The Brain Trust - Episode 15: Early Diagnosis in the New ADRD Treatment Era

Kate Rowland, MD

Announcement

00:03

Welcome to the Brain Trust, a physician's guide to diagnosing Alzheimer's disease and related dementias, brought to you from the Illinois Academy of Family Physicians. I'm Dr Kate Rowland, family physician, member of the IASP and faculty at Rush University. Funding for this podcast series was provided by a grant from the Illinois Department of Public Health. The goal of the Brain Trust and this podcast series is to educate and empower the primary care clinician in the early detection diagnosis and management of Alzheimer's disease and related dementias. Clinical resources, free CME and other educational materials are available online at thebraintrustprojectcom. Cme credit is available for each podcast. The Illinois Academy of Family Physicians is accredited by the Accreditation Council of Continuing Medical Education to provide continuing medical education for physicians. Information on how to receive credit can be found on the Brain Trust Project website. Thank you for joining us as we empower each other and provide training on the early detection of Alzheimer's disease and related dementias. And now today's episode.

Raj Shah, MD

Host

01:08

Welcome to our new episode in the podcast series the Brain Trust about ADRD or Alzheimer's Disease and Related Dementias, and the early detection in primary care settings, and in today's podcast we'll be talking about early diagnosis in the new and upcoming era of ADRD treatment and really it's to discuss like how are things going to change in primary care diagnosis and early detection as we start seeing the introduction of some new disease-modifying drugs from ADRD, a situation we haven't experienced in my lifetime and career over the 23 years in working in primary care geriatrics and the Rush Alzheimer's Disease Center.

01:52

And what we're hoping that people will learn from today's episode is a little bit about sort of one reason why the current processes will have to change and then to identify, you know, one action you can take as a primary care physician in your system to support your patients that may be coming through and hearing about these new treatments and requesting sort of some evaluation of their cognition.

02:15

So my name is Dr Raj Shah and I'll be the moderator today. I'm a professor in the family and preventive medicine at the Rush Alzheimer's Disease Center at Rush University in Chicago and I have the pleasure of traveling on my way back home on a Friday afternoon after a significant heat wave and at least it's cooled down today. And on my way back to the Western suburbs, I'll be passing by Loyola Hines and the

VA, meeting up with my friend and colleague that you've also met before, dr Avinash Manta, who's the assistant professor in geriatrics and associate program director of their Geriatric Fellowship at Loyola Hines, and we're going to talk about this issue and what we're understanding in the early days of this and how we're going to have to adjust over time. So, avinash, thanks for having me over, really appreciate it, and I'm getting a chance to talk about this.

Avinash Manta, MD

Guest

03:02

Great to be here Raj, Thanks a lot.

Raj Shah, MD

Host

03:04

Yeah, so just remind us, because we had had another podcast with you and I had visited your practice here at the Hines VA. So can you just remind us a little bit about the practice of what you see at the VA and the diversity of the population in Hines?

Avinash Manta, MD

Guest

03:18

Sure, yeah, so I would say that I wear multiple hats. Most of my job program is called home-based primary repair at the VA, so I do home visits on some very complex sort of medical complex homebound veterans and this is a diverse population with ages, races and now increasingly with also gender as well. And I also do our geriatrics clinic once a week where I work pretty heavily with trainees. So I teach everyone from students, medical students, residents and also geriatric fellows for the year that they're in our fellowship program. I also do some vocational and creative work nursing home work and I also am pretty heavily involved with our geriatric fellowship.

Raj Shah, MD

Host

04:05

Yeah, no, that's great and I'm glad we have you as a resource around sort of this discussion we're both going to be having today just about our understanding of this really like fast-changing environment that's going on.

04:18

Like I will tell you, just working in this space for 23 years, I was always hoping for some of these days to come by where we would have those disease modifying agents. That's what excited me about going into

geriatrics and then eventually in the Alzheimer's disease space was that we would start seeing things that weren't the standard medications that we had, like the acetylcholinesterase inhibitors or the drugs like memantine that essentially were more on the symptomatic control side but not necessarily changing some of the dynamics of the pathology that was happening in the brain and leading to the decline and the loss of cognition and function and behavior changes and then all that tying into sort of caregiver distress. But boy, the last couple of years have been a remarkable change with, after like 400 clinical trials that didn't show benefit, to now having a couple of agents in the pipeline. Can you tell me a little bit about what you know about these agents that are kind of working their way through and sort of some of the properties, about what they're involved with?

