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Global Perspective

A Newsletter for Alzheimer's Disease International, (The International Federation of Alzheimer's & Related Disorders Societies, Inc.)

Cross-Cultural Studies Symposium Takes New Perspective on AD

Speakers from China, France, Italy, Nigeria and the U.S. (listed here with their topics) participated in the Cross Cultural Symposium during the 6th Conference

Robert Katzman, M.D., (U.S.) Chief, Neurosciences Dept., UCSD School of Medicine, *Risk Factors & Cross Cultural Studies*;

Jean-Francois Foncin, M.D., (France) Directeur d'Etudes a l'Ecole Pratique des Hautes Etudes Laboratoire Montyon La Salpetriere, *Genetic Factors in Alzheimer's disease*;

Pr. Luigi Amaducci, M.D., (Italy) SMID Center, *Prevalence of Alzheimer's Disease: European Studies & Proposed Cross Cultural Studies*;

Barry Gurland, M.D., (U.S.) Center for Geriatrics & Gerontology, U.S.A., *Methodological Issues & Findings in Cross Cultural Study; Upper Manhattan Study*;

Dennis Evans, M.D., (U.S.) Rush-Presbyterian-St. Lukes, Chicago, *East Boston Study*;

Benjamin O. Osuntunkon, M.D., (Nigeria) Department of Psychiatry, Indiana University Medical School, U.S., *Alzheimer's Disease in Nigeria*;

Mingyuan Zhang, M.D., (China) Shanghai Institute of Mental Health, *Dementia Survey in Shanghai*.

A number of people who were unable to attend wrote or called for information on the symposium. We wrote for abstracts of the presentations. However, because of busy schedules, and perhaps difficulties with the mails, we have not yet received all of them, (but have been assured they are on the way).

We have elected to go to press with the abstracts we have received from Drs. Katzman, Amaducci, and Foncin (pages 3, 4, & 6) and hope to include the rest in a future issue.

6th International Conference Hailed as Intensive Well-Planned Success!

ADI's 6th International Conference opened with a dynamic pre-conference on Sunday, September 22nd, where representatives from Latin-American countries, Spain, and Hispanics from the USA, discussed common goals and strategies for care of Alzheimer patients and their families. Participants' strong desire to continue the dialogue—and pledges of support—promise to help formalize development of the Spanish-speaking ADI Region.

More than 90 presentors filled the five-day Conference held in Mexico City, September 23-27, 1990. Participants lauded planners as the daily sessions covered the gamut of scientific, medical and social Alzheimer's concerns.

Conference Proceedings are being prepared under the direction of Dr. Luis Miguel Gutierrez. "A public announcement will advise when they are available," says 6th Conference Secretariat Lic. Lilia Mendoza.



Lilia Mendoza (center) Conference Secretariat, 6th International Conference & Pres., Mexican Alzheimer's Association, stands for photographs with (from left) Edward Truschke, ADI Secretary General; Michael Coote, Pres., Alzheimer Society of Ireland & Conference Secretariat, 5th International Conference, Ireland 1989; Jerome H. Stone, Chairman Emeritus, Alzheimer Association, U.S. & ADI Treasurer; and, Richard Gehring, Chairman, Alzheimer's Association, U.S.

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ADI Grows, Moves Forward in Public Policy, Education, MSAB Action Plan

Five new members were welcomed into ADI membership during the International Federation's Annual Meeting held in Mexico City, September, 1990. The addition of Argentina, South Africa, Spain, Switzerland and Venezuela, brings the total membership to 20 countries (distributed over five continents).

A major work of ADI has been the conduct of annual International Conferences on Alzheimer's disease. This has resulted in an increased exchange of scientific information and heightening of awareness worldwide about the impact of Alzheimer's on its victims and their families, a key to achieving ADI's goals.

ADI saw important advances in its own development during meetings in Mexico City. Notably, two Committees emerged, and an action plan for the ADI Medical and Scientific Advisory Board was given.

Ad Hoc Public Policy Committee Defines '91 Objectives

The Public Policy Ad Hoc Committee met to explore problems and opportunities in communicating with governments in members' countries, to gain awareness and support for the needs of persons with Alzheimer's disease and their families.

The group, is functioning under the co-leadership of Jeanne Bentley, Canada; Francesca Jordan, Australia; Nancy Lombardo, U.S. and Svante Svahnstrom, France. Meeting twice during the Mexico City Conference, the Committee looked at directions ADI might take in addressing the need to raise awareness and effectively advocate for more governmental funding for research and support provided to families.

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In the context of ADI goals and accomplishments and hopes for the future, they discussed ways to help move forward the public policy work of ADI.

They set three reasonable tasks to be accomplished by the Committee in 1991: (1) To create a glossary of terms used in the field of Alzheimer's disease and relating to care in the community. (2) To conduct a survey of members to obtain a profile of members' public policy programs and goals. (3) To undertake introduction of Home Care as a major public policy issue for ADI. Added was a fourth task of preparing the Committee for the next meeting.

In Amsterdam, September 1991, the Committee plans to meet twice. The first meeting will be a sharing session. For the second meeting, Committee members plan to discuss results of the survey and information gained through the sharing sessions to enable them to set new goals for the next year.

Trainer's Network Kicks Off Education Initiative

An Education initiative began during the Conference by way of a Trainer's Network. It comprises persons from eight countries, including: Argentina, Australia, Canada, Mexico, the Netherlands, New Zealand, Scotland, and the United States.

Jan Killeen, serving as facilitator, stated in a memo to Network members, "Hopefully there will be a number of benefits for members of the network: a). Sharing information on similar projects; b). Exchanging reports on methods and effectiveness of initiatives; c). Avoiding the duplication of effort where others have already produced materials which may be built on, translated or adapted; d). Highlight training policy/resource issues to inform the policy network."

MSAB Sets '91 Action Plan

The action plan for the ADI Medical & Scientific Advisory Board calls for the Board's Steering Committee to develop a document for discussion by the MSAB Executive Committee and, a full Medical & Scientific Advisory Board meeting during the Conference in Amsterdam.

Conference Overview

The following abstracts together with the Cross-cultural abstracts elsewhere in this issue of *Global Perspective*, provide an overview and insight into the broad range of topics covered during the 6th Conference.

