**ROLE OF PHYSICAL ACTIVITY IN AMELIORATING NEUROPSYCHIATRIC SYMPTOMS IN ALZHEIMER’S DISEASE: A NARRATIVE REVIEW**

**Running title: Physical Activity and Neuropsychiatric Symptoms**

Nicola Veronese 1,2, Marco Solmi 3,4, Cristina Basso5, Lee Smith6, Pinar Soysal 7

1 National Research Council, Neuroscience Institute, Aging Branch, Padova, Italy.

2Geriatrics Unit, Department of Geriatric Care, Ortho Geriatrics and Rehabilitation, E.O. Galliera Hospital, National Relevance and High Specialization Hospital, Genova, Italy.

3 Department of Neurosciences, University of Padova, Padova, Italy.

4 Centro Neuroscienze Cognitive, University of Padua, Padua, Italy.

5 Regional Epidemiology Service, Azienda Zero, Veneto Region, Italy.

6 The Cambridge Centre for Sport and Exercise Sciences, Department of Life Sciences, Anglia Ruskin University, Cambridge, UK.

7 Department of Geriatric Medicine, Bezmialem Vakif University, Faculty of Medicine, Istanbul, Turkey.

Word Count: 3815

Funding or Sponsor: No

Conflict of Interest: No

**Corresponding Author:** Pinar SOYSAL, MD, Associate Professor

Department of Geriatric Medicine, Bezmialem Vakif University, Faculty of Medicine, Istanbul, Turkey

Phone: +90 [(0212) 523 22 88](https://www.google.com.tr/search?q=bezmialem+%C3%BCniversitesi&oq=bez&aqs=chrome.2.69i57j69i60j69i59j35i39j0l2.3942j0j8&sourceid=chrome&ie=UTF-8) Fax: +90 (212) 453 18 70.

Email: [dr.pinarsoysal@hotmail.com](mailto:dr.pinarsoysal@hotmail.com)

**ABSTRACT (226/250)**

**Objective:** Neuropsychiatric symptoms (NPs) affect almost all patients with Alzheimer’s disease (AD). Because of the complications associated with the pharmacological treatment, non-pharmacological treatment (such as physical activity) can be considered as an additional complementary treatment option for NPs. The aim of this review is to evaluate the impact of physical activity on NPs in patients with AD.

**Methods:** We searched Pubmed and Google Scholar for potential eligible articles until 01st March 2018.

**Results:** Although there are contradictory results showing the impact of physical exercise on NPs, most of them reported that it had a significant effect on depression and sleep disturbances in patients with AD. The beneficial effects could be explained through several mechanisms, including modulated production of neurotransmitters; increasing neurotrophins, such as brain-derived neurotrophic factor; reduction of oxidative stress and inflammation; elevation of cerebral blood flow; hypothalamic pituitary adrenal axis regulation; support of neurogenesis and synaptogenesis. Physical activity can also improve cardiovascular risk factors, which may exaggerate NPs. There is limited evidence for other NPs such as agitation, disinhibition, apathy, hallucinations, and anxiety.

**Conclusion:** Physical activity may ameliorate depression and sleep disturbances in patients with AD. Therefore, physical activity can be a "potential" add-on treatment to drugs to reduce or prevent these symptoms onset and recurrence in patients with AD. However, further studies are needed to focus on relationship between physical activity and other NPs.

**Keywords:** Alzheimer’s disease, neuro­psychiatric symptoms, physical exercise, physical activity

**Key points:**

* Physical activity has a positive effect on cognitive flexibility, depressive symptoms, cardiovascular health, and general wellness which are predictors of AD.
* Physical activity can ameliorate depression and sleep disturbances in patients with AD.
* Physical activity can be considered as potential add-on treatment to drugs to reduce or prevent some NPs onset and recurrence, with no serious side effects and many proven health benefits.

**INTRODUCTION**

As global population becomes older, one of the most common chronic health condition is Alzheimer’s disease (AD) .1 That means that not only AD, but also the burden it brings to families, caregivers, healthcare systems and governments will increase in the next future. In addition to cognitive impairment, neuropsychiatric symptoms (NPs) in dementia are amongst the strongest causes of the burden and often occur as a result of deterioration in mood, thought, perception, and behavior.2 These symptoms have been traditionally divided into four clusters: hyperactivity cluster (agitation, aggression, euphoria, disinhibition, irritability, aberrant motor activity), psychosis cluster (hallucinations and delusions), mood liability cluster (depression and anxiety), and instinctual cluster (appetite disturbance, sleep disturbance, and apathy) 2 and they pave the way for long-term hospitalization, accelerated disease progression, dependence on activities of daily living, decreased quality of life, increased mortality and cost of care. 3 Several previous studies found that NPs are more closely related to caregiver burden than other symptoms, such as deteriorated cognitive function or limitations in the activities of daily-living 4,5 and caregivers of the patients with NPs are more vulnerable. 6 One or more of NPs can affect approximately 97% of patients with AD during the course of the disease. 3,7 A recent study also demonstrated that the prevalence of having at least one NPs among patients with mild cognitive impairment (MCI) and mild–moderate dementia was 74% and 85%, respectively. 8 When these high ratios are considered, it is clear that preventing or at least treating NPs is very important in patients with AD. However, dealing with NPs is very complex for both health care professionals and families.

Although currently pharmacological therapies (such as antidepressants, antipsychotics, anxiolytics, anticonvulsants and cholinesterase inhibitors) are used to reduce the frequency and severity of NPs when non-pharmacological interventions are ineffective, they provide only moderate symptoms control in most of the patients.9,10 Additionally, they have serious adverse effects (e.g. sedation, postural hypotension, metabolic syndrome issues and electrolyte changes, drug interactions, cardiac arrhythmia, extrapyramidal symptoms and falls).10–13 Because of the complications associated with the pharmacological treatment, current guidelines recommend that non-pharmacological interventions should be attempted first, followed by the least harmful medication for the shortest time possible time. 14 Therefore, new interventions, added to drug therapy, are considered a potential alternative treatment to reduce or prevent NPs onset and recurrence. Potential non-pharmacological options traditionally include aromatherapy, multisensory stimulation, therapeutic use of music, animal-assisted therapy, massage that are particularly useful for middle-late stages of dementia, whilst physical activity is probably more useful in early-middle stages. 15

Among non-pharmacological interventions, physical activity seems to be the most promising candidate. Physical activity can reduce the risk or delay the onset of AD 16 and has a positive effect on cognitive flexibility, depressive symptoms, cardiovascular health, sleep (Rem sleep behaviour disorder, RBD), and general wellness which are predictors for ongoing neurodegenerative process in patients without dementia 17,18, it can also improve cognitive functions and NPs in patients with dementia, and the role of physical activity is a novel area of research in dementia, in particular in AD. 19–22 Furthermore, many geriatric syndromes may also be prevented by reducing NPs. 23 However, there is a limited number of studies upon the effect of physical activity on NPs, of which the results are conflicting.19–21 Therefore, this review is aimed to explain the current literature and the effects of physical activity on NPs in patients with AD, and to raise awareness about this issue.

**METHODS**

We searched Pubmed and Google Scholar for potential eligible articles until 01st March 2018. We included all articles on physical exercise and/or physical activity in the treatment of NPs in people affected by AD. Studies were excluded if they did not include only patients with AD.

We screened for the concepts of physical exercise and physical activity associated with the most common NPs in AD, i.e. agitation/ aggression/ euphoria/ disinhibition/ irritability/ aberrant motor activity/ hallucinations/ delusions/ psychosis / depression/ anxiety/ appetite disturbance/ sleep disturbance/ apathy.

We finally included papers known to the authors on the topic (academics and clinical experts in the field) and we reviewed the references lists of all included papers. Priority was given to systematic reviews (with or without meta-analyses), followed by randomized controlled trials, observational studies, and to expert guidelines, without excluding any paper for its nature.

