

Transcript Details

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Addressing Barriers to Early Detection for Alzheimer's Disease

Opening Announcer:

You're listening to ReachMD. Uncover the truth about Alzheimer's in this special series, Alzheimer's Disease: Towards Earlier Detection.

Dr. Birnholz:

In the effort to detect and diagnose Alzheimer's disease, time is of the essence, but there are numerous barriers that clinicians face in practice to establishing a diagnosis quickly and accurately, which effects quality of care for patients. My guest today is going to help us address these barriers, as well as look ahead to the future of Alzheimer's diagnostic protocols and treatment paradigms. This is ReachMD, and I'm Dr. Matt Birnholz. On this episode of *Alzheimer's Disease: Towards Earlier Detection*, I'll be speaking with Dr. Marwan Sabbagh, Professor of Neurology at the Barrow Neurological Institute and Chief of the Memory Disorders division.

Dr. Sabbagh, welcome to the program.

Dr. Sabbagh:

Thank you for having me.

Dr. Birnholz:

So, Dr. Sabbagh, to help us get grounded here, help us understand why is early detection for Alzheimer's so important?

Dr. Sabbagh:

I really am very sincere in saying that I worry about the fact that most Alzheimer's is not detected early. I think that we don't have a good organized or systematic approach to screening people for cognitive decline. Primary care physicians, this is out of their comfort zone, and so we do need to develop kind of better ways of going about it. But early detection clearly, and early diagnosis clearly means that we start treatment earlier, which has been shown in multiple studies to have better long-term outcomes, and with the new treatments on the horizon will be imperative if we want to find people who are suitable for those kinds of treatments.

Dr. Birnholz:

What about some of the barriers that you've witnessed from your practice to reaching an early identification for the disease?

Dr. Sabbagh:

First, I am a sub-specialist. I am a dementia neurologist, all I do is this, so I feel pretty comfortable doing this, but I know a lot of doctors don't. I don't think they know what questions to ask. I think people know how to do a mini-mental status exam, they know how to do a MoCA, they know how to do a clock draw, but they don't know what questions to ask, they don't know how to screen people for incipient cognitive decline. A lot of people are just dismissing this as you're old, you're depressed, there's nothing to worry about, and they don't take a memory complaint seriously. So, there are a lot of obstacles to even getting to a person like me, and by the time they get to me, there is clear evidence of considerable decline. The additional perspective, of course, there are few dementia neurologists around, so even trying to get into a general neurologist has been challenging.

Dr. Birnholz:

Let's turn, now, to some of the methods that you use to assess for Alzheimer's when you're looking at patients. As a sub-specialist you're often seeing patients, I'm sure, as they've gone down the line of diagnostic inquiry, but I'm curious about what you use to help further the assessment and then detect Alzheimer's.

Dr. Sabbagh:

Yeah. So, this is a very critical thing, and I'm teaching my junior neurology residents about how to be organized. I think we have to demystify what it comes to, or an organized approach to, dementia assessment and cognitive assessment. I take a structured interview. There are 3 structured interviews that are available; one is called the AD8, the other is called the IQ code, and the third one is AQ Alzheimer Questionnaire, and I use that as part of my HPI, history of present illness. Then, I will do not just a cognitive screening such as a MoCA, but I will do something called an aggregate risk analysis, and there are published scales, essentially, saying if you have this risk, plus this risk, plus this risk, the probability of Alzheimer's is high, and that's how I go about it. The other thing, I try to determine if the memory loss or cognitive decline is affecting their daily life. So, if they answer it is not, but it is present, then that's likely to be mild cognitive impairment. In the parlance of the psychiatrist, that would be minor neurocognitive disorder. If the cognitive decline is affecting their daily life, then we would call that dementia and, in the psychiatric parlance, major neurocognitive disorder, with the idea of trying to differentiate what kind of dementia it is. So, to be very clear, both mild cognitive impairment and dementia are descriptive terms without being etiologic in their diagnosis. So, Alzheimer's is a kind of dementia, and so, the newest term used is dementia due to Alzheimer's, and if it's prodromal Alzheimer's with a mild cognitive impairment, we would call that mild cognitive impairment due to Alzheimer's. So, what I would do beyond simply a very good history, physical, structured interview, screening assessment tools, aggregate analysis, rendering an initial diagnosis is, what can I be informed with, using my toolbox? And that's where I think the field really struggles. The standard medical tradition that is still common in American neurology practice is you get an MRI, you get a B12 level, and you get a TSH or thyroid level, simply to exclude the possibility of other conditions contributing to the dementia. But, most MRIs show a little bit of white matter change, a little bit of atrophy, thyroid functions tend to be, often are normal, B12 levels are often normal. So, all I know on the basis of that, is that those conditions, meaning strokes, tumors, water on the brain, thyroid dysfunction, and vitamin deficiencies, have been excluded, but it does not necessarily include a diagnosis of Alzheimer's disease and, in fact, that accuracy of a clinical diagnosis of Alzheimer's disease is roughly around 70-75%. In other words, the medical community is not very good, not very good, about diagnosing Alzheimer's disease, and the consequence is that we are delaying our diagnosis. There are new tools available to use, with genetic testing, spinal fluid analysis, PET scans, which do improve the diagnostic accuracy, but they're not commonly used in American neurology practice, despite their availability. So, I think the field is kind of at a crossroads, because there is a hesitance on routine use of these diagnostic biomarkers, but there is a lack of confidence in making a diagnosis.