► Finding a Cure and Easing the Burden: A Balanced Approach

Alzheimer's disease is a challenge of international scope that needs to be met by a balanced approach including basic research into finding the cure, and care reform, necessary to ease the burden of victims and their families. Tremendous advances in neuroscience are allowing us to understand the mechanism of cell death and develop therapeutic strategies designed to slow the progression of the disease. Short term treatments are focusing on replacing missing neurotransmitter elements such as acetylcholine; long term approaches depend on better understanding of neuronal viability such as the dependent on trophic factors. Advances in the understanding of the molecular biology of amyloid may lead to diagnostic tests based on either CSF studies or brain imaging. Despite those exciting advances, it is also important that we examine carefully the effectiveness of care systems that are present in different countries to care for victims of this disease. All countries will be facing an increasing burden from the elderly population. Major ethical issues concerning health care rationing, and balancing the priorities of youth and age, will need to be addressed. Alzheimer's disease is truly a lead issue both in the development of neuroscience and in the exploration of the quality of life for the elderly in different societies. **Peter J. Whitehouse, M. D., University Hospitals of Cleveland & Case Western Reserve University.**

► The Elderly Familial Policy for Intellectually Dependent People: An Example, the Gerontological Village in the City of Grenoble, France.

The Gerontological Village, an example of specialized domiciliary care, where staff training is provided (as well as information to family members) also offers day care,

—Continued on page 7

Risk Factors and Cross-Cultural Studies

A major challenge in regard to our understanding of Alzheimer's disease is to determine the causes or risk factors for this disorder. Cross-cultural studies offer a unique approach to determining risk factors since there may be very different "exposures" to a risk factor in differing countries. For example, in cardiovascular disease, the data in regard to a low incidence of heart attacks in countries such as Japan, where there is very little fat in the diet, has played a role in identifying the importance of diet in that disorder.

Several types of risk factors are now becoming apparent in Alzheimer's disease. There is general agreement that a history of Alzheimer's disease in a first-degree relative, that is, father, mother, brother or sister, increases the risk of the disorder. Another risk that has been found to be present rather consistently in different case control studies has been head trauma of sufficient degree to produce unconsciousness. Before a risk factor can be considered to be a cause of a disease, there must be biologic explanation

as well as consistency and strength of association in epidemiological studies. In regard to these risk factors, it is possible that both produce excess production or abnormal degradation of the beta amyloid precursor protein in the form of diffuse plaques within the brain which then leads, in association with other factors, to the development of the Alzheimer process and ultimately progressive dementia.

In a study in Shanghai that will be reported later in the symposium by Dr. Zhang, lack of education has been found to be a major risk factor for the development of dementia. Two-thirds of the cases were of the Alzheimer type. Lack of education in Shanghai is especially evident because over 26% of the elderly cohorts studied had had no formal education whatsoever and in these individuals there was an approximately 50% increase in the prevalence of dementia past age 75. Similar data has been found in other international studies. What could be the biological basis for such a finding? One possibility is that individuals

who had no opportunity for formal education have lower brain reserve than individuals with education, so that when the biological process called Alzheimer's disease begins in the brain and begins to destroy nerve cells and their connections, that is, synapses, the individual without education has fewer total number of synapses and less redundancy or reserve and therefore begins to show symptoms three or four years earlier than individuals who have had education. This is an unproven hypothesis, but it is a testable one that needs to be explored in the future since it would have very important social implications.

It is likely that these beginning findings emerging from cross cultural studies will be added to, in future years, by new risk factors to be discovered by continuing this important approach to the understanding of Alzheimer's disease.

—Robert Katzman, M.D., Chief,
Department of Neurosciences,
University of California,
San Diego,
School of Medicine.

Strategies Sought to Raise Alzheimer Awareness. . .

New ADI members seek ways to raise the level of Alzheimer awareness in their countries. One strategy members use is the Focus Week (or Month), January is "Alzheimer Awareness Month" in Canada; a week in April is "Alzheimer's Action Week" in Australia. In the U. S., the Alzheimer's Association has "NADM—National Alzheimer's Disease Month" and Scotland conducts "Dementia Awareness" in 1991 from June 23-30.

In its newsletter to members Alzheimer's Scotland points out, "This will be our biggest and best chance in 1991 to let the public know about dementia and what we are doing to help both sufferers and carers. It is also an opportunity to fundraise on a national and local level."

In most countries, six months to a year in advance, special events for the designated period are devised to draw media attention. Often, it is hoped the events will also generate some funds. Special observances, educational opportunities and gala events are

held by local groups and national associations. Press releases and informative Alzheimer's Awareness Kits sent to the news media help tell about AD and the Society. Public Service Announcements are distributed by Chapters and National.

A special event provides a "peg" on which to hang an Alzheimer story, together with information about AD (its impact on its victims and their families, its potential effect on the economy). This formula seems to provide a key to the success of awareness efforts worldwide.

And why all this aggressive public information and awareness activity? For a response, we quote the Alzheimer's Scotland newsletter, "Through a combination of national and local publicity and fundraising events we have the chance to "sell" the good work of Alzheimer's Scotland and all its supporters." And it should be noted that the funds raised help strengthen and expand the Society's service programs.

Public Policy Programs: "A Fair Go For Dementia"

Alzheimer's societies in Australia, Canada, New Zealand, and the U. S., all have dynamic advocacy programs to seek change in public policy and encourage earmarking of governmental funds for research to find the cause, treatment and cure of AD, and to provide support to afflicted persons, their families and carers.

Australia and New Zealand put out a publication *A Fair Go For Dementia* to help members in approaching legislators. The latest version of the U. S. publication *National Program to Conquer Alzheimer's Disease*, was released in time for the Association's Third Public Policy Forum held in Washington D. C., April 20-24, 1991.

The Public Policy Forum offers Chapter members workshops on critical issues, techniques and strategies in addressing legislators on a one to one basis. Then, opportunities to meet their legislators are provided. Hearings and other special events are included during the Forum.

The WHO Program for Research on Aging, Age-Associated Dementia Project

This study is supported by the World Health Organization Program for Research on Aging; National Institute of Aging-National Institutes of Health (U.S.A.); and the Italian Multicenter Study on Dementia (S.M.I.D. Center). Participants include: A. Lippi, M.D.; P. Nencini, M.D.; M.P. Amato; M.D.; M. Baldereschi, M.D.; and L. Amaducci, M.D.

The World Health Organization (WHO) on the basis of the resolution 40.29 of the World Health Assembly (May 1987), promoted a Program for Research on Aging (PRA); and, the WHO Advisory Committee on Health Research identified four priority areas (1):

- Dementia of healthy aging;
- Age-Associated Dementias;
- Nutritional changes associated with aging, with special emphasis on osteoporosis;
- Age-related changes in immune function.