**DOES PHYSICAL ACTIVITY REDUCE NPs?**

The main characteristics of the studies exploring physical activity and exercise in AD are reported in **Table 1.** Several studies have investigated whether physical activity may have beneficial effects on depression. One of them showed that lack of physical activity was an independent predictor of depression in patients with AD. 24 In a randomized controlled trial (RCT) study, Vreugdenhil et al*.*, found in a sample of community dwelling adults with AD that performing a home based exercise program including daily strength-balance exercises and 30 minutes of brisk walking, resulted in a significant reduction in depression score compared to a control group. 25 In another RCT by Teri et al., 153 patients with AD were randomly allocated to an exercise intervention group (n = 76) or a control group (n = 76). The intervention group conducted moderate intensity exercise with aerobic/ endurance activities, strenght training, balance and flexibility training for 12 weeks. The intervention resulted in a significant reduction in depression. 26 Williams and Tappen randomized 45 nursing home residents, with moderate to severe AD, into three groups: the first included a 16-week programme of comprehensive exercise (strength, flexbility, balance, supervised walk), one only supervised walking and the third one social conversation. Reduced depressive symptoms were observed in all three groups with some evidence of superior benefit of exercise. 27 Yu et al., similarly reported that individualized moderate intensity cycling three times a week for six months reduced patients’ depression. 28 A study of Stella et al.*,* found that performing aerobic activity for 60 minutes, as well as exercises to improve felxibility, strength and functional balance over 6 months in home-dwelling patients led to a reduction in depression and caregiver burden.29 Another RCT published by Hoffman et al. revealed that moderate-to-high intensity aerobic exercise could decrease Neuropsychiatric Inventory (NPI) scores in patients with mild AD. 30

On the other hand, several studies have investigated whether physical activity may have beneficial effects on sleep disturbances in patients with AD. In a RCT by [McCurry](https://www.ncbi.nlm.nih.gov/pubmed/?term=McCurry%20SM%5BAuthor%5D&cauthor=true&cauthor_uid=21797835) et al., patients with better adherence to walking (≥4 d/wk) had significantly less total wake time and better sleep efficiency. 31 Similarly, [Shih](https://www.ncbi.nlm.nih.gov/pubmed/?term=Shih%20YH%5BAuthor%5D&cauthor=true&cauthor_uid=28057424) et al. also demonstrated that the longer the weekly duration of walking is linked to better the sleep quality, and less sundown syndrome.32 [Nascimento](https://www.ncbi.nlm.nih.gov/pubmed/?term=Nascimento%20CM%5BAuthor%5D&cauthor=true&cauthor_uid=23647635) et al. found that three one-hour sessions per week of a multimodal exercise program for 6 months improved sleep disturbances in exercise group, compared to a control group.33

Lastly, in a study by [Venturelli](https://www.ncbi.nlm.nih.gov/pubmed/?term=Venturelli%20M%5BAuthor%5D&cauthor=true&cauthor_uid=27540967)et al., walking at moderate intensity could reduce agitation as well as sundowning syndrome symptoms in patients with AD. 34

However, positive effects of exercise were not consistently shown by all studies. 35 In a study by Kurz et al., community dwelling adults with MCI or AD treated with cognitive rehabilitation programme including motor exercises 3 hours a week for 4 weeks, experienced significant reduction in depression and improved activities of daily living in MCI patients, but not in AD patients. 36 The null effect in patients with AD was explained by difficulty in performing some components of the exercise program which were linked to the cognitive abilities of this group. Rolland *et al*., carried out a study where exercise was performed by 132 patients with mild to severe AD one hour/twice weekly, there was no significant effects on NPs and depression, likely owing to the low levels of activity performed. 37 Another study by Yu *et al*., carried out a moderate intensity cycling intervention and found that it did not change NPs severity, but there was signitificant reduction in caregiver distress. 38 Additionaly, Steinberg *et al*., divided 27 patients with AD into an intervention (n=14) and control group (n=13). The intervention group received a daily program of aerobic, balance and flexibility, and strength training, a trend towards increasing depression scores was found in the exercise group. 35 Therefore, exercise in AD may be associated, at least in some patients, with increased distress apart from its many beneficial effects.

The main reasons for these different results may be owing to differences in intervention content between studies (Table 1). Firstly, type of exercise ranged from walking to more comprehensive programs, such as aerobics, resistance, endurance activities, strength training, hydrotherapy, balance and flexibility training. 39 It seems that comprehensive, regular and long-term exercise is more effective to reduce NPs and caregiver burden. 40,41 Secondly, frequency and duration of exercise varies from a daily program of exercise to 30 minutes three times a week and 30–45 minutes once a week, but in general, higher frequency of exercise is related to lower NPs. 39 Thirdly, the setting in which the study was conducted can further affects our results, since the nature of the patients significantly changed between nursing home, hospital or their home. 37,39 However, there is no evidence which place of exersice is more suitable for patients with AD. Therefore, the features of optimal exercise to improve NPs are not clear.

On the other hand, another handicap about this topic is that most of the studies have tried to show how physical activity affects depression and sleep disturbances, but there is a limited research to assess the other NPs such as disinhibition, apathy, hallucinations, anxiety. Therefore, further studies are needed in order to focus on relationship between physical activity and each of NPs.

**POTENTIAL MECHANISMS OF PHYSICAL ACTIVITY ON NPs**

1. **Neuropathologic mechanisms**

There are multiple etiologies, such as genetic (receptor polymorphism), neurobiological (neurochemical, neuropathology), psychological (e.g., premorbid personality, response to stress), and social aspects (e.g., environmental change and caregiver factors) for the occurence of NPs.42,43 It is known that it is a complex process, and it is difficult to explain it for one reason only. Little is known about the neurobiology of NPs. Studies have indicated that different genetic factors may be associated with various NPs. 44–46 The relationship between serotonergic system genes or polymorphisms in dopamine receptors and psychotic symptoms 44,45; polymorphic variation at the tryptophan gene and aggression 46; polymorphisms of serotonin gene or the interleukin-1 gene promoter and depression 47 were found in patients with AD. Neurotransmitter changes in dementia may cause NPs. It was reported that in AD patients with aggressive behaviour, ratios of choline acetyltransferase activity to dopamine D1 receptor binding and dopamine concentration in the temporal cortex were reduced 48 and that aggression and agitation may be caused by increased dopamine system activity and altered serotonergic modulation of dopamine neurotransmission.49 In addition, lower norepinephrine levels are associated with higher depressive symptoms in patients with AD, whereas higher norepinephrine levels have been found in the substantia nigra of patients with psychosis. 50 According to some researchers, the increased concentrations of somatostatin, vasopressin, neuropeptide Y, and hypothalamic–pituitary–adrenal (HPA) axis dysregulation may lead to lose the inhibitory effect of the hypothalamus in demented patients, and causing stress-related symptoms, such as agitation, sleep disturbance, restlessness. 10,51 Similar to Cushing’s patients, chronic stressors and long term elevation of stress hormones are associated with an accelereted cognitive impairment and also with depression, anxiety in patients with AD. 52,53 Another mechanism of the occurrence of NPs may be that the release of pro-inflammatory cytokines, including interleukin IL-1, IL-6, and tumor necrosis factor-α, and oxidative stress, contribute to the pathogenesis of both to neuroinflammation and behavioral symptoms.54 Last, in recent years, several studies showed that some of the NPs are associated with hypoperfusion in specific brain regions.55,56 For example, hypoperfusion in frontosubcortical structures, temporal cortex, frontal cortex, and right middle frontal gyrus may trigger apathy, aggression, depression and sleep loss respectively. 55,56

