Dementia (major neurocognitive disorder): what you need to know



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Disclosures

- Inventor on patent / patent application with MassGeneral Brigham on the Alzheimer's and COVID smell tests and therapeutic targets for Alzheimer's and ALS
- Scientific Co-founder and Shareholder, Aromha, Inc.
- Will discuss some off-label uses of drugs for Alzheimer's disease

By 2050, the number of people age 65 and older with Alzheimer's dementia is projected to reach 12.7 million.

-2022 Alzheimer's Facts and Figures



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1 in 3 seniors dies with Alzheimier's or another dementia.

–2022 Alzheimer's Facts and Figures



Family members and friends provided more than \$271 billion in unpaid care to people living with Alzheimer's and other dementias in 2021.

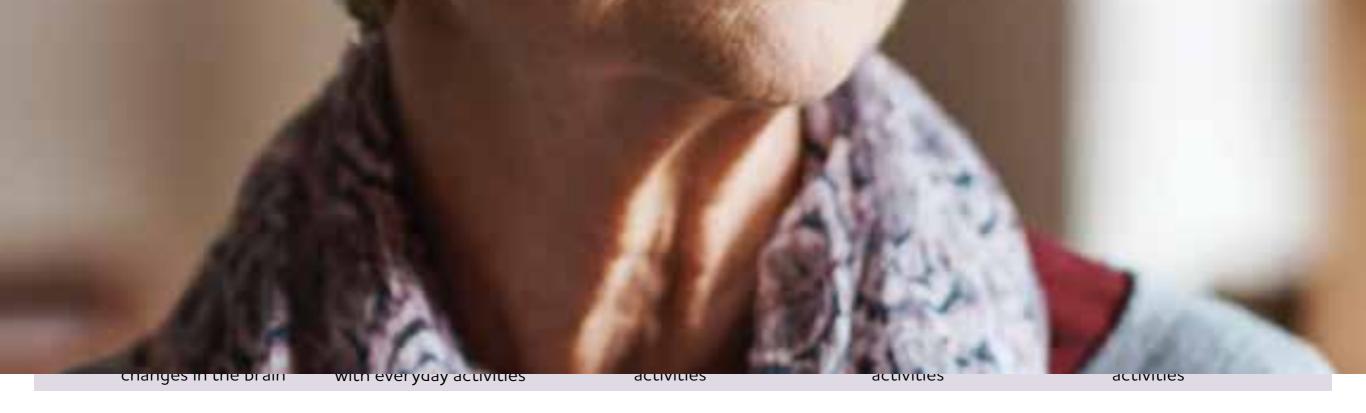
–2022 Alzheimer's Facts and Figures

55% of primary care physicians caring for people living with Alzheimer's report there are not enough dementia care specialists in their communities to meet patient demands.

