6° CONVEGNO NAZIONALE SUI CENTRI DIURNI ALZHEIMER

FONDAZIONE CASSA DI RISPARMIO DI PISTOIA E PESCIA

Centro Monteoliveto

"Casa dell'Anziano"

ANTICHI E NUOVI INTERVENTI TERAPEUTICI IN CENTRO DIURNO ALZHEIMER

12.10 La demenza nel disabile intellettivo che invecchia
Luc De Vreese (Modena)
Introduce: *Nicola Cariglia (Pistoia)*

15 - 16 Maggio 2015

Auditorium
Via Panconi, 14 - Pistoia

Hindawi Publishing Corporation
International Journal of Family Medicine
Volume 2011, Article ID 319574, 9 pages
doi:10.1155/2011/319574

Research Article

Prevalence of Depression and Dementia among Adults with Developmental Disabilities in Manitoba, Canada

Shahin Shooshtari,[1] Patricia Joan Martens,[2] Charles A. Burchill,[2] Natalia Dik,[2] and Saba Naghipur[3]

TABLE 2: Dementia prevalence (per 100 population), 2000/01–2004/05.

Study population and age groupings	Total *N*	Number with dementia	Prevalence (95% CI)
DD cohort			
20–54 Yrs	1,401	73	5.21 (4.05, 6.37)
55+ Yrs	218	30	13.76 (9.19, 18.33)
Matched comparison group (no DD)			
20–54 Yrs	2,798	39	1.39(0.96, 1.83)
55+ Yrs	433	15	3.46 (1.74, 5.19)

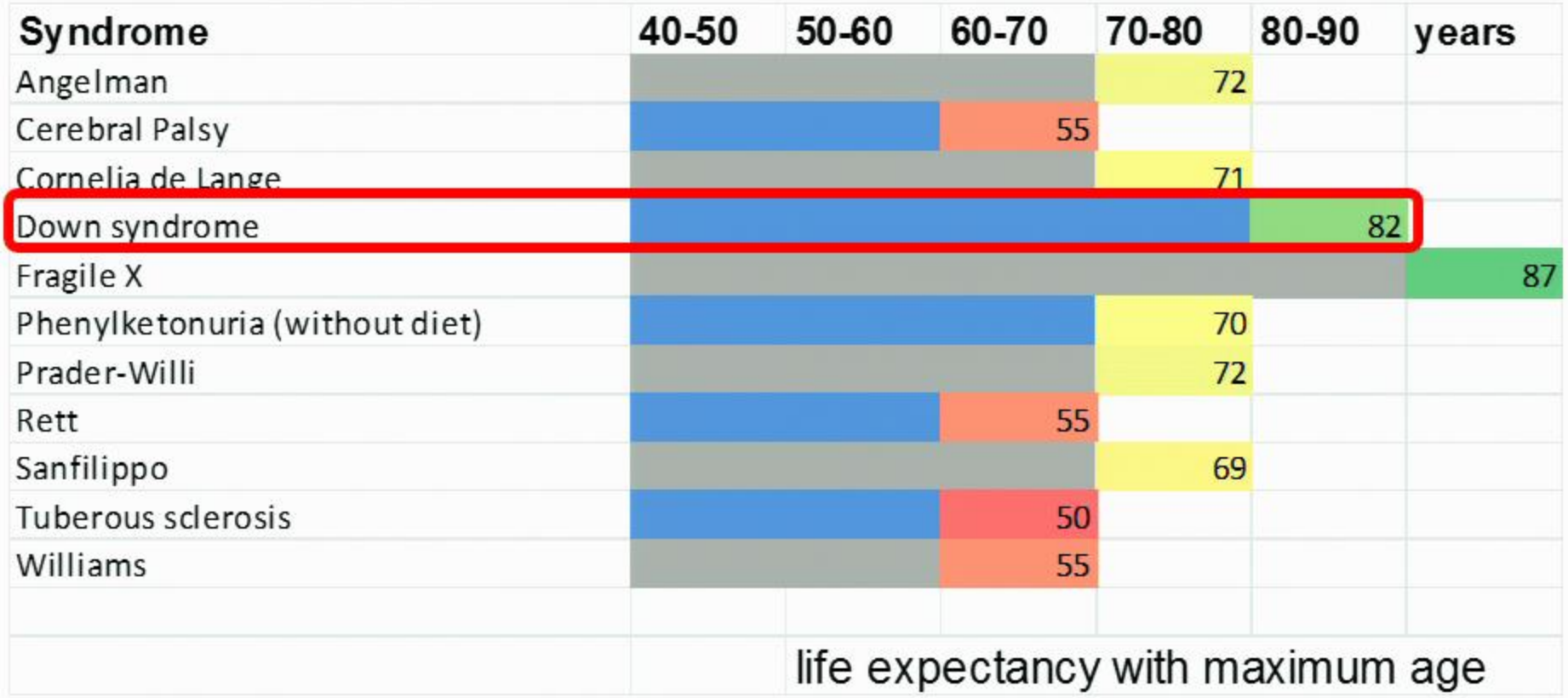
La prevalenza di demenza è da 4 a 5 volte superiore rispetto alla popolazione generale

La nuova longevità

Changes in mortality and causes of death in the Swedish Down syndrome population.

- All individuals with DS that died between 1969 and 2003 in Sweden, and all individuals born with DS in Sweden between 1974 and 2003 were included.
- Data were obtained from the Swedish Medical Birth Register, the Swedish Birth Defects Register, and the National Cause of Death Register.
- Median age at death has increased by 1.8 years per year

Englund A. et al. *Am J Med Genet A*. 2013 Apr;161A(4):642-9

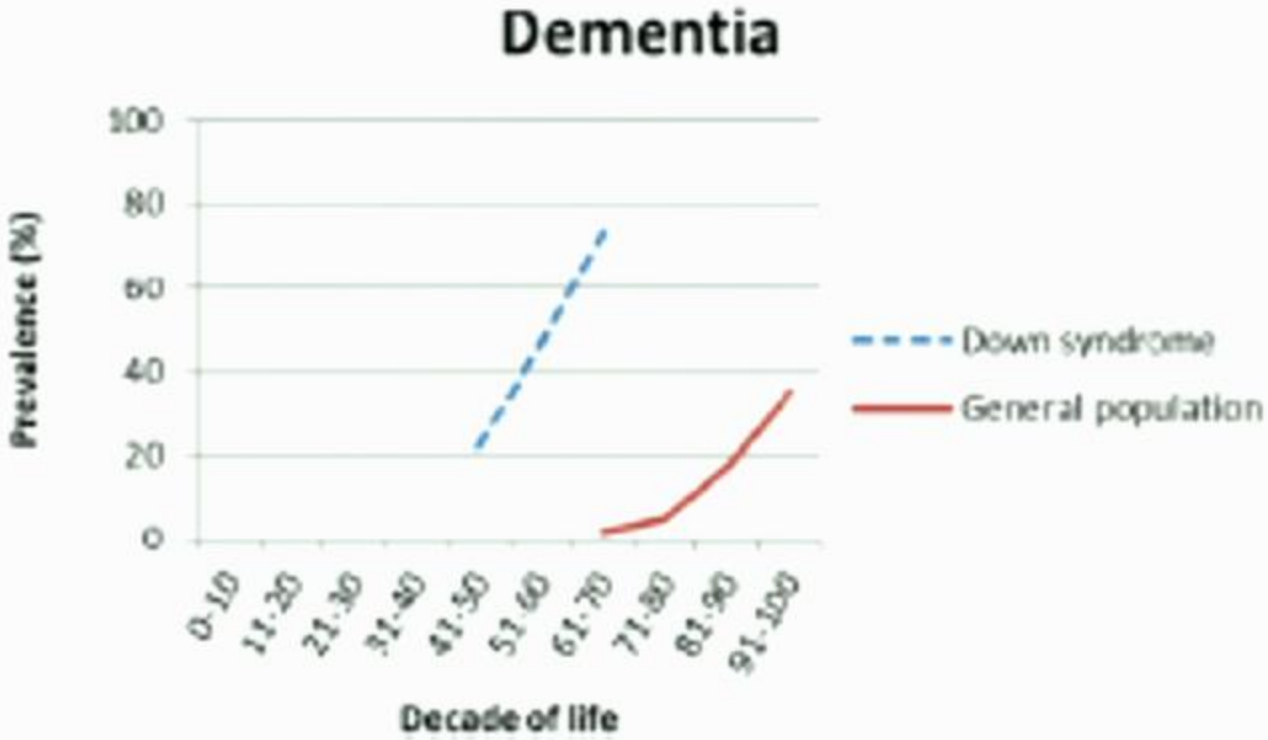


Coppus AM. *Dev Disabil Res Rev* 2013;18(1):6-16.

