



HAL
open science

Impact of Physical Activity on Alzheimer's Disease: A Randomised Controlled Study

Toulotte Claire, Caby Isabelle, H el ene Olivier, Nicolas Olivier

► **To cite this version:**

Toulotte Claire, Caby Isabelle, H el ene Olivier, Nicolas Olivier. Impact of Physical Activity on Alzheimer's Disease: A Randomised Controlled Study. *Journal of Intellectual Disability - Diagnosis and Treatment*, 2016, 4 (2), pp.110-116. 10.6000/2292-2598.2016.04.02.4 . hal-03374933

HAL Id: hal-03374933

<https://hal.science/hal-03374933>

Submitted on 18 Oct 2021

HAL is a multi-disciplinary open access archive for the deposit and dissemination of scientific research documents, whether they are published or not. The documents may come from teaching and research institutions in France or abroad, or from public or private research centers.

L'archive ouverte pluridisciplinaire **HAL**, est destin ee au d ep ot et  a la diffusion de documents scientifiques de niveau recherche, publi es ou non,  emanant des  tablissements d'enseignement et de recherche fran ais ou  trangers, des laboratoires publics ou priv es.

1 **Impact of physical activity on Alzheimer's disease: a randomised controlled study.**

2

3 **Toulotte Claire**^{1, 2}, Caby Isabelle^{2, 3}, Olivier Hélène², Olivier Nicolas³

4

5 Toulotte Claire : ctoulotte@wanadoo.fr

6 Caby Isabelle : isabelle.caby@univ-artois.fr

7 Olivier Hélène : h.olivier2@wanadoo.fr

8 Olivier Nicolas : nicolas.olivier@univ-lille2.fr

9

10 ¹ Université de Valenciennes, Faculté des Sciences et Métiers du Sport, Le Mont Houy,
11 F-59313, Valenciennes Cedex 09, France ; LAMIH, CNRS, UMR CNRS 8201, F-
12 59313, Valenciennes Cedex 09, France.

13 ² University of Artois, Faculté des sciences du sport et de l'éducation physique, Chemin
14 du Marquage, F-62800, Liévin, France.

15 ³ University of Lille Nord de France, F-59000, Lille, France; URePSSS, EA 4488, F-
16 59790, Ronchin, France.

17

18 Corresponding author:

19 Toulotte Claire

20 Université d'Artois, Faculté des sciences du sport

21 Chemin du marquage

22 62 800 LIEVIN

23 FRANCE

24 Tel : (33) 321-45-85-15 ; Fax : (33) 321-45-85-01.

25 0321458500 / Fax: 0321458501

26 ctoulotte@wanadoo.fr

27

28

1 **Impact of physical activity on Alzheimer’s disease: a randomised controlled study**

2 **ABSTRACT**

3 **Purpose:** To study the effects of physical training on behavior and balance issues in
4 elderly people afflicted with Alzheimer’s disease. **Method:** Forty patients (average age:
5 80 years old) participated in the study. The individuals were placed into two groups: a
6 control group, which did not participate in any kind of training, and a trained group,
7 which followed an eight-week training program. The training program comprised 2–3
8 sessions of light physical activity or walking per week; each session had an average
9 duration of 15–55 min. Before (T1) and after (T2) the training program, an assessment
10 of the psychical, psychological, physical, and functional parameters was conducted.
11 **Results:** Upon completion of the physical training program, there was a significant ($p <$
12 0.05) improvement in the Tinetti test (T1: 19.5 ± 4.2 s; T2: 20.1 ± 4.1 s), a significant
13 decrease in the completion time of the “get up and go” track for all of the participants
14 (T1: 23.1 ± 8.1 s; T2: 19.5 ± 6.1 s), and a significant reduction in the seriousness of the
15 behavioral issues observed. **Conclusion:** This preliminary study revealed that physical
16 training had an overall beneficial impact on Alzheimer’s patients, especially on their
17 behavior and balance.

18 **Keywords:** elderly people, physical activity, behavior, balance.