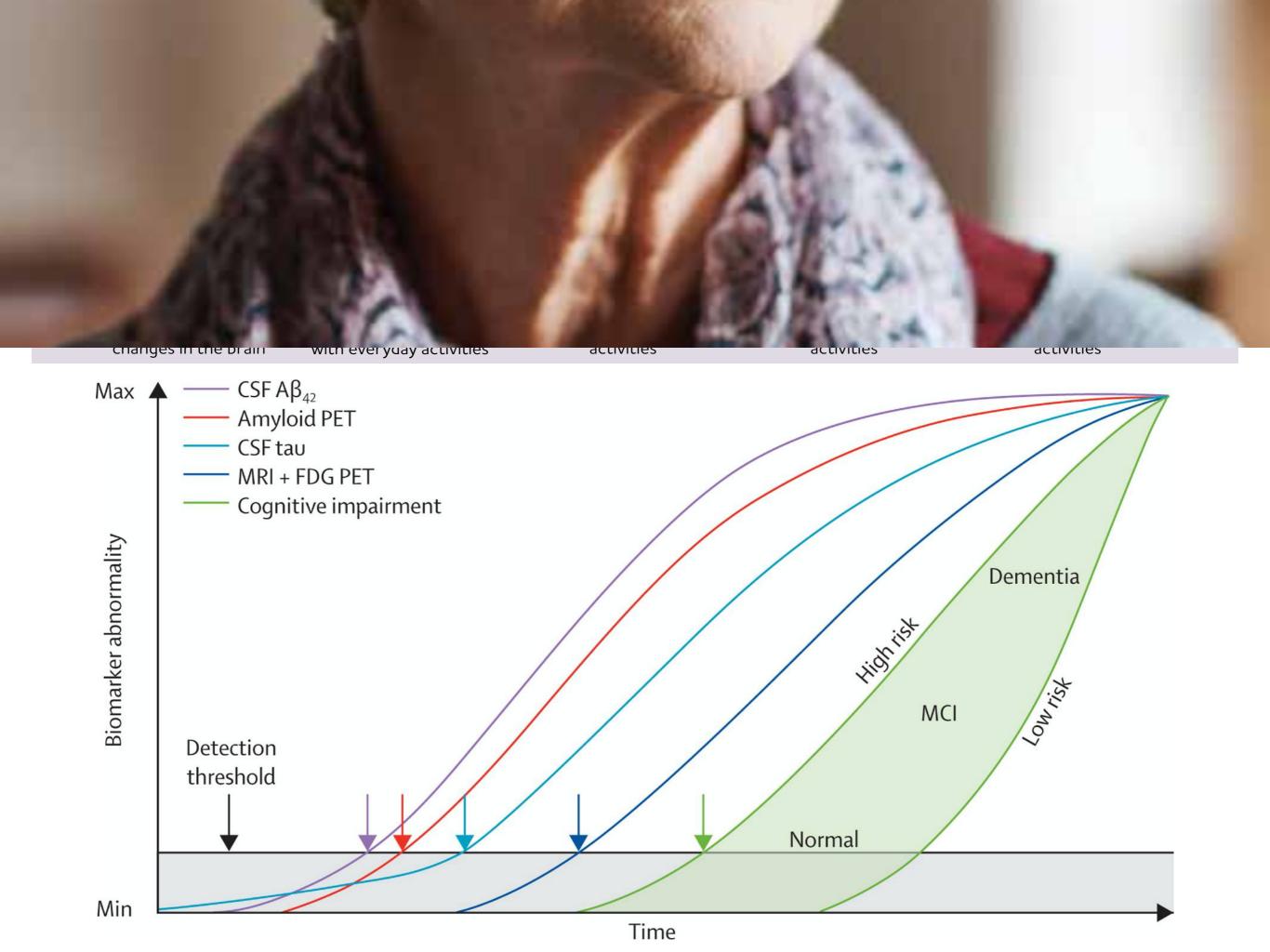
with Alzheimer's and other dementias in 2021.

-2022 Alzheimer's Facts and Figures

Preclinical AD	Mild Cognitive	Dementia Due to AD	Dementia Due to AD	Dementia Due to AD
	Impairment Due to AD	Mild	Moderate	Severe
No symptoms but	Very mild symptoms	Symptoms interfere	Symptoms interfere	Symptoms interfere
possible biological	that may not interfere	with some everyday	with many everyday	with most everyday
changes in the brain	with everyday activities	activities	activities	activities



Fewer than 1 in 5 Americans (18%) are familiar with mild cognitive impairment (MCI).



2 cases - trajectories of cognitive decline

Patient 1

- 74 year old housewife with minimal worries about memory, but family has noted some changes
- Family history of AD
- MRI shows atrophy
- PET scan positive for amyloid
- Rx: Aricept (and support)

2 cases - trajectories of cognitive decline

Patient 1

- 74 year old housewife with minimal worries about memory, but family has noted some changes
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Patient 2

- 68 year old lawyer
- Family history of AD
- 23 and me says high risk
- Losing details in highly demanding situations
- MRI shows atrophy in hippocampus and parietal lobe
- CSF positive for AD biomarkers
- Rx: Aricept (and support)

2 cases - trajectories of cognitive decline

Patient 1

- 74 year old housewife with minimal worries about memory, but family has noted some changes
- Family history of AD
- MRI shows atrophy
- PET scan positive for amyloid
- Rx: Aricept (and support)

