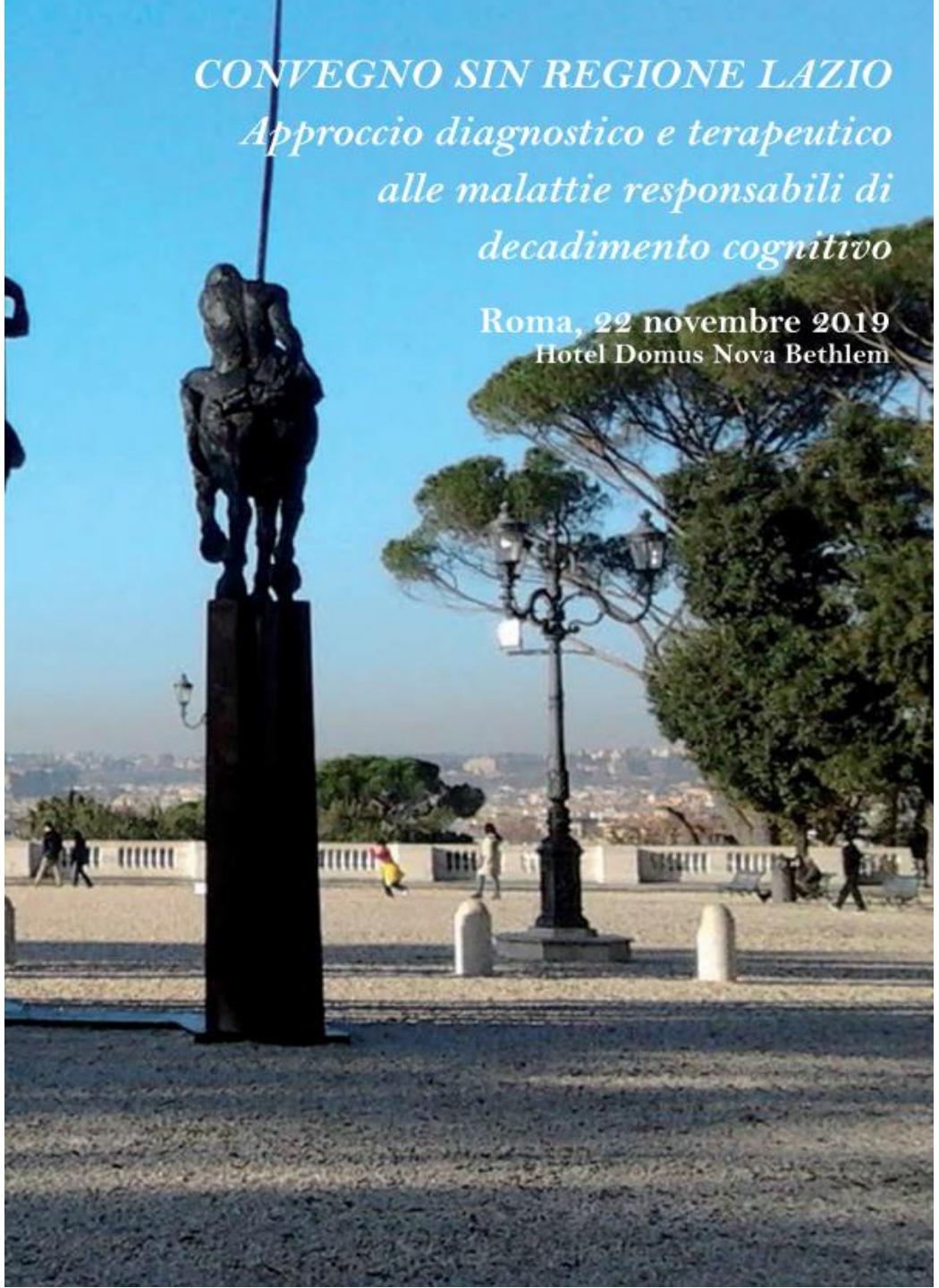


PREVENZIONE DEL DETERIORAMENTO COGNITIVO E STILI DI VITA

Nicola Vanacore

Centro Nazionale di Prevenzione e Promozione della Salute

ISTITUTO SUPERIORE DI SANITÀ

LA NEUROPATOLOGIA DELLE PERSONE ANZIANE SENZA DEMENZA

ANN NEUROL 2013;74:478–489

Much of Late Life Cognitive Decline Is Not due to Common Neurodegenerative Pathologies

Patricia A. Boyle, PhD,[1,2] Robert S. Wilson, PhD,[1,2,3] Lei Yu, PhD,[1,3]
Alasdair M. Barr, PhD,[4] William G. Honer, MD,[5]
Julie A. Schneider, MD,[1,3,6] and David A. Bennett, MD[1,3]

Results: Cognition declined a mean of about 0.11U per year (estimate = −0.109, standard error [SE] = 0.004, $p < 0.001$), with significant individual differences in rates of decline; the variance estimate for the individual slopes was 0.013 (SE = 0.112, $p < 0.001$). In separate analyses, global Alzheimer pathology, amyloid, tangles, macroscopic infarcts, and neocortical Lewy bodies were associated with faster rates of decline and explained 22%, 6%, 34%, 2%, and 8% of the variation in decline, respectively. When analyzed simultaneously, the pathologic indices accounted for a total of 41% of the variation in decline, and the majority remained unexplained. Furthermore, in random change

Participants

Participants came from two clinical-pathologic cohort studies of aging and dementia: the Religious Orders Study and the Memory and Aging Project[14,15]. The Religious Orders Study began in 1994 and involves older Catholic nuns, priests, and monks recruited from more than 40 groups across the United States. The Rush Memory and Aging Project began in 1997 and involves older lay persons recruited from retirement communities, subsidized housing facilities, and social service agencies in the Chicago metropolitan area. Persons in both studies agreed to annual clinical evaluations and brain autopsy at death. Written informed consent was obtained in each study after procedures were fully explained, and both studies were approved by the Institutional Review Board of Rush University Medical Center. The follow up participation rates for both studies exceed 95% of survivors and autopsy rates exceed 80%. At the time of these analyses, data were available from 856 deceased persons with at least 2 cognitive evaluations (mean number of annual evaluations=7.5, SD=3.8, range: 2-18 years); notably, more than 80% of the persons included in these analyses had 4 or more cognitive assessments, about 60% had 5 or more, and about 25% had more than 9 assessments.

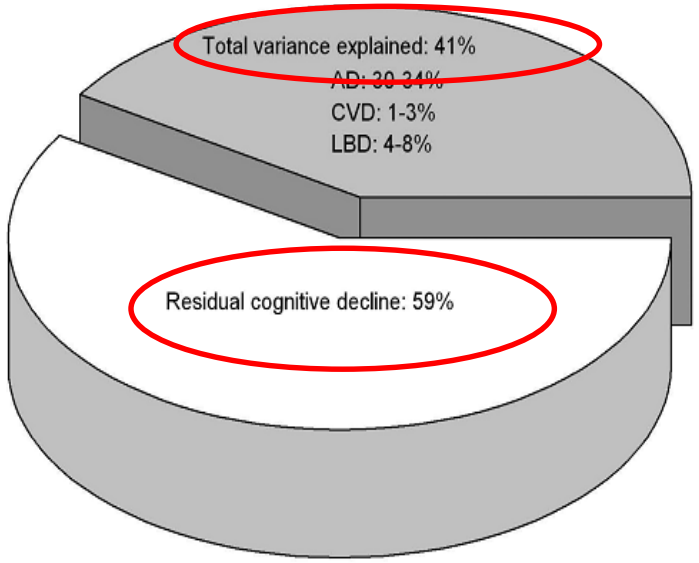
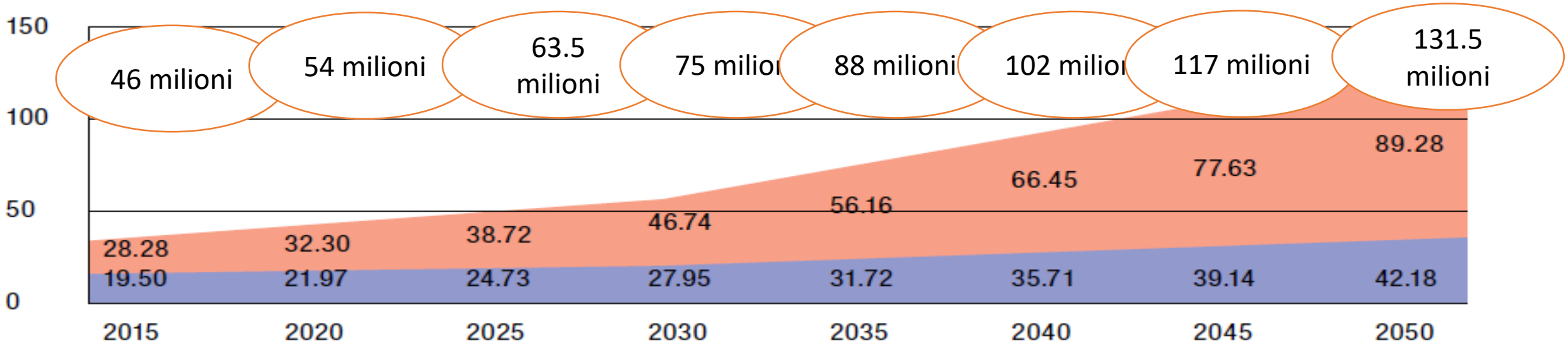


Figure 3.
Variation in cognitive decline explained by the pathologic indices (grey) and the residual, unexplained variation in cognitive decline (white) derived from fully adjusted models.

1. IL CONTESTO EPIDEMIOLOGICO

NUMERO DI CASI ATTESI DI DEMENZA NEI PAESI RICCHI E IN QUELLI IN VIA DI SVILUPPO



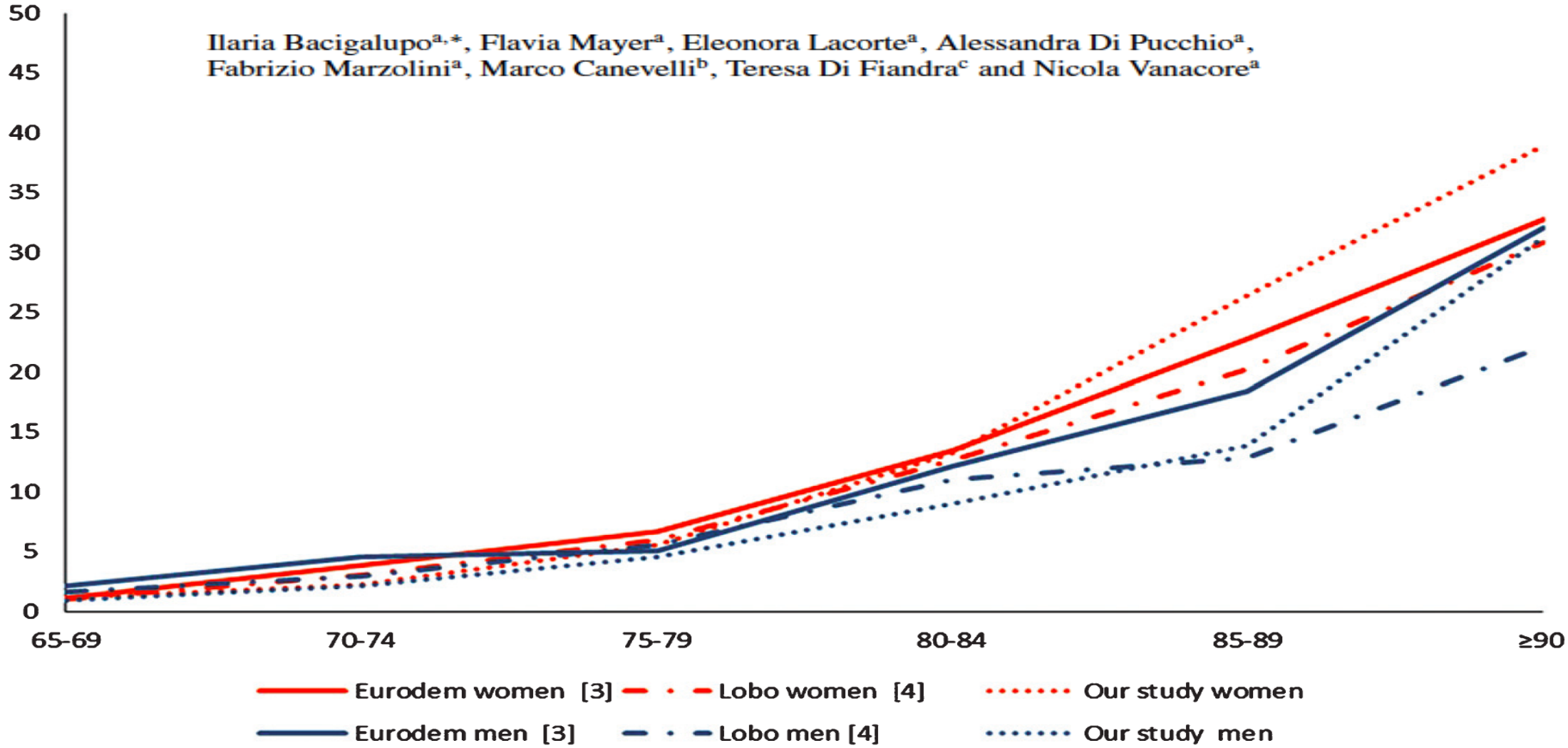
The growth in numbers of people with dementia (millions) in high income (HIC) and low and middle income countries (LMIC)

High Income ■ Low and Middle Income ■

ADI 2015. World Alzheimer Report 2015. The Global Impact of Dementia. An Analysis of prevalence, Incidence, cost and Trends

A Systematic Review and Meta-Analysis on the Prevalence of Dementia in Europe: Estimates from the Highest-Quality Studies Adopting the DSM IV Diagnostic Criteria

Ilaria Bacigalupo[a,*], Flavia Mayer[a], Eleonora Lacorte[a], Alessandra Di Pucchio[a], Fabrizio Marzolini[a], Marco Canevelli[b], Teresa Di Fiandra[c] and Nicola Vanacore[a]



PREVALENZA PER DEMENZA IN EUROPA (Lobo et al. 2000)

6.4%

Age – group	Prevalenza X 100 ab maschi	Prevalenza X 100 ab femmine
65-69	1.6	1
70-74	2.9	3.1
75-79	5.6	6
80-84	11	12.6
85-89	12.8	20.2
90 +	22.1	30.8

Analisi pooled dei dati
11 studi pubblicati dal 1991-1997
Criteri clinici DSM III-R; CAMDEX, AGECAT
Nessuna valutazione di qualità

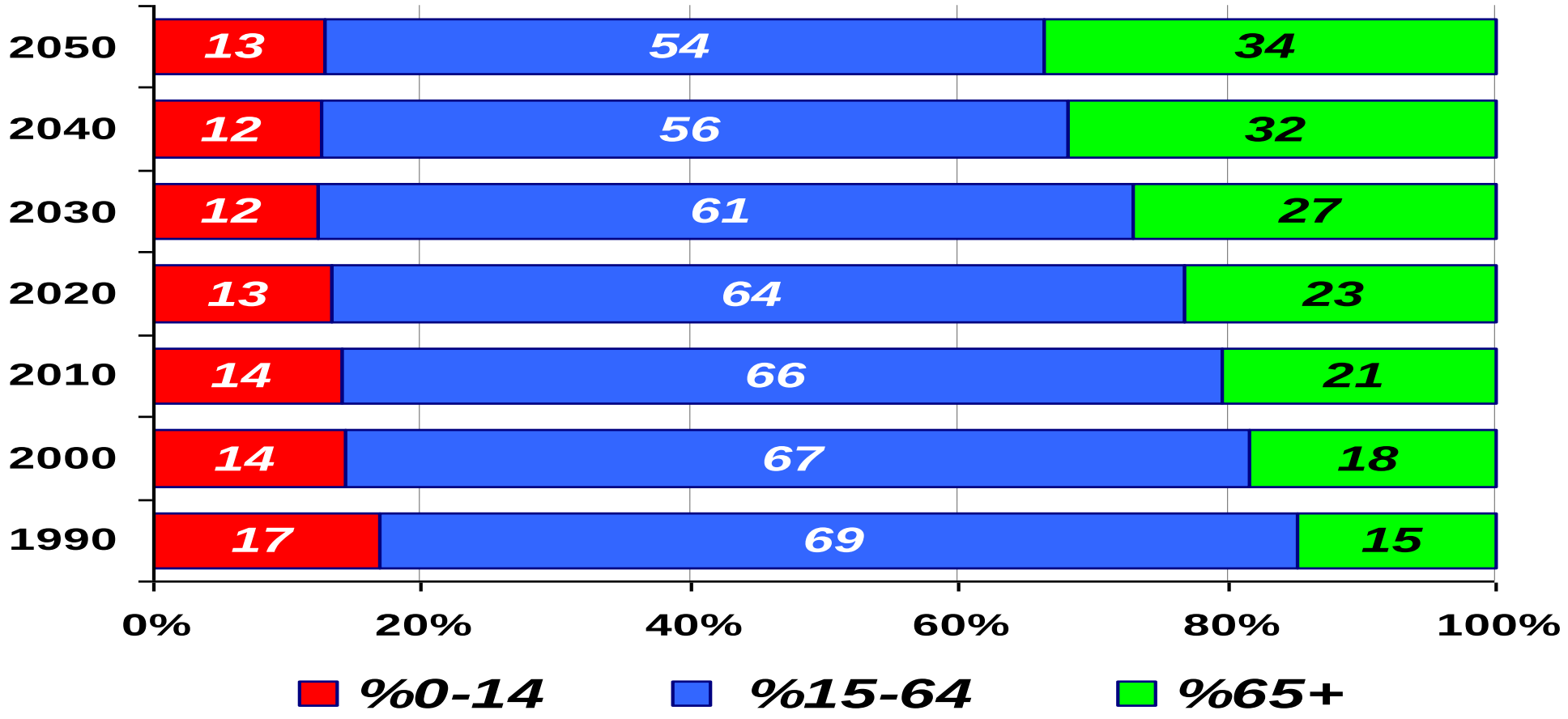
PREVALENZA PER DEMENZA IN EUROPA (Bacigalupo et al. 2018)

7.1%

Age – group	Prevalenza X 100 ab maschi	Prevalenza X 100 ab femmine
65-69	1.1	0.9
70-74	2.2	2.1
75-79	5.6	4.6
80-84	13.3	9.0
85-89	26.4	13.9
90 +	38.9	31.2

Meta-analisi
9 studi pubblicati dal 2002-2015
Criteri clinici DSM IV
Valutazione di qualità con checklist ADI
Due studi includono anche pazienti istituzionalizzati.