Given the well-known adverse effects of drugs to control NPs, non-pharmacological interventions have gained increasing attention in recent years. Although there is currently contradictory results of the studies to show the impact of physical activity on NPs, it could be explained by several hypotheses through aforementioned mechanisms.57 Firstly, many experimental studies demonstrated that exercise can modulate the production of neurotransmitters (including dopamine, noradrenaline, and serotonin) and which, in turn, may decrease aggressive or depressive behaviour. 57,58 For example, voluntary wheel-running activity increases noradrenaline in several brain regions, such as hippocampus, locus coeruleus and amygdala, which play a role in NPs. 59 Because AD is related to serotonergic deficit that account for NPs in this disease, Selective-Serotonin-Reuptake-Inhibitors (SSRIs) have been used to treat agitation, depression, anxiety, aggressive behavior, and irritability successfully. 10,60,61 Similar to SSRI, physical activity can also lead to raise in tryptophan, is a precursor of serotonin, resulting in an increased serotonin in the brain. Thus, it can avoid disruption of serotoninergic signaling and may have anti-depression like effect on NPs. 62,63 Both noradrenaline and serotonin stimulation are two important factors in enhanced brain-derived neurotrophic factor (BDNF) transcription following physical exercise.59 It is well known that BDNF is fundamental mediator to regulate neuronal survival, synaptic plasticitya and neurogenesis in the brain, in particular in the hippocampus, which is the cerebral area mainly involved on memory andbehavior. 59,64,65 Many studies prove that exercise can increase increased BDNF mRNA levels and other growth factors in the hippocampus and improve mental performance in experimental animals.59,64–66 Therefore, when all these findings are considered, it can be thought that noradrenaline and/or serotonin may participate in the up-regulation of BDNF in response to exercise, and, which, in turn, they can reduce NPs in AD patients. In addition, calcium levels in the brain are increased, which simulates dopamin synthesis during physical exercise. 67 In patients with AD, the reduced dopaminergic functions have been reported to pave the way to psychiatric symptoms (like apathy and depression) due to the deterioration of memory, motivational process and sleep-wake regulation. 68 Therefore, dopaminergic pathways have been targeted in treatment eg. using methylphenidate, with the resultant reduction in apathy symptoms, and improvement in global cognition, but adverse events, including delusions, agitation, anger, irritability, and insomnia in patients with AD. 69 On the other hand, AD patients with aggression or agitation are treated by dopamine-blocking agents, such as antipsychotics, whose use in geriatric patients may be likely to increase risk of mortality as a result of cardiovascular or infectious events. 70 The regulation of levels of dopamine in the brain following physical exercise may ameliorate NPs without any serious adverse effects like drugs affecting on dopaminergic patways. Secondly, it is possible that physical activity has many beneficial effects on the neuroendocrine stress system providing proper behaviour. The previous experimental studies showed that long-term voluntary exercise, but not short time or long-term forced exercise, may impact HPA axis regulation, contributing to a reversal of the effects of uncontrolled stress, and providing appropriate cortisol responses to stress 53, which, in turn, may prevent cognitive decline and NPs. Thirdly, physical activity may provide neuroprotection against reducing oxidative stress and inflammation. Although exercise can lead to short-term inflammatory response, and production reactive oxygen species (ROS), moderate-regular exercise causes more sustained anti-inflammatory effect and the resistance to oxidative stress by enhancing the antioxidant defense mechanisms.62 For example, [Reuben](https://www.ncbi.nlm.nih.gov/pubmed/?term=Reuben%20DB%5BAuthor%5D&cauthor=true&cauthor_uid=12890077) et al found that higher physical activitywas assosiated with lower levels of the inflammatory markers IL-6 and CRP in 870 adults aged 70 to 79. 71  Additionally, regular exercise has protective effect on accumulation of visceral fat, which is a source for inflammatory cytokines.72 Moreover, because inflammation and oxidative stress are also linked to frailty, which is a significant cause of cognitive and physical disability in older adults, physical exercise may play a key role in maintaining functionality in patients with dementia in long term indirectly. 73,74 Therefore, physical activity can be a good option for improvement in NPs by reducing oxidative stress, and inflammation with limited side effects and many proven health benefits. Lastly, it was demonstrated that moderate-intensity exercise resulted in both acute augmentation of blood flow to the brain, and higher resting cerebral blood flow and brain metabolism by means of glucose uptake in the exercise group than sedentary adults.75,76 This effect may contribute to improve the some of NPs resulting from hypoperfusion or hypometabolism.

1. **Cognitive Enhancer Effects**

Although NPs can occur during any stage of AD, a recent study found that there was an association of higher NPI scores with severity and duration of the late onset AD rather than early onset AD. 77 Therefore, any intervention, which can enhance cognitive function, may also add to reduce NPs. Recent epidemiological studies demonstrated that lifestyle changes, such as physical exercise, may delay the onset or progression of AD.59 These studies also reported that patients with AD were less active in midlife and that inactivity (defined as not meeting physical activity guidelines) was associated with a 250% increased risk of developing AD, and that high activity could contribute toa 60% decrease in the incidence of AD. 78,79

For instance, Donovan et al. found that higher amyloid-beta burden (position emission tomography measures of cortical aggregate amyloid beta) was related to increased anxious-depressive symptoms, even in cognitively healthy older people. 80 Another study showed that amyloid deposition strongly correlated with agitation in patients with AD and MCI**.** 81Experimental studies with AD demonstrated that physical exercise can decrease significantly amyloid-β42 protein in animal brains. 82,83 Similarly, human studies indicated that  low exercisers had higher mean levels of brain amyloid than high exercisers in autosomal dominant AD mutation carriers, and that high-intensity aerobic exercise decreases plasma concentrations of Aβ42 in patients with MCI. 84

Additionaly, although there are few exercise training and brain volumes studies, there is strong evidence that regular physical exercise can increase plasticity, synaptogenesis, neurogenesis and volume in several brain regions, including hippocampus, medial temporal lobe and fronto-parietal regions, which are involved in clinical conditions such as depression, anxiety, agitation, aggression and disinhibition, respectively. 10,85–87 Similar to BDNF, insulin-like growth factor- 1 (IGF-1) and vascular endothelial growth factor (VEGF), which are two important factors to modulate neuronal plasticity, especially in the hippocampus, are induced by exercise. 88 Addition to neuroprotection effect, it was also shown that elevated serum IGF-1 levels can improve mood factors, such as depression, anxiety, anger, fatigue, and confusion. 89

All aforementioned mechanisms indirectly support that physical exercise can ameliorate NPs by protecting neuronal integrity and enhancing cognitive functions.

**3. Cardiovascular and general well-being**

All of the cardiovascular factors lead to cerebral small vessel diseases, including WMD and subcortical lacunar infarcts (lacunes), and to deteriorated brain network; thus, AD patients may develop NPs.90 The pevious studies domonstrated that WMD and lacunes in the right basal ganglia were associated with depression 91,92; that psychotic symptoms were associated with lacunes in the left basal ganglia 92,93; and that anxiety and aberrant motor behaviours were related to white matter disease.94

Benefits of physical exercise are well known in both the cardiovascular system and psychological health. The effects of physical exercise on metabolite processes are a decrease in serum levels of glucose, cholesterol, cortisol and metabolic syndrome, an increase in high density lipoprotein, insulin production. 95 Physical activity can reduce endothelial dysfunction by improvement through the activation of nitric oxide /endothelial NO synthase, resulting in the arranging of angiogenesis in the brain and the maintenance of neuronal plasticity 96, which may reduce the effect of WMD burden. 97 Increased cardiorespiratory fitness was also associated with lower WMD. 98 Therefore, physical exercise would also be helpful for NPs due to cardiovascular health.