19

1 Introduction

2 The rehabilitation and care of patients afflicted with Alzheimer's disease is a major
3 public health challenge. In 2006, it was estimated that 26.6 million people worldwide
4 are affected by this disease [1]. By 2050, it is estimated that 106.8 million people will
5 have Alzheimer's disease, a ratio of 1 to 85. This disease causes problems with memory
6 (in particular, recent memory), temporary spatial disorientation, apraxia, issues with
7 language, and anosognosia. Changes in behavior and humor are present throughout the
8 disease progression. A study by Ownby et al. [2] revealed that depression affects a large
9 number of Alzheimer's patients: as the disease progresses, the number of issues with
10 communication increases. Behavioral problems are frequent; indeed, agitated behaviors
11 are 2× more prevalent in patients with Alzheimer's disease. The appearance of
12 behavioral issues worsens the prognosis and correlates with the evolution towards
13 dementia [3,4,5]. According to Beauchet et al. [6], 25% of people with this disease have
14 issues with walking and balance. Since cognitive decline is known to be a cause of
15 falling, people with cognitive decline experience 2× the risk of falling. Indeed,
16 demented people have a fall risk 8–10× higher than non-demented people. The
17 limitation of physical activities has been identified as an important indicator in balance
18 [7].

1 The beneficial effects of physical activity on organisms are generally accepted and are
2 now understood for specific subsets of the population. The regular practice of physical
3 activity can delay or slow down some deleterious processes linked to ageing or to a
4 specific pathology [8]. Physical activity seems to affect these processes through three
5 different mechanisms: it preserves physical [9,10,11], psychological [12,13], and social
6 health [14], enabling a person to preserve their independence and integration in a group.
7 Indeed, functional independence is the basis for balance, health, and quality of life [15].
8 Establishing physical exercises for Alzheimer's patients has salutary effects on both
9 their physical and psychological functions and could be a way to improve their
10 cognitive and behavioral processes. Therefore, it could increase their quality of life
11 [16,17,18,19].

12 Beauchet et al. [6] demonstrated the benefit of regular physical activity (e.g., walking,
13 cycling, gardening, swimming) for individuals with or at risk of Alzheimer's disease.
14 This benefit is twofold: physical activity decreases the risk of dementia in healthy
15 individuals and reduces behavioral and locomotive problems in demented patients.
16 Therefore, physical activity can play a protective role. A daily practice of at least 30
17 minutes of physical activity can reduce psycho-behavioral issues and influence mood by
18 reducing negative thoughts and increasing positive ones [12].

1 Regardless of the pathology, physical exercise seems to play a determining role in
2 therapeutic care. However, the beneficial effects of physical activity for patients with
3 Alzheimer's disease are not yet well known. The objective of this preliminary study was
4 to analyze the effects of physical training for these patients using individual and group
5 physical activities. We hypothesized that this type of exercise program would have a
6 positive impact on their behavior, depressive state, and balance.

7

1 1. Materials and methods

2 2.1 Participants

3 The study comprised a population of 40 individuals, with an average age of 80 years
4 old, including residents of two institutions with an Alzheimer division located in France
5 in the Pas-de-Calais department. Before the beginning of this study, the purpose was
6 explained to the volunteers and the families. Forty volunteers participated in this study,
7 which was reviewed and approved by the local University Ethics Committee. Before
8 experimentation and after being informed of the entire protocol, each patient and each
9 family signed a written consent form. A summary of the patients' anthropometric,
10 psychological, and physical characteristics is available in Table 1.

11 The inclusion criteria were elderly patients who: had Alzheimer's or a similar disease,
12 could understand instructions and agree to participate in physical activities, and were
13 not bedridden, or have moving disabilities that would preclude physical activity.

14 The psychological state of the patients was evaluated every year with a Mini Mental
15 State examination (MMS) [20].

16 Then, the 40 subjects were randomly divided into 2 groups of 20 subjects. We
17 placed the participants into two groups: an experimental group with 20 patients who
18 followed an eight-week training program and a control group with 20 patients who did

1 not participate in any physical activity during this period. The evaluation was made
2 after an eight-week training program in order to assess if the training load was
3 sufficient.

4

5 2.2 Experimental protocol

6 The participants were evaluated two days before the start of the training program and
7 two days after it by the same evaluator. The evaluations consisted of balance tests,
8 behavioral tests, and a test for depression.

