Public health planning for dementia must start now

For many families around the world, the difficulties and costs associated with dementia are painfully real. Yet in some countries governments and policymakers remain in denial about the urgent need to plan for a future in which dementia will be increasingly common. A report published by WHO on April 11, 2012, provides new data on the enormity of the current and future challenges and stresses the need for action to avert a dementia-related crisis. The report should serve as a wake-up call for governments and policy makers, but will they listen?

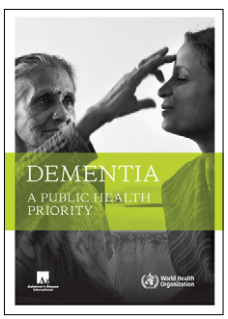
Dementia: a public health priority, the first report from WHO dedicated to dementia, was developed jointly with Alzheimer's Disease International (ADI), an umbrella organisation for more than 70 Alzheimer's associations. Data from previous reports were assessed by four international working groups and were combined with the results of a new survey of 30 countries. Overall, 35·6 million people were estimated to be living with dementia in 2010, with 7·7 million new cases each year; 115·4 million people are expected to have dementia in 2050, more than 70% of them in low or middle income countries. Prevalence in these countries seems to be closer to that in high-income countries than previously thought. The global economic burden of dementia is difficult to estimate but was perhaps as high as US$ 604 billion (about 1% of GDP) in 2010. This figure will undoubtedly rise as migration means that fewer people with dementia have family members nearby who are willing, or can afford, to provide informal care and as the costs of formal and informal care both increase.

The alarming findings extend beyond incidence, prevalence, and cost. According to the report, as of January, 2012, fewer than 15 countries had published national or subnational dementia policies or plans; a few others, including India and China, are working towards strategies, but most are not. 19 of the 22 low or middle income countries included in the new survey were reported to have no financial benefits available for people with dementia. Stigma remains a common barrier to diagnosis and support, and the representatives of seven of the low or middle income countries reported that dementia is still commonly thought to have spiritual or supernatural causes. Some countries were judged to be still at the stage of ignoring the problem of dementia, with no countries at the stage of accepting dementia as a disability and including people with dementia in society as fully as possible. But the report does also offer some hope and potential solutions, with advice on how to run public awareness campaigns and develop and implement dementia plans, such as stressing the need for a time frame, monitoring, and financial commitment.

The authors of the report are open about its limitations. The new survey included relatively few countries, selected from among the members of ADI. Data were sparse for young-onset dementia and for many regions, particularly central and eastern Europe, north Africa and the Middle East, sub-Saharan Africa, and Central Asia. Although in general high-income regions had better coverage, the number of population-based studies of dementia was found to be in decline, perhaps owing to complacency or squeezed research funding, and estimates in these countries are in danger of becoming outdated.

Another limitation is that, despite the potential benefits for people with dementia, their families, and society highlighted in the report, provision for dementia could remain a low priority in many countries. Governments might be reluctant to prioritise dementia over issues that seem more pressing in the short-term, such as communicable diseases or economic difficulties. There is also the question of whether any dementia strategies that are initiated will be adequate. For example, although Australia has had a national dementia strategy since 2005, services in the country were recently criticised by Alzheimer's Australia; the Australian government has since announced plans to make dementia a higher priority, but the fact remains that even when a country has a dementia strategy the needs of people with dementia and their carers are not necessarily met, nor any benefits sustained. Encouragingly, WHO has told *The Lancet Neurology* that it plans to translate the report into languages other than English, to provide technical support and advice to countries that want to take action, and to monitor progress periodically.

Dementia: a public health priority will be a valuable resource for governments and organisations that already want to prepare for the impending dementia crisis. If others are also able to begin to make dementia a public health priority, the benefits to people with dementia and their families, and to wider society, could be immense. ■ *The Lancet Neurology*



WHO/Alzheimer's Disease International

For ***Dementia: a Public Health Priority*** see http://www.who.int/mental_health/publications/dementia_report_2012/en/

For more on **Alzheimer's Disease International** see http://www.alz.co.uk/

For an **Editorial** on **dementia services in Australia** see *Lancet* 2012; **379:** 1462

First-line treatment for CIDP: a new piece of the puzzle

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Chronic inflammatory demyelinating polyradiculoneuropathy (CIDP) is a disease of peripheral nerves that can cause substantial disability for long periods of time.[1] The primary goal in treating chronic diseases should be a sustained clinically meaningful improvement or remission without long-term treatment. The potential benefits of corticosteroids and intravenous immunoglobulin (IVIg) for patients with CIDP have been known for a long time.[2,3] More recently, corticosteroids and IVIg were shown to be efficacious in the long-term, and remissions were shown to be induced after a relatively short treatment regimen with corticosteroids.[4,5] Whether IVIg induces remissions has not been proven. An urgent question is what the optimum first-line treatment is for patients with CIDP. In one head-to-head comparison in which the short-term benefits were addressed, no difference was shown between a single course of 2·0 g/kg IVIg and 6 weeks treatment with oral prednisolone starting with 60 mg a day with subsequent tapering.[6]

