Alzheimer’s: A Rapidly Escalating Epidemic That Requires Greater Federal Funding — Now

Earlier this year, I wrote about the National Alzheimer’s Project Act (NAPA) as a historic legislative victory for the Alzheimer’s cause in the U.S. NAPA provides a national strategic plan to address and overcome the rapidly increasing crisis of Alzheimer’s. However, there are no appropriations authorized within the act. The fact is that for every dollar spent on Alzheimer’s care, less than a penny is invested in finding a cure. This seems senseless.

Our country and our government need to increase the investment in Alzheimer’s research just as we have done for other diseases with significant success. Federal funding for cancer research is about $6 billion annually; cardiovascular disease research is $4 billion annually; and HIV/AIDS research is about $3 billion each year. The federal budget for AD research is merely $480 million annually.

Research on Alzheimer’s and Movement Disorders Center
Recipient Announced

In the field of AD research just as we have done for other diseases with significant success. Federal funding for cancer research is about $6 billion annually; cardiovascular disease research is $4 billion annually; and HIV/AIDS research is about $3 billion each year. The federal budget for AD research is merely $480 million annually. Research on Alzheimer’s and Parkinson’s diseases consumes less than 2 percent of the entire National Institutes of Health (NIH) budget.

Chronic Underinvestment Delays Progress

Chronic underinvestment and fiat federal funding for research is leaving promising investigation unfunded and delaying scientific progress. Experienced researchers and promising new investigators are leaving the field of AD research and moving to better-funded programs.

Yet, I believe there is promise and hope within reach. Alzheimer’s research within our Center of Excellence on Brain Aging and other institutions is producing groundbreaking discoveries that offer new possibilities. I am confident that we will be able to prevent this disease, but not without more research and a stronger financial commitment from Congress, supporting both small and large-scale studies. Basic researchers need funding to continue their work to understand the cellular mechanisms involved in the development of Alzheimer’s and find therapeutic ways to prevent the neuronal damage associated with the disease.

We need additional funding to carry out large scale, controlled, clinical trials — which can cost as much as $25 million and take three to five years — that will identify therapies and treatments capable of slowing or halting the onset and progression of Alzheimer’s.

Your Support Matters

If NAPA is to be more than symbolic, policy makers need to develop and put into effect a fiscally prudent plan to overcome Alzheimer’s. Though we have made significant strides in Alzheimer’s research, we never lose sight that there is still much work to be done.

We need your help; please voice your support for increased Alzheimer’s research funding.

Warm Regards,
Ralph A. Nixon, M.D., Ph.D.
Director
Center of Excellence on Brain Aging
New research reveals that lifestyle factors may play a significant role in protecting your brain as you age. It may be possible to reduce your risk of Alzheimer’s disease and other dementias by eating right, exercising, staying mentally and socially active, and keeping stress at bay. Though Dr. Galvin says we cannot stop the aging process, we can take measures, at any point in our lives, to age healthily. While these measures are not absolutely protective against Alzheimer’s disease, they make for reasonable choices.

1. **Stay Physically Active**
Physical activity is paramount as we age, for many reasons, especially cardiovascular health. Regular exercise increases blood flow to your entire body, including your brain. According to the Alzheimer’s Research & Prevention Foundation, physical exercise may reduce your risk of developing Alzheimer’s disease by fifty percent. Regular exercise can also slow further deterioration in those who have already started your risk of developing cognitive problems. If you’ve been inactive for a while, initiate exercise by adding more movement and balance and coordination into your day. Park at the far end of the parking lot, take the stairs, or walk around the block. For most healthy adults, Dr. Galvin and his team recommend 20 minutes of moderate aerobic activity, five times a week.