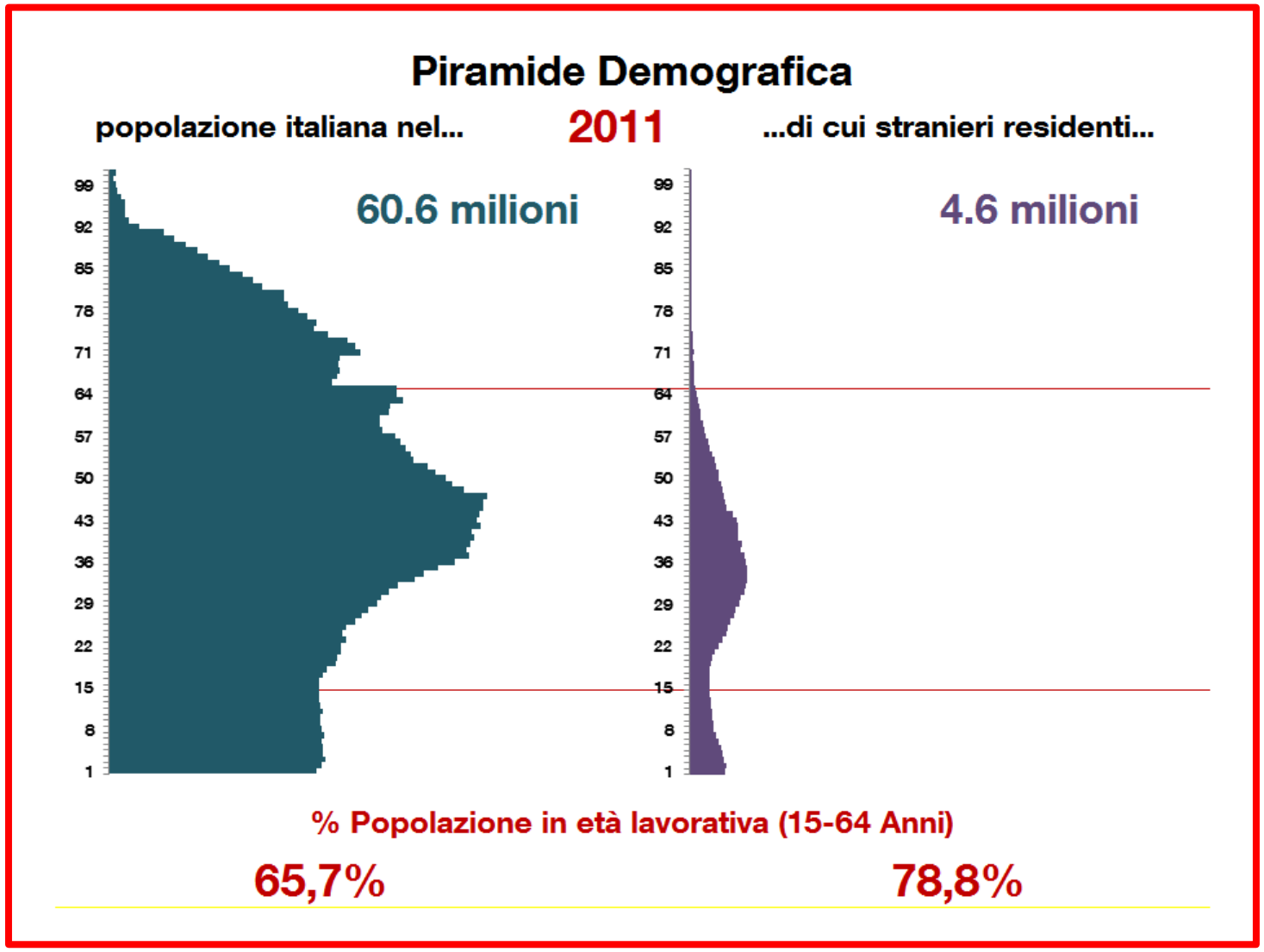
Struttura per età della popolazione residente in Italia fino al 2050



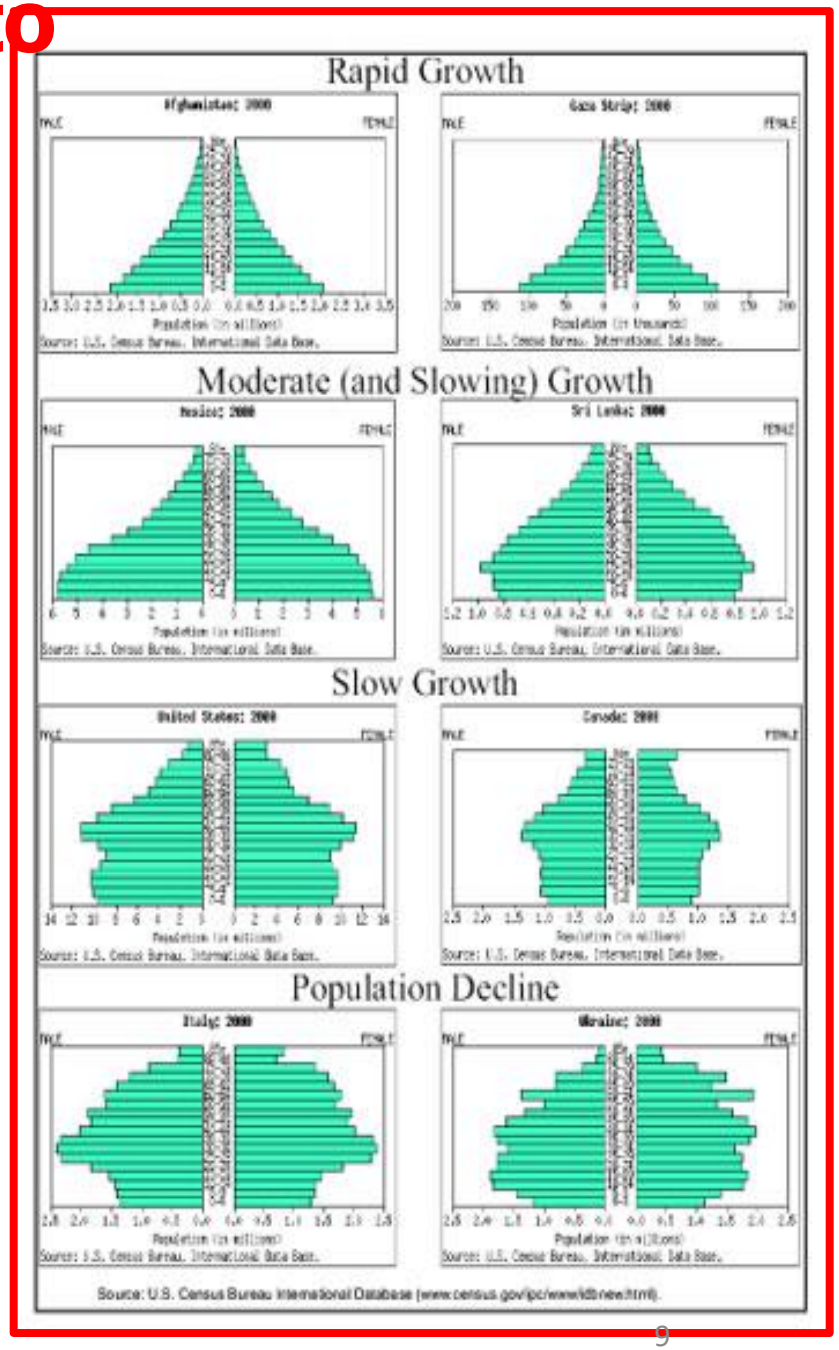
Fonte dati ISTAT: previsioni demografiche 2005 - 2050

(Carla Sorrentino)

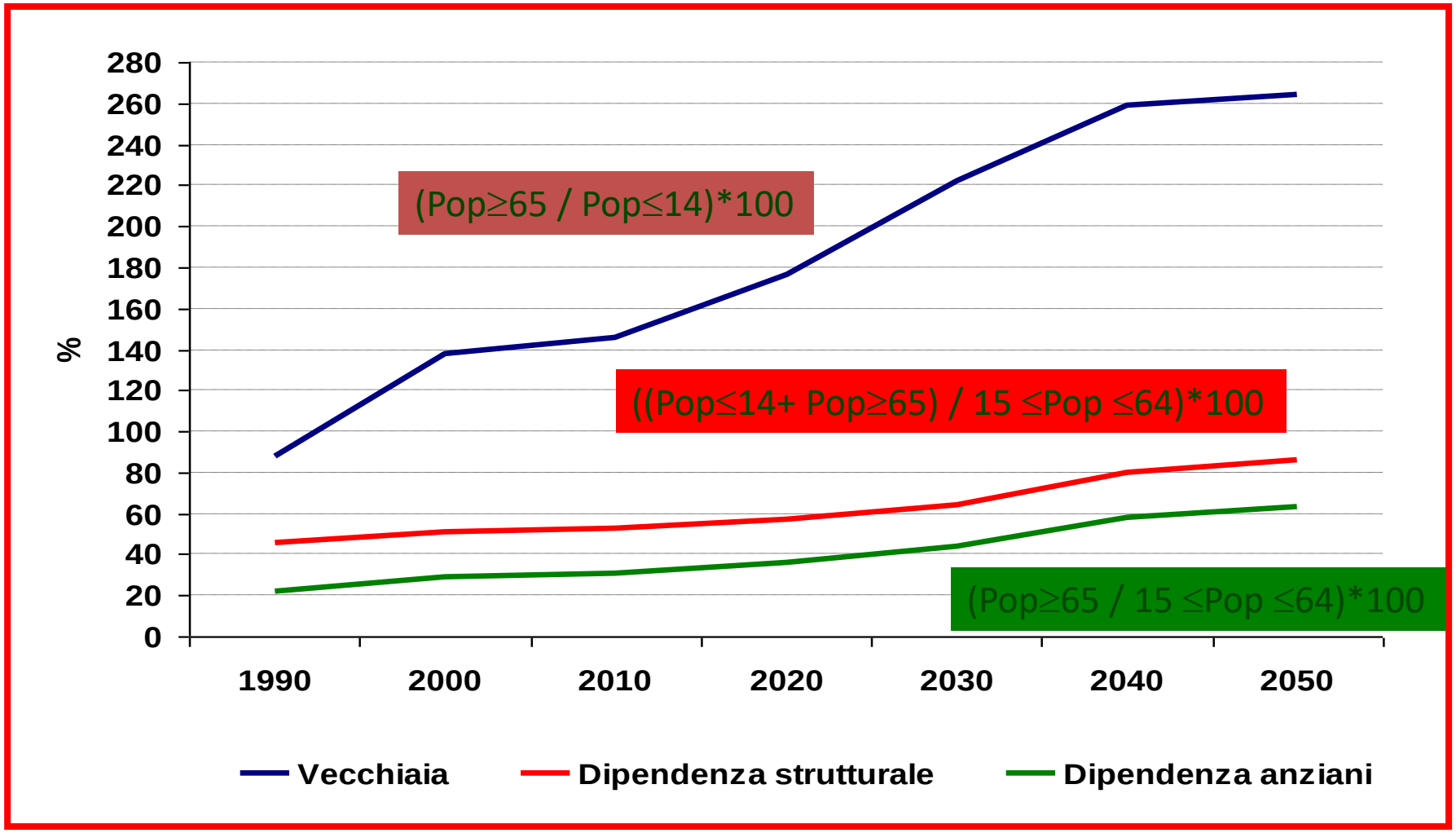
Struttura demografica e invecchiamento



http://www.ilpost.it/wp-content/uploads/2013/05/grafico.gif



Indici di struttura della popolazione fino al 2050

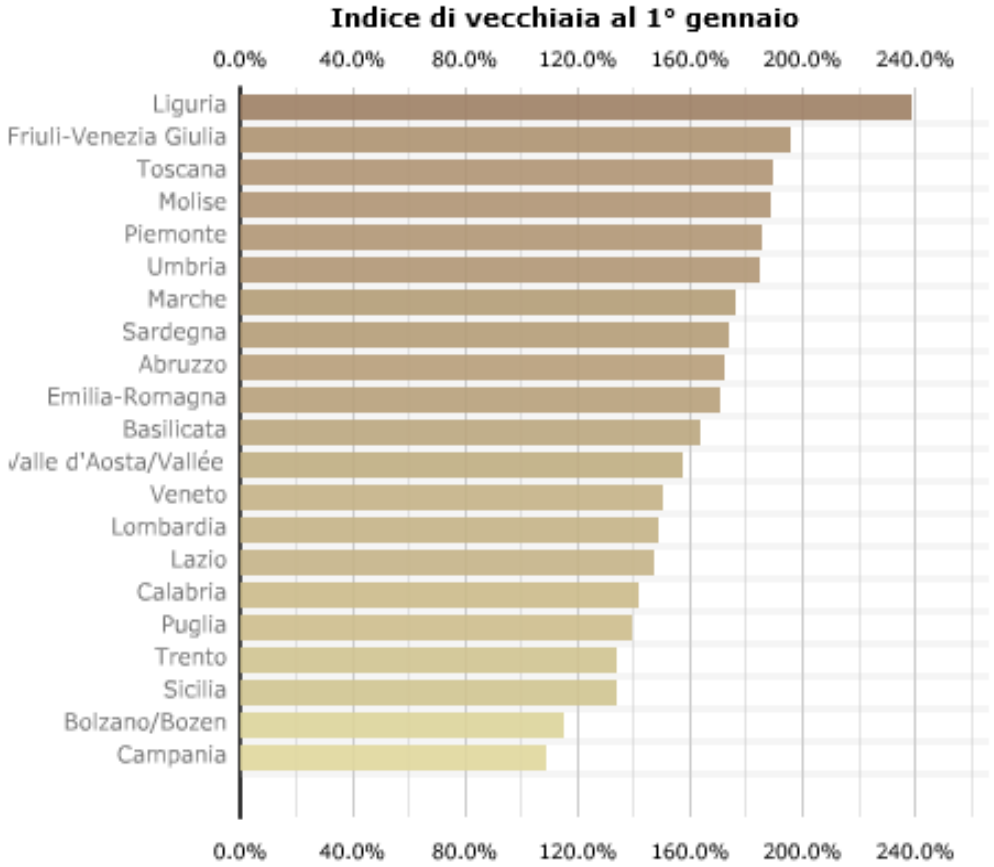


Fonte dati ISTAT: previsioni demografiche 2005 - 2050

(Carla Sorrentino)

