	-0.386	-0.158
Singh-Manoux., 2008 (low SES)	-0.260	-0.378	-0.142
Wang et al., 2016	-0.259	-0.388	-0.130
Yue et al., 2016	-0.244	-0.363	-0.124
Zhong et al., 2011	-0.262	-0.383	-0.114
Executive function			
Reference	ES	LL	UL
Gardener et al., 2018	-0.198	-0.324	-0.071
Gatto et al., 2009	-0.210	-0.325	-0.095
Suemoto et al., 2015	-0.176	-0.332	-0.019
Lim et al., 2016	-0.169	-0.287	-0.052
Masley et al., 2014	-0.145	-0.258	-0.032
Muller et al., 2007	-0.177	-0.299	-0.054
Rogne et al., 2013	-0.140	-0.244	-0.037
Smith et al., 2011	-0.199	-0.312	-0.086
Memory			
Reference	ES	LL	UL
Cohen et al., 2009	-0.157	-0.265	-0.048
Gardener et al., 2018	-0.140	-0.251	-0.029
Gatto et al., 2009	-0.157	-0.274	-0.040
Geijselaers et al., 2016	-0.151	-0.264	-0.038
Imran et al., 2020	-0.127	-0.234	-0.021
Komulainen et al., 2007	-0.125	-0.231	-0.019
Lim et al., 2016	-0.147	-0.257	-0.038
Masley et al., 2014	-0.142	-0.252	-0.031
Matsumoto et al., 2018	-0.134	-0.243	-0.025
Muela et al., 2018	-0.119	-0.224	-0.014
Muller et al., 2007	-0.135	-0.244	-0.026
Rogne et al., 2013	-0.128	-0.231	-0.025
Singh-Manoux., 2008 (High SES)	-0.157	-0.273	-0.041
Singh-Manoux., 2008 (Intermed SES)	-0.163	-0.282	-0.045
Singh-Manoux., 2008 (low SES)	-0.152	-0.264	-0.039
Suemoto et al., 2015	-0.161	-0.251	-0.072
Attention			
Reference	ES	LL	UL
Cohen et al., 2009	-0.064	-0.217	0.089
Geijselaers et al., 2016	-0.163	-0.364	0.037
Haley et al., 2007	-0.078	-0.239	0.083
Lim et al., 2016	-0.142	-0.321	0.038
Masley et al., 2014	-0.130	-0.315	0.054
Muela et al., 2018	-0.067	-0.222	0.089
Suemoto et al., 2015	-0.186	-0.377	0.005
Zhong et al., 2011	-0.180	-0.387	0.027

ES: effect size; LL: low limit; UL: upper limit.

Table S6. Sensitivity analyses by removing studies one by one from the pooled adjusted cross-sectional analysis. The effect size and 95% interval confidence (95% IC) represents the pooled estimations after excluding from the analysis the corresponding reference.

Global cogniton			
Reference	ES	LL	UL
Casado-Naranjo et al., 2016	-0.140	-0.228	-0.053
Del Brutto et al., 2020	-0.160	-0.251	-0.068
Feinkohl et al., 2013	-0.151	-0.244	-0.058
Gatto et al., 2009	-0.161	-0.252	-0.070
Jiang et al., 2016	-0.123	-0.203	-0.043
Komulainen et al., 2007	-0.151	-0.239	-0.062
Lim et al., 2016	-0.156	-0.246	-0.066
Matsumoto et al., 2018	-0.162	-0.252	-0.072
Muela et al., 2018	-0.146	-0.235	-0.057
Singh-Manoux., 2008 (High SES)	-0.170	-0.257	-0.084
Singh-Manoux., 2008 (Intermed SES)	-0.168	-0.256	-0.080
Singh-Manoux., 2008 (low SES)	-0.155	-0.247	-0.064
Wang et al., 2016	-0.158	-0.257	-0.060
Yue et al., 2016	-0.130	-0.208	-0.052
Zhong et al., 2011	-0.153	-0.247	-0.059
Executive function			
Reference	ES	LL	UL
Gardener et al., 2018	-0.124	-0.234	-0.014
Gatto et al., 2009	-0.139	-0.241	-0.039
Kempton et al., 2016	-0.139	-0.251	-0.027
Suemoto et al., 2015	-0.107	-0.201	-0.013
Masley et al., 2014	-0.070	-0.131	0.010
Muller et al., 2007	-0.110	-0.208	-0.011
Rogne et al., 2013	-0.117	-0.229	-0.004
Smith et al., 2011	-0.131	-0.225	-0.036
Memory			
Reference	ES	LL	UL
Cohen et al., 2009	-0.097	-0.159	-0.034
Gardener et al., 2018	-0.092	-0.160	-0.024
Gatto et al., 2009	-0.103	-0.172	-0.034
Geijselaers et al., 2016	-0.099	-0.166	-0.031
Imran et al., 2020	-0.079	-0.137	-0.021
Komulainen et al., 2007	-0.081	-0.141	-0.021
Lim et al., 2016	-0.093	-0.158	-0.028
Masley et al., 2014	-0.085	-0.149	-0.020
Matsumoto et al., 2017	-0.089	-0.155	-0.024
Muela et al., 2018	-0.076	-0.135	-0.017
Muller et al., 2007	-0.078	-0.139	-0.016
Rogne et al., 2013	-0.095	-0.165	-0.025
Singh-Manoux., 2008 (High SES)	-0.103	-0.171	-0.034
Singh-Manoux., 2008 (Intermed SES)	-0.106	-0.168	-0.043
Singh-Manoux., 2008 (low SES)	-0.096	-0.163	-0.029
Suemoto et al., 2015	-0.096	-0.162	-0.031
Attention			
Reference	ES	LL	UL
Cohen et al., 2009	-0.072	-0.191	0.046
Geijselaers et al., 2016	-0.174	-0.337	-0.011
Haley et al., 2007	-0.085	-0.214	0.043
Lim et al., 2016	-0.143	-0.289	0.003
Masley et al., 2014	-0.138	-0.294	0.019
Muela et al., 2018	-0.072	-0.196	0.053
Suemoto et al., 2015	-0.184	-0.377	0.009
Zhong et al., 2011	-0.178	-0.337	-0.019

