SOCIETÀ ITALIANA DI GERONTOLOGIA E GERIATRIA

53° Congresso Nazionale SIGG
Firenze, venerdì 28 novembre 2008

L'importanza di una diagnosi (1) differenziale precoce (2) tra malattia di Alzheimer (AD) e demenza a corpi di Lewy (DLB)

Orazio ZANETTI

Società Italiana di Gerontologia e Geriatria
U.O. Alzheimer - Centro per la Memoria
IRCCS, Centro S.Giovanni di Dio - Fatebenefratelli,
Brescia, Italy

DOBBIAMO FOCALIZZARCI SU CIO' CHE SI PUO' FARE PIUTTOSTO CHE SULL'ASSENZA DI UNA CURA

Editorials represent the opinions of the authors and not necessarily those of the BMJ or BMA

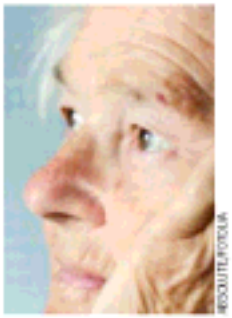
For the full versions of these articles see bmj.com

EDITORIALS

Caring for people with dementia

The focus should be on what can be done rather than on the lack of a cure

Doctors occupy a unique vantage point for ensuring optimal quality of care for people with dementia and their families. Both the patient with dementia and their carer—many of whom live together—need to be provided for. Doctors have a part to play in promoting quality of care from diagnosis until death, through assessment of changes in cognitive functioning—such as memory, day to day functioning, and behaviour—alongside identification and treatment of comorbidities. Referral to specialist psychological and psychosocial services is integral to provision of high quality care.[4]



RESEARCH, p 258

Mamta Downs professor in dementia studies, Bradford Dementia Group, University of Bradford, Bradford BD5 0BB
m.downs@bradford.ac.uk
Barbara Bowers associate dean for research and Helen Dennie Schutte professor, School of Nursing, University of Wisconsin, Madison, WI 53792-2455, USA

Competing interests: None declared.
Provenance and peer review: Commissioned; not externally peer reviewed.

BMJ 2008;336:225-6
doi 10.1136/bmj.39429.434907.80

LE RISPOSTE CONCRETE

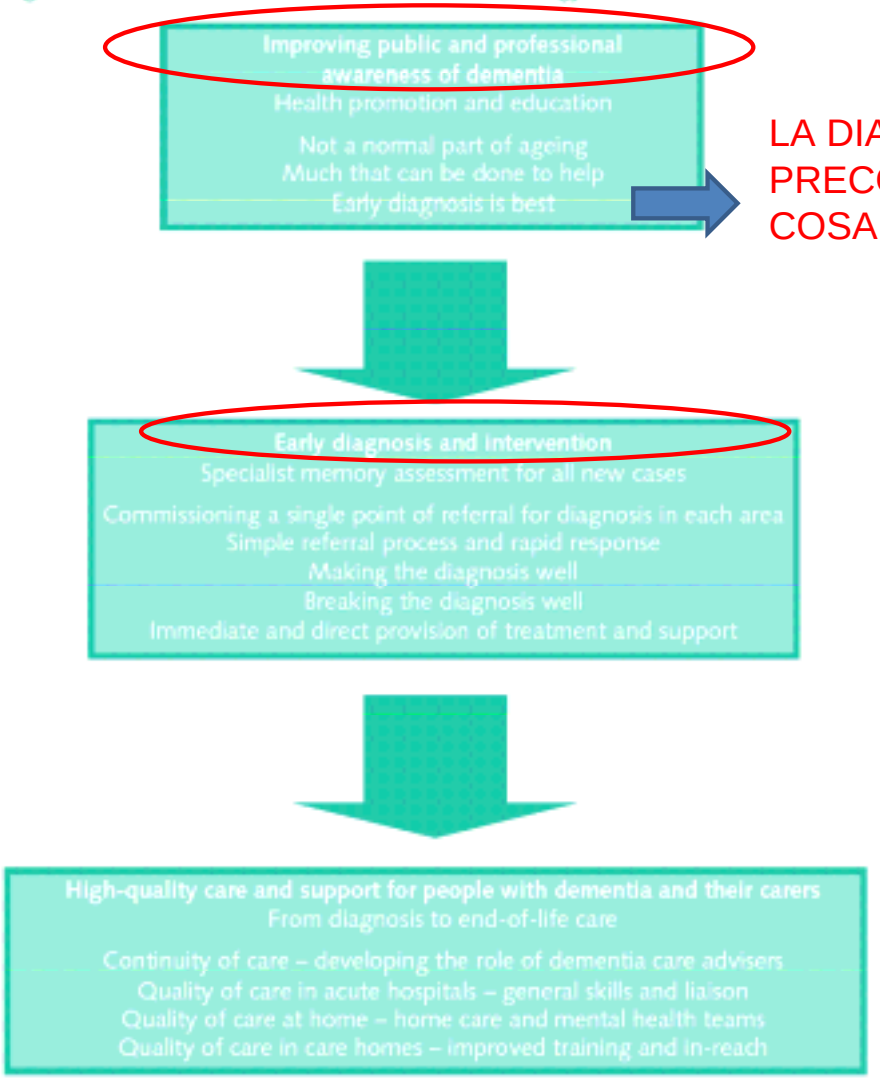
DH Department of Health

UK

Title	Transforming the Quality of Dementia Care: Consultation on a National Dementia Strategy
Author	DH/SCLG&CP/SCPI/SR
Publication Date	19 Jun 2008
Target Audience	PCT CEs, NHS Trust CEs, SHA CEs, Care Trust CEs, Foundation Trust CEs, Medical Directors, Directors of PH, Directors of Nursing, Local Authority CEs, Directors of Adult SSs, PCT PEC Chairs, NHS Trust Board Chairs, Special HA CEs, Directors of HR, Directors of Finance, Allied Health Professionals, GPs, Communications Leads, Emergency Care Leads
Circulation List	Voluntary Organisations/NDPBs
Description	The Department of Health is developing a national strategy for dementia services. This consultation draws on evidence from a wide range of reports and stakeholders, a series of listening events involving over 3,000 people and the recommendations of an External Reference Group. It invites everyone to give their views on the ideas set out in the document, as well as contribute new ideas to the debate.
Cross Reference	N/A
Superseded Documents	N/A
Action Required	N/A
Timing	**Responses should be submitted by 11 September 2008**