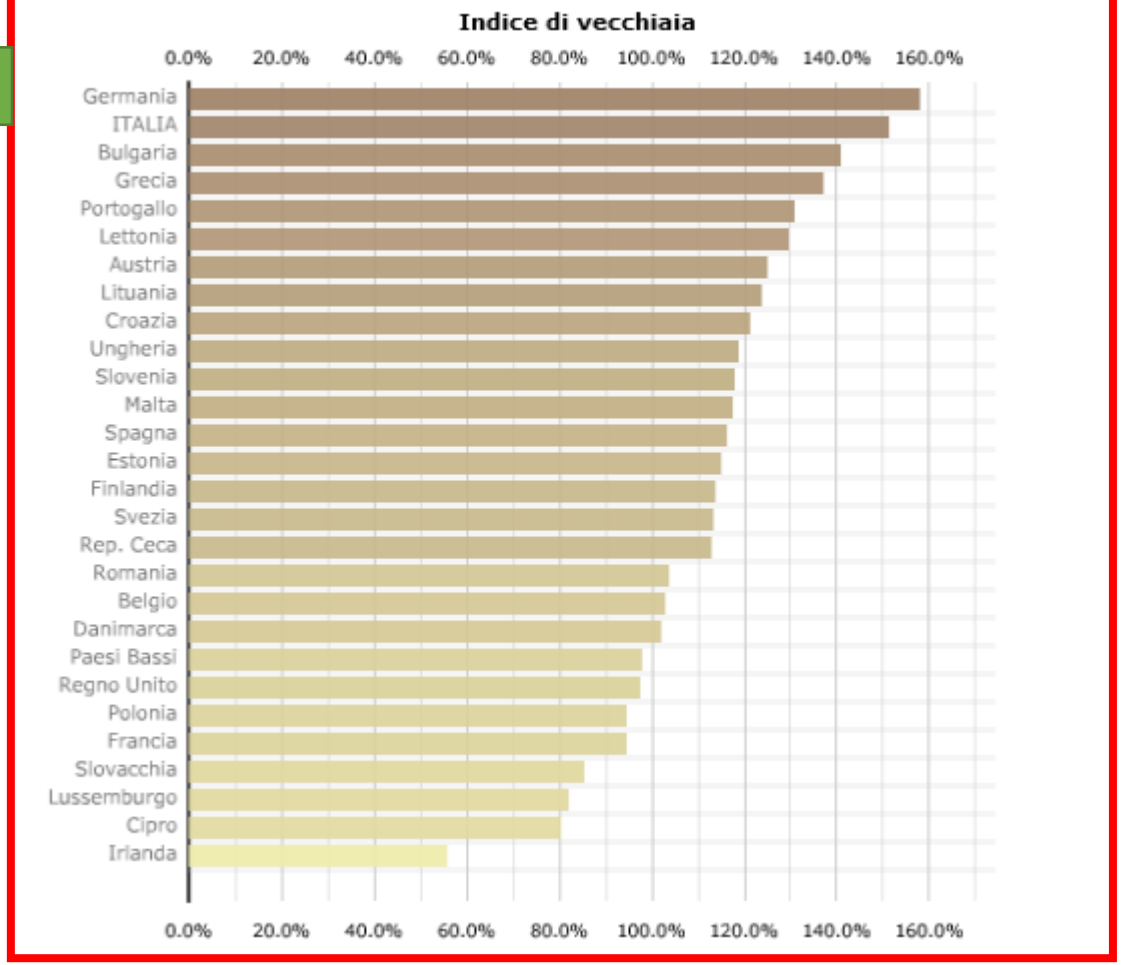
L'Italia: un paese che invecchia.
Nel 2016 l'indice di vecchiaia è di 161,4 anziani ogni 100 giovani

L'ITALIA E LE SUE REGIONI



2014

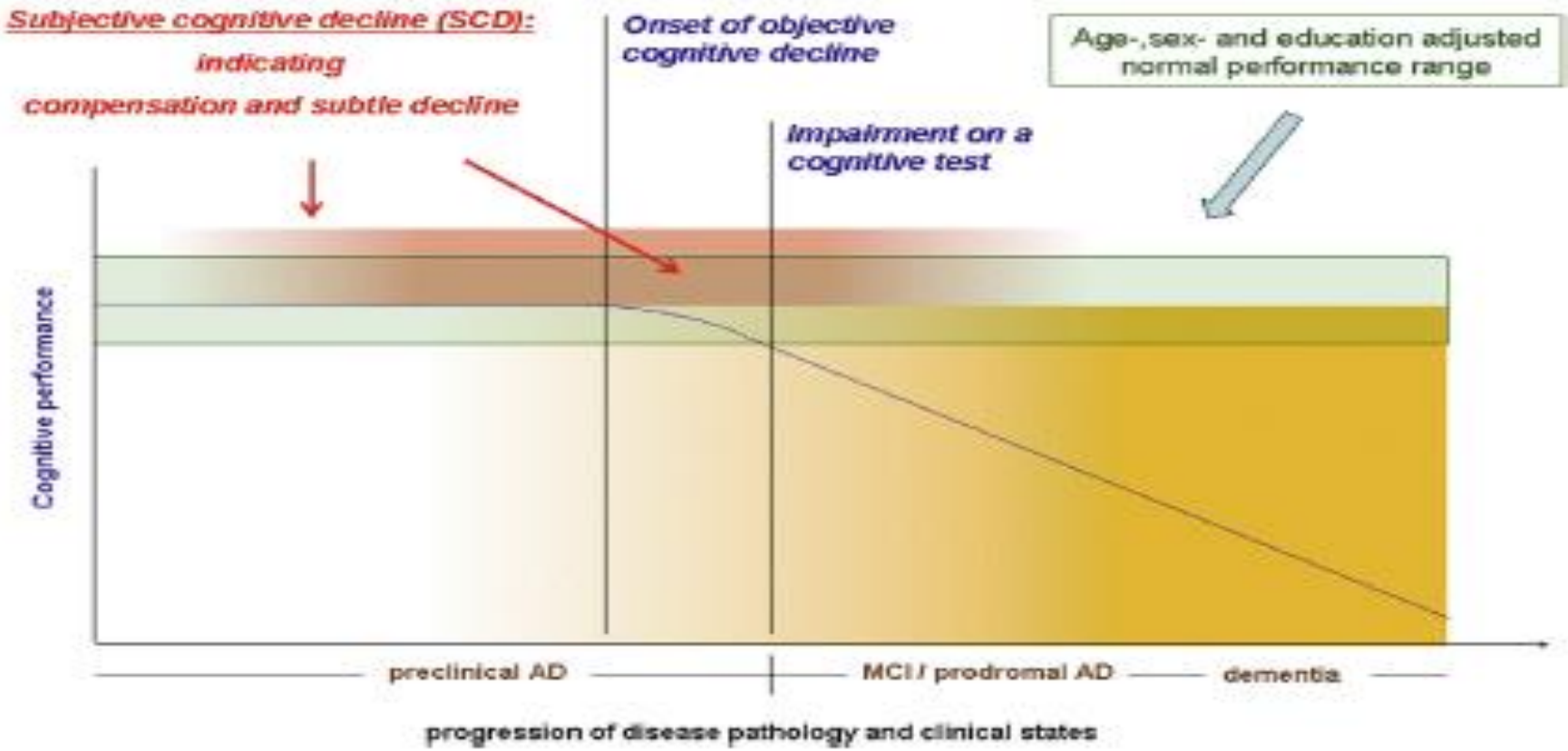
L'ITALIA NEL CONTESTO EUROPEO



Indice di vecchiaia: rapporto percentuale tra il numero degli ultrassessantacinquenni ed il numero dei giovani fino ai 14 anni

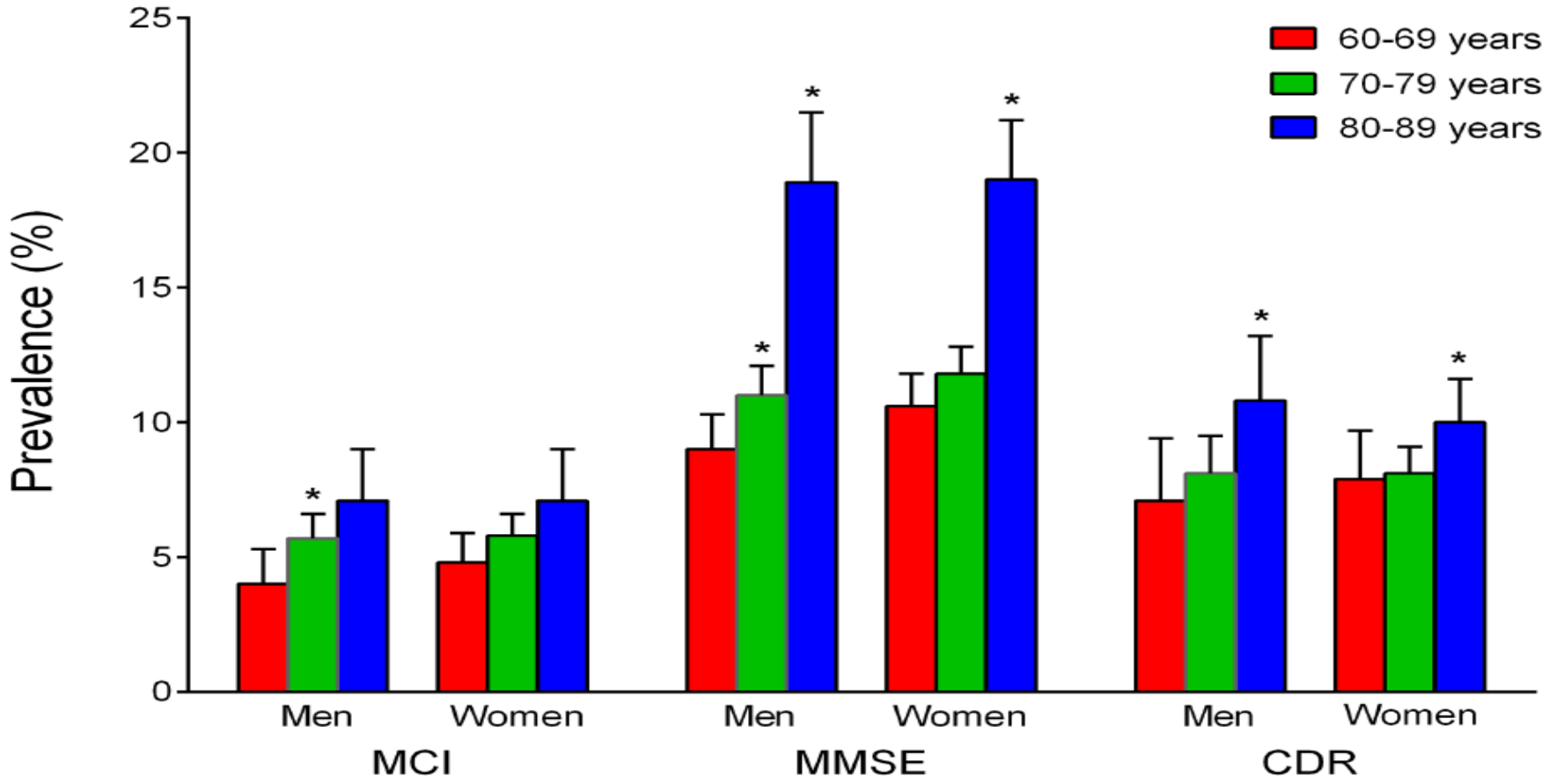
F. Jessen et al. / Alzheimer's & Dementia ■ (2014) 1–9

Course of cognitive symtomes in AD



RESEARCH ARTICLE

The Prevalence of Mild Cognitive Impairment in Diverse Geographical and Ethnocultural Regions: The COSMIC Collaboration



Casi di demenza stimati nei soggetti ≥65 anni residenti in Italia al 1 gennaio 2019

	Maschi			Femmine		
Età	Residenti	Prevalenza	Casi stimati	Residenti	Prevalenza	Casi stimati
65-69	1,662,603	0.009	14,963	1,828,370	0.011	20,112
70-74	1,511,424	0.021	31,740	1,722,428	0.022	37,893
75-79	1,215,576	0.046	55,916	1,513,105	0.056	84,734
80-84	900,445	0.09	81,040	1,276,137	0.133	169,726
85-89	495,508	0.139	68,876	883,456	0.264	233,232
≥90	209,328	0.312	65,310	565,200	0.389	219,863
Totale	**5,994,884**		**317,846**	**7,788,696**		**765,561**

Casi di MCI stimati nei soggetti ≥60 anni residenti in Italia al 1 gennaio 2019

Età	Prevalenza	Residenti	Casi stimati
60-69	0.045	7,337,210	330,174
70-79	0.058	5,962,533	345,827
80-89	0.071	3,555,546	252,444
Totale		**16,855,289**	**928,445**