The Age-Associated Dementias project is a cross-national, multicenter, epidemiological research. Its principal research goals are: the standardization and validation of research instruments for cross-national diagnosis of dementia and dementia subtypes; the estimates and the comparison across study centers of the prevalence and incident rates of dementia; and the study of risk factors for dementia.

Participating Countries

The study is coordinated by the Italian Multicenter on Dementia (S.M.I.D. Centre), located in Florence, Italy, under the supervision of a Steering Committee composed by an international panel of experts.

Canada, Chile, Malta, Nigeria, Spain, and the United States of America, are the participating countries. In each, at least one urban and one rural area have been identified as field areas. In each country, the population study is represented by the aging population over 65. The proposed sample size for each field area is 2,500. The field areas and sample-sizes for each participating country are shown in table 1.

In Canada, the study is carried out jointly

by the Canadian National Study of Dementia in which five provinces are involved. Three areas located in Quebec Province, British Columbia and Atlantic Provinces, also participate in the WHO study.

**Table No. 1
WHO-PRA AGE-ASSOCIATED DEMENTIAS
FIELD AREAS**

COUNTRY	FIELD AREA	>65 YEARS	SAMPLE
			SIZE
CANADA	Quebec Province	650,666	2,500
	British Columbia	349,490	2,500
	Atlantic Provinces	249,610	2,500
CHILE	Concepcion	17,283	2,500
	Quillon	1,142	2,500
	Florida	919	
	Santa Juana	901	
MALTA	La Vailletta	1,680	1,680
	Gozo	3,120	3,120
NIGERIA	Idikan District (Ibadan)	500	500
	Igboora	1,800	1,800
SPAIN	Margaritas District (Getafe)	2,032	2,032
	Arevalo County	3,840	2,500
USA (Indiana)	Marion County	9,192	2,500

In Chile, the study is conducted on the white population resident in the city of Concepcion, and in 3 little villages: Quillon, Florida and Santa Juana.

In Malta, the sample is the whole population over the age of 65 (n=4,800) resident in the capital La Vailletta and in the Gozo island.

In Nigeria, the study population, that is the subjects over the age of 65, resident in the Ibikan District of Ibadan (n=2,500) and in the rural area of Igboora (n=2,500) will be identified by the means of a private census.

In Spain, a district of the city of Getafe, a metropolitan area of Madrid, and a rural area, Arevalo County, 100 Km from Madrid have been selected.

Finally, the black population of Marion County, near Indianapolis, Indiana, U.S.A., will be studied in comparison with Nigerian population.

Study Design

The first step in the study is the standardization of the diagnosis of dementia across

the centers. Then, the pilot and the field study will follow in each participating country. The standardization of the diagnosis of dementia is a major issue of the cross-national study and one of the main goals.

The evaluation of the inter-observer agreement on the diagnosis of dementia is based on the sharing across centers of records filled in for actual patients, the blind re-assessment of the records and, agreement analysis by means of the kappa index (2). Iteration of this process might be necessary to reach the desired level of agreement.

Pilot and Field Studies

The pilot study will be carried out in each participating country. In the pilot study the screening instrument to be used in the field study will be validated on a sample of the study population and or clinical series of demented and non-demented patients in order to reach a suitable number of dementia cases. The proposed screening instruments to be validated in the pilot study are the Information-Memory Concentration Test (3) and the Mini Mental Status Examination (4). Both the tests will be validated, using the final clinical diagnosis as the gold standard.

Only one test will be selected for the field study. The cut-off score will be established on the basis of the best balance between sensitivity and specificity for each possible score. In the selection of the cut-off score the subject's educational level will be taken into account and different cut-off scores will be selected for different levels of education.

In the pilot study the cut-off score of the neuropsychological examination to be used in the diagnostic process will be validated by using the same procedure.

The field study is a prospective one and it is arranged in a cross-sectional and in a longitudinal survey. The cross-sectional survey allows us to identify the prevalence of dementia cases and to collect data on exposures to risk factors in non-demented subjects. The same population sample will be reassessed two years later, to identify

the incidence cases and to estimate the relative risk.

Instruments

A multi-phase procedure will be used for case identification and diagnosis. The procedure includes the screening (Phase One), the diagnosis of dementia (Phase Two), and of dementia subtypes (Phase Three).

☐ Phase One:

In Phase one, the screening test for cognitive impairment will be administered by lay personnel to the sampled subjects. The screening test will be administered in the local language and the items will be harmonized to specific cultures.

Subjects identified as potential cases by the screening test will also undergo the subsequent phases of the diagnostic procedure. A representative sub-sample (about 10%) of subjects above the cut-off level will undergo the clinical evaluation as a check on false negatives.

Together with the screening test the lay personnel will administer a risk factor interview to all the sampled subjects. The data collection on exposure to different risk factors in non-cases allows us to estimate the relative risk after the identification of the incident cases. The interview includes putative risk factors for Alzheimer's disease (dementia or Down's syndrome in the relatives, parental age at subject's birth, head trauma) questions on demographic factors (age, race, ethnicity, marital status, residence, living in institutions, education and occupation), and risk factors relevant to vascular and other dementias (smoking, alcohol consumption, hypertension, diabetes).

☐ Phase Two:

The subjects scoring under the cut-off level at the screening test will undergo the second phase of the diagnostic procedure. First of all, the degree of the cognitive impairment will be evaluated by means of the neuropsychological examination from CAMDEX (5). This neuropsychological examination will identify false positives at the screening test. A sample of this popu-

lation (about 10%) will also undergo the subsequent diagnostic procedure as check.

The evaluation of the functional impairment will be based on an interview with a surrogate informant on the patient's present difficulty in the activities of daily living. This interview is based on CAMDEX (5) and on the Pfeiffer Functional Scale (6).

The clinical evaluation will also include a medical history and the physical and neurological examination according to CERAD. (7). Patients affected by depressive pseudodementia will be identified by means of a structured version of the Hamilton Depression Scale (8) and the DSM-III-R criteria for major depression (9). The diagnosis of dementia will be done according to both the DSM-III-R (10) and the ICD-10 (11) criteria.

☐ Phase Three:

Demented subjects will be classified into different diagnostic categories. The differential diagnosis will also be supported by laboratory tests and neuroimaging, when possible. The diagnostic criteria will be the NINCDS-ADRDA (12) for Alzheimer's disease and the ICD-10 for vascular and secondary dementias (11).