Avinash Manta, MD

Guest

05:24

So we've had one drug that has recently gotten FDA approval which is called acetylcanumab, and we have a second one that's a Godfrey trials. So they, as you mentioned, are disease modifying agents and they act on amyloid right. So we know amyloid is sort of the pathogen theology by idle satyrists disease amyloid plaques. So by basically helping to sort of essence decrease and in fact to reduce down to zero the amyloid burdened at the brain, they just thought that these drugs in evidence and in trials have been shown to actually act on the disease state itself as a disease modifying agent and to have some pretty important effects to we are slowed down this Alzheimer's disease by anywhere from four to six months over a 18 month period. So this is, you know, big news for us. It's the abstinence treatment, it's the abstinence thing. So applications, and it's a exciting time and I would say it's going to really be imperative for us over in primary care to know and understand these drugs and the indications, because we're finding that the biggest benefit of these drugs is in that very early stage.

Raj Shah, MD

Host

06:44

That's definitely like this. You know the thing that I think we have to think a little bit more about. So, like for years, right, we've been talking about how do we get our colleagues and family, medicine, our partners, our systems to be able to say, yeah, like, early detection is important, right, like we need to detect people early in these processes, and usually what we had at that time to say it wasn't about the drug, right, like it was for early detection. But early detection was to give families an answer about what is going on, so they reduce some stigma, to connect them to social services, to make sure they're safe and not getting taken advantage of if they're having some of these cognitive changes happening, and then to help the caregivers right to start thinking about services and planning for a future with a disease that was going to progress and get worse. And now, even though these drugs aren't going to like cure Alzheimer's or you know, but they're just to help stabilize a little bit longer and to change their trajectory over time as a disease modifier, they make a difference because now we actually have something that we have to make an early diagnosis. Because the drugs weren't helpful in people that had more severe Alzheimer's disease. They were approved for people with mild cognitive impairment, where cognition problems are happening, but they're still functioning pretty well or early Alzheimer's disease.

08:08

So that we just have to think our way through, like you know, how do we now even prioritize more what's happening in primary care? And I guess our concern up till now has been, you know, in primary care we try to use time right, Like if we saw somebody in an early stage, we would try our best to, you know, maybe monitor them a little bit longer to see what was happening because we weren't sure what treatments were available. But now, if we wait too long, some of these individuals may not qualify for some of the medications that are available. So, you know, I think there's going to be a change in sort of how we approach what happens in primary care because of these treatments, and that's going to lead us to decisions about how we approach these things. So these drugs are infusion medications, right? I think that's.

08:52

The other difference that we have to think about is that they're not pills like the former medications that we can write a prescription that can go to their pharmacy and fill, so they're going to have to be given by special groups of people, like in infusion centers with neurologists and trained individuals to deliver it and to monitor it, and not everybody will qualify. But you know in other conditions sometimes what we do. When we get new drugs that are a little bit more difficult to manage, we say, oh, we think you might have this problem with your memory. Well, let me write you a referral so you can go see that specialist and then they'll diagnose you and then they'll start the care pattern. But why is that going to be hard? Do we think you know if we and not even possible when we're dealing with something like Alzheimer's disease, and that you know we're going to have to think about a different model of primary care physician involvement?

Avinash Manta, MD

Guest

09:41

Right, and you said we need to diagnose this early, right. So it's imperative that we so, if patients have a concern with their memory, that we're doing an early cognitive assessment, that we're doing a history, that we're doing a exam, that we're doing some sort of a cognitive screen and we are the first point of access, right. So, of course, as you know, family doctors, we want to make sure that we're doing an appropriate work for any complaint in the you know, same way that we wouldn't just send up if some patient has a cough where it's not having them go to a pulmonary, just right. We want to make sure that we're doing, you know, good medicine, right? So, yeah, and it's also going to be frankly impossible, with just the numbers and the volume of the patients that are, you know, have memory concerns, for all them to go to a neurologist. That just as impossible If we want to make sure that we feel comfortable doing this and that we feel comfortable talking to patients about their cognitive concerns.

10:33

Because, as you mentioned, we have patients, if they have that mild cognitive impairment stage, which is so-called pre-dementia.

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These are patients who may have memory loss, a complaint of it, but it's not impacting their everyday life.