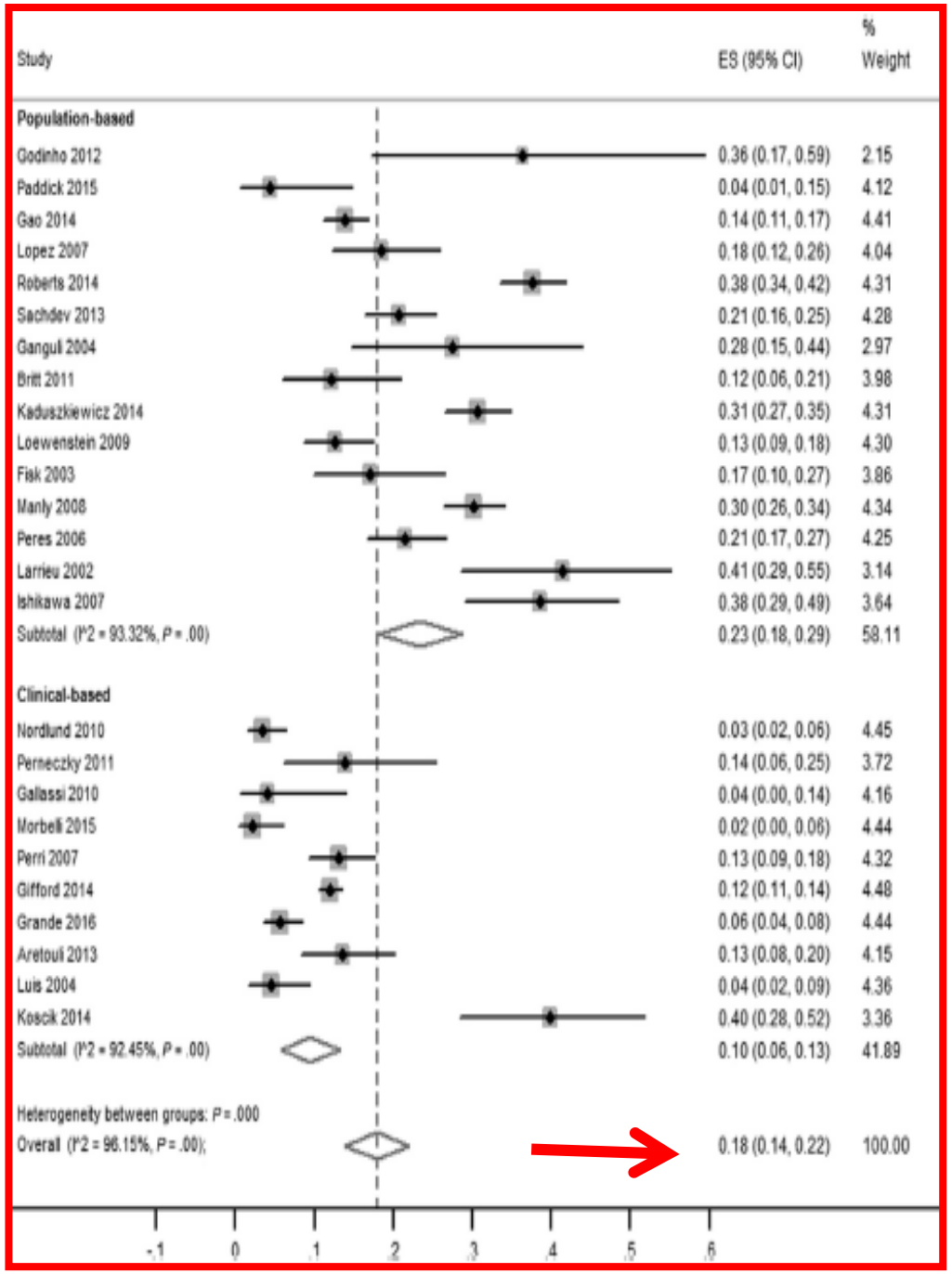
JAMDA

journal homepage: www.jamda.com

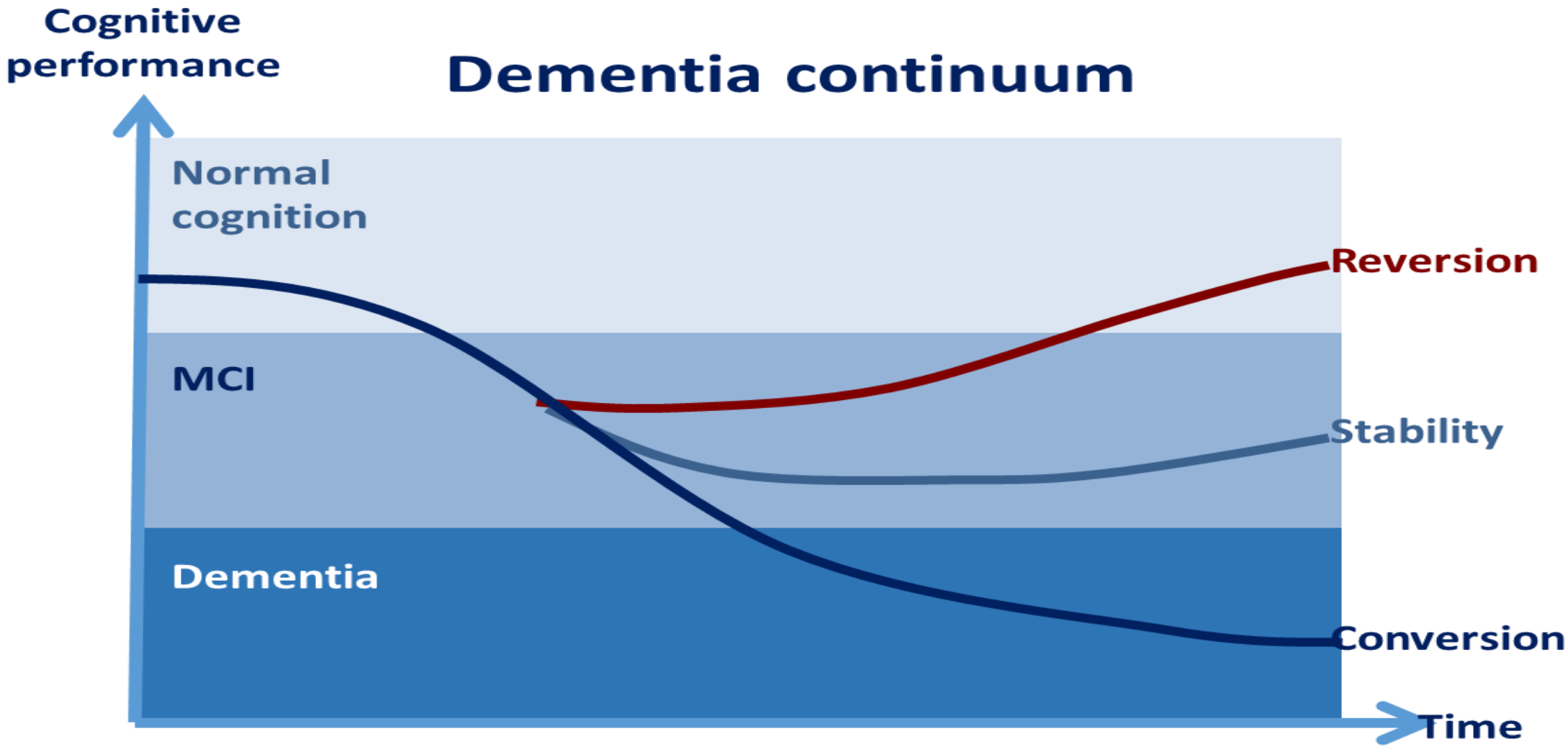
Original Study

Spontaneous Reversion of Mild Cognitive Impairment to Normal Cognition: A Systematic Review of Literature and Meta-Analysis

Marco Canevelli MD[a,*], Giulia Grande MD[b], Eleonora Lacorte MSci[c], Elisa Quarchioni MStat[c], Matteo Cesari PhD[d,e], Claudio Mariani MD[b], Giuseppe Bruno PhD[a], Nicola Vanacore PhD[c]



Reversione alla normalità del MCI



2. LE EVIDENZE SULLA PREVENZIONE

Potential for primary prevention of Alzheimer's disease: an analysis of population-based data

Sam Norton, Fiona E Matthews, Deborah E Barnes, Kristine Yaffe, Carol Brayne

Lancet Neurol 2014; 13: 788–94

Summary

Background Recent estimates suggesting that over half of Alzheimer's disease burden worldwide might be attributed

	Relative risk (95% CI)*	Communality (%)†
Diabetes mellitus	1·46 (1·20–1·77)	50·9%
Midlife hypertension	1·61 (1·16–2·24)	65·0%
Midlife obesity	1·60 (1·34–1·92)	43·7%
Physical inactivity	1·82 (1·19–2·78)	49·0%
Depression	1·65 (1·42–1·92)	37·4%
Smoking	1·59 (1·15–2·20)	58·1%
Low educational attainment	1·59 (1·35–1·86)	45·6%

*Sources are provided in the appendix. †The proportion of the variance in each risk factor shared with the other risk factors, estimated using the Health Survey for England 2006.[17]

Table 1: Relative risks for Alzheimer's disease and shared variance between risk factors

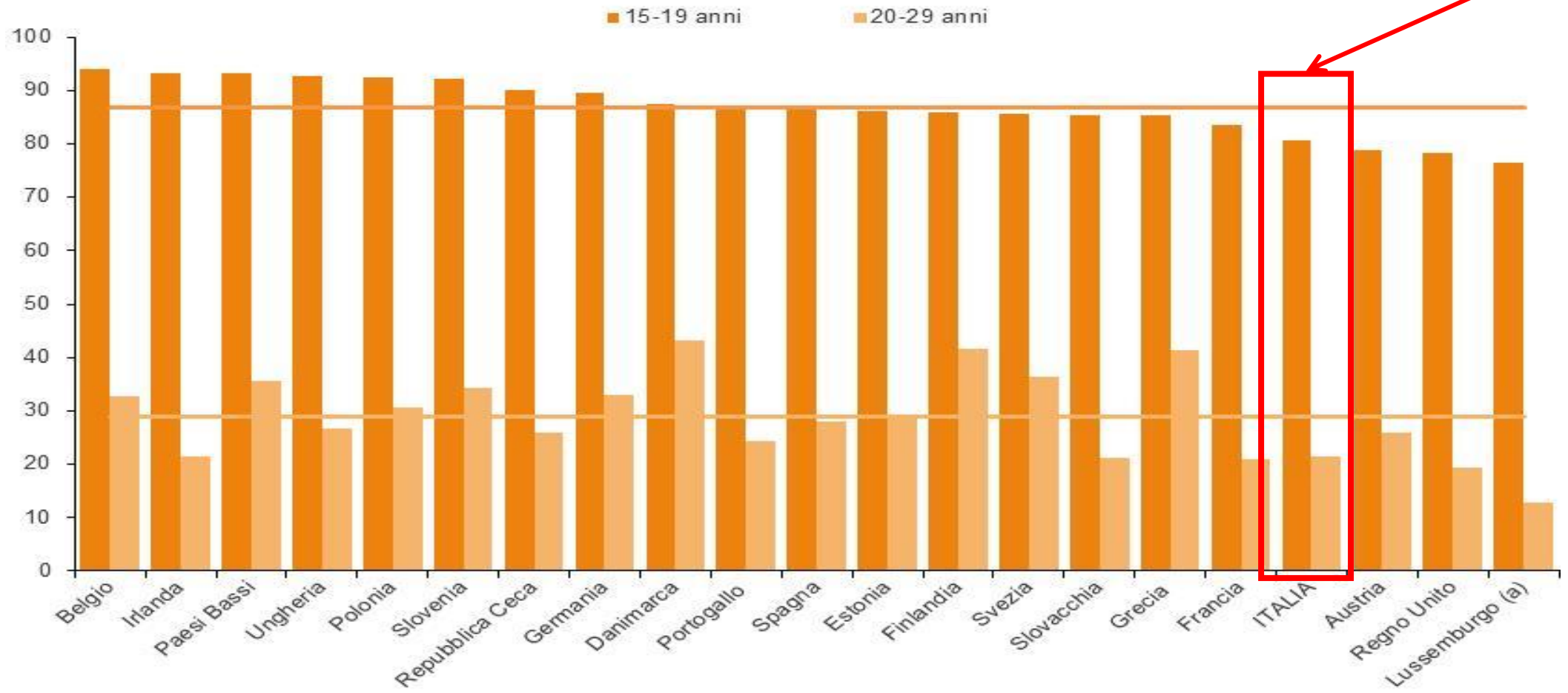
	Prevalence*	PAR (95% CI)	Number of attributable cases in 2010 (95% CI)†
Europe			
Diabetes mellitus	6·9%	3·1% (1·4–5·0)	222 (98–364)
Midlife hypertension	12·0%	6·8% (1·9–13·0)	492 (136–934)
Midlife obesity	7·2%	4·1% (2·4–6·2)	299 (172–448)
Physical inactivity	31·0%	20·3% (5·6–35·6)	1461 (401–2564)
Depression	18·5%	10·7% (7·2–14·5)	774 (520–1049)
Smoking	26·6%	13·6% (3·8–24·2)	978 (277–1745)
Low educational attainment	26·6%	13·6% (8·5–18·6)	978 (614–1342)
Combined‡	..	54·0% (27·2–73·7)	3891 (1959–5311)
Adjusted combined§	..	31·4% (15·3–46·0)	3033 (1472–4332)

PAR=population-attributable risk. *Sources detailed in the appendix. †In thousands. ‡Assuming independence of the risk factors. §Adjusting for non-independence of the risk factors.

Table 2: **Estimates for population-attributable risk and the number of attributable cases in 2010**

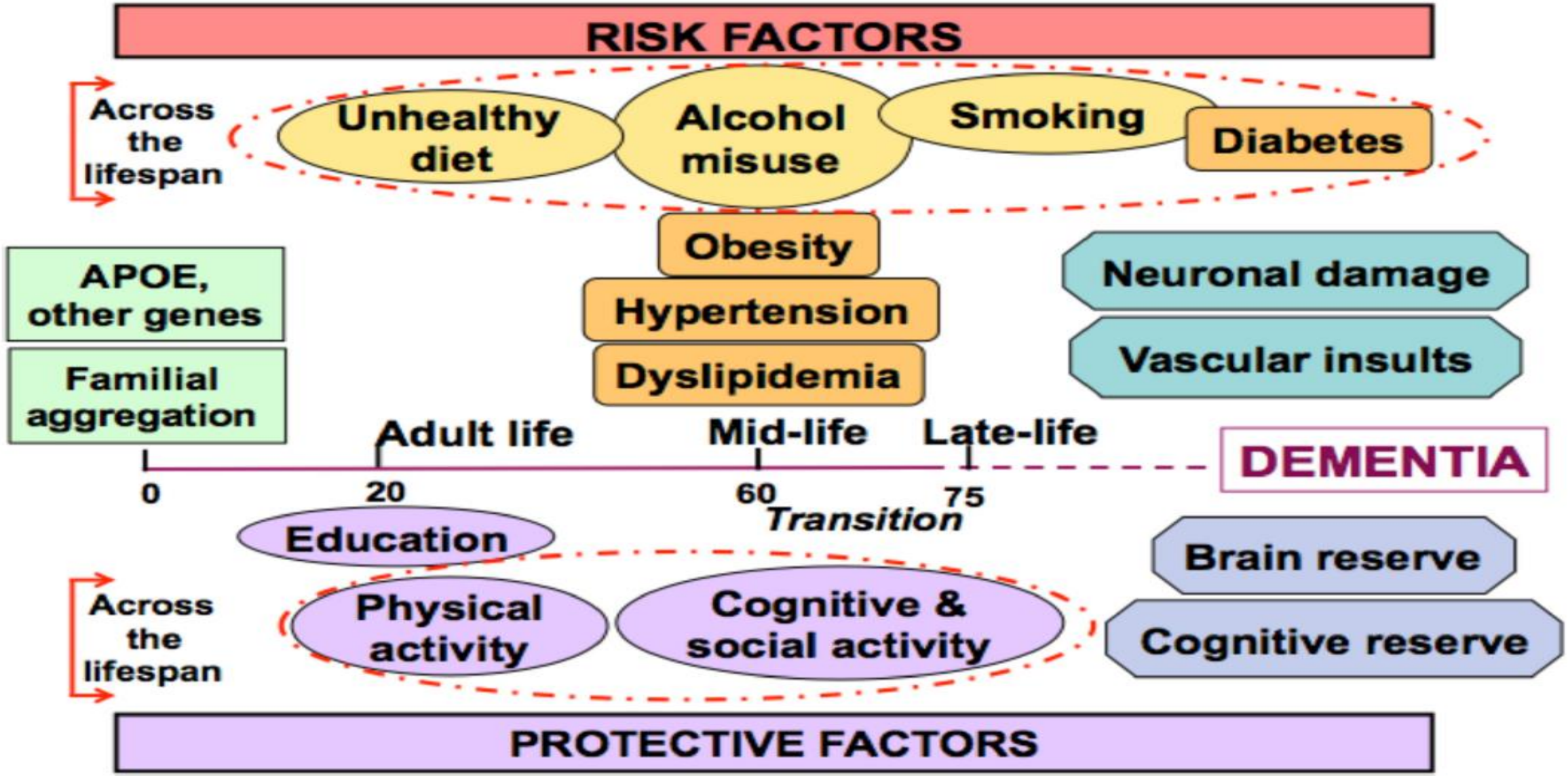
SCOLARITA' (13.6% in relazione demenza)

Tassi di partecipazione al sistema di istruzione e formazione dei giovani 15-19enni (livelli ISCED 3-4-5) e 20-29enni (livelli ISCED 5-6) nei 21 paesi Ue aderenti all'OCSE (Anno 2012 - valori percentuali)



Advances in the prevention of Alzheimer's Disease

Figure 1. Risk factors for dementia and Alzheimer's disease across the lifespan (Figure modified from [51])



F1000Prime Reports 2015, **7**:50

A two-decade comparison of prevalence of dementia in individuals aged 65 years and older from three geographical areas of England: results of the Cognitive Function and Ageing Study I and II

Fiona E Matthews, Antony Arthur, Linda E Barnes, John Bond, Carol Jagger, Louise Robinson, Carol Brayne, on behalf of the Medical Research Council Cognitive Function and Ageing Collaboration

SI PUO' MODIFICARE LA FREQUENZA DELLA DEMENZA ?