 10 years later still living at home, conversant about current events, somewhat inaccurate Patient 2

- 68 year old lawyer
- Family history of AD
- 23 and me says high risk
- Losing details in highly demanding situations
- MRI shows atrophy in hippocampus and parietal lobe
- CSF positive for AD biomarkers
- Rx: Aricept (and support)
- 2 years later wandering, needs nursing home placement

Differential Diagnosis of Dementia

- Alzheimer's disease
- Lewy Body Dementia
- Vascular Dementia
- Fronto-temporal dementia (behavioral, semantic, logopenic)
- Tauopathies: progressive supranuclear palsy (falls, impaired upgaze); corticobasal ganglion degeneration (generally unilateral)
- Normal Pressure Hydrocephalus (magnetic gain, urinary incontinence)
- CJD and other rapidly progressive dementias
- Autoimmune encephalitis

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overlap

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DSM-IV and DSM-5 criteria for dementia

DSM-IV criteria for dementia	DSM-5 criteria for major neurocognitive disorder (previously dementia)	
 A1. Memory impairment A2. At least one of the following: Aphasia Apraxia Agnosia Disturbance in executive functioning 	 A. Evidence of significant cognitive decline from a previous level of performance in one or more cognitive domains*: Learning and memory Language Executive function Complex attention Perceptual-motor Social cognition 	
B. The cognitive deficits in A1 and A2 each cause significant impairment in social or occupational functioning and represent a significant decline from a previous level of functioning.	irment in social or independence in everyday activities. At a minimum, assistance should be required	
C. The cognitive deficits do not occur exclusively during the course of delirium.	C. The cognitive deficits do not occur exclusively in the context of a delirium.	
	D. The cognitive deficits are not better explained by another mental disorder (eg, major depressive disorder, schizophrenia).	

For diagnostic criteria of dementia subtypes such as Alzheimer disease or frontotemporal dementia, please refer to UpToDate topics on the clinical manifestations and diagnosis of individual dementia subtypes.

DSM: Diagnostic and Statistical Manual of Mental Disorders.

* Evidence of decline is based on concern of the individual, a knowledgeable informant, or the clinician that there has been a significant decline in cognitive function and a substantial impairment in cognitive performance, preferably documented by standardized neuropsychological testing or, in its absence, another quantified clinical assessment.

References:

- American Psychiatric Association Diagnostic and Statistical Manual, 4th ed, APA Press, Washington, DC 1994.
- American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), American Psychiatric Association, Arlington, VA 2013.

from UpToDate

Evaluation

- Forgetting proper names
- short term memory (repeating questions, new compensatory techniques under equal load)
- Word finding difficulty
- Visual perceptual deficits
- Changes in emotion
- Gait instability
- Urinary incontinence
- Rule out on depression, although new onset depression can be AD or FTD