10:45

And those patients who have mild dementia who may have the most complex this sorts of tasks that are affected, the IADLs, as we call them right. You know things like driving and finances, managing money, you know managing medications, things like that. So you know, for us to be on those front lines, to be doing that initial sort of workup and evaluation is important Because we're going to be that first sort of connection point within the system and for us to sort of do that like initial workup to then have the patient go to a neurologist. You know, if we diagnose them, you know with or if we have a concern about MCI or the early AD, to maybe do some more testing you know PET scans, things like that or to, if we have a concern otherwise, for them to go see a neurologist. You know, of course, if it's patients very young, if they're under 65, if they have a very rapid onset dementia, if they have, you know, parkinson's signs and symptoms. Those are, of course, reasons why we want a neurologist to be involved anyway.

Raj Shah, MD

Host

11:46

Yeah, no, and I think that's good. And it just brings me to okay, now, if we decide that we're going to need more primary care involvement in the earlier stage, how are we going to help our colleagues? Right, because I think we were talking offline just before. You know, we were going to go on the podcast and just talking about how things go at the VA as an example and you were mentioning like oh yeah, you know, like in our practice in the geriatrics clinic, we do screen for memory regularly. It's just part of our culture, right, like we do it. But what kind of response have you been seeing? Like in the more general primary care is you know up till now in the current state at the VA about sort of like screening, you know, like testing for cognition, if concerns are there? It seems like it's been a little bit more limited, right, because there's just such a list of priorities that it just hasn't hit like the top thing for people.

Avinash Manta, MD

Guest

12:34

Exactly right.

12:35

So of course we know, as you know, as the front lines of medicine, you know, primary care doctors we're, of course our patients have a lot of concerns, right.

12:42

So we have to manage them with our hypertension and their diabetes and their arthritis and their depression and know what's happened with all their specialist visits and their labs and their imaging and their recent hospital stay and like all that stuff, right? So in that kind of environment, you know, this sort of work is a challenge and it's hard and it does require time, right. And so I would say that really at the

VA and I'm going to guess, you know, probably elsewhere too most of the primary care doctors are not doing cognitive screens and their visits right, like in their clinics. They're not doing MOCA, mmsc or slums as a routine thing in their clinics, right. So that may be like a way that you know and hopefully a forum like this may also help too but to say, hey, look, we have to change that infrastructure, so to speak, to make sure that you know we can do that. You know, first, cognitive screen in that primary care visit, right, and so that you know first work up, right.

Raj Shah, MD

Host

13:35

So yep, yeah, and I think it's just even like, even are just noticing, like in the annual medical Medicare visit, wellness visit, which is an opportunity to look at this Not everybody's doing that regularly right now because you've got options, you can just ask the person, right, are you having any troubles with your cognition?

13:53

And that's good enough, versus doing like some full, like testing of what might be happening. So you know, I think then it becomes what are some tools Because I know we're not the first ones to think about how difficult this is going to be at primary care to change the sort of mindset like we have to think about if somebody comes to us with memory problems or use our annual wellness visit to ask about this and maybe do some you know, pen and paper type screening mechanism so we understand where the deficits may be, you know. So I think one of the things we'd found as we were preparing for this podcast is that the Alzheimer's Association had recently put out this primary care kind of clinical decision pathway and we'll put this into our brain trust toolkit, probably as a link to that resource. So if you know, people want to look at that on their own, but do you want to kind of talk through. What they were suggesting is sort of a pathway of handling sort of this early diagnosis in sort of primary care practices.

Avinash Manta, MD

Guest

14:52

Yeah, so it's a very comprehensive document. I really do have to acknowledge them for that and actually compliment them for that. It's a very sort of well thought out document and so basically it begins with if a patient has a concern about memory or cognition, right, and so that is the universe point of contact. I would say too, it's important for us who are actually seeing elders to maybe ask that question preemptively anyway, because a lot of patients will not actually volunteer that right. There's a stigma associated with that. We have patients who think that, oh, it's a normal aging thing, right, so we should also be the ones to ask that question too. But anyway, if there is a concern with the patient's memory, then of course we do our sort of usual history at exam and do a good social history, family history about Alzheimer's, all those things, and we can then in turn do some baseline labs which we all sort of know, I would think in a B12, your TSH, full like acid levels, rpr, cbc, cmp, all those things. Do some imaging, if indicated, but also, I would say, to feel comfortable, doing some sort of a cognitive screen, which I mentioned earlier, whether that's a TSMOKO or a SLOMS or MMSE, but at least tests take about five to