2. **Be Mentally Fit**
Offer, we hear the expression, “Use it or lose it.” This holds true especially as we age. Staying mentally active is an important strategy for protecting the brain from cognitive decline. Dr. Galvin recommends reading books/various sections of the newspaper, playing card games, solving riddles, learning a musical instrument, taking interest in a new hobby (e.g., gardening) and going to museums. Such activities may protect the brain perhaps by establishing “cognitive reserve” (the brain’s ability to operate effectively even when some function is disrupted, or the amount of damage that the brain can sustain before changes in cognition are evident). The more organized you are in your daily life, the less likely you are to forget things. Use a calendar, electronic planner or diary to help with daily tasks. Reserves a special place in your home to keep your wallet, keys, etc. so that there is less chance of loss.

3. **Be Engaged and Socialize**
Social interaction helps ward off depression and stress, both of which can contribute to memory loss. Look for opportunities to get together with loved ones, friends and others — especially if you live alone. When you’re invited to share a meal or attend an event, go! Dr. Galvin stresses social engagement as a key lifestyle factor and recommends going to sporting events, playing social games (e.g., bingo), taking trips, volunteering or doing unpaid community work, or participating in groups such as senior centers or social clubs. “Social networks are important as we age,” he says. “Besides our spouse and children it is important to have other friends that we see regularly that we feel close to and at ease with — friends we can discuss private matters with and can call upon for help.”

4. **Eat Healthy**
A heart-healthy diet may be as good for your brain as it is for your heart. Limiting saturated and trans fats is the most important step you can take to reduce your blood cholesterol and decrease risk of heart disease. Increase your intake of whole grains, fruits and vegetables. Select low-sodium foods, low-fat proteins (e.g., fish, lean cuts of meat) and enjoy smaller portions. Many researchers and clinicians believe in the Mediterranean diet as one way to keep Alzheimer’s at bay. This diet originated when a study was started in the 1950s to explore why some countries had lower rates of heart disease than others. Results showed that heart disease among inhabitants of the Mediterranean island of Crete was a small fraction of that in the United States. Researchers attributed much of the difference to the Cretan diet — one that was high in fruits, vegetables, legumes, grains, olive oil, and included more fish than red meat. The Mediterranean Diet is now being investigated for its possible role in Alzheimer’s prevention.

5. **Stop Smoking and Reduce Alcohol Intake**
Smoking and heavy drinking are two of the most preventable risk factors for AD. When you stop smoking, the brain benefits from improved circulation almost immediately, regardless of your age. However, brain changes from alcohol abuse can only be reversed in their early stages. Alcoholism is associated with extensive cognitive problems. Because alcohol’s effects on cognition, brain disorders, and brain chemistry share some features with Alzheimer’s effects on these three areas, it is plausible that alcohol use might also increase the risk of developing AD. It is best to reduce the level of alcohol. Dr. Galvin adds that an occasional glass of wine is certainly within healthy limits.

6. **Stay Focused and Organized**
You are responsible for your daily life, the less likely you are to forget things. Use a calendar, electronic planner or diary for important dates. Keep to-do lists. Reserve a special place in your home to keep your wallet, keys, etc. so that there is less chance of loss.

7. **Create Life Space**
Mounting evidence shows that a constricted “life space” (being housebound or socially isolated) is associated with increased risk of Alzheimer’s disease. Older adults whose life space is restricted to the home environment have a substantially increased risk of AD, according to a recent study published online in the American Journal of Geriatric Psychiatry. Dr. Galvin states that it is unclear why restricted life space is associated with a higher risk of developing Alzheimer’s, but he says that it may be an indicator of how actively we are engaging in our environment and challenging our brains. He recommends creating more “rooms” in our life to enjoy... whether they are areas in our neighborhoods, locations outside of town, or venturing to new places outside our comfort circle. “The idea is to keep our brains thinking... new environments challenge our cognitive abilities.”

8. **Reduce Stress**
Stress that is chronic or severe takes a heavy toll on the brain, leading to shrinkage in a key memory area of the brain known as the hippocampus, hampering nerve cell growth, therefore increasing your risk of Alzheimer’s disease and dementia. Dr. Galvin recommends nourishing your inner self with meditation or prayer; taking a walk in the park; enjoying a yoga class;... or simply relaxing in a warm bath.