- Oggi in Italia le persone con SD sono circa 48.000, di cui il **13%** ha più di **44** anni
- La spettanza di vita alla nascita è di **61,6** anni per i maschi e di **57,8** anni per le femmine

Epidemiologia

Dementia in Alzheimer's disease (DAD)



Nonostante il verificarsi di AD patologia nel cervello di individui con SD a partire dall'età di 40 anni (Wisniewski et al., 1994), la DAD esordisce in media attorno ai 50-55 anni di età (con un *range* tra 38-70 anni) con tassi di incidenza crescente con l'avanzare dell'età (da 2,53/100 persone-anno a 13,31/100 persone-anno rispettivamente nelle fasce di età <50 e ≥ 65 anni).

Coppus A. et al. *J Intellect Disabil Res* 2006;50:768-77.

Glasson EJ et al. *J Intellect Disabil Res* 2014;58:393-8.

Nelle persone con SD la demenza nella Malattia Alzheimer (*Dementia in Alzheimer's Disease*; Prasher, 2005) è la causa più importante di fragilità e di mortalità (fino al **30%**).

Coppus AM. *Dev Disabil Res Rev* 2013;18(1):6-16.
Prasher V.P. *Alzheimer's disease and Dementia in Down Syndrome and Intellectual Disabilities*, Abingdon: Radcliffe Publishing, 2005.

ETHNOGERIATRICS AND SPECIAL POPULATIONS

Survival in Elderly Persons with Down Syndrome

Antonia M. W. Coppus, MD,[*†] *Heleen M. Evenhuis, MD, PhD,*[‡] *Gert-Jan Verberne,*[†] *Frank E. Visser, MD, PhD,*[§] *Ben A. Oostra, PhD,*[‖] *Piet Eikelenboom, MD, PhD,*[#] *Willem A. van Gool, MD, PhD,*[#] *A. Cecile J. W. Janssens, PhD,*[**] *and Cornelia M. van Duijn, PhD*[*]

Relative preservation of cognitive and functional ability is associated with better survival in this study population. Clinically, the most important disorders in persons with DS that are related to mortality are dementia, mobility restrictions, visual impairment, and epilepsy but not cardiovascular diseases. Also, level of intellectual disability and institutionalization are associated with mortality. J Am Geriatr Soc 56:2311–2316, 2008.

Stadiazione compressa per adulti con Sindrome di Down

Primo Stadio o Lieve

da 2 a 4 anni o più

Stadio Medio- o Moderato

aa 2 a10 anni

Ultimo stadio o Severo

da 1 a 3 anni o più

Stages of Alzheimer's Disease

Source: Janicki, M.P., Riva del Garda, 2012

Hindawi Publishing Corporation
BioMed Research International
Volume 2014, Article ID 623487, 7 pages
http://dx.doi.org/10.1155/2014/623487

Research Article

Factors Determining Disease Duration in Alzheimer's Disease: A Postmortem Study of 103 Cases Using the Kaplan-Meier Estimator and Cox Regression

R. A. Armstrong

TABLE 1: Demographic details of the 103 cases used in the study (*N*: number of cases; FAD: familial Alzheimer's disease; SAD: sporadic Alzheimer's disease). Data for age at death, duration, and disease onset are means with range and standard deviations in parentheses.

Patient group	*N*	Age at death (years)	Duration (years)	Onset (years)
Early-onset FAD	19	61.9 (46–74, 10.8)	11.1 (3–20, 6.5)	50.7 (38–59, 6.5)
Early-onset SAD	22	70.4 (57–88, 11.1)	16.0 (6–30, 9.3)	54.4 (49–58, 4.2)
Late-onset FAD	12	77.4 (70–85, 5.1)	7.0 (1–15, 4.6)	70.4 (61–84, 7.6)
Late-onset SAD	50	80.1 (70–98, 6.6)	6.8 (1–21, 4.5)	73.5 (62–93, 7.2)

Contents lists available at SciVerse ScienceDirect

Research in Developmental Disabilities

2013;34:1881-5

Incidence of dementia in older adults with intellectual disabilities

Andre Strydom [a,*], Trevor Chan [b], Michael King [a], Angela Hassiotis [a], Gill Livingston [a]

Anche nelle altre forme di DI, la demenza è molto frequente: quasi un **terzo** degli ultra60enni sviluppa una demenza conclamata, con tassi di incidenza di **circa cinque** volte superiore rispetto a quelli della popolazione generale (54,6/1000 persone-anno con un picco di 97,8/1000 persone- anno nelle fasce di età tra 70-74 anni). Prevale la demenza Alzheimer (≈ 50%) come nella popolazione generale.

Screening

ASSOCIAZIONE ITALIANA PSICOGERIATRIA

PSICOGERIATRIA 2007; III: 19-27

ARTICOLO ORIGINALE

Uno studio di attendibilità della versione italiana della scala Dementia Questionnaire for Persons with Intellectual disabilities (DMR)

A reliability study of the Italian version of Dementia Questionnaire for Persons with Intellectual disabilities (DMR)

LUC PIETER DE VREESE[1], ULRICO MANTESSO[2], MARCO SCARAZZINI[3], CRISTINA MENEGATTI[3], TIZIANO GOMIERO[4]

Tab. 2 Gli *item*, le sottoscale e somma dei punteggi del DMR.

Sottoscale	N item	Punteggio (minimo-massimo)
1. Memoria episodica recente	8	0 - 16
2. Memoria episodica remota e autobiografica	7	0 - 14
3. Orientamento spaziale e temporale	7	0 - 14
Somma degli Scores Cognitivi (SOS)	**22**	**0 - 44**
4. Comunicazione verbale	4	0 - 8
5. Abilità di base	8	0 - 16
6. Umore	6	0 - 12
7. Attività e interessi	6	0 - 12
8. Comportamenti problematici	6	0 - 10
Somma degli Scores Sociali (SCS)	**30**	**0 - 60**

Research in Developmental Disabilities 34 (2013) 3962–3977

Contents lists available at ScienceDirect

Research in Developmental Disabilities

Review

A systematic review on assessment instruments for dementia in persons with intellectual disabilities

Elisabeth L. Zeilinger *, Katharina A.M. Stiehl, Germain Weber

As an example for the group of informant-based assessment instruments, the *National Task Group on Intellectual Disabilities and Dementia Practices—Early Detection Screen for Dementia* (NTG—EDSD) can be mentioned. The assessment of dementia needs to focus on the individual changes in the respective person. To detect early signs of dementia it is widely recommended to compare an early assessed baseline with periodic re-assessments (e.g., Aylward, Burt, Thorpe, Lai, & Dalton, 1997; Deb & McHugh, 2010; Kalsy & Oliver, 2005). The NTG—EDSD incorporated this recommendation and is available in several languages, including English, French, German, Greek, Italian, and Spanish. Especially in Europe a multi-lingual availability of instruments is important in order to make data comparable. Combined with the advantage of being a baseline assessment the NTG—EDSD has the potential of becoming an agreed upon procedure for the assessment of dementia in persons with ID.

Report NTG

'My Thinker's Not Working': A National Strategy for Enabling Adults with Intellectual Disabilities Affected by Dementia to Remain in Their Community and Receive Quality Supports

- Fattori relativi alla popolazione
- Le sfide per le persone affette da demenza e DI
- Supporti della comunità
- Educazione e formazione
- Finanziamento
- Possibili soluzioni
- Piano d'azione e (raccomandazioni) per le persone con DI e demenza)

Available from: www.aadmd.org/ntg
www.psicogeriatria.it

BADL - ATTIVITÀ DI BASE DELLA VITA QUOTIDIANA
KATZ INDEX OF INDEPENDENCE IN ACTIVITIES OF DAILY LIVING

1. **Fare il bagno (vasca, doccia, spugnature)**

- ☐ 1. Fa il bagno da solo (entra ed esce dalla vasca da solo)
- ☐ 2. Ha bisogno di assistenza soltanto nella pulizia di una parte del corpo (es. schiena)
- ☐ 3. Ha bisogno di assistenza per più di una parte del corpo

DSQIID. *Dementia Screening Questionnaire for Individuals with Intellectual Disabilities.*

Deb, S., Hare, M., Prior, L. and Bhaumik, S. (2007), *British Journal of Psychiatry*, 190, 440-444. doi: 10.1192/ bjp.bp.106.024984

Questionario Parte 2

Esempio: Non Riesce a lavarsi/fare il bagno senza aiuto.

