Volume 10, Numbers 1 & 2
Alzheimer's Disease Education & Referral Center

CONNECTIONS

Driving and Dementia

Health Professionals Can Play Important Role

As a person ages, driving skills change due to both muscle and vision degeneration, slowing reaction time, and the effects of illnesses and medications. Although older drivers are among the safest drivers in the United States, car crashes are the leading cause of injury-related fatalities in 65–74 year olds and the second leading cause of fatalities for those 75 years of age or older, after falls. In 1995, one out of every 11 drivers was over age 70. By the year 2020, one out of every 5 drivers will be over age 65.

Studies suggest that older drivers with dementia are at greater risk for accidents compared to other drivers. On-road tests of driving skills have shown that drivers with mild dementia were more prone to errors than a control group. Other surveys note that drivers with dementia had twice as many "close calls" as other drivers, perhaps because they have significant problems, for example, in processing visual information.

Although studies have analyzed this problem in different ways—for example, dementia has been classified using different measurement scales—almost all studies point to the same general conclusion: drivers with dementia should undergo regular, on-road testing of skills to ensure safety of the driver, passengers, and others.

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Tips for Caregivers: When Driving Should Stop

What course of action is open to the caregiver of a person with Alzheimer's disease when faced with clear evidence that driving should stop? How can the caregiver avoid confrontation when suggesting that a driver's license should be surrendered? How does the caregiver balance the dignity of the person with AD with the safety of others? How can a health care professional help?

Some drivers with dementia will begin limiting their

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News From the ADEAR Center
Alzheimer's Disease Education & Referral Center
A Service of the National Institute on Aging

Minority Outreach Workshop Blends Spiritual and Practical

Successful outreach to educate minority communities about Alzheimer's disease is built on relationships that take time to establish. A key ingredient is the ability to achieve rapport with your audience. Rapport helps engender trust, but it takes time, energy, determination, and enthusiasm, especially where loss and grief are ingrained in the culture of the community. Effective education requires knowledge of the minority community's strengths and weaknesses.

Darlyne Redd, MSSA, LSW

Darlyne Redd, MSSA, LSW, knows about rapport and the time it takes to develop trust. Since 1992, she has worked at the University Memory and Aging Center (UMAC) of University Hospitals of Cleveland/Case Western Reserve University. Ms. Redd is presently the Manager for Minority Outreach.

In her early years, as she was organizing community outreach to African Americans, Ms. Redd

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Grief Workshop

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discovered that most people don't want to attend a presentation specifically about Alzheimer's disease or dementia. The stigma associated with dementia is difficult to overcome. "If you focus on AD alone, you will end up with a very limited audience. The African American community is not jumping up and down to discuss dementia and participate in research. I believe that this goes across cultures," commented Ms. Redd.

In 1997, Ms. Redd was invited to participate in "Matters of the Heart and Mind: A Grief Workshop," sponsored by the Nu Chi local chapter of the Chi Eta Phi Sorority, a national African American nurses' association. That year, the Nu Chi Chapter won a grant from the National Institute on Aging for an outreach project. Seeing an opportunity to present Alzheimer's disease education to a wider audience, Ms. Redd began partnering with the sorority to produce Grief Workshops in 1998. Since then, she has presented four "Matters of the Heart and Mind" workshops, with two forums expanding to two days to cover more topics.

"Matters of the Heart and Mind" is a unique blend of the spiritual and practical. Tips and advice are presented on how to plan for end-of-life events, and how to deal with grief that results from loss. Alzheimer's disease, of course, is about profound loss: of identity, personality, memories, mobility, and independence. Social workers, nurses, caregivers, church and spiritual workers, families and the general public make up the audience. Health care professionals learn how to improve ways they can reach out to help minority communities. They learn about specific cultural and religious customs related to death and dying among African Americans. "We try to get our participants talking, to plan ahead so they don't end up in a crisis. We encourage them to go home and talk, put things in writing, and prepare their legal documents," says Ms. Redd. She believes that African Americans must change their ways of thinking about end-of-life planning, especially related to memory loss and Alzheimer's disease. As a rule, elder African Americans tend to maintain the mentality of an underclass, she says, even though they now have more money and are better educated than previous generations. Still, she notes, "African Americans die younger, die sicker, and die more often from violence than whites. We deal with losses, sudden changes, and abrupt endings as a way of life. It can lead to a chronic state of grief."

Participants listen to a panel of experts on grief and loss during a 1999 "Matters of the Heart and Mind" Workshop coordinated by Darlyne Redd, of the University Memory and Aging Center (UMAC) of University Hospitals of Cleveland/Case Western Reserve University.

Ms. Redd relies upon the strong ties African Americans have with the church. Religion provides part of the foundation African American elders need for support and social contact. The Grief Workshop prominently features local spiritual leaders as panel participants. They discuss faith perspectives on life after death, end-of-life care, and the customs and rituals of death.

Workshops usually begin with an invocation from a minister and a welcome from Karl Herrup, PhD, Director of the University Memory and Aging Center. Speakers discuss the range of emotions that accompany grief and loss. Caregivers share their challenges and triumphs. Social workers identify available resources and support services. Doctors and nurses weigh the pros and cons of long-term care, and hospice and palliative care versus traditional care. Lawyers offer advice on estates and preparation of proper legal documents. Funeral directors offer guidance on funerals and burial planning. Each workshop ends with a closing ceremony—a "healing circle" led by another local minister.

And of course, Ms. Redd seeks minority candidates for participation in research. As a result of one two-day workshop, Ms. Redd had 14 inquiries specifically about Alzheimer's disease out of about 85 attendees, and 4 actually enrolled in UMAC research programs.

Ms. Redd has written a manual on how to present a "Matters of the Heart and Mind" workshop. The manual is a "how to" guide with step-by-step instructions covering:

- planning committees
- sponsorships
- financing
- session topics and speakers
- a timeline
- sample collateral materials
- suggested publicity materials
- follow-up and thank-yous

Collaboration with other parts of the minority community is of critical importance to success. Other helpful suggestions include:

- Funding can be kept low with underwriting assistance, but charge general public participants $5, so organizers will know how many are attending.
- Check the community calendar to avoid conflicts.
- Start planning early.
- Be respectful of elders: don't call them by their first names; use surnames.
- Make sure the facility is accessible for handicapped people and make sure parking is close and free.
- Do not hold the workshop in a church because this may be offensive to certain members of your potential audience.
- Offer continuing education credits (CEUs) to health care professionals.
- "Toot your own horn" and don't forget to place yourself on your own program.

Darlyne Redd has worked hard to find innovative ways to reach out to the African American community to discuss Alzheimer's disease and dementia. UMAC is perceived to be a resource in the community, by helping to provide education on subjects rarely discussed by African Americans. More and more members of the community are learning that support services and local resources are available as they encounter the grief and loss of Alzheimer's disease.