IL PRESENTE

Figure 1: The vision of the National Dementia Strategy



LA DIAGNOSI PRECOCE E' LA COSA MIGLIORE

Conferenza

"L'Europa contro la malattia di Alzheimer "

Parigi, Bibiliothèque Nationale de France

30-31 ottobre 2008

Malattia di Alzheimer
più di 100 anni dopo

- Soltanto il 60% circa dei pazienti con AD ottiene una diagnosi
- Circa la metà di questi pazienti riceve un trattamento con Ache-i

Cummings, 2004

Giacobini, 2005

INTERNATIONAL JOURNAL OF GERIATRIC PSYCHIARTY
Int. J. Geriatr Psychiatry 2007; **22**: 47–54.
Published online 17 October 2006 in Wiley InterScience
(www.interscience.wiley.com) **DOI**: 10.1002/gps.1652

Access to diagnostic evaluation and treatment for dementia in Europe

Gunhild Waldemar[1]*, Kieu T. T. Phung[1], Alistair Burns[2], Jean Georges[3], Finn Ronholt Hansen[4], Steven Iliffe[5], Christine Marking[6], Marcel Olde Rikkert[7], Jacques Selmes[9], Gabriela Stoppe[8] and Norman Sartorius[10] on behalf of the European Dementia Consensus Network (EDCON)

Table 1. Estimated number and percentage of AD patients treated with galantamine, rivastigmine, donepezil, and memantine in Europe in 2004

Country	Estimated number of patients with dementia according to Alzheimer Europe	Estimated number of AD patients (60% of all dementia cases)	Number of patients treated according to IMS 2nd quarter 2004	Estimated percentage of patients treated (%)
Austria	97,137	58,282	19,042	32
Belgium	129,389	77,633	23,274	30
Bulgaria	49,746	29,858	1,638	6
Cyprus	2,705	1,623		
Czech Republic	98,064	58,838	5,132	9
Denmark	65,959	39,575	11,003	28
Estonia				
Finland	58,797	35,278		
France	758,229	454,937	233,673	50
Germany	1,032,969	619,781	160,128	26
Greece	131,283	78,769	76,542	97
Hungary	90,614	54,368	1,493	3
Iceland	2,510	1,506		
Ireland	31,702	19,021	8,811	46
Italy	719,205	431,523	76,350	18
Latvia				
Lithuania	34,164	20,498		
Luxembourg	4,664	2798		
Malta				
Netherlands	164,910	98,946	7,917	8
Norway	57,758	34,655		
Poland	311,879	187,127	30,377	16
Portugal	103,690	62,214	20,405	33
Romania	139,787	83,872		
Slovenia				
Slovak Republic	42,197	25,318	2,542	10
Spain	488,956	293,374	118,133	40
Sweden	131,643	78,986	37,122	47
Switzerland	88,304	52,982	14,581	28
United Kingdom	741,042	444,637	78,816	18

DOI: 10.1002/gps

KEY POINTS

- Access to facilities for diagnosis and treatment of dementia is insufficient in most European countries.
- Treatment rates for Alzheimer's disease varies considerably across Europe.
- The European Dementia Consensus Network (EDCON) recommends appropriate legal, educational, administrative, and economic measures to improve the access to diagnosis and treatment.

INTERNATIONAL JOURNAL OF GERIATRIC PSYCHIATRY
Int. J. Geriatr. Psychiatry 2007; **22**: 47–54.
Published online 17 October 2006 in Wiley InterScience
(www.interscience.wiley.com) **DOI**: 10.1002/gps.1652

Access to diagnostic evaluation and treatment for dementia in Europe

Gunhild Waldemar[1]*, Kieu T. T. Phung[1], Alistair Burns[2], Jean Georges[3], Finn Rotholt Hansen[4], Steven Iliffe[5], Christine Marking[6], Marcel Olde Rikkert[7], Jacques Selmes[8], Gabriela Stoppe[9] and Norman Sartorius[10] on behalf of the European Dementia Consensus Network (EDCON)

PHARMACOEPIDEMIOLOGY AND DRUG SAFETY 2008; **17**: 655–660
Published online 29 May 2008 in Wiley InterScience (www.interscience.wiley.com)**DOI**: 10.1002/pds.1613

ORIGINAL REPORT

Prevalence of cholinesterase inhibitors in subjects with dementia in Europe†

Antoine Pariente MD, MPH[1,2,3]*, Catherine Helmer MD, PhD[4], Yvon Merliere PhD[5], Nicholas Moore MD, PhD[1,2,3], Annie Fourrier-Réglat PharmD, PhD[1,2,3] and Jean-Francois Dartigues MD, PhD[2,3,4]

Table 1. Prevalence of dementia, of treatment and market share for cholinesterase inhibitors in nine European countries on 1 January 2005