Dr. Birnholz:

And clearly there are some barriers there. There has to be a good reason, it can't simply be because they are new, that there's a novelty effect and that people are just not aware. There must be some barriers to being able to employ some of these more accurate diagnostic tests. What are these barriers, in your experience?

Dr. Sabbagh:

So, I, as a sub-specialty neurologist, feel comfortable using them, but most neurologists don't. So, the first barrier to your audience is that there is a comfort level issue about using the test. Second is, many of the tests are not paid for or reimbursed by insurance. And then the third is kind of the how-to guide or counsel on the basis of what you find. So there's a lot of barriers to using the tests, but they're not insurmountable.

Dr. Birnholz:

And, just to be clear, is there some connection there as to why some practitioners are reluctant to seek these further tests?

Dr. Sabbagh:

Well, there's a lot of things to say about that. First, I think the fact is, a lot of doctors are stuck on medical tradition, and just do what has been taught, meaning they do the B12, the TSH and MRI because that's what they were taught, and so, they have coalesced around that concept. The second thing is that doctors don't feel comfortable, so there is a comfort level in using some of the tests, and third, is this misplaced idea that they feel that they can make a diagnosis without the use of the tests, although the data clearly suggests that we're very inaccurate, 1 out of 4 times inaccurate, in making a diagnosis. So, part of this is reeducating the workforce, the medical neurology workforce, to kind of think about using these tests.

Dr. Birnholz:

Does your management change when you're able to arrive at a more accurate diagnosis and does the outcome for patients and the perspective by patients change when they have an accurate diagnosis?

Dr. Sabbagh:

You know, I am a person that wants to be precise and informed. I don't want to simply get tests for the sake of tests. If a normal B12 tells me that they have a normal B12, but doesn't tell me they have Alzheimer's, and I don't find it to be a very informative test, although that is medical tradition and I order it, but if I have a person, for example, with progressive cognitive decline, no focality, looking like Alzheimer's, and my PET says they have, hypometabolism in the parietal and temporal regions, then that increases the probability of Alzheimer's dementia. So, in other words, I use the tests to inform the diagnosis, and by extension it affects and influences the

treatment recommendations and guidelines. There is a major study going on right now called the IDEAS study, and it is used to determine if having amyloid PET reimbursed by Medicare can be useful in affecting the outcome on the basis of amyloid PET. In other words, if I got a PET, would I do something different? Would I inform my patients differently? How would I change my management or diagnosis on the basis of the PET? it turns out to be highly useful and highly informative and influences the treatment guidelines or treatment recommendations per patient, then it could be a very useful test and likely would be reimbursed in the future. So, I try to use the tests to inform me in this very manner.

Dr. Birnholz:

Well, with that I very much want to thank my guest, Dr. Marwan Sabbagh, for joining us. We've been talking about barriers to earlier detection for Alzheimer's disease and the future of Alzheimer's diagnostic protocols and treatment paradigms. This is ReachMD, and I'm Dr. Matt Birnholz. For access to this and other episodes of *Alzheimer's Disease: Towards Earlier Detection*, visit ReachMD.com. Thank you for listening.

Closing Announcer:

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