



Compared to Just Two Years Ago, Primary Care Physicians Report Substantial Changes in Their Knowledge and Use of the National Kidney Foundation's Chronic Kidney Disease Staging Criteria

BioTrends Research Group, Inc. recently published its Special Report: Referrals in Nephrology II. This report is based on online survey results from over 300 physicians. It provides insight into the referral patterns and co-management of patients with chronic kidney disease (pre-dialysis) from the perspective of nephrologists, endocrinologists, and primary care physicians. The report focuses on understanding these physicians' awareness of kidney disease, triggers for referral, knowledge of and treatment with therapies for hypertension, diabetes, renal anemia, secondary hyperparathyroidism and hyperphosphatemia. It also models the number of chronic kidney disease non-dialysis patients under the care of a nephrologist as well as the number of additional, unique patients being followed by endocrinologists and primary care physicians.

Compared to just two years ago when this study was last fielded, there has been a substantial increase in awareness and use

of the National Kidney Foundation chronic kidney disease staging criteria among non-nephrologists. This change was particularly strong among primary care physicians, and seems to be driving earlier diag-



nosis and referrals to nephrologists. Additionally, over 40 percent of nephrologists report that referring physicians are more aware of kidney disease than in the past. Despite these positive changes, nephrologists report that many patients are still

referred to them later than what they would consider the ideal time for referral.

While anti-hypertensives, statins and diabetes agents are the most commonly used therapies in chronic kidney disease non-dialysis patients, these medications are most often initiated by non-nephrologists. Use of bone and mineral metabolism and renal anemia therapies, while used less frequently, are typically initiated by nephrologists. Changes may continue as over two-fifths of primary care physicians expect to become more involved in the care of chronic kidney disease non-dialysis patients in the future.

About BioTrends Research Group, Inc. BioTrends Research Group, Inc. provides syndicated and custom market research to pharmaceutical manufacturers competing in clinically evolving, specialty pharmaceutical markets. For information on BioTrends publications and research capabilities, please contact us at (610)

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Experts Recommend Universal Screening of Newborns for Congenital Adrenal Hyperplasia

Endocrine Society Unveils Clinical Practice Guideline on Managing Congenital Adrenal Hyperplasia

Recently, The Endocrine Society released a new clinical practice guideline on the diagnosis and treatment of congenital adrenal hyperplasia (CAH). The guideline features a series of evidence-based clinical recommendations developed by an expert task force.

The guideline, published in the September 2010 issue of the *Journal of Clinical Endocrinology & Metabolism (JCEM)*, a publication of The Endocrine Society, is endorsed by the American Academy of Pediatrics, Pediatric Endocrine Society, the European Society for Paediatric Endocrinology, the European Society of Endocrinology, the Society for Pediatric Urology, the Androgen Excess and PCOS Society, and the CARES Foundation.

CAH is a genetic disorder of the adrenal glands that affects about one in 10,000 to 20,000 newborns, both male and female. The adrenal glands make the steroid hormones cortisol, aldosterone and androgens. In individuals with CAH, the adrenal glands produce an imbalance of these hormones which can result in ambiguous genitalia in newborn females, infertility and the development of masculine features such as development of pubic hair, rapid growth in both girls and boys before the expected age of puberty.

"If CAH is not recognized and treated, both girls and boys undergo rapid postnatal growth and early sexual development or, in more severe cases, neonatal salt loss and death," said Phyllis Speiser, MD, of Cohen Children's Medical Center of New York and Hofstra University School of Medicine, and chair of the task force that developed the guideline. "We recommend that every newborn be screened for CAH and that positive results be followed up with confirmatory tests."