Furthermore, besides the potential benefits for the cardiovascular system and brain, physical exercise has been shown to be beneficial for fatigue, sleep-disorders, pain, and constipation in older adults, very common conditions in patients with AD, exacerbating NPs. 99,100

**4. Caregiver factors**

Caregiver burden increases with the progression of cognitive symptoms and the severity of NPs of the patients and it can cause depression and other severe illnesses in caregivers. 101 Caregiver burden worsens relationship between caregiver and patients with AD, which may increase the frequency and severity of NPs. 102 Therefore, there is a bidirectional relationship between caregiver burden and NPs in patients with AD and strategies to support caregivers of patients with AD should have multicomponent interventions to improve the health and well-being of dementia caregivers. Physical exercise for people affected by AD can reduce both caregiver burden and NPs, particularly in early stages of AD. It was reported that when aerobic and functional balance exercises were performed to patients with AD over six months for 60 minutes 3 times per week, caregiver’s burden significantly decreased compared to controls. 29 Moreover, walking with relatives and regular long walking time can relieve sundown syndrome and improve sleep quality, which are major factors of caregiver burden. 32 On the other hand, balance-gait impairments, falls, or fear of falling, which are more frequent in older dementia patients, may result in a decline in daily living activities, which leads to decreased functional ability and a loss of independence. 100 Because it is well known that more funtional dependence is associated with more caregiver burden, physical exercise can contribute to maintenance motor and nonmotor functioning of the patients with AD by increasing muscle mass, endurance, muscle strengthening; thus it can lead to a reduced caregiver burden, indirectly. 100 Accordingly, a caregiver who is less distressed by NPs is more likely to exhibit more positive behaviors towards the patient, which may contribute to further alleviation of NPs. 10

Patients with AD should try to engage in physical activity through all stages of the condition. When possible, they should aim to meet the recommended physical activity guideline of at least 150 minutes of moderate-intensity aerobic physical activity throughout the week. 103 However, it should be noted that this will not be achievable in the later stages of the condition. To engage patients with AD in programs of physical activity specific barriers will need to be considered and these are dependent on the stages of AD and the individual.  Those individuals with early stages of dementia should still be predominantly independent and could acquire recommended levels of physical activity through a number of activity domains (structure exercise/ sport, active travel [walking/ cycling], household activity and occupational activity). Those is the later stages of AD will likely be experiencing memory loss, problems with communication and daily activities, and changes in behavior and physical problems. It would be recommended that individuals in the later stages of the condition are referred to an exercise specialist or a physiotherapist who can prescribe physical activity on an individual basis. Some appropriate activities for those in the middle stages of dementia may include Tai Chi, chair based exercises, swimming or walking. Activities in the later stages of AD will likely be limited and may include activities such as balancing in a standing position, sitting unsupported or simply moving on a regular basis.

**Conclusion**

Although there are not univocal results for showing the impact of physical activity on NPs, most of them demonstrate a positive effect of physical activity on ameliorating depression, and sleep disturbances (RBD) which are common in patients with AD. The potential beneficial effects of physical activity in AD could be explained by several mechanisms including modulated production of neurotransmitters, increasing neurotrophins; reducing oxidative stress and inflammation; elevation of cerebral blood flow; HPA regulation; supporting neurogenesis and synaptogenesis. Physical activity can also improve cardiovascular factors and general well-being and finally can reduce caregiver burden. Therefore, because of the complications associated with the pharmacological treatment, physical exercise can be considered as "potential" add-on treatment to drugs to reduce or prevent NPs onset and recurrence, with no serious side effects and many proven health benefits. However, there are methodological differences of performing exercise in the literature, and the features of optimal exercise to prevent NPs are not clear. Therefore, future studies need to focus on explaining the positive effects of physical activity on each of NPs separately, and identifying potential mechanisms.

**References:**

1. Isik AT. Late onset Alzheimer’s disease in older people. *Clin Interv Aging*. 2010;5:307-311. doi:10.2147/CIA.S11718.

2. Petrovic M, Hurt C, Collins D, et al. Clustering of behavioural and psychological symptoms in dementia (BPSD): A european alzheimer’s disease consortium (EADC) study. *Acta Clin Belg*. 2007;62(6):426-432. doi:10.1179/acb.2007.062.

3. Steinberg M, Shao H, Zandi P, et al. Point and 5-year period prevalence of neuropsychiatric symptoms in dementia: the Cache County Study. *Int J Geriatr Psychiatry*. 2008;23(2):170-177. doi:10.1002/gps.1858.

4. Coen RF, Swanwick GRJ, O’Boyle CA, Coakley D. Behaviour disturbance and other predictors of carer burden in Alzheimer’s disease. *Int J Geriatr Psychiatry*. 1997;12(3):331-336. doi:10.1002/(SICI)1099-1166(199703)12:3<331::AID-GPS495>3.0.CO;2-J.

5. Shim SH, Kang HS, Kim JH, Kim DK. Factors associated with caregiver burden in dementia: 1-year follow-up study. *Psychiatry Investig*. 2016;13(1):43-49. doi:10.4306/pi.2016.13.1.43.

6. Ulstein ID, Sandvik L, Wyller TB, Engedal K. A one-year randomized controlled psychosocial intervention study among family carers of dementia patients--effects on patients and carers. *Dement Geriatr Cogn Disord*. 2007;24(6):469-475. doi:10.1159/000110740.

7. TARIOT PN, MACK JL, PATTERSON MB, et al. THE BEHAVIOR RATING-SCALE FOR DEMENTIA OF THE CONSORTIUM TO ESTABLISH A REGISTRY FOR ALZHEIMERS-DISEASE. *Am J Psychiatry*. 1995;152(9):1349-1357.

8. Yatawara C, Hiu S, Tan L, Kandiah N. Neuropsychiatric symptoms in South-East Asian patients with mild cognitive impairment and dementia: Prevalence, subtypes, and risk factors. *Int J Geriatr Psychiatry*. 2017:1-9. doi:10.1002/gps.4693.

9. Tampi RR, Tampi DJ, Balachandran S, Srinivasan S. Antipsychotic use in dementia: a systematic review of benefits and risks from meta-analyses. *Ther Adv Chronic Dis*. 2016;7(5):229-245. doi:10.1177/2040622316658463.

10. Matura S, Carvalho AF, Alves GS, Pantel J. Physical Exercise for the Treatment of Neuropsychiatric Disturbances in Alzheimer’s Dementia: Possible Mechanisms, Current Evidence and Future Directions. *Curr Alzheimer Res*. 2016;13(10):1112-1123. doi:10.2174/1567205013666160502123428.

11. Reese TR, Thiel DJ, Cocker KE. Behavioral disorders in dementia: Appropriate nondrug interventions and antipsychotic use. *Am Fam Physician*. 2016;94(4):276-282.

12. Soysal P, Isik AT. Severe hyponatremia due to escitalopram treatment in an elderly adult with Alzheimer’s disease. *J Am Geriatr Soc*. 2014;62(12):2462-2463. doi:10.1111/jgs.13149.

13. Soysal P, Isik AT, Stubbs B, et al. Acetylcholinesterase inhibitors are associated with weight loss in older people with dementia: A systematic review and meta-analysis. *J Neurol Neurosurg Psychiatry*. 2016;87(12):1368-1374. doi:10.1136/jnnp-2016-313660.

14. Gauthier S, Cummings J, Ballard C, et al. Management of behavioral problems in Alzheimer’s disease. *Int Psychogeriatr*. 2010;22(3):346-372. doi:10.1017/s1041610209991505.

15. Azermai M. Dealing with behavioral and psychological symptoms of dementia: A general overview. *Psychol Res Behav Manag*. 2015;8:181-185. doi:10.2147/PRBM.S44775.

16. Rovio S, Kåreholt I, Helkala E-L, et al. Leisure-time physical activity at midlife and the risk of dementia and Alzheimer’s disease. *Lancet Neurol*. 2005;4(11):705-711. doi:10.1016/S1474-4422(05)70198-8.

17. Lerche S, Gutfreund A, Brockmann K, et al. Effect of physical activity on cognitive flexibility, depression and RBD in healthy elderly. *Clin Neurol Neurosurg*. 2018;165:88-93. doi:10.1016/j.clineuro.2018.01.008.

