

Transcript Details

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Recognizing Alzheimer's Disease at the Earliest Stages: Key Signs and Symptoms

Opening Announcer:

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

Dr. Russell:

Quality care for Alzheimer's disease starts with an early documented diagnosis and timely intervention in order to provide the best opportunity for individuals to benefit from available treatment options in the beginning stages of Alzheimer's disease. I'm Dr. John Russell and joining me today is Dr. Howard Fillet, Founding Executive Director and Chief Science Officer of the Alzheimer's Drug Discovery Foundation. Dr. Fillet, welcome to ReachMD.

Dr. Fillet:

Thank you, it's great to be here. I appreciate it.

Dr. Russell:

So doctor, I know all our clinicians are thinking about the cognitive changes that happen early on with Alzheimer's. Are there some behavioral things, and is any research looking into this that might happen early on with our patients?

Dr. Fillet:

There's been a lot of research on the behavioral aspects of Alzheimer's disease. First of all, 90% of people with early Alzheimer's, mild cognitive impairment, or, and I want to distinguish between Alzheimer's disease, which would be the way I use the term referring to the pathology of the disease in the brain, versus clinically describing people as having mild cognitive impairment from Alzheimer's disease or mild dementia from Alzheimer's disease. And so, people with mild dementia from Alzheimer's disease, about 20 to 40%, depending on the study you read, will have depression at the onset of the disease and we think that probably this is a biological result of this disease, or neurobiological result of disease, but it could be a reaction to change in life as a result of the ongoing cognitive impairment. Of course it's critically important to recognize depression at the time of diagnosis, because there's also an entity which is depression, cognitive impairment secondary to depression, and it's a reversible form of cognitive impairment. And before we can make a diagnosis of, let's say, mild dementia or even mild cognitive impairment, which would be memory impairment without real functional disability or other cognitive symptoms like aphasia or apraxia or anosognosia that we need to treat depressive symptoms. And if we resolve those depressive symptoms and we look at the substrate that's left after the treatment of depressive symptoms, either way, if the dementia remains after the depressive symptoms—of course we've relieved the dysphoria—it's likely that by treating the depression there could be some improvement in cognitive symptoms, but the dementia remains. So depression is one important behavioral symptom. Apathy affects 90% of people with early dementia and I want to distinguish apathy from depression, because apathy is a neurological term that refers to people who are disconnected between their motivational centers and their ability to execute because they have executive dysfunction. And so very often we'll see patients in our offices and the wife will say, "I think he's depressed because he just sits around and he says he wants to play golf, but he never goes." And that's apathy because although the patient may have the motivation to want to play golf, they can't execute the cognitive sequences to make the arrangements and all that stuff. So apathy is an early behavioral symptom. And then, you have the other behavioral symptoms that are quite disabling like agitation, psychosis, and other kinds of symptoms related to negative behaviors, and those are also big risk factors as the disease progresses for things like nursing home placement and spousal or caregiver depression and caregiver symptoms. And so we have to look out for those and most of the time these negative symptoms of agitation and anxiety and so on can be treated with behavior management and psychosocial interventions, and of course we prefer that to giving people antipsychotics. Unfortunately, psychosis and these behavioral symptoms of agitation are quite common in people with Alzheimer's, especially as they progress, and we don't have any drugs at this time that are specifically

indicated for the treatment of psychosis and agitation in people with Alzheimer's disease. And all of the drugs like the anti-anxiety agents, the sedatives, are either contraindicated or have serious side effects and can make symptoms worse and of course the anti-psychotics have black box warnings.

Dr. Russell:

If you're just tuning in, you're listening to Alzheimer's Disease: Towards Earlier Detection, on ReachMD. I'm your host, Dr. John Russell and I'm speaking with Dr. Howard Fillet, Founding Executive Director and Chief Science Officer at the Alzheimer's Drug Discovery Foundation. So doctor, why do you think it's so important for treatment for patients to get that early diagnosis for Alzheimer's disease?