9. **Control Type 2 Diabetes**
Diabetes and Alzheimer’s disease are connected in ways that still aren’t completely understood. While not all research confirms the connection, many studies indicate that people with diabetes — especially type 2 diabetes — are at higher risk of eventually developing Alzheimer’s disease. If you have type 2 diabetes, controlling your blood sugar is the first step to reducing your risk of Alzheimer’s disease.

10. **Get Plenty of Sleep**
Our brain needs regular, restful sleep in order to function at prime capacity. For most, this means eight hours of sleep per night. Sleep deprivation is linked with impaired ability to think, problem-solve, and process, store, and recall information. Deep sleep is critical for memory formation and retention. If you experience nightly sleep deprivation, you may be at greater risk of developing symptoms of Alzheimer’s disease.

Alzheimer’s disease is a disease of a lifetime; yet there are many ways to build a better brain as we age. If you’re concerned about memory loss — especially if memory loss impedes your ability to complete your routine activities — consult your doctor or call the Pearl Barlow Center (212.263.3210).
Clinical Trials Propel Medical Advancement

Clinical trials are research studies in which new methods and treatments — diagnostic procedures, drugs, and other therapies — are tested in research participants to determine if they are safe and effective to screen for, diagnose, treat or prevent a variety of diseases. Such trials help scientists answer a variety of questions about new methods and therapies: what diseases should they be used for? What doses are most effective? And which patients can benefit from them the most?

All Alzheimer’s drugs in use today were tested and made available to research participants/patients through clinical trials. Without these trials, there is little opportunity for a new treatment to emerge or for science to find a cure. Says Steven H. Ferris, Ph.D., Director of the Silberstein Alzheimer’s Institute’s Aging and Dementia Clinical Research Center (ADCRC), “Over the last 15 years, scientists have made enormous strides in understanding how Alzheimer’s disease affects the brain. Yet, the drugs available for the treatment of Alzheimer’s only improve the symptoms of the disease; they do not reduce the progression of irreversible damage to brain cells that causes clinical symptoms to worsen. Participation in clinical studies provides an opportunity to advance and accelerate medical research that contributes to the better health of future generations. We are all working towards the goal of finding ways to prevent or cure the disease, as well as bringing to market in the near future therapies and treatments that slow or stop the progression.”

Pioneering research at the COE’s Silberstein Alzheimer’s Institute and at other distinguished research institutions across the country promises to have a measurable impact on the lives of current and future Alzheimer’s patients. But a lack of volunteers for Alzheimer’s clinical trials is significantly impeding progress toward the development of new treatments. According to the Alzheimer’s Association, “Recruiting and retaining trial participants is now the greatest obstacle, other than funding, to developing the next generation of Alzheimer treatments.”

Presently, at the Silberstein Alzheimer’s Institute, a very active clinical trials program exists with eight trials in progress. The Institute’s trial study program is focused on developing and evaluating new drug treatments; novel imaging techniques for early diagnosis; and specialized assessments of behavioral problems and memory changes. The Institute’s studies also include non-pharmacological new treatments, as well as strategies that support and enhance the well-being of family caregivers of Alzheimer’s patients.

Dr. Ferris adds, “For those that may have concerns, it is important to note that a clinical trial is not the first step in the development of a new drug or treatment. In fact, it is one of the last.” Research and development generally begins in a laboratory. After extensive laboratory testing, researchers may test a promising drug or technique on animals. Later, a small group of volunteers willing to undergo experimental treatments take part in initial human studies to assess safety and dosing, and to provide an initial indication of possible benefit. Based on the results of these animal and early clinical studies, only promising drugs and treatments that have shown reasonable safety and initial efficacy are made available for larger clinical trials designed to confirm clinical effectiveness.

No matter how promising a new treatment looks when tested with lab animals, it cannot be used to treat people until it has been carefully evaluated through the several phases of clinical study. “Each clinical trial is unique, with its own potential benefits and risks. Before one decides to take part in a clinical trial, we encourage our research participants and their families to ask questions before entering into a study,” adds Dr. Ferris.