18. Florido R, Kwak L, Lazo M, Nambi V, Ahmed HM, Hegde SM, Gerstenblith G, Blumenthal RS, Ballantyne CM, Selvin E, Folsom AR, Coresh J NC. Six-Year Changes in Physical Activity and the Risk of Incident Heart Failure: The Atherosclerosis Risk in Communities (ARIC) Study. *Circulation*. 2018. doi:10.1161/CIRCULATIONAHA.

19. Thuné-Boyle IC V, Iliffe S, Cerga-Pashoja a, Lowery D, Warner J. The effect of exercise on behavioral and psychological symptoms of dementia: towards a research agenda. *Int Psychogeriatr*. 2012;24(7):1046-1057. doi:10.1017/S1041610211002365.

20. Lowery D, Cerga-Pashoja A, Iliffe S, et al. The effect of exercise on behavioural and psychological symptoms of dementia: The EVIDEM-E randomised controlled clinical trial. *Int J Geriatr Psychiatry*. 2014;29(8):819-827. doi:10.1002/gps.4062.

21. Fleiner T, Dauth H, Gersie M, Zijlstra W, Haussermann P. Structured physical exercise improves neuropsychiatric symptoms in acute dementia care: A hospital-based RCT. *Alzheimer’s Res Ther*. 2017;9(1). doi:10.1186/s13195-017-0289-z.

22. Hernández-Díaz S, Garcés de los Fayos EJ. Analysis of scientific output about cognitive effects of physical activity on Alzheimer’s disease. SPORT TK-EuroAmerican Journal of Sport Sciences. 2015;4(1): 73-76.

23. Soysal P, Veronese N, Thompson T, et al. Relationship between depression and frailty in older adults: A systematic review and meta-analysis. *Ageing Res Rev*. 2017;36:78-87. doi:10.1016/j.arr.2017.03.005.

24. Regan C, Katona C, Walker Z, Livingston G. Relationship of exercise and other risk factors to depression of Alzheimer’s disease: the LASER-AD study. *Int J Geriatr Psychiatry*. 2005;20(0885-6230 (Print) LA-eng PT-Journal Article SB-IM):261-268. doi:10.1002/gps.1278.

25. Vreugdenhil A, Cannell J, Davies A, Razay G. A community-based exercise programme to improve functional ability in people with Alzheimer’s disease: A randomized controlled trial. *Scand J Caring Sci*. 2012;26(1):12-19. doi:10.1111/j.1471-6712.2011.00895.x.

26. Teri L, Gibbons LE, McCurry SM, et al. Exercise plus behavioral management in patients with Alzheimer disease: a randomized controlled trial. *JAMA*. 2003;290(15):2015-2022. doi:10.1001/jama.290.15.2015.

27. Williams CL, Tappen RM. Exercise training for depressed older adults with Alzheimer’s disease. *Aging Ment Heal*. 2008;12(1):72-80. doi:10.1080/13607860701529932.

28. Yu F, Nelson NW, Savik K, Wyman JF, Dysken M, Bronas UG. Affecting Cognition and Quality of Life via Aerobic Exercise in Alzheimer’s Disease. *West J Nurs Res*. 2013;35(1):24-38. doi:10.1177/0193945911420174.

29. Stella F, Canonici AP, Gobbi S, Galduroz RFS, Cação J de C, Gobbi LTB. Attenuation of neuropsychiatric symptoms and caregiver burden in Alzheimer’s disease by motor intervention: a controlled trial. *Clinics*. 2011;66(8):1353-1360. doi:10.1590/S1807-59322011000800008.

30. Hoffmann K, Sobol NA, Frederiksen KS, et al. Moderate-to-high intensity physical exercise in patients with Alzheimer’s disease: A randomized controlled trial. *J Alzheimer’s Dis*. 2015;50(2):443-453. doi:10.3233/JAD-150817.

31. McCurry SM, Pike KC, Vitiello M V., Logsdon RG, Larson EB, Teri L. Increasing walking and bright light exposure to improve sleep in community-dwelling persons with Alzheimer’s disease: Results of a randomized, controlled trial. *J Am Geriatr Soc*. 2011;59(8):1393-1402. doi:10.1111/j.1532-5415.2011.03519.x.

32. Shih YH, Wang JJ, Shih YH, Pai MC, Huang YC. Sundown Syndrome, Sleep Quality, and Walking Among Community-Dwelling People With Alzheimer Disease. *J Am Med Dir Assoc*. 2017;18(5):396-401. doi:10.1016/j.jamda.2016.10.016.

33. Nascimento CMC, Ayan C, Cancela JM, Gobbi LTB, Gobbi S, Stella F. Effect of a multimodal exercise program on sleep disturbances and instrumental activities of daily living performance on Parkinson’s and Alzheimer’s disease patients. *Geriatr Gerontol Int*. 2014;14(2):259-266. doi:10.1111/ggi.12082.

34. Venturelli M, Sollima A, Cè E, et al. Effectiveness of Exercise- and Cognitive-Based Treatments on Salivary Cortisol Levels and Sundowning Syndrome Symptoms in Patients with Alzheimer’s Disease. *J Alzheimers Dis*. 2016;53(4):1631-1640. doi:10.3233/JAD-160392.

35. Steinberg M, Sheppard Leoutsakos JM, Podewills LJ, Lyketsos CG. Evaluation of a home-based exercise program in the treatment of Alzheimer’s disease: The Maximizing Independence in Dementia (MIND) study. *Int J Geriatr Psychiatry*. 2009;24(7):680-685. doi:10.1002/gps.2175.

36. Kurz A, Pohl C, Ramsenthaler M, Sorg C. Cognitive rehabilitation in patients with mild cognitive impairment. *Int J Geriatr Psychiatry*. 2009;24(2):163-168. doi:10.1002/gps.2086.

37. Rolland Y, Pillard F, Klapouszczak A, et al. Exercise program for nursing home residents with Alzheimer’s disease: A 1-year randomized, controlled trial. *J Am Geriatr Soc*. 2007;55(2):158-165. doi:10.1111/j.1532-5415.2007.01035.x.

38. Yu F, Thomas W, Nelson NW, Bronas UG, Dysken M, Wyman JF. Impact of 6-month aerobic exercise on Alzheimer’s symptoms. *J Appl Gerontol*. 2015;34(4):484-500. doi:10.1177/0733464813512895.

39. Thuné-Boyle IC V., Iliffe S, Cerga-Pashoja A, Lowery D, Warner J. The effect of exercise on behavioral and psychological symptoms of dementia: towards a research agenda. *Int Psychogeriatrics*. 2012;24(7):1046-1057. doi:10.1017/S1041610211002365.

40. Williams CL, Tappen RM. Exercise training for depressed older adults with Alzheimer’s disease. *Aging Ment Health*. 2008;12(1):72-80. doi:10.1080/13607860701529932.

41. Christofoletti G, Oliani MM, Bucken-Gobbi LT, Gobbi S, Beinotti F, Stella F. Physical activity attenuates neuropsychiatric disturbances and caregiver burden in patients with dementia. *Clinics*. 2011;66(4):613-618. doi:10.1590/S1807-59322011000400015.

42. Alzheimer’s Association. 2015 Alzheimer’s disease facts and figures. *Alzheimers Dement*. 2015;11(3):332-384. doi:10.1016/j.jalz.2015.02.003.

43. Cerejeira J, Lagarto L, Mukaetova-Ladinska EB. Behavioral and psychological symptoms of dementia. *Front Neurol*. 2012;MAY. doi:10.3389/fneur.2012.00073.

44. Hollingworth P, Hamshere ML, Holmans PA, et al. Increased familial risk and genomewide significant linkage for Alzheimer’s disease with psychosis. *Am J Med Genet Part B Neuropsychiatr Genet*. 2007;144(7):841-848. doi:10.1002/ajmg.b.30515.