ES: effect size; LL: low limit; UL: upper limit

Table S7. Sensitivity analyses by removing studies one by one from the pooled unadjusted longitudinal analysis. The effect size and 95% interval confidence (95% IC) represents the pooled estimations after excluding from the analysis the corresponding reference.

Global cognition			
Reference	ES	LL	UL
Cohen-Manheim et al., 2016	-0.200	-0.424	0.023
Del Brutto et al., 2020	-0.176	-0.375	0.024
Feinkohl et al., 2013	-0.177	-0.381	0.028
Wendell et al., 2016	-0.287	-0.383	-0.190
Executive function			
Reference	ES	LL	UL
Alhazzouri et al., 2015	-0.068	-0.162	0.025
Cohen-Manheim et al., 2016	-0.139	-0.314	0.035
Frazier et al., 2014	-0.106	-0.269	0.057
Gardener et al., 2018	-0.173	-0.338	-0.008
Rogne et al., 2013	-0.151	-0.340	0.038
Romero et al., 2009	-0.168	-0.336	-0.001
Memory			
Reference	ES	LL	UL
Alhazzouri et al., 2015	-0.134	-0.297	0.029
Arntzen et al., 2012	-0.088	-0.195	0.191
Cohen-Manheim et al., 2016	-0.149	-0.310	0.012
Frazier et al., 2014	-0.150	-0.309	0.009
Gardener et al., 2018	-0.185	-0.344	-0.025
Komulainen et al., 2007	-0.117	-0.269	0.035
Romero et al., 2009 (CCAimt)	-0.175	-0.347	-0.003
Wendell et al., 2009	-0.183	-0.344	-0.022
Wendell et al., 2016	-0.176	-0.352	0.001
Zhong et al., 2012	-0.171	-0.335	-0.007
Attention			
Reference	ES	LL	UL
Arntzen et al., 2012	-0.067	-0.204	0.071
Cohen-Manheim et al., 2016	-0.215	-0.697	0.267
Wendell et al., 2009	-0.307	-0.779	0.165
Wendell et al., 2016	-0.299	-0.754	0.154

ES: effect size; LL: low limit; UL: upper limit

Table S8. Sensitivity analyses by removing studies one by one from the pooled adjusted longitudinal analysis. The effect size and 95% interval confidence (95% IC) represents the pooled estimations after excluding from the analysis the corresponding reference.

