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/professional-recommendations-of-clinically-validated-tools-used-to-diagnose-mci-in-ad/16058/

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

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

Professional Recommendations of Clinically Validated Tools Used to Diagnose MCI in AD

Announcer:
Welcome to CME on ReachMD. This episode is part of our MinuteCE curriculum.

Prior to beginning the activity, please be sure to review the faculty and commercial support disclosure statements as well as the learning objectives.

Dr. Sabbagh:
Hello, I'm Marwan Sabbagh, Professor of Neurology at the Barrow Neurological Institute. I have Dr. Cohen and Dr. Isaacson joining me today. Dr. Cohen, would you introduce yourself, please?

Dr. Cohen:
Yes, of course. I'm Sharon Cohen. I'm a Behavioral Neurologist and the Medical Director of Toronto Memory Program in Toronto, Canada.

Dr. Isaacson:
Great. I'm Richard Isaacson. I'm a Preventive Neurologist down at the Institute for Neurodegenerative Diseases in Florida. And that's in Boca Raton, Florida.

Dr. Sabbagh:
Thank you both for joining me today. We are in a new era, as we all acknowledge, in the era of Alzheimer's treatment, diagnosis, and therapeutics. And today, we really want to kind of think about how we're re-engineering our lives, our practices, our workflows, our patient flows, to accommodate these new and rapid changes. So the first question I'm going to send to you, Dr. Isaacson, is what tools are available today to diagnose MCI, mild cognitive impairment, due to Alzheimer's disease? And how do you use them in your clinical practice?

Dr. Isaacson:
Well, the good old-fashioned tool as a neurologist, we take a pretty detailed clinical history. And we really try to find out from the, not just the patient, but also the care partner, a spouse, a child, a friend, you know, tell me about these problems? When did they start? Aand have there been any impacts on the activities of daily living? Because really, the construct of mild cognitive impairment means that there are, you know, changes in cognition, but they're not yet affecting activities of daily living. And if we can get an earlier diagnosis in that stage before dementia, that's when we not only have new tools available in terms of drugs and other treatments, I think that's when we can really have the most benefit. So the tools that I start off with in diagnosis are just the good old-fashioned clinical history.

Of course, we proceed to neuropsychological testing. You know, sometimes it's tough to get neuro-psych testing, there's a long waiting list and whatnot, we do a little bit of computer-based testing. And then to get a more formal diagnosis, the more full battery by neuropsychologist, of course.

And then the thing that I'm really excited about are using biomarkers. And you know, it's just a couple of weeks have gone by and in the new draft, and they're not fully approved, but the new research criteria for diagnosing Alzheimer's disease include blood-based

biomarkers. And again, those are draft and those are research criteria, so not exactly, you know, maybe commonly agreed upon by clinicians to that using blood-based biomarkers in primetime. But our program is using a lot of blood-based biomarkers. There's now several, both amyloid from different companies and, you know, there's the tau test and neurofilament light test that's out that's available commercially. We also have research protocols that we do. But whether it's using a blood test, or an amyloid PET scan, or a tau PET scan, or even spinal taps for amyloid and tau, that's really how we round out things. Of course, we want to make sure that there's no other potential causes nondementia, non-neurodegenerative causes so we can do some other blood tests. And you know, depending on the person, we may want to refine things.

But yeah, amazing new tools and a new era in our disease treatment and diagnosis.

Dr. Sabbagh:
Thank you, Dr. Isaacson, Dr. Cohen, so Dr. Isaacson brings up the whole era and discussion about biomarkers and how we're transforming. What are your perspectives on the biomarker utilization in the diagnosis?

Dr. Cohen:
Well, that's terribly important that we have biologic confirmation of underlying Alzheimer's disease. If we have someone with mild cognitive impairment, and I totally agree, you need a history, you need to know impact of cognitive symptoms on day-to-day function and you need cognitive testing to document that there is an impairment, and then you are left with a syndromic diagnosis of MCI. You can be suspicious that the underlying cause is Alzheimer's because the general neurologic exam is normal, the onset was insidious, and maybe the symptoms are progressive. We're still going to be wrong, you know, 50% or more of the time if we say this is MCI likely due to Alzheimer's. It's likely but, you know, when you go on to confirmatory biologic testing, we find, hey, you know, this had the phenotype of Alzheimer's. It's not. You know, what else is it? So having biomarker confirmation and the gold standard CSF, AD biomarkers or PET amyloid imaging, very important. Blood-based biomarkers are coming in to the scene, still not really primetime in clinical practice. The hope is that within the next few years, we'll be able to rely on them more either as a pre-screener for who goes on to amyloid PET or CSF testing.

But I think in the meantime, there's a lot of opportunity to scale up CSF. Our European colleagues do this well, especially in Northern Europe. But there isn't such an aversion to doing, you know, spinal taps, and patients accept this. We know in our clinic in Toronto, patients accept this. And so we should roll this out. You know, it wasn't so long ago that we used to do spinal taps routinely for MS workup. And I think that is the more scalable, cost-effective test. We're never going to have enough PET scanners, at least not in Canada, to accommodate the population that needs it. And, you know, we want - and oncology uses a lot of the PET scanning time. And so be it. You know, we need to find other ways that are meaningful for patients. And there's going to be a big demand. The era where you can just say, oh, mild cognitive impairment, that's normal aging, we're all a bit forgetful, that's over. That needs to be over. We need biologic confirmation for anybody who has even mild memory problems.

Dr. Sabbagh:
I agree with both of you. I myself have started to change my workflow to rely a little less outsourcing the neuro-psych testing, really driving, particularly the amnestic forms, really driving harder toward a biomarker confirmation. But we do have PET available, but the reimbursement has been a challenge. So we've been doing a lot of CSF testing. And it - you know, if you - the way you approach it to your patients, is you tell them, I think it's a lot about how the provider, the physician informs the patient about this. I have to tell you, I don't get as much resistance as I used to. And we're finding it to be very, very accurate. In fact, today, this morning in clinic, I reviewed CSF results with two patients so it can be done. I think it should be done routinely. What we don't know is how, where, and when we'll start to see plasma biomarkers start to incorporate themselves in the workflow. So Richard, you're ahead of us. So we're starting to see that come to be, but we're not - I haven't seen it kind of established in clinical workflow.

So thank you. Dr. Cohen. Thank you, Dr. Isaacson. And thank you audience. I hope you learned something. This is a very exciting time and I look forward to hearing and talking more about these topics.

Announcer:
You have been listening to CME on ReachMD. This activity is jointly provided by Global Learning Collaborative (GLC) and TotalCME, LLC. and is part of our MinuteCE curriculum.

To receive your free CME credit, or to download this activity, go to ReachMD.com/CME. Thank you for listening.