Other recommendations from the guideline include:

Prenatal treatment of CAH should continue to be regarded as experimental. Such therapies should be pursued through protocols approved by Institutional Review Boards at centers capable of collecting outcomes data on a large number of patients so that risks and benefits of this treatment can be defined more precisely;

Diagnosis should rest on clinical and hormone data while genotyping should be reserved for equivocal cases and genetic counseling;

Regarding treatment, glucocorticoid

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Reportlinker Adds Alzheimer's Disease: Drug Treatment Strategies, 2010

Reportlinker.com announces that a new market research report is available in its catalogue:

This report presents the findings of a comprehensive survey of current clinical practices in the treatment of Alzheimer's Disease (AD). This was carried out following the participation of more than 220 physicians, practicing predominantly in the US. The purpose of this study was to establish current everyday drug treatment practices for AD and how current drug classes, individually and in combination, are prescribed for mild, moderate and severe stages of the disease. As part of this survey, more than 200 physicians also reported on the principal challenges of treating this disease and these findings are presented, analysed and discussed in this report.

The treatment of AD remains an area of significant unmet need, with therapies based largely on two drug classes: the cholinesterase inhibitors and the NMDA receptor antagonists. These drugs target the symptoms of the disease, however there is considerable need for disease-modifying therapies. Other therapeutic agents are used to treat this disease, which have also been surveyed as part of this work. This survey investigated the use of these drug classes for the treatment of mild, moderate and severe AD, as

well as examining the use of drug combinations. While available drugs to treat AD are limited, current practices in how they are used and combined in treating mild, moderate and severe disease, vary greatly. This survey has examined current treatment practices, which includes off-label use.

In a therapeutic field where treatments for AD are very limited, physicians seek to extent their understanding in this area in an effort to better understand how current drugs and combinations can best be used to target mild, moderate and severe stages. Knowledge in these areas is also important to drug developers, who seek a better understanding of patient needs and outcomes as part of their own efforts to develop more effective therapies. The present survey was carried out to meet interest in these areas. This report presents an analysis of the survey findings and includes:

1. Clinics: comprehensive details of current treatments for AD, provided by more than 220 clinics.
2. Markets and opportunities: in-depth information and analysis relevant to therapeutic markets and opportunities in the

- AD field.
3. Physicians: of the participants, 92% practiced in the US, 2% practiced in Canada and 6% in other countries. Of these, 28% worked in a geriatric department, 20% practiced in a hospital general department, 15% worked in a general practice and 10% worked in a university research/clinical practice. Approximately 90% of the participants worked as Geriatricians and 5% were General Physicians.
4. Disease stages: estimates of the percentage (%) of AD patients treated by study participants for mild, moderate or severe disease.
- 5) Mild AD: estimates of the percentage (%) of mild AD patients who are prescribed Cholinesterase Inhibitors (e.g. donepezil, Aricept®; rivastigmine, Exelon®; galantamine, Reminyl®; NMDA Receptor Antagonist (e.g. memantine - Namenda®, Axura®, Ebixa®; Nootropics (e.g. piracetam - Nootropil®); and other drug classes.
- 6) Mild AD: first choice and second choice drug combinations of two or more of the drug classes Cholinesterase Inhibitors; NMDA Receptor Antagonist;

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Celebrating Comprehensive Health Care: The Affordable Care Act's Six-Month Anniversary

September 23, 2010 marks the six-month anniversary of the Affordable Care Act—the landmark legislation President Obama signed last March to ensure all Americans enjoy affordable, high-quality health coverage. We celebrate this anniversary because of the lasting benefits now beginning to take hold and the even greater gains to come over the next 10 years.

The clear need for the Affordable Care Act was driven home anew last week with the release of the 2009 Census data on health insurance coverage, poverty, and income. The numbers delivered a stark reminder of how important this legislation is. In the midst of the Great Recession, 50.7 million people went without health insurance—without the financial security and access to health care services that health insurance provides. More than 4 million more

Americans went without health insurance compared to 2008—a dramatic change in a single year that demonstrates just how fragile our health care system is.

In many cases, Americans lost coverage as they lost their jobs—and the employer-sponsored coverage that accompanied those jobs. Sometimes, these individuals, or more likely their family members, were able to obtain coverage through Medicaid, which offers safety-net coverage to some low-income individuals. Other times, though, workers did not qualify, or could not afford to maintain their employer-based coverage through COBRA, the federal program that enables workers to continue to pay for health insurance. Nor could many of them access coverage in the individual market, where the cost of insurance is high, the coverage is mostly inadequate,

and insurance companies can pick and choose who they cover.