seven minutes. It all depends on the test and how it's done. So it's not like a ton of time and also, as you mentioned too, medicare wellness. For us it can be like a nice time to actually put this into anyway. And so once that's been done, then we see the results of all those tests and of the imaging and of the labs and are screening. And if there is a concern about MCI or about early AD, you know, maybe at that point to then have them go to a neurologist, because we are finding that, you know, with these new drugs that they have to have a confirmed amyloid and also tau protein on their PET scanning, right? So they're gonna have to go through amyloid PET scanning. So at that point you may be having them go to a neurologist and then having them see. And if they do actually qualify for these drugs, then of course, great. Then we'll have to make a whole sort of infrastructure about these patients having to go to a hospital to get the infusions every two weeks or every month, right? So we have that all in place. If they don't, or if they don't have any amyloid or any tau on their imaging, then we of course you know.

17:12

Go back to, you know one of the other causes you know are there was there a stroke Like? Is there vascular dementia, like, is there Parkinson's? Is there some reason to involve a neurologist anyway? Or, of course, looking at their medications, you know, is there some medication that they're on that can be causing them to have some sort of cognitive impairment, or is there a depression present and then the afterwards?

17:32

So this document also goes into the, you know, follow-up visit too and it goes through extensive list of things which are all sort of great geriatric principles. You know, things like doing an assessment of their ADLs and of their IADLs, right. So their functional status, you know how they live, going through all their medications, going through their driving and their safety driving, assessing for any sort of behavioral symptoms you know, agitation, apathy, things like that. Looking at their social supports, right, which is, of course it's very important in our in our world that we wanna make sure that patients are, you know, have maximal support in the home and to go through advanced care planning, to go through advanced directives, to go through and coach them, like all these things, and to then try to actually stage their dementia and to maybe do a repeat cognitive assessment. So this is all in their second visit.

18:20

So it's a very comprehensive document that actually goes to all of this and actually also says you know what reasons would you, you know, want to refer to a neurologist or to a neuropsychologist? Yeah, I think in our world is always important because we always wanna make sure is the patient being referred at the appropriate time, right. So it says you know why would you want to refer to a neurologist or to a neuropsychologist? And we talked about this earlier on. But you know some patient who is very young, who has rapid onset dementia, who has Parkinson's signs and symptoms, some other sort of neurologic, you know finding on exam, right, some other things that we're concerned about. You know abnormal gait, things like that, and you know a when to involve neuropsychology. So it's a very good, you know, very comprehensive document which I think is a really good starting point for us over in primary care.

Raj Shah, MD

Host

19:06

Yeah, and in some ways it just kind of gives us those key, you know, reminders, as you were saying, of good primary care practice and geriatrics practice, and we just have to know all we're really doing is we, because of some of the timings of these medications, about where they're most efficacious? Is that we have to shift all of our work a little bit earlier in the process? Right, we just. And then we also have to be prepared, as these drugs get better, marketed and known, that people are gonna come to us right, more often and now say I'm having memory concerns, right, because they know they have to tell their doctors earlier if they're gonna get some of the advantages of some of these treatments. So there might be more volume coming in people asking for this evaluation. We know we have to do it earlier and then we also have to know that, as far as the treatment goes, it might be, you know, based on the studies that were going on and estimate, like, for every 10 people that go through one of these like pathways for evaluation on the drug, maybe only one of them will qualify because of that amyloid and tau burden. So it's gonna change some of the dynamics.

20:09

But it's a nice document to kind of summarize those steps. But you know, some of these guidelines of you know are written in a format where they try to take the input from everybody, but it's like a national kind of a plan, right Like. So they have to keep it conceptually more broad. And sometimes when I look at these plans I always kind of think like in my head, like boy, you know what's gonna actually work in a primary care office, right Like it sounds great on paper and you know to have a nice little flow diagram on two sheets with a little bit of an update. But what do you think about, you know, when you read the plan and you kind of thought about you know, like, how practices happen in primary care at the VA and their constraints, like what's gonna be challenging about this plan to implement and what might we have to think about in, you know, primary care context that might have to be changed or improved to make it work.

Avinash Manta, MD

Guest

20:58

So I think that their guidance about that first visit is, I would say, you know, for the most part, pretty reasonable, right? So location, you know, has a memory concern to, of course, do a history, do an exam, do some sort of a cognitive screening test, to do some basic labs and some imaging. Of course we're gonna have to, as I mentioned earlier I would say it isn't common to actually have most primary care offices to do some sort of a cognitive screening test. So we're gonna have to try to make sure that, hey, you know that these doctors know you know how to do and are familiar with the MMSC or the MoCA or the Slums, right? So I think that's important. So I think that, that, you know, first visit might be doable.