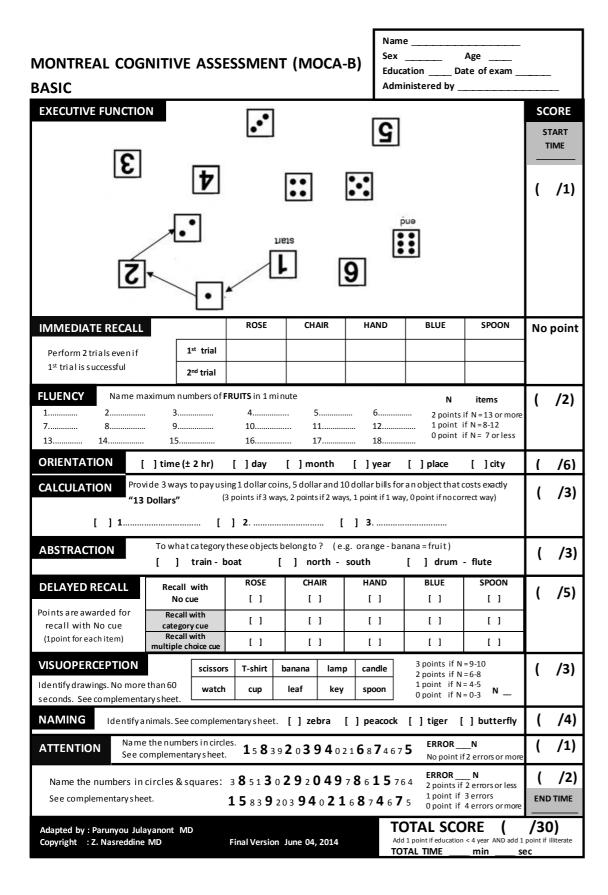
Evaluation

- review medications: beta blockers, anti-cholinergics for prostatism, recent change in statin prescription
- MOCA (18 25 Mild Cognitive Impairment; 10-17 moderate cognitive impairment) / Depression screen
- Blood Tests for Reversible Causes: vitamin B12, TSH
- neuroimaging (MRI / CT)
- if rapidly progressive, consider anti-TPO, autoimmune panel (Mayo Clinic), CJD testing
- LP (to rule out NPH and rule in amyloid)
 - -large volume LP (30 cc) with timed gait test before and after tap. Would only pursue if the patient is a surgical candidate.
- FDG-PET imaging (very rarely used; covered by Medicare if AD vs. FTD)
- Apolipoprotein E genotyping (not clinically useful if considering aducanumab)