In addition to the trials available at the Silberstein Alzheimer’s Institute, the Alzheimer’s Association has developed a new program, TrialMatch, which is a clinical trial matching service, enabling people with Alzheimer’s, caregivers, families and physicians to locate clinical trials based on personal criteria (diagnosis, stage of disease) and location. More than 100 research studies pertaining to Alzheimer’s disease and related dementias are underway nationwide and recruiting volunteers.

To participate or inquire about clinical trials at the Silberstein Alzheimer’s Institute, please visit our website (www.aging.med.nyu.edu) or call our Clinical Trials Coordinator at 212-263-5708.

For more information on the Alzheimer’s Association TrialMatch program, please visit www.alz.org; or call the dedicated TrialMatch program phone number 1-800-272-3900.

Clinical Trials: What are some of the questions you may want to ask your doctor are:

- Why is this study being done?
- What are the risks/side effects of this treatment?
- Will I know if the treatment is working?
- What is the length of the study?
- How often will I need to come for check-ups?
- Who will guide my care during the length of the study?
- How much experience do you have with this particular treatment?
- Will I still be seeing my regular doctor?
- What costs are involved? Will my insurance cover these costs?
- Will I be able to find out the results of the study?
- If the treatment works, can I continue with it even after the study ends?
- If I am harmed as a result of the research, what treatment will I be entitled to?
- What are my options if I decide not to participate in a clinical trial?
An unknown disease appeared in New Guinea in the early 1900s. Decades later, anthropologists and government officials reported that the disease, termed kuru, was rampant amongst the South Fore people, an indigenous tribe. This specific community was practicing mortuary cannibalism, and this conduct was later held responsible for the transmission of the fatal kuru epidemic. This distinctive aspect of the neurodegenerative illness made it even more fascinating to Western researchers who devoted their time to concentrating on it. It was not until 1982 when scientists identified and defined a specific disorder, prion disease, that the riddle behind kuru was partially solved. Since then, prion (pronounced “pree-on”) diseases have gained much public attention as rare, progressive neurodegenerative disorders that affect both humans and animals.

Also known as transmissible spongiform encephalopathies (TSE), this group of diseases includes bovine spongiform encephalopathy (BSE, or “mad cow disease”) in cattle; Creutzfeldt-Jakob disease (CJD) in humans; scrapie in sheep; and chronic wasting disease (CWD) in deer and elk. In humans, prion diseases are rapidly progressive, universally fatal and there are no known treatments or cures. Creutzfeldt-Jakob Disease is the most common and there are three known types: 1) sporadic, or spontaneous; 2) familial, termed genetic or inherited; which is due to a defect in the prion protein gene; 3) and acquired, which is transmitted by infection due to exposure to the infectious prion from contaminated meat, or from surgical transplant of tissue contaminated with prion, or use of contaminated instruments during surgical procedures. Past experiences with mad cow disease and prion disease are rare, the transmission of this group of universally fatal diseases are our priority. Our results indicate that both passive and active immunization are highly effective at preventing disease and cognitive deficits in ruminants.

The hallmark of prion diseases is the presence of microscopic vacuolization of the brain tissue or spongiform degeneration (tissue deterioration leading to a spongiform texture) and an abnormal protein, called scrapie prion protein (PrPSc). As Dr. Wisniewski explains, “The prion protein induces abnormal folding of normal cellular prion proteins in the brain, leading to brain damage. Since the abnormal prion protein cannot be broken down through the body’s normal process, it aggregates mostly in the brain causing degeneration and disease.” As an infection takes hold, prion proteins invade brain tissue and convert normal prion protein to the infectious form. In time, the diseased animal or human develops dementia, loses control of its limbs, and eventually dies. In humans, depending on what part of the brain is affected, prion diseases impair brain function, causing memory changes, personality changes, a decline in intellectual function, and problems with movement. The average worldwide occurrence of prion diseases is approximately one case per million people per year.