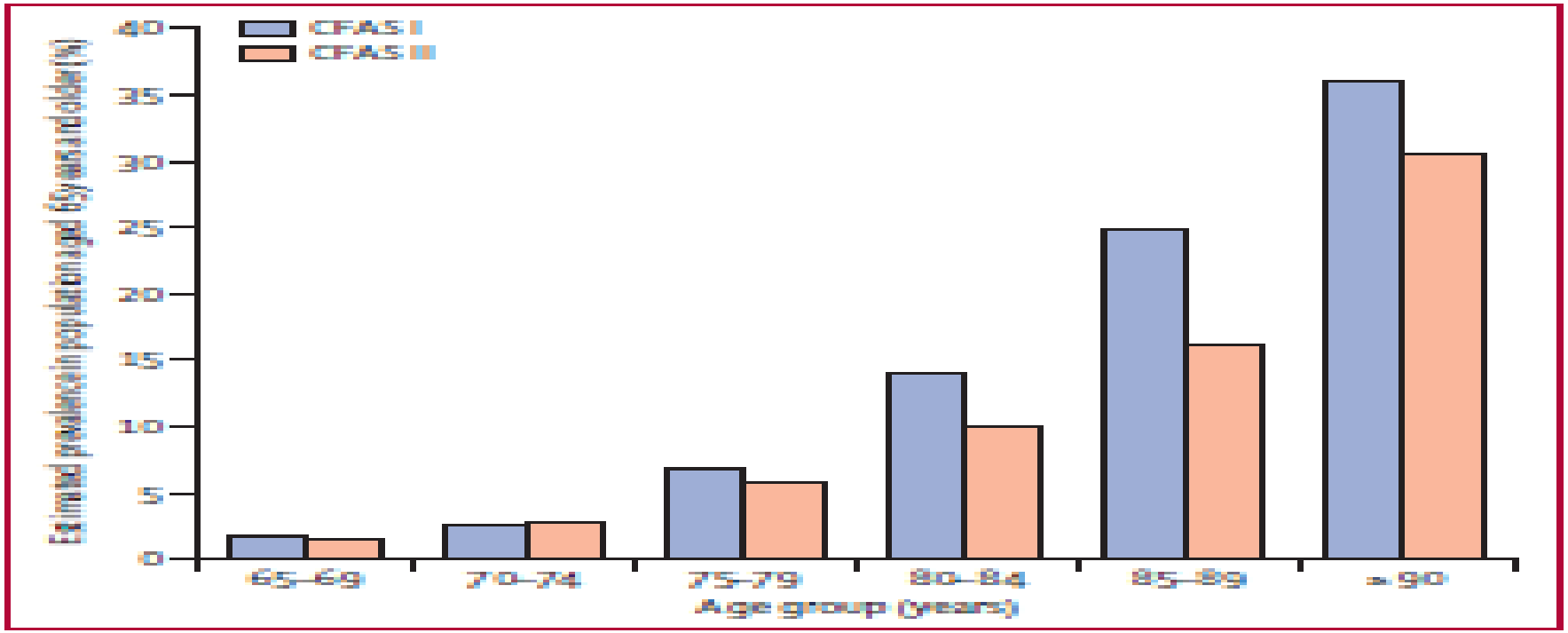


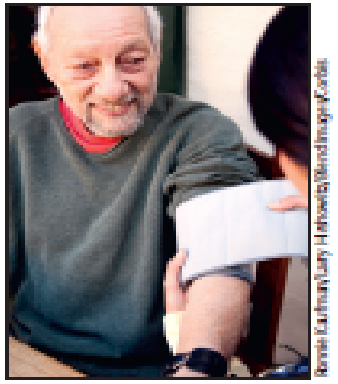
Figure 1: CFAS I and CFAS II age-specific dementia prevalence
CFAS=Cognitive Function and Ageing Study.

Good news on dementia prevalence—we can make a difference

The findings of the Cognitive Functioning and Ageing Study (CFAS) I and II are unequivocally good news. New data, reported in *The Lancet*,[1] suggest that the prevalence of dementia in the UK in 2011 was significantly lower than would have been expected based on the estimated prevalence in 1991. For CFAS I, data were taken from three geographical areas—Cambridgeshire, Newcastle, and Nottingham—to generate an estimate of the prevalence of dementia in the UK in 1991. This was based on a randomly selected sample of 7635 people aged 65 years and older interviewed in these areas, with 1457 being diagnostically assessed for dementia. An algorithmic diagnostic approach was used so that the resulting estimate, which was standardised to the 1991 population structure, could be compared with future results. For CFAS II, investigators used an identical diagnostic method to estimate the prevalence of dementia in the UK in 2011. On the basis of the age

It is plausible that changes in health behaviour and provision, including smoking cessation and improved management of cardiovascular risk factors such as hypertension, have prevented or delayed the onset of dementia at a population level. The next questions must be: how much further can we go in pursuit of this preventive agenda? How many more cases can be prevented? What do we need to do to have the greatest effect? These questions need empirical investigation followed by purposeful strategy formulation and implementation.

A powerful message from these data[1] is that what we as individuals and services do matters in terms of dementia. The CFAS data point to substantial added value from existing healthy lifestyle messages. They suggest that lifestyle changes—eg, in diet, exercise, and smoking—might reduce the risk of dementia and promote more general health and wellbeing. This



Bonnie Kaufman/Lucy Howells/Wendimagen/Corbis

Published Online
July 16, 2013
http://dx.doi.org/10.1016/S0140-6736(13)61579-2

See Online/Articles
http://dx.doi.org/10.1016/S0140-6736(13)61570-6

The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

Incidence of Dementia over Three Decades in the Framingham Heart Study

Claudia L. Satizabal, Ph.D., Alexa S. Beiser, Ph.D., Vincent Chouraki, M.D., Ph.D., Geneviève Chêne, M.D., Ph.D., Carole Dufouil, Ph.D., and Sudha Seshadri, M.D.

Table 2. Temporal Trends in the Incidence of Dementia.*

Subtype	No. of Cases	Total No. of Observation Periods	5-Yr Cumulative Hazard Rate (95% CI)†				5-Yr Hazard Ratio (95% CI)‡				P Value for Trend
			Epoch 1	Epoch 2	Epoch 3	Epoch 4	Epoch 2	Epoch 3	Epoch 4	Trend§	
Overall dementia	371	9015	3.6 (2.9–4.4)	2.8 (2.2–3.5)	2.2 (1.8–2.8)	2.0 (1.5–2.6)	0.78 (0.59–1.04)	0.62 (0.47–0.83)	0.56 (0.41–0.77)	0.80 (0.72–0.90)	<0.001
Alzheimer's disease	264	9015	2.0 (1.5–2.6)	2.0 (1.5–2.6)	1.7 (1.3–2.3)	1.4 (1.0–1.9)	1.00 (0.70–1.43)	0.88 (0.62–1.25)	0.70 (0.48–1.03)	0.88 (0.77–1.00)	0.052
Vascular dementia	84	9014	0.8 (0.6–1.3)	0.8 (0.5–1.2)	0.4 (0.2–0.7)	0.4 (0.2–0.7)	0.89 (0.51–1.56)	0.46 (0.25–0.86)	0.45 (0.23–0.87)	0.71 (0.56–0.90)	0.004

* The baseline examination period was between 1977 and 1983 for the first epoch, between 1986 and 1991 for the second epoch, between 1992 and 1998 for the third epoch, and between 2004 and 2008 for the fourth epoch.
† The 5-year cumulative hazard rates (the cumulative incidence of dementia per 100 persons over a period of 5 years) are adjusted for age and sex.
‡ The 5-year hazard ratios (the incidence of dementia during each epoch relative to the incidence during the first epoch) are adjusted for age and sex.
§ We estimated linear trends (the decline per decade in the 5-year incidence of dementia) using the elapsed mean time (in decades) between the first epoch and each consecutive epoch.

Table 1. Baseline Characteristics.*

Characteristic	Epoch 1 (N=2457)	Epoch 2 (N=2135)	Epoch 3 (N=2333)	Epoch 4 (N=2090)	P Value for Trend
Age at entry (yr)					<0.001
Mean	69±7	72±7	72±8	72±9	
Range	60–89	60–96	60–101	60–101	
Female sex (%)	59	57	57	56	0.01 (age-adjusted, <0.001)
Educational level (%)					<0.001
No high school diploma	36	24	15	5	
High school diploma	32	37	37	32	
Some years of college	19	21	24	29	
College degree	13	17	24	34	
Positive for at least one APOE ε4 allele (%)†	22	21	21	21	0.47 (age-adjusted, 0.98)
Mean systolic blood pressure (mm Hg)	137±19	143±22	138±20	131±18	<0.001
Mean diastolic blood pressure (mm Hg)	76±10	77±11	73±10	72±10	<0.001
Use of antihypertensive medication (%)	33	43	44	62	<0.001
Smoking (%)	20	14	9	6	<0.001
Mean HDL cholesterol (mg/dl)	50±16	49±15	50±16	57±18	<0.001
Use of lipid-lowering agents (%)	NA	NA	12	43	<0.001
Mean body-mass index‡	26±4	27±5	27±5	28±5	<0.001
Type 2 diabetes (%)	10	11	15	17	<0.001
Cardiovascular disease (%)	23	26	25	22	0.52 (age-adjusted, <0.001)
Stroke (%)	3.6	3.3	3.8	3.1	0.51 (age-adjusted, 0.02)

EXTRA Dementia and Geriatric Cognitive Disorders

Dement Geriatr Cogn Disord Extra 2018;8:60–71
DOI: 10.1159/000487079
Received: December 15, 2017
Accepted: January 21, 2018
Published online: February 21, 2018

Original Research Article

An Estimate of Attributable Cases of Alzheimer Disease and Vascular Dementia due to Modifiable Risk Factors: The Impact of Primary Prevention in Europe and in Italy

Flavia Mayer[a] Alessandra Di Pucchio[a] Eleonora Lacorte[a]
Ilaria Bacigalupo[a] Fabrizio Marzolini[a] Gianluigi Ferrante[a]
Valentina Minardi[a] Maria Masocco[a] Marco Canevelli[b]
Teresa Di Fiandra[c] Nicola Vanacore[a]

[a]National Center for Disease Prevention and Health Promotion, National Institute of Health, Rome, Italy; [b]Department of Human Neuroscience "Sapienza" University of Rome, Rome, Italy; [c]General Direction of Prevention, Ministry of Health, Rome, Italy

Obiettivi

Considerando i sette fattori di rischio noti,
l'obesità, la sedentarietà, il fumo, la depressione,
l'ipertensione, il diabete il basso livello di istruzione,

L'obiettivo dello studio è stato:

a) **stimare, in Europa, il numero di casi di demenza Vascolare (VaD) attribuibili ai potenziali fattori di rischio modificabili;**

b) **stimare, in Italia, a livello nazionale e regionale, il numero di casi di demenza di Alzheimer (AD) e di VaD che potrebbero essere evitati attraverso politiche di prevenzione dei fattori di rischio modificabili.**

Risultati

Risk Ratios for the seven lifestyle factors for AD and VaD, and shared variance within each factor.

Fattori di Rischio	Rischio Relativo (95%CI)		Communality (%)°
	AD	VaD	
Diabete	1.46 (1.20–1.77)	2.28 (1.94–2.66)	50.9%
Ipertensione	1.61 (1.16–2.24)	1.59 (1.20–2.11)	65.0%
Obesità	1.60 (1.34–1.92)	1.33 (1.02–1.75)	43.7%
Sedentarietà	1.82 (1.19–2.78)	1.61 (1.09–2.38)	49.0%
Depressione	1.65 (1.42–1.92)	2.92 (1.87–4.56)	37.4%
Fumo	1.59 (1.15–2.20)	1.26 (1.05– 1.50)	58.1%
Basso livello di scolarizzazione	1.59 (1.35–1.86)	2.75 (2.19–3.45)	45.6%

°Proporzione di varianza condivisa con gli altri 6 fattori di rischio

Table 2: Estimate of the population attributable risk and number of attributable cases in 2010 for AD and VaD in EUROPE.

Risk factor	Prevalence (%)*	AD*		VaD		Total number (in thousands) of attributable cases in 2010 for AD and VaD
		PAR (95%CI)	Number (in thousands) of attributable cases in 2010 (95%CI)	PAR (95%CI)**	Number (in thousands) of attributable cases in 2010 (95%CI)°	
Diabetes mellitus	6.9	3.1% (1.4–5.0)	222 (98–364)	8.1% (6.1-10.3)	187 (141 - 237)	409
Midlife hypertension	12	6.8% (1.9–13.0)	492 (136–934)	6.6%(2.3-11.8)	153 (54 - 271)	645
Midlife obesity	7.2	4.1% (2.4–6.2)	299 (172–448)	2.3% (0.1-5.1)	54 (3-118)	353
Physical inactivity	31.0	20.3% (5.6–35.6)	1461 (401–2564)	15.9% (2.7-30.0)	367 (63 - 691)	1828
Depression	18.5	10.7% (7.2–14.5)	774 (520–1049)	26.2% (13.9-39.7)	605 (320 - 916)	1379
Smoking	26.6	13.6% (3.8–24.2)	978 (277– 1745)	6.5% (1.3-11.7)	149 (30 - 271)	1127
Low educational attainment	26.6	13.6% (8.5–18.6)	978 (614– 1342)	31.8% (24.0-39.5)	733 (555 - 910)	1711
Combined		54.0% (27.2–73.7)	3891 (1959–5311)	66.8% (42.5-83.0)	1541 (980 - 1916)	5432
Adjusted combined		31.4% (15.3–46.0)	3033 (1472–4332)	37.8% (21.2-52.5)	873 (488 - 1211)	3906

*Estimats from Norton et al.[3]

** Estimated using prevalence from Norton et al. [3] and RR reported in table 1.

°Estimated multiplying PAR per numer of prevalent cases of VaD in Europe (=15.8 from Lobo et al. [2] * numer of total cases of dementia from Brookmeyer et al. [9])

Table 3. Prevalence of the 7 risk factors in the Italian regions

Italian regions	Prevalence[a], %							PAR adjustet combined		PAR adjustet combined condidering a reduction of each risk factor by 20%	
	obesity	physical inactivity	smoking	symptoms of depression	hyper-tension	diabetes	low educational attainment	AD	VaD	AD	VaD
Abruzzo	10.9	39.8	29.7	5.2	17.3	3.8	35.2	45.5	52.2	39.1	45.7
Basilicata	9.4	76.07	19.2	3.1	22.7	4.7	40.4	51.7	57.8	45.2	51.4
Calabria	11.2	50.74	24.7	5.8	25.1	6.0	35.6	49.1	56.2	42.6	49.5
Campania	13.6	51.81	28.3	6.6	21.9	6.2	39.5	50.7	57.9	44.1	51.2
Emilia Romagna	11.8	25.78	28.3	7.6	18.6	4.0	36.1	43.1	51.8	36.8	45.3
Friuli Venezia Giulia	10.5	23.37	26	6.4	20.8	3.9	37.1	42.0	51.1	35.8	44.7
Lazio	9.5	36.94	29.1	5.3	19.8	4.4	29.6	44.0	50.3	37.7	43.8
Liguria	8.4	34.03	25.5	6.8	17.0	3.8	32.3	42.5	50.5	36.3	44.0
Lombardia	8.2	25.2	24.3	6.4	18.1	3.5	29.4	39.3	47.5	33.4	41.2
Marche	8.3	29.39	24.1	4.9	20.2	4.2	30.3	40.8	48.4	34.8	42.0
Molise	13.4	29.97	27	10.1	22.9	4.8	22.7	43.3	50.3	37.0	43.6
Piemonte	8	38.74	24.2	5.3	18.7	4.0	38	44.4	52.6	38.1	46.1
Province of Bolzano	7.6	12.84	23.9	4.5	15.6	2.1	48.8	37.8	49.1	32.1	43.2
Province of Trento	7.9	19.73	25.5	4.7	18.5	3.4	32.1	38.0	46.4	32.2	40.2
Puglia	12.4	47.11	25.4	4.0	20.0	5.5	43.6	48.6	56.1	42.1	49.6
Sardegna	10.1	30.69	27	8.4	20.8	5.5	45	46.2	56.4	39.8	49.9
Sicilia	13.3	45.31	28.5	6.3	21.0	6.4	39.4	49.2	56.7	42.6	50.1
Toscana	8.2	33.32	26	6.3	17.3	4.5	36.5	43.3	51.9	37.0	45.5
Umbria	10.2	25.36	30.3	8.2	20.8	4.3	33.3	43.2	51.7	36.9	45.2
Valle d'Aosta	9.6	27.77	25.2	5.7	17.2	3.0	38.9	42.0	50.8	35.9	44.5
Veneto	9.9	26.04	22.7	5.5	20.1	3.8	38.3	41.7	50.9	35.6	44.5
Italy	10.5	36.8	26.4	6.0	19.8	4.7	36.5	45.2	53.1	38.9	46.6
Communality, %	26.4	7.0	5.1	8.4	28.6	26.1	15.8				

Red: worse than national value. Yellow: similar to national value. Green: better than national value.