Drug	Prevalence of dementia	Prevalence of treatment	Single drug user subjects	Reimbursements of ChI in multi-ChI users (%)
France	755 000	153 000 (20.3%)	146 000	
Donepezil			93 000 (63.8%)	51.9
Galantamine			24 000 (16.2%)	21.9
Rivastigmine			29 000 (20.0%)	26.3
Spain	520 000	91 000 (17.5%)	86 000	
Donepezil			40 000 (46.7%)	36.7
Galantamine			29 000 (33.5%)	39.9
Rivastigmine			17 000 (19.7%)	23.3
Belgium	130 000	18 000 (13.8%)	17 000	
Donepezil			9000 (54.6%)	44.4
Galantamine			3000 (19.0%)	23.4
Rivastigmine			5000 (26.4%)	32.3
Portugal	125 000	14 000 (11.2%)	13 000	
Donepezil			8000 (62.3%)	52.3
Galantamine			3000 (24.0%)	30.4
Rivastigmine			2000 (13.7%)	17.2
Poland	305 000	24 000 (7.9%)	23 000	
Donepezil			16 000 (69.4%)	60.0
Galantamine			7000 (30.4%)	39.8
Rivastigmine			50 (0.2%)	0.3
Germany	995 000	67 000 (6.7%)	63 000	
Donepezil			40 000 (63.6%)	53.7
Galantamine			9000 (14.0%)	17.8
Rivastigmine			14 000 (22.5%)	28.5
UK	730 000	49 000 (6.7%)	46 000	
Donepezil			33 000 (72.1%)	63.2
Galantamine			5000 (10.6%)	14.0
Rivastigmine			8000 (17.3%)	22.8
Italy	810 000	48 000 (5.9%)	45 000	
Donepezil			28 000 (63.6%)	53.7
Galantamine			12 000 (25.7%)	32.8
Rivastigmine			5000 (10.6%)	13.5
Netherlands	165 000	5000 (3.0%)	4000	
Donepezil			0	0
Galantamine			3500 (85.7%)	85.8
Rivastigmine			500 (14.3%)	14.2
Overall	4 535 000	469 000 (10.3%)	443 000	
Donepezil			267 000 (60.2%)	49.8
Galantamine			95 500 (21.6%)	27.3
Rivastigmine			80 550 (18.2%)	22.9

Published online 29 May 2008 in Wiley InterScience (www.interscience.wiley.com) DOI: 10.1002/pds.1613

ORIGINAL REPORT

Prevalence of cholinesterase inhibitors in subjects with dementia in Europe[*]

Antonio Forette MD, MPH[1,2,3], Catherine Hélène MD, PhD[4], Yves Morlaye PhD[4], Nicholas Moore MD, PhD[1,2,3], Annie Fourrier-Réglat PharmD, PhD[1,2,3] and Jean-François Dartigues MD, PhD[1,2,3]

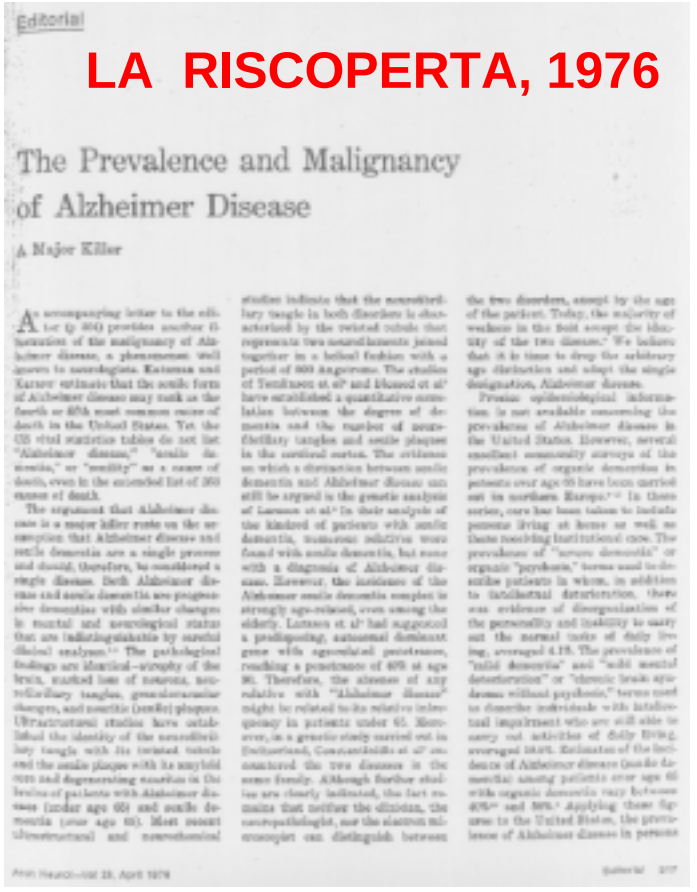
THE LANCET *1997*

Department of medical history

Auguste D and Alzheimer's disease

LA SCOPERTA
(1906)

Konrad Maurer, Stephan Volk, Hector Gerbaldo



Editorial

LA RISCOPERTA, 1976

The Prevalence and Malignancy of Alzheimer Disease

A Major Killer

McKhan et al., Neurology 1984: I criteri clinici

Position Paper

Research criteria for the diagnosis of Alzheimer's disease: revising the NINCDS–ADRDA criteria

Bruno Dubois*, Howard H Feldman*, Claudia Jacova, Steven T DeKosky, Pascale Barberger-Gateau, Jeffrey Cummings, André Delacourte, Douglas Galasko, Serge Gauthier, Gregory Jicha, Kenichi Meguro, John O'Brien, Florence Pasquier, Philippe Robert, Martin Rossor, Steven Salloway, Yaakov Stern, Pieter J Visser, Philip Scheltens