Global cognition			
Reference	ES	LL	UL
Cohen-Manheim et al., 2016	-0.093	-0.240	0.053
Del Brutto et al., 2020	-0.102	-0.248	0.044
Feinkohl et al., 2013	-0.027	-0.102	0.048
Wendell et al., 2016	-0.125	-0.255	0.004
Executive function			
Reference	ES	LL	UL
Alhazzouri et al., 2015	-0.040	-0.144	0.063
Cohen-Manheim et al., 2016	-0.046	-0.136	0.044
Frazier et al., 2014	-0.019	-0.080	0.041
Gardener et al., 2017	-0.061	-0.144	0.023
Rogne et al., 2013	-0.030	-0.125	0.064
Romero et al., 2009	-0.063	-0.150	0.025
Memory			
Reference	ES	LL	UL
Alhazzouri et al., 2015	-0.001	-0.054	0.052
Arntzen et al., 2012	-0.005	-0.061	0.052
Cohen-Manheim et al., 2016	-0.001	-0.051	0.049
Frazier et al., 2014	0.001	-0.046	0.049
Gardener et al., 2017	-0.017	-0.063	0.030
Komulainen et al., 2007	0.002	-0.035	0.039
Romero et al., 2009 (CCAimt)	-0.008	-0.065	0.049
Wendell et al., 2009	-0.016	-0.065	0.033
Wendell et al., 2016	-0.005	-0.063	0.053
Zhong et al., 2012	-0.007	-0.060	0.045
Attention			
Reference	ES	LL	UL
Arntzen et al., 2012	-0.030	-0.112	0.052
Cohen-Manheim et al., 2016	-0.033	-0.176	0.010
Wendell et al., 2009	-0.050	-0.108	0.008
Wendell et al., 2016	-0.057	-0.128	0.014

ES: effect size; LL: low limit; UL: upper limit

Table S9. Meta-regression of IMT and cognition domains by percentage of females and mean age, BMI, and baseline IMT values of included studies.

	n	% female		n	Age		n	BMI		n	Baseline IMT	
		β (95%CI)	p		β (95%CI)	p		β (95%CI)	p		β (95%CI)	p
Global cognition												
Cross-sectional data												
<i>Unadjusted</i>	15	-0.007	0.225	15	-0.008	0.174	8	0.003	0.736	13	-0.136	0.552
<i>Adjusted</i>	15	-0.002	0.597	15	-0.006	0.083	8	0.002	0.701	13	-0.110	0.462
Longitudinal data												
<i>Unadjusted</i>	3	0.007	0.873	4	-0.010	0.202	3	0.002	0.973	3	-0.430	0.641
<i>Adjusted</i>	3	0.025	0.271	4	-0.001	0.331	3	-0.018	0.667	3	-0.628	0.259
Executive function												
Cross-sectional data												
<i>Unadjusted</i>	8	0.003	0.401	7	-0.001	0.895	8	0.068	0.057	7	0.458	0.721
<i>Adjusted</i>	8	0.003	0.277	7	-0.001	0.973	8	0.039	0.241	7	0.404	0.705
Longitudinal data												
<i>Unadjusted</i>	5	0.007	0.728	6	-0.001	0.878	-	-	-	5	-0.369	0.577
<i>Adjusted</i>	5	0.015	0.350	6	-0.002	0.486	-	-	-	5	-0.281	0.565
Memory												
Cross-sectional data												
<i>Unadjusted</i>	14	-0.002	0.555	15	-0.003	0.573	14	-0.043	0.147	16	-0.245	0.205
<i>Adjusted</i>	14	0.000	0.877	15	-0.002	0.447	14	-0.031	0.139	16	-0.161	0.192
Longitudinal data												
<i>Unadjusted</i>	9	-0.013	0.141	10	0.000	0.938	7	0.009	0.928	10	-0.758	0.306
<i>Adjusted</i>	9	-0.010	0.132	10	0.000	0.977	7	0.006	0.789	10	-0.105	0.711
Attention												
Cross-sectional data												
<i>Unadjusted</i>	7	-0.0003	0.982	8	-0.021	0.100	5	-0.120	0.262	7	-2.093	0.148
<i>Adjusted</i>	7	-0.001	0.949	8	-0.018	0.137	5	-0.0107	0.259	7	-2.028	0.172
Longitudinal data												
<i>Unadjusted</i>	3	0.073	0.372	4	-0.012	0.584	3	0.108	0.638	4	-1.348	0.262
<i>Adjusted</i>	3	0.010	0.462	4	-0.006	0.270	3	0.013	0.635	4	-0.295	0.297

NA: Not Available; BMI: body mass index; IMT: intima media thickness.

Table S10. Subgroup analyses of the association between IMT and cognition domains by IMT and cognition measurement procedure characteristics of included studies. n represents number of studies included in each subgroup analysis; bold font indicates effects size similar to the reported in the main analyses and italics indicates effect size opposite to the reported in the main analyses.

