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How Do You Counsel Patients About Amyloid-Related Imaging Abnormalities?

Announcer:
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Dr. Isaacson:
Welcome to another episode of the Frontline of Alzheimer's Care, where we address burning questions from real clinicians who treat Alzheimer's disease about amyloid-targeting therapies. I'm Dr. Richard Isaacson, and helping me answer these questions today, are Drs. Gayatri Devi and Pierre Tariot.

Today, we have some very important questions from Dr. Stander and nurse practitioner, Ms. Grigaitis-Reyes, about the safety of anti-amyloid therapies.

Ms. Grigaitis-Reyes:
How do you discuss the need for APOE testing and all that that entails with your patients and families?

Dr. Stander:
Have you designed a consent form for candidates that fairly balances out the potential benefits versus the risks?

Dr. Isaacson:
Dr. Devi what are some best practices from you?

Dr. Devi:
I think, you know, it has to be very personalized in terms of approaching risk for Alzheimer's, risk for side effects when you have the APOE4 allele. I tend to be because of this potential for significant side effects with the anti-amyloid therapies, particularly if they have an E4 allele I tend to actually err on the side of more rather than less in terms of discussing risks. And I'll talk to them about potential significant risks for patients. I go over in great detail with them what possibilities there could be for bleeding and then I try to change my approach in terms of treatment by going up very, very slowly in terms of titration.

Dr. Isaacson:
Dr. Devi, you have experience with designing a consent form. I've seen it, and I've had our mutual patients sign it. Maybe you could tell us a little bit about kind of what went into writing that and what are the key points that you make when conveying this risk versus benefit information to patients?

Dr. Devi:
So my consent highlights that the fact that there's absolutely no prospect of any improvement or restoring of cognition with treatment. I wanted patients to understand that because I think there's so much hope amongst patients and their families, and they might put themselves needlessly at risk with false hope, with the feeling that maybe this will cause improvement. So I'm very clear on highlighting that. And I also am very clear in grouping together both the amyloid-related edema and the amyloid-related hemorrhage as together,

you know, and giving them a percentage - not trying to parse it down to E4 versus patients without E4, but trying to give them the worst scenario in terms of what could potentially happen. So that way, they go in with their eyes wide open-and they're very clear that all we're hoping to do is to slow progression, all - and this is in a context of possible serious side effects. Although it's important to note that most of these side effects are not serious with the ARIA hemorrhage and the ARIA edema, and only about less than 0.5%, either for lecanemab or aducanumab, reaches what's considered a serious problem.

Dr. Isaacson:
Dr. Tariot I really value your thoughts here. These are, you know, drugs that have some degree of risk. You know, we want to promise not to overpromise but how do you convey this? And what are some best practices in terms of the medical communication here?

Dr. Tariot:
Yeah. Well, I love Dr. Stander's suggestion that you already implemented both of you of having a consent form. Our draft consent form is still being worked out. But it's probably a little more detailed than what Dr. Devi talked about. We talk about what ARIA is, what the symptoms and signs are, how we monitor for it, the role of genetics, to answer Dr. Grigaitis-Reyes's question. This is where we have the discussion about APOE4 and ARIA risk. We talked about the baseline microhemorrhages as being a risk factor, anticoagulants being a risk factor. We talk about the necessity of MRI monitoring because if you can't have an MRI or if you're not willing to have serial MRIs, you can't get the therapy. We actually talk about the cost and how the cost might be covered. And lastly, we emphasize that it's critical that all the other medical providers know that the person is on this therapy.

Dr. Isaacson:
Great. Well, I think these are really practical and important suggestions and, you know, different patients may kind of need different types of information. We need a standard consent form for all, but I think from a practical clinical perspective when discussing the consent form, we may need to pivot more to the APOE section for certain patients and more to the promising not to overpromise section where if people have unrealistic expectations when people have unrealistic expectations, we may want to vamp on that section of the consent form too. So I think these are really important – really, really important points.

Thank you to Dr. Stander and Ms. Grigaitis-Reyes for such insightful questions. And to our viewers, check out our other episodes, where we talk more with clinicians and figure out what they want to know about the clinical use for anti-amyloid therapies. Thanks so much for joining us.

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