In the long run—that is, beginning in 2014—the Affordable Care Act will protect American families from this kind of catastrophe. Expanded Medicaid coverage and income-based help with the costs of private insurance will enable low- and middle-income families to have access to affordable, comprehensive health insurance. And they will be able to purchase this coverage without worrying about pre-existing conditions or loopholes in their insurance policies because the Affordable Care Act also reforms health insurers' discriminatory practices. The new law also creates new health insurance exchanges where consumers can shop for high-value coverage. In the end, 32 million people will gain health coverage. But this six-month anniversary also marks important first steps toward these

larger changes. The Department of Health and Human Services has already:

- ✓ Created a new coverage option for people with pre-existing conditions.
- ✓ Implemented a reinsurance program for companies that provide health coverage to their retirees.
- ✓ Mailed more than 1 million rebate checks to Medicare enrollees with high drug costs.

Now, families with sick children know their children are guaranteed health insurance coverage in spite of their pre-existing conditions. Individuals with high health care costs know they won't be bankrupted by absurdly low annual and lifetime limits on their benefits. Families with young, uninsured workers can cover these young adults through their parents'

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Celebrating Comprehensive Health Care

Continued from page 2

policies until they are 26 years old. And no one who has purchased coverage needs to worry that an insurance company can cancel their policy under false pretenses as soon as they get sick.

These early steps don't fix all of the problems in our health insurance system, but they address some of the most egregious ones.

In the months to come, the tempo of health reform implementation will speed up and the tangible benefits will become even more apparent. Specifically, in 2011:

Medicare beneficiaries with very high drug costs will save more than \$1,500 as the dreaded "doughnut hole" in their prescription drug benefit closes.

States will have greater financial incentives to provide long-term services and supports at home, where elders and people with disabilities prefer to live, rather than in nursing homes.

Medicare and Medicaid will begin using their payment systems to induce

quality improvements in the delivery system, for example by reducing hospital payments when a patient suffers from a hospital-acquired infection, and by rewarding doctors and other providers who do a good job of managing patients with complex conditions.

These reforms and others to be implemented over time will secure important new health care benefits for millions of Americans, insured and uninsured alike, setting the stage for the major reforms to come in 2014 and beyond.

In the weeks to come, though, we will hear a lot of rhetoric from the opponents of health reform. They will call for repealing the new law and either reverting to the old status quo or starting health reform over from scratch. Reverting to the unaffordable health system in place before this landmark reform would leave millions of Americans uninsured, while ignoring the unsustainable growth of health care costs.

But repealing only parts of the

Affordable Care Act would carry a heavy price, too. One recent analysis notes that repealing the requirement that all individuals carry health insurance and the subsidies that help individuals and families afford this coverage would cause health insurance to cost twice as much in 2019 as it will under the Affordable Care Act.

We have made so much progress since the passage of the Affordable Care Act on March 23. And there is more to come. As the implementation of all the pieces of health reform unfolds, we will see our fragile health care system gain new vibrancy and strength. Millions of Americans will gain the health coverage and financial security they deserve.

Karen Davenport is the Director of Health Policy at the Center for American Progress. To read more of our analysis and recommendations for health care reform, go to the Health Care page of our website.

The Center for American Progress is a nonpartisan research and educational institute dedicated to promoting a strong, just and free America that ensures opportunity for all. We believe that Americans are bound together by a common commitment to these values and we aspire to ensure that our national policies reflect these values. We work to find progressive and pragmatic solutions to significant domestic and international problems and develop policy proposals that foster a government that is "of the people, by the people, and for the people."

By Karen Davenport
www.americanprogress.org/experts/
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PPTA Urges CMS for Appropriate Hospital Outpatient Reimbursement For Plasma Protein Therapies

The Plasma Protein Therapeutics Association (PPTA) recommends that the Centers for Medicare and Medicaid Services (CMS) finalize its Proposed Rule regarding reimbursement to better ensure patient access to vital medicines in the hospital outpatient setting.