Follow-up:

Dementia cases will be followed, after one year in order to collect information on the natural history of the disease. Depressed patients, bordering or doubtful cases, will be rechecked after a six-month interval in order to confirm the diagnosis.

—Prof. Luigi Amaducci, M.D.; Italian Multicenter Study on Dementia (S.M.I.D. Center), and the Dept. of Neurologic & Psychiatric Sciences, University of Florence, Italy.

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Why Do They Call it Respite Care???

The term *Respite Care* was coined to refer to any form of care that would provide relief of the burden of care for the caregiver. Most often this involved day care, in-home care and short-term institu-

tional care. As programs developed, it was recognized that a great service can also be provided Alzheimer patients, often improving their quality of life. The name and programs may vary, but the need does not.

Genetic Factors in Alzheimer's Disease

I am going to present the case for a genetic theory of AD. Genetics, as a part of biology, may be subdivided into formal or Mendelian genetics, population genetics, and molecular genetics. Formal genetics and population genetics are a necessary step towards any molecular genetics study.

Epidemiology Studies

Epidemiology studies show that the presence of a case of AD in the near family of a person significantly augments the risk for AD for that person. Apart from the increased risk with age, this finding is the only undisputed clue causal epidemiology has to offer concerning AD etiology. A large number of small pedigrees, drawn from interrogation of relatives of an AD index case, show AD "running in a family" over two or three generations. Neither epidemiology studies nor small pedigrees do offer a proof of genetic transmission of AD: vertical transmission of an agent, or environmental factors common to a family, could give similar results.

Pedigrees are Studied

A few pedigrees of families with AD have been studied more extensively, drawing on written records to study transmission over more than three generations in a large number of individuals. These pedigrees carry early onset AD, which has often been construed as indicating the existence of two distinct forms of AD, one, mostly early onset, Mendelian dominant, the other, mostly late onset ("senile dementia of the Alzheimer type", SDAT), sporadic.

A **FAD gene** (McKusick's AD1) was mapped to chromosome 21 by St. George Hyslop, e.a., in 1987, and recently confirmed: In some instances (early onset forms) a linkage can be demonstrated between AD phenotype and markers on chromosome 21. The locus thus defined is situated between the centromere and the polymorphic marker S16, not very close to that marker (non-negligible recombination fraction), meaning that no molecular genetic diagnosis of (even familial) AD is available, and that direct access to the gene may be far away.

Formal Genetic Studies

These might bring some light to controversial issues in AD nosology, and indeed might lead to a unifying theory. The data to be discussed come from an ongoing study I originated in 1972. This study has lately been continued largely through the SMID-SUD facilities in southern Italy, notable by Drs. Amalia Bruni and Maria-Paola Montesi. Dr. D. Salmon (Paris) took an important part in the mathematical genetics study.

The object of study is an extended kindred (family "N") with early onset AD (mean age at onset 42 years), originat-

Glossary:

Allele: In genetics, one of a series of hereditary characters alternative to each other.

Epidemiology: The branch of medicine that deals with epidemic diseases, (breaking out suddenly and more or less unpredictably in a particular area in such a way as to affect many individuals).

Genotype: The genetic constitution of an organism

Pedigree: A line of ancestors, a list or table of descent and relationship.

Phenotype: The aggregate of genetic characteristics visibly manifested by an organism.

ing in Calabria (Italy) The methods we largely developed for this study stress the use of objective sources (municipal and hospital records, parish registers), and "blanket" study, with the purpose of minimizing bias in data collection. The pedigree now comprises about 6,000 subjects linked to the proband through the transitive (ascent, descent, marriage) set of relationships. Sixty-one of them are known to be or have been affected by early onset AD and thirteen are obligate transmitters under Mendelian dominant transmission, phenotype unknown. All known affected members of the kindred are descendants of a woman born in 1715 who died aged 45. Transmission is compatible with Mendelian autosomal dominant with "complete penetrance."

A striking feature of AD in family "N" is its phenotype variability as determined by the variability of the age of expression, whereas age at onset has often been deemed characteristic of separate forms of AD. Age at death of demented victims of AD in family "N", which we took as index of age of expression, has a mean of 50 years, with extremes 38 and 65 years, standard deviation six years: it takes twenty-four years to encompass 95% of the patients.

A description would be given by a theoretical age-specific mortality curve fitted with observed data. Weibull and Kaplan-Meier survival models, which suppose constant or adjusted risk, usually provide a good fit for cancer survival studies, but is very poor with our AD data. Best fit is given by a log-normal distribution, reflecting a (random) stochastic process with a zero lower bound of the variable.

In test, the environment hypothesis as an explanation for the variations in age of expression, we compared patients having lived respectively in the nineteenth and the twentieth centuries, or in Europe and in America: a cross-cultural study. There is absolutely no difference in the phenotype of AD, as defined by mean and standard deviation of the age of expression, between any of the groups: a nineteenth century illiterate farm laborer in Southern Italy and a twentieth century business executive in north-eastern America share the same destiny. So much for the influence of aluminium pots and pans or the protective role of instruction on the expression of AD.

The Role of Expression Genes

We then have to study the possible role of expression genes in the variety of expression of AD. We chose to study the pairwise correlation between age at death of the affected parent and that of an affected child. If there is an expression gene linked with the FAD gene, this correlation will tend to 1, depending on the penetrance of the expression gene. If there is an unlinked dominant fully penetrant major expression gene, correlation will be 0.5. In other situations with an unlinked expres-

sion gene, a less strong but positive correlation is expected. Environmental factors shared by parent and child, if playing a role in gene expression, would also result in a positive correlation. In family "N", pairwise correlation between age at death of a demented parent and a demented child is 0.001, that is, zero: neither environmental (see above) nor expression genes play any role in the expression of AD in family "N". In that family, AD transmission is Mendelian autosomic dominant, monogenic, independent of environment; the large variability in expression age is purely stochastic.

We Then Apply These Results

...to a theoretical kindred identical to family "N," except the age of expression is 38 years later, bringing uncorrected mean age at onset to age 80. Combining age specific AD mortality with the survival curve of a control population show that most carriers of late onset AD will die before expression of the disease; only one over five genotype carriers will express the disease phenotype; apparent mean age at onset is lower than the theoretical one, since a larger portion of carriers "scheduled to express the phenotype" after age 80, is going to die before expression of disease.