Lancet Neurol 2007; 6: 734–46

Published Online July 9, 2007

DOI:10.1016/S1474-4422(07)70178-3

August 2007

Lancet Neurol 2007; 6: 734–46
Published Online
July 9, 2007
DOI:10.1016/S1474-4422(07)70178-3

Panel 2: Diagnostic criteria for AD

Probable AD: A plus one or more supportive features B, C, D, or E

Core diagnostic criteria

1

A. Presence of an early and significant episodic memory impairment that includes the following features:

1. Gradual and progressive change in memory function reported by patients or informants over more than 6 months
2. Objective evidence of significantly impaired episodic memory on testing: this generally consists of recall deficit that does not improve significantly or does not normalise with cueing or recognition testing and after effective encoding of information has been previously controlled
3. The episodic memory impairment can be isolated or associated with other cognitive changes at the onset of AD or as AD advances

Supportive features

2

B. Presence of medial temporal lobe atrophy

- Volume loss of hippocampi, entorhinal cortex, amygdala evidenced on MRI with qualitative ratings using visual scoring (referenced to well characterised population with age norms) or quantitative volumetry of regions of interest (referenced to well characterised population with age norms)

3

C. Abnormal cerebrospinal fluid biomarker

- Low amyloid β_{1-42} concentrations, increased total tau concentrations, or increased phospho-tau concentrations, or combinations of the three
- Other well-validated markers to be discovered in the future

4

D. Specific pattern on functional neuroimaging with PET

- Reduced glucose metabolism in bilateral temporal parietal regions
- Other well validated ligands, including those that foreseeably will emerge such as Pittsburg compound B or FDDNP

E. Proven AD autosomal dominant mutation within the immediate family

History of DLB

In 1996, a consortium of scientists initially proposed diagnostic guidelines (McKeith et al., Neurology 1996;47:1113-1124).
Second revision: McKeith et al., Neurology 1999; 53:902-905

HIGH LIGHT
CME

Diagnosis and management of dementia with Lewy bodies

Third report of the DLB consortium

I.G. McKeith, MD, FMedSci; D.W. Dickson, MD; J. Lowe, DM; M. Emre, MD; J.T. O'Brien, DM; H. Feldman, MDCM; J. Cummings, MD; J.E. Duda, MD; C. Lippa, MD; E.K. Perry, DSc; D. Aarsland, MD; H. Arai, MD; C.G. Ballard, MD; B. Boeve, MD; D.J. Burn, FRCP; D. Costa, MD; T. Del Ser, MD, PhD; B. Dubois, MD; D. Galasko, MD; S. Gauthier, MD, FRCPC; C.G. Goetz, MD; E. Gomez-Tortosa, MD, PhD; G. Halliday, PhD; L.A. Hansen, MD; J. Hardy, PhD; T. Iwatsubo, MD; R.N. Kalaria, FRCPath; D. Kaufer, MD; R.A. Kenny, MD; A. Korczyn, MD; K. Kosaka, MD; V.M.-Y. Lee, PhD, MBA; A. Lees, MD; I. Litvan, MD; E. Londos, MD, PhD; O.L. Lopez, MD; S. Minoshima, MD, PhD; Y. Mizuno, MD; J.A. Molina, MD; E.B. Mukaetova-Ladinska, MD, PhD; F. Pasquier, MD, PhD; R.H. Perry, DSc; J.B. Schulz, MD; J.Q. Trojanowski, MD, PhD; and M. Yamada, MD, PhD, for the Consortium on DLB*

NEUROLOGY 2005;65:1863–1872

Diagnosis and management of dementia with Lewy bodies

Third report of the DLB consortium

Central feature (essential for a diagnosis of possible or probable DLB)

Dementia defined as progressive cognitive decline of sufficient magnitude to interfere with normal social or occupational function. Prominent or persistent memory impairment may not necessarily occur in the early stages but is usually evident with progression. Deficits on tests of attention, executive function, and visuospatial ability may be especially prominent.

Core features (two core features are sufficient for a diagnosis of probable DLB, one for possible DLB)

Fluctuating cognition with pronounced variations in attention and alertness

Recurrent visual hallucinations that are typically well formed and detailed

Spontaneous features of parkinsonism

Suggestive features (If one or more of these is present in the presence of one or more core features, a diagnosis of probable DLB can be made. In the absence of any core features, one or more suggestive features is sufficient for possible DLB. Probable DLB should not be diagnosed on the basis of suggestive features alone.)

REM sleep behavior disorder

Severe neuroleptic sensitivity

Low dopamine transporter uptake in basal ganglia demonstrated by SPECT or PET imaging

NEUROLOGY 2005;65:1863–1872

Importanza clinica diagnosi differenziale LBD-AD: prevalenza

- **LBD è la seconda causa di demenza neurodegenerativa, dopo AD**

- **10-20% dei casi** ***(Perry et al. J Neurol Sci 1990, Stevens et al. Br J Psychiatry 2002)***

AD 47%
DLB 22%
VD 23%

Dementia with Lewy bodies according to the consensus criteria in a general population aged 75 years or older

T Rahkonen, U Eloniemi-Sulkava, S Rissanen, A Vatanen, P Viramo, R Sulkava

See Editorial Commentary, p 697–698

J Neurol Neurosurg Psychiatry 2003;**74**:720–724

See end of article for authors' affiliations

Correspondence to: Dr Terhi Rahkonen, Division of Geriatrics, Department of Public Health and General Practice, University of Kuopio, PO Box 1627, 70211 Kuopio, Finland; terhi.rahkonen@uku.fi

Received 19 August 2002
In revised form 14 January 2003
Accepted 15 January 2003

Objective: To estimate the prevalence of dementia with Lewy bodies (DLB) according to the consensus criteria in a general population aged 75 years or older.