To order the "Matters of the Heart and Mind: A Grief Workshop" Program Planning Manual, contact:
Darlyne Redd, MSSA, LSW
Manager of Minority Outreach
University Memory and Aging Center
University Hospitals of Cleveland/
Case Western Reserve University
Cleveland, OH 44120-1013
Tel.: 216-844-6327
e-mail: dar8@po.cwru.edu

Gap in Reading Levels May Explain Apparent Differences in Cognitive Testing

The research of Jennifer Manly, PhD, and colleagues at Columbia University suggests that methodological and analytical approaches, not actual racial or ethnic disparities in cognition, may in some cases help explain differences between older African Americans and non-Hispanic whites on cognitive test performance.

The Columbia group's findings, published in the March 2002 *Journal of the International Neuropsychological Society*, offer a powerful new tool—adjusting test results for quality of education—as one way to make cognitive testing of older people more culturally neutral. In the study, when test scores of participants with similar quality of education, measured by reading level, were compared, differences in test scores between two racial groups mostly disappeared.

The report challenges a standard approach used in research on cognition and dementia. Because differences in education might affect test scores or health status, most studies that have adjusted for the number of years of schooling still found that older African Americans did not score as well on cognitive tests as non-Hispanic whites. Manly's work looks instead at the quality of education. Inequalities in the educational experience of those who grew up in an era of segregated schools, Manly reasons, might be attributed to less funding and resources for such schools as well as fewer days per year that schools in the agrarian South were open for instruction. These discrepancies in early education, Manly suggests, have the potential to persist throughout life, as indicated in differences in reading levels between older African Americans and non-Hispanic whites.

At the NIA, racial and ethnic differences in cognitive function and dementia are an increased focus of research. "Several studies have reported racial and ethnic differences in cognitive performance in older adults and in the prevalence of Alzheimer's disease," notes Molly Wagster, PhD, program director for neuropsychology of aging research and project officer for the Manly study. "Because cultural, educational, or other differences might affect performance on this type of testing, there have been questions about whether measurement techniques are as culturally neutral as they could be."

Participants were drawn from a community-based study of cognitive aging in New York City's ethnically diverse neighborhoods of northern Manhattan. Random sampling was used to select 192 African Americans and 192 non-Hispanic whites age 65 and older. The two groups were matched in age, sex, and number of years of education. Participants were given medical evaluations at the start of the study to confirm that they did not have dementia and that they had no problems with daily activities. A battery of neuropsychological tests was then administered to examine memory, learning, and thinking abilities. Older people with low levels of reading ability could only name letters or read short, common words. Those with higher reading levels were able to pronounce complex, less common words out of context.

The African American group scored lower on the neuropsychological test battery overall as compared to non-Hispanic whites. But when reading scores were factored in, most differences between the groups were no longer statistically significant. The exceptions were category fluency (a test in which people must name objects in a category during a set period of time) and a drawing test, where differences between racial groups were observed even after adjusting for reading level.

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Driving and Dimentia

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When should a person with dementia due to Alzheimer's disease stop driving? Is a diagnosis of AD an automatic signal that a driver's license should be surrendered?

While there are no "right" answers to these questions, recent studies suggest that a diagnosis of mild or early-stage AD is not necessarily the moment that a driver's license should be forfeited. People with mild dementia sometimes can continue driving safely, but their caregivers should monitor driving closely, because the progressive nature of dementia will eventually affect driving ability. In addition to the normal process of aging and its effects on driving, dementia slowly erodes cognitive functions critical to driving, including attention, judgment, reaction time, spatial skills, and problem-solving abilities.

Once a diagnosis of dementia has been made, regular assessments of driving capability should be conducted by trained staff at the State motor vehicle department. Even if the person with dementia demonstrates safe driving, driving should gradually be limited to avoid more challenging situations, such as heavy traffic, unfamiliar roads, night driving, or long distance highway driving.

Warning Signs

Many of the general symptoms of Alzheimer's disease affect driving ability, including:

- loss of memory, particularly for recent events
- loss of alertness and diminished attention span
- loss of coordination
- difficulty judging distance and space
- becoming lost or disoriented in familiar places
- inability to perform routine tasks and difficulty doing multiple tasks
- mood swings, confusion, irritability
- difficulty processing information
- difficulty with decision-making and problem solving

Symptoms of dementia can lead to the following dangerous driving situations, which could cause a serious accident, fender bender, or near miss:

- driving too slowly
- stopping for no reason
- failing to observe traffic signs or signals
- becoming lost in familiar territory
- lacking good judgment or not anticipating dangerous situations
- having trouble navigating turns (particularly unprotected left turns), lane changes, or highway exits
- drifting into other lanes or driving on the wrong side of the street
- signaling improperly or not signaling at all
- difficulty seeing pedestrians, objects, or other vehicles
- falling asleep while driving or becoming drowsy
- parking incorrectly

Guidance for Caregivers

Doctors are perceived as authority figures whose opinions may be taken more seriously than those of a caregiver or family member by the person with dementia. According to the American Academy of Neurology, patients and their families should be informed that patients with AD with a Clinical Dementia Rating (CDR) of 1 or more have a higher crash rate, and therefore should not drive. A CDR of 0.5 can cause driving safety problems when compared to other older drivers, thus a referral to a trained examiner for evaluation of driver skills should be considered. Reevaluation every 6 months is recommended. A CDR stage 1 is roughly equivalent to a Mini-Mental State Examination (MMSE) score of less than 25 but greater than 19; a CDR of 0.5 is roughly equivalent to an MMSE score of 25 or greater.

During the appointment, a physician should evaluate the patient's physical condition, cognitive skills, and medication use, and should take a thorough driving history, including:

- how often the patient drives, where, when, and why
- familiarity with, and types of roads used
- types of traffic conditions
- caregivers' observations of driving skills
- accidents, near misses, traffic tickets

If patients are clearly a risk to themselves or others, the physician should take action to "prescribe" that driving cease, using the prescription pad. The discussion should be open and sensitive to the issues involved, particularly the perceived threat to independence. The discussion should be noted in the patient's medical record. The physician should be prepared to offer advice on available alternative forms of transportation and counsel the patient on ways to cope without a car, according to the American Academy of Family Physicians. It's also a good idea for the doctor to follow-up with the caregiver to see if his or her advice is being followed.

Although physicians may find themselves in an ethical dilemma about whether to maintain patient confidentiality, or report driver impairment to legal authorities, their overall goal should be to prevent injury. In some States, physicians are even required to report patients who are no longer capable of driving. If a patient refuses to stop driving despite advice from the physician, the physician can consider a referral for further testing or additional opinions. An on-road test administered by trained personnel is considered the best overall method to evaluate driving abilities.

Studies Underway

The National Institute on Aging and the National Highway Traffic Safety Administration (NHTSA) are teaming up to fund studies of how Alzheimer's disease affects the ability to drive. One such effort at the Washington University at St. Louis Alzheimer's Disease Center (ADC) will gather opinions on driving with dementia from people with early, mild-stage AD, caregivers, members of advocacy organizations, health care professionals, and insurance experts. This information will help guide the NHTSA in an education campaign. Strategies on how and when to stop driving will also be developed. The Rush-Presbyterian-St. Lukes Medical Center ADC in Chicago is also funded by this NHSTA and NIA grant.