9 2.3 Measured parameters

10 2.3.1 Tinetti test [21]

11 The Tinetti test precisely identifies walking and balance deficiencies in elderly people
12 during different daily life situations. The test is divided into two parts and is evaluated
13 with 28 points. The first part evaluates balance and is scored on 16 points. Balance
14 during sitting, standing, and in a closed eyes position are observed during this portion.
15 The second part of the test is dedicated to walking and is evaluated on 12 points.
16 Straight walking is performed and different parameters are evaluated: the length, height,
17 symmetry, and continuity of the steps.

18

1 2.3.2 Get up and go test [22]

2 This test evaluates various parameters such as the sitting/standing transfer, walk, and
3 direction changes. The test methodology is the following: participants started by sitting
4 on a chair with armrests, they had to get up and walk 3 meters towards a wall, turn
5 around without touching the wall, and come back to sit on the chair. The test was timed;
6 the timer started as soon as the person tried to get up from the chair and stopped when
7 they returned to a seated position.

8

9 2.3.3 Neuropsychiatric Inventory [23] (NPI)

10 This test provides information about the existence, seriousness, and consequences of
11 any behavioral issues. It assesses 12 types of behaviors (delirious ideas, hallucinations,
12 agitation, depression, anxiety, mood elation, apathy, disinhibition, irritability, abusive
13 moving behavior, appetite issues, and sleeping difficulties). If a participant presented
14 one of these behaviors, the seriousness of the behavioral issue and consequences, i.e.,
15 the extent that this behavior was demanding for the person, was evaluated. The
16 seriousness is evaluated on 36 points and is designated as “light, medium, or strong”.
17 The impact is graded on 60 points and is scored as “none, minimal, slightly, moderately,
18 serious, or very serious”. This test was evaluated by a person from the institute who
19 knew the patients well.

1 2.3.4. The mini-GDS (Geriatric Depression Scale) [24]

2 For the participants who exhibited depressive behavior (indicated by the results of the
3 NPI test), we employed the mini-GDS. This is a scale for geriatric depression with four
4 questions (1st: do you feel discouraged and sad?, 2nd: do you have the feeling that your
5 life is empty?, 3rd: do you feel happy most of the time?, and 4th: do you feel that your
6 life is hopeless?). The participants must situate themselves in the past (approximately
7 one week) and should reply with a yes or no.

8

9 2.4 Training program

10 The training program was based on physical activity and walking to improve the
11 patient's balance and behavior issues.

12 To correctly perform the physical activity, the population was divided into four groups,
13 which were determined following the Autonomy Gerontology Iso-Resources Group
14 (AGGIR) matrix. This tool can evaluate the degree of loss of autonomy or the degree of
15 physical and psychological dependence. The first group corresponds to the autonomous
16 residents and comprised four people. The second group consisted of five people and
17 corresponds to the residents who are a bit less autonomous but who still have a lot of
18 capacities. The third group comprised four people who are more dependent and have

1 walking issues. Finally, the last group corresponds to the patients in wheelchairs. It
2 consisted of four people. In addition to these groups, three residents received short,
3 individual sessions because they could not stay focused for long periods of time.

4 All of the patients followed a program of two sessions of physical activity and one
5 walking session per week for two months. The gymnastic sessions lasted 15–55
6 minutes, depending on the capacity of the group. The walking sessions generally lasted
7 5–15 minutes and were performed individually. All of the groups performed the same
8 type of exercise but with different durations and intensities, depending on their capacity.
9 A different theme was proposed for each session: development of muscular strength,
10 flexibility (using objects such as rings, hoops, sticks, balls, or scarves), or static and
11 dynamic balance.

12 Each session was divided into three parts: a warm-up consisting of an articular
13 mobilization of the body; the main part of the session, composed of exercises for
14 muscular strength, flexibility, movement, and games to facilitate competition between
15 the residents without putting them in failure situations; and a cooling down period with
16 stretching, breathing, and relaxation exercises. All of the exercises were proposed by an
17 adapted physical activity teacher.