Methods: The "Kuopio 75+ study" is a population based health survey focused on the clinical epidemiology of dementia and functional capacity among elderly subjects aged 75 years or older. On 1 January 1998, a random sample of 700 subjects was drawn from a total population born before 1 January 1923, living in the city of Kuopio, northeast Finland (n = 4518). The study subjects underwent a structured interview and clinical examination.

Results: 601 elderly subjects (86% of the random sample) were examined. A dementia disorder was diagnosed in 137—a prevalence of 22.8% (95% confidence interval 19.4% to 26.2%). The prevalence of DLB was 5.0% (3.2% to 6.7%), comprising 22% of all demented subjects. Probable DLB was diagnosed in 20 subjects (3.3% (1.9% to 4.8%)), and possible DLB in 10 (1.7% (0.6% to 2.7%)). The prevalence of Alzheimer's disease was 10.6% (47% of all demented subjects), of vascular dementia, 5.3% (23%), and of other types of dementing disorders, 1.8% (8%).

Conclusions: In a general population aged 75 years and older, the prevalence of a disorder fulfilling the diagnostic criteria of DLB is half that of Alzheimer's disease and the same as for vascular dementia.

DEMENZE CON PARKINSONISMO

- PARKINSON DEMENZA
- DEMENZA A CORPI DI LEWY
- PARALISI SOPRANUCLEARE PROGRESSIVA
- ATROFIA MULTISISTEMICA
- DEGENERAZIONE CORTICOBASALE
- DEMENZA FRONTOTEMPORALE

DIAGNOSIS AND MANEGEMENT OF DEMENTIA WITH LEWY BODIES

THIRD REPORT OF THE DLB CONSORTIUM

NEUROLOGY 2005;65:1863–1872

Demenza

Il disturbo di memoria può non essere presente negli stadi precoci; deficit nei test di attenzione, funzioni esecutive e abilità visuo-spaziali.

Core features
(2 sufficienti per diagnosi probabile, 1 per possibile)

1- fluttuazioni della cognitività

2- ricorrenti allucinazioni visive

3- parkinsonismo

NEUROLOGY 2005;65:1863–1872

Caratteristiche suggestive
(se 1 o più insieme a 1 o più dei core è probabile; se 1 o più in assenza dei "core" possibile)

1- disturbo REM

2- ipersensibilità ai neurolettici

3- ridotto *uptake* di dopamina nei gangli della base

NEUROLOGY 2005;65:1863–1872

Criteri di supporto

1) cadute, sincopi, perdita di coscienza

2) disautonomia, uptake ridotto MIGB, basso uptake occipitale PET/SPECT

3) conservazione lobo temporale

NEUROLOGY 2005;65:1863–1872

DLB meno probabile

1- malattia cerebrovascolare evidente con segni neurologici focali o documentati al neuroimaging

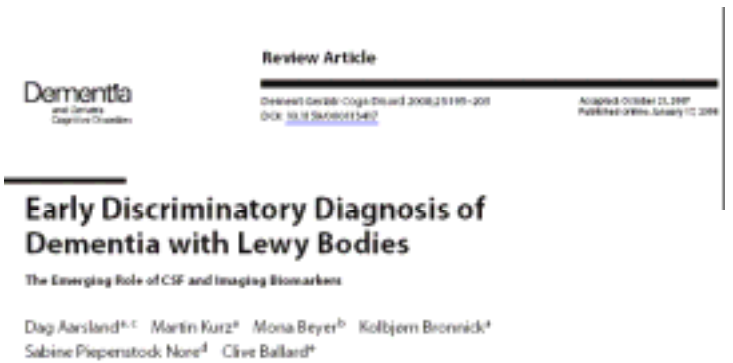
2- con qualunque malattia somatica o disordine cerebrale sufficiente a giustificare in parte o in tutto il quadro clinico

3- se il solo parkinsonismo compare per la prima volta in uno stadio di demenza severa

NEUROLOGY 2005;65:1863–1872

Table 1. Sensitivity and specificity of biomarkers for discrimination of DLB and AD

Biomarker and reference	Sensitivity %	Specificity %	Cases in study		
			DLB	AD	NC
Cerebrospinal fluid					
Phospho tau 181p [47]	74 80	85[a] 79[b]	60	94	60
Ratio aβ 1–42 to aβ 1–37 [48]	71	74	21	21	23
Aβ-ox [49]	88	70[c]	21	23	23
Total tau and tau/amyloid quotient [46]	not reported	76 and 71	25	33	46


Review Article

Dementia

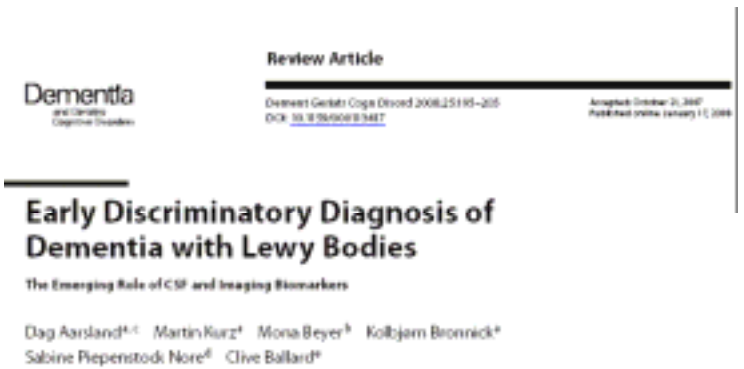
Early Discriminatory Diagnosis of Dementia with Lewy Bodies

The Emerging Role of CSF and Imaging Biomarkers

Dag Aarsland[a–c] Martin Kurz[a] Mona Beyer[b] Kolbjørn Brønnick[a]
Sabine Piepenstock Nore[d] Clive Ballard[a]