45. Holmes C, Smith H, Ganderton R, et al. Psychosis and aggression in Alzheimer’s disease: The effect of dopamine receptor gene variation. *J Neurol Neurosurg Psychiatry*. 2001;71(6):777-779. doi:10.1136/jnnp.71.6.777.

46. Craig D, Hart DJ, Carson R, McIlroy SP, Passmore AP. Allelic variation at the A218C tryptophan hydroxylase polymorphism influences agitation and aggression in Alzheimer’s disease. *Neurosci Lett*. 2004;363(3):199-202. doi:10.1016/j.neulet.2004.02.054.

47. Ueki A, Ueno H, Sato N, Shinjo H, Morita Y. Serotonin transporter gene polymorphism and BPSD in mild Alzheimer’s disease. *J Alzheimer’s Dis*. 2007;12(3):245-253. doi:10.3233/JAD-2007-12306.

48. Minger SL, Esiri MM, McDonald B, et al. Cholinergic deficits contribute to behavioral disturbance in patients with dementia. *Neurology*. 2000;55(10):1460-1467. doi:10.1212/WNL.55.10.1460.

49. Engelborghs S, Vloeberghs E, Le Bastard N, et al. The dopaminergic neurotransmitter system is associated with aggression and agitation in frontotemporal dementia. *Neurochem Int*. 2008;52(6):1052-1060. doi:10.1016/j.neuint.2007.10.018.

50. Zubenko GS, Moossy J, Martinez AJ, et al. Neuropathologic and Neurochemical Correlates of Psychosis in Primary Dementia. *Arch Neurol*. 1991;48(6):619-624. doi:10.1001/archneur.1991.00530180075020.

51. Gil-Bea FJ, Aisa B, Solomon A, et al. HPA axis dysregulation associated to apolipoprotein E4 genotype in Alzheimer’s disease. *J Alzheimer’s Dis*. 2010;22(3):829-838. doi:10.3233/JAD-2010-100663.

52. Nation DA, Hong S, Jak AJ, et al. Stress, exercise, and Alzheimer’s disease: A neurovascular pathway. *Med Hypotheses*. 2011;76(6):847-854. doi:10.1016/j.mehy.2011.02.034.

53. Du X, Pang TY. Is dysregulation of the HPA-axis a core pathophysiology mediating co-morbid depression in neurodegenerative diseases? *Front Psychiatry*. 2015;6(MAR). doi:10.3389/fpsyt.2015.00032.

54. Takeda S, Sato N, Morishita R. Systemic inflammation, blood-brain barrier vulnerability and cognitive/non-cognitive symptoms in Alzheimer disease: relevance to pathogenesis and therapy. *Front Aging Neurosci*. 2014;6(7):171. doi:10.3389/fnagi.2014.00171.

55. Matsuoka T, Narumoto J, Shibata K, et al. Insular hypoperfusion correlates with the severity of delusions in individuals with alzheimer’s disease. *Dement Geriatr Cogn Disord*. 2010;29(4):287-293. doi:10.1159/000295115.

56. Benoit M, Clairet S, Koulibaly PM, Darcourt J, Robert PH. Brain perfusion correlates of the Apathy Inventory dimensions of Alzheimer’s disease. *Int J Geriatr Psychiatry*. 2004;19(9):864-869. doi:10.1002/gps.1163.

57. Zheng X, Takatsu S, Ishikawa R, Hasegawa H. Moderate intensity, exercise-induced catecholamine release in the preoptic area and anterior hypothalamus in rats is enhanced in a warm environment. *J Therm Biol*. 2018;71:123-127. doi:10.1016/j.jtherbio.2017.11.003.

58. Garcia C, Chen MJ, Garza AA, Cotman CW, Russo-Neustadt A. The influence of specific noradrenergic and serotonergic lesions on the expression of hippocampal brain-derived neurotrophic factor transcripts following voluntary physical activity. *Neuroscience*. 2003;119(3):721-732. doi:10.1016/S0306-4522(03)00192-1.

59. Ma Q. Beneficial effects of moderate voluntary physical exercise and its biological mechanisms on brain health. *Neurosci Bull*. 2008;24(4):265-270. doi:10.1007/s12264-008-0402-1.

60. Rodríguez JJ, Noristani HN, Verkhratsky A. The serotonergic system in ageing and Alzheimer’s disease. *Prog Neurobiol*. 2012;99(1):15-41. doi:10.1016/j.pneurobio.2012.06.010.

61. Siddique H, Hynan LS, Weiner MF. Effect of a serotonin reuptake inhibitor on irritability, apathy, and psychotic symptoms in patients with Alzheimer’s disease. *J Clin Psychiatry*. 2009;70(6):915-918. doi:10.4088/JCP.08m04828.

62. Tortosa-Martínez J, Clow A. Does physical activity reduce risk for Alzheimer’s disease through interaction with the stress neuroendocrine system? *Stress*. 2012;15(3):243-261. doi:10.3109/10253890.2011.629323.

63. Lapmanee S, Charoenphandhu J, Teerapornpuntakit J, Krishnamra N, Charoenphandhu N. Agomelatine, venlafaxine, and running exercise effectively prevent anxiety- and depression-like behaviors and memory impairment in restraint stressed rats. *PLoS One*. 2017;12(11). doi:10.1371/journal.pone.0187671.

64. Garza AA, Ha TG, Garcia C, Chen MJ, Russo-Neustadt AA. Exercise, antidepressant treatment, and BDNF mRNA expression in the aging brain. *Pharmacol Biochem Behav*. 2004;77(2):209-220. doi:10.1016/j.pbb.2003.10.020.

65. Cotman CW, Berchtold NC. Exercise: A behavioral intervention to enhance brain health and plasticity. *Trends Neurosci*. 2002;25(6):295-301. doi:10.1016/S0166-2236(02)02143-4.

66. García-Mesa Y, Pareja-Galeano H, Bonet-Costa V, et al. Physical exercise neuroprotects ovariectomized 3xTg-AD mice through BDNF mechanisms. *Psychoneuroendocrinology*. 2014;45:154-166. doi:10.1016/j.psyneuen.2014.03.021.

67. Pérez CA, Cancela Carral JM. Benefits of Physical Exercise for Older Adults With Alzheimer’s Disease. *Geriatr Nurs (Minneap)*. 2008;29(6):384-391. doi:10.1016/j.gerinurse.2007.12.002.

68. D’Amelio M, Puglisi-Allegra S, Mercuri N. The role of dopaminergic midbrain in Alzheimer’s disease: Translating basic science into clinical practice. *Pharmacol Res*. January 2018. doi:10.1016/j.phrs.2018.01.016.

69. Herrmann N, Rothenburg LS, Black SE, et al. Methylphenidate for the treatment of apathy in alzheimer disease: Prediction of response using dextroamphetamine challenge. *J Clin Psychopharmacol*. 2008;28(3):296-301. doi:10.1097/JCP.0b013e318172b479.

70. Miller LJ. The use of cognitive enhancers in behavioral disturbances of Alzheimer’s disease. *Consult Pharm*. 2007;22(9):754-762. doi:10.4140/TCP.n.2007.754.

71. Reuben DB, Judd-Hamilton L, Harris TB, Seeman TE. The associations between physical activity and inflammatory markers in high-functioning older persons: MacArthur studies of successful aging. *J Am Geriatr Soc*. 2003;51(8):1125-1130. doi:10.1046/j.1532-5415.2003.51380.x.

72. Pedersen BK. The diseasome of physical inactivity - and the role of myokines in muscle-fat cross talk. *J Physiol*. 2009;587(23):5559-5568. doi:10.1113/jphysiol.2009.179515.