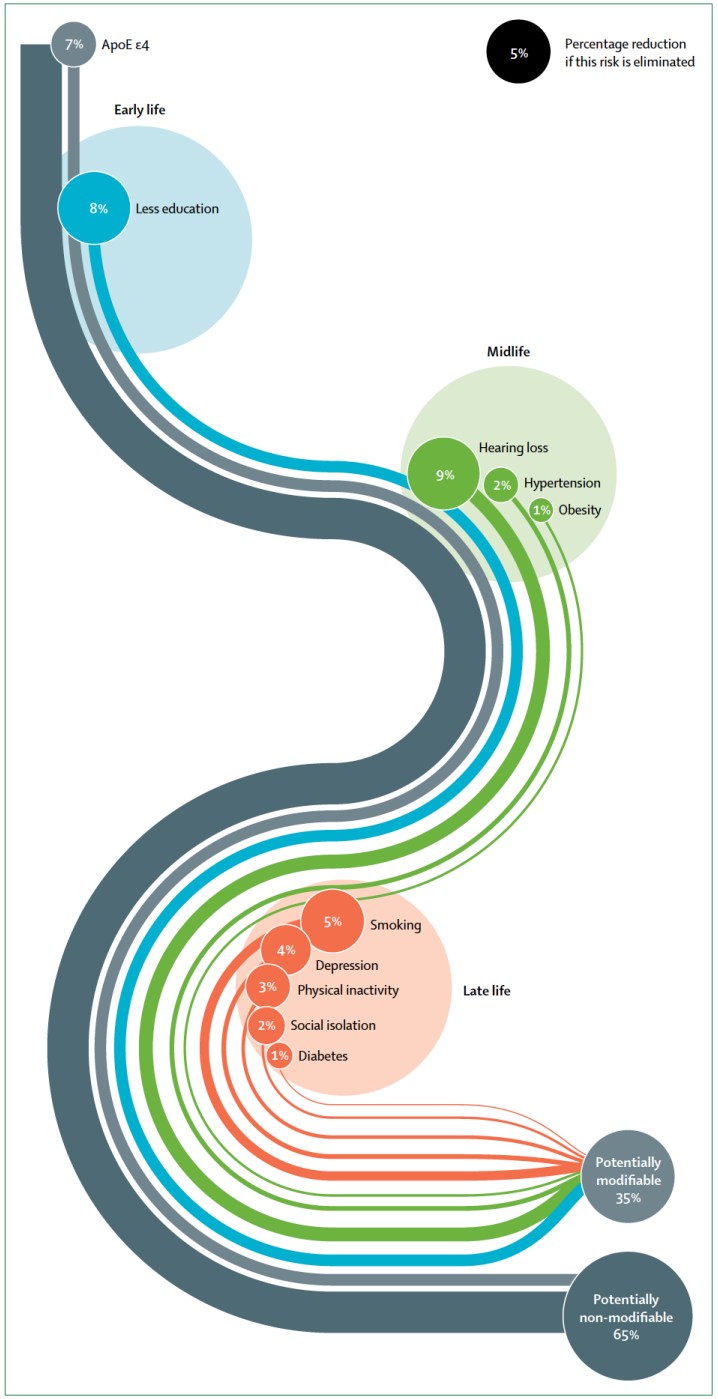
[a] Source of the PASSI study [10], time interval between 2013 and 2016.

Table 4: Number of prevalent cases of AD and VaD on January 1, 2016 in each Italian region either assuming no reduction in the distribution of risk factors, or assuming a 20% reduction in the distribution of risk factors.

Italian Regions	Resident population at January 1, 2016	AD			VaD		
		Prevalent cases at january 1, 2016	condidering a reduction of each risk factor by 20%		Prevalent cases at january 1, 2016	condidering a reduction of each risk factor by 20%	
			Prevalent cases	Reduction		Prevalent cases	Reduction
Abruzzo	1326513	15215	14247	-6.4%	4574	4277	-6.5%
Basilicata	573694	6231	5831	-6.4%	1879	1758	-6.5%
Calabria	1970521	19132	17878	-6.6%	5822	5433	-6.7%
Campania	5850850	45341	42327	-6.6%	13917	12988	-6.7%
Emilia Romagna	4448146	53310	49972	-6.3%	15946	14912	-6.5%
Friuli Venezia Giulia	1221218	15257	14315	-6.2%	4581	4287	-6.4%
Lazio	5888472	57529	53919	-6.3%	17457	16319	-6.5%
Liguria	1571053	22909	21497	-6.2%	6816	6376	-6.5%
Lombardia	10008349	102578	96501	-5.9%	31222	29246	-6.3%
Marche	1543752	19165	18007	-6.0%	5726	5362	-6.4%
Molise	312027	3813	3573	-6.3%	1137	1061	-6.7%
Piemonte	4404246	52641	49338	-6.3%	15971	14942	-6.4%
Province of Bolzano	520891	4701	4433	-5.7%	1428	1344	-5.9%
Province of Trento	538223	5643	5316	-5.8%	1685	1581	-6.2%
Puglia	4077166	38498	35987	-6.5%	11763	11000	-6.5%
Sardegna	1658138	16602	15528	-6.5%	5066	4736	-6.5%
Sicilia	5074261	46818	43727	-6.6%	14273	13324	-6.7%
Toscana	3744398	46566	43667	-6.2%	13965	13063	-6.5%
Umbria	891181	11333	10622	-6.3%	3384	3162	-6.5%
Valle D'Aosta	127329	1386	1301	-6.1%	420	394	-6.3%
Veneto	4915123	51472	48319	-6.1%	15581	14591	-6.4%
Italy	60665551	636141	595605	-6.4%	192616	180026	-6.5%

n=40536 n=12590

Idee



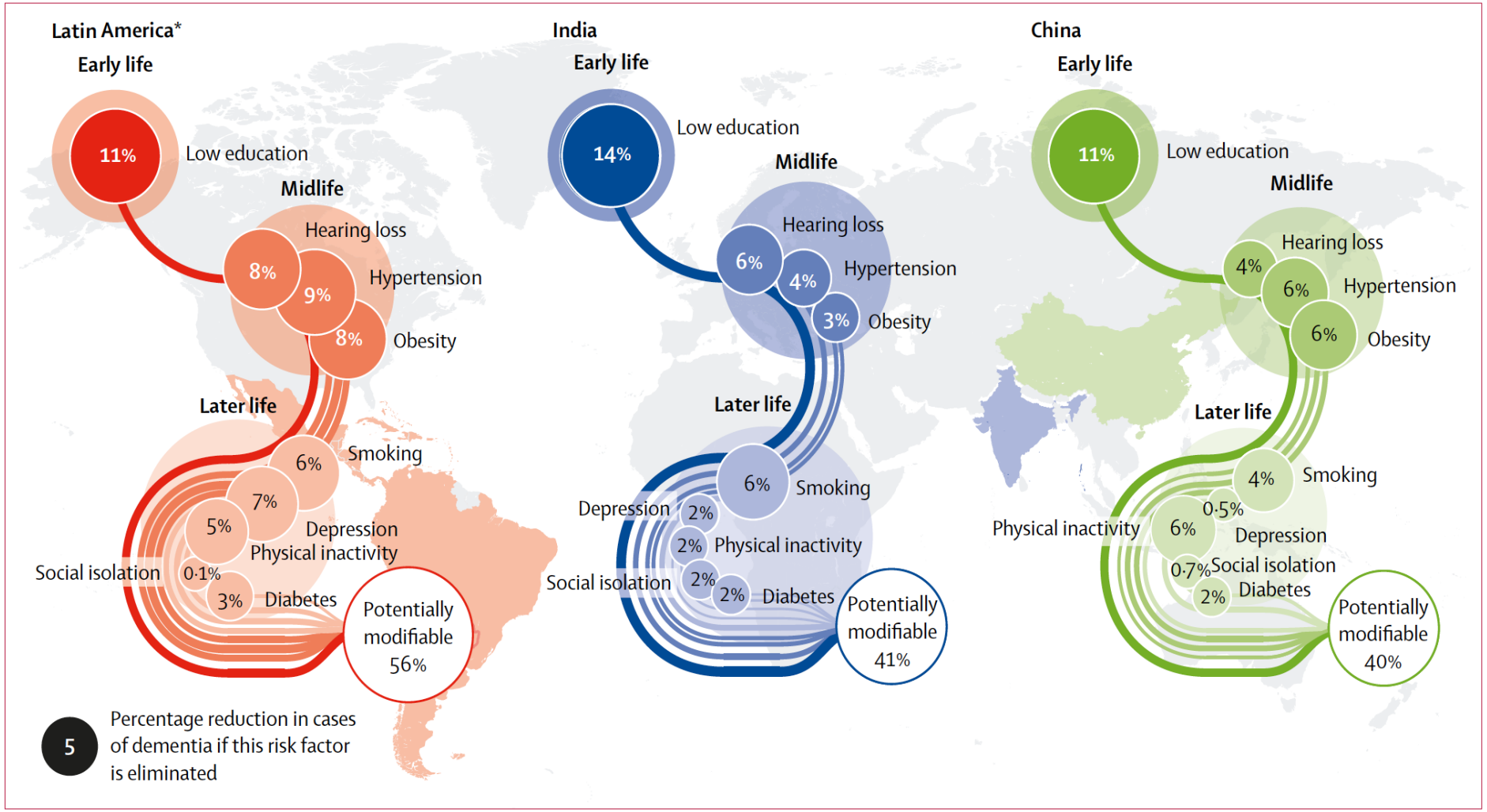
	Relative risk for dementia (95% CI)	Prevalence	Communality	PAF	Weighted PAF*
Early life (age <18 years)					
Less education (none or primary school only)	1·6 (1·26–2·01)	40·0%	64·6%	19·1%	7·5%
Midlife (age 45–65 years)					
Hypertension	1·6 (1·16–2·24)	8·9%	57·3%	5·1%	2·0%
Obesity	1·6 (1·34–1·92)	3·4%	60·4%	2·0%	0·8%
Hearing loss	1·9 (1·38–2·73)	31·7%	46·1%	23·0%	9·1%
Later life (age >65 years)					
Smoking	1·6 (1·15–2·20)	27·4%	51·1%	13·9%	5·5%
Depression	1·9 (1·55–2·33)	13·2%	58·6%	10·1%	4·0%
Physical inactivity	1·4 (1·16–1·67)	17·7%	26·6%	6·5%	2·6%
Social isolation	1·6 (1·32–1·85)	11·0%	45·9%	5·9%	2·3%
Diabetes	1·5 (1·33–1·79)	6·4%	70·3%	3·2%	1·2%

Data are relative risk (95% CI) or %. Total weighted PAF adjusted for communality=35·0%. PAF=population attributable fraction. *Weighted PAF is the relative contribution of each risk factor to the overall PAF when adjusted for communality.

Table 1: **Potentially modifiable risk factors for dementia**

Livingston G. Lancet. 2017;390(10113):2673-2734.

Idee



Mukadam M. Lancet Glob Health 2019;7:e596–603

nutrients

MDPI

DIETA MEDITERRANEA

Review

The Association between the Mediterranean Dietary Pattern and Cognitive Health: A Systematic Review

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Non-pharmacological treatments for sleep disturbance in mild cognitive impairment and dementia: A systematic review and meta-analysis

Rónán O'Caoimh[a,b,c,d,*], Helen Mannion[a], Duygu Sezgin[a], Mark R. O'Donovan[a], Aaron Liew[a], D. William Molloy[c]

Environmental Health

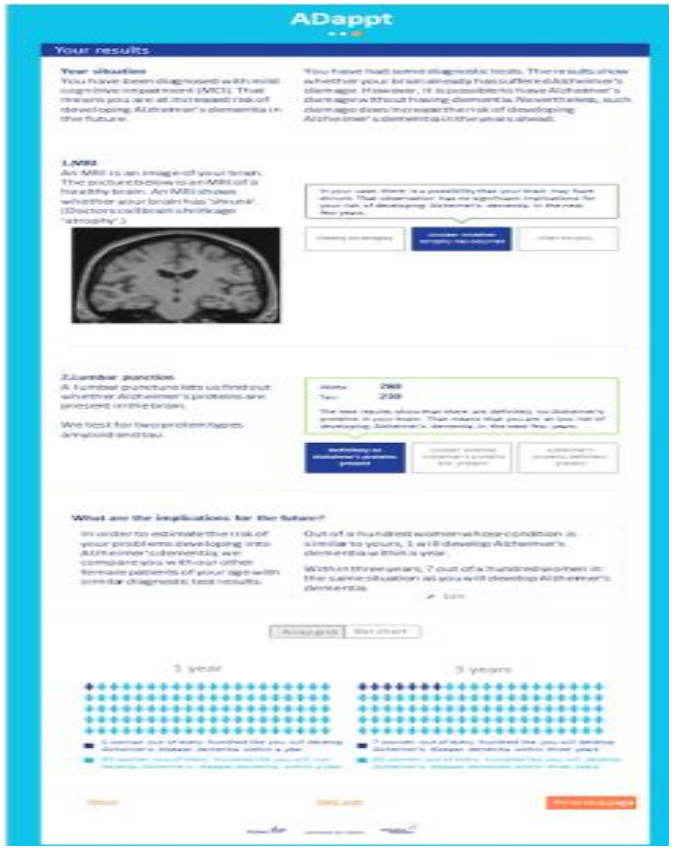
RESEARCH Open Access

INQUINAMENTO ATMOSFERICO

Long-term exposure to air pollution and hospitalization for dementia in the Rome longitudinal study

Francesco Cerza[1*], Matteo Renzi[1], Claudio Gariazzo[2], Marina Davoli[1], Paola Michelozzi[1], Francesco Forastiere[3,4] and Giulia Cesaroni[1]

ABIDE PROJECT
biomarcatori



Lifestyle for Brain Health (LIBRA)

RESEARCH ARTICLE

International Journal of Geriatric Psychiatry

Lifestyle for Brain Health (LIBRA): a new model for dementia prevention

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Table 1 Algorithm for calculating individual Lifestyle for Brain Health (LIBRA) score[a]

Modifiable risk factor	Relative risk (RR)	Ln (RR)/beta weight	Score	Available in MAAS
Low/moderate alcohol consumption	0.74	−0.30 (reference)	−1.0	+
Coronary heart disease	1.36	0.31	+1.0	+
Physical inactivity	1.39	0.33	+1.1	+
Renal dysfunction	1.39	0.33	+1.1	+
Diabetes	1.47	0.39	+1.3	+
High cholesterol	1.54	0.43	+1.4	+
Smoking	1.59	0.46	+1.5	+
Obesity	1.60	0.47	+1.6	+
Hypertension	1.61	0.48	+1.6	+
Mediterranean diet	0.60	0.51	+1.7	–
Depression	1.85	0.62	+2.1	+
High cognitive activity	0.38	−0.97	−3.2	+
Low unsaturated fat intake[b]	—	—	–	–

Note: Ln, natural logarithm; MAAS, Maastricht Ageing Study.
[a]LIBRA score represents the sum of the scores assigned to the individual risk factors.
[b]RR not available from meta-analyses.

Model 1: LIBRA score based on modifiable risk factors only. The LIBRA scores ranged from −4.2 (protective) to 9.2 (risk) with a mean of 1.5 and a standard deviation of 2.5 (Table 2). Individual risk scores dif-

Note: Values are presented as *n* (%), mean (SD), or median (range).
[a]*p*-value for the difference between participants with dementia and non-demented individuals.
[b]Model 1, Lifestyle for Brain Health (LIBRA) score (modifiable risk factors only); model 2, LIBRA score + education; model 3, LIBRA score + education, age, and sex.

DAL RISCHIO DI POPOLAZIONE A QUELLO INDIVIDUALE: CARTE DEL RISCHIO COGNITIVO ?

ARTICLES

Predicting risk of dementia in older adults

The late-life dementia risk index

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ABSTRACT

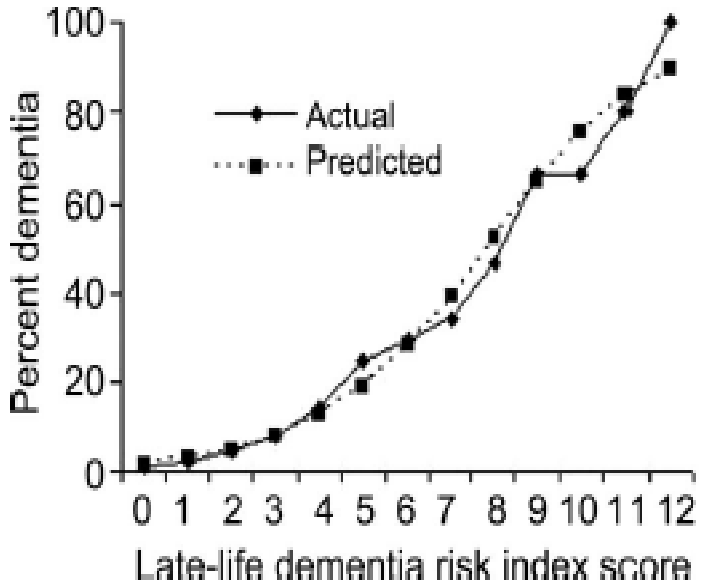
Objective: To develop a late-life dementia risk index that can accurately stratify older adults into those with a low, moderate, or high risk of developing dementia within 6 years.