☒ **Sempre stato così.**

Se la persona ha sempre avuto bisogno di aiuto

☒ **Sempre stato così, ma peggiora.**

Se la persona sembra aver avuto un declino delle sue capacità in quest'area

☒ **Sintomo nuovo**

Se la persona aveva acquisito questa abilità nell'età adulta e l'ha persa recentemente

☒ **Non è il suo caso (non applicabile)**

la persona si lava senza nessun aiuto ed è sempre stato così

1	Non riesce a lavarsi e/o a fare il bagno senza aiuto	☐	☐	☐	☐
2	Non riesce a vestirsi senza aiuto	☐	☐	☐	☐
3	Si veste in modo inappropriato (es., confonde avanti e dietro, o incompleto)	☐	☐	☐	☐
4	Si spoglia in contesti inappropriati (es., in pubblico)	☐	☐	☐	☐
5	Necessita di assistenza per mangiare	☐	☐	☐	☐
6	Necessita di assistenza per usare i servizi igienici	☐	☐	☐	☐
7	Incontinente (includendo anche incidenti occasionali)	☐	☐	☐	☐
8	Non inizia una conversazione	☐	☐	☐	☐
9	Non riesce a trovare le parole	☐	☐	☐	☐
10	Non riesce a seguire semplici istruzioni	☐	☐	☐	☐
11	Non riesce a seguire più di una istruzione per volta	☐	☐	☐	☐
12	Si interrompe a metà di un compito	☐	☐	☐	☐
13	Non riesce a leggere	☐	☐	☐	☐
14	Non riesce a scrivere (nemmeno il proprio nome)	☐	☐	☐	☐
15	Cambiamenti nel ritmo del sonno (dorme di più o di meno)	☐	☐	☐	☐
16	Si sveglia frequentemente durante la notte	☐	☐	☐	☐
17	Di notte è confuso	☐	☐	☐	☐
18	Dorme durante il giorno	☐	☐	☐	☐
19	Vagabonda di notte	☐	☐	☐	☐
20	Si disorienta in ambienti familiari	☐	☐	☐	☐
21	Vagabonda (incluso fuori dall'abitazione)	☐	☐	☐	☐
22	Perde il senso del tempo (ora del giorno, giorno della settimana, stagione)	☐	☐	☐	☐
23*	Non sicuro nel camminare su piccole fessure, linee sul pavimento o superfici irregolari.	☐	☐	☐	☐
24	Il cammino instabile, perde l'equilibrio	☐	☐	☐	☐
25	Non riesce a camminare senza aiuto	☐	☐	☐	☐
26	Non riconosce persone familiari (operatori/parenti)	☐	☐	☐	☐
27	Non ricorda i nomi di persone familiari	☐	☐	☐	☐
28	Non ricorda eventi recenti	☐	☐	☐	☐
29	Ritiro dalle attività sociali	☐	☐	☐	☐
30	Ritiro dai contatti personali	☐	☐	☐	☐
31	Perdita di interesse in hobbies/attività	☐	☐	☐	☐
32	Sembra vivere in un mondo tutto suo	☐	☐	☐	☐
33	Comportamenti ossessivi o ripetitivi (es., svuota ripetutamente gli armadi)	☐	☐	☐	☐
34	Nasconde o accumula oggetti	☐	☐	☐	☐
35	Perde oggetti	☐	☐	☐	☐
36	Ripone oggetti familiari in luoghi impropri	☐	☐	☐	☐
37	Non sa cosa fare con oggetti familiari	☐	☐	☐	☐
38	Sembra insicuro/a	☐	☐	☐	☐
39	Sembra ansioso/a o nervoso/a	☐	☐	☐	☐
40	Sembra depresso/a	☐	☐	☐	☐
41	Mostra aggressività (verbale o fisica)	☐	☐	☐	☐
42	Convulsioni/Epilessia	☐	☐	☐	☐
43	Parla da solo/a	☐	☐	☐	☐

Dementia Screening Questionnaire for Individuals with Intellectual Disabilities-Italian version (DSQIID-I): a multicentre validation study in aging adults with Down syndrome and other forms of Intellectual Disabilities

Tiziano Gomiero[a], Marco Bertelli[b], Shoumitro Deb[c], Elisabeth Weger[a], Annachiara Marangoni[a], Elisa De Bastiani[a], Ulrico Mantesso[a], Luc Pieter De Vreese[d]

a Project DAD (Down Alzheimer Dementia) ANFFAS Trentino Onlus, Trient, Italy
b Research and Clinical Centre (CREA) of San Sebastiano Foundation, Florence, Italy
c Imperial College London, Department of Medicine, Division of Brain Sciences, UK
d Local Health Agency, Dementia Project, Modena, Italy

	N	%
male	162	58.7
female	114	41.3

1.1.4. Dichotomic Diagnosis of ID (DS *vs.* non-DS)

	N	%
SD	85	30.8
non SD	191	69.2

1.1.1. Mean age

	Minimum	Maximum	Mean	SD
Age	39	80	54.61	7.559

Journal of Policy and Practice in Intellectual Disabilities, submitted

Sintomi di esordio

Behavioral changes in Down syndrome diagnosed with Alzheimer's dementia.

Behavioral changes	Example reference
Apathy	Jervis (1948) and Deb et al. (2007)
"Episodic noisy excitement"	Jervis (1948)
Irritability	Jervis (1948) and Stanton and Coetzee (2004)
Wandering & confusion	Jervis (1948), Prasher and Filer (1995) and Deb et al. (2007)
Destructive, aggressive or difficult behavior	Jervis (1948), Prasher and Filer (1995), Urv, Zigman, and Silverman (2008) and Stanton and Coetzee (2004)
Lethargy, withdrawal, loss of interest	Crapper, Dalton, Skoptiz, Scott, and Hachinski (1975) and Stanton and Coetzee (2004)
"Silliness"	Crapper et al. (1975)
Limited response to people	Crapper et al. (1975)
Social inadequacy, isolation	Urv et al. (2008) and Stanton and Coetzee (2004)
Extreme changes in appetite (typically weight loss)	Crapper et al. (1975)
Restlessness	Prasher and Filer (1995) and Stanton and Coetzee (2004)
Sleep disturbance	Prasher and Filer (1995), Deb et al. (2007), Urv et al. (2008) and Stanton and Coetzee (2004)
Incontinence	Prasher and Filer (1995)
Excessively uncooperative	Cooper and Prasher (1998) and Stanton and Coetzee (2004)
Anxiety & fearfulness	Urv et al. (2008) and Stanton and Coetzee (2004)
Sadness	Urv et al. (2008)
Stealing & general regressive behavior	Urv et al. (2008)
Personality changes	Stanton and Coetzee (2004)
Increased dependence	Stanton and Coetzee (2004)

Nieuwenhuis-Mark RE. Res Dev Disabil 2009;30:827-38

Behavioral changes in Down syndrome diagnosed with Alzheimer's dementia.

Behavioral changes	Example reference
Apathy	Jervis (1948) and Deb et al. (2007)
"Episodic noisy excitement"	Jervis (1948)
Irritability	Jervis (1948) and Stanton and Coetzee (2004)
Wandering & confusion	Jervis (1948), Prasher and Filer (1995) and Deb et al. (2007)
Destructive, aggressive or difficult behavior	Jervis (1948), Prasher and Filer (1995), Urv, Zigman, and Silverman (2008) and Stanton and Coetzee (2004)
Excessively uncooperative	Cooper and Prasher (1998) and Stanton and Coetzee (2004)
Anxiety & fearfulness	Urv et al. (2008) and Stanton and Coetzee (2004)
Sadness	Urv et al. (2008)
Stealing & general regressive behavior	Urv et al. (2008)
Personality changes	Stanton and Coetzee (2004)
Increased dependence	Stanton and Coetzee (2004)

As an explanation for this "frontal signs first" hypothesis, Azizeh et al. (2000) suggested that the sequence of brain regions affected by Alzheimer's dementia may differ with earlier amyloid deposition in the frontal lobes in the Down population while in the general population the hippocampus (and thus episodic memory) would atrophy first. Holland et al. (1998) extended Mortimer's (1988) reserve capacity model by implying that early compromise was to be found in the frontal lobes in Down syndrome. Also relevant to this discussion is that the frontal lobes have been found to be underdeveloped in Down syndrome (Crome & Stern, 1972) and this could suggest that only a small amount of neuropathology may tip the threshold into impairments, especially on frontal tasks in these people.