Table 1. Sensitivity and specificity of biomarkers for discrimination of DLB and AD

Biomarker and reference	Sensitivity %	Specificity %	Cases in study		
			DLB	AD	NC
Structural MRI					
Preservation of hippocampus and medial temporal lobe in DLB compared to AD [65]	38	100	26	28	26



Review Article

Dementia

Dement Geriatr Cogn Disord 2008;25:195–205

Early Discriminatory Diagnosis of Dementia with Lewy Bodies

The Emerging Role of CSF and Imaging Biomarkers

Dag Aarsland Martin Kurz Mona Beyer Kolbjørn Brønnick Sabine Piepenstock Nore Clive Ballard

Table 1. Sensitivity and specificity of biomarkers for discrimination of DLB and AD

Biomarker and reference	Sensitivity %	Specificity %	Cases in study		
			DLB	AD	NC
SPECT					
^{99m}Tc-HMPAO SPECT: occipital hypoperfusion and preserved medial temporal perfusion					
Lobotesis et al. [72]	65	87	23	50	20
Shimizu et al. [73]	81	85	36	96	
Hanyu et al. [74]	85	85	20	75	
Reduced activity of the striatal dopamine uptake site using ^{123}I-FP CIT SPECT					
O'Brien et al. [94]	78	94	38	34	
McKeith et al. [99]	78	90	151	147	
Walker et al. [97]	88	100	27	17	16
Decreased cardiac uptake on MIBG-SPECT: heart-to-mediastinum ratio of MIBG uptake					
Wada-Isoe et al. [89]	100	91	20	32	29
Yoshita et al. [84]	100	100	37	42	10
Hanyu et al. [86]	95	87	32	40	


Review Article

Dementia

Early Discriminatory Diagnosis of Dementia with Lewy Bodies

Walker et al. JNNP 2007

Table 3 Initial clinical, imaging and autopsy diagnosis

Case No	Clinical diagnosis	No of core features of DLB	Visual rating diagnosis	Semiquantitative diagnosis	Neuropathological diagnosis
1	AD	0	Abn	Abn	DLB+AD
2	DLB	3	Abn	Abn	DLB
3	DLB	2	N	Abn	DLB
4	DLB	2	Abn	Abn	DLB+AD+CVD
5	CBD	1	Abn	N	DLB+AD
6	DLB	2	Abn	Abn	DLB
7	DLB	2	Abn	Abn	DLB+CVD
8	DLB	3	Abn	Abn	DLB
9	AD	0	N	N	AD+CVD
10	AD	0	N	N	AD+CVD+metastatic carcinoma
11	DLB	2	Abn	N	AD+CVD
12	DLB	2	N	N	AD
13	DLB	2	N	N	CBD
14	DLB	2	N	N	AD
15	AD	1	N	N	Unspecified pathology
16	AD	0	N	N	AD +CVD
17	DLB	1	Abn	N	FTLD
18	DLB	2	N	N	AD
19	DLB	2	N	N	AD+CVD
20	AD	0	N	N	AD+CVD

- **Diagnosi clinica: sensibilità 75%, specificità 42%**
- **SPECT con DaTSCAN: sensibilità 88%, specificità 100%**

SOCIETÀ ITALIANA
DI GERONTOLOGIA
E GERIATRIA

53° Congresso Nazionale SIGG
Firenze, venerdì 28 novembre 2008

Conclusione intermedia: disponiamo di criteri diagnostici sufficientemente affidabili

Importanza clinica diagnosi differenziale LBD-AD: terapia

Ipersensibilità ai neurolettici:
53% in LBD, no in AD *(Aarsland et al. J Clin Psychiatry 2005)*

In LBD meglio neurolettici con minore potere anti-dopaminergico (quietiapina)

Risposta agli inibitori dell'acetilcolinesterasi: particolarmente buona in LBD *(McKeith et al. Lancet 2000);* AchI possono essere usati come prima scelta per la terapia dei sintomi psichiatrici in LBD

(Aging Clin Exp Res 2007; 19: 349-355)

Aging Clinical and Experimental Research

ORIGINAL ARTICLES

Prescription patterns and efficacy of drugs for patients with dementia: physicians' perspective in Italy

Giovanni B. Frisoni[1,2,3], Elisa Canu[1], Cristina Geroldi[1,2], Barbara Brignoli[1], Livio Anglani[1], Samantha Galluzzi[1], Valeria Zacchi[4], and Orazio Zanetti[5]

[1]Laboratory of Epidemiology Neuroimaging & Telemedicine, [2]Psychogeriatric Ward, IRCCS San Giovanni di Dio – FBF, Brescia, [3]AFaR Associazione Fatebenefratelli per la Ricerca, Rome, [4]Medical Service Office, [5]Alzheimer's Unit, IRCCS Centro San Giovanni di Dio – FBF, Brescia, Italy

Table 1 - *Features of 88 Alzheimer Evaluation Units (Unità di Valutazione Alzheimer – UVAs) taking part in the present survey.*

		Number or mean	Percentage or 95% CI	Range
Specialty of physician in charge	Neurology	57	64%	–
	Geriatrics	27	31%	–
	Other	4	5%	–
Number of patients prescribed cholinesterase inhibitors per year		73	63-84	40-217
Availability of imaging scanner on-site	Computed tomography	73	81%	–
	Magnetic resonance	61	68%	–
	Single photon emission tomography	34	38%	–
	Positron emission tomography	14	15%	–
Patients' age		74.1	73.9-75.6	55-82

[Aging Clin Exp Res 2007; 19: 349-355]

Aging Clinical and Experimental Research

ORIGINAL ARTICLES

Prescription patterns and efficacy of drugs for patients with dementia: physicians' perspective in Italy

