Transcript Details
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Debunking Misconceptions Regarding the Revised Alzheimer's Diagnostic Criteria

Announcer:
You're listening to *NeuroFrontiers* on ReachMD. On this episode, we'll hear from Dr. Clifford Jack Jr., who's a Professor of Radiology and the Alexander Family Professor of Alzheimer's Disease Research at the Mayo Clinic in Rochester, Minnesota. He'll be discussing common misconceptions associated with the revised criteria for diagnosing and staging Alzheimer's disease. Here's Dr. Jack now.

Dr. Jack:
We define Alzheimer's disease to be a biological process that begins with the appearance of Alzheimer's disease neuropathologic change and biomarkers of Alzheimer's neuropathologic change while people are asymptomatic; point number two, the diagnosis is given by early changing Core 1 biomarkers, and in the document, we provide guidance on which biomarkers are suitable for the purpose of diagnosis, including benchmark diagnostic performance criteria that a biomarker should meet in order to be considered fit for the purpose of diagnosis; point number three is biological staging by Core 1 and Core 2 biomarkers is done, and it's important. And then finally, we describe integrated staging that includes both core biomarkers and clinical symptoms.

So there are some common misconceptions about these criteria, and if I could just quickly address a few, I think it would help improve understanding of these criteria. So one common misconception is that we recommend biomarker testing for clinical purposes in currently asymptomatic people, and that is absolutely not the case. We are very clear that we recommend against biomarker testing in asymptomatic people for clinical purposes. A corollary to this is the misconception that our committee recommendations will create a pool of asymptomatic persons who have been diagnosed with Alzheimer's disease and will therefore be harmed by this with no benefit. The fact is that we recommend against any biomarker testing in asymptomatic persons. Therefore, biomarker testing outside of research would never happen if our recommendations are followed.

The second misconception is that we are recommending a change in the definition of Alzheimer's disease from plaques and tangles to plaques only. This also is not true. The fact is that in an individual with an abnormal Core 1 biomarker nearly always will meet neuropathologic criteria for intermediate to high likelihood of Alzheimer's disease neuropathologic change, which includes plaques and tangles.

The third misconception is that we ignore or demote the importance of clinical assessment and clinical judgment. And again, this is not true. We emphasize very strongly in the document that clinical judgment is paramount and that our recommendations are to use biomarkers as an assist to clinical judgment. Specifically, I can quote something from the document. "The biologically based diagnosis of Alzheimer's disease is meant to assist rather than supplant the clinical evaluation of individuals with cognitive impairment."

A fourth misconception is around the role of biomarkers in clinical trials. Two misconceptions that I've heard are that we recommend that biomarkers can be primary endpoints in clinical trials and that proof of clinical efficacy is not necessary. The truth is there's absolutely nothing in the document that even remotely suggests this.

Announcer:
That was Dr. Clifford Jack Jr. talking about the common misconceptions surrounding the revised criteria for diagnosing and staging Alzheimer's disease. To access this and other episodes in our series, visit *NeuroFrontiers* on ReachMD.com, where you can Be Part of the Knowledge. Thanks for listening!