Nieuwenhuis-Mark RE. Res Dev Disabil 2009;30:827-38

BRITISH JOURNAL OF PSYCHIATRY (2007), 191, 150–157. doi: 10.1192/bjp.bp.106.028845

Prevalence of dementia in intellectual disability using different diagnostic criteria

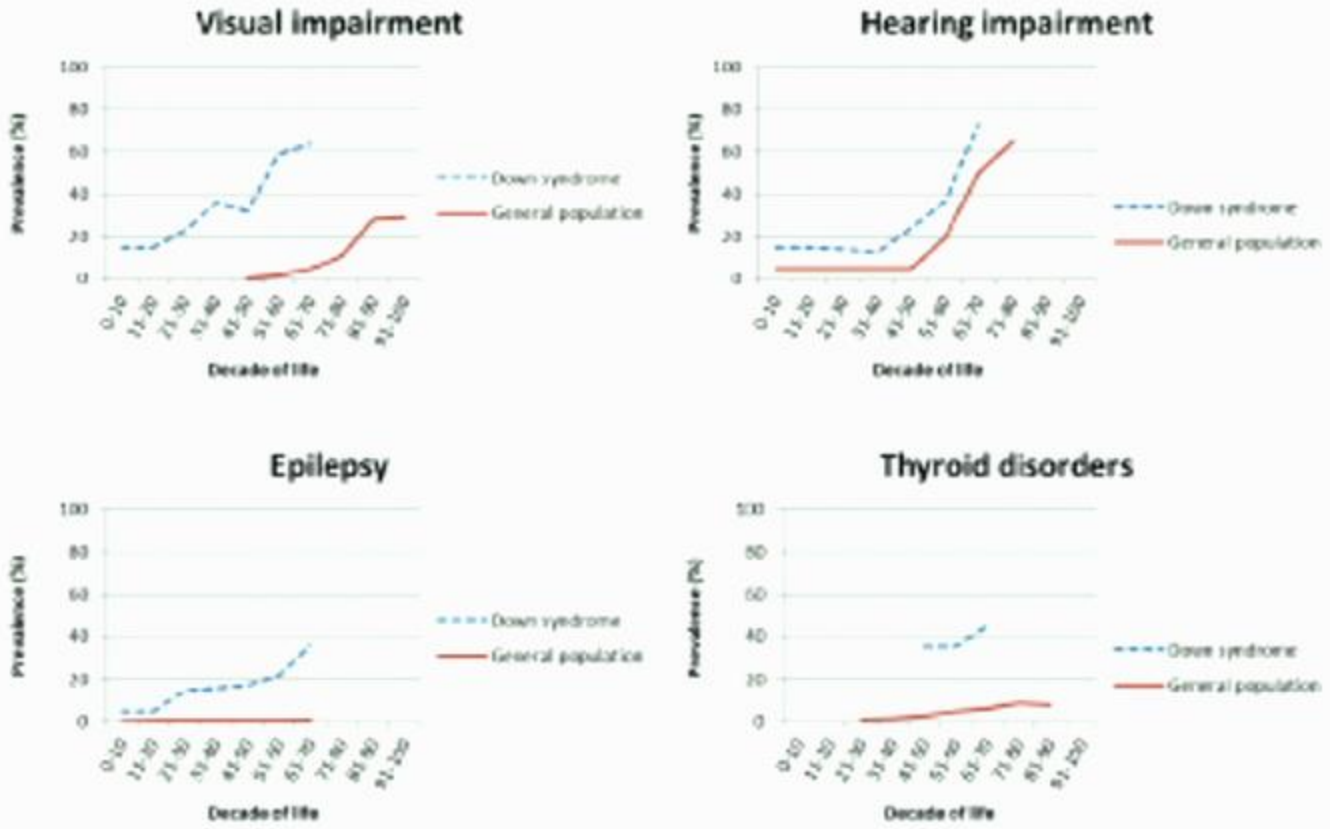
A. STRYDOM, G. LIVINGSTON, M. KING and A. HASSIOTIS

The most common initial symptom was **general deterioration in functioning**, followed by **behavioural or emotional change**. Deterioration in memory or other cognitive functions was rarely noticed to be prominent in the early stages of the disorder. Other early symptoms included **episodes of confusion**.

Symptoms that significantly discriminated between those with and without dementia in those who screened positive were deterioration in **self-care ability**, deterioration in **IADL**, change in **memory**, development of **muddled thinking**, development of problems with **thinking ahead and planning**, and newly developed **perseveration**.

Declino cognitivo e comorbilità organica e/o psichiatrica

(e) *uncertain with complications:* criteria for definite dementia had been met, but symptoms might be caused by some other substantial concern, usually a medical condition unrelated to a dementing disorder (e.g., loss of vision, poorly resolved hip fracture, loss of social support network due to relocation)



Glasson EJ et al. *J Intellect Disabil Res* 2014;58:393-8.

RESEARCH ARTICLE

International Journal of Geriatric Psychiatry

Factors associated with depression and anxiety in older adults with intellectual disabilities: results of the healthy ageing and intellectual disabilities study

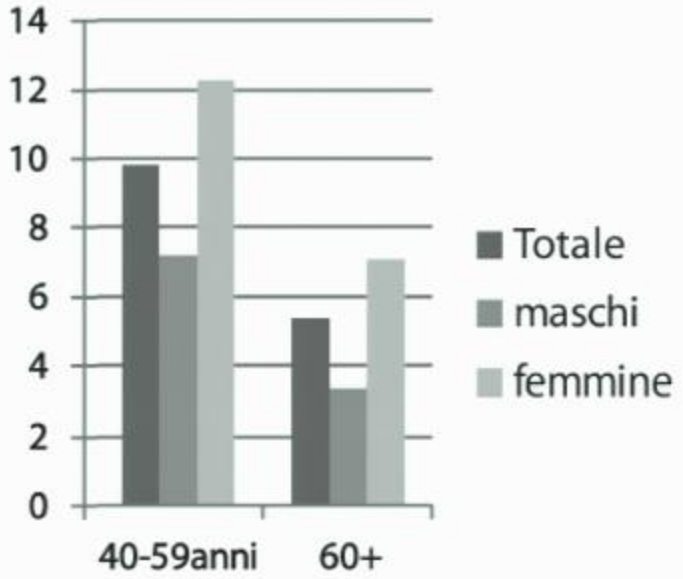
Heidi Hermans[1,2] and Heleen M. Evenhuis[1]

HA-ID study: 980 soggetti con DI, di cui 861 con SD; età media 61,5 anni (50-93)

epression and anxiety (%)		
creased depressive symptoms	166 (16.8)	138 (47.6)
creased anxiety symptoms	161 (16.3)	128 (44.1)
lajor depression	—[3]	42 (14.5)
nxiety disorders	—[3]	23 (7.9)

[3] Studied in 290 participants only

Increased depressive symptoms were positively associated with increased anxiety symptoms, number of life events during the past year and chronic diseases (heart failure, stroke, chronic obstructive pulmonary disease, coronary artery disease, diabetes mellitus and malignity in the previous 5 years)