Global cognition	Type	Manual/automated		Classification	mHz		Place	Laterally		Cognition method				
		ES (95%CI)	n		ES (95%CI)	n		ES (95%CI)	n	Classification	ES (95%CI)	n		
Cross-sectional data														
<i>Unadjusted</i>	Manual	-0.18 (-0.25; 0.11)	1	Range	-0.17 (-0.32; -0.02)	6	Bilateral	-0.26 (-0.38; -0.13)	12	Domain specific assessments	-0.27 (-0.39; -0.15)	13		
	Automated	-0.26 (-0.49; -0.02)	7	>7	-0.28 (-0.42; -0.14)	5	Right	-0.04 (-0.21; 0.13)	1	Global test of cognition	-0.12 (-0.30; 0.06)	2		
	Not specified		-0.26 (-0.38; -0.15)	7	Not specified	-0.33 (-0.70; 0.04)	4	Left	-0.54 (-0.82; -0.27)	1				
								Not specified	-0.18 (-0.32; -0.04)	1				
	<i>Adjusted</i>	Manual	-0.11 (-0.19; -0.03)	1	Range	<i>-0.06 (-0.15; 0.03)</i>	6	Bilateral	-0.15 (-0.25; -0.05)	12	Domain specific assessments	-0.17 (-0.26; -0.07)	13	
Automated		<i>-0.14 (-0.29; 0.01)</i>	7	>7	-0.23 (-0.34; -0.04)	5	Right	-0.04 (-0.21; 0.13)	1	Global test of cognition	-0.06 (-0.20; 0.07)	2		
Not specified			-0.18 (-0.28; -0.07)	7	Not specified	-0.20 (-0.43; 0.03)	4	Left	-0.28 (-0.56; -0.01)	1				
								Not specified	-0.18 (-0.32; -0.04)	1				
Longitudinal data														
<i>Unadjusted</i>	Manual	-0.24 (-0.41; -0.06)	1	Range	-0.28 (-0.41; -0.15)	1	Bilateral	-0.28 (-0.41; -0.15)	1	Domain specific assessments	-0.20 (-0.42; 0.02)	3		
	Automated	-	-	>7	-	-	Right	-	-	Global test of cognition	-0.24 (-0.41; -0.06)	1		
	Not specified		-0.20 (-0.42; 0.02)	3	Not specified	-0.15 (-0.43; 0.13)	2	Left	-0.01 (-0.10; 0.09)	1				
								Not specified	-0.30 (-0.45; -0.16)	1				
	<i>Adjusted</i>	Manual	-0.07 (-0.24; 0.10)	1	Range	-0.05 (-0.18; 0.07)	2	Bilateral	-0.05 (-0.18; 0.07)	2	Domain specific assessments	-0.09 (-0.24; 0.05)	3	
Automated		-	-	>7	-	-	Right	-	-	Global test of cognition	-0.07 (-0.24; 0.10)	1		
Not specified			-0.09 (-0.24; 0.05)	3	Not specified	-0.12 (-0.34; 0.11)	2	Left	-0.01 (-0.20; 0.02)	1				
								Not specified	-0.24 (-0.38; -0.10)	1				
Executive functions														
Cross-sectional data	<i>Unadjusted</i>	Manual	-	-	Range	-0.28 (-0.51; -0.05)	3	Bilateral	-0.17 (-0.28; -0.07)	6	Domain specific assessments	-0.20 (-0.33; -0.07)	4	
		Automated	-0.09 (-0.33; 0.14)	4	>7	0.16 (-0.21; -0.12)	4	Right	-0.18 (-0.59; 0.24)	2	Global test of cognition	-0.14 (-0.41; 0.14)	4	
		Not specified		-0.24 (-0.37; -0.11)	4	Not specified	0.04 (-0.13; 0.21)	1	Left	-	-			
									Not specified	-	-			
		<i>Adjusted</i>	Manual	-	-	Range	-0.20 (-0.36; -0.04)	3	Bilateral	-0.15 (-0.28; -0.02)	6	Domain specific assessments	-0.08 (-0.15; -0.02)	4
	Automated		-0.07 (-0.16; 0.02)	4	>7	-0.08 (-0.20; 0.04)	4	Right	-0.06 (-0.22; 0.10)	2	Global test of cognition	-0.14 (-0.41; 0.14)	4	
	Not specified			-0.21 (-0.42; 0.00)	4	Not specified	0.04 (-0.13; 0.21)	1	Left	-	-			
									Not specified	-	-			
	Longitudinal data													
	<i>Unadjusted</i>	Manual	-0.35 (-0.42; -0.27)	2	Range	-0.05 (-0.14; 0.04)	3	Bilateral	-0.15 (-0.34; 0.04)	5	Domain specific assessments	-0.16 (-0.41; 0.09)	3	
Automated		-0.08 (-0.18; 0.02)	3	>7	-0.35 (-0.42; -0.28)	1	Right	-0.08 (-0.18; 0.02)	1	Global test of cognition	-0.10 (-0.16; 0.07)	3		
Not specified			0.00 (-0.09; 0.09)	1	Not specified	-0.15 (-0.50; 0.19)	2	Left	-	-				
								Not specified	-	-				
<i>Adjusted</i>		Manual	-0.05 (-0.13; 0.02)	2	Range	-0.02 (-0.12; 0.08)	3	Bilateral	-0.03 (-0.12; 0.06)	5	Domain specific assessments	-0.02 (-0.08; 0.05)	3	
	Automated	-0.10 (-0.28; 0.09)	3	>7	-0.06 (-0.14; 0.02)	1	Right	-0.09 (-0.19; 0.01)	1	Global test of cognition	-0.10 (-0.18; 0.09)	3		
	Not specified		0.04 (-0.05; 0.13)	1	Not specified	-0.14 (-0.52; 0.24)	2	Left	-	-				
								Not specified	-	-				

