

lives? **Objective(s):** This overview will address the most important methodological topics that need to be considered when a clinical trial with a candidate intervention is planned, the perspective given is centered on Alzheimer disease issues and it is mainly a European one but it does not represent a formal regulatory view. **Methods:** The following topics will be focused: (1) Paradigms to disentangle symptomatic versus disease modifying effects; (2) Prodromal disease; (3) surrogate end-points. The issue of disentangling symptomatic versus disease modifying effects will include a discussion on different trials design, clinical developments in cascade, and the appropriateness of endpoints. **Conclusions:** A summary view of how the clinical development of a candidate intervention may look like if started in 2005 will be provided.

TUESDAY, JUNE 21, 2005

SYMPOSIA

S3-01

CROSS-CULTURAL ISSUES FOR CARE

S3-01-01 10/66 PROGRAM

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Background: There is a need for more research into dementia in developing countries where up to 66% of those with dementia live, but only 10% of research is conducted. The 10/66 Dementia Research group was founded in 1998 as a network of researchers, mainly from developing countries, wishing to redress this imbalance, and to provide evidence of use to advocacy groups and policymakers. **Objectives:** To give an overview of the 10/66 Dementia Research Group's programme of pilot and population-based research in developing countries. **Methods:** ADI's 10/66 Dementia Research Group has now completed pilot studies of dementia diagnosis and care arrangements for people with dementia in 26 centres in 16 mainly developing countries in Latin America, the Caribbean, Africa, India, China and SE Asia. We have demonstrated the feasibility of diagnosing dementia in a simple one-stage research interview. We also showed that caregivers in developing countries experience considerable psychological, economic and practical strain. Although larger households were associated with lower carer strain, strain was as marked as in the developed world. Many carers had cutback on paid work to care. Those in the poorest countries were most likely to use expensive private medical services, and to spend more in relative terms on health. Lack of awareness was a major problem sometimes leading to stigma and blame attaching to the caregiver. **Conclusions:** ADI's 10/66 Dementia Research Group is now working on population-based studies in Cuba, Brazil, Dominican Republic, Venezuela, Peru, Argentina, Mexico, India and China. The aims, and designs of these studies shall be described, including preliminary descriptions of risk factor profiles between continents, and early data on the workings of the new DSMIV one phase computerised diagnostic algorithm. We will also outline the new 10/66 caregiver education and training intervention, which we implement and evaluate in the course of our field work. The descriptive studies will provide much needed data for policymakers, in prioritising service development. The intervention may suggest new and generalisable models of care for health care systems with limited specialist resources. Cross cultural issues

S3-01-02 SACRAMENTO AREA LATINO STUDY ON AGING (SALSA) STUDY

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Cultural and racial/ethnic influences on dementia risk and care are exceedingly complex but important. The aging population is increasingly diverse with respect to culture and this diversity is changing dementia risk and challenging care. Cultural change is a major, global force that affects both

the risk of dementia and the success of interventions. Most research evaluating racial/ethnic differences in dementia compares people of different ancestry and different cultures. Little is known about patterns of occurrence or different causes of dementia in communities that are not European or white North American. Such differences may be influenced by cultural specific behaviors and practices, by ancestral factors (ie: genes) and by differences in exposures to environmental risk factors. The effects of culture and ethnicity on dementia risk are likely to be related to discrimination, socioeconomic disadvantage and lack of access to care. Research comparing people with the same ancestry living in different cultures may more effectively disentangle the effects of these factors although comparison of developed to developing countries introduces substantial bias. Diagnostic practices are also influenced by culture and place making cross-cultural and cross-national comparisons of disease difficult. Development of clinical assessment tools that are completely 'culture-free' is not possible and is ineffective for improving detection of dementia in nonwhite cultural groups. The Sacramento Area Latino Study on Aging is a study of older Mexican Americans. Our findings suggest that cultural orientation affects the risk of prevalent (US oriented vs. Mexican OR= 0.36,0.21-0.61) and incident dementia (RH=0.50,0.34-0.95). This may be due to immigration status, higher adoption of deleterious health practices, and higher risk of type 2 diabetes, stroke and obesity. Diagnostic test bias is related to education and does not explain these differences since, in SALSA, immigrants and traditionally oriented individuals are less educated. ApoE4 is less frequent in Mexican Americans (6%) and contributes less to dementia risk than in European populations. Vascular risk factors such as type 2 diabetes, obesity and hypertension are more common among those with more traditional cultural orientation placing them at higher risk for dementia.

S3-01-03 ASIAN CROSS CULTURAL ISSUES IN DIAGNOSING DEMENTIA

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Background: While the prevalence rate of dementia reported in studies in western countries ranges from 2% to 7%, the rate reported by Asian researchers is much lower (0.3% to 5%). This discrepancy is probably related to methodological problems in diagnosing dementia rather than representing a genuine difference of dementia prevalence. **Objective:** The present presentation will review the current development of clinical diagnosis of dementia in various Asian countries. **Methods:** A review of the literature shows that cognitive assessment remains a primary method for diagnosing dementia in most Asian countries. However, the validity of cognitive assessments was affected by the lower level of education in the older population in many Asian countries. Given that level of education is a significant factor that affects an individual's performance on most screening tools that are developed in the West, common clinical assessments such as the Mini-Mental State Examination and the Dementia Rating Scale have been shown to be less sensitive in differentiating normal elderly from dementia patients in Asian countries where they generally have a lower level of education than their counterparts in western countries. Thus, adjusted cut-off scores, which were higher than those reported in the West, were recommended for use to increase the sensitivity in diagnosis (Chiu et al., 1994; Chan et al., 2003). In addition, informant ratings, which rely less on the level of education, has been widely applied as screening instruments in Asian countries. Inventories that have been studied empirically included the Cognitive Abilities Screening Instrument (Japan), Elderly Cognitive Assessment Questionnaire (Singapore), Informant Questionnaire on the Cognitive Decline of Elderly (Singapore), and the Alzheimer's Disease Behavioral Pathology Rating Scale (Hong Kong). Validity of these instruments will be discussed. **Conclusions:** Clinical interview and cognitive assessments remain to be the primary diagnostic tools for dementia, but more studies are needed to improve the sensitivity and validity of these methods. Although some advanced techniques such as fMRI which may be less affected by the level of education and culture have been reported to be