Dr. Fillet:

Well, you know the main thing, I think, for the primary care doctor, is to recognize that Alzheimer's average age of onset is somewhere in the late 70s. And most of these people have multiple comorbidities like diabetes and hypertension and congestive heart failure and atrial fibrillation, and we showed many years ago that the adverse outcomes from cognitive impairment in this elderly, frail, generally frail, population are mostly mediated through its impact on chronic disease management. And I'll give you the best example I can give which was my dad. My dad was an insulin-dependent diabetic. He was also an engineer. He used the slide-rule. He wrote graphs. He never used the computer. And he did high intensive insulin therapy with, he was one of the first people on the MiniMed device and for 35 years he was never admitted to the hospital with diabetes. And the year he got his early Alzheimer's, he was admitted 4 times with ketoacidosis. His wife couldn't help him with the insulin injections, he was getting up in the middle of the night and injecting himself, he had multiple hypoglycemic episodes, and it was all due to cognitive impairment. And that's just one example. I mean, imagine a patient with congestive heart failure, mild congestive heart failure, and all they need to do to stay out of the hospital is to watch their weight, stick to their low-salt diet, and take their diuretic. And now, let's say they're living alone, and they forget to take their medicine, they take the wrong diet, they end up in the emergency room. Early Alzheimer's disease dementia is not recognized, they get tuned-up in the hospital, after 3 or 4 days they get sent home, and 15 days later they're back in with a hospital readmission. Why? Because nobody recognized that this is a person with cognitive impairment who needs home care and medication monitoring. We just published a paper on the impact of cognitive impairment on potentially avoidable hospitalizations showing that people with cognitive impairment from Alzheimer's disease are at much greater risk for 30-day readmissions than people who do not have cognitive impairment. And the economic costs and the effect on quality of care of a failure to recognize cognitive impairment from Alzheimer's disease, mild cognitive impairment or early dementia even, can be critically important in the management of diabetes and hypertension and COPD and heart failure and atrial fibrillation, and all these illnesses that our patients suffer. So, if for no other reason, from a primary care point of view, we need to recognize that a patient has cognitive impairment and then figure out a way to help them with their chronic disease management of the multiple comorbidities that these patients have. And also, closing the circle on this, there have been a lot of recent studies showing that hypertension, and diabetes, and all these medical conditions, are not only contributing factors directly to vascular dementia, but probably contribute to Alzheimer's pathology as well. So, there's a 2-way street here by effectively continuing to manage people with diabetes, which is a risk factor for Alzheimer's disease, and hypertension which is a risk for vascular cognitive impairment in Alzheimer's disease, and so on. We also can have an impact on the occurrence and the rate of progression, presumably of, I believe, we can have an impact on the progression of Alzheimer's disease itself.

Dr. Russell:

Dr. Fillet, is there a final point you'd like to share with our ReachMD audience?

Dr. Fillet:

You know, I've been doing this for over 35 years and I have never ever been more excited about our field than I am today. There's so much more awareness. There's more research funding coming into our field, and we know how to take care of these people. The resources can be out there and it's just a matter of having physicians who recognize the importance of this, because patients need their doctors to take care of them when they have Alzheimer's disease. I am so convinced that this is a primary care illness. I am a primary care geriatrician and I love my patients and I know that for 30, over 35 years, I've been helping them. Even in the day before there were any medications on the market, I was able to help my patients to manage this disease. And I'll end with a quote from Hippocrates. Hippocrates said, more than 2000 years ago, "The role of the physician is sometimes to treat, often to relieve pain, and always to comfort and care," and we need to do that for our Alzheimer patients, just like we do it for our diabetes and our hypertensives and the rest of our primary care patients.

Dr. Russell:

What a wonderful sentiment from so many years ago. So, I'd like to thank you, Dr. Howard Fillet, for joining us today on ReachMD.

Dr. Fillet:

Thank you.

Closing Announcer:

You've listening to ReachMD. Uncover the truth about Alzheimer's in this special series, Alzheimer's Disease: Towards Earlier Detection. To revisit any part of this discussion and to access other episodes visit ReachMD.com/timehidesalzheimers. Thank you for listening.