21:39

The second visit, follow-up visit, where they list it's a great geriatric template where they list about nine things to actually address at this follow-up visit. I think you know that might be like a bridge too far or for, like a lot of us, because of our time constraints, because of all the other issues that we have to actually deal with with our patients, you know. So we're managing everything else that they have and

that's where I think you know some things that are on this list. You know where it talks about, for example, social supports, or it talks about ADLs, iadls, or it talks about advanced care planning. Those are things that we can involve a social worker right, so it's a member of our team. We can involve a pharmacist when it comes to medications. We can maybe involve the nurse when it comes to doing some sort of a repeat cognitive screening, right? So maybe yes, we have to use our team, yeah, yeah.

Raj Shah, MD

Host

22:26

And the other thing is like, at that stage too, I think we have to have some shared decision making with the patient and their family right, about what is the most important thing to cover at that particular time. We don't have to feel like, oh, they only get one follow-up care visit with us. That's just not how primary care works. So it's just a way that they can get we can kind of say like, okay, we got to cover like these nine things over the next year or so, right, so we have a plan like what do we want to deal with today? So we can maybe make it a little bit easier and cover it over multiple visits, but then I think so you definitely highlighted some of the challenges in adding some of the testing and then, like the follow-up, we also have to probably work. And well, this will be some. Maybe a future talk is about how do we prepare the primary care physicians to be ready to look for some of the side effects of these medications, because, as they remove amyloid and about 30% of people, they can cause some changes in the brain, some edema or some small bleeds or microbleeds. That can really affect somebody's cognition and if we catch it earlier, we can help them by stopping the drug or using some other treatments to recover some function. So it's going to take the primary care physician to be involved in some of the looking out for adverse events and working with their neurology colleagues in detecting those two.

23:45

But now that we've taken the constraints into mind, I mean I'm kind of curious like how your organization, the VA, is sort of approaching some of these conversations. Any change, right? We all live with change and we're going to experience a change with these new drugs. Where do you think the VA is in some of the discussion? Are you still sort of at an exploratory stage about finding information about how the VA is going to handle this with the patients? Is it sort of like oh, we've got a national plan together and we're going to follow that and it's just matter of training everybody? Is it something sort of we're still looking for information and working with our colleagues to plan out this pathway? Where are things at the VA?

Avinash Manta, MD

Guest

24:22

Yeah, I would say that we're more in a planning stage. Right now, I think we're giving each hospital and each VA hospital is approving these drugs on their own. So you know, saying whether it's doable and feasible at a hospital-wide level, I'm not aware of any national guidance yet. Of course, with the VA being a national healthcare, we have a different protocol than the outside world. We didn't know what it

comes to insurance, like all that stuff. So, yeah, it's certainly an interesting time, but I think that this information is really important for us as primary care doctors to understand and to know that these drugs are on the horizon and it's going to certainly change our practice with our elder patients who have dementia.

Raj Shah, MD

Host

25:08

Yeah, no, I think that was a great wrap up for a really busy session with a lot of information to give, because there's a lot of moving pieces happening today. So, Avinash, thank you so much for your time and providing your input about your experience and what's been happening at the VA as we think about these care pathways and earlier evaluations for people with memory concerns or using the annual wellness visit, and why it feels different because of these new disease modifying agents that are about to come to market. I'm sure there'll be more talks about this and build up over this, but I think this is a good start and really appreciate the time. So, thank you to all of our listeners and we look forward to further conversations about this topic and you know we're always open to you, you know, as our audience if there's certain things that you want us to cover in the brain trust. But thanks again, we'll talk to you later. Bye-bye, Thank you, Rush.

Kate Rowland, MD

Announcement

26:04

Thank you to our expert faculty and to you, our listeners, for tuning into this episode. If you have any comments, questions or ideas for future topics, please contact us at podcastatthebraintrustcom. For more episodes of the Brain Trust, please visit our website, thebraintrustprojectcom. You'll find transcripts, speaker disclosures, instructions to claim CME credit and other Alzheimer's resources as well. Subscribe to this podcast series on healthcare now radio, spotify, apple, google Play or any major podcast platform. Thank you again and we hope you tune into the next episode of the Brain Trust.