Few studies of CIDP have been done on which the choice of treatment can be based, which explains the large treatment variations. Therefore, the study by Eduardo Nobile-Orazio and colleagues[7] reported in this issue of *The Lancet Neurology* is timely. In this study, IVIg and intravenous methylprednisolone therapy were both given for 6 months. Patients more often discontinued intravenous methylprednisolone (11 [52%] of 21) than IVIg (three [13%] of 24) therapy because of inefficacy or adverse events (relative risk 0·54, 95% CI 0·34–0·87; p=0·0085), but patients who responded to intravenous methylprednisolone did not require any other therapy for the next 6 months.

The results showed that the magnitude of improvement in neurological deficit (modified Rankin, Rotterdam, and short-form 36 scores, overall neuropathy limitation scale [ONLS] score, Medical Research Council sum score, grip strength, inflammatory neuropathy cause and treatment sensory sum score, and timed 10-m walk) was similar between the two treatment groups but that the percentage of patients responding to IVIg (88% [21 of 24]) was higher than the percentage of patients responding to intravenous methylprednisolone (48% [ten of 21]). Previous studies showed a much more rapid improvement after IVIg than after corticosteroids.[2,8] The time to improvement after corticosteroid treatment is at least several months but could be much longer.[5,9] At 15 days and 2 months, six and nine patients, respectively, had already dropped out of the intravenous methyprednisolone group because of worsening after treatment or failure to improve. This period could be too early for intravenous methylprednisolone to have an effect in many patients. The imbalance in the baseline characteristics might also have offset methylprednisolone in the comparison: patients in the intravenous methylprednisolone group were about one point more disabled on the modified Rankin scale and the OLNS. The dose of methylprednisolone in this study (2·0 g per month) is high compared with doses used in previous studies of corticosteroids.[5,9–11] The proportion of patients improving by at least one point in the ONLS or modified Rankin score on pulsed intravenous methylprednisolone is in the same range as found in the prednisolone versus dexamethasone for chronic inflammatory demyelinating polyradiculopathy trial (PREDICT), in which pulsed high-dose dexamethasone was compared with prednisolone.[5] This finding could mean that higher dosing such as that

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used in the study by Nobile-Orazio is not necessary and will only lead to more adverse events, which could be an explanation for the high dropout rate at 15 days in the intravenous methylprednisolone group. Another problem might have been that more patients in the IVIg group were treated with IVIg previously and thus were known to be responsive to this treatment. Therefore, the design of the study could have underestimated the efficacy of intravenous methylprednisolone. Nevertheless, the study shows that if a rapid improvement is needed (eg, because of severe disability), IVIg is the first choice therapy.

Nobile-Orazio and colleagues' study[7] has important clinical implications. As said before, in patients with a chronic disease, remission should be the goal of therapy and transient side-effects or discomfort should be weighted against this treatment goal. On the basis of this goal, given the data from this study and the PREDICT study, one could argue that a patient without contraindications for corticosteroids should be started on pulsed high-dose intravenous methylprednisolone or dexamethasone for 6 months. About half of patients will respond to this treatment and remain in remission. The other half, who do not improve or who deteriorate on intravenous methylprednisolone, can safely be switched to IVIg and most will improve on this treatment. Nine of 11 patients in Nobile-Orazio and colleagues' study[7] were taken off intravenous methylprednisolone within 2 months and the adverse events were similar between the two groups, making this strategy safe and the time on corticosteroids relatively short. Costs, convenience, and patient autonomy are other factors that should be taken into account when choosing between IVIg and corticosteroids.

No reliable predictors of response exist for either treatment and this should be an important area of research. Combining IVIg and pulsed high-dose corticosteroids for 6 months could combine the best of both worlds: fast recovery and induction of remission. This combination requires a new study. Yet another piece of the jigsaw puzzle has been added, but there are many more to go.

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I have received departmental honoraria for serving on scientific advisory boards and a steering committee for CSL-Behring.

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Reducing the risk of recurrent stroke in patients with AF

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Previous stroke or transient ischaemic attack (TIA) is the most powerful independent predictor of stroke in patients with atrial fibrillation (AF), with an annual rate of subsequent stroke of between 6% and 10% per year in the absence of anticoagulation.[1–3] The time interval from the most recent stroke or TIA is inversely related to stroke rate, but previous stroke or TIA occurring in the past 1–3 years still confers a high (>5% per year) risk of stroke.[4] The rate seems to be lower for patients with AF and previous TIA versus those with AF and previous stroke, but it is still substantial, and the responses to anticoagulation are similar for patients with both types of brain ischaemia.[5] The absolute reduction in stroke provided by anticoagulation for patients with AF and previous stroke is larger than that of any other medical intervention for stroke prevention.[6]

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