73. Soysal P, Stubbs B, Lucato P, et al. Inflammation and frailty in the elderly: A systematic review and meta-analysis. *Ageing Res Rev*. 2016;31:1-8. doi:10.1016/j.arr.2016.08.006.

74. Soysal P, Isik AT, Carvalho AF, et al. Oxidative stress and frailty: A systematic review and synthesis of the best evidence. *Maturitas*. 2017;99:66-72. doi:10.1016/j.maturitas.2017.01.006.

75. Barnes JN. Exercise, cognitive function, and aging. *Adv Physiol Educ*. 2015;39(2):55-62. doi:10.1152/advan.00101.2014.

76. Chapman SB, Aslan S, Spence JS, et al. Shorter term aerobic exercise improves brain, cognition, and cardiovascular fitness in aging. *Front Aging Neurosci*. 2013;5(NOV). doi:10.3389/fnagi.2013.00075.

77. Ferreira M do C, Abreu MJ, Machado C, Santos B, Machado Á, Costa AS. Neuropsychiatric Profile in Early Versus Late Onset Alzheimer’s Disease. *Am J Alzheimer’s Dis Other Dementiasr*. 2017:153331751774406. doi:10.1177/1533317517744061.

78. Friedland RP, Fritsch T, Smyth KA, et al. Patients with Alzheimer’s disease have reduced activities in midlife compared with healthy control-group members. *Proc Natl Acad Sci*. 2001;98(6):3440-3445. doi:10.1073/pnas.061002998.

79. Laurin D, Verreault R, Lindsay J, MacPherson K, Rockwood K. Physical activity and risk of cognitive impairment and dementia in elderly persons. *Arch Neurol*. 2001;58(3):498-504. doi:noc00302 [pii].

80. Donovan NJ, Locascio JJ, Marshall GA, et al. Longitudinal Association of Amyloid Beta and Anxious-Depressive Symptoms in Cognitively Normal Older Adults. *Am J Psychiatry*. 2018:appi.ajp.2017.1. doi:10.1176/appi.ajp.2017.17040442.

81. Zhang N, Zhang L, Li Y, et al. Urine AD7c-NTP Predicts Amyloid Deposition and Symptom of Agitation in Patients with Alzheimer’s Disease and Mild Cognitive Impairment. *J Alzheimers Dis*. 2017;60(1):87-95. doi:10.3233/JAD-170383.

82. Adlard PA. Voluntary Exercise Decreases Amyloid Load in a Transgenic Model of Alzheimer’s Disease. *J Neurosci*. 2005;25(17):4217-4221. doi:10.1523/JNEUROSCI.0496-05.2005.

83. Zhao G, Liu HL, Zhang H, Tong XJ. Treadmill exercise enhances synaptic plasticity, but does not alter β-amyloid deposition in hippocampi of aged APP/PS1 transgenic mice. *Neuroscience*. 2015;298:357-366. doi:10.1016/j.neuroscience.2015.04.038.

84. Brown BM, Sohrabi HR, Taddei K, et al. Habitual exercise levels are associated with cerebral amyloid load in presymptomatic autosomal dominant Alzheimer’s disease. *Alzheimer’s Dement*. 2017;13(11):1197-1206. doi:10.1016/j.jalz.2017.03.008.

85. Hayes SM, Alosco ML, Forman DE. The Effects of Aerobic Exercise on Cognitive and Neural Decline in Aging and Cardiovascular Disease. *Curr Geriatr Rep*. 2014;3(4):282-290. doi:10.1007/s13670-014-0101-x.

86. Mah L, Binns MA, Steffens DC. Anxiety symptoms in amnestic mild cognitive impairment are associated with medial temporal atrophy and predict conversion to Alzheimer disease. *Am J Geriatr Psychiatry*. 2015;23(5):466-476. doi:10.1016/j.jagp.2014.10.005.

87. Trzepacz PT, Yu P, Bhamidipati PK, et al. Frontolimbic atrophy is associated with agitation and aggression in mild cognitive impairment and Alzheimer’s disease. *Alzheimer’s Dement*. 2013;9(5 SUPPL.). doi:10.1016/j.jalz.2012.10.005.

88. Erickson KI, Weinstein AM, Lopez OL. Physical Activity, Brain Plasticity, and Alzheimer’s Disease. *Arch Med Res*. 2012;43(8):615-621. doi:10.1016/j.arcmed.2012.09.008.

89. Cassilhas RC, Viana VAR, Grassmann V, et al. The impact of resistance exercise on the cognitive function of the elderly. *Med Sci Sports Exerc*. 2007;39(8):1401-1407. doi:10.1249/mss.0b013e318060111f.

90. Hashimoto M, Ikeda M. [White Matter Lesion and Alzheimer’s Disease: The Association between Small Vessel Disease and Neuropsychiatric Symptoms in Alzheimer’s Disease]. *Brain Nerve*. 2015;67(4):427-432. doi:10.11477/mf.1416200158.

91. Casanova MF, Starkstein SE, Jellinger KA. Clinicopathological correlates of behavioral and psychological symptoms of dementia. *Acta Neuropathol*. 2011;122(2):117-135. doi:10.1007/s00401-011-0821-3.

92. Palmqvist S, Sarwari A, Wattmo C, et al. Association between Subcortical Lesions and Behavioral and Psychological Symptoms in Patients with Alzheimer’s Disease. *Dement Geriatr Cogn Disord*. 2011;32(6):417-423. doi:10.1159/000335778.

93. Steinberg M, Hess K, Corcoran C, et al. Vascular risk factors and neuropsychiatric symptoms in Alzheimer’s disease: The Cache County Study. *Int J Geriatr Psychiatry*. 2014;29(2):153-159. doi:10.1002/gps.3980.

94. Berlow YA, Wells WM, Ellison JM, Sung YH, Renshaw PF, Harper DG. Neuropsychiatric correlates of white matter hyperintensities in Alzheimer’s disease. *Int J Geriatr Psychiatry*. 2010;25(8):780-788. doi:10.1002/gps.2418.

95. Knöchel C, Oertel-Knöchel V, O’Dwyer L, et al. Cognitive and behavioural effects of physical exercise in psychiatric patients. *Prog Neurobiol*. 2012;96(1):46-68. doi:10.1016/j.pneurobio.2011.11.007.

96. Lange-Asschenfeldt C, Kojda G. Alzheimer’s disease, cerebrovascular dysfunction and the benefits of exercise: From vessels to neurons. *Exp Gerontol*. 2008;43(6):499-504. doi:10.1016/j.exger.2008.04.002.

97. Fleischman DA, Yang J, Arfanakis K, et al. Physical activity, motor function, and white matter hyperintensity burden in healthy older adults. *Neurology*. 2015;84(13):1294-1300. doi:10.1212/WNL.0000000000001417.

98. Johnson NF, Kim C, Clasey JL, Bailey A, Gold BT. Cardiorespiratory fitness is positively correlated with cerebral white matter integrity in healthy seniors. *Neuroimage*. 2012;59(2):1514-1523. doi:10.1016/j.neuroimage.2011.08.032.

99. Pedersen BK, Saltin B. Exercise as medicine - Evidence for prescribing exercise as therapy in 26 different chronic diseases. *Scand J Med Sci Sport*. 2015;25:1-72. doi:10.1111/sms.12581.

100. Lamotte G, Shah RC, Lazarov O, Corcos DM. Exercise Training for Persons with Alzheimer’s Disease and Caregivers: A Review of Dyadic Exercise Interventions. *J Mot Behav*. 2017;49(4):365-377. doi:10.1080/00222895.2016.1241739.

101. Srivastava G, Tripathi R, Tiwari S, Singh B, Tripathi S. Caregiver burden and quality of life of key caregivers of patients with dementia. *Indian J Psychol Med*. 2016;38(2):133. doi:10.4103/0253-7176.178779.