Specifically, for CY 2011, CMS proposes to set the payment level of separately payable non-pass-through drugs and biologicals, which include most plasma protein therapies, at average sales price (ASP) plus 6 percent. PPTA supports this proposal, believing that by setting payment rates at no less than ASP plus 6 percent, CMS will help ensure at this time that hospital outpatient departments remain a viable option for beneficiaries to receive therapies such as alpha-1 proteinase inhibitor, blood clotting factors and intravenous immune globulin (IVIG).

Furthermore, the proposed payment rate for hospital outpatient departments would put such products on par with the rates paid for pass-through drugs and biologicals in the physician office setting, thus, better assuring Medicare patients that they will have access to their necessary

medications in either site of service.

"By matching payment levels in both the hospital outpatient department and the physician office, the choice of setting would be driven by clinical, not financial considerations, as it should be," said Julie Birkofer, Senior Vice President, PPTA North America.

Additionally, PPTA praised the agency's proposal to continue reimbursing hospitals for the "furnishing fee" for blood clotting factors, recommending that the proposal be made final.

While CMS' proposal makes strides with ensuring patient access to plasma protein therapies for small patient populations, PPTA continues to have concerns with the agency's flawed policy of using hospital claims data that includes drugs and biologicals sold as part of the heavily discounted 340B Drug Pricing Program when setting Outpatient Prospective Payment System (OPPS) payment rates. The 340B program limits the cost of covered outpatient drugs to certain federal grantees, federally-qualified health centers and qualified disproportionate share hospital.

In recent years, analysis of hospital claims data by multiple experts reveal that the inclusion of 340B hospitals when establishing rates artificially lowers the payment level that CMS generates, concluding that if CMS were to exclude 340B hospitals from its claims data analysis, the rate would more appropriately be as high as ASP plus 12 percent. This payment rate would be consistent with the calculation of other payment methodologies, including the ASP, the average manufacturer's price, and the best price. The Association continues to recommend that these data be removed from rate setting calculations.

PPTA appreciates the opportunity to comment on the Proposed Rule. The Association especially supports CMS' decision to continue the blood clotting factor furnishing fee in the OPPS for CY 2011 and urges the agency to finalize it with the pertinent update.


View PPTA's Comment Letter. For more information about PPTA, please visit www.pptaglobal.org.

The Plasma Protein Therapeutics Association (PPTA) represents the world's leading manufacturers of plasma-derived

and recombinant biological therapies, collectively known as plasma protein therapies and the collectors of source plasma. These critical therapies are infused or injected by more than 1 million people worldwide to treat a variety of rare, life threatening diseases and serious medical conditions including hemophilia, primary immunodeficiency diseases and alpha-1 antitrypsin deficiency. PPTA members produce in excess of 80 percent of the plasma protein therapies used in the United States today and more than 60 percent worldwide. PPTA is a global trade association that administers international, voluntary standards programs to help ensure the highest quality and safety of plasma protein therapies and the plasma collected to manufacture them. Additionally, PPTA works in partnership with the patient community and consumer advocates to help ensure continued access to lifesaving plasma protein therapies.

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Experts Recommend Universal

Continued from front page

dosage should be minimized to avoid iatrogenic Cushing's Syndrome. Mineral-corticoids and, in infants, supplemental sodium are recommended in classic CAH patients; Clinicians should avoid the routine use of experimental therapies to promote growth and delay puberty, and patients should avoid adrenalectomy;

Early single-stage genital repair should be considered for severely virilized girls and should be performed only by surgeons experienced in this type of procedure;

Clinicians should consider patients' quality of life, consulting mental health professionals as appropriate;

At the transition to adulthood, clinicians should monitor for potential complications of CAH; and

Clinicians should exercise judicious use

of medication during pregnancy and in symptomatic patients with nonclassic CAH.

"People with classic CAH should have a team of health care providers, including specialists in pediatric endocrinology, pediatric urologic surgery (for girls), psychology and genetics," said Speiser. "Other than having to take daily medication, people with classic CAH can have a normal life."

