

Conclusions: The results emphasize the importance of ongoing screening for depressive and anxious symptomatology in carers over time, particularly in women. Health professionals in primary care should be capacitated to assess and offer timely and appropriate support to family carers of PLWD in order to improve their mental health. Finally, interventions for carers should be an essential part of national dementia plans.

FC43: Decision-Making Capacity and Awareness in People with Young-Onset Alzheimer's Disease

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Objectives: There is a lack of research on differences between decision-making capacity and awareness according to age at onset of dementia. We investigated the relationship between decision-making capacity and awareness domains in people with young-(YOAD) and late-onset Alzheimer's Disease (LOAD).

Methods: A cross-sectional study included 169 consecutively selected people with AD and their caregivers (124 people with LOAD and 45 people with YOAD). Decision-making capacity was assessed with the MacCAT-T and awareness with the ASIIDD scale.

Results: People with YOAD were more cognitively impaired, but more aware of their cognitive deficits and health condition, with moderate effect sizes. We did not find any other significant differences between the groups in the other domains of awareness. In addition, there were no significant differences in the domains of decision-making capacity between groups. All PwAD presented deficits in the domains of decision-making capacity with a greater impairment in the understanding domain (YOAD = mean 3.67, SD 1.57; LOAD = mean 3.80, SD 1.22). Understanding was the domain of MacCAT-T most significantly associated with awareness domains: ASIIDD Total ($p < 0.001$), awareness of cognitive deficits and health condition ($p < 0.001$), awareness of emotional state ($p < 0.008$), awareness of social functioning and relationships ($p < 0.001$), and awareness of impaired functional activity ($p < 0.001$). However, age at onset only impacted total ASIIDD ($p < 0.013$) and awareness of cognitive deficits and health condition ($p < 0.001$).

Conclusions: Better awareness involved better understanding in the YOAD group. Clinically, our findings shed light on the need to consider the differences in the domains of awareness and their relationship with other clinical aspects such as decision-making capacity according to age at onset of AD.

FC44: Sex differences in population attributable fractions of modifiable dementia risk factors: evidence from Rush University Memory and Aging Project.

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Objectives: Understanding how the importance of modifiable risk factors for dementia varies by cognitive status and sex is vital for the development of effective approaches to dementia prevention. We aimed to calculate population attributable fractions (PAFs) for incident dementia associated with sets of risk factors while exploring sex differences in individuals who are cognitively normal (CN) or has mild cognitive impairment (MCI).

Methods: Longitudinal data from the Rush University Memory and Aging Project (MAP) were analysed. Included participants were aged over 50 years and were CN or with a diagnosis of MCI at their baseline assessment. Analyses considered fifteen potential dementia risk factors covering cardiometabolic, lifestyle, psychosocial and sensory domains. We used Cox proportional hazard models to estimate the hazard ratios for incident dementia associated with dementia risk factors and calculated weighted PAFs. All analyses were repeated stratified by sex.

Results: The analytical sample comprised 754 cognitively normal participants (77.2% female) and 242 participants with a diagnosis of MCI (71.9% female), of whom 214 (28.4%) and 120 (49.6%) were diagnosed with dementia across the follow-up, respectively. Although the weighted overall PAF was similar for CN (24.7%) and MCI (25.2%) subgroups, sex differences were present in both. Compared to in females, PAFs were higher in males in both CN (42.5% vs. 25.1%) and MCI (51.6% vs 12.3%) subgroups. The profiles of contributing risk factors also varied by sex. In males, the highest PAFs were smoking (11.1%), vision impairment (6.2%) and stroke (6.0%) in CN and smoking (13.3%), physical inactivity (12.9%) and heart attack (7.9%) in MCI. In females, the highest PAFs were unmarried marital status (4.9%), depression (4.1%) and social isolation (3.8%) in CN and vision impairment (4.4%), increased alcohol intake (3.5%) and depression (2.6%) in MCI.

Conclusions: These findings support the notion that dementia risk is modifiable after the onset of MCI. They also highlight the potential benefits of considering an individual's cognitive status and sex when formulating dementia prevention strategies.

FC45: Is dementia a tragedy? Comments from the philosophy of ambiguity.

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Introduction: In public discourse and media, as well as in medical settings, dementia is often portrayed as a tragedy, a perspective that contributes to stigma. Descriptions using metaphors like decaying fruit, or statements labeling dementia as death in life" and a tsunami for healthcare systems," not only perpetuate negative emotions like fear and helplessness, but also promote social distance. These dehumanizing expressions can intensify the suffering of those living with dementia and those around them, besides complicating understanding of the condition, exacerbating social isolation, and hindering timely medical attention. Questioning the narrative of dementia as a tragedy does not imply denying or underestimating the challenges and suffering associated with this condition. However, diagnosis should not hinder the recognition of moments of pleasure, the potential for internal growth of the person living with dementia and those around them, as well as the persistence of connection and dignity. The philosophy of ambiguity offers a useful framework for countering a stigmatizing narrative and addressing dementia with a more compassionate and nuanced approach. The philosophy of ambiguity, primarily expounded by Simone de Beauvoir, invites us to recognize the coexistence of multiple realities and the simultaneous presence of contradictions. This is reflected in the complex contradictions and paradoxes present in our experiences, both personal and social. Health itself is an ambiguous concept, representing not only the absence of illness but also a dynamic and multifaceted state, culturally and contextually influenced. By focusing on preserved abilities, we can contribute to the well-being of those living with dementia, reinforcing their dignity and self-esteem. The success of this approach depends on having adequate social support and an effective healthcare system. Understanding dementia in a broad social and cultural context allows us to overcome the traditional Manichean view that categorizes it strictly as either tragedy or well-being. It is crucial for medical personnel to use empathetic and respectful communication to maintain dignity and foster hope in those living with dementia. Listening carefully and avoiding stigmatizing language are fundamental to recognizing individual worth and creating a more compassionate and humane care environment.