Methods: Subjects were 3,375 participants in the Cardiovascular Health Cognition Study without evidence of dementia at baseline. We used logistic regression to identify those factors most predictive of developing incident dementia within 6 years and developed a point system based on the logistic regression coefficients.

Table 2 The late-life dementia risk index

Characteristic	Points
Age 75–79 y*	1
Age 80–100 y*	2
Low 3MS†	2
Low DSST†	2
BMI <18.5	2
≥1 APOE ε4 allele	1
MRI white matter disease (grade ≥3)	1
MRI enlarged ventricles (grade ≥4)	1
Internal carotid artery thickness ≥2.2 mm	1
History of coronary bypass surgery	1
Time to put on and button shirt >45 s	1
Lack of alcohol consumption	1
Possible range	0 to 15
c Statistic (95% CI)	0.81 (0.79–0.83)

Figure Calibration of the late-life dementia risk index



2 The architecture of diagnostic research

DAVID L SACKETT, R BRIAN HAYNES

NOMOGRAMMA DI FAGAN

However, if the patient has a different pretest likelihood, say 50%, then either the table must be reconstructed for this higher figure, or the pretest probability needs to be converted to a pretest odds (50% is a pretest odds of $(1-0.5)/0.5 = 1$), and then multiplied by the likelihood ratio for the test result (5.1 in this case), giving a post-test odds of 5.1, which then can be converted back into a post-test probability of $5.1/(1+5.1) = 84\%$. These calculations are rendered unnecessary by using a nomogram, as in Figure 2.1.

The Medical Literature

Users' Guides to the Medical Literature

III. How to Use an Article About a Diagnostic Test

B. What Are the Results and Will They Help Me in Caring for My Patients?

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for the Evidence-Based Medicine Working Group

INTERPRETAZIONE DEL RAPPORTO DI VEROSIMIGLIANZA*
(LR, *likelihood ratio*)

LR positivo: probabilità che il test sia positivo in persone malate rispetto alla probabilità che sia positivo in persone sane = sensibilità/ (1- specificità)
(più è elevato maggiore è la probabilità di malattia)
LR negativo: probabilità che il test sia negativo in persone malate rispetto alla probabilità che sia negativo in persone sane = (1- specificità)/ sensibilità
(più è basso minore è la probabilità di malattia)

LR positivo	LR negativo	Cambiamento della probabilità di malattia	Risultato
>10	<0.1	grande	conclusivo
5-10	0.1-0.2	moderato	moderatamente utile
2-5	0.2-0.5	piccolo	a volte utile
<2	>0.5	minimo	raramente utile
1	1	nessuno	non utile

(*) *Modificato da: Small-for-Gestational-Age Fetus, Investigation and Management. RCOG guideline n.31. RCOG: London, UK; 2002*

NOMOGRAMMA DI FAGAN

Pre test=50%

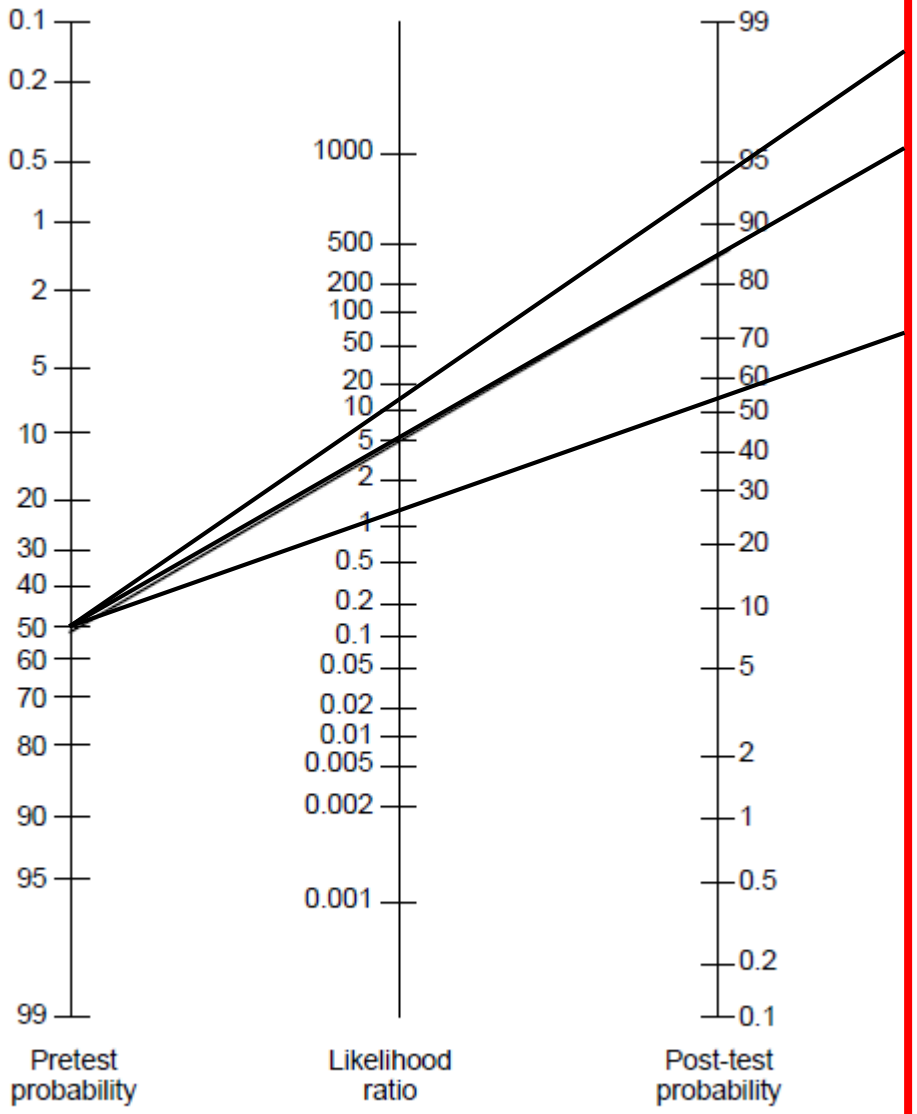

Figure 2.1 Nomogram for converting pretest likelihoods (left column) to post-test likelihoods (right column) by drawing a straight line from the pretest likelihood through the likelihood ratio for the test result.

LR =10 Post test = 92%

LR =5 Post test = 84%

LR =1 Post test = 55%

USO DEI NOMOGRAMMI NELL'AMBITO DELLA DEMENZA/MCI

Prediction Model of Conversion to Dementia Risk in Subjects with Amnestic Mild Cognitive Impairment: A Longitudinal, Multi-Center Clinic-Based Study

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[a]*Department of Neurology, Sungkyunkwan University School of Medicine, Samsung Medical Center, Seoul, Korea*

Table 1
Demographic and clinical characteristics of the subjects

	Model 1		Model 2	
	Training set (n=222)	Validation set (n=116)	Training set (n=167)	Validation set (n=75)
Age	71.4±7.3	71.8±7.4	71.5±7.3	71.6±7.6
Female, n (%)	141 (63.5)	80 (69.0)	109 (65.3)	53 (70.7)
Education				
≥9 y	129 (58.1)	64 (55.2)	103 (61.7)	46 (61.3)
BMI				
≥18.5 &<23	79 (35.6)	38 (32.8)	61 (36.5)	27 (36.0)
<18.5	11 (4.9)	7 (6.0)	9 (5.4)	6 (8.0)
≥23 &<25	61 (27.5)	31 (26.7)	43 (25.8)	22 (29.3)
≥25	71 (32.0)	40 (34.5)	54 (32.3)	20 (26.7)
aMCI type, n (%)				
Modality				
Visual	42 (23.4)	22 (19.0)	40 (23.9)	14 (18.7)
Verbal	45 (26.1)	30 (25.9)	20 (23.9)	18 (24.0)
Both	135 (50.5)	64 (55.2)	87 (52.1)	43 (57.3)
Severity				
Early stage	57 (25.7)	32 (27.6)	41 (24.5)	18 (24.0)
Late stage	165 (74.3)	84 (72.4)	126 (75.5)	57 (76.0)
Multiplicity				
Single	51 (24.8)	31 (26.7)	41 (24.5)	20 (26.7)
Multiple	174 (75.2)	85 (73.3)	126 (75.5)	55 (73.3)
APOE4				
Carrier	NA	NA	70 (41.9)	40 (53.33)
ADD conversion				
Yes	130 (58.6)	78 (67.2)	99 (59.3)	51 (68.0)

BMI, body mass index (kg/m^2); aMCI, amnestic mild cognitive impairment; ADD, Alzheimer's disease dementia.

Table 2
Multivariable analysis of clinical and neuropsychological factors associated with conversion to dementia

	Model 1		Model 2	
	OR (95% CI)	Points*	OR (95% CI)	Points*
Age	1.10 (1.05–1.15)	0–100	1.10 (1.05–1.16)	0–100
Modality				
Visual	Ref	0	Ref	0
Verbal	1.82 (0.79–4.21)	14	2.50 (0.77–8.10)	23
Both	4.30 (1.95–9.47)	35	6.21 (2.15–7.90)	47
Severity				
Early stage	Ref	0		
Late stage	2.15 (1.06–4.36)	18		
Multiplicity				
Single	Ref	0	Ref	0
Multiple	3.60 (1.78–7.29)	31	2.58 (1.11–6.01)	24
APOE4	NA			
Non-carrier			Ref	0
Carrier			4.71 (2.12–10.49)	40

*The total points made from the sum of each point indicate the overall risk score.

Jang et al 2017

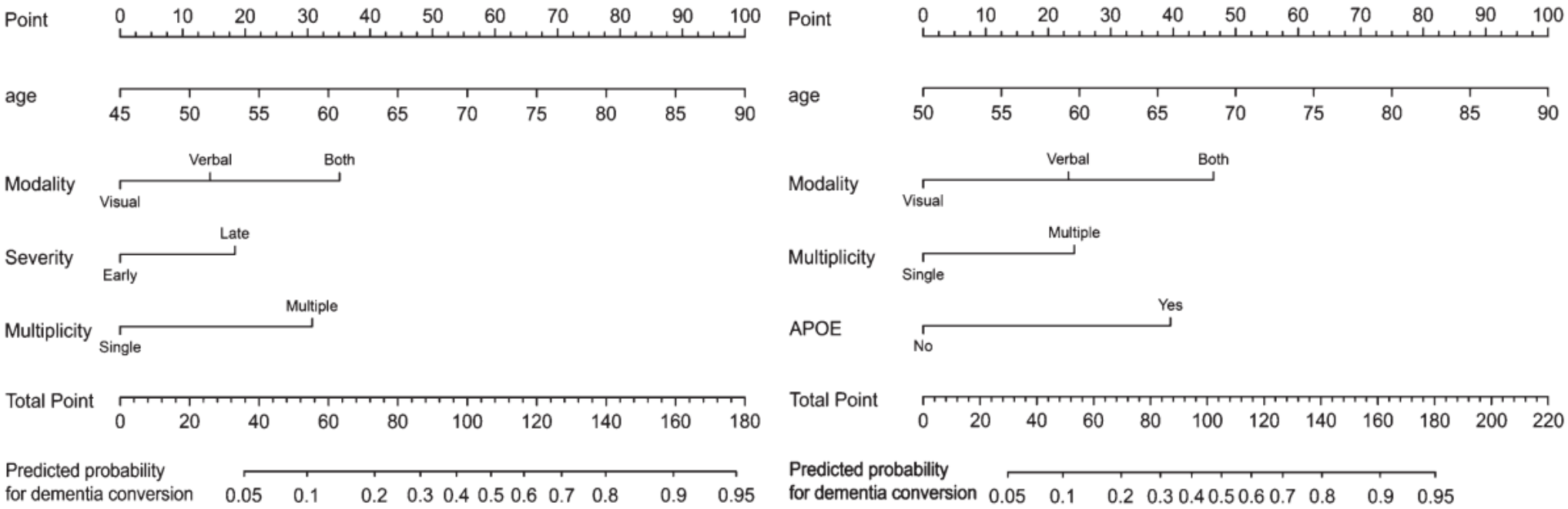
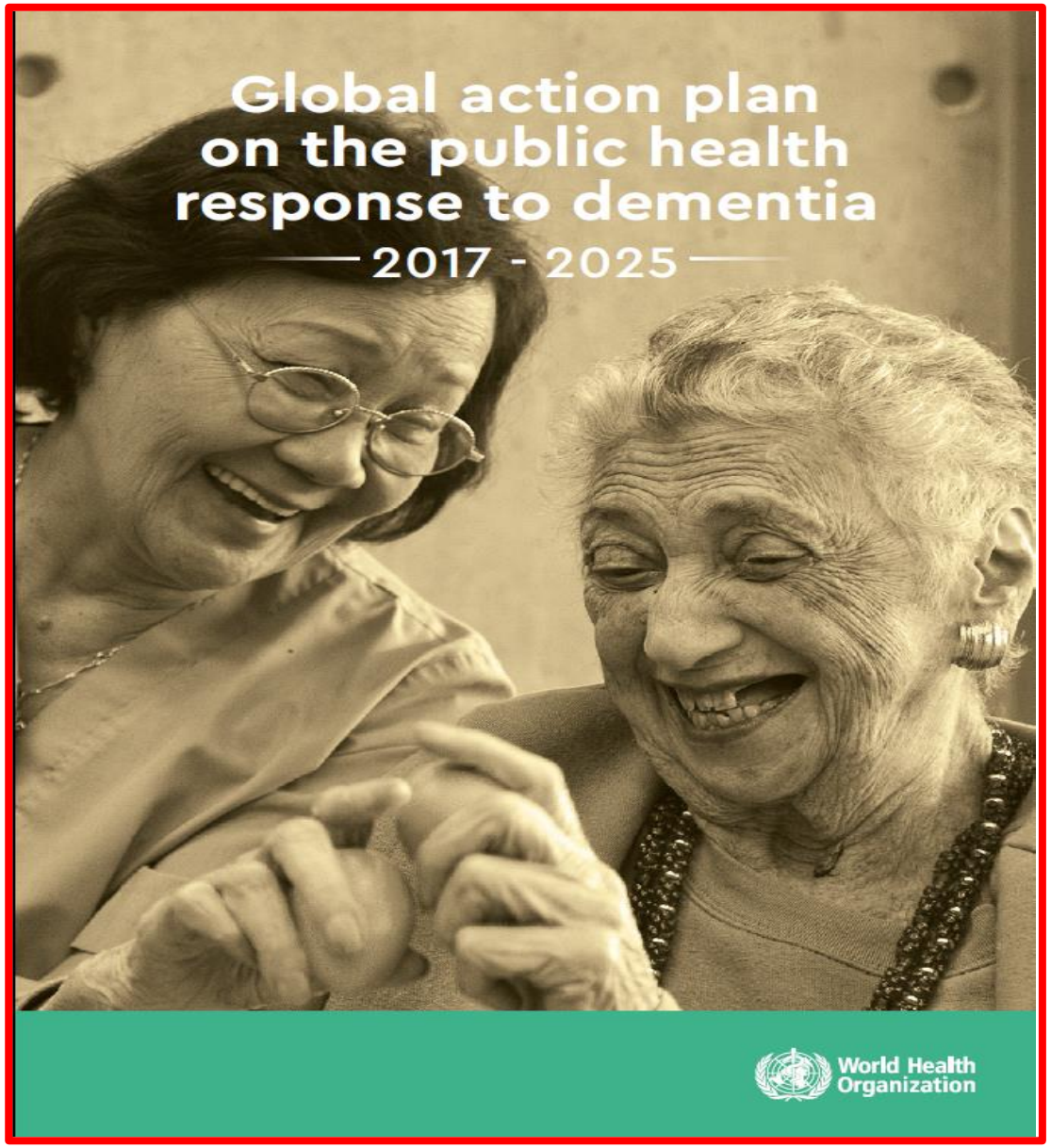


Fig. 1. Nomogram.