This representation of AD epidemiology is strikingly similar to that proposed in 1988 by Breitner, e.a., starting from a large sample of (mostly late onset) AD cases. The minor differences between the Breitner

representation and our model may be due to the implicitly monoallelic nature of our model. The dispersion of the age of manifestation of "real" AD would be attributed, according to our theory, to a combination of allelic multiplicity and stochastic variation inside one allelic species.

A Unifying Theory

We present an unifying theory or frame of reference for the interpretation of the many data steadily accumulating about AD; Alzheimer's disease is Mendelian monogenic polyallelic, possible multilocal, disease on the model of the thalassomies, which used to be known under the synthetic eponym "Cooley's" disease," until genetics and molecular biology allowed mapping of the involved genes to two different chromosomes. The various clinical forms (early onset, late onset...) could then be attributed to various mutations in the alpha of (more frequently) the beta chain globine genes.

Empirical formal genetics of late onset AD is a nearly hopeless endeavor, with so many missing links (carriers dying before expression age) breaking the chain of transmission. Moreover, AD genes are very frequent in the general populations (0.20 in our simplified monoallelic late onset model). As a consequence, linkage studies of late onset FAD are at best very difficult, due in particular to false recombinations. This may account for discrepan-

cies between the results of linkage studies using respectively early onset and late onset familial AD.

The so-called "normal aged" with plaques and tangles really are AD genotype carriers who died before clinical phenotype expression. This conception entails that a very large proportion of humans are carriers of various alleles of the AD gene(s), but does not invalidate the disease paradigm for Alzheimer's disease, as distinct from an aging paradigm: measles used to affect almost all children before vaccination, and yet is a disease.

Proposed diagnostic procedures must distinguish between Alzheimer genotype and Alzheimer phenotype. Peripheral markers might only be indicative of genotype, which, if not coupled with an indication relating to the allele involved (early or late onset), would be almost useless as a predictor of clinical course.

Any apparent difference between populations regarding AD epidemiology may be due to ascertainment bias, and/or to demographic factors, and/or to founder effect, but not to environment. Systemic cross-cultural, or cross-population, studies of founder effect and rare alleles are a promising way for the understanding of the natural history of Alzheimer's disease.

—Prof. J. F. Foncin, M. D.
Ecole Pratique des Hautes
Unité 106, INSERM
Laboratoire Montyon LaSalpêtrière;
Paris France

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assessment, group or collective residences, psychogerontological units and coordination between geriatricians and psychiatrists. **Professor Robert Hugonot, Faculty of Medicine, University of Grenoble, France.**

► Institutional Response to the Sexuality of the Elderly with Dementia

Health care professionals and society in general are slow to accept the critical importance of sexual expression in the later years of the human cycle. The Hebrew Home for the Aged at Riverdale has analyzed its practices on this subject, as well as reports by similar facilities; redefined its

written policies on sexual expression by its residents; and instituted an education program for residents, families, professional staff, and personnel. Lectures, case studies, and follow-up evaluations are components of a three hour training program to modify cultural barriers regarding sexuality in a predominantly Jewish resident population. Evaluations reflect positive responses to needs for intimacy, and more freedom of expression in a broad range of attitudes and behaviors. This paper will report on this education and self-study process with an emphasis on the special needs of patients with dementia. Specifi-

cally, the impact of "problem sexual behaviors" will be addressed in the context of family and staff responses. Issues of continuity of sexuality through personal intimacy with one's partner, masturbation, gender continuity, and related activities including dance and touch will be explored. **Jacob Reingold, Hebrew Home for the Aged, Riverdale, New York City**

► Resilience in the Face of Dementia

Caring for a family member with dementia is psychologically stressful. There is now a body of research to indicate which carers

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Alzheimer Europe to Raise Awareness with EC

Alzheimer Europe (AE) began in September 1990 when representatives of six European national Alzheimer's societies met with Dr. Franz Baro and Dr. Henk ter Haar and Michael Coote, in Louvain, Belgium, to discuss formation of a European presence to establish Alzheimer awareness with the European Council, Commission, Parliament and other national and supra-national organizations to gain support for the Alzheimer cause.

AE delegates plan to make personal contact with their members of the European Parliament, keep them informed of progress of Alzheimer Europe, and when

appropriate, urge them to put forward and support proposals that will benefit Alzheimer patients and carers.

A second AE meeting was held in Amsterdam in January 1991. Members represented were: Belgium (Franz Baro), England (Nori Graham), Finland (Leila Mustanoja), France (Laurence d'Aramon), Germany (Eleanor von Rotenhan), Ireland (Michael Coote), The Netherlands (Henk ter Haar), Poland (Tadeusz Parnowski), Scotland (Evelyn McPake), and Spain (Micheline Selmes). Members unanimously endorsed the existing Executive Commit-

tee: Michael Coote, Chairman; Franz Baro, Honorary Secretary; and Henk ter Haar, Honorary Treasurer. Leila Mustanoja will serve as newsletter editor and Jacques Selmes, as public relations officer. Miet Wouters will serve as coordinating secretary.

AE premises and facilities are provided in Brussels through its membership in ECAS, (European Citizens Action Service). ECAS helps strengthen the position of voluntary sector non-governmental organizations in relation to the EC institutions.

Alzheimer Europe will also serve to fulfill the European Region role of ADI.

Finding Yet Another Way...

Alzheimer societies around the world are creative in the way they meet the service needs of patients and families. The following article tells of Yet Another Way an Alzheimer's association helps relieve the burden of caregivers and helps improve the quality of life of persons with Alzheimer's disease. This idea will appeal to ADI members who are seeking additional ways to expand their patient and family services programs on a limited budget.

Persons with Alzheimer's disease can enjoy daily walks. Unfortunately, Alzheimer's disease soon leaves some patients too confused to venture out alone. Confined, they become restless and frustrated. And, families—with conflicting outside business and social commitments—may not always be as free to help as they might like.

Now enters a new Canadian ADS Chapter-based program called *Walkabout*.

It began when the Family Support Committee of the Alzheimer Society of Cornwall and District heard about how the problem affected one patient and her family, they introduced her to one of their members, who is an avid walker. The two women went out together daily, often for up to five miles at each outing. As the walks continued, her family was delighted to see the patient's social skills improve. They also noted that she became less restless and slept through the night.

Based on this initial experience, the idea of volunteers walking with Alzheimer patients has grown into a full-fledged program. Begun in 1989, the Society's

Walkabout has matched nineteen volunteers with Alzheimer patients.