Dr. Wisniewski’s research focuses on developing preventive and therapeutic approaches for prion diseases. He explains, “Since no effective treatment for prion diseases exists, therapeutic approaches for this group of universally fatal diseases are our priority. Our results indicate that both passive and active immunization are highly effective at preventing disease and cognitive deficits in ruminants.”

Presently, Dr. Wisniewski has various studies underway. If successful, these kinds of investigations will lead to safe and effective methods to prevent prion infections in humans and animals, as well as therapies that work in either the pre-symptomatic or symptomatic phases of disease. “The past decade has provided us with an increased understanding of prions and the disease itself, but research challenges remain — we need to fully understand the role of PrPc and accordingly develop reliable therapies,” added Dr. Wisniewski.

1 Active immunization: Active immunization introduces a foreign molecule into the body, which causes the body to react against the targeted. Vaccination is an active form of immunization.

2 Passive immunization: Passive immunization is where purified components of the normal immune system, such as antibodies, that can attack the target are transferred to a person so that the body does not need to produce these components itself. This method of immunization, normally administered by injection, begins to work very quickly, but it is short lasting. Example: Influenza.


About Thomas Wisniewski, M.D.
Professor of Neurology, Pathology and Psychiatry, and Director of the Conformational Disorders Laboratory at NYU Langone, Thomas M. Wisniewski, M.D., was recently appointed Scientific Associate Director of the Center of Excellence on Brain Aging. In this newly created position, Dr. Wisniewski will assist in the efforts to cultivate scientific innovation, building upon the Center’s steady progress; and further develop the CDE’s interdisciplinary science strategy focused on brain aging. His focus will be on advancing collaboration between basic, translational and clinical teams; supporting researchers with grant proposals; and providing mentorship and guidance to junior investigators.

Over the years, Dr. Wisniewski has played a key role in the advancement of research within the field of Alzheimer’s disease. He runs an active research laboratory focused on neurodegenerative disorders, in particular the mechanisms which drive amyloid deposition in Alzheimer’s and prion-related diseases. This work has led to more than 200 peer-reviewed publications. In recent years, his accomplishments in novel imaging methodologies for brain amyloid deposits have been of keen interest to the scientific community. An important aim of the Wisniewski lab has been to translate research findings into therapeutic interventions, including use of a vaccine approach for both prion and Alzheimer’s diseases.

Dr. Wisniewski obtained his M.D. at Kings College School of Medicine in the United Kingdom. He completed his Neurology and Neuropathology Residencies at NYU and Columbia-Presbyterian, respectively. He is a board certified Neurologist and Neuropathologist.

MRI of a sporadic Creutzfeldt-Jakob patient showing increased bright signal in areas of the brain highlighted by the arrows. These areas correspond microscopically to parts of the brain with extensive “spongiform change.” This is a change to the brain substance where numerous holes develop and neurons die, as seen in the picture on the right.
NYU Parkinson and Movement Disorders Center Receives Two Multi-Million Dollar Gifts

The COE’s Parkinson and Movement Disorders Center received recently two multi-million dollar gifts — a $2.25 million donation from a family foundation wishing to remain anonymous at this time. The Safra donation will be used to further Parkinson’s disease research and education, expand staff, and support the NYU/JCC Parkinson’s Wellness Program that has been in effect for four years, renaming it as the Edmond J. Safra Parkinson’s Wellness Program.

The second multi-million dollar gift will fund an endowed professorship and two fellowships, one clinical and another research-oriented. The first holder of this esteemed professorship is Dr. Di Rocco. The gift will provide funding for groundbreaking research studies and training of future generations of researchers and clinicians. “Our goal is to provide world-class cognitive, neuropsychological, and functional strength therapies to help improve the quality of life for patients with Parkinson’s disease and other movement disorders,” said Dr. Di Rocco. “These gifts will allow us to expand our research and clinical programs, and in so doing, build our practices.”

Did You Know?