Washington University ADRC Co-Director Dr. John Morris, recently stated, "Some persons with dementia, especially those in the very mild stages, often continue to drive safely, at least for the time being. Some prevailing attitudes are at odds with this viewpoint, however, and support that driving cessation occur at the time dementia is diagnosed, regardless of the driving ability of the individual. The challenge is knowing when and how to initiate a driving cessation process when driving is no longer safe. Our study will begin to address some of these issues by talking to the people most involved."

For More Information:

Carr, David B. (2000). The Older Adult Driver. *American Family Physician*, 61(1), 141-150. Internet: www.aafp.org/afp/20000101/141.html.

Dubinsky, Richard M.; Stein, Anthony C.; Lyons, Kelly. (2000). Practice Parameter: Risk of Driving and Alzheimer's Disease: An Evidence-Based Review. *Neurology*, 54, 2205-2211.

Foley, Daniel J.; Helmovitz, Harley K.; Guralnik, Jack M.; Brock, Dwight B. (2002). Driving Life Expectancy of Persons Aged 70 Years and Older in the United States. *American Journal of Public Health*, 92(8). 1284–1289.

Kakaiya, Ram; Tisovex, Richard; Fulkerson, Phillip. (2000). Evaluation of Fitness to Drive. The Physician's Role in Assessing Elderly or Demented Patients. *Postgraduate Medicine*, 107(3), 229–236.

Tips for Caregivers

(Continued from page 1)

driving, realizing that they are having problems. But others may not recognize patterns of dangerous driving, or are unable to assess their own skills. They tend to overestimate their driving abilities, and often deny having trouble. Denial can often be attributed to fear of loss of independence, freedom, and control: life without a car is unacceptable.

When trying to determine if driving has become dangerous, a caregiver can ask this question of himself or herself: would I permit my grandchild or any child to ride with this driver? Other family members should be consulted for additional opinions. However, adult children should be alert to the possibility that a caregiver may try to protect their loved one by withholding information about driving problems.

Involve the Driver in Planning

Taking away the car keys is one of the most difficult decisions facing caregivers of people with Alzheimer's. Planning and honest communication are key. Involve the driver and other family members in discussions. To prepare for this discussion, imagine what it would be like if you had to stop driving. An open discussion with all family members presents an opportunity for all to voice opinions and concerns. Caregivers must also be careful to guard against two extremes: over-reacting to a minor incident and ignoring alarming trends.

Build a Record

Before confronting a person with dementia with accusations of dangerous driving, it's helpful for caregivers to document incidents, to present a record of observations of driving behavior. The record should note time, date, place, and a brief description of the occurrence. Of course, a serious crash, traffic tickets for moving violations, scrapes and dents, and other physical evidence of accidents are indicators that driving needs to cease immediately.

A plan to gradually limit driving is preferable to a sudden halt. As part of the plan, caregivers can use a document such as one developed by The Hartford Insurance Company, called "The Agreement with My Family about Driving." This document involves the person with mild dementia while that person is still capable of sound reasoning and designates a person to be responsible for taking steps to curtail or stop driving when safety becomes an issue. Adopting a plan allows caregivers to have a course of action mapped out before a crisis occurs. Of course, not everyone with dementia will either agree to this plan or adhere

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to it. The Hartford also provides a "Warning Signs for Drivers with Dementia" worksheet to help document driving incidents.

Help from Professionals

When caregivers encounter opposition to pleas to stop driving, they can turn to professionals for help. Physicians, attorneys, care managers, financial planners, support groups, and the department of motor vehicles offer objective, third-party opportunities for guidance. A call to the State motor vehicle department to arrange for a driver's test is usually confidential. Attorneys and other planners can help by offering an objective assessment of driving skill, allowing the caregiver to defer to an expert's opinion.

Finding Alternatives

The perceived loss of freedom from loss of a license can cause depressed mood and social withdrawal. To divert attention away from the loss of driving privileges, caregivers should focus instead on other activities the person may still be able to enjoy. If the car is used to maintain social contact, then a plan to stop driving must address how to continue those contacts. Trips to see friends or to visit the library, barbershop, hairdresser, or grocery store can continue by seeking alternate forms of transportation, so that the person with AD doesn't feel abandoned, isolated, or restricted. These include:

- taxis, but only when there are no problem behaviors, and the driver has clear directions, and a friend or relative meets the person with AD at both the start and end of the trip
- public transportation in urban areas or where available, but again, only when there are no problem behaviors, and someone can meet the person with AD at the end of the trip, and
- relying on friends and relatives to run errands or help transport to social or religious events.

Another alternative is for caregivers to arrange to have prescription medications, groceries, and meals delivered, and to have hairdressers make home visits. Senior and special needs transportation services can be found in the local phone book, or by contacting the local Agency on Aging. Religious and community groups also may be good sources of help.

Most experts agree that "copiloting," in which the caregiver rides with the person with dementia, is not a safe option. The passenger cannot foresee dangerous situations in time to give instructions, and the demented driver cannot always follow directions.

Other Solutions

The best course of action for caregivers is to use common sense, communicate openly and frequently, and seek help from professionals. Poor driving by a person with dementia is unlikely to improve. When all else fails, and the person with dementia insists on driving even if he or she poses a hazard, caregivers can:

- hide the car keys
- replace the keys with a set that won't start the car, or file down the ignition key
- disable the car or sell it
- move the car out of sight
- have police confiscate the person's driver's license

In the future, with further research, it may be possible to find technological solutions that could allow drivers with dementia to reduce their risk of crashes. Research may yet yield more reliable predictors of crash risk for drivers with dementia and help create retraining programs to allow continued safe driving for some period of time.

For More Information:

Alzheimer's Association. (2001) *Fact Sheet: Driving*. Alzheimer's Association, 919 North Michigan Avenue, Suite 1100, Chicago, IL 60611-1676, 1-800-272-3900. Internet: www.alz.org/ResourceCenter/FactSheets/FSDriving.pdf.

Family Caregiver Alliance. (2001). *Fact Sheet: Driving and Dementia*. Family Caregiver Alliance, 690 Market Street, Suite 600, San Francisco, CA 94104, 415-434-3388. Internet: www.caregiver.org/factsheetsdementia_driving_nationalC.html.

Maryland Motor Vehicle Administration. (1999). *Is it Time to Stop Driving? A Sensitive Guide for Caregivers of People with Alzheimer's and Related Disorders*. Publication DC-169. Available from the Motor Vehicle Administration, 6601 Ritchie Highway, NE, Room 200, Glen Burnie, MD 21062, 1-800-638-8347 in Maryland, or 301-729-4550. Internet: www.mva.state.md.us.

National Institute on Aging. (2002). *AGE PAGE: Older Drivers*. Available from the National Institute on Aging, PO Box 8057, Gaithersburg, Maryland, 20898-8057, 1-800-222-2225. Internet: www.nia.nih.gov/health/agepages/drivers.htm.