Giovanni B. Frisoni[1,2], Elisa Cassi[1], Cristina Geroldi[1,2], Barbara Brignoli[1], Livio Anglani[1], Samantha Galluzzi[1], Valeria Zanetti[1], and Orazio Zanetti[1]

[1]Laboratory of Epidemiology, Neuroimaging & Telemedicine, [2]Psychogeriatric Ward, IRCCS San Giovanni di Dio – FBF, Brescia, [3]AFaR Associazione Fatebenefratelli per la Ricerca, Rome, [4]Medical Service Pfizer, [5]Alzheimer's Unit, IRCCS Centro San Giovanni di Dio – FBF, Brescia, Italy

Table 2 - *Proportion of patients prescribed drugs for cognitive and non-cognitive symptoms in 88 Alzheimer Evaluation Units (Unità di Valutazione Alzheimer – UVAs).*

	Alzheimer's disease	Vascular dementia	Dementia with Lewy bodies	Frontotemporal lobar degeneration	ANOVA	
	Mean (95% CI)	**Mean (95% CI)**	**Mean (95% CI)**	**Mean (95% CI)**	**F**	***p***
Prevalence of diagnosis	45.9 (42.7-49.1)	15.5 (13.5-17.5)	4.6 (3.6-5.6)	4.1 (3.2-5.0)		
Drugs for cognitive symptoms						
Cholinesterase inhibitors	92 (88-95)[1]	45 (38-52)[3]	79 (72-86)[2]	34 (26-42)[3]	70.6	<0.0005
Donepezil	44.9 (41.6-48.2)	19.5 (15.5-23.6)	35.6 (26.2-38.9)	16.3 (11.3-21.3)		
Rivastigmine	29.3 (26.8-31.7)	14.9 (12.1-17.9)	41.5 (34.7-48.3)	11.3 (7.7-14.8)		
Galantamine	17.5 (15.1-19.9)	10.4 (7.4-13.3)	11.6 (7.6-15.5)	6.6 (4.3-8.9)		
Ginkgo biloba	3 (1-4)	5 (2-8)	1 (0-3)	2 (0-4)	1.9	0.13
Nootropics	6 (3-8)[1]	18 (12-24)[2]	3 (1-5)[1]	6 (3-9)[1]	13.4	<0.0005
Drugs for non-cognitive symptoms						
SSRIs	28 (24-32)[1]	29 (25-33)[1]	16 (12-19)[2]	35 (28-42)[1]	11.1	<0.0005
Atypical neuroleptics	26 (22-30)	23 (19-27)	29 (23-35)	31 (25-36)	2.2	0.09
Traditional neuroleptics	14 (10-17)[1]	11 (8-14)[2]	6 (2-9)[3]	15 (11-19)[1]	6.1	0.001
Benzodiazepines	10 (7-12)	11 (8-13)	12 (8-15)	13 (10-16)	0.9	0.44

SSRIs: selective serotonin uptake inhibitors. [1,2,3]between diagnostic groups: no or same marks denote no difference, different marks denote significant difference on Tukey *post-hoc* test for honestly significant difference.

[Aging Clin Exp Res 2007; 19: 349-355]

Aging Clinical and Experimental Research

ORIGINAL ARTICLES

Prescription patterns and efficacy of drugs for patients with dementia: physicians' perspective in Italy

Giovanni B. Frisoni[1,2], Elisa Cora[1], Cristina Geroldi[1,2], Barbara Belgeri[1], Livio Anghisi[3], Samantha Galluzzi[1], Valeria Zocchi[4], and Orazio Zanetti[1]

[1]Laboratory of Epidemiology, Neuroimaging & Telemedicine, [2]Psychogeriatric Ward, IRCCS San Giovanni di Dio – FBF, Brescia, [3]AFaR Associazione Fatebenefratelli per la Ricerca, Rome, [4]Medical Service Office, [5]Alzheimer's Unit, IRCCS Centro San Giovanni di Dio – FBF, Brescia, Italy

Table 3 - *Perceived efficacy of cholinesterase inhibitor drugs for cognitive and non-cognitive symptoms in 88 Alzheimer Evaluation Units (Unità di Valutazione Alzheimer – UVAs).*

		Alzheimer's disease	Vascular dementia	Dementia with Lewy bodies	Frontotemporal lobar degeneration	ANOVA	
		Mean (95% CI)	**Mean (95% CI)**	**Mean (95% CI)**	**Mean (95% CI)**	**F**	***p***
Donepezil	Cognitive ss.	6.1 (5.7-6.4)[1] ***	4.7 (4.1-5.3)[2] ***	4.3 (3.7-4.8)[2] n.s.	2.7 (2.2-3.2)[3] ***	31.0	<0.0005
	Non-cognitive ss.	4.5 (4.1-4.9)[1]	3.6 (3.0-4.2)[1]	3.8 (3.3-4.4)[1]	2.1 (1.6-2.6)[2]	14.8	<0.0005
Rivastigmine	Cognitive ss.	5.9 (5.6-6.3)[1] ***	4.6 (4.1-5.2)[1] ***	5.3 (4.7-5.9)[1] **	2.6 (2.1-3.1)[2] **	34.1	<0.0005
	Non-cognitive ss.	4.7 (4.3-5.1)[1]	3.6 (3.0-4.1)[2]	4.7 (4.1-5.4)[1]	2.1 (1.6-2.6)[3]	22.1	<0.0005
Galantamine	Cognitive ss.	5.4 (5.0-5.7)[1] ***	4.5 (3.9-5.0)[2] ***	3.8 (3.2-4.4)[3] n.s.	2.4 (1.8-2.9)[4] *	23.3	<0.0005
	Non-cognitive ss.	4.3 (3.9-4.8)[1]	3.3 (2.8-3.9)[2]	3.5 (2.9-4.2)[2]	2.0 (1.5-2.5)[3]	13.1	<0.0005
ANOVA	Cognitive ss.	F=4.6 p=0.01	F=0.2 p=0.83	F=6.1 p=0.003	F=0.4 p=0.69		
	Non-cognitive ss.	F=0.8 p=0.44	F=0.3 p=0.74	F=4.1 p=0.02	F=0.0 p=0.97		

ss.= symptoms. Scores denote perceived efficacy: 0=none to 10=extreme. [1,2,3,4]No or same marks denote no difference, different marks denote significant difference across columns on Tukey *post-hoc* test for honestly significant difference. Difference between cognitive and non-cognitive symptoms is significant at *p<0.05, **p<0.01, and ***p<0.001 on *t*-test for repeated measures; n.s.: not significant.

