Transcript Details
This is a transcript of a continuing medical education (CME) activity. Additional media formats for the activity and full activity details (including sponsor and supporter, disclosures, and instructions for claiming credit) are available by visiting:
https://reachmd.com/programs/cme/Amyloid-Therapies-in-Practice-Not-All-Are-Created-Equal/56761/

Released: 04/28/2026
Valid until: 04/28/2027
Time needed to complete: 39m

ReachMD
www.reachmd.com
info@reachmd.com
(866) 423-7849

Amyloid-β Therapies in Practice: Not All Are Created Equal

Dr. Sabbagh:
This is CE on ReachMD, and I'm Dr. Marwan Noel Sabbagh. Joining me today is Dr. Danielle Cabral.

Well, let's get right into it, Dr. Cabral. Dani, how does amyloid biology shape what amyloid beta therapies can and cannot do for patients?

Dr. Cabral:
Thanks, Marwan, great question. So Alzheimer's biology shapes both the promise and the limits of amyloid beta therapies. So at the core, these therapies target 1 specific key feature of Alzheimer's disease, what we know the earliest to start in the process of the development of this disease, which is amyloid plaque accumulation, of course, and that's why they can modify disease trajectory, but only under the right conditions.

We found over many years of studying these therapies, as you know better than anyone. So here's the biologic reality. Amyloid is a very early event. We're thinking 25 years before symptoms start. This starts accumulating. So by the time patients present with symptoms, there's already various downstream negative effects, such as tau spread, synaptic dysfunction, neurodegeneration, vascular disease, and other things that we're still learning about, neuroinflammation. So when we remove the amyloid, we can't reverse the disease. There's already so much damage that's happened, but we're interrupting 1 key driver of that ongoing injury.

So what can these therapies do? So we have both FDA-approved lecanemab and donanemab, and we have evidence that these are very effective at removing the amyloid, and the primary endpoints of those pivotal trials showed that it slows clinical progression in early symptomatic Alzheimer's disease. So early symptomatic is the key words there.

And so then across both of these trials, it appears that there's roughly a 25%-30% slowing of the cognitive and functional decline, so clinical measures on scales, and then up to 60% in certain groups with post hoc analyses. We know that appears in those who are earlier in the course of disease, so earlier tau buildup in the brain and less symptoms, so in the mild cognitive impairment group, they seem to have more of a benefit from these medications in terms of slowing.

And so that's very meaningful for our patients, and it's been a game changer, truly in our field. But it's so important to reiterate, this is slowing, not stopping. This is modification and not reversal of the disease.

And so what can't these anti-amyloid drugs do, as far as we know? So we can't get patients back to their cognitive baseline. They don't address vascular disease, mixed pathology. So we know many people have not just Alzheimer's, but also Lewy body disease and other things going on. And we're still learning about the impact of anti-amyloid therapies on tau, though it does seem like tau, there is some lowering of that with these treatments, but still there's a lot to learn.

Certainly, these treatments don't eliminate the need for comprehensive care, clinical care for patients incorporating the care partner, and that they're stage dependent. So the approved medications are only for mild cognitive impairment mild dementia stages, where amyloid still is a major driver that can be acted upon.

And so differentiating lecanemab and donanemab, there's practical distinctions. Lecanemab is ongoing every-2-week dosing, and donanemab is monthly dosing intended to have limited duration, to be stopped when the treatment demonstrates a normalization of the amyloid levels via amyloid PET scan, so theoretically between 12 to 18 months.

And so what we're seeing, the efficacy, it's slowing, but it's a modest slowing, but certainly a game changer from what we've had. So they differ meaningfully in implementation and monitoring.

Dr. Sabbagh:
And Dani, it's an excellent summary and a very important topic, because at the end of the day, we have a lot of patients who qualify for these treatments. We have to level-set expectation that these drugs make you less worse, not better. But I've seen now dozens of patients actually have a meaningful slowing in the rate of decline.

And so I think this is a very exciting time, because it's now the beginning of the transformation of Alzheimer's from a terminal disease to a chronic disease.

Thank you for that commentary, and now you know. And thanks for listening.