Table S10. Subgroup analyses of the association between IMT and cognition domains by IMT and cognition measurement procedure characteristics of included studies. (continued) n represents number of studies included in each subgroup analysis; bold font indicates effects size similar to the reported in the main analysis and italics indicated effect size opposite to the reported in the main analysis.

Memory	Manual/automated				mHz			Laterally			Cognition method		
	Type	ES (95%CI)	n	Classification	ES (95%CI)	n	Place	ES (95%CI)	n	Classification	ES (95%CI)	n	
Cross-sectional data													
<i>Unadjusted</i>	Manual	-0.61 (-1.06; -0.16)	1	Range	<i>-0.11 (-0.23; 0.01)</i>	6	Bilateral	-0.13 (-0.26; -0.01)	11	Domain specific assessments	-0.19 (-0.34; -0.05)	11	
	Automated	-0.14 (-0.26; -0.02)	9	>7	<i>-0.21 (-0.43; 0.02)</i>	8	Right	-0.15 (-0.41; 0.11)	2	Global test of cognition	-0.05 (-0.13; 0.02)	5	
	Not specified	-0.11 (-0.30; -0.08)	6	Not specified	-0.13 (-0.40; 0.13)	2	Left	-0.16 (-0.54; 0.23)	3				
							Not specified	-	-				
	<i>Adjusted</i>	Manual	-0.61 (-1.06; -0.16)	1	Range	<i>-0.05 (-0.12; 0.01)</i>	6	Bilateral	-0.11 (-0.19; -0.02)	11	Domain specific assessments	-0.12 (-0.20; -0.03)	11
		Automated	<i>-0.06 (-0.13; 0.01)</i>	9	>7	-0.19 (-0.34; -0.03)	8	Right	-0.05 (-0.13; 0.02)	2	Global test of cognition	-0.04 (-0.12; 0.03)	5
Not specified		-0.12 (-0.20; -0.04)	6	Not specified	-0.04 (-0.15; 0.07)	2	Left	-0.10 (-0.39; 0.19)	3				
						Not specified	-	-					
Longitudinal data													
<i>Unadjusted</i>	Manual	-0.29 (-0.39; -0.18)	2	Range	0.02 (-0.12; 0.15)	3	Bilateral	-0.14 (-0.30; 0.01)	7	Domain specific assessments	-0.18 (-0.43; 0.06)	6	
	Automated	-0.34 (-0.75; 0.07)	4	>7	<i>-0.29 (-0.53; -0.05)</i>	5	Right	-0.21 (-0.76; 0.35)	2	Global test of cognition	-0.14 (-0.31; 0.04)	4	
	Not specified	0.00 (-0.04; 0.05)	4	No specified	-0.06 (-0.20; 0.08)	2	Left	-0.02 (-0.07; 0.03)	1				
							Not specified	-	-				
	<i>Adjusted</i>	Manual	-0.05 (-0.12; 0.03)	2	Range	-0.06 (-0.02; 0.14)	3	Bilateral	-0.03 (-0.11; 0.05)	7	Domain specific assessments	0.00 (-0.08; 0.08)	6
		Automated	-0.08 (-0.25; 0.10)	4	>7	-0.02 (-0.09; 0.04)	5	Right	-0.03 (-0.07; 0.12)	2	Global test of cognition	-0.02 (-0.06; 0.03)	4
Not specified		-0.01 (-0.03; 0.05)	4	Not specified	-0.06 (-0.20; 0.08)	2	Left	-0.02 (-0.07; 0.03)	1				
						Not specified	-	-					
Cross-sectional data													
<i>Unadjusted</i>	Manual	-	-	Range	-0.11 (-0.28; 0.06)	1	Bilateral	0.07 (-0.06; 0.19)	4	Domain specific assessments	0.01 (-0.16; 0.18)	4	
	Automated	-0.41 (-0.70; -0.11)	4	>7	-0.13 (-0.31; 0.05)	7	Right	-	-	Global test of cognition	-0.30 (-0.60; 0.00)	4	
	Not specified	0.07 (-0.05; 0.18)	4	Not specified	-	-	Left	-0.39 (-0.76; -0.01)	4				
							Not specified	-	-	Domain specific assessments	-0.03 (-0.16; 0.11)	4	
	<i>Adjusted</i>	Manual	-	-	Range	-0.11 (-0.28; 0.06)	1	Bilateral	0.01 (-0.05; 0.06)	4	Global test of cognition	-0.30 (-0.60; 0.00)	4
		Automated	-0.41 (-0.70; -0.11)	4	>7	-0.14 (-0.29; 0.02)	7	Right	-0.38 (-0.78; 0.01)	4			
Not specified		0.01 (-0.05; 0.07)	4	Not specified	-	-	Left	-	-				
						Not specified	-	-					
Longitudinal data													
<i>Unadjusted</i>	Manual	-0.26 (-0.43; -0.08)	1	Range	-0.11 (-0.39; 0.16)	2	Bilateral	-0.26 (-0.44; -0.09)	1	Domain specific assessments	-0.22 (-0.60; 0.27)	3	
	Automated	-0.65 (-0.71; -0.59)	1	>7	-0.65 (-0.71; -0.59)	1	Right	-0.32 (-0.97; 0.34)	2	Global test of cognition	-0.26 (-0.44; -0.09)	1	
	Not specified	-0.00 (-0.07; 0.06)	2	No specified	-0.01 (-0.08; 0.06)	1	Left	-0.01 (-0.08; 0.06)	1				
							Not specified	-	-	Domain specific assessments	-0.03 (-0.08; 0.01)	3	
	<i>Adjusted</i>	Manual	-0.16 (-0.33; 0.01)	1	Range	-0.08 (-0.22; 0.05)	2	Bilateral	-0.16 (-0.33; 0.01)	1	Global test of cognition	0.16 (-0.33; 0.01)	1
		Automated	-0.06 (-0.12; 0.00)	1	>7	-0.06 (-0.12; 0.00)	1	Right	-0.04 (-0.11; 0.02)	2			
Not specified		0.00 (-0.07; 0.06)	2	Not specified	-0.01 (-0.08; 0.06)	1	Left	-0.01 (-0.08; 0.06)	1				
						Not specified	-	-					