The Hartford Financial Services Group, Inc. (2000). *Why Dementia and Driving Is a Difficult Issue: Alzheimer's, Dementia & Driving*. Available from The Hartford,
200 Executive Boulevard
Southington, CT 06489
860-547-500
(specify English or Spanish).
Internet: www.thehartford.com/alzheimers/.

Reading Gap

(Continued from page 3)

More information is needed to explain the persistent differences on those two measures, the researchers said.

Manly recommended further research to sort out methodological and analytical approaches, such as accounting for quality of education, from real racial or ethnic disparities in cognitive test performance. Such problems in methodology and analysis make it difficult to establish whether one group or another truly may have greater rates of cognitive decline and dementia in minority groups. "We need to develop measures designed to assess cognitive abilities in a way that is compatible with African American and other cultures," she notes. "With these, we will have greater confidence in any measures which show—or do not show—differences in cognitive health and dementia among various groups. Dr. Manly pursues such research as a neuropsychologist at the NIA-supported Alzheimer's Disease Center at Columbia University. Part of Dr. Manly's focus at the Center concentrates on research to improve the accuracy in diagnosing cognitive impairment and decline over time.

Researchers at Columbia are now adding tests of reading levels to their assessments of cognitive ability and are looking to see how accounting for quality of education might affect previous findings on levels of cognitive performance and rates of dementia among different groups in the community. In addition, Manly and her colleagues are carrying out further research on the effect of quality of education and literacy among Spanish-speaking Caribbean Hispanics through a pilot grant from the Columbia Center for the Active Life of Minority Elders (CALME), a Resource Center for Minority Aging Research (RCMAR) funded by the NIA and the National Institute of Nursing Research.

Online Training in Dementia Rating Scale Available

The Clinical Dementia Rating (CDR), developed by faculty of Washington University in St. Louis, is an instrument that guides a clinician in rating dementia-related deficits in cognitive and functional skills. The CDR is used widely in research settings and is a helpful tool for tracking dementia progression from very mild through severe stages. Training is needed to utilize the CDR interview and scoring table correctly. The Alzheimer's Disease Research Center (ADRC) at Washington University offers free CDR training online to assist health professionals in the U.S. and abroad.

Dr. John Morris, Co-Director, Washington University Alzheimer's Disease Research Center, is shown here in one of the online training videos for the Brief Training & Reliability Module of the Clinical Dementia Rating Scale.

Interested individuals should visit the Washington University ADRC's home page at www.adrc.wustl.edu, click on Education, then choose Clinical Dementia Rating from the pull-down menu. The on-line training system is based on Washington University ADRC's Brief Training & Reliability Module (BTRP) for the CDR. The BTRP provides a basic level of training and reliability certification for clinicians and other professionals who have prior experience in geriatric and dementia care.

Prospective trainees must apply and be approved for access. Passwords are required to view each separate training module in the BTRP training program. Passwords are usually sent within 72 hours. Trainees can start, stop, and pause any video that is currently playing on the computer by using the VCR-like controls that have been integrated with each video. Scores are submitted electronically.

A helpful guide in the clinical care of AD patients, the CDR is a clinical staging instrument used to characterize cognitive and functional performance in patients at risk for or suspected of having Alzheimer's disease or another dementing disorder. Common applications include patient evaluation in memory assessment clinics, research studies of normal elderly and those with dementia, and clinical trials of therapeutic agents that may influence progression of dementia.

The CDR characterizes six domains of cognitive and functional performance: Memory, Orientation, Judgment & Problem Solving, Community Affairs, Home & Hobbies, and Personal Care. The necessary information to make each rating is obtained through a semi-structured interview of the patient and a reliable informant (e.g., a family member). The CDR Table provides descriptive anchors that guide the clinician in making appropriate ratings based on interview data and clinical judgment. In addition to ratings on a 5-point scale for each domain (except Personal Care, which is rated on a 4-point scale) an overall CDR score is derived by standard algorithm. This score is useful for globally staging the level of impairment: 0 = No impairment, 0.5, 1, 2, and 3 indicate Very Mild, Mild, Moderate and Severe Dementia.

New Publications Available from ADEAR

The ADEAR Center has developed several new publications, and updated others. Many are available to preview on the ADEAR Web site at www.alzheimers.org, and some can be ordered in bulk. Please see the back page of *Connections* to mail or fax your order. New publications in the ADEAR inventory include:

Alzheimer's Disease Medications Fact Sheet

The four currently approved medications to treat mild to moderate Alzheimer's disease are described in this helpful pamphlet. These medications are called "cholinesterase inhibitors," and a chart listing the four medications—Reminyl (galantamine), Exelon (rivastigmine), Aricept (donepezil), and Cognex (tacrine)—provides information on the manufacturer's recommended dosage, common side effects, and possible drug interactions. None of these medications stops the disease itself, but they can help delay or prevent symptoms from becoming worse for a limited time and may help control some behavioral problems. The *Alzheimer's Disease Medications Fact Sheet* is available to preview on the ADEAR Center Web site at www.alzheimers.org/pubs/medications.htm.

Alzheimer's Disease Medications

Multi-Infarct Dementia Fact Sheet

Multi-infarct dementia is the most common form of vascular dementia, and accounts for 10–20 percent of all cases of progressive dementia, second only to AD. This revised publication describes how multi-infarct dementia is caused by a series of strokes, what happens when a stroke occurs, and some of the main causes of strokes. Risk factors for strokes, and symptoms and diagnosis for multi-infarct dementia, are described. Information on treatment to prevent further strokes is presented, along with how to help someone with this disease. An extensive list of resources for additional information is provided. The *Multi-Infarct Dementia Fact Sheet* is available to preview on the ADEAR Center Web site at www.alzheimers.org/pubs/mid.htm.

Multi-Infarct Dementia

Fact Sheet

Spanish Alzheimer's Disease Fact Sheet

Now available in Spanish, *La Enfermedad de Alzheimer Folleto Informativo (Alzheimer's Disease Fact Sheet)* describes the latest developments in AD research, lists currently approved medications, and discusses possible causes of AD. This new translation also describes symptoms and diagnostic advances, and provides resources for additional assistance. Also noted are bilingual print and telephone resources. *La Enfermedad de Alzheimer Folleto Informativo* is available to preview on the ADEAR Center Web site at www.alzheimers.org/pubs/adfact-spanish.html.

La Enfermedad de Alzheimer

Folleto Informativo

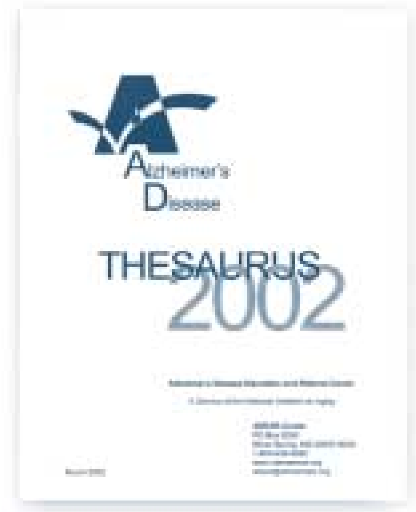
See the back page for ordering information.