18

19

2.5 Statistics

The statistical calculations were carried out with the SigmaStat software. The results are expressed as an average and its standard deviation ($m \pm SD$). A student's t-test for an independent sample was used to check the homogeneity of the two groups (age, weight, and MMS examination). The two-way repeated measures analysis of variance (time*group) was used to compare the "get up and go" test. To compare the Tinetti test, behavioral problems, depression, and mini-GDS for the training group before and after the training period, a paired t-test was used. The threshold of significance was set at $p < 0.05$.

1 2. Results

2 The anthropometric characteristics (age, weight, and MMS) did not present significant
3 differences ($p = 0.868$; $p = 0.841$; $p = 0.160$, respectively) between the trained and
4 control groups (table 1). Furthermore, there were no significant differences ($p = 0.183$)
5 between the two groups regarding mobility (“get up and go” test). Therefore, the two
6 groups were equivalent before training with regards to anthropometry (age and weight),
7 mental capacity (MMS), and physical condition (“get up and go”).

8

9 Table 1

10

11 3.1 Balance tests

12 3.1.1 Get up and go test and Tinetti test (tables 2 and 3)

13 Only the “get up and go” test was measured before and after eight weeks of training
14 (table 2). For both groups, there was a significant difference after the eight-week period:
15 a significant decrease ($p < 0.05$) in the completion time of the circuit for the trained
16 group and a significant increase ($p < 0.05$) for the control group.

17 Table 2

1 Table 3

2 Table 3 represents the average scores on the Tinetti test of the trained group. At T2, the
3 values are significantly higher (T1: 19.5 ± 4.2 ; T2: 20.1 ± 4.1 ; $p < 0.05$).

4

5

6 3.2 Tests of behavior and depression (table 4)

7 Table 4

8 3.2.1 NPI

9 As mentioned earlier, the NPI is divided into two parts: the seriousness of the issue and
10 its consequences. Therefore, we separated the results into two parts. A significant
11 difference ($p < 0.05$) between the two tests was observed for the seriousness of the
12 problem (graph 2). A similar result was found for the consequences of the problem
13 (graph 3).

14

15 3.2.2 Mini-GDS

16 The mini-GDS was performed on the people reported as depressive in the NPI. Of the
17 10 people identified, three were not testable because of the advanced stage of the
18 disease. No differences were noticed during the eight-week period for the other seven
19 patients (T1: 2.29 ± 0.76 ; T2: 1.57 ± 0.53 ; $p > 0.05$).

20

3. Discussion

The objective of this study was to examine the effects of a short-term physical activity training program, comprising both collective and individual care, for behavior and balance issues in elderly people with Alzheimer's disease. For each test performed (Tinetti and "get up and go" tests), significant improvements were found in the training group (tables 2 and 3). This difference was only a slight amount but after the eight-week physical program, the staff saw an increase in physical capacity and a behaviour change. In the absence of mental or physical stimulation, the control group declined rapidly because these subjects were very vulnerable and frail. These results are promising and help to validate the role of physical activity on the well-being (physical and psychological) and the physical and psychological capacities of people afflicted with Alzheimer's disease. The results are in agreement with previous studies and justify the development of care support programs involving physical activity for this pathology.

Although the risk of falling is high for Alzheimer's patients, our results indicate that a program of physical activity is an important element to maintain balance functions. Furthermore, the results of the NPI revealed a decrease in the seriousness and consequences of behavioral issues at T2 (table 4). Therefore, it seems that physical activity not only leads to improvements in physical problems, it also plays a major role

1 in alleviating behavioral issues, confirming the conclusions of several studies on this
2 subject [25,26,27]. Participation in a program of regular physical exercise can reduce or
3 prevent various functional failures that occur from aging.

4 There were several expected effects of the physical activity on cognition as well, i.e.,
5 improved self confidence, stress and anxiety management, maintenance of focus,
6 attention, memorization, listening training, and instruction comprehension [14]. Regular
7 physical activity can also provide relief to depression symptoms and behaviors, as well
8 as improvement to personal control efficiency. Oppert et al. [28] hypothesized that
9 regular physical activity could maintain the cognitive functions of elderly individuals,
10 which could decrease the risk of dementia and Alzheimer's disease. Indeed, Larson et
11 al. [29] have shown a 32% decrease in the risk of contracting Alzheimer's disease for
12 elderly individuals who train more than three times per week. In a meta-analysis, Etnier
13 et al. [30] found that active people have better cognitive performances than inactive
14 ones. Rejeski et al. [31] purported that there exists a real impact of physical activity on
15 the mental health, quality of life, and well-being of the aging population.