The Hormone Foundation, the patient education affiliate of The Endocrine Society, has published a new bilingual fact sheet about congenital adrenal hyperplasia for patients. It defines CAH and explains how the condition is diagnosed and treated. The fact sheet can be found online at: <http://www.hormone.org/Resources/>

[upload/congenital-adrenal-hyperplasia-bilingual-081310.pdf.](#)

Other members of the task force that developed this guideline include: Ricardo Azziz of Cedars-Sinai Medical Center in Los Angeles, Calif.; Laurence Baskin and Walter Miller of the University of California San Francisco; Lucia Ghizzoni of the University of Turin in Italy; Terry Hensle of Columbia University in New York, N.Y.; Deborah Merke of the National Institutes of Health Clinical Center; Heino Meyer-Bahlburg of New York State Psychiatric Institute in New York, N.Y.; Victor Montori of Mayo Clinic in Rochester, Minn.; Sharon Oberfield of Columbia University College of Physicians & Surgeons in New York, N.Y.; Martin Ritzen of Karolinska Institute in

Stockholm, Sweden; and Perrin White of the University of Texas Southwestern Medical Center in Dallas.

Founded in 1916, The Endocrine Society is the world's oldest, largest and most active organization devoted to research on hormones and the clinical practice of endocrinology. Today, The Endocrine Society's membership consists of over 14,000 scientists, physicians, educators, nurses and students in more than 100 countries. Society members represent all basic, applied and clinical interests in endocrinology. The Endocrine Society is based in Chevy Chase, Maryland. To learn more about the Society and the field of endocrinology, visit our site at www.endo-society.org.



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Mexican-Americans with Heart Rhythm Disorder Have Increased Risk for Second Stroke

Mexican-American stroke survivors with a heart rhythm disorder have more than twice the risk for another stroke compared to non-Hispanic whites, according to a study published in *Stroke: Journal of the American Heart Association*.

Mexican-Americans' recurrent strokes are also more likely to be severe, though they don't have a greater risk of death after stroke, researchers said.

Researchers compared 88 Mexican-American and 148 non-Hispanic white stroke survivors who had atrial fibrillation, a disorder in which the heart's upper chambers (called the atria) beat irregularly and don't pump blood effectively, possibly causing blood to pool within the atria and blood clot formation in the heart.

They found that the likelihood of suffering another stroke during the study follow-up period was more than double for Mexican-Americans than for non-Hispanic whites. Although stroke recurrence was higher and strokes were more severe among Mexican-Americans, death rates didn't dif-

fer between the two groups.

"Based on some of our prior research, we were not necessarily surprised by the higher recurrence risk in Mexican-Americans with atrial fibrillation, but the greater severity of recurrent strokes in Mexican-Americans was surprising," said Darin B. Zahuranec, M.D., study co-author and an assistant professor of neurology at the University of Michigan Cardiovascular Center in Ann Arbor.

Results are based on cases of ischemic stroke and transient ischemic attack from the Brain Attack Surveillance in Corpus Christi Project, a population-based stroke surveillance study. The data were collected between January 2000 and June 2008. Corpus Christi has a large Mexican-American population and is located along the Gulf coast of Texas.

The study also showed that Mexican-American patients were younger, less likely to have completed 12 years of education, more likely to have diabetes, and less likely to have a primary care physician.

Researchers found no ethnic differences between the two groups in the severity of the first stroke.

Nineteen Mexican-Americans and 14 non-Hispanic whites had at least one recurrent stroke over a median follow-up of 427.5 days; all but one event was an ischemic stroke (one Mexican-American patient experienced intracerebral hemorrhage).

One reason for the difference could be that the management of warfarin — a blood thinning drug — among Mexican-Americans may not be optimal, Zahuranec said. However, the study found no ethnic difference in the proportion of patients who were prescribed warfarin at hospital discharge. They did not evaluate data looking at outpatient use of warfarin after hospital discharge which might have contributed to the increased risk of stroke in Mexican-Americans.

Atrial fibrillation affects approximately 2.2 million Americans; about 15 percent of strokes occur among individuals with

atrial fibrillation.

Co-authors are J.R. Simpson, M.D.; L.D. Lisabeth, Ph.D.; B.N. Sánchez, Ph.D.; L.E. Skolarus M.D.; J.E. Mendizabal, M.D.; M.A. Smith, DrPH; N.M. Garcia, B.S.; and L.B. Morgenstern, M.D. Author disclosures are on the manuscript.