Taylor WD. *N Engl J Med* 2014; 371:1228-1236

Research in Developmental Disabilities 33 (2012) 1722–1731

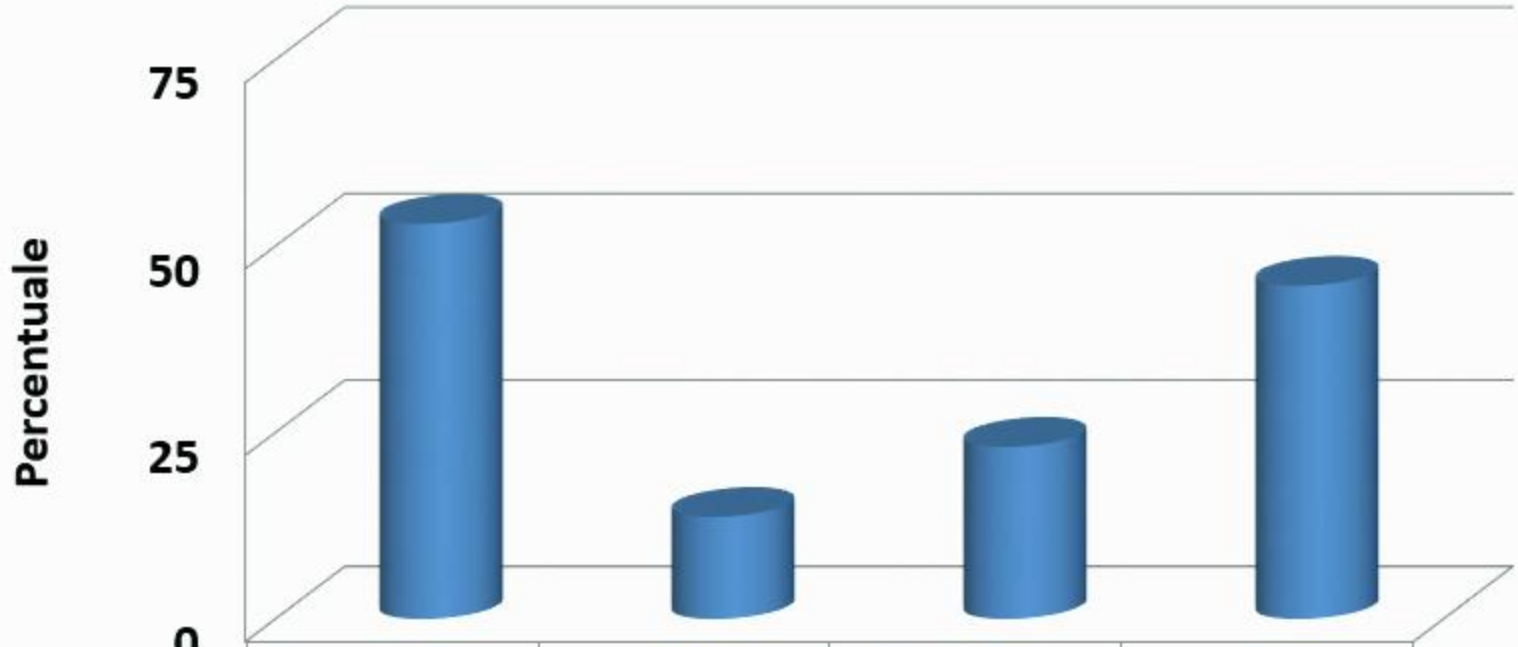
Contents lists available at SciVerse ScienceDirect

Research in Developmental Disabilities

Cardiovascular risk factors (diabetes, hypertension, hypercholesterolemia and metabolic syndrome) in older people with intellectual disability: Results of the HA-ID study

C.F. de Winter [a,b,*], L.P. Bastiaanse [a,c], T.I.M. Hilgenkamp [a,d], H.M. Evenhuis [a], M.A. Echteld [a]

HA-ID study:
980 persone con DI, di cui 861 con SD; età media 61,5 anni (50-93)



	Ipertensione	DM	Ipercolest.	Sdr metabolica
Prevalenza	53	13,7	23,1	44,7

RESEARCH ARTICLE

International Journal of Geriatric Psychiatry

Factors associated with depression and anxiety in older adults with intellectual disabilities: results of the healthy ageing and intellectual disabilities study

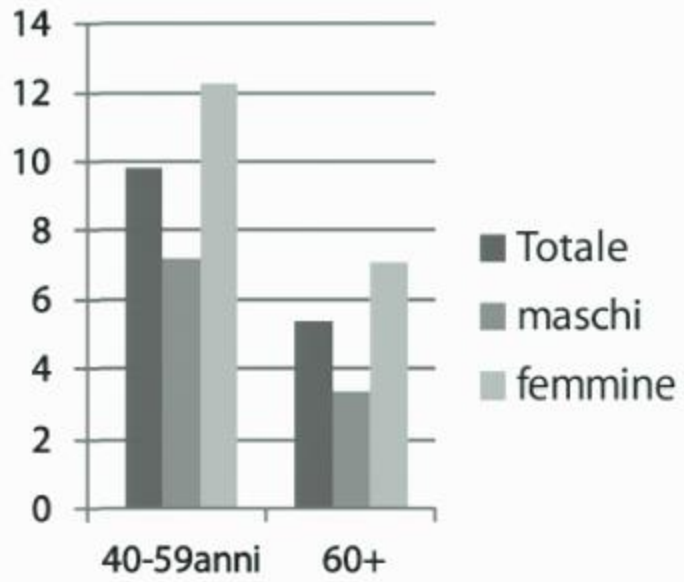
Heidi Hermans[1,2] and Heleen M. Evenhuis[1]

HA-ID study: 980 soggetti con DI, di cui 861 con SD; età media 61,5 anni (50-93)

Depression and anxiety (%)		
Increased depressive symptoms	166 (16.8)	138 (47.6)
Increased anxiety symptoms	161 (16.3)	128 (44.1)
Major depression	—[3]	42 (14.5)
Anxiety disorders	—[3]	23 (7.9)

[3] Studied in 290 participants only

Increased depressive symptoms were positively associated with increased anxiety symptoms, number of life events during the past year and chronic diseases (heart failure, stroke, chronic obstructive pulmonary disease, coronary artery disease, diabetes mellitus and malignity in the previous 5 years)



Taylor WD. *N Engl J Med* 2014; 371:1228-1236

II. Physical and Mental Health

Many health problems remain unrecognised

- Communication/insight difficulties
- Physical limitations/reluctance of family members
- Behaviour problems
- Diagnostic overshadowing
- Lack of specialist care in ID

Coppus AM. *Dev Disabil Res Rev* 2013;18(1):6-16.

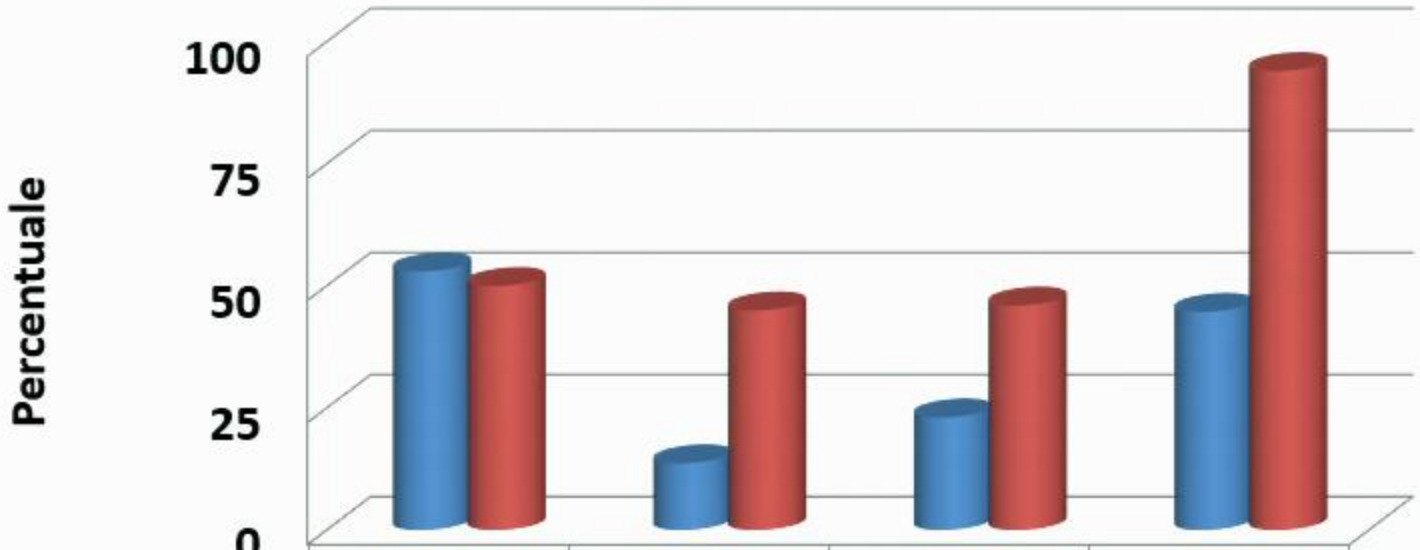
Research in Developmental Disabilities 33 (2012) 1722–1731

