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https://reachmd.com/programs/cme/challenges-in-recognizing-and-diagnosing-mci-in-ad-earlier/16053/

Released: 09/08/2023
Valid until: 09/08/2024
Time needed to complete: 1h 04m

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Challenges in Recognizing and Diagnosing MCI in AD Earlier

Announcer:
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Dr. Isaacson:
My name is Dr. Richard Isaacson. I'm a Preventive Neurologist at the Institute for Neurodegenerative Diseases of Florida, and that's in Boca Raton, Florida. Today we'll be talking about Challenges in Recognizing and Diagnosing MCI, or Mild Cognitive Impairment Due to Alzheimer's Disease Earlier.

The clinical use of measurement-based care and diagnostic tools used to diagnose MCI earlier are several, but they're also tricky to understand and detailed. So how early is too early to diagnose? Before after symptoms begin? And who to screen and how to screen them, that's what we'll cover today. We'll talk about how to take a clinical history, the different types of cognitive tests we can consider varying an emerging blood tests that are I think a lot of people are excited about. And then the old standard, which is really the gold standard, which is spinal fluid testing, via spinal taps, or brain imaging through amyloid or tau PET. So with that, let's begin.

When we think about how early is the right way to go, well, believe it or not, Alzheimer's disease and other neurodegenerative dementias start in the brain decades sometimes before symptoms begin. So as an example, if at age 85, say 40% or so people have Alzheimer's, that disease first started in their brain between the ages of 55 and 65. Now it starts silently, but still it starts. If at age 65, about 10% or so people have Alzheimer's, then the disease first started in their brains between the ages of 35 and 45. And while there is a long prodromal period of silent disease, when we reach the first early symptomatic phase of mild cognitive impairment, that's when we can do something. And that's when we have new therapies that I think the field and especially myself and my patients are very excited about.

So who to screen and when to screen them? There's a focus on patients who report memory complaints, including caregivers that report them or family members who report cognitive problems to the clinician. It's really important also to think about risk factors. What puts person at a higher risk for Alzheimer's disease? There are several modifiable risk factors, as well as age, of course, as a nonmodifiable risk factor, genetics, and a variety of others. It's also important to establish a workflow, especially for an initial screening, and also follow-up screenings. There's something called the Annual Medicare Wellness Visit that's paid for, and maybe working into each of those Annual Medicare Wellness Visits, the element of cognitive screening as well as, how are you doing with your memory? And how are your thinking skills doing? And just be more proactive at the annual physical, not just to really talk about the physical, but talk about the mental and cognitive as well.

So how do you screen? I wish I had a easy, straightforward and quick answer, but it's complicated. The first and best way to screen is really to take a detailed clinical history and also take a neurological history. Have there been any changes in your memory and thinking skills over the past several months or years? Getting a report from an informant, like a caregiver or a family member, a spouse or child is really critical, but also asking the patient. It's also important to incorporate the standardized cognitive screening instruments, including

questionnaires or cognitive testing in the office. And if it's worrisome results, then you can consider referral for full neuropsychological testing. Well, we can't cover all the different options. There's a variety of screening tools in the waiting room like the AD8, the Mini-Cog only takes a few minutes, which is a 3-word recall, as well as drawing a clock. And I think most people are aware of the MoCA and the Mini Mental Status Exam, which take at least 7 to 10 minutes or so, but give a lot more depth of information. But again, these are still screening and not full diagnostic tests.

Where the field is going is really focusing on biomarkers. Doing a structural MRI to look for different areas of brain atrophy is critical. Amyloid PET scans and even tau PET scans in the last few years are now available to truly get biological confirmation. Although these tests are expensive, and they're not always available throughout every place. And there's also some radiation. FDG PET which is glucose PET or looking for glucose hypometabolism is also available, and of course spinal taps, looking for AB42 to 40 ratio and looking at tau. And the emerging tests include the amyloid blood tests, different tau isoforms, and NfL, or neurofilament light, and GFAP or glial fibrillary acidic protein, which looks for neuroinflammation. And while the biomarkers are the kind of the gold standard to be certain that someone has a diagnosis of mild cognitive impairment due to Alzheimer's disease rather than a different variety of cognitive decline, using spinal taps or PET scans are really the gold standard today.

Well, we can look at MRIs and look for atrophy. That's helpful. But I think in the future, in terms of really where our field is going is to use blood tests. Blood tests are now available in the United States, but they aren't yet the gold standard, but they've even been raised certainly worked into the draft research diagnostic criteria that came out in the summer of 2023.

So with that I'll conclude. I hope this was helpful and thanks for spending time with us today.

Announcer:
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