Nearly 15 million family and friends provided 17 billion hours of unpaid care to those with Alzheimer’s and other dementias in 2010. Caregivers may want to consider options such as dedicated day care centers for adults with Alzheimer’s; respite care to give caregivers a break; and support groups to help caregivers deal with stress and depression.

- The economic value of the unpaid care provided to those with Alzheimer’s and other dementias totaled $202.6 billion.
- Because of the demands of caregiving on their own health, Alzheimer’s and dementia caregivers had $7.9 billion in additional health care costs.
- More than 60 percent of Alzheimer’s and dementia caregivers rate the emotional stress of caregiving as high or very high; one-third report symptoms of depression.

Source: Alzheimer’s Association, 2010 statistics
American Heart Association

Berry-Topped Pudding Pie

Reported at the Alzheimer's Association International Conference was an NYU Langone co-authored study that focused on former NFL football players to gain insight into how sports-related head injuries may impact risk for Alzheimer’s disease or late-life cognitive decline. Findings revealed that the retired athletes were at elevated risk for mild cognitive impairment (MCI), considered to be an intermediate stage between the expected cognitive decline in normal aging and that of the more pronounced decline of dementia.

The study compared the neurocognitive performances of the retired athletes to a healthy age- and education-matched control group (non-athlete males) and a clinic-based sample of patients with MCI. “Our research reveals that repetitive head trauma from several years of playing football may result in diminished brain reserve, and lead to the earlier expression of age-related neurodegenerative diseases such as MCI and Alzheimer’s,” said Stella Karantzoulis, Ph.D., co-author of the study, clinical neuropsychologist, the Pearl Barlow Center and Assistant Professor of Neurology at NYU Langone.

In 2001, all retired NFL players who belonged to the NFL Players’ Association (n = 3,729) were mailed a general health survey. In 2008, an additional survey specifically focusing on memory issues (including an Alzheimer’s screening questionnaire known as the AD8, developed by James E. Galvin, M.D., M.P.H., Director of the COE’s Pearl Barlow Center) was sent out to all players over age 50 who responded to the first survey. A total of 513 follow-up surveys were returned with the AD8 completed by both the former player and his spouse. The mean age of all the players who responded was 61. Just over 35 percent of respondents had an AD8 score that suggested possible dementia. By comparison, according to the Alzheimer’s Association 2011 Facts and Figures Report, of Americans ages 65 and over, 13 percent have Alzheimer’s.

The researchers used this follow-up survey data to identify former players with probable MCI. After additional telephone screening interviews to confirm likely cognitive change, eligible respondents underwent extensive neurocognitive testing. The researchers compared the neuropsychological test results for the former athletes to those of two other groups with no background playing professional sports: (1) demographically similar non-athletes on neurocognitive testing. When we compared the retired players to the MCI group, the profile of neurocognitive scores was highly similar, although the athletes were slightly less impaired overall. This is surprising given that the athletes were clearly impaired compared to the demographically similar non-athletes on neurocognitive testing. When we compared the retired players to the MCI group, the profile of neurocognitive scores was highly similar, although the athletes were slightly less impaired overall.

“We found that the former athletes were very preliminary and additional studies are necessary to confirm this conclusion,” she added.

Dr. Karantzoulis and colleagues plan to follow up with a larger trial that will attempt to establish the true risk of dementia-related disorders in retired players once other factors such as hypertension, obesity, and diabetes, each of which can contribute to MCI, are accounted for. The scientists will also look at genetic factors known to contribute to Alzheimer’s.

Often, the question is asked, will helmets help? Researchers say not in this case. Helmets can help prevent skull fracture, but with MCI-associated head trauma, the damage to the brain occurs within the skull. The force of a hit causes softer brain tissue to thrust and jam against the inside of the skull then settle back. The only way to prevent brain injury is to reduce the amount of violent contact to the head. That’s not possible during games, but it might be during practice.

