

different levels of instrumental ADL (IADL) impairment at baseline, from 6.6 ± 2.8 years (IADL score, 8-12) to 5.0 ± 2.5 years (IADL score, 21-31) ($P < 0.001$). The time from AD diagnosis to death also differed between patients receiving antihypertensive/cardiac therapy (no/yes, 6.1 ± 2.7 vs 5.3 ± 2.8 years; $P < 0.001$), antidiabetics (no/yes, 5.8 ± 2.8 vs 4.1 ± 2.4 years; $P < 0.001$), nonsteroidal anti-inflammatory drugs (NSAIDs)/acetylsalicylic acid; no/yes, 6.0 ± 2.8 vs 5.2 ± 2.6 years; $P < 0.001$), and antipsychotics (no/yes, 5.8 ± 2.8 vs 4.7 ± 2.5 years; $P = 0.020$). IADL score at baseline and antihypertensive/cardiac therapy, antidiabetics, and antipsychotics were independent predictors of survival after AD diagnosis in a general linear model, after controlling for sex, age, and cognitive ability. Basic ADL, number of medications, and specific concomitant medications (lipid-lowering agents, NSAIDs/acetylsalicylic acid, antidepressants, and anxiolytics/sedatives/hypnotics) at baseline were not significant predictors. **Conclusions:** IADL, but not basic ADL, was an important predictor that should be considered by clinicians and community-based services when estimating AD prognosis. Antidiabetic therapy was a strong risk factor for reduction in life expectancy.

P3-139 CHARACTERISING THE AUSTRALIAN IMAGING, BIOMARKERS, AND LIFESTYLE (AIBL) STUDY OF AGEING COHORT AT 36 AND 54 MONTHS

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Background: The AIBL study is following 1112 individuals (768 healthy controls (HC), 133 with MCI and 211 with AD) prospectively, with cognitive testing, imaging, health and lifestyle data and biomarker assays every 18 months. We report transition rates to MCI and AD and the emergence of other cognitive syndromes at 36 and 54 months of follow-up. **Methods:** Every 18 months participants undertook detailed cognitive assessment, completed health and lifestyle questionnaires and gave 80 ml of blood. Initially one quarter underwent amyloid and MRI brain imaging at baseline and every follow-up. **Results:** At 36 months 74.1% (824) returned for assessment. Since baseline 73 had died and 215 did not return. At 36 months 610 were classified as HC, 56 as MCI and 154 as AD. There were 3 cases of vascular dementia and one of dementia due to Parkinson's disease. At 54 months 718 (64.6%) could have their diagnostic status determined, with 294 having withdrawn and 100 having died. There were 560 HCs, 51 MCIs, 102 ADs and 5 non-AD dementia cases at 54 months. HCs transitioned to MCI or AD at a rate of 4.6% by 36 and 6.6 by 54 months. At 36 months 35.3% of MCIs had developed AD. **Conclusions:** Perhaps because the baseline HCs were well educated, healthy and with an average age of 70 at baseline, transition to MCI or AD from this group has been slow to date, but the development of AD in our MCI cohort has been within expected parameters. Having AD or MCI was associated with an increased risk of death or drop out. We are currently collecting 72 month data and have expanded the cohort to compensate for those who dropped out.

P3-140 GENERAL PRACTITIONER DEMENTIA DOCUMENTATION: A RANDOMISED CONTROLLED TRIAL USING INTERVENTIONS OF EDUCATION AND AUDIT

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Background: General practitioners (GPs) may be good at diagnosing dementia but poor at documenting the diagnosis, creating a barrier for appropriate management. In regional areas the GP is often the most accessible doctor, and patients may expect them to identify and manage this condition. The objective of this study was to test education and audit as interventions to improve documentation of dementia diagnoses by GPs. **Methods:** The

design was multi-centered with clusters of GPs at 16 locations randomized using Excel software into one of four groups, three intervention and one control. The intervention applied separately and together, consisted of education - a workshop on GP dementia guidelines, and audit - the proportion of documented dementia diagnoses in patients aged 65 years and over compared with a predicted prevalence of 5% in this age group. The setting was Regional North-Queensland, Australia, spanning 1000 km. Participants were 56 GPs (8% of GP population) from 27 practices, 55\$ with over 20 years in practice, 33% female, 57% International Medical Graduates. The outcome measures were the change in audit at 0 and 6 months of the trial. Multivariate linear regression analysis measured the effect on this outcome of independent variables consisting of the interventions applied separately and together, years in practice and International medical training. **Results:** 61 GPs entered the trial with 56 completing. Five withdrew due to work commitments or relocation. Over 10,000 patient files provided data for audits. Analysis was performed on two data sets; intention to treat - all completing GPs (n=56), and per protocol - GPs providing individual data who complied with their intervention (n=37). Audit significantly increased documentation in the smaller sample ($p=0.017$) but not in the larger ($p=0.50$). Education had no significant effect. Combining education and audit did not increase the treatment effect. Neither 'over twenty years in practice' nor 'international medical training' significantly influenced the outcome. **Conclusions:** The intention to treat analysis produced no significant outcomes possibly due to poor protocol compliance. However, per protocol analysis suggested that audit might increase GP documentation of dementia diagnoses while education may not.

P3-141 CAREGIVER AND CLINICIAN DISAGREEMENTS IN RECOGNIZING NEUROPSYCHIATRIC SYMPTOMS IN ALZHEIMER'S DISEASE PATIENTS

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Background: Caregiver and Clinician disagreements in recognizing neuropsychiatric symptoms in Alzheimer's disease patients Florindo Stella 1,2, Jerson Laks 3, Larissa Pires de Andrade 1, João de Castilho Cação 4, Orestes Forlenza 2 1. UNESP - Universidade Estadual Paulista, Biosciences Institute, Brazil.2. Laboratory of Neurosciences (LIM-27), Department and Institute of Psychiatry, Faculty of Medicine, University of São Paulo, SP, Brazil.3. Center for Alzheimer's Disease and Related Disorders, Institute of Psychiatry, Federal University of Rio de Janeiro, RJ, Brazil.4. FAMERP - Faculty of Medicine, Geriatric Unity, São José do Rio Preto, SP, Brazil. **Background:** Interpretation of neuropsychiatric symptoms in Alzheimer's disease (AD) represents a critical strategy to appropriately diagnose and treat the patients. To improve the accuracy of recognition of psychopathological manifestations remains a challengeable issue. Aims: To analyze disagreements between caregiver and clinician with regard to recognizing neuropsychiatric manifestations of AD patients. **Methods:** We analyzed interpretations of neuropsychiatric manifestations in 156 caregivers responsible for their respective 156 AD patients. We compared caregiver report with clinician impression concerning all domains from the Neuropsychiatric Inventory-Clinician Rating Scale (NPI-C). **Results:** We observed important disagreements in recognizing for the majority of neuropsychiatric domains when we compared caregiver report with clinician impression in the same patient. Apathy/Indifference, Agitation, Anxiety, and Depression were domains with higher disagreements in interpreting psychopathological symptomatology, while Hallucinations and Elation/Euphoria were domains with lower disagreements (Table). **Conclusions:** Disagreements between caregiver report and clinician impression concerning interpretation of neuropsychiatric symptoms in AD patients reflect a requirement for accurate