ES: Effect size; CI: Confidence Interval.

Table S11. Meta-bias for the association between IMT and cognitive function domains.

	Coefficient	p
Cross-sectional Unadjusted		
Global cognition	-2.193	0.224
Executive function	-0.023	0.988
Memory	0.188	0.002
Attention	-3.491	0.002
Cross-sectional Adjusted		
Global cognition	-0.104	0.695
Executive function	-0.135	0.200
Memory	-1.868	0.018
Attention	-1.917	0.086
Longitudinal Unadjusted		
Global cognition	-6.497	0.087
Executive function	1.743	0.692
Memory	0.945	0.826
Attention	-0.648	0.584
Longitudinal Adjusted		
Global cognition	-2.102	0.602
Executive function	-1.479	0.512
Memory	1.992	0.103
Attention	-0.057	0.937

Figure S2. Funnel plot for comparison-specific cross-sectional pooled effect sizes for global cognition.

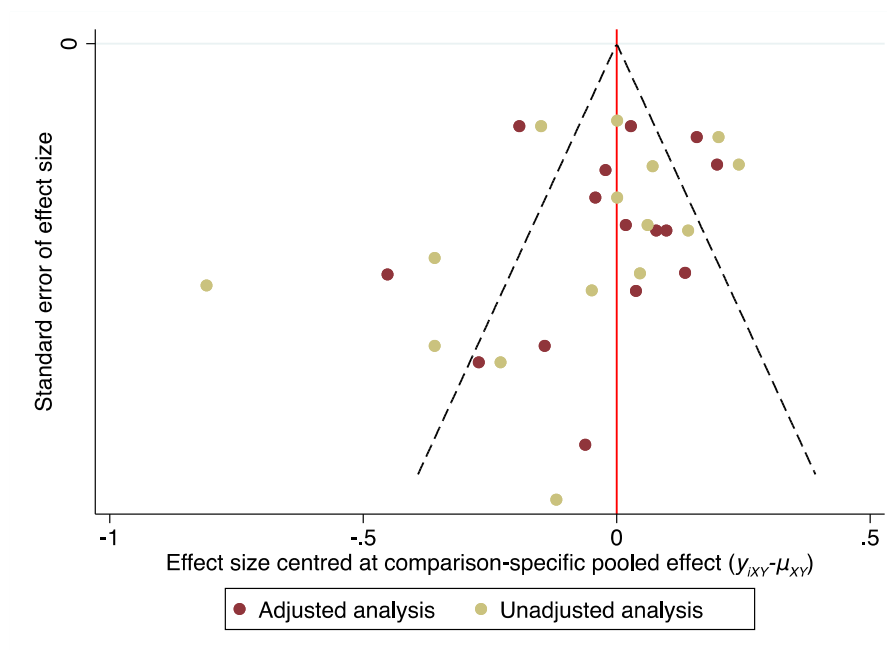


Figure S3. Funnel plot for comparison-specific cross-sectional pooled effect sizes for executive functions.

