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What's the Best Way to Identify Mild Cognitive Impairment and Early Alzheimer's Disease?

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Dr. Isaacson:
Welcome to a new episode of the Frontline of Alzheimer's Care, where clinicians who manage Alzheimer's disease in the community asked us their questions about amyloid-targeting therapies. I'm Dr. Isaacson, and helping me answer these questions today are doctors Gayatri Devi and Pierre Tariot. We have two important questions from doctors Stander and Grove regarding the identification of patient candidates for these therapies.

Dr. Stander:
Do you think that all candidates for these medications should undergo comprehensive neuropsychological testing or simpler testing in the office such as MoCA, in conjunction with their other clinical scenario sufficient to identify appropriate candidates for these meds?

Dr. Grove:
Is there a cut off on the MoCA, the MMSE, or similar tests for determining who would be a good candidate for amyloid-targeting therapy?

Dr. Isaacson:
Well, I'm very much looking forward to your comments, Dr. Devi. And I think I know what I would say, but Dr. Devi, what are your thoughts here in terms of does everyone need neuropsych testing? And what is that comparative utility of these different scales?

Dr. Devi:
Well, you know, generally speaking, all these drugs, donanemab, aducanumab, and lecanemab are meant to be used for patients with mild or very early Alzheimer's disease, which means a Mini Mental or MoCA below 23-24 is probably - you don't want to use it for patients with lower scores than that.

Having said that when's the earliest? How quickly can you start using the medications? I feel that there's a place for neurocognitive testing using either something like a downloadable, the Alzheimer's Association Toolkit, which gives you a cognitive assessment tool you can use, or the MoCA, which is way better than the Mini Mental Status Exam in terms of determining people very early on who might have cognitive impairment and may benefit from treatment.

We know that most cases of mild Alzheimer's disease and even moderate Alzheimer's disease are underrecognized and undertreated. And we also know that these drugs are most effective in patients with mild Alzheimer's disease. So the earlier we can diagnose, the better we are at treating, and the better the outcome might be over time. So particularly important, I think to get a proper cognitive assessment, and I think there's a role for neuropsychologists or more extensive battery to see if there's a problem. And let's say you did a MoCA, and you find that this is a very high functioning patient, perhaps a physician or a lawyer, who's complaining of cognitive

problems, but they're scoring at 28 or 29 on their MoCA, it may be worthwhile then to have them get a neurocognitive assessment from a psychologist to see if there is very early objective evidence of cognitive impairment, which when paired with biomarkers, may make that person a candidate for a monoclonal antibody treatment with either lecanemab, aducanumab, or donanemab.

So I think early treatment, early diagnosis, very important. And the best way we can do that now is with cognitive testing in conjunction with available biomarkers and hopefully soon with blood-based biomarkers.

Dr. Isaacson:
Great. Well, those are very practical, right on point, and is a tough question to answer because everyone has different, you know, preferences with neuropsych testing, the availability of neuropsych testing is challenging. Not many people have the time to do extensive testing, especially in the office. Pierre, what are your thoughts?

Dr. Tariot:
It's hard to add anything to that eloquent response. I like the MoCA a lot. I think that would be my general recommendation. But of course if I were in primary care, I might want a two-tiered approach. Something like the Mini-Cog, which is repeat these 3 words draw a clock, recall the 3 words, as a kind of triage instrument. If that's abnormal, then move on. But if it's not abnormal this year, do it again later on. That's all I would add.

Dr. Isaacson:
Great. Well, that was very comprehensive. As we use these agents, and as we track people over time, I think maybe we'll get even more comfortable with which cognitive measure to select and which cognitive measures move during the course of treatment.

So thank you so much for those comments. And thank you to Dr. Stander and Dr. Grove for such important questions. To our viewers, check out our other episodes for more great questions about the clinical use of amyloid-targeting therapies. Thanks so much for watching.

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