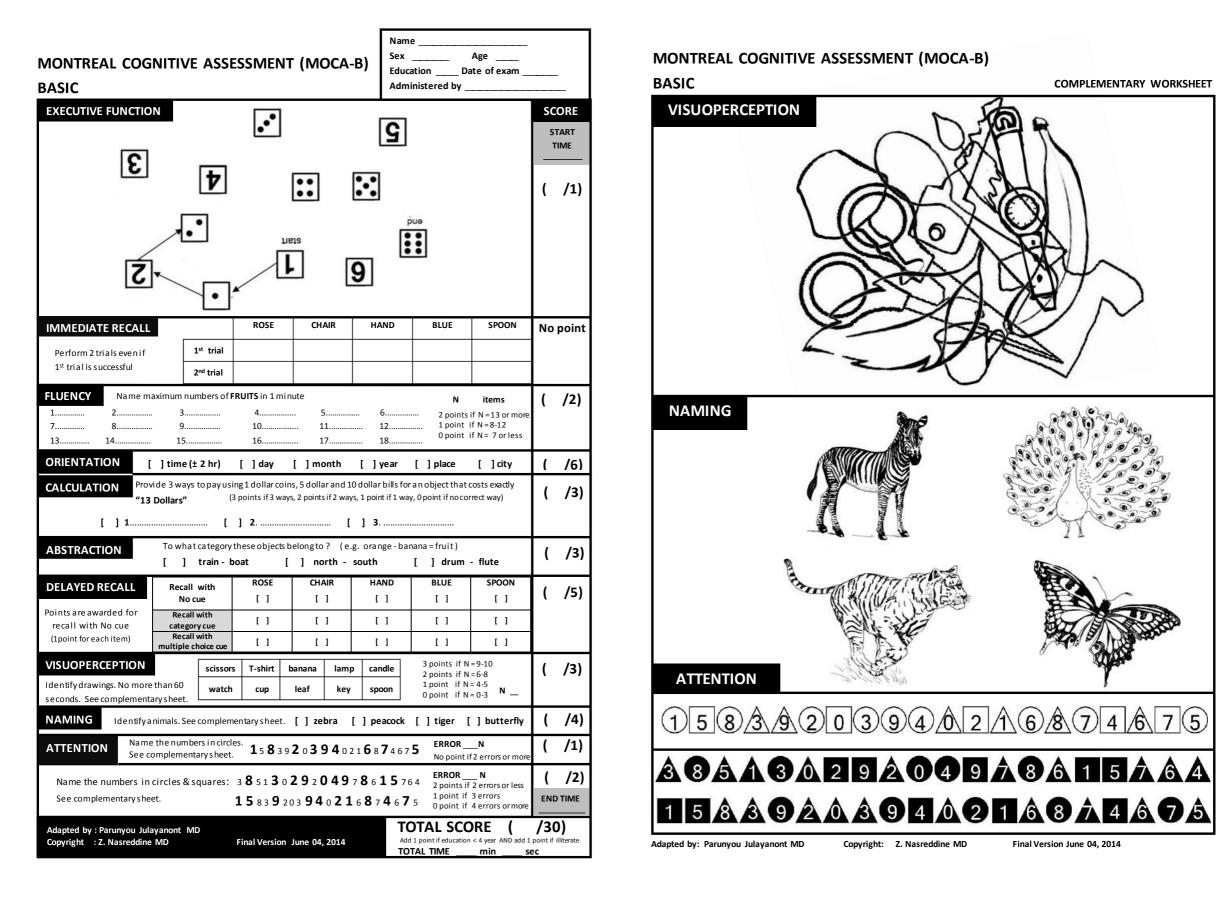
routine

specialized

MOCA - Training required 9/1/2020



MOCA - Training required 9/1/2020



Depression Screen

Short Patient Health Questionnaire (PHQ-2)

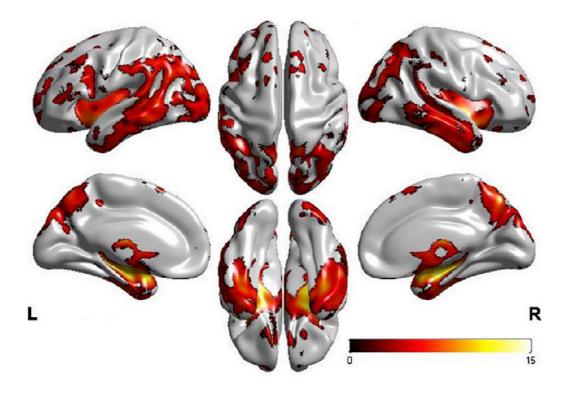
Name:			Date:		
Over the past 2 weeks, how often have you been bothered by any of the following problems?		Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things?		0	1	2	3
Feeling down, depressed, or hopeless?		0	1	2	3
Total point score:			+	+	+
Score int	erpretatio	n ^[1] :			
PHQ-2 score		Probability of major depressive disorder (%)		Probability of any depressive disorder (%)	
1		15.4		36.9	
2		21.1		48.3	
3		38.4		75.0	
4		45.5		81.2	
5		56.4		84.6	
6		78.6		92.9	

Reference:

 Kroenke K, Spitzer RL, Williams JB. The Patient Health Questionnaire-2: validity of a two-item depression screener. Med Care 2003; 41:1284.

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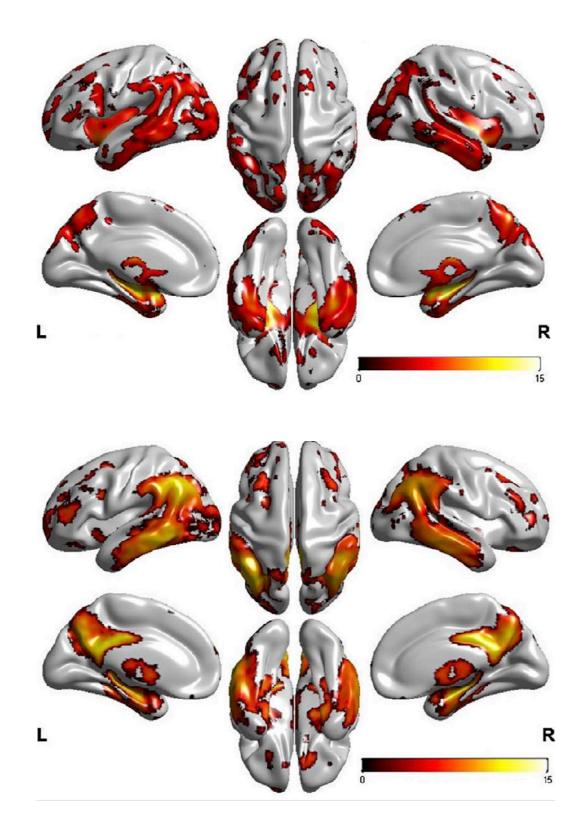
Imaging Neurodegeneration in Living Seniors