Contents lists available at SciVerse ScienceDirect

Research in Developmental Disabilities

Cardiovascular risk factors (diabetes, hypertension, hypercholesterolemia and metabolic syndrome) in older people with intellectual disability: Results of the HA-ID study

C.F. de Winter [a,b,*], L.P. Bastiaanse [a,c], T.I.M. Hilgenkamp [a,d], H.M. Evenhuis [a], M.A. Echteld [a]



	Ipertensione	DM	Ipercolest.	Sdr metabolica
Prevalenza	53	13,7	23,1	44,7
Prima diagnosi	50	45	46	94

Iacono et al. BMC Health Services Research 2014, 14:505
http://www.biomedcentral.com/1472-6963/14/505

BMC
Health Services Research

RESEARCH ARTICLE Open Access

A systematic review of hospital experiences of people with intellectual disability

Teresa Iacono[1*], Christine Bigby[2], Carolyn Unsworth[3], Jacinta Douglas[4] and Petya Fitzpatrick[2]

A number of reviews have explored underlying contributors to poor hospital experiences by people with intellectual disability [13,28-30]. These reviews have similarly revealed that some people with intellectual disability are fearful of hospital encounters, there is reliance on carers during the entirety of stays, and problem attitudes and limited knowledge of hospital staff, sometimes with dire outcomes.

Delirium nelle persone con DI: un gran sconosciuto

«I do not know of any screening tool or algortihm in older ID persons with or without dementia.
I do not know of any major research study in this area.
I think the field of ID is still trying to detect dementia *per se* rather than focus on subgroups.
Maybe in the future.»

Vee Prasher, 1 Aprile 2015

JIDR Journal of Intellectual Disability Research
Published on behalf of mencap and in association with IASSID

Journal of Intellectual Disability Research doi: 10.1111/jir.12026

VOLUME 58 PART 4 pp 393–398 APRIL 2014

Brief report

The triple challenges associated with age-related comorbidities in Down syndrome

E. J. Glasson,[1] D. E. Dye[2] & A. H. Bittles[3,4]

with their ill-effects exacerbated by **long-term medication, polypharmacy**, immobility and general inactivity.

Drugs Aging
DOI 10.1007/s40266-014-0236-7

Published online: 09 January 2015

REVIEW ARTICLE

Pharmacological Management of Behavioral and Psychiatric Symptoms in Older Adults with Intellectual Disability

Nicole Eady · Ken Courtenay · André Strydom

Abstract Given medical and social advances, the life expectancy of individuals with intellectual disability (ID) has increased dramatically, leading to a generation of older individuals with such disabilities. This review focuses on the pharmacological treatment of behavioral and psychiatric symptoms and disorders in older adults with ID. Older adults with ID often present with medical co-morbidities and mental health issues. Medication management of behavioral and psychiatric problems is complicated by a higher risk for adverse events, lack of decision-making capacity, and complex care networks. Some studies have shown that individuals with ID and co-morbid mental disorders are undertreated in comparison with those with similar disorders in the general population, resulting in poorer outcomes. However, older adults with ID are also at risk of polypharmacy, and older age is a risk factor for development of side effects. A general principle is that medication treatment for psychiatric disorders in older individuals with ID should be started at low dosages and

	N	%
Use as antiepileptic	33	12.0
Use as mood stabiliser **22,1%**	20	7.2
Use not specified	8	2.9
No ATC N03 drug use	215	77.9

61 subjects (22.1% of the study sample) are under ATC N03 drug therapy

	N	%
FGA	40	14.5
SGA **28,3%**	14	5.1
FGA/SGA not specified	19	6.9
FGA e SGA in combined use	5	1.8
No ATC N05A use	198	71.7

FGA: first generation antipsychotics, SGA: second generation antipsychotics;
(28.3% of the study sample) are under ATC N05A drug therapy.

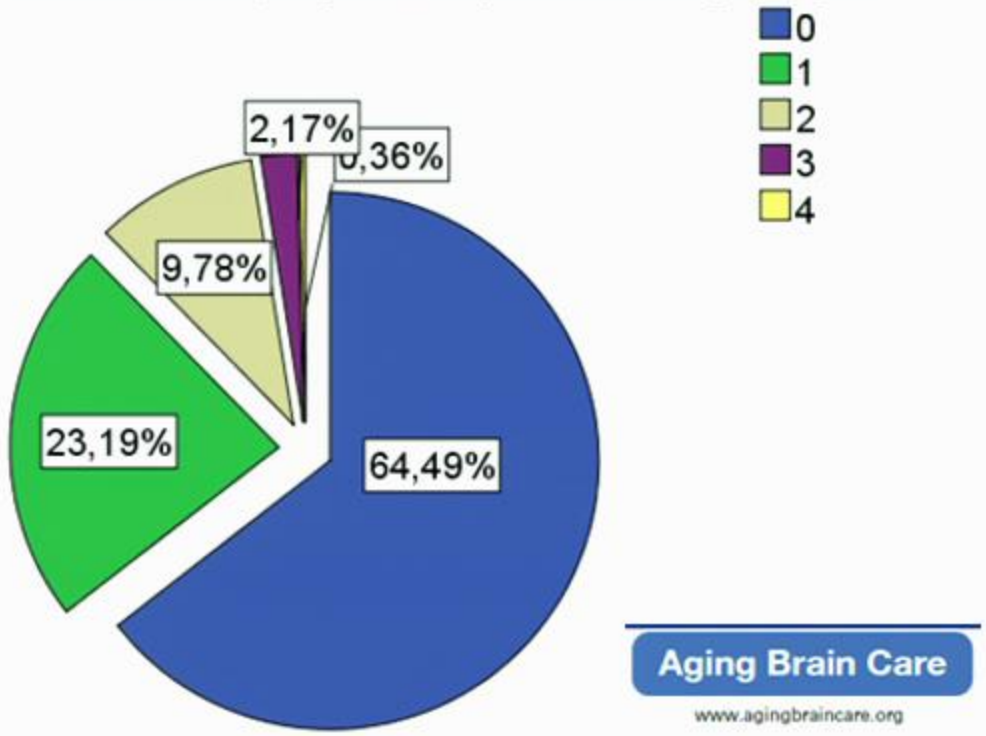
	N	%
No ATCN06 use	256	92.8
Antidepressant therapy	20	7.2

14 subjects in SSRI therapy, 4 subjects treated with Trazodone, one with NaSSA and one subject with SNRI

	N	%
No ATCN05B use	239	86.6
Anxiolitic use **13,4%**	32	11.6
Combined use (n=2)	5	1.8

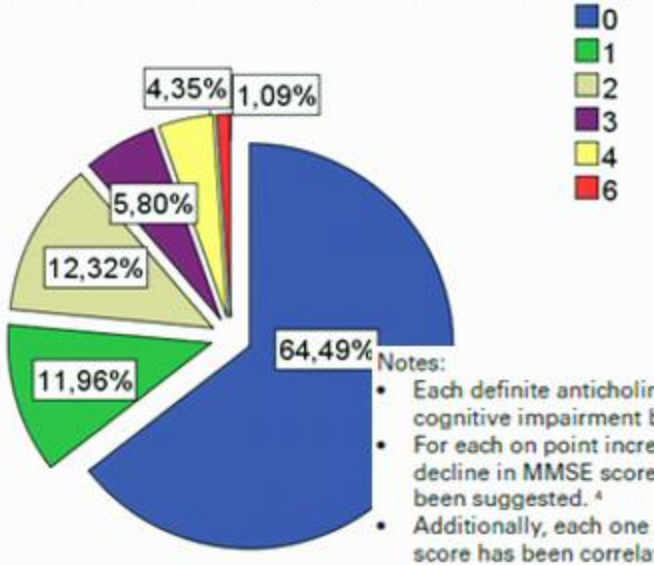
	N	%
No ATC N0C use	259	93.8
Hypnotic and sedative use **6,2%**	11	4.0
Combined use (n=2)	6	2.2