Spanish Caregiver Guide

Another recent ADEAR publication—the *Caregiver Guide*—is now available in Spanish. *Guía Para Quienes Cuidan Personas con la Enfermedad de Alzheimer* is a handy, concise booklet offering specific tips for day-to-day caregiving for people with AD. It discusses common issues, including diagnosis, communication, bathing, dressing, eating, activities, incontinence, sleeping, wandering, driving, and visiting the doctor. More than 60,000 *Caregiver Guides* in English have been distributed by ADEAR since November 2001, and this new translation promises to be a useful addition to the Spanish-language materials available at ADEAR. *Guía Para Quienes Cuidan Personas con la Enfermedad de Alzheimer* is available to preview on the ADEAR Center Web site at www.alzheimers.org/pubs/careguide-spanish.html.

Alzheimer's Disease Thesaurus 2002

Librarians and researchers can make online Alzheimer's disease database searches faster and easier with this newly updated reference tool. The *Alzheimer's Disease Thesaurus* 2002 contains more than 2,000 index terms that librarians and other information seekers can use to search the online *Combined Health Information Database* (www.chid.nih.gov) for books, journal articles, videos, and many other materials on Alzheimer's disease. This 119-page reference lists descriptors alphabetically, by subject, and by keywords. Entries include related terms, cross-references, and scope notes. Cost is $15 per copy, and it is available to preview online at www.alzheimers.org/chid.html.



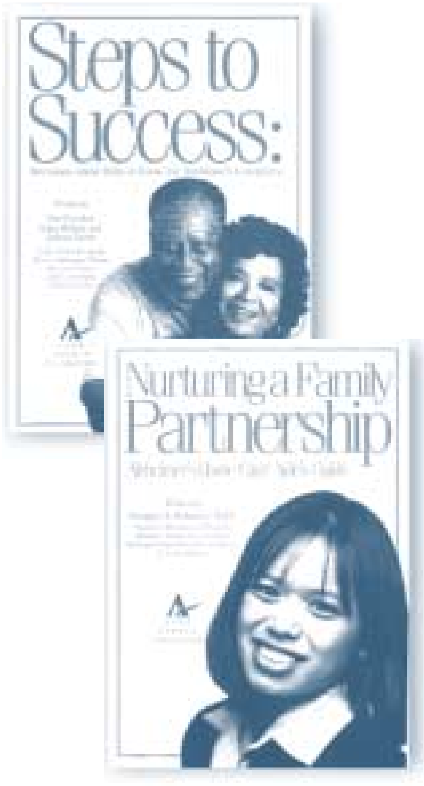
Connections Reprint: FTD

A recent edition of *Connections* featured articles on frontotemporal dementia (FTD) and tauopathies, and is now available as a *Connections Reprint*. FTD is a relatively rare group of neurodegenerative diseases that include Pick's disease, supranuclear palsy, and corticobasal degeneration. Researchers continue to study the symptoms, etiology, and potential treatments for these diseases. The article on tauopathies discusses the formation of abnormal tau proteins that cause the tangles found in many of these diseases. The full text version of the *Connections* newsletter is available to preview on the ADEAR Center Web site at www.alzheimers.org/pubs/conv09n4.html.

Steps to Success and Nurturing a Family Partnership

Two new publications from the AARP Andrus Foundation can guide families and home care aides in caring for a person with AD at home. *Steps to Success: Decisions about Help at Home for Alzheimer's Caregivers*, written by Lisa Gwyther, Edna Ballard, and Juliessa Pavon, of the Bryan Alzheimer's Disease Research Center at Duke University, helps family caregivers decide whether outside help is right for them, what type of help they may need, how much it will cost, and what to expect.

Nurturing a Family Partnership Alzheimer's Home Care Aide's Guide, written by Margaret Perkinson, of the Alzheimer's Disease Research Center at Washington University at St. Louis, gives tips to home care professionals on understanding the family, developing a system of communication, and dealing with conflicts or job stress. For a single, free copy of either publication, call the ADEAR Center at 1-800-438-4380, contact the Andrus Foundation at 1-800-775-6776, or visit the Web site at www.andrus.org.



New Trials Underway, Others Expand Recruitment

Two new clinical trials to examine Alzheimer's disease treatment and prevention are now underway, while other major trials continue to add new recruitment sites. For more information on these and other AD studies, visit ADEAR's clinical trials database at www.alzheimers.org/trials or call the ADEAR Center at 1-800-438-4380.

▼ *Cholesterol Lowering Agent to Slow Progression of Alzheimer's Disease (CLASP)*

CLASP is a 15-month, Phase III clinical study to investigate the safety and effectiveness of simvastatin (Zocor®), one of the class of drugs known as statins, to slow the development of AD. Statins, the most commonly used class of lipid lowering agents, have proven very effective in reducing the risk of heart disease and stroke. There is compelling evidence from laboratory research in animal model and cell culture systems, observational epidemiological studies, and small clinical trials, to test on a larger scale the theory that lowering cholesterol may also reduce the pathology of AD.

Beginning in September, this randomized, double-blind, placebo-controlled trial will be conducted at approximately 40 sites nationwide, enrolling a total of 400 subjects. Study participants will be age 50 or older, with mild to moderate AD, who are free of life-threatening disease, and do not require lipid lowering treatment according to current guidelines. The primary outcome, slowed progression of AD, will be measured by the cognitive portion of the Alzheimer's Disease Assessment Scale. Secondary outcomes will include measures of clinical global change, mental status, functional ability, behavioral disturbances, and quality of life.

CLASP, funded by the NIA through the Alzheimer's Disease Cooperative Study, is based at the University of California San Diego. Principal Investigator for the study is Mary Sano, Ph.D., of Columbia University's Alzheimer's Disease Center.

▼ *Treatment of Agitation/Psychosis in Dementia and Parkinsonism (TAP/DAP)*

Behavioral problems, including agitation and psychosis, are common among patients with dementia, and are a major source of stress for patients and caregivers alike. However, many of the most commonly used drugs to treat agitation/ psychosis can worsen parkinsonism, and have been linked to severe extrapyramidal reactions (abnormal involuntary movements, alterations in muscle tone, and postural disturbances) in some types of dementia.

TAP/DAP is a 10-week phase IV clinical trial to test the efficacy, safety, tolerability, and influence on parkinsonism of quetiapine and donepezil, when used separately and in combination, to treat agitation and psychosis among patients with dementia and coexistent parkinsonism. Quetiapine (Seroquel®) is an atypical antipsychotic shown to have lower risk of extrapyramidal motor effects. Donepezil (Aricept®) is an acetylcholinesterase inhibitor. Recent evidence suggests that these drugs may ameliorate behavioral problems associated with dementia coexisting with parkinsonism.