Atrophy of brain tissue (Structural MRI)

Jack, et al., Neuron. (2013)

Imaging Neurodegeneration in Living Seniors



Atrophy of brain tissue (Structural MRI)

Glucose uptake (FDG PET)

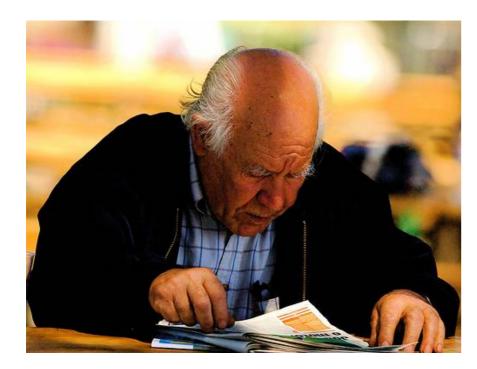
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Treatment - cognitive phase

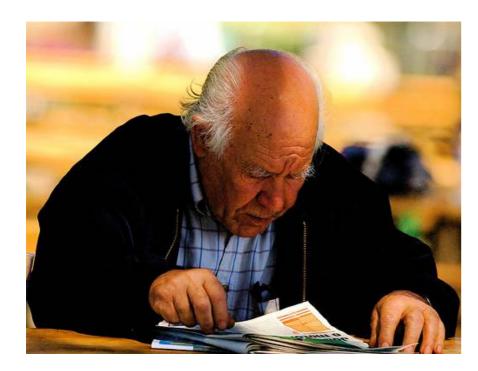
- Acetylcholinesterase inhibitors (titrate after 1 month)
 - donepezil: 5 mg or 10 mg PO qd
 - galantamine ER 8 mg, 16 mg, then 24 mg PO qd
 - rivastigimine 4.6 mg / 9.5 mg / 13.3 mg patches
 also FDA approved for parkinson's disease dementia
- adverse effect (10%): nausea / vomiting, diarrhea usually in first few days. Taking on full stomach will alleviate.
- adverse effect: vivid dreams taking after breakfast will alleviate
- adverse effect: urinary urgency timed urination

Treatment - behavioral phase

- memantine (behavioral changes) starter pack for 1st month, then 10 mg bid
- optimize sleep sleep hygiene, melatonin 1 h before bedtime
- Caregiver counseling behavioral techniques to deescalate irritability, agitation including distraction and anchoring with music, pictures, and other sens
- anti-psychotics (off-label with black box warning)
 check EKG and refer to geriatric psychiatrist or neurologist