Prevalence of no, single or multiple anticholinergic drug use



Aging Brain Care
www.agingbraincare.org

Distribution of ABC scores (sum of definite anticholinergics)



Notes:

- Each definite anticholinergic may increase the risk of cognitive impairment by 46% over 6 years. [3]
- For each on point increase in the ACB total score, a decline in MMSE score of 0.33 points over 2 years has been suggested. [4]
- Additionally, each one point increase in the ACB total score has been correlated with a 26% increase in the risk of death. [4]

Criteri diagnostici

Table I Criteria for dementia in the classification systems

Impaired domain/ symptoms	DSM–IV	ICD–10	DC–LD
Memory			
Short- and/or long-term	+	+	+
Higher cortical functions[2]			
Executive function	O		
Thinking		O	O
Judgement		O	O
Other cognitive skills			O
Information processing		O	
Aphasia/ language skills	O		
Apraxia	O		
Agnosia	O		
Behavioural and emotional function[2]			
Emotional lability		O	O
Irritability		O	O
Apathy		O	O
Social behaviour		O	O
Other criteria			
Change from premorbid state/decline in level of functioning[1]	+		+
Duration of at least 6 months		+	+
Exclusions			
Not caused by delirium	+	+	+
Not caused by mental illness	+		+

+, required for diagnosis.

1. The ICD–10 classification requires a decline in memory and other cognitive function, but does not have a separate criterion for change or deterioration in function.

2. At least one of the circled is required.

Validity of Criteria for Dementia in Older People With Intellectual Disability

Andre Strydom, M.B.Ch.B., M.Sc., M.R.C.Psych., Ph.D.,
Trevor Chan, M.B.Ch.B., M.R.C.Psych., M.Sc.,
Cormac Fenton, M.B.Ch.B., M.Sc., M.R.C.Psych., Rebekah Jamieson-Craig, Dclin.Psych.,
Gill Livingston, M.B.Ch.B., F.R.C.Psych., M.D.,
Angela Hassiotis, M.D., M.A., M.R.C.Psych., Ph.D.

poor outcomes at T2. **Conclusion:** *Dementia diagnostic criteria show substantial reliability and satisfactory validity in ID. The diagnoses were, however, less stable than in the general population and some caution is advisable in those with more severe ID or additional sensory disability. MCI definitions require further consideration in the ID population.* (Am J Geriatr Psychiatry 2013; 21:279–288)

Published in final edited form as:
J Policy Pract Intellect Disabil. 2013 September 1; 10(3): . doi:10.1111/jppi.12042.

Intellectual Disability, Mild Cognitive Impairment, and Risk for Dementia

Wayne P. Silverman[1], **Warren B. Zigman**[2], **Sharon J. Krinsky-McHale**[2], **Robert Ryan**[2], and **Nicole Schupf**[3]

The concept of mild cognitive impairment (MCI) has gained currency in the general population as a 'preclinical' stage of dementia in which the cognitive and functional losses are greater than would be expected as part of normal ageing, but are not sufficient to warrant formal diagnosis.

The validity of this term has been questioned, even within the normal population, and **there are practical difficulties of applying it to people with intellectual disability**

Trattamento farmacologico

Risultati negativi

- **Donepezil**
  - De la Torre R. et al. *Prog Brain Res* 2012;197:1-14.
- **Memantina**
  - Hanney M. et al. *Lancet* 2012;379:528-36.
- **Rivastigmina**
  - Prasher V. et al. *Int J Geriatr Psychiatry* 2013;28:219-20.

Trattamento non farmacologico

The projected effect of risk factor reduction on Alzheimer's disease prevalence

Deborah E Barnes, Kristine Yaffe

Lancet Neurol 2011; 10: 819–28

At present, about 33·9 million people worldwide have Alzheimer's disease (AD), and prevalence is expected to triple over the next 40 years. The aim of this Review was to summarise the evidence regarding seven potentially modifiable risk factors for AD: diabetes, midlife hypertension, midlife obesity, smoking, depression, cognitive inactivity or low educational attainment, and physical inactivity. Additionally, we projected the effect of risk factor reduction on AD prevalence by calculating population attributable risks (the percent of cases attributable to a given factor) and the number of AD cases that might be prevented by risk factor reductions of 10% and 25% worldwide and in the USA. Together, up to half of AD cases worldwide (17·2 million) and in the USA (2·9 million) are potentially attributable to these factors. A 10–25% reduction in all seven risk factors could potentially prevent as many as 1·1–3·0 million AD cases worldwide and 184 000–492 000 cases in the USA.

- Diabete
- Ipertensione
- Fumo
- Obesità
- Depressione
- Inattività cognitiva
- Bassa scolarizzazione
- Inattività fisica

Journal of **Policy and Practice in Intellectual Disabilities**

Journal of Policy and Practice in Intellectual Disabilities
Volume 10 Number 1 pp 1–24 March 2013

Guidelines for Structuring Community Care and Supports for People With Intellectual Disabilities Affected by Dementia

Nancy Jokinen*, Matthew P. Janicki†, Seth M. Keller‡, Philip McCallion§, Lawrence T. Force¶, and the National Task Group on Intellectual Disabilities and Dementia Practices

*University of Northern British Columbia, Prince George, British Columbia, Canada; †University of Illinois at Chicago, IL; ‡American Academy of Developmental Medicine and Dentistry, Lumberton, NJ; §University at Albany, Albany, NY; and ¶Mt. St. Mary College, Newburgh, NY, USA

The guidelines also provide information on nonpharmacological options for providing community care for persons affected by dementia as well as commentary on abuse, financial, managing choice and liability, medication, and nutritional issues.

Journal of **Policy and Practice in Intellectual Disabilities**

Journal of Policy and Practice in Intellectual Disabilities
Volume 9 Number 2 pp 92–102 June 2012

Impact of Dementia-derived Nonpharmacological Intervention Procedures on Cognition and Behavior in Older Adults With Intellectual Disabilities: A 3-year Follow-up Study

Luc P. De Vreese*, Ulrico Mantesso†, Elisa De Bastiani†, Elisabeth Weger†, Annachiara C. Marangoni†, and Tiziano Gomiero†
*Department of Primary Care, Psychogeriatric Service, Local Health District of Modena, Modena; and †ANFFAS Trentino Onlus, Trento, Italy

Journal of **Policy and Practice in Intellectual Disabilities**

Journal of Policy and Practice in Intellectual Disabilities
Volume 10 Number 1 pp 1–24 March 2013

Guidelines for Structuring Community Care and Supports for People With Intellectual Disabilities Affected by Dementia

Nancy Jokinen*, Matthew P. Janicki†, Seth M. Keller‡, Philip McCallion§, Lawrence T. Force¶, and the National Task Group on Intellectual Disabilities and Dementia Practices

*University of Northern British Columbia, Prince George, British Columbia, Canada; †University of Illinois at Chicago, IL; ‡American Academy of Developmental Medicine and Dentistry, Lumberton, NJ; §University at Albany, Albany, NY; and ¶Mt. St. Mary College, Newburgh, NY, USA

The guidelines also provide information on nonpharmacological options for providing community care for persons affected by dementia as well as commentary on abuse, financial, managing choice and liability, medication, and nutritional issues.