The Chapter's Family Support Services Committee and staff members Linda McDevitt and Shelley Vaillancourt, developed the program. Linda explains that before a *Walkabout* match is made, volunteers take a 6-hour training course that involves case studies and role playing. Linda and Shelley monitor the program closely, keeping in regular telephone contact with volunteers and caregivers. *Walkabout* matches are assessed every six months, and volunteers meet at least three times a year to discuss their experiences.

"The hardest thing volunteers have to face is knowing that the time will come when their companions will no longer be well enough to continue the walks," Linda says. She works with volunteers, helping them through the adjustment.

Linda recommends the program to other Chapters since it is inexpensive to run and it provides much-needed relief for caregivers, as well as exercise and companionship for persons with Alzheimer's. She points out that it appears that even very confused patients have less tendency to wander when they are in the program.

The Society has developed a *Walkabout* Program Manual and is currently producing a training video. For information, write to Linda McDevitt, Alzheimer Society of Cornwall and District; Box 1852; Cornwall, Ontario, K6H 6N6; Canada. Tel: (613) 932-4914

ADI Membership Criteria Approved

A policy establishing criteria for membership in Alzheimer's Disease International (The Federation of Alzheimer's Disease and Related Disorders Societies, Inc.) was approved by the ADI Council during its annual meeting on September 22, 1990, Mexico City. The policy is as follows:

The following criteria shall be considered in determining eligibility for membership in ADI:

1. Organizational maturity
 - a. A Board of Directors with adequate representation of Family Members affected by Alzheimer's disease or related disorders.
 - b. National credibility and favorable image in their own country.
2. Programs and services such as:
 - a. Helpline
 - b. Support Groups
 - c. Public information and education programs
 - d. Development program to provide a network of Chapters, etc.
3. Financial ability to participate in ADI, such as:
 - a. Membership dues
 - b. Attendance at meetings
 - c. Communications
4. In all the above, consideration must be given as to whether the applicant operates in the best interest of any person with Alzheimer's disease or related disorders and their families.

MEMBERSHIP LIST UPDATE

One of the most important activities of ADI is the networking that occurs among its members to exchange information about programs and sharing "How-to" information. Another aspect of ADI communications involves "mentoring," where a ma-

ture national organization extends a supportive hand to an emerging Alzheimer Society. Listed below are the Alzheimer's Disease International (The International Federation of Alzheimer's & Related Disorders Societies, Inc.) eighteen full members

and two provisional members (Spain and Venezuela). *Global Perspective* readers are encouraged to contact their own national societies for information about Alzheimer's and support, as needed—and, to offer *your* support—because it, too, is needed.

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Laurence d'Aramon, President
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Michael H. Coote, Chairman
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Pr. Luigi Amaducci, M.D.
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Lic. Lilia Mendoza, President
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NETHERLANDS

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Alzheimer Stichting
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FAX: 64-03-654-910

SCOTLAND

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FAX: 44-324-824560

SOUTH AFRICA

Michael D. Livni, Co-Chairman
Alzheimer's & Related Disorders Association
P. O. Box 81183
Parkhurst, Johannesburg 2120
South Africa
Tel: 27-11-782-7586

SPAIN (Provisional Member)

Mrs. Micheline Selmes, President,
Alzheimer Espana
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SPAIN
Tel: 34-1-259-2064/250-2896
FAX: 34-1-250-8905

SWEDEN

Birgitta Ekerot, President
Alzheimer's Society of Sweden
Sunnanvag 18L
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SWITZERLAND

Mr. Oskar Diener, Secretary General
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Dr. Nori Graham, Chairman
Alzheimer's Disease Society
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FAX: 44-81-675-8040

UNITED STATES

Richard Gehring, Chairman
Alzheimer's Association
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Chicago, Illinois 60601
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VENEZUELA (Provisional Member)

Dra. Mira Josic, Presidente
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Canadian ADS First to Respond to Alzheimer's Challenge

The Alzheimer Society of Canada was the first such national Society in the world.

From its beginnings in 1978, the organization has progressed steadily with the formation of local organizations and development of provincial associations as needs were identified. The Society is structured in a three-tiered system with the national office, located in Toronto, to coordinate Canadian and international activities. Provincial Associations have been established in each province to directly assist local organizations. These may be small informal support groups to full fledged chapters of regional offices with staff offering a variety of support services.

Geography Dictates Structure

Canada has ten provinces and two territories stretching approximately 5,150 kilometers (3,100 miles) from east to west, and north to south with an area approximately 3,852,000 square miles and a population of 26 million people.

Our Board of Directors reflects this structure, with the president, vice president, and six members at large elected by the members for a two year term. Each provincial association appoints a representative to the Board. Over 14,000 Canadians belong to the society through their provincial and local associations.

The mission of the Society is "to alleviate the personal and social consequences of Alzheimer's disease and to promote the search for a cause and cure." This is done through the Board programs of Education, Support Services, Research and Advocacy.

1990 a Year of Growth; Research Commitment Raised

This past year was one of great growth for our Society. Our staff increased from 8 full time and one day per week part time, to 16 full time and one 1/2 time position. This increase reflects the demands placed on the Society. Our budget for the next year will be \$3.6 million dollars.

The commitment to research has grown from \$140,000 in 1988/89, to \$800,000 in 1990/91, which represents 22% of the budget. The research granting process looked at two distinct areas last year, the scientific area through a Career Scientist Award, as

well as Post Doctoral and Doctoral Awards; and the social consequences area through a variety of caregiver issues. Also, the federal government through the Medical Research Council in partnership with Price Daxion, a corporate sponsor and the Society initiated a fellowship program. Local and provincial organizations contribute to various local research projects.

Canadian Government Funds Care Standards Development

The federal government, through the

Seniors Independence Program Health & Welfare, funded a proposal for the development of the Standards of Care program. This program of three years duration has a budget of \$550,000.

We have grown in our 12 years of existence, yet we still face many challenges before we fully meet the goals of our mission, if ever.

We look forward to being the host country for the 1993 Alzheimer's Disease International Conference.

—Jeanne Bentley, President,
Alzheimer Society of Canada

UK Spearheads Alzheimer Movement in Europe

The Alzheimer's Disease Society in the United Kingdom was formed in 1979 with the initiatives of two carers, Cora Phillips and Morella Kayman.

The Society's Main Aims Are To:

- Provide support to families and others concerned by linking them through membership, branches and support groups.

- Provide practical help and information on Alzheimer's disease and related disorders; on the services, benefits and other resources available for sufferers and carers, from Health and Social Services, voluntary organizations and the private sector.

- Provide guidance for the carer and training for professionals concerned with sufferers and carers.