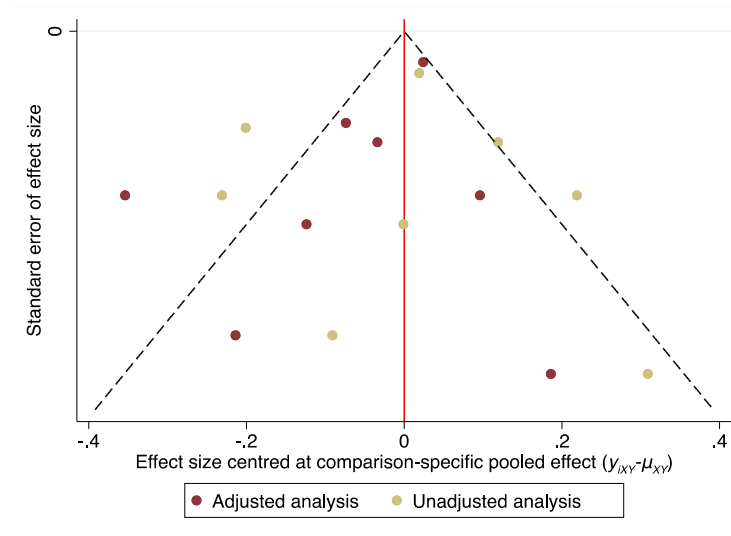


Figure S4. Funnel plot for comparison-specific cross-sectional pooled effect sizes for memory.

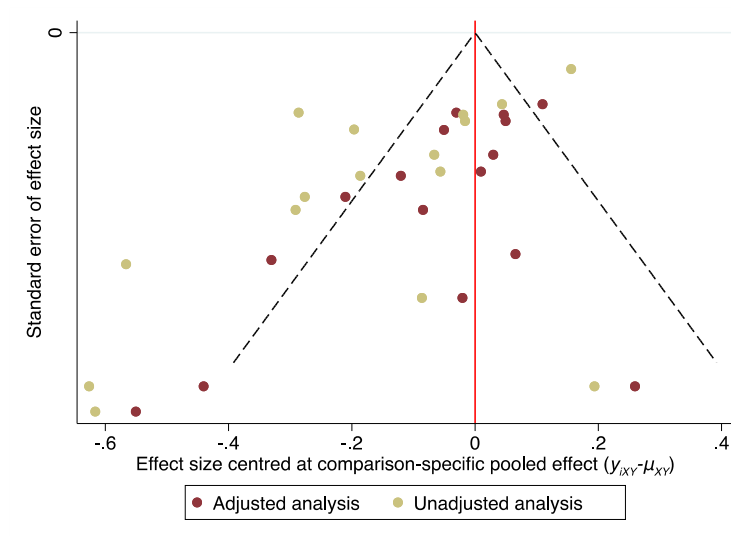


Figure S5. Funnel plot for comparison-specific cross-sectional pooled effect sizes for attention.

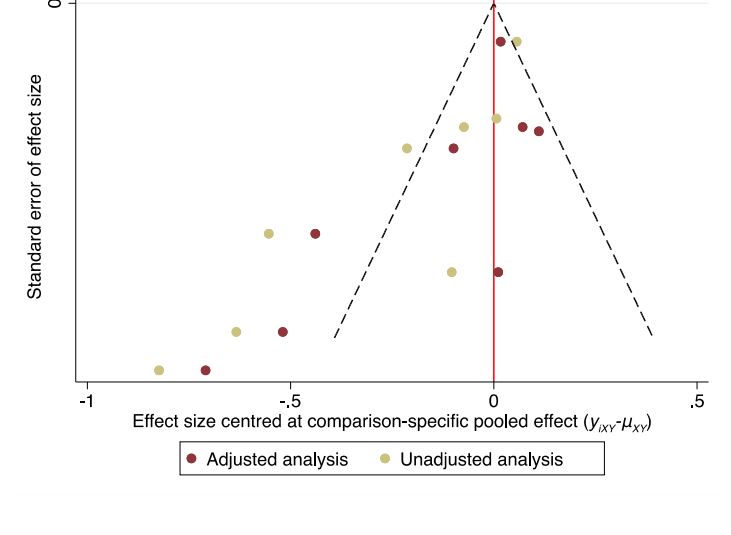


Figure S6. Funnel plot for comparison-specific longitudinal pooled effect sizes for global cognition.

