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Who Is Ready for Amyloid-Targeting Therapy?

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Episode 2

Dr. Cabral:
I'm Dr. Cabral, here today with Dr. Weisman. Today's discussion focuses on one of the most important clinical decisions: Which patients are appropriate candidates for disease-modifying treatments?

What framework do you use when deciding whether a patient is an appropriate candidate for these anti-amyloid therapies, Dr. Weisman?

Dr. Weisman:
It's a loaded question because there's an appropriate patient and there's an optimal patient. And my sort of optimal patient may not be always the most appropriate patient, but sometimes we sort of work together to cobble it together.

But what I am looking for is someone obviously who has the disease and in the proper stage. They have Alzheimer's disease in the MCI to early Alzheimer's stage. They must have confirmed amyloid pathology by definition. They cannot have a non-amyloid dementia. They must have a baseline MRI evaluation that does not show multiple microhemorrhages or any other exclusionary problems. And then they have to be otherwise healthy. They have to have sort of a softer little bit of it as well because they have to have a reliable caretaker. They themselves have to be interested in their health. Not everyone is interested enough to get these therapies, and that's okay. They're a good fit for a lot of people, but not for everybody, and they're not going to be a great fit for certain people.

And when the proper inclusion and exclusion criteria are met, then what I'm really looking forward to is a patient who gets it. And these people are mild, so they really do understand and they get the information, and the caretaker as well.

So when you set real expectations about how we're going to be slowing the cognitive decline, we're not going to be reversing things, we're not going to be stabilizing things. Although we hope that happens, we're going to be slowing it down, on average. And that's what I want people to understand, that they're going to be getting more time in a milder state but not reversing anything.

So when that happens, that's great, and that's very gratifying. So much personal gratification.

How about you? Anything to add?

Dr. Cabral:
Yeah, no, thanks. That was so clear, and clearly, it's very real world the way you're describing it. And I'm curious, a lot of clinicians are curious about these treatments, but they're hesitant to get their foot in the door with them. So can you say how long did it take you to really get your rhythm with identifying that person that was going to know what they were getting into and successfully go through with it, even if, say, they developed ARIA?

Dr. Weisman:
Right. I would say the first 10 to even 50 cases really helped me set some boundaries that I had had in my head, where I needed people to be dosing on-site. But you know that was not the case all the time, and so I kind of loosened some of my criteria. And again, sort of real-world implementation of these therapies outside a clinical trial. It took me about 10 to 50 cases to be like, okay, yeah, clearly green light. Clearly this is a problem, and kind of like you said, get your pace.

Dr. Cabral:
That's so helpful to hear for people who haven't done too many, and you grow your confidence the more you do. And so I'm sure that patients that you thought would be good candidates may have been hesitant for some reason, and you don't want to talk them into it, but at the same time, we believe in these, and we've seen people benefit. And so maybe you could speak to your own confidence in talking about and having a shared consent conversation.

Dr. Weisman:
Well, a lot of times we've seen what happens with the disease and the patient has not, so there is an informational asymmetry that way too. So people need to know what they're not signing up for, for sure.

Dr. Cabral:
Great. Excellent. Well, thank you. I think we nailed it. Thanks so much, and we'll see you next time.

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