Journal of **Policy and Practice in Intellectual Disabilities**

Journal of Policy and Practice in Intellectual Disabilities
Volume 9 Number 2 pp 92–102 June 2012

Impact of Dementia-derived Nonpharmacological Intervention Procedures on Cognition and Behavior in Older Adults With Intellectual Disabilities: A 3-year Follow-up Study

Luc P. De Vreese*, Ulrico Mantesso†, Elisa De Bastiani†, Elisabeth Weger†, Annachiara C. Marangoni†, and Tiziano Gomiero†
*Department of Primary Care, Psychogeriatric Service, Local Health District of Modena, Modena; and †ANFFAS Trentino Onlus, Trento, Italy

Baseline demographic and clinical characteristics of the study sample

		SCU $n = 14$				DC $n = 22$				NH $n = 24$			
Sex	Male	7 (50%)				11 (50%)				12 (50%)			
DS Present	DS	10 (71.4%)				15 (66.2%)				5 (16.7%)			
Age	Mean	53.2				55.2				51.9			
	SD	(6.9)				(7.5)				(5.5)			
IQ values	Mean	29.9				32.7				27.3			
	SD	(11.6)				(14.8)				(13.3)			
Level of IQ	Category	Pr	Se	Mo	Mi	Pr	Se	Mo	Mi	Pr	Se	Mo	Mi
N/%		6	4	4	0	8	3	8	3	13	5	4	2
		43%	28.5%	28.5%	0	36%	14%	36%	14%	54.2%	20.8%	16.7%	8.3%
DMR/SCS	Mean	25.4				13.6				15.1			
	SD	(10.9)				(14.3)				(10.9)			
DMR/SOS	Mean	19.3				16.9				13.9			
	SD	(10.6)				(12.4)				(8.7)			

Pr = Profound (≤25); Se = Severe (26–35); Mo = Moderate (36–49); Mi = Mild (≥50); SCU = special care unit; DC = day center; NH = nursing home

Gentle Care
Person-centred Care
Stimolazione multisensoriale
Attività a mediazione di un cane
Musicoterapia
Ambiente

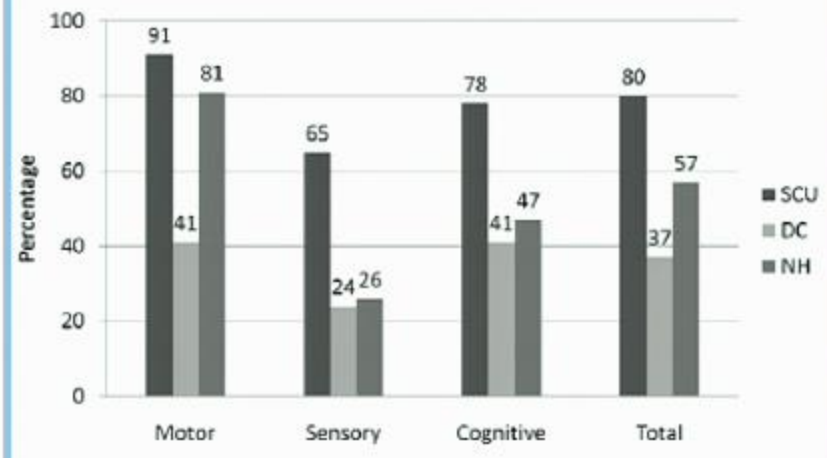


FIGURE 1

Appropriateness[1] of the environment in the three settings.

[1]Based on the questionnaire (Chiogna & Dalprà, 2009).

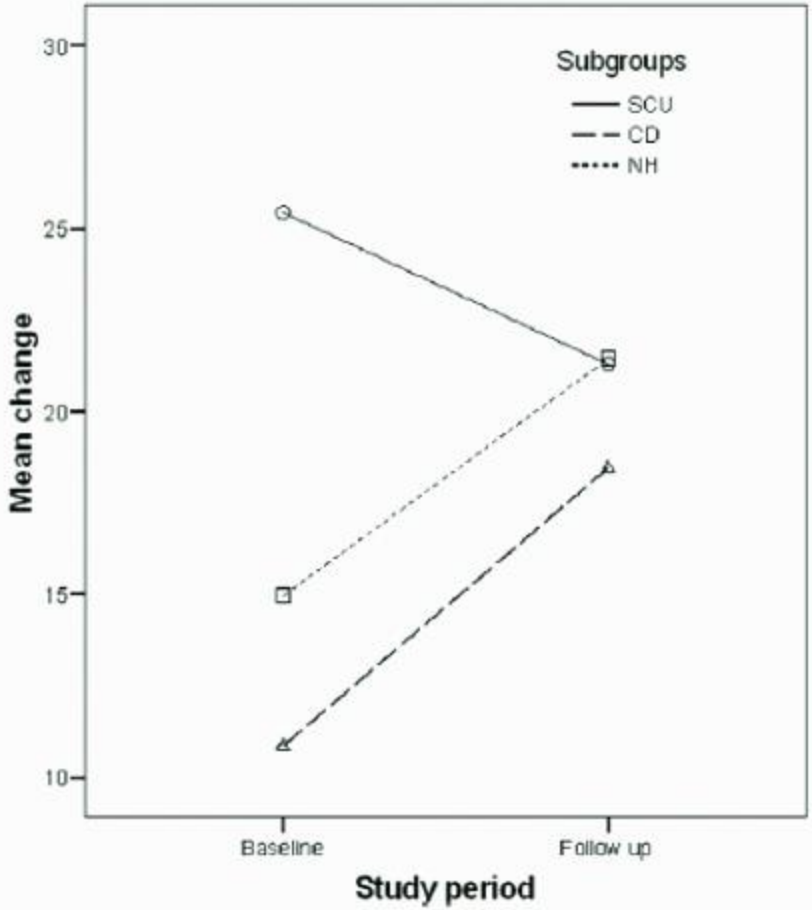


FIGURE 3

Mean DMR/SCS obtained by the three study groups across the 3-year period.

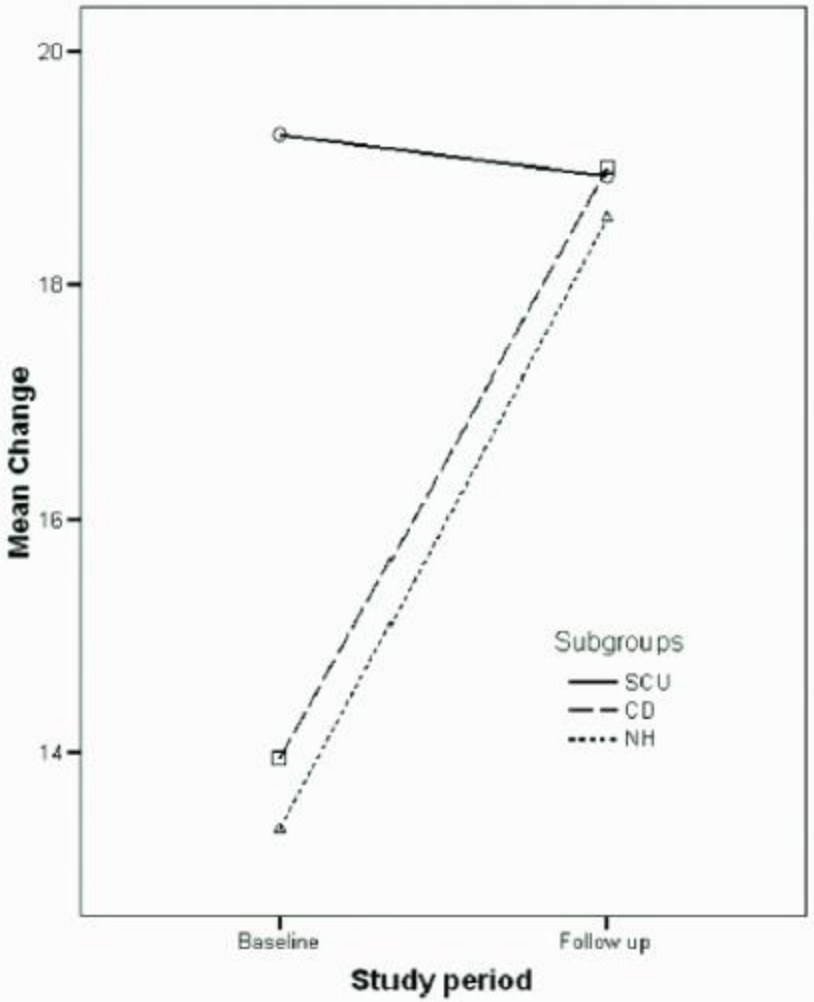


FIGURE 4

Mean DMR/SOS obtained by the three study groups across the 3-year period.

measures have not been included in this study. There were however, some indirect indicators of cost-effectiveness of the DAD Project, such as the hospitalization rate and number of traumatic falls. SCU residents were admitted to the hospital for 17 days against an average of 46 days in the control settings. There were only three falls among the SCU residents during the whole 3-year period, whereas the incidence of falls in the control settings was three falls per year.

To take home…

- Adulti/anziani con DI sono ad elevato rischio per la demenza
- La valutazione e la diagnosi di demenza non è agevole ma è possibile
- La frequente multimorbosità impone interventi di prevenzione primaria e secondaria
- Sono urgenti studi sul *delirium* e sugli interventi psicosociali per queste persone «le più fragili tra le fragili»