Researchers at 20 centers around the country are conducting the double-blind, placebo-controlled study, based at the University of Rochester and coordinated by the Alzheimer's Disease Cooperative Study. Subjects must be age 50 or older and have all of the following conditions to participate:

- primary dementia (probable Alzheimer's disease or dementia with Lewy bodies),
- psychosis or agitation, and
- parkinsonism or extrapyramidal motor features (2 or more of the following: resting tremor, bradykinesia, limb rigidity, shuffling, short-stepped gait).

Participants must have a caregiver/ study partner who provides informed consent to participate and is willing and able to accompany the subject to all clinic visits to report on the activities of the subject and his/her behavior. The caregiver/ study partner must see the subject at least 4 days each week for at least one hour each visit.

▼ *PREADVISE update*

The Prevention of Alzheimer's Disease with Vitamin E and Selenium (PREADVISE) trial is an important addition to the Selenium and Vitamin E Cancer Prevention Trial (SELECT). Previous studies have suggested that vitamin E and selenium may increase antioxidant defenses in the brain; this study evaluates their potential to protect against AD. Men over the age of 62, or 60 if African-American or Hispanic, enrolled or enrolling in SELECT, are eligible. The PREADVISE portion of the trial involves annual checkups that take less than 15 minutes.

New findings on vitamin E have also heightened interest in this study. Approximately 100 of the SELECT study sites are likely to participate in PREADVISE. Several sites are now recruiting, and more are expected to be approved this summer. Researchers at the University of Kentucky Alzheimer's Disease Center are leading this study, sponsored by the NIA. For more information, see the PREADVISE Web site at www.mc.uky.edu/preadvise.

▼ Healthy Aging & Memory Study update

The Healthy Aging & Memory Study (HAMS) is a simulated prevention trial to test the effectiveness of a number of AD measurement tools when completed at home, over the phone, or on the Internet. This 4-year study will enroll 650 healthy, non-demented participants age 75 or older, and is now underway in 39 sites, coordinated by the Alzheimer's Disease Cooperative Study (ADCS) at San Diego. HAMS will evaluate how reliable, efficient, accurate, and sensitive several new instruments are in detecting changes in normal aging that lead to early AD.

▼ Clinical Antipsychotic Trials of Intervention Effectiveness (CATIE) update

The CATIE study began in 1999 and is a 5-year effort to examine drug treatments for schizophrenia, and to find out the best treatment for people with AD who have hallucinations, delusions, aggression, or agitation. The trial is sponsored by the National Institute of Mental Health. Two new sites—in Connecticut and New Jersey—were recently added to those recruiting for the AD portion of this study, bringing the total to 30 across the U.S. Recruiters are hoping to enroll 450 in the AD trial, and 1,600 in the schizophrenia portion of the trial.

The AD study uses three medications known as atypical antipsychotics—olanzapine (Zyprexa®), quetiapine (Seroquel®), and risperidone (Risperdal®)—which are the newest medications that are currently available for treating these problems. Participants may also receive an antidepressant, citalopram (Celexa®). At the beginning of the study, some participants may receive placebo before they receive one of the study medications, but they will not remain on placebo if they do not improve. The trial lasts for 36 weeks.

Participants are given a thorough evaluation at no cost to ensure that this study is appropriate. In addition, participants and the caregiver, family member, or friend who comes with them will be offered basic counseling and education about AD. For more information and a list of study locations visit www.catie.unc.edu.

Studies in Preparation

The following ADCS studies are in the planning stages:

- Huperzine—Huperzine, an alkaloid derived from a traditional Chinese herbal remedy for fever, exhibits anticholinesterase activity and will be investigated as a potential AD medication. It is currently approved for AD treatment in China.
- Homocysteine—18-month clinical trial designed to test whether reducing homocysteine levels with high-dose vitamin supplements can slow the rate of cognitive decline in people with AD.
- Valproate—2-year trial to determine whether low-dose valproate, an anti-convulsant drug, can help delay the emergence of agitation and psychosis and delay clinical progression of AD.
- Indole-3-Propionic Acid (IPA)—preliminary study to examine the safety and tolerability of IPA, a highly potent, naturally occurring anti-oxidant that has been shown to interfere with the action of enzymes contributing to amyloid plaque formation.

Subscribe to E-Mail Alerts to get Timely Information

Two new e-mail alert services are now available through the ADEAR Center, to help subscribers stay abreast of developments in Alzheimer's disease research. Subscribers can now receive e-mail notification when new issues of the *Connections* newsletter are posted to the ADEAR Web site and when new publications are introduced. E-mail alerts are available now for the following services:

- NIA Press Releases
- Alzheimer's Disease Clinical Trial Updates
- *Connections* Newsletter
- New Publications

More than 7,300 subscribers have signed up for one or more of our e-mail alerts. To subscribe, go to www.alzheimers.org/maillist.html, simply type in your e-mail address and choose the alerts you want to receive.

What do we do at ADEAR?

Staff will:

- ✓ answer questions about Alzheimer's disease
- ✓ provide information about the latest research findings on Alzheimer's disease
- ✓ tell you about drug testing and studies of new treatments
- ✓ suggest additional groups to contact for more information and services
- ✓ send you publications about Alzheimer's disease and related disorders

To contact an information specialist, call the Center's toll-free number: 1-800-438-4380, M–F, 8:30–5 (EST); fax: 301-495-3334; Internet: www.alzheimers.org, e-mail: adear@alzheimers.org, mail: ADEAR Center, PO Box 8250, Silver Spring, MD 20907-8250

CHID Highlights

CHID Highlights describes materials recently added to the Alzheimer's disease file of the Combined Health Information Database (CHID). The items selected represent topics and formats of general interest to readers of *Connections* and ADEAR Center users or their clients. Please order directly from the source listed for each item. Journal articles are available in many university and medical school libraries. CHID is accessible on the Internet at www.chid.nih.gov, by following the link at www.alzheimers.org, or by following the National Library of Medicine's link to CHID at www.nlm.nih.gov/medlineplus/databases.html.

Diagnosis and Disease Management

Diagnosis and Management of Alzheimer's Disease and Other Dementias

Green, R.C. Professional Communications, Inc. 2001. 224 p.

Available from Professional Communications Inc., Fulfillment Center, PO Box 10, Caddo, OK 74729-0010. 1-800-337-9838; Fax: 580-367-9989. Internet: www.pcibooks.com. PRICE: $21.95.

This book provides primary care physicians with current educational information on the diagnosis and management of Alzheimer's disease and other dementias. Part 1 includes "Definitions of Dementia"; "Epidemiology of Dementia"; "Evaluation of the Older Patient with Cognitive Problems"; and "Dementing Disorders Not Due to Alzheimer's Disease." Part 2 includes "Risk Factors, Genetics, Biomarkers, and Diagnostic Accuracy"; "Natural History"; "Neuropathology"; and "Current and Emerging Therapies." Part 3 discusses "Management of Agitation and Behavioral Symptoms" and "Family Education and Support." Part 4 includes "Resources for Clinicians and Families" and "References."