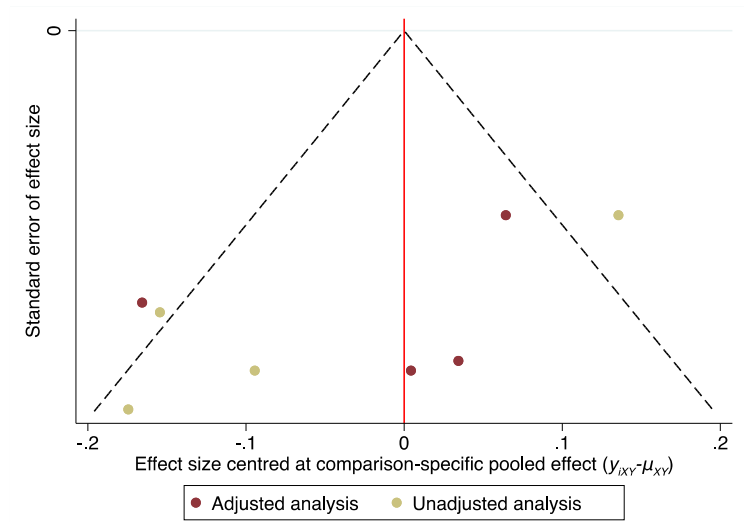


Figure S7. Funnel plot for comparison-specific longitudinal pooled effect sizes for executive functions.

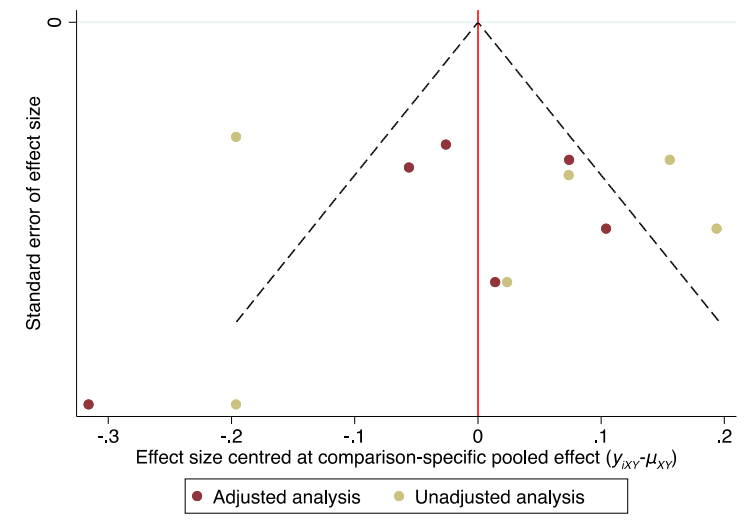


Figure S8. Funnel plot for comparison-specific longitudinal pooled effect sizes for memory.

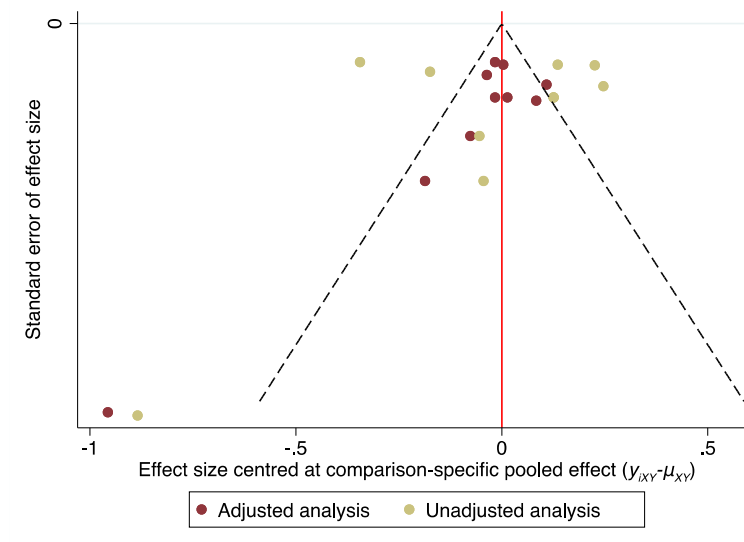


Figure S9. Funnel plot for comparison-specific longitudinal pooled effect sizes for attention.