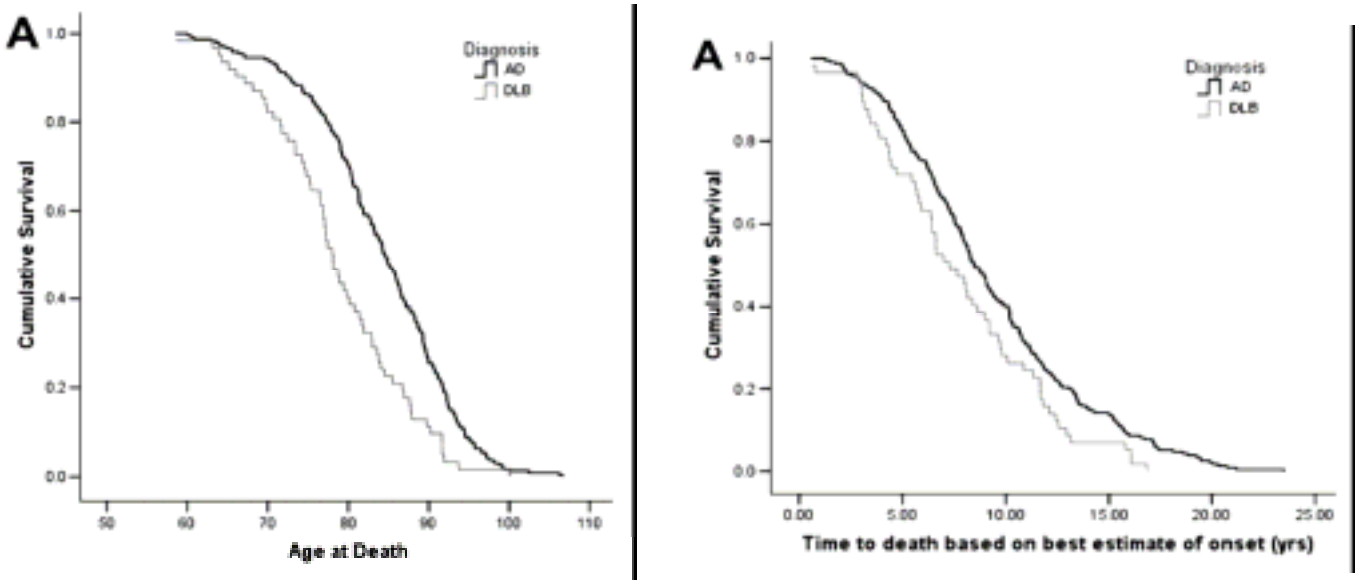
A.Tomasoni, O.Zanetti, C.Geroldi, B.Solerte,
Cattedra di Geriatria, Università degli studi di Pavia e IRCCS Centro S.Giovanni di Dio-Fatebenefratelli, Brescia
(dati non pubblicati)

- CONFRONTO DELLA RISPOSTA ALLA TERAPIA ANTICOLINESTERASICA IN MALATI DI ALZHEIMER VS AFFETTI DA DEMENZA A CORPI DI LEWY
- STUDIO OSSERVAZIONALE RETROSPETTIVO
- RICERCA DI POSSIBILI FATTORI PREDITTIVI ALLA RISPOSTA ANTICOLINESTERASICA

	AD (n 20)	LBD (n 25)	p
Sesso (femminile)	13(65%)	19(76%)	n.s.
età •	76±6	76±6	n.s.
età d'esordio	72±6	74±6	n.s.
BADL perse	0,5±1,1	1,6±1,8	**0,028**
IADL perse	3,2±2,8	4,1±2,6	n.s.
MMSE	19,0±5,8	19,0±4,3	n.s.

Rate annua di progressione della malattia valutata tramite MMSE, prima e dopo introduzione di ACHEI	**AD**	**LBD**
∆MMSE dall'esordio all'introduzione di ACHEI	-4,7± 4,5	-17,1± 33,7
∆MMSE dopo l'introduzione di ACHEI	-2,8± 5,3	-2,2± 5,7
p	n.s.	**0.037**

Importanza clinica diagnosi differenziale LBD-AD: prognosi



Importanti determinanti: segni extrapiramidali, depressione

Williams et al. Neurology 2006

Importanza clinica diagnosi differenziale LBD-AD: difficoltà cliniche

I Criteri clinici per LBD hanno alta specificità (80-90%) ma bassa sensibilità *(McKeith et al. Neurology 2005)*

Difficoltà definizione fluttuazione (mancanza di metodi di valutazione validi e ripetibili)

Esordio con deficit mnesico, soprattutto se esordisce prima del deficit motorio *(Merdes et al. Neurology 2003)*

“Sapessi tu quanti mulini, a guardar meglio sono veramente giganti; quante lucciole sono veramente lanterne!”

G. Bufalino: Qui pro quo.
Bompiani, Milano, 1991, p.48