Alzheimer's Disease—General Information

The Forgetting. Alzheimer's: Portrait of an Epidemic

Shenk, David. Random House, Inc. 2001. 292 p.

Available from local book stores or Random House, Inc. 1540 Broadway, New York, NY 10036; Internet: www.randomhouse.com. PRICE: $13.95.

An eloquent and moving description of Alzheimer's disease, *The Forgetting* is an exploration of, and meditation on, the nature of memory and perceptions of self. It is a readable, accessible, and understandable description of the history of AD, research efforts, and the human impact of the disease. Shenk writes convincingly that Alzheimer's struck such historical figures as Ralph Waldo Emerson, Jonathan Swift, and Frederick Law Olmstead. Sensitive portraits of today's patients, their families, and their caregivers serve to illustrate the pattern of regression found in AD. Shenk captures the sense of loss patients and their families feel, calling AD a "death by a thousand subtractions." The author describes the science of AD in terms that are easy for those who know nothing about AD to grasp. Shenk explains the complexities of AD research, and having become a passionate advocate, sees new excitement among scientists that progress is being made toward finding a cure.

Managing Nutrition—for Caregivers

Managing Nutrition in Dementia Care: A Supportive Approach for Caregivers

Weiss, E.H., et. al. Alzheimer's Association—Western New York Chapter. 2001. 30 p.

Available from the Alzheimer's Association—Western New York Chapter, 1284 French Road, Depew, NY 14043. 716-656-8448 or 1-800-273-6737. Internet: www.alzwny.org. PRICE: $5.00 plus shipping.

This booklet offers practical ideas to improve eating and nutrition for people with dementia. It includes nutrition goals for people with dementia, dietary guidelines and a food guide pyramid for older people, a nutritional risk checklist, and food safety guidelines. It gives suggestions for storing food safely, getting enough fiber, measuring dietary fiber, getting enough fluids, spotting the signs of possible dehydration, avoiding drug and food interactions, determining a reasonable weight, increasing calories to prevent weight loss, using finger foods, changing food textures to reduce chewing and swallowing problems, positioning for better eating and drinking, and reducing undesirable mealtime behaviors.

Guide for Clergy

Alzheimer's Disease: A Guide for Clergy

Alzheimer's Association. 2000. 13 p.

Available from the Alzheimer's Association, 919 North Michigan Avenue, Suite 1100, Chicago, IL 60611-1676. 1-800-272-3900 or 1-800-223-4405. Fax: 770-442-9742. TDD: 312-335-8882. Internet: www.alz.org. PRICE: $15 for 50 copies.

Members of the clergy will find information about how to recognize, communicate with, and respond to someone with AD. This booklet also offers suggestions for the spiritual care and comfort for people with AD and their caregivers. The booklet starts with an overview of AD, including its costs, diagnosis, treatment, and signs. It explains what to do if you recognize the signs of AD in a member of the congregation, and describes some of the cognitive and behavioral changes that occur in AD. Then, it suggests strategies for approaching and communicating with a person with AD, and for meeting the spiritual needs of the person with AD and family members. Finally, it describes the Safe Return Program and other resources available from the Alzheimer's Association.

Facility Staff Training

Caring for People with Alzheimer's Disease: A Manual for Facility Staff

Gwyther, L.P. American Health Care Association. 2001. 116 p.

Available from the American Health Care Association Bookstore, 1560 Tilco Drive, Frederick, MD 21704. 1-800-663-7387. Fax: 301-695-7597. Internet: www.ahcabookstore.org. PRICE: $16.95.

In this book, professional caregivers will learn how to provide positive, person-centered care for people with AD and related disorders. Chapters include reviews of the cognitive, functional, mood, and behavioral changes that occur in AD; practical suggestions for coping with challenging behaviors; and strategies for communicating, adapting activities of daily living, activity planning, and modifying the environment to defuse difficult caregiving moments. Case vignettes illustrate the use of these strategies. Suggestions on ways to help families adjust to long-term care placement, ideas for creating warm and supportive care environments, and tips to help caregivers cope when they are having a bad day, are included.

Best Friends Staff: Building a Culture of Care in Alzheimer's Programs

Bell, V.; Troxel, D. Health Professions Press. 2001. 272 p.

Available from Health Professions Press, PO Box 10624, Baltimore, MD 21285-0624. 1-888-337-8808, or 410-337-8539; FAX: 410-337-8539. Internet: www.healthpropress.com. PRICE: $34.00.

This book is a guide to training long-term care staff in the Best Friends approach to dementia care. Ten chapters address the following subjects: (1) key concepts of the Best Friends model, (2) staff recruitment and development, (3) training staff members in the medical and scientific basics of dementia, (4) teaching staff to empathize with the person with dementia, (5) using a strength-based assessment for people with dementia, (6) exploring the concept of friendship, (7) using life stories to enhance care, (8) teaching staff effective methods of verbal and nonverbal communication, (9) strategies to enrich and expand activity programming, and (10) responding to families' issues. Chapters 2 through 10 include Training Tool Kits to help staff learn concepts presented in the chapter. The tool kits include warm-ups, handouts and other training materials, group activities, and exercises. Appendices provide annotated lists of the programs and professionals featured in the book, and a list of suggested resources for trainers.

Video Guide

Alzheimer Videos: An Annotated Guide

Alzheimer's Disease and Related Disorders Association, Inc. 2000. 116p.

Available from the Alzheimer's Association, Inc., PO Box 930408, Atlanta, GA 31193-0408. 1-800-223-4405. PRICE: $20.00.

This annotated guide to videos on AD and related disorders includes information about 356 videos selected for their usefulness and applicability for a wide variety of audiences. Most videos were produced since 1993; the small number of earlier titles were included for their unique content. Each entry contains a summary of the content along with producer, distributor, and production information. The guide is arranged alphabetically by title and includes subject, audience, and running-length indexes as well as contact information for ordering videos.

Late Stage Care

Steps to Facing Late-Stage Care: Making End-of-Life Decisions

Alzheimer's Association. 2000. 15p.

Available from the Alzheimer's Association, 919 North Michigan Avenue, Suite 1100, Chicago, IL 60611-1676. 1-800-272-3900, TDD: 312-335-8882 or Fax: 312-335-1110. Price: free.

This brochure is designed to help families make end-of-life decisions about the care of a loved one with Alzheimer's disease. It discusses the use of advance directives to honor the individual's wishes, and explains the different levels of medical care (aggressive, conservative, and palliative/comfort) that are available for people in the end stages of AD. It explores the factors to consider in implementing artificial nutrition, using antibiotics to treat infections, and establishing a do-not-resuscitate (DNR) order. It also offers suggestions for resolving family conflicts, requesting a brain autopsy, coping with feelings, and making end-of-life decisions.

Calendar of Events

View the calendar online at http:
www.alzheimers.org/calendar.