The study was funded by the National Institutes of Health.

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Christian Medical Association Doctors: U.S. Government Must Link AIDS, Anti-Trafficking Efforts

Highlighting a just-published study showing that sex slaves spread AIDS even after their rescue from human trafficking overlords and pimps, the nation's largest faith-based association of doctors today called for more concerted U.S. government action related to the link between AIDS and human trafficking.

Christian Medical Association (CMA) CEO Dr. David Stevens said, "Today's published study in the Journal of the American Medical Association highlights the link between HIV-AIDS and human trafficking. We have been encouraging U.S. health officials over the past several years to incorporate strong and clear policies that address this link, and to devote greater energies and resources to the health aspects of human trafficking, or modern-day slavery."

CMA's Medical Consultant on Health

and Human Trafficking, Dr. Jeffrey Barrows, said, "Very few published medical studies to date have addressed this link, so this study is a real breakthrough that we hope will stimulate concrete action in our government and the public health community. This study should help U.S. and international government officials better recognize and emphasize the public health implications of human trafficking, and sex trafficking in particular."

Dr. Barrows said, "Health officials have just begun to recognize this link, and stronger emphasis is needed. Interventions aimed at eradicating sex trafficking, rescuing and restoring sex-trafficked victims, and preventing future sex trafficking need to be a more strongly emphasized strategy in the President's Emergency Plan for AIDS Relief (PEPFAR) and other AIDS-

related programs. Anti-trafficking measures should be specifically and consistently emphasized in AIDS-related grant stipulations and proposal evaluations."

The Christian Medical Association offers on its web site a training module for physicians on health and human trafficking. The module carries Category One continuing medical education credit, and has already been used by over 500 individuals.

To schedule an interview, please contact Margie Shealy at (423) 844-1047 or by e-mail: margie.shealy@cma.org. The Christian Medical Association is equipped with Ku Band Digital Uplink satellite and ISDN lines.

Source: Christian Medical Association



E Cigarette Popularity Increases Despite 'Quit Or Die' Policy of Health Organizations

Electronic cigarettes have been on the market in the United States for years, but have only recently become the victim of health organization and pharmaceutical company ire

Electronic cigarette sales and popularity continues to increase on a daily basis despite the US Food and Drug Administration's attempts to label the products as unsafe and untested for their intended purpose. Thousands of electronic cigarette reviews online dispute the stance of the FDA, many of them stating that the products have not only been tested, but by and large have been found to be less harmful than traditional cigarettes.

The American Cancer Society recently stated in many words that they have a "quit or die" policy concerning the e cigarette versus tobacco cigarettes while bringing their own pre-written legislation before state lawmakers to outright ban the e cigarette from the market. This legislation makes no attempt to make it illegal to sell e cigarettes to minors, but would rather have it banned altogether to prevent adults from making an informed decision on their own.

The ACS continues to push this quit or die agenda along with many other special interest health organizations that are directly funded by pharmaceutical companies to push their products above and beyond any other alternative on the market at the cost of American lives.

Evidence is mounting as more and more physicians and health care practitioners are suggesting to smokers that are unable to quit to make the switch to e cigarettes as part of a harm reduction effort. Highly funded special interest groups tend to state, however, that quitting entirely is the only acceptable means of harm reduction. Unfortunately for American smokers, eliminating smoking alternatives like e cigarettes from the open market will force them to quit with "approved" methods or be destined to spend a fortune throughout their lives on a habit that is one of the most difficult

on the planet to cease.

"This is basically a 'die or spend money' situation that they're forcing people into and it's not right," says William Ellis of World of E Cigarettes. "They don't have a right to make the decision on how someone wants to stop or even continue smoking if that's what that person wants to do. They're not elected officials and they have no business writing legislation in secrecy and pushing it on our lawmakers to be crammed down our throats."

