intensive lipid lowering was associated with an improved ACE-R, animal naming and TMT A time. Further trials investigating intensive lipid lowering therapy may be warranted. References: Bath PM, Scott P, Blackburn DJ, Anolkar S, Krishnan K, et al. (2017) Intensive versus Guideline Blood Pressure and Lipid Lowering in Patients with Previous Stroke: Main Results from the Pilot ‘Prevention of Decline in Cognition after Stroke Trial’ (PODCAST) Randomised Controlled Trial. PLOS ONE 12(1): e0164608. http://dx.doi.org/10.1371/journal.pone.0164608.

P3-451 THE TEXAS ASSESSMENT OF PROCESSING SPEED (TAPS) PERFORMANCE IN PATIENTS WITH COGNITIVE IMPAIRMENT

April R. Wiechmann1, Laura W. Green2, Kristen Reuter1, James R. Hall1, 1University of North Texas Health Science Center, Fort Worth, TX, USA; 2Vanderbilt University, Nashville, TN, USA; 3University of North Texas Health Science Center, Ft. Worth, TX, USA. Contact e-mail: april.wiechmann@unthsc.edu

Background: Visual cognition, the amalgamation of processes that help us understand what we see, is crucial to everyday functioning. Declines in common visuospatial abilities and processing speed may reflect the dementia patient’s hindered ability to absorb and maintain visual information in working memory. The unique pattern of visual cognitive deficits depends on the cause and severity of dementia. Two of the most widely used neuropsychological assessments of visual processing include the Trails Making Test and the coding subtest of the WAIS-IV. The Texas Assessment of Processing Speed (TAPS) was created as a quick, cost effective coding test that can be administered in a clinical setting. Methods: Participants were administered TAPS as part of a neuropsychological battery in a university-based outpatient memory disorders clinic. Consensus diagnosis was determined using established criteria. The study compared TAPS performance with Coding and across varying levels of cognitive impairment (AD (N=99), vascular dementia (N=16), amnestic MCI (N=25), and non-amnestic MCI (N=44). Results: Significant differences for diagnostic groups, F(3, 177)=8.655, p=.000, was found. The covariates of age and education were also significant, but gender was not. Post-hoc paired comparisons revealed no differences between AD and vascular dementia groups and no differences between MCI groups, but dementia groups were significantly worse than MCI groups. As expected, TAPS is highly correlated with coding (r=.817, p=.000). TAPS demonstrated good construct validity. TAPS performance significantly correlated with all IADLs, indicating that low performance on TAPS correlated with an inability to independently manage medications, finances, transportation, laundry, housekeeping, food preparation, shopping, and telephone use. Conclusions: As far as we are aware, no data on TAPS performance by diagnosis has yet been published. Such data would enable clinicians to use the assessment as a diagnostic tool. The TAPS is quicker to administer and shorter than the coding subtest from the WAIS-IV. The results also indicate that TAPS may be useful in monitoring functional ability in dementia patients.

P3-452 SCREENING FOR ALZHEIMER’S DISEASE: COGNITIVE IMPAIRMENT IN SELF-REFERRED AND MEMORY CLINIC-REFERRED PATIENTS

Bjørn-Eivind Kirsebom1,2, Ragna Espenes1,2, Knut Waterloo2, Stein Harald Johnsen1,3, Erik Hessen4, Tormod Fladby1,4, 1University Hospital of Northern Norway, Tromsø, Norway; 2Faculty of Health Sciences, UIT, The Arctic University of Norway, Tromsø, Norway; 3Akershus University Hospital, Lørenskog, Norway; 4University of Oslo, Oslo, Norway. Contact e-mail: bjorn-eivind.kirsebom@unn.no

Background: Declining cognitive function is a core feature of Alzheimer’s disease, and cognitive assessment is fundamental in tracking disease progression. At present, cohorts including at-risk subjects are recruited by different means, which may differentially select patient groups with varying cognitive and clinical features. Methods: Cross-nationally, 579 cases and controls 45-89 years old, were recruited Here, we compare inclusions from: 1) response to advertisements and news bulletins N=180), and 2) referrals by general practitioner to memory outpatient clinics N=87). Cases were classified as control (n=134) or symptomatic (subjective cognitive disorder (SCD) or mild cognitive impairment (MCI), n=302) cases according to highly standardized criteria. All controls and cases had standardized clinical and cognitive examinations following a pre-determined research protocol, laboratory examinations including lumbar puncture and blood samples. We compared recruitment strategies to levels of functioning in two screening tests (MMSE, Clock test) and four cognitive subdomains: memory (CE-RAD), visual cognition (VOSP), speed of processing (TMTA) and executive function (TMTB, COWAT). Results: Independent t-test analysis of the MCI, SCD and control-groups were performed. The MCI group (n=138) showed significant reductions in all cognitive domains compared to controls (n=134). Significant reductions in verbal learning (CERAD) and executive function (TMTB) were also found in the SCD group (n=164) compared to controls (n=134). At symptom group level, including both SCD and MCI, we found significant reductions in verbal learning and memory recall in memory clinic referrals (n=85 compared to self-referrals (n=178). However, this deficit was only found within the MCI group, showing a significant difference in performance for verbal learning when comparing self-referrals (n=69) and memory clinic referrals (n=45). Within the SCD group we found no significant differences in cognitive performance between self-referrals (n=109) and memory clinic referrals (n=41). Conclusions: Both self- and memory clinic referrals showed reductions in cognitive performance compared to controls, and also the SCD group was significantly impaired compared to controls. Cognitive impairment for memory clinic referrals compared to self-referrals was only found within the MCI group.

P3-453 A PHYSIOLOGICAL BASIS FOR SOCIO-EMOTIONAL DEFICITS IN FRONTOTEMPORAL DEMENTIA

Charles R. Marshall1, Chris Hardy1, Lucy L. Russell1, Rebecca L. Bond2, Camilla N. Clark1, Katrina M. Dick1, Emilie V. Brotherhood1, Jonathan D. Rohrer1, James M. Kilner3, Jason D. Warren1, 1Dementia Research Centre, Institute of Neurology, University College London, London, United Kingdom; 2Institute of Neurology, University College London, London,