- Promote and press publicly for adequate and high quality services. These include improved services for assessment, support at home, day care, residential care, nursing home and hospital care for sufferers and all necessary aid.

- Promote and disseminate research findings and help advance the frontiers of knowledge about the disease.

- Raise public awareness by active work in the community, informed use of the news media, political representation and by all other available means.

- Generate funds to promote the above aims in a professional manner.

The Society is structured and organized into health authority regions in England, Wales and Northern Ireland. Within this structure, it has ten Regional Offices, 118

branches, 77 support groups and 54 individual contact people.

The Society's branches usually have independent local funding and may undertake some form of service provision such as Day Care or Sitting Services. Support Groups are informal and are more likely to provide, for example, monthly self-help support groups for carers to exchange ideas and experiences. Individual contact people provide local help and advice by telephone, a few may offer personal visits.

ADS National has a National Information and Advice Service from the National Office in London, which deals with 18,000± enquiries annually. Many of the enquirers will be put in touch with a local contact. The National Society also provides a wide range of publications and undertakes development work through the country.

Respite Care High on Society's Agenda

The Society is currently encouraging branches to develop Respite Care with additional funding. They have secured commercial funding from Ladbrokes to extend six of the Society's Day Centers, and operate their own Respite Care Fund.

Their public policy efforts include: Extending public awareness of the disease; Pressing central and local government to provide adequate, quality services particularly in the field of community care for dementia; Pressing central government for increased welfare benefits for carers; Lobbying health care professionals and gov-

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Alzheimer Publications from Around the World

Living With Alzheimer's Disease, by Dr. Gordon Wilcock. Penguin Books, July 1990. A complete self-help guide for family and professional carers.

La enfermedad de Alzheimer: Que es y Como Sobrellevarla. by I. Maribel Taussig, PhD. Dirección: University of Southern California; Andrus Gerontology Center; University Park, MC 0191; Los Angeles, California 90089-0191; U.S.A.

Alternative Homes for People with Dementia: New Directions in Service Principles & Design. Guidelines on principles of care plus short descriptions of 23 homes recently designed for people with dementia. Descriptions cover statutory, voluntary and private sector provision, and discuss desirable and undesirable characteristics of the schemes. This is a practical, concise and current guide to some key developments in accommodation for people with dementia, £2.00. ISBN 0 9510320 11. Available from: BASE, 119 Hassell Street, Newcastle, Staffordshire ST5 1AX. TEL: 0782-661033.

Carers, Professionals & Alzheimer's Disease: Proceedings of the FIFTH ALZHEIMER'S DISEASE INTERNATIONAL CONFERENCE; Dublin, September 1989. Edited by Desmond O'Neill. £21.00 USD \$41. Paperback 336 pages. ISBN 0 86196 298 2 April 1991. Published by: John Libbey & Company, Ltd.; 13 Smiths Yard; Summerley Street; London SW18 4HR, England.

Dedicated to the Aged: A Manual for an Active Old Age. Part of a wider project that includes a book and video for carers Available in English from Cattedra di Geriatria, Università Cattolica del Sacro Cuore; Largo F. Vito 1; 00168, Rome, Italy.

Understanding Difficult Behaviors, by Robinson, Spencer & White. Geriatric Education Center of Michigan. Deals with eleven difficult behaviors exhibited by people with dementia. Eastern Michigan University Gerontology Program; Ypsilanti, Michigan 48197.

❖ Calendar of International Events ❖

JUNE 12-15, 1991

Fifth Nordic Neuroscience Meeting, University of Kuopio, Finland. Conference Secretariat; 5th Nordic Neuroscience Meeting Secretariat; Neuroscience Center; University of Kuopio; Box 21; S.F.-70211 Kuopio, Finland. FAX: 358-71-173019. Tel: 358-71-162695 or 173012.

JUNE 30-JULY 2, 1991

First International Congress on Biomarkers of Aging: Expression and Regulation; School of Medicine, University of Bologna, Italy. Organizing Secretariat: UP Service S.r.l.; Miss Annalise Eusebo; P. O. Box n. 336; 60100 Ancona, Italy. Tel: 71-206237-8. FAX: 71-200527.

AUGUST 18-23, 1991

Fifth Congress of the International Psychogeriatric Association (IPA), **MOVED** from Jerusalem to Rome, Italy; The Cavalieri Hotel. Secretariat: 3137 Greenleaf Avenue; Wilmette, Illinois 60691, USA. Tel: (708) 866-7227. FAX: (708) 866-6984.

SEPTEMBER 11-14, 1991

2nd European Congress of Gerontology, Madrid, Spain. Organizing Secretariat: Geyseco, S.A. Group; Capitán Haya, 60, 2º; 28020 Madrid, Spain. Tel: 34-1-571 38 04. FAX: 34-1-571 42 66.

SEPTEMBER 23-25, 1991

7th International Conference of Alzheimer's Disease International, Amsterdam. Contact: RAI Organizatie Bureau Amsterdam bv; Europapkeijn 12; 1078 GZ Amsterdam; The Netherlands.

OCTOBER 31-NOVEMBER 3, 1991

4th Asia/Oceania Regional Congress of Gerontology, Yokohama, Japan. Congress Secretariat: c/o Japan Gerontological Society; Kyorin Bldg. #701, 4-2-1 Yushima; Bunkyo-ku, Tokyo 113-Japan. Tel: 813-814-8104. FAX: 813-814-8604.

NOVEMBER 2-6, 1991

II Congresso Latino Americano de Neuropsicologia & 1 Congresso Brasileiro de Neuropsicologia. Centro de Convenções Rebouças, São Paulo, Brazil. Official languages: Portuguese, Spanish & French. Organização de Eventos Rebouças; Av Rebouças, 600; CEP 05402 São Paulo, Brazil. Tel: (011) 881-1344. FAX: (011) 881-1125.

NOVEMBER 9-14, 1991

1st Latin American Conference of COMLAT-IAG; VII Latin American Conference of Geriatrics & Gerontology; and, IX Brazilian Society of Geriatrics & Gerontology, at Maksoud Plaza Hotel, São Paulo, Brazil. Tel: 55 31 221 3138. FAX: 55 31 227 0243.

NOVEMBER 18-20, 1991

International Conference on the Social Dimension of Senile Dementia: The Senile Individual and the Welfare Society: Danish Views, Moves & Projects, Experiences. Conference Secretariat: The Geriatric Educational Aid Centre; 5 Hellasvej; DK 7620 Lemvig. Tel: (45) 9789 13 77; FAX: (45) 9789 10 57.