World of E Cigarettes is an online authority on electronic cigarettes and related products. Visit their website at <http://worldofecigarettes.com>

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Primary Care Physicians Report

Continued from front page

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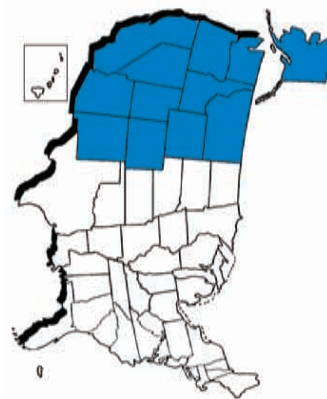
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Alzheimer's Disease

Continued from front page

Nootropics; Colostrinin; Vitamins and other drugs for the treatment of mild disease.

7) Moderate AD: estimates of the percentage (%) of moderate Alzheimer's disease patients who are prescribed Cholinesterase Inhibitors (e.g. donepezil, Aricept®; rivastigmine, Exelon®; galantamine, Reminyl®; NMDA Receptor Antagonist (e.g. memantine - Namenda®, Axura®, Ebixa®; Nootropics (e.g. piracetam - Nootropil®); and other drug classes.

8) Moderate AD: first and second-choice drug combinations of two or more of the drug classes Cholinesterase Inhibitors; NMDA Receptor Antagonist; Nootropics; Colostrinin; Vitamins and other drugs for the treatment of moderate disease.

9) Severe AD: estimates of the percentage (%) of severe AD patients who are prescribed Cholinesterase Inhibitors (e.g. donepezil, Aricept®; rivastigmine, Exelon®; galantamine, Reminyl®; NMDA Receptor Antagonist (e.g. memantine - Namenda®, Axura®, Ebixa®; Nootropics (e.g. piracetam - Nootropil®); and other drug classes.

10) Severe AD: first and second-choice drug combinations of two or more of the drug classes Cholinesterase Inhibitors; NMDA Receptor Antagonist; Nootropics; Colostrinin; Vitamins and other drugs for the treatment of severe disease.

11) The principal challenges and issues encountered in the treatment of Alzheimer's disease.

Background to Alzheimer's disease

A prevalence study in 2005 estimated there were 24.3 million people suffering from dementia globally, with 4.6 million new cases added every year. In the absence of a cure, the study suggested dementia sufferers will double every 20 years to 81.1 million by 2040. Of those reported to be suffering from dementia, 60% were living in developing countries, a figure expected to rise to 70% by 2040. Rates of increase of dementia are not uniform, and between 2001 and 2040 were projected to increase by 100% in developed countries and by more than 300% in India, China, and their south Asian and western Pacific neighbours. More than 50% of these dementia cases are due to AD.

Today, approximately five million Americans suffer from AD, a figure expected to rise to 14 million by 2050 if a cure is not found. One in eight persons in the US over the age of 65 and nearly half of those over 85 have AD. Direct and indirect costs of AD and other dementias in the US amount to more than \$148 billion annually. It is estimated that 10 million Americans are caring for a person with AD or another dementia, one third of whom are over the age of 60. It is estimated the worldwide costs for dementia care are over \$315 billion annually.



Mexican-Americans

Continued from page 6

encing the science content. Revenues from pharmaceutical and device corporations are available at www.americanheart.org/corporatefunding.

Editor's note:

The American Heart Association has an online Spanish-language tool that identifies if a person is in poor, intermediate or ideal health, called Marcando Los 7 Pasos Para Mi Salud. For a simple step-by-step approach and action plan that may help individuals achieve healthier lives, visit heart.org/marcando7pasos.

Additional public resources:

www.americanstroke.org

Atrial fibrillation

Additional media resources Downloadable stock footage and animation are available at www.newsroom.heart.org, click on "Multimedia Resources"

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SOURCE American Heart Association

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Study highlights:

- Mexican-American stroke survivors with atrial fibrillation had more than double the risk for a second stroke compared to non-Hispanic white survivors with the disorder.

- Strokes were more severe among these Mexican-Americans than among non-Hispanic whites; however, researchers found no major differences in death rates between the two groups.

- Researchers said the findings could help physicians develop strategies to prevent recurrent stroke in Mexican-Americans.



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