102. Mahoney R, Regan C, Katona C, Livingston G. Anxiety and depression in family caregivers of people with Alzheimer disease: the LASER-AD study. *Am J Geriatr Psychiatry*. 2005;13(9):795-801. doi:10.1176/appi.ajgp.13.9.795.

103. http://www.who.int/dietphysicalactivity/factsheet\_olderadults/en/

**Table 1. Effect of physical activity on neuropsychiatric symptoms in people affected by Alzheimer’s Disease.**

| **Author, year** | **Type of study** | **Sample**  **size** | **Mean age (SD)** | **Type of physical exercise** | **Frequency** | **Main findings** |
| --- | --- | --- | --- | --- | --- | --- |
| [Hoffmann](https://www.ncbi.nlm.nih.gov/pubmed/?term=Hoffmann%20K%5BAuthor%5D&cauthor=true&cauthor_uid=26682695) et al., 2016 30 | RCT | 200 patients with mild AD  Exercise:107  Control:93 | Exercise group:  69.8± 7.4;  Control group:  71.3 ±7.3 | Moderate-to-high intensity aerobic exercise | 60-min sessions three times a week for 16 weeks | Significant reduction in NPs in patients with mild AD |
| Kurz et al.,2009 36 | RCT | Community dwelling  Exercise group (10 AD  patients and 18 MCI  patients)  Control group  = 12 MCI patient) | MCI control:  70.8 ±6.9;  MCI intervention:  70.4 ±8.4;  AD intervention  66.0 ±8.7 | Activity planning, self-assertiveness training, relaxation techniques, stress management, use of external memory  aids, memory training, and motor exercise | 3  hours/week for 4 weeks | Significant improvement in ADL, verbal memory and reduction in depression in MCI patients, but not  in AD patients |
| [McCurry](https://www.ncbi.nlm.nih.gov/pubmed/?term=McCurry%20SM%5BAuthor%5D&cauthor=true&cauthor_uid=21797835)et al., 2011 31 | RCT | 132 AD patients and their in-home caregivers  Walking group:32  Light group:34  combination group: 33  Control group:33 | Walking group:  82.2 ± 8.5,  Light group:  80.6 ± 7.3,  Combination group:  80.0 ± 8.2,  Control group:  81.2 ± 8.0 | A caregiver-supervised, self-paced walking program | 30 continuous minutes/day  ≥ 4 days a week for 6 months | Significant improvements in total wake time and  better sleep efficiency intervention groups compared to control group |
| [Nascimento](https://www.ncbi.nlm.nih.gov/pubmed/?term=Nascimento%20CM%5BAuthor%5D&cauthor=true&cauthor_uid=23647635) et al., 2014 33 | RCT | Patients with AD  Exercise group: 19  Control group: 16 | Exercise group: 76.8 ± 6.8;  Control group:  77.9 ±5.9 | Multimodal exercise program (warm up, muscular resistance, balance and motor coordination, aerobic ﬁtness) | Three 1-h sessions per week,  for 6 months | Signiﬁcant improvements in sleep disturbances in exercise group and maintenance or worsening in control group |
| Regan et al., 2005 24 | Cross-sectional | 224 community based patients with AD  Depressed patients=51  No depressed patients=173 | 81.0 | Participants were  divided into absent,  moderate (regular walks or gardening), or vigorous  exercise (aerobics classes or ballroom dancing) | NA | Lack of exercise was an  independent predictor of  depression |
| Rolland et al., 2007 37 | RCT | 132 patients with mild to severe AD of  five different nursing  homes.  Exercise group= 67; control group =67. | Exercise group:  82.8±7.8;  Control group:  83.1 ± 7.0 | Collective exercise  program  (walk, strength, balance, and flexibility training) | 1 hour/twice weekly, for  for 12 months. | Significantly slower  decline of ADL in exercise group.  No significant training  effects on behavioral  disturbances and depression. |
| [Shih](https://www.ncbi.nlm.nih.gov/pubmed/?term=Shih%20YH%5BAuthor%5D&cauthor=true&cauthor_uid=28057424) et al.,2017 32 | Cross-sectional | 184 patients with AD | 78.5 ±7.6 | Walking | walking time period | Longer weekly duration of walking is associated with better the sleep quality, and less sundown syndrome |
| Steinberg et al., 2009 35 | RCT | 27 randomized home dwelling adults patients with AD  Exercise group =14  Control group = 13. | Exercise group:  76.5±3.9;  Control group:  74.0± 8.1 | Aerobic exercises program  (flexibility, strength, balance) | Daily,  for 12 weeks | A trend for improved performance on functionality, but  increasing  depression scores in  the exercise group |
| Stella et al., 201135 | RCT | Community dwelling  patients with AD and  their caregivers.  Exercise group = 16  Control group = 16. | 77.8±5.8 | Aerobic exercises (flexibility, strength, and agility) and functional balance exercises | 60 minutes three times per week, for six months | Significant reduction in neuropsychiatric conditions, depression, and caregiver’s burden in exercise group |
| Teri et al., 2003 26 | RCT | Community dwelling  adults with AD.  Exercise group= 76  Control group = 76. | Exercise group= 78±6;  Control group =  78±8 | Moderate intensity exercise with aerobic/ endurance activities, strenght training, balance and flexibility training | 2 sessions per week for the first three  weeks, followed by weekly  sessions for four weeks and  biweekly sessions over the  next 4 weeks of 30 minutes  duration. | Significant decrease in  depression and  a trend for less institutionalization due to NPs in the exercise  group |
| [Venturelli](https://www.ncbi.nlm.nih.gov/pubmed/?term=Venturelli%20M%5BAuthor%5D&cauthor=true&cauthor_uid=27540967)et al.,  2016 34 | RCT | 80 patients with AD   Aerobic exercise = 20,  Cognitive Training group = 20,  Combination group = 20,  Control group= 20 | Aerobic exercise 84 ± 7;  Cognitive T. group,  86 ± 9;  Combination group  85 ± 8;  Control group:  84 ± 10 | Walking at moderate intensity | 5 days/week, 1 hour before sunset,  for 3 months | Improvement in NPs, agitation and sundowning syndrome symptoms  in aerobic exercise |
| Vreugdenhil et al.,  2012 25 | RCT | Community dwelling  adults with  AD and their caregivers.  Exercise group = 20  Control group = 20 | 74.1 | Home based exercise  program of daily exercises and walking under the supervision of their caregiver | At least 30 minutes a day, for 12 weeks | A trend for  improvement for those who exercised on measures of  depression and caregiver burden |
| Williams and  Tappen, 2008 27 | RCT | 45 nursing home residents with moderate to severe AD.  Three interventional groups were comprehensive exercise, supervised walking and social conversation. | 87.9±5.95 | Group 1:  comprehensive exercise  (strength, flexibility and  balance, supervised walk);  Group 2: Supervised walking;  Group 3: Social conversation | Exercise 5 times per week  with the duration of  30 minutes**,** for 16 weeks | Significant decrease in  depression and improved  mood in all three treatment  groups |
| Yu et al., 2013 28 | Open-label study  (one group) | Community dwelling  adults with mild to  moderate AD.  Exercise  group = 11. | 81.4±3.6 | Individualized moderate  intensity cycling | 3 times a  week (10 to 45 minutes  per session) over 6  months | Linear decrease in depression  over time |
| Yu et al.,  2015 38 | Open-label study  (one group | Community-dwelling older adults with mild-to-moderate AD  n= 26 | 78 ± 8 | Aerobic Exercise  (Moderate intensity cycling intervention) | Progressively increased by 5-min increments from 15 min initially to 45 min per session over  6  months | No changes in NPs severity, but signitificant reduction in caregiver distress |

**Notes**: AD: Alzheimer’s Disease; ADL: Activity Daily Living; MCI: Mild Cognitive Impairment; NA: Not Available; NPs: Neuropsychiatric symptoms; RCT: Randomized Controlled Trial