treatment were described. We now report findings with additional treatment up to 52 weeks. **Results:** A previous report had noted robust significant improvements with the CI-PCM program in comparison with usual care at 28 weeks. Overall, the difference between CI-PCM and usual care at 28 weeks was 2.7 points on the NYU CIBIC-Plus (see Figure 1). We now report continuing improvements with the CI-PCM program up to 52 weeks of treatment and continuing worsening in the subjects receiving memantine treatment alone. Since the NYU CIBIC-Plus contains a subject interview with cognitive and behavioral components, and a caregiver interview with functional and behavioral components, an analysis of the individual component changes at 52 weeks was performed. This indicated significant improvements at 52 weeks with the CI-PCM program versus controls for all components except cognition (see Table 1). **Conclusions:** At 28 weeks of treatment, a direct comparison of the magnitude of the effect of the CI-PCM program on the NYU CIBIC-Plus global measure indicated a 900% increment over that of memantine treatment alone (2.7 versus 0.3). This absolute effect magnitude of the CI-PCM vs. memantine alone increases to 3.3 at 52 weeks 11 times the effect of memantine alone at 28 weeks. We conclude that great benefits, perhaps 11 x those of medication, can be achieved with scientific management in persons with advanced AD.

**Table 1**

**Component Analysis at Week 52 of the Differences Between the Subject Group which was Randomized to Receive the Comprehensive, Individualized, Person Centered Management (CI-PCM) Program Plus Memantine Treatment Versus the Subject Group which was Randomized to Receive Memantine Treatment Alone**

| Subject Interview                              | Treatment vs Control | *P*-value |
|------------------------------------------------|----------------------|-----------|
| I a. Cognitive Component                        | NS                   |           |
| I b. Behavioral Component Total Score           | P-value = 0.005      |           |
| I c. Behavioral Component Global Rating         | P-value = 0.002      |           |

**NYU CIBIC-Plus Caregiver Interview**

|                                  | *P*-value |
|----------------------------------|-----------|
| II a. Functional Component       | 0.028     |
| II b. Behavioral Component Total Score | 0.006     |
| II c. Behavioral Component Global Rating | 0.013     |

*a*-test for equality of means (independent samples test); Equal variances assumed

All behavioral disturbance assessments and the functional assessment showed significant improvements at 52 weeks in the subject group who received the Comprehensive Individualized Person Centered Management (CI-PCM) program plus memantine treatment versus the subject group who were randomized to receive the memantine treatment alone. No significant differences between the CI-PCM plus memantine treatment and the memantine treatment alone group were observed for the cognitive component assessment.

**Figure 1. Clinician’s Interview Based Impression of Change (CIBIC-Plus) Global Scores**

**Background:** A FDA safety communication in August 2011 warned of a dose dependent risk of QT prolongation with citalopram and recommended dose restriction in patients over age 60 but did not provide data for this age group. The objective of this analysis is to show the differences in QT interval for citalopram versus placebo in older adults with AD.

**Methods:** CitAD was a randomized, placebo-controlled, multicenter clinical trial for agitation in AD. Study participants were recruited from seven clinical centers in the U.S. and one in Canada which included memory clinics, geriatric psychiatry clinics, Veterans Administration geriatric clinics, nursing homes, community outreach, and Alzheimer Research Centers. 186 people, 181 of whom were over the age of 60, having probable AD with clinically significant agitation were recruited from September 2009 to January 2013. Participants were assigned 1:1 to citalopram (target dose of 30 mg/day) or placebo. After the FDA safety communication about citalopram, participants were notified of the warning and ded dose restriction in patients over age 60 but did not provide data for this age group. The objective of this analysis is to show the differences in QT interval for citalopram versus placebo in older adults with AD.

**Results:** Citalopram treatment was associated with a larger increase in QTc interval than placebo (difference in week 3 QTc adjusting for baseline QTc: 18.1 ms [95% CI: 6.1 to 30.1]; *p* = 0.004). More participants in the citalopram group had an increase ≥ 30 ms from baseline to week 3 (7 in citalopram versus 1 in placebo; Fisher’s exact *p* = 0.05), but only slightly more in the citalopram group met a gender-specific threshold for prolonged QTc (450 ms for males; 470 ms for females) at any point during follow-up (3 in citalopram versus 1 in placebo, Fisher’s exact *p* = 0.61). One of the citalopram participants who developed prolonged QTc also displayed ventricular bigeminy on the ECG. No participants in either group had a cardiovascular-related death.

**Conclusions:** While citalopram at 30 mg / day was associated with improvement in agitation in patients with AD, because of concerns about QT prolongation, we cannot generally recommend citalopram at that dose.