DECEMBER 8-11, 1991

International Conference on Care of the Elderly: The Complementary Roles of Formal & Informal Support Systems for the Elderly. Secretariat: Int'l & Reg. Affairs Dept.; Hong Kong Council of Social Service; 11/F, Duke of Windsor Social Service Bldg.; 15 Hennessey Road; Wanchai, Hong Kong. Tel: (852) 8642992. FAX: (852) 8654916.

DECEMBER 8-12, 1991

Pan-European Society for Neurology, 2nd Congress-Vienna, Congress Center Hofburg. Congress President Prof. Dr. F. Gerstenbrand; c/o Medizinische Ausstellung u. Werbegesellschaft; M. Rodler & Co. Ges. m.b.H. Freyung 6; A-1014 Vienna Postfach 155, Austria. Tel: 0222/533 29 35. FAX: 0222/535 60 16

MAY 15-17, 1992

Reflections and Visions: Caring for People with Dementia in the 90's at Central Institute of Technology, Upper Hutt (Wellington), New Zealand. For information: ADARDS NZ, Inc.; P. O. Box 2808; Christchurch, New Zealand. (Please send a large stamped, self-addressed envelope).

SEPTEMBER 1992

8th International Conference of Alzheimer's Disease International, Brussels, Belgium. Belgium Alzheimer Liga; Tel:32-16-46-0496.

JULY 4-9, 1993

15th International Congress of Gerontology, Budapest, Hungary Conference Secretariat: Budapest Convention Centre; P. O. Box 233; H-1444 Budapest, Hungary. FAX: (361) 185-2127. Scientific Information: Tel: (361) 113-5411.

7th International Conference Update

On Monday, September 23rd 1991, in Amsterdam, ADI's 7th International Conference will commence with a formal ceremony when Ms. H. d'Ancona, Minister of Welfare, Health and Cultural Affairs in The Netherlands joins with Princess Yasmin Aga Khan Jeffries, President of Alzheimer's Disease International; Dr. A. M. Koopman-Iwema, President of the Dutch Alzheimer Foundation; and, Dr. D. H. Sipsma, Conference Chairperson, to open the Conference. Minister d'Ancona's participation emphasizes the importance of research into Alzheimer's disease and its implications for society in the decades ahead.

Five plenary sessions will cover: Cooperation of the partners in Alzheimer's disease; The Dutch System of care for the Elderly; Risk Factors for Alzheimer's disease; Psychiatric factors in dementia; Diagnostic assessment in dementia; The role of neuropsychological assessment; Markers for Alzheimer's disease; Intervention therapy in Alzheimer's disease: Possibilities of drugs and memory training; and, Intervention therapy.

In a joint meeting with the Dutch Society of Psychogeriatrics, the measurement of burden and ways of relieving the burden of caregivers at home will be explored by

a number of speakers. ADI member country reports will provide an exchange of experiences by representatives of those countries. Free papers, and a video session, are also scheduled. Workshops will cover: Legal Issues; Training of family members; Policy making and fundraising; Environmental design; How to get the G.P. involved in dementia problems, etc.

Excursions are planned for visiting a variety of Dutch care facilities. A canal boat excursion will take participants to the National Maritime Museum. An official reception is planned, and a "Dutch Evening."

Non-commercial exhibitions will offer displays from Alzheimer Societies around the world, arts and craft items made by Alzheimer patients, and a creative visualization of developments in the care of dementia sufferers.

The Conference will be held at the RAI Conference Center in Amsterdam. The headquarters hotel for members will be the Novotel, "400 feet from the Rai Centre." To register, or for more information, contact: Conference Secretariat; 7th International Conference of ADI; c/o RAI Organisatie Bureau Amsterdam bv.; Europaplein 12; 1078 GZ Amsterdam; The Netherlands. Tel: 31-(0)20-549 12 12; FAX: 31-(0)20-46 44 69.

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are more susceptible to psychological distress. Evidence is presented to refute recent trends to medicalize the condition of caregivers. Despite the burden that they shoulder, caregivers generally cope, do not decompensate with clinical depression, and probably do not use health resources excessively. This paper focuses on ways to improve caregiving abilities and family coping strategies. Previous interventions with carers have included education; assertiveness; individual and family counseling; mobilization of supports; training in specific techniques such as behavior modification; and training in relaxation or meditational techniques. No effects on patients have been demonstrated but carers can be shown to have increased knowledge, decreased burden, change in atti-

tude, better coping skills, decreased psychological morbidity and recently, delayed institutional placement. It is concluded that the carers of dementia sufferers while distressed, are not clinically depressed and cope in a variety of ways. Their condition should not be medicalized. Training of family caregivers can improve their coping skills, reduce their stress and delay patient institutionalization. **Henry Brodaty, M.D., Memory Disorders Clinic, Prince Henry Hospital, Little Bay, Sydney, Australia.**

► Children and Teenagers Face Dementia

The caregiver's burden has been extensively evaluated. We focused our study on children and teenagers reactions when an Alzheimer's patient shares the same resi-

UK Spearheads Movement in Europe—from page 10

ernment for full assessment procedures for sufferers and carers; Development of a national strategy for training for dementia.

There is little specific public money for dementia in the UK. The Society receives a central government grant towards its national office costs; it undertakes external fundraising work through corporate donors, charitable trusts, legacies and individual donations. Media appeals for fundraising are used.

The Society mainly supports carers, but aims to provide approximately one tenth of the income it generates (over and above that needed for expenses) to give towards research. Most of this has gone to two projects, one on genetic research and one on an epidemiological follow-up study.

Mark Your Calendar:
ADI's 7th International
Conference, in Amsterdam,
September 23-27, 1991,

The Next Issue of Global Perspective

ADI members are invited to participate in publication of *Global Perspective* by providing articles and photographs related to issues of interest to members. Articles describing your national organization's program to address specific problems and goals and organizational issues are of particular interest. Deadline for the next issue is July 15, 1991. Please send materials to Rachel Billington, Global Perspective Editor, Alzheimer's Disease International; 70 E. Lake Street; Chicago, Illinois 60601.

dence, whether he is a parent or a grandparent. The caregiving task can be modified by this outcome and even can lead to institutionalization. We examine how the family reactions can be changed (severer interventions (counseling, face to face interviews or support groups). **Michelle Miccas, M. D., Centre de Medecine Geriatrique; 170, Avenue de Casselardit; 313 Toulouse, France.**