16 Accordingly, the importance of physical activity on social health can also be
17 hypothesized because of the social link established between people during adapted
18 physical activities and between people and the physical activity teacher. Therefore,

1 physical exercises play an important role in the maintenance of the overall functional
2 state, and they enable the stabilization and improvement of altered cognitive functions.

3 The limited duration of the training program likely reduces the possible progression
4 level of the physical activity. Despite this limitation, the training program produced
5 encouraging and significant effects for the development and continuation of this type of
6 care. Indeed, the nursing staff in the medical center, who had a deeper look and
7 knowledge of the patients selected for the study and who were able to assess any
8 eventual long-term improvements, were globally surprised by the effects of the program
9 and capacity for development of some of the participants. The staff judged the program
10 as beneficial, not only regarding their long-term personal experiences with the patients,
11 but also when considering the feelings given by the patients themselves.

12 Consideration of the patient's feelings was relatively complex because of the nature of
13 Alzheimer's disease. The large variations we observed in the behavior over the short
14 period of time can limit the significance and reliability of the responses given to the
15 evaluation and satisfaction questionnaires (mini-GDS), which was done to gather the
16 impressions of the participants on the program. Despite this inherent difficulty, the
17 impressions about the program were positive: the large majority of patients showed
18 their willingness to continue with the program.

1 The set-up of the program presented stimulating and sometimes difficult challenges.
2 Patients with Alzheimer's disease or a similar pathology are particularly difficult to
3 handle and follow up. For example, failure situations should be avoided, which would
4 have negative impacts on this subset of patients. A progressive program should be
5 established to allow patients to engage in a positive dynamic [25,26,27]. Failure
6 situations often cause the patient to discontinue the program. Therefore, close attention
7 and precise knowledge of the capacities of each patient is necessary to develop realistic
8 training and to reach fixed goals.

9

10 4. Conclusion

11 This preliminary study, which was performed under good experimental conditions, has
12 established the beneficial effects of patients that perform physical exercise. Despite the
13 lack of long-term results, it validates the positive role of physical activity on the
14 behavior and balance regulation of patients affected by Alzheimer's disease.

15

16

17

18

1 **Clinical message:**

- 2 • The objective of this study was to examine the effects of a short-term physical
3 activity training program, for behavior and balance issues in elderly people with
4 Alzheimer's disease.
- 5 • The results are in agreement with previous studies and justify the development
6 of care support programs involving physical activity for this pathology.

7

8 **Ethics** : the procedures followed were in accordance with the Declaration of Helsinki
9 1975.

10

11 **Acknowledgements** : We acknowledge the physiotherapists and the participants for
12 their contributions.

13

14 **Conflict of interest** : The authors declare that there is no conflict of interest.

15

16 **Funding support** : This research didn't receive any funding support.