In a recent press release, William H. Thies, M.D., Chief Medical and Scientific Officer of the Alzheimer’s Association, commented, “The relationship of brain and head injury to Alzheimer’s, and how those factors relate to and interact with other Alzheimer’s risk factors is a very interesting and important topic that deserves much more research attention.”

Note: Study co-authors: Randolph Christopher Ph.D., ABPP-CN, Clinical Professor of Neurology at Loyola University Medical Center; and Guskiewicz, Kevin M. Ph.D., ATC, Sports Medicine Research Laboratory, University of North Carolina, Chapel Hill.

Berry-Topped Pudding Pie

Serves: 8 / 1 slice per serving / Baking Time: 50 minutes / Cooling Time: 2 hours

Ingredients

- • Canola or corn oil for pie pan
- • 2 large egg whites
- • 1/2 teaspoon vanilla extract
- • 1/8 teaspoon cream of tartar
- • 1/8 teaspoon salt
- • 1/2 cup sugar
- • 3/4 cup walnuts or pecans, finely chopped
- • 1 small package fat-free, sugar-free instant lemon or vanilla pudding mix, prepared with 2 cups cold fat-free milk
- • 12 ounces fresh berries or other fruit, sliced if needed
- • 1/2 cup fat-free frozen whipped topping, thawed (optional)

...findings revealed that the retired athletes were at elevated risk for mild cognitive impairment...
Financial Planning: Essential Yet Often Overlooked

Inability to manage finances begins very early in people with Alzheimer’s disease. Studies show that individuals start having difficulty managing bank statements and paying bills in the pre-dementia phase — mild cognitive impairment — and then, often within a year, lose their capacity to understand the more basic financial skills, e.g., counting coins and making change.

“It is essential for people with Alzheimer’s and their family members to receive advice about financial planning during the early stage of the disease, while the person with dementia has the capacity to make decisions about who will manage finances in the future,” says Mary Mittelman, Dr. P.H. of the Center of Excellence on Brain Aging. Dr. Mittelman has been evaluating psychosocial interventions for family members of people with Alzheimer’s for more than two decades. She is Director of the Psychosocial Research and Support Program at the COE, and Research Professor in the Department of Psychiatry at NYU Langone Medical Center. She was the Principal Investigator of the NYU-Spouse Caregiver Intervention study, which was funded by the National Institutes of Health for more than two decades.

“Planning with appropriate experts during the early stage of dementia can help people diagnosed with Alzheimer’s and their families confront difficult and emotional questions about future treatment, caregiving, and financial and legal arrangements,” adds Dr. Mittelman. Physicians agree — patients newly diagnosed with Alzheimer’s disease and their families need to seek guidance early on in terms of how to plan for the patient’s progressive loss of ability to handle finances. “Too often, I’ve heard about families arguing about who will manage finances in the future,” remarks Dr. Mittelman.

Legal Terms You’ll Need to Know:

Will: Indicates how a person’s assets and estate will be distributed upon death.
Living Will: Records a person’s wishes for medical treatment near the end of life.
Power of Attorney: Gives a caregiver the authority to act on behalf of the older person.
Trust: Estate-planning document allows person to transfer assets and avoid probate and other legal problems.
Joint Ownership: Makes it easier to gain access to older person’s finances.
Representative Payee: A caregiver receives government checks for an older person unable to manage money.
Medigap Insurance: Pays portion of medical bills not covered by Medicare.

Nutrition Analysis Per Serving

| Calories | 169 |
| Total Fat | 6.5 g |
| Trans Fat | 0 g |
| Carbohydrates | 25 g |
| Fiber | 3 g |
| Sugar | 18 g |
| Protein | 5 g |

Source: American Heart Association. Recipe courtesy Alton Brown. Look for other healthy recipes in American Heart Association cookbooks or at www.heart.org/recipes

Cooking Instructions

Preheat the oven to 300°F. Pour a small amount of oil onto a paper towel and lightly wipe the bottom and side of an 8- or 9-inch pie pan.

