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Expert Opinion on How the New DMTs Fit into Everyday Clinical Practice

Announcer:
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Dr. Sabbagh:
Hello, I'm Marwan Sabbagh, Professor of Neurology at the Barrow Neurological Institute. I am also a Behavioral Neurologist. Joining me today is Dr. Sharon Cohen and Dr. Richard Isaacson. Dr. Cohen?

Dr. Cohen:
Hi there. I'm a Behavioral Neurologist at Toronto Memory Program. I'm the Medical Director here.

Dr. Isaacson:
Hi. I'm Richard Isaacson. I'm a Preventive Neurologist at the Institute for Neurodegenerative Diseases in Florida. And that's in Boca Raton, Florida.

Dr. Sabbagh:
Thank you both for joining me today. This topic is going to become relevant because you - all three of us know our workflow is changing, and changing rapidly. We've already discussed the idea of using biomarkers. We've now started to understand the new treatments from a conceptual standpoint, but now we have to actually take those conceptual standpoints and build them into our workflow, in our framework. Dr. Isaacson, how are the new drugs used to manage mild cognitive impairment caused by Alzheimer disease used in clinical practice and used in your clinical practice?

Dr. Isaacson:
Yeah, so I think of the answer to this question kind of two ways. One is how do we view the use in terms of the physician and the clinical practice and, you know, the staff members at the practice and the allied healthcare professionals? And then I think about things in terms of the actual patient and the family members. So when it comes to the practice, you know, there really needs to be a structure in place when using these drugs, and resources and infrastructure, to basically not only provide the drug in a careful, metered and, you know, accurate, safe way, but also not just to infuse the drug, because these are IV infusions either once a month or every other week, depending on individual drug, but it's also the safety and the monitoring. And, you know, in our practice, and you know, and in the colleagues that I work with, really the whole crew needs to get together and say, how do we make sure to mitigate against the potential risk of side effects? And how do we infuse this in a safe way? How do we make sure we have communication channels? Is the patient doing okay? Are there headaches? Are there anything? Because, you know, we're excited about the steps that we've taken, and you know, the efficacy is there, and it's better than we've ever had in terms of anti-amyloid therapies. And this is great. Bu, and doctors take an oath, and that's do no harm. And these drugs can be given safely, and they can be given carefully. But you know, getting in place, when do the MRIs have to happen? When is the infusion? What is the dose? What if someone misses a dose? What do you do next? What are the different protocols? Oh, we see some, you know, vasogenic edema? We see some ARIA, what do we do? Who do we

call? What is the communication workflow? Who in the clinic does this? Which staff does what? So I think that's one thing.

And the second part is, you know, being realistic. How does this work for families and patients and travel? Is someone close to the clinic? Does someone have to travel in? Is it a train ride? Are they leaving for summer vacation? What happens if you miss a dose? When do you restart it?

So I think this is really a whole new era of conversation and communication between healthcare providers, and the patients and families.

Dr. Sabbagh:
Thank you, Dr. Isaacson. Dr. Cohen?

Dr. Cohen:
Yeah, I think setting expectations at the outset are so important. What are we going to get out of this drug? How much commitment do we need to make? How long-term is the therapy? So that you have some buy-in from patients and family. And you need to do things differently than what we've traditionally done. So these new drugs, and treating patients with these new drugs has nothing to do with how we've treated patients with Alzheimer's before. This is not a pill. This is a, you know, an intravenous infusion. We need infusion centers, we need to monitor for infusion-related reactions. We have cholinesterase inhibitors and with memantine, we didn't use MRI for monitoring for safety. Now we need to do that. And with the symptomatic treatments, we were looking to make people a little bit better, at least temporarily. Here, we're hoping to make them, as you said Dr. Sabbagh, less worse, you know, to slow down progression. So how do you monitor for that? So it really takes some rethinking.

And our patients can have multiple medical problems. They can be on a number of different medications. And we need to think carefully about who are the best candidates? And who might have increased risks? If people are all on blood thinners, if people show up in the emergency room with what looks like a stroke, are our colleagues in emergency medicine going to be knowledgeable enough to handle this? So you know, I agree with Dr. Isaacson, the communication, not just between practicing physician and patient, but with the rest of the medical community is really vital. You need to know that you have an MRI facility with radiologists who are going to report the kind of information you need, do the MRI sequencing that's going to be valuable, and following patients that emergency medicine colleagues are going to know how to identify ARIA, and what to do or not to do.

So it's an exciting but challenging new era, and I welcome these new medications, but we're going to have to up our game. And we're also going to have to make sure that our patients don't miss an opportunity because we haven't diagnosed them early enough. So encouraging colleagues to refer patients early, making sure that we confirm a diagnosis of Alzheimer's and don't just let someone with mild cognitive impairment fester until they get worse and maybe are no longer eligible for a drug. So lots of challenges, but lots of opportunities.

Dr. Sabbagh:
I want to pick up on both of what you said. I will tell you that in our practice, our we're pool has actually changed already, and quite significantly. We've dot-phrased this and we have a dot-lecanemab work dot-phrase that has a checklist. They want to make sure the MRI is done. The checklist has how many microhemorrhages at baseline? What is apoE genotype? How did you confirm the amyloid status? Is it with CSF or PET? What was the result? Did you confirm the diagnosis? So even before I ever write an order form for the monoclonals, we've already done a checklist to ensure that all the appropriate safeguards are have been put into place.

You know, we now have this new website that just came online less than a month ago the cms.gov. Fortunately, our checklist seems to reflect a lot of what the cms.gov website is saying. But the practice flow workflow in the Alzheimer's space, particularly with Alzheimer's, is changing. Mild cognitive impairment is changing. It’s changing quite rapidly and significantly, and how we did things before it's not going to how we do things in the future.

I do or want to say one more thing, which is despite our excitement and enthusiasm, in my experience, most patients would not get the medication, too severe, they have a pacemaker, they can't get an MRI, they have severe microhemorrhages; a lot of reasons for them not to get the monoclonal, not that they do get the monoclonal. So we hope that a lot of people have this access, but it may not be as many people as we originally hoped.

And with that, I thank you both for joining me today. I hope this audience you learned something today. I look forward to speaking with you all again in the future.

Announcer:
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