17

1 References

- 2 [1] Brookmeyer R, Johnson E, Ziegler-Graham K, Arrighi HM. Forecasting the
3 global burden of Alzheimer's disease. *Alzheimers Dement* 2007; 3: 186-91.
- 4 [2] Ownby RL, Crocco E, Acevedo A, John V, Loewenstein D. Depression and risk
5 for Alzheimer diseases: systematic review, meta-analysis, and metaregression
6 analysis. *Arch Gen Psychiatry* 2006; 63: 530-38.
- 7 [3] Koss E, Weiner M, Ernesto C, Cohen-Mansfield J, Ferris SH, Grundman M et al.
8 Assessing patterns of agitation in Alzheimer's disease patients with the cohen-
9 mansfield agitation inventory. The Alzheimer's disease cooperative study. *Alzheimer*
10 *Dis Assoc Disord* 1997;11 Suppl 2: S45-50.
- 11 [4] Pariel-Madjlessi S, Pouillon M, Robcis I, Sebban C, Frémont P, Belmin J.
12 Depression: an underrated consequence of stroke in elderly. *Psychol Neuropsychiatr*
13 *Vieil* 2005; 3 :7-16.
- 14 [5] Bakchine S. Troubles comportementaux dans les démences de type Alzheimer.
15 In : Habib M, Joanette M, Puel M, editors. *Démence et syndromes démentiels.*
16 *Approche neuropsychologique.* Paris: Masson 1991; p. 213-22.
- 17 [6] Beauchet O, Allali G, Berrut G, Hommet C, Dubost V, Assal F. Gait analysis in
18 demented subjects: interests and perspectives. *Neuropsychiatric Disability Treatment*
19 2008; 4: 155-60.
- 20 [7] Allan LM, Ballard CG, Rowan EN, Kenny RA. Incidence and prediction of falls
21 in dementia: a prospective study in older people. *PloS One* 2009; 4:1-8.
- 22 [8] Bean JF, Vora A, Frontera WR. Benefits of exercise for community-dwelling
23 older adults. *Arch Phys Med Rehabil* 2004; 85: S31-S42.
- 24 [9] Ferrucci L, Izmirlian G, Leveille S, Phillips CL, Corti MC, et al. Smoking, physical
25 activity, and active life expectancy. *Am J Epidemiol* 1999; 149: 645-53.

- 1 [10] Wu SC, Leu SY, Li CY. Incidence of and predictors for chronic disability in
2 activities of daily living among older people in Taiwan. *J Am Geriatr Soc* 1997; 47:
3 1082-86.
- 4 [11] Cress E, Buchner D, Prohaska T, Rimmer J, Brown M et al. Physical activity
5 programs and behavior counseling in older adult populations. *Med Sci Sports Exerc*
6 2004; 36: 1997-2003.
- 7 [12] Rolland Y, Abellan van Kan G, Vellas B. Physical activity and Alzheimer's
8 disease: from prevention to therapeutic perspectives. *J Am Med Dir Assoc* 2008; 9:
9 390-405.
- 10 [13] Ruscheweyh R, Willemer C, Krüger K, Duning T, Warnecke T, Smmer J et al..
11 Physical activity and memory functions: an interventional study. *Neurobiol Aging*
12 2011; 32: 1304-19.
- 13 [14] Depiesse F. *Vieillesse et activité physique*. Elsevier Masson 2009.
- 14 [15] Rejeski WK, Mihalko SL. Physical activity and quality of life in older adults. *J*
15 *Ferontol A Biol Sci Med* 2001; 56: 23-25.
- 16 [16] Mauvieux B, Davenne D, Gruau S, Sesboüé B, Denise P. Effet de l'entraînement
17 physique et sportif sur le rythme circadien de la température et le rythme veille-
18 sommeil chez la personne âgée. *Science et sports* 2002; 18: 93-103.
- 19 [17] Albinet C, Bernard P-L, Palut Y. Contrôle attentionnel de la stabilité posturale
20 chez la personne âgée institutionnalisée : effets d'un programme d'activité physique.
21 *Ann Réadapt Med Phys* 2006; 49: 625-631.
- 22 [18] Vogel T, Bréchat PH, Lonsdorfer J. Consultation de l'aptitude physique du
23 senior (CAPS) comprenant un programme court de reconditionnement en endurance:
24 le programme d'endurance personnalisé sur cycle (PEP'C). Premiers résultats d'une
25 étude pilote. *Science et sports* 2007; 24: 21-26.