In a large mixing bowl, using an electric mixer, beat the egg whites, vanilla, cream of tartar, and salt on medium speed until foamy. With the mixer still running, gradually add the sugar in a slow steady stream, until stiff peaks form. (The peaks shouldn’t fold over when the beater is lifted.) Very gently fold in 1/2 cup of the nuts.

Using a flexible spatula or rubber scraper, spread the meringue over the bottom and up the side of the pie pan and onto the lip of the pan, but not over the edge of the pan. Sprinkle the bottom of the pan with the remaining nuts.

Bake for 50 minutes, or until the meringue is firm and lightly browned. Transfer to a cooling rack and let cool completely, at least 2 hours.

Using the package directions, prepare the pudding. Spread over the cooled crust. Arrange the fruit decoratively over the pudding. Top with the whipped topping.

Note: In warm weather, meringues will get gummy after a few days, so it’s best to serve this dessert within 24 hours.

Nutrition Analysis Per Serving

| Calories Per Serving: | 169 |
| Total Fat: | 6.5 g |
| Trans Fat: | 0 g |
| Carbohydrates: | 25 g |
| Fiber: | 3 g |
| Sugar: | 18 g |
| Protein: | 5 g |

Source: American Heart Association. Recipe courtesy Alton Brown. Look for other healthy recipes in American Heart Association cookbooks or at www.heart.org/recipes
My father was recently diagnosed with Alzheimer’s. I’m conflicted in terms of whether or not I should tell him about his diagnosis?

Medical ethics requires that a patient is informed of his/her diagnosis — it is the individual’s moral and legal right to know of his medical condition. Research confirms that disclosure of a diagnosis of Alzheimer’s disease has no long lasting psychological effect on the patient. In fact, in many cases it has led to a reduction in anxiety and depression symptoms, not only in the patient but in the caregiver as well. My professional opinion is that unless there are unusual circumstances involved, the physician and medical care team should disclose the diagnosis to the individual. In some cases, patients have trouble absorbing all the information provided to them during the initial consultation; therefore, often, we suggest a follow-up meeting in order to obtain further information. Since I am not aware of your father’s medical history or stage of disease, I would offer the following advice in general terms: disclosing the diagnosis early in the disease process allows him to maximize his quality of life and play an active role in planning for his future, including discussing future care options, considering whether or not to participate in research, and writing an advance directive or living will.

Be sensitive to your father’s feelings and emotions as the response to this knowledge may vary from acceptance of what he may have suspected and possibly relief in learning of his medical diagnosis to denial or depression. Let your father know how much you love him; that you will care for him; and that you will always be open to talking with him about his disease and treatment plan. My last bit of advice would be to seek help for yourself. Whether or not you are the primary caregiver, family members of Alzheimer’s patients often experience high levels of emotional stress and depression. The road ahead will be challenging at times and I would therefore stress the importance of having resources and support to help you through the journey.

NYU Langone Medical Center
Center of Excellence on Brain Aging
145 East 32nd Street, 2nd & 5th Floors
New York, NY 10016
T: 212.263.0731
E: aging@nyumc.org
W: http://aging.med.nyu.edu/

Editorial Staff
Camy Sleeman, Editor in Chief/Copy Editor
Daniel Raabe, Art Director
Alic Freund, Editorial Associate

© 2011 NYU Langone Medical Center

Letters to the Editor: We encourage you to write to us — voice your comments and feedback on articles you have read in our newsletters. We will select a few for publication in each issue. Letters may be submitted via email to camy.sleeman@nyumc.org. We reserve the right to edit letters for length.

Your Involvement Matters
We, at the Center of Excellence on Brain Aging, are committed to defeating Alzheimer’s disease, Parkinson’s disease and other neurodegenerative cognitive disorders. We hope you will join us in this endeavor and therefore we ask for your help. Please get involved, either through a philanthropic donation, clinical trial, volunteering of time or services, or organ donation. Your involvement today can benefit the lives of many for years to come.

For more information or financial planning for gifts and bequests, please contact: Alic Freund at 212.263.2615.