**Fructose Consumption is Associated with a Higher Risk of dementia and Alzheimer's disease: A Prospective Cohort Study**

**eMethod:**

**Dementia surveillance and flagging of suspected cognitive impairment**

The Epidemiology of Dementia Study has tracked incident cases of dementia in the Framingham cohort. Although not formally initiated until 1986, the initial baseline dementia-free Original cohort was determined from 1976-78. Tracking for incident dementia in the Offspring cohort also began in 1976 and subjects have had serial MMSE since 1991. Participants whose performance on the MMSE drops 5 or more points across multiple examinations or 3 or more points from the previous examination or who are referred by themselves, their family, a physician from the community or from a FHS ancillary study examination, are flagged for a follow-up neurological and neuropsychological evaluation. Once flagged with suspected cognitive impairment, participants completed annual neurological and neuropsychological assessments until they develop dementia or were adjudicated to be normal. If assessments were suggestive of possible mild cognitive impairment (MCI) or dementia, the case was referred to our dementia review committee, comprising a neurologist and neuropsychologist.

**Case ascertainment for incident dementia**

Follow-up for incident dementia occurred in person every 6 months with complete neuropsychological testing, clinical dementia rating, and assessment of activities of daily living. We also performed twice yearly physical and neurological exams as well as a review of medications, medical history and incident events. Such assessments alternated between examinations conducted in person and by phone (i.e., neurological exams occurred every 6 months and at least annually in person) during follow-up, suspected cases of dementia were reviewed by an independent committee. Dementia was diagnosed according to the Diagnostic and Statistical Manual of Mental Disorders, 4th edition.[1](#_ENREF_1) A diagnosis of AD dementia was based on the criteria of the National Institute of Neurological and Communicative Disorders and Stroke and the AD and Related Disorders Association for definite, probable, or possible AD.[2](#_ENREF_2)

**REFERENCES**

1. American Psychatric Association.Arlington V. *Diagnostic and Statistical Manual of Mental Disorders.4th ed.* American Psychiatric Publishing; 2000.

2. McKhann G, Drachman D, Folstein M, Katzman R, Price D, Stadlan EM. Clinical diagnosis of Alzheimer's disease: report of the NINCDS-ADRDA Work Group under the auspices of Department of Health and Human Services Task Force on Alzheimer's Disease. *Neurology.* 1984;34(7):939-944.