- 1 [19] Hill KD, Logiudice D, Lautenschlager NT, Said CM, Dodd KJ, Suttanon P.
2 Effectiveness of balance training exercise in people with mild to moderate severity
3 Alzheimer's disease: protocol for a randomized trial. *BMC Geriatr* 2009; 9: 29.
- 4 [20] Folstein MF, Folstein SE, McHugh PR. « Mini-mental state ». A practical
5 method for grading the cognitive state of patients for the clinician. *J Psychiatr Res*
6 1975; 12 : 189-98.
- 7 [21] Tinetti ME, Baker DI, Claus E, Garrett P, Gottschalk M, Koch M, et al. A
8 multifactorial intervention to reduce the risk of falling among elderly people living in
9 the community. *N Engl J Med* 1994; 331: 821-827.
- 10 [22] Podsiadlo D, Richardson S. The timed "Up & Go": a test of basic functional
11 mobility for frail elderly persons. *J Am Geriatr Soc* 1991; 39 : 142-8.
- 12 [23] Cummings JL, Mega M, Gray K, Rosenberg-Thompson S, Carusi DA, Gornbein
13 J. The Neuropsychiatric Inventory: Comprehensive assessment of psychopathology
14 in dementia. *Neurology* 1994; 44: 2308-2314.
- 15 [24] Clément JP, Nassif RF, Leger JM, Marchan F. Mise au point et contribution à la
16 validation d'une version française brève de la Geriatric Depression Scale de
17 Yesavag. *L'Encéphale* 1997; XXIII: 91-9.
- 18 [25] Williams CL, Tappen RM. Effect of exercise on mood in nursing home residents
19 with Alzheimer's disease. *Am J Alzheimers Dis Other Demen* 2007; 22: 389-97.
- 20 [26] Lautenschlager NT, Cox KL, Flicker L et al. Effects of physical activity on
21 cognitive function in older adults at risk for Alzheimer's disease. *JAMA* 2008; 300:
22 1027-37.
- 23 [27] Hernandez SS, Coelho FG, Gobbi S, Stella F. Effects of physical activity on
24 cognitive functions, balance and risk of falls in elderly patients with Alzheimer's
25 dementia. *Rev Bras Fisioter* 2010; 14 : 68-74.

1 [28] Oppert JM, Simon C, Rivière D. Activité physique: arguments scientifiques,
2 pistes pratiques. Collection « Les synthèses du PNNS ». Paris: Ministère de la Santé.
3 2006; p. 58.

4 [29] Larson EB, Wang L, Bowen JD, Mc Cormick WC, Teri L, Crane P et al.
5 Exercise is associated with reduced risk for incident dementia among persons 65
6 years of age and older. *Ann Intern Med* 2006; 144 : 73-81.

7 [30] Etnier JL, Nowell PM, Landers DM, Sibley BA. A meta-regression to examine
8 the relations ship between aerobic fitness and cognitive performance. *Brain Res Rev*
9 2006; 52 : 119-30.

10 [31] Rejeski WJ, King AC, Katula JA, Kritchevsky S, Miller ME, Walkup MP et al.
11 Physical activity in prefrail older adults: confidence and satisfaction related to
12 physical function. *J Gerontol B Psychol Sci Soc Sci* 2008; 63 : 19-26.

13
14
15
16
17
18
19
20
21

1 Table 1: Anthropometric characteristics for the trained and control groups

	Control group	Trained group
	n = 20	n = 20
Age (year)	80.7 ± 7.8	80.2 ± 9.2
Weight (kg)	66.1 ± 13.7	65.2 ± 14.6
Mini Mental State	18.9 ± 6.3	15.8 ± 4.4

2 *The values are the average ± SD; n: number of subjects*

3

4

5

6

7

8

9

10

11

12

1 Table 2: Comparison between the average time (seconds) spent completing the “get up
2 and go” test before (T1) and after the eight-week training period (T2) for the training
3 and control groups

	T1	T2
Control group	19.5 ± 6.1 *	23.1 ± 8.1
Trained group	25.1 ± 2.9	19.6 ± 7.1 §

4 *The values are the average ± SD; * significant intra-group difference (p<0,05); §*
5 *significant inter-group (p<0,05).*

6

7

8

9

10

11

12

13

14

15

1 Table 3: Comparison between the average score on the Tinetti test before (T1) and after
2 the eight-week training period (T2) for the training group.

	T1	T2
Trained group	19.5 ± 4.2 *	20.1 ± 4.1

3 *The values are the average ± SD; * significant intra-group difference (p<0,05).*

4

5

6

7

8

9

10

11

12

13

- 1 Table 4: Comparison between the average score on the NPI test before (T1) and after
 2 the eight-week training period (T2) for the training group.

	T1	T2
NPI (seriousness), 36 points	9.0 ± 5.5 *	7.1 ± 5.1
NPI (impact), 60 points	13.8 ± 8.7 *	11.5 ± 7.9

3 *The values are the average ± SD; * significant intra-group difference (p < 0.05)*

4