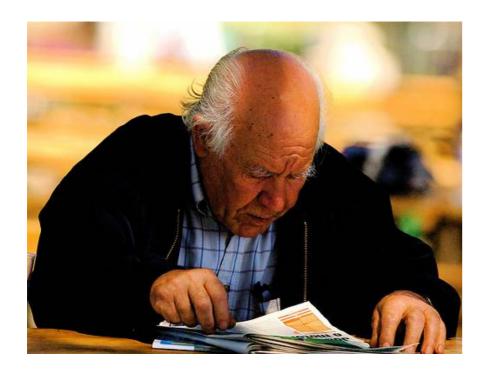












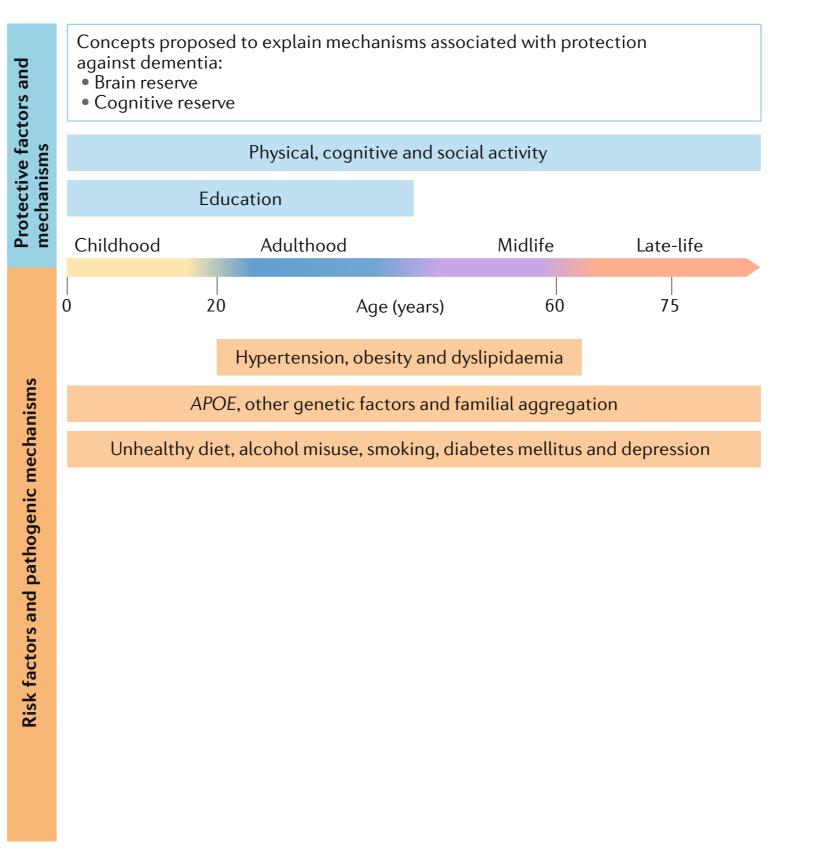








Prevention of Dementia: Lifestyle Modifications



Prevention of Dementia: Lifestyle Modifications

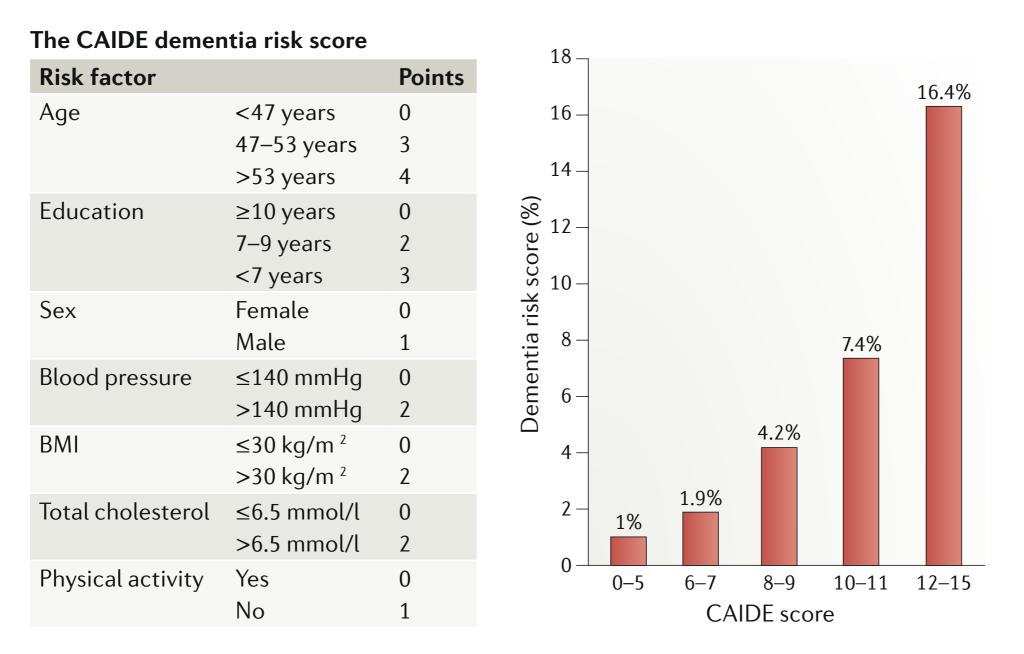


Fig. 2 | **CAIDE risk score.** The Cardiovascular Risk Factors, Aging and Dementia (CAIDE) risk score enables the prediction of the later risk of dementia on the basis of the risk factor profile present in midlife (age 40–65 years).

Aduhelm aducanumab