September 19–21, 2002

First International Conference on Interdisciplinary Gerontology
Bad Ischl, Austria

Contact:
Verein M.A.S.
c/o Institut fur Interdisziplinare
Gerontologie
Wiesingerstrasse 4
4820 Bad Ischl, AUSTRIA
+43-6132-21 410 (phone/fax)
congress@mas.or.at

September 20, 2002

8th Annual Dementia Conference: The Changing Faces of Long-Term Care in Alabama
Tuscaloosa, AL

Contact:
University of Alabama
College of Continuing Studies
2nd Floor Martha Parham West
Box 870388
Tuscaloosa, AL 35487-0388
205-348-6225
Fax: 205-348-9276

September 25–28, 2002

Second International Conference on Metals and the Brain: From Neurochemistry to Neurodegeneration
Fez, Morocco

Contact:
Conference Services Office
King's Holidays
Rue Ahmed Chbihi, Immb 3
Appt 4, Ave des FAR
VN Fes MAROC
+00-212-55-93-04-99
Fax: 00-212-55-93-34-55
kingcongres2002@iam.net.ma

October 3–5, 2002

2nd International Symposium on Alzheimer's Disease in the Middle East
Antalya, Turkey

Contact:
World Events Forum
5030 N. Marine Drive
Suite 2608
Chicago, IL 60640
773-784-8134
Fax: 208-575-5453
www.worldeventsforum.com/alz.htm

October 9, 2002

Caring for the Elderly Conference
Ft. Lauderdale, FL

Contact:
Rabbi Joshua Kreindler
Jewish Federation of Broward
County
5890 South Pine Island Road
Davie, FL 33328
954-252-6900
Fax: 954-252-6893

October 9–13, 2002

American College of Nurse Practitioners National Clinical Symposium
Albuquerque, New Mexico

Contact:
American College of Nurse
Practitioners
National Clinical Symposium Office
2647 134th Ave NE
Bellevue, WA 98005-1813
425-861-0911
Fax: 425-861-0907
www.nurse.org/acnp

October 10–12, 2002

Assisted Living Federation of America Fall National Conference & Expo
Washington, DC

Contact:
Assisted Living Federation of
America
11200 Waples Mill Road, Suite 150
Fairfax, VA 22030
703-691-8100
Fax: 703-691-8106
www.alfa.org

October 12–14, 2002

Third International Conference on Family Care: Empowerment Through Innovation
Washington, DC

Contact:
Les Plooster
National Alliance for Caregiving
4720 Montgomery Lane, Suite 642
Bethesda, MD 20814
301-718-8444
Fax: 301-652-7711
www.caregiving.org/content/
conference2002.html

October 13–16, 2002

127th Annual Meeting of the American Neurological Association
New York, NY

Contact:
American Neurological Association
5841 Cedar Lake Road, Suite 204
Minneapolis, MN 55416
952-545-6284
Fax: 952-545-6073
www.aneuroa.org/annual.htm

October 16–20, 2002

American Academy of Family Physicians Scientific Assembly
San Diego, CA

Contact:
American Academy of Family
Physicians
11400 Tomahawk Creek Parkway
Leawood, KS 66211-2672
1-800-926-6890
Fax: 913-906-6082
www.aafp.org/assembly.xml

October 23–26, 2002

18th International Alzheimer's Disease International Conference: Dementia—Meeting the Challenge Together
Barcelona, Spain

Contact:
Suport Servicios S.A.
Calvet, 30, entr. 2
08021 Barcelona, SPAIN
+93-2017571
Fax: +93-2019789
www.alzheimer2002.com

October 28, 2

Ethics of Genetic Testing for Dementia: A Mini-Symposium
St. Louis, MO

Contact:
Carol Dyer
Alzheimer's Disease Research Center
Washington University Medical Center
4488 Forest Park Avenue, Suite 130
St. Louis, MO 63108
314-286-2688
Fax: 314-286-2763
www.adrc.wustl.edu/adrc

October 31–Nov. 1, 2002

The 3rd Neurobiology of Aging Conference: Molecular and Cellular Basis of Synaptic Loss and Dysfunction in Alzheimer's Disease
Orlando, FL

Contact:
April Williams
Neurobiology of Aging Conference Secretariat
Elsevier Science
The Boulevard
Langford Lane
Kidlington, Oxford OX5 1GB
United Kingdom
+44 0 1865 843089
Fax: +44 0 1865 843958
www.nba-interactivemeeting.com

November 2–7, 2002

32nd Annual Meeting of the Society for Neuroscience: In Pursuit of the Answers
Orlando, FL

Contact:
Society for Neuroscience
11 Dupont Circle, NW
Suite 500
Washington DC 20036
202-462-6688
Fax: 202-462-9740
info@sfn.org
www.sfn.org

November 9–13, 2002

Putting the Public Back Into Public Health: APHA 130th Annual Meeting & Exposition
Philadelphia, PA

Contact:
American Public Health Association
800 I Street NW
Washington DC 20001-3710
www.apha.org

November 13, 2002

Empowering the Patient
Springfield, MA

Contact:
Jeannie Banas
Alzheimer's Association
Massachusetts Chapter
PO Box 2873
Springfield, MA 01101-2873
413-787-1113
Jeannie.Banas@alz.org

November 22–26, 2002

55th Annual Scientific Meeting of the Gerontological Society of America: Relationships in a Changing World—From Aging Cells to Aging Societies
Boston, MA

Contact:
Gerontological Society of America
1030 15th Street NW, Suite 250
Washington, DC 20005
202-842-1275
Fax: 202-842-1150
www.geron.org/AnnualMeeting/annual.htm

March 13–16, 2003

NCOA-ASA Joint Conference: Making Our World a Good Place to Grow Old
Chicago, IL

Contact:
The National Council on the Aging-American Society on Aging Joint Conference
833 Market Street, Suite 511
San Francisco, CA 94103-1824
415-974-9600
Fax: 415/495-6509
www.agingconference.org/jc03/index.html

March 18–21, 2003

Alzheimer's Australia National Conference: Today's Challenges, Tomorrow's Choices
Melbourne, Australia

Contact:
Waldron Smith Management
61 Danks Street
Port Melbourne
Vic 3207 Australia
+61 3 9645 6311
Fax: +61 3 9645 6322
info@wsm.com.au

FREE PUBLICATIONS ORDER FORM

Alzheimer's Disease Education and Referral (ADEAR) Center

☐ *Alzheimer's Disease Medications Fact Sheet* (No. Z-171)
☐ *Multi-Infarct Dementia Fact Sheet* (No. Z-43)
☐ *Alzheimer's Disease Fact Sheet–SPANISH* (No. Z-12-A)
☐ *Caregiver Guide–SPANISH* (No. Z-169-A)
☐ *Alzheimer's Disease Thesaurus, 2002–SPANISH* (No. C-02)
☐ *Connections Reprint: Frontotemporal Dementia* (No. Z-174)

☐ Check here if you are a health professional or a professional caregiver and would like your name added to the ADEAR Center mailing list to receive future issues of *Connections*.

To order any of the above materials send this page to:

ADEAR Center, PO Box 8250, Silver Spring, MD 20907-8250

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Web site: http://www.alzheimers.org

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