Table 3
Risk of dementia conversion for low, intermediate and high-risk individuals according to the dementia risk score

	Low risk profile	Intermediate risk profile	High risk profile
Risk score	0	107	184
Age	45 years	65 years	90 years
Visual/Verbal/Both aMCI	Visual aMCI	Verbal aMCI	Both aMCI
Early versus Late stage aMCI	Early stage aMCI	Late stage aMCI	Late stage aMCI
Single versus Multiple aMCI	Single aMCI	Multiple aMCI	Multiple aMCI
Risk of dementia	<5%	50%	>95%

3. DOCUMENTI NAZIONALI ED INTERNAZIONALI DI RIFERIMENTO



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Action areas

15. **The global action plan comprises seven action areas,** which form the underlying structural framework:

1 Dementia as a public health priority

2 Dementia awareness and friendliness

3 Dementia risk reduction

4 Dementia diagnosis, treatment, care and support

5 Support for dementia carers

6 Information systems for dementia

7 Dementia research and innovation

RISK REDUCTION OF COGNITIVE DECLINE AND DEMENTIA

WHO GUIDELINES

EVIDENCE PROFILES

Physical activity interventions
Tobacco cessation interventions
Nutritional interventions
Interventions for alcohol use disorder
Cognitive interventions
Social activity
Weight management
Management of hypertension
Management of diabetes
Management of dyslipidaemia
Management of depression
Management of hearing loss

World Health Organization

GUIDELINE DEVELOPMENT METHODS

The process of development of these guidelines followed the *WHO handbook for guideline development* and involved:

1) recruitment of the guideline development group (GDG);
2) declaration of interest by GDG members and peer reviewers;
3) scoping review to formulate questions and select outcomes;
4) identification, appraisal and synthesis of available evidence;
5) formulation of recommendations with inputs from a wide range of stakeholders; and
6) preparation of documents and plans for dissemination.

The GDG, an international group of experts, provided input into the scope of the guidelines and assisted the steering group in developing the key questions. A total of 12 PICO (population, intervention, comparison and outcome) questions were developed.

To address the PICO questions, a series of searches for systematic reviews was conducted and Grading of Recommendations Assessment, Development and Evaluation (GRADE) evidence profiles prepared. During a meeting at WHO headquarters in Geneva, 2–3 July 2018, the GDG discussed the evidence, sought clarifications and interpreted the findings in order to develop recommendations. The GDG considered the balance of benefit and harm of each intervention; values and preferences; costs and resource use; and other relevant practical issues for providers in LMIC.

When making a strong recommendation, the GDG was confident that the desirable effects of the intervention outweigh any undesirable effects. When the GDG was uncertain about the balance between the desirable and undesirable effects, the GDG issued a conditional recommendation. **Strong recommendations** imply that most individuals would want the intervention and should receive it, while **conditional recommendations** imply that different choices may be appropriate for individual patients and they may require assistance at arriving at management decisions. The GDG members reached a unanimous agreement on all the recommendations and ratings.

Physical activity interventions	Physical activity should be recommended to adults with normal cognition to reduce the risk of cognitive decline. *Quality of evidence: moderate* *Strength of the recommendation: strong*
	Physical activity may be recommended to adults with mild cognitive impairment to reduce the risk of cognitive decline. *Quality of evidence: low* *Strength of the recommendation: conditional*
Tobacco cessation interventions	Interventions for tobacco cessation should be offered to adults who use tobacco since they may reduce the risk of cognitive decline and dementia in addition to other health benefits. *Quality of evidence: low* *Strength of the recommendation: strong*
Nutritional interventions	The Mediterranean-like diet may be recommended to adults with normal cognition and mild cognitive impairment to reduce the risk of cognitive decline and/or dementia. *Quality of evidence: moderate* *Strength of the recommendation: conditional*
	A healthy, balanced diet should be recommended to all adults based on WHO recommendations on healthy diet. *Quality of evidence: low to high (for different dietary components)* *Strength of the recommendation: conditional*
	Vitamins B and E, polyunsaturated fatty acids and multi-complex supplementation should not be recommended to reduce the risk of cognitive decline and/or dementia. *Quality of evidence: moderate* *Strength of the recommendation: strong*

Interventions for alcohol use disorder	Interventions aimed at reducing or ceasing hazardous and harmful drinking should be offered to adults with normal cognition and mild cognitive impairment to reduce the risk of cognitive decline and/or dementia in addition to other health benefits. *Quality of evidence: moderate (for observational evidence)* *Strength of the recommendation: conditional*
Cognitive interventions	Cognitive training may be offered to older adults with normal cognition and with mild cognitive impairment to reduce the risk of cognitive decline and/or dementia. *Quality of evidence: very low to low* *Strength of the recommendation: conditional*
Social activity	There is insufficient evidence for social activity and reduction of risk of cognitive decline/dementia.
	Social participation and social support are strongly connected to good health and well-being throughout life and social inclusion should be supported over the life-course.

Weight management	Interventions for mid-life overweight and/or obesity may be offered to reduce the risk of cognitive decline and/or dementia. *Quality of evidence: low to moderate* *Strength of the recommendation: conditional*
Management of hypertension	Management of hypertension should be offered to adults with hypertension according to existing WHO guidelines. *Quality of evidence: low to high (for different interventions)* *Strength of the recommendation: strong*
	Management of hypertension may be offered to adults with hypertension to reduce the risk of cognitive decline and/or dementia. *Quality of evidence: very low (in relation to dementia outcomes)* *Strength of the recommendation: conditional*
Management of diabetes mellitus	The management of diabetes in the form of medications and/or lifestyle interventions should be offered to adults with diabetes according to existing WHO guidelines. *Quality of evidence: very low to moderate (for different interventions)* *Strength of the recommendation: strong*
	The management of diabetes may be offered to adults with diabetes to reduce the risk of cognitive decline and/or dementia. *Quality of evidence: very low* *Strength of the recommendation: conditional*

Management of dyslipidaemia	Management of dyslipidaemia at mid-life may be offered to reduce the risk of cognitive decline and dementia. *Quality of evidence: low* *Strength of the recommendation: conditional*
Management of depression	There is currently insufficient evidence to recommend the use of antidepressant medicines for reducing the risk of cognitive decline and/or dementia.
	The management of depression in the form of antidepressants and/or psychological interventions should be provided to adults with depression according to existing WHO mhGAP guidelines.
Management of hearing loss	There is insufficient evidence to recommend use of hearing aids to reduce the risk of cognitive decline and/or dementia.
	Screening followed by provision of hearing aids should be offered to older people for timely identification and management of hearing loss as recommended in the WHO ICOPE guidelines.

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CONFERENZA UNIFICATA

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LA CONFERENZA UNIFICATA

Nell'odierna seduta del 30 ottobre 2014:

ALLEGATO *A)*

PIANO NAZIONALE DEMENZE — STRATEGIE PER LA PROMOZIONE ED IL MIGLIORAMENTO DELLA QUALITÀ E DELL'APPROPRIATEZZA DEGLI INTERVENTI ASSISTENZIALI NEL SETTORE DELLE DEMENZE

OBIETTIVO 3
Implementazione di strategie ed interventi per l'appropriatezza delle cure

Obiettivo 3: Implementazione di strategie ed interventi per l'appropriatezza delle cure

- Migliorare la capacità del SSN nell'erogare e monitorare i Servizi, attraverso l'individuazione e l'attuazione di strategie che perseguano la razionalizzazione dell'offerta e che utilizzino metodologie di lavoro basate soprattutto sull'appropriatezza delle prestazioni erogate

- Migliorare la qualità dell'assistenza delle persone con demenza al proprio domicilio, presso le strutture residenziali e semiresidenziali e in tutte le fasi di malattia
- Promuovere l'appropriatezza nell'uso dei farmaci, delle tecnologie e degli interventi psico-sociali

ALLEGATO *A)*

PIANO NAZIONALE DEMENZE — STRATEGIE PER LA PROMOZIONE ED IL MIGLIORAMENTO DELLA QUALITÀ E DELL'APPROPRIATEZZA DEGLI INTERVENTI ASSISTENZIALI NEL SETTORE DELLE DEMENZE

Azioni:

3.1 Sviluppo di Linee Guida e documenti di consenso:

3.1.1 Sviluppo delle Linee Guida (LG) che si rendano necessarie nel panorama della promozione di corrette pratiche preventive e clinico-assistenziali basate sulle evidenze scientifiche, con attenzione alle aree di particolare criticità;

3.1.2 Elaborazione di tali LG nell'ambito del Sistema nazionale linee guida (SNLG), con il coinvolgimento di tutti gli attori istituzionali (Ministero della salute, Istituto Superiore di sanità, Regioni, AGENAS) e la collaborazione delle maggiori Associazioni di pazienti e familiari e delle principali Società scientifiche;

3.1.3 Monitoraggio della diffusione e dell'implementazione delle LG, nonché dell'aderenza ad esse, effettuato a livello regionale attraverso l'uso di indicatori condivisi;

3.1.4 Formulazione e approvazione di ulteriori documenti di consenso che, pur non configurandosi come LG perché pertinenti ad aree di maggiore incertezza, siano comunque ritenuti utili strumenti di appropriatezza e qualità;

MINISTERO DELLA SALUTE

DECRETO 27 febbraio 2018.

Istituzione del Sistema Nazionale Linee Guida (SNLG).

IL MINISTRO DELLA SALUTE

salute», con specifico riferimento all'art. 11, comma 1, lettera *a)*;

Ritenuto, pertanto, di provvedere, ai sensi del predetto art. 5, comma 3, all'individuazione dei compiti e delle funzioni del Sistema nazionale per le linee guida (SNLG);

Acquisita l'Intesa in sede di Conferenza permanente per i rapporti tra lo Stato, le regioni e le province auto-

1. Disturbi dello spettro autistico
2. Disturbi specifici dell'apprendimento
3. Gravidanza fisiologica
4. HIV/AIDS
5. Insufficienza Renale
6. Malattia di Parkinson
7. Psoriasi
8. Taglio Cesareo
9. Antimicrobial stewardship
10. Bronchite cronica ostruttiva
11. Cardiopatia ischemica
12. Demenza
13. Diabete
14. Frattura di femore
15. Infezioni correlate all'assistenza
16. Ipertensione arteriosa
17. Malattie cerebrovascolari
18. Obesità
19. Scompenso cardiaco
20. Trauma maggiore
21. Neoplasie: colon, mammella, stomaco, pancreas, polmone
22. Vaccinazione operatori sanitari

Box 1: Tematiche prioritarie per LG SNLG stabilite dal Comitato Strategico SNLG

Giornale Italiano di Nefrologia

Un primo bilancio per il Sistema Nazionale Linee Guida

Editoriali

Primiano Iannone, Daniela Coclite, Antonello Napoletano, Alice Fauci, Giuseppe Graziano, Laura Iacorossi, Daniela D'Angelo

Centro Nazionale Eccellenza Clinica, Qualità e Sicurezza delle Cure (CNEC), Istituto Superiore di Sanità

evidence
open access journal published by the GIMBE Foundation

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Best Practice OPEN ACCESS

Linee guida per la diagnosi, il trattamento e il supporto dei pazienti affetti da demenza

Antonino Cartabellotta[1*], Roberto Eleopra[2], Simone Quintana[3], Luca Pingani[4], Carlo Ferrarese[5], Fabrizio Starace[6], Marco Masina[7], Gianluigi Mancardi[8]

[1]Medico, Fondazione GIMBE, [2]Medico, Fondazione IRCCS Istituto Neurologico Carlo Besta, [3]Medico, Scuola di Specializzazione in Neurologia, Università di Parma, [4]Tecnico della riabilitazione psichiatrica, Azienda USL di Reggio Emilia, [5]Medico, Università degli Studi di Milano Bicocca, [6]Medico Azienda USL di Modena, [7]Medico, Azienda USL di Bologna, [8]Medico, Università degli Studi di Genova

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***Disclaimer*. I Le LG internazionali non sono assimilabili alla LG SNLG ai fini della L. 24/2017 in quanto non elaborate dai soggetti ex art 5 comma 1. Inoltre pur provenendo, da fonti alto livello scientifico, tali LG possono tuttavia , contenere raccomandazioni e consigli clinici non direttamente applicabili al contesto sanitario italiano e/o non compatibili con le disposizioni di legge, i regolamenti degli ordini professionali o i provvedimenti delle agenzie regolatorie italiane.**

Pertanto, i lettori sono invitati a considerare attentamente questa eventualità e a verificare la possibilità di adottare o adattare le raccomandazioni al contesto nazionale

Piano Nazionale Demenze

PRESIDENZA
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LA CONFERENZA UNIFICATA

Nell'odierna seduta del 30 ottobre 2014:

OBIETTIVO 1
Interventi e misure di Politica sanitaria e socio-sanitaria

Azioni:

1.1. Promozione di strategie per la prevenzione primaria e secondaria;

I PIANI NAZIONALI DEMENZA

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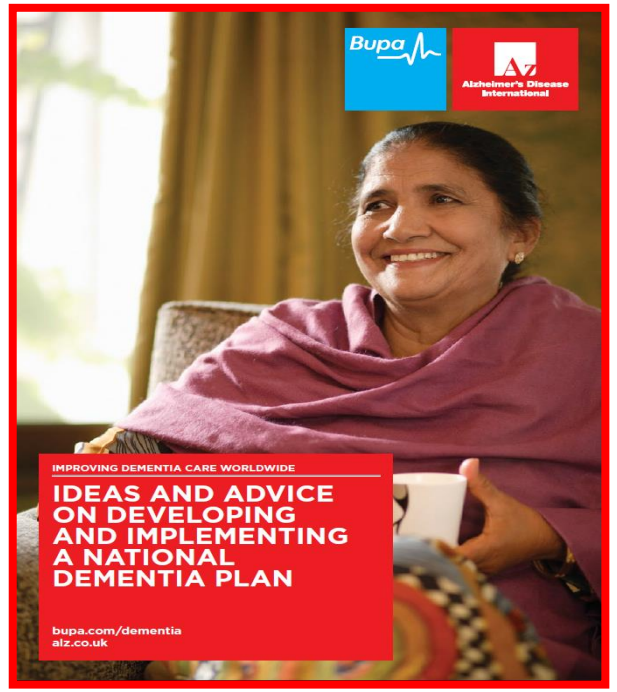
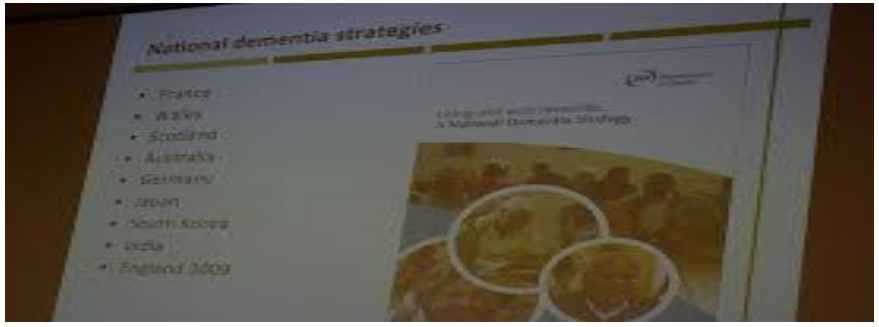
LA CONFERENZA UNIFICATA

Nell'odierna seduta del 30 ottobre 2014:





Appello al ministero dalla Federazione Alzheimer Italia: si finanzi il piano nazionale demenze

Al 14 novembre hanno firmato 116.000 persone

Piano Nazionale della Prevenzione

All'attuale rilevante peso epidemiologico, sociale ed economico delle malattie croniche, peraltro, si deve aggiungere la previsione di aumento nei prossimi anni legata all'innalzamento dell'età media della popolazione e all'incremento della popolazione globale. Si stima che nel 2050 la numerosità delle persone di età superiore ai 60 anni sarà globalmente intorno ai 2 miliardi. L'invecchiamento della popolazione sta celermente procedendo non solo nei Paesi ad alto reddito, ma anche in quelli a medio e basso reddito. Un effetto negativo di tale fenomeno è costituito dall'aumento della disabilità legata a malattie croniche non trasmissibili e del numero di soggetti con ridotta autonomia, scarsa inclusione sociale e minore partecipazione alla vita attiva. Inoltre, al crescere dell'età risulta crescere in modo esponenziale il numero delle persone affette da demenza.

Finanziamento

un apposito finanziamento (complessivamente, 440 milioni, di cui 240 quale "vincolo d'uso" sulla quota del riparto CIPE destinata al raggiungimento degli obiettivi dal Piano sanitario nazionale – ai sensi dell'articolo 1, comma 34, della legge 27 dicembre 1992, n. 662 - e i restanti 200 derivanti dalla quota indistinta del fondo sanitario regionale);