

Summit 2023

Dementia in a new era:
prevent, diagnose, treat



**World Dementia
Council** Leading the Global Action
Against Dementia


A timely diagnosis

Transcript of a session from the
World Dementia Council summit
20 March 2023



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The World Dementia Council has 24 members working across six continents. Council members are global leaders who work in research, academia, industry and civil society. They attend meetings, vote on key issues and participate in the organisation's work. The council also includes members who are living with dementia.

The Council also has multiple associate members consisting of international organizations as well as national governments. They help to ensure that the council's agenda aligns with other global dementia initiatives, providing the council with important strategic advice, guidance and intelligence. As they do not have full membership status, associate members don't vote on issues such as the election of a new chair or new members, or on matters of governance.

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Chair



Philip Scheltens

**Professor of Cognitive Neurology and Director Alzheimer Center,
University of Amsterdam Medical Centers**

Prof. dr. Philip Scheltens studied at the VU University Amsterdam, Netherlands, gaining his MD in 1984, and PhD in 1993. He became Professor of Cognitive Neurology and founder of the Alzheimer Center at Amsterdam University Medical Centers in 2000, which he directed until 2022. Currently he devotes most of time heading the Dementia Fund at EQT Life Sciences, that he started in 2020. He has been the (inter)national PI for over 35 studies, including phase 1-3 multicenter clinical trials. He supervised >75 PhD theses since 2000. He founded the Dutch national plan against dementia and served as chair of the board. He is co-editor-in-chief of Alzheimer's Research & Therapy and co-leads various EU projects. He authored over 1100 peer reviewed papers and > 75 book chapters and co-edited several major textbooks. He is member of the Royal Dutch Academy of Arts and Sciences (KNAW) since 2011. In 2016 he was awarded the European Grand Prix for Alzheimer's Research. In 2020 he was Knighted in the Order of the Netherlands Lion by the King of the Netherlands. In 2021 he was elected honorary member of the European Academy of Neurology and was appointed chair of the World Dementia Council.

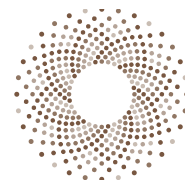
Speakers



Fiona Carragher

Chief Research and Policy Officer Alzheimer's Society

Fiona Carragher joined Alzheimer's Society as Executive Director of Research and Influencing in January 2019. She plays a pivotal role at the Society as we aim to be a leading force for change and use research and influencing to push for breakthroughs that will improve the lives of people affected by dementia now and in the future. Driving evidence-based policy making and connecting science and research into practise has underpinned her career. Before joining Alzheimer's Society Fiona was the Deputy Chief Scientific Officer for NHS England providing leadership for the 50,000 healthcare science professionals in the NHS and expert advice to the health system on science, innovation, and diagnostics. She led a broad portfolio of policy responsibilities including establishing the UK Antimicrobial Resistance Diagnostics programme, the system wide Action Plan on Hearing Loss and the CSO Knowledge Transfer Partnership programme. She is a passionate advocate for women in health and led the establishment of the first Women in Science and Engineering fellowship programme in the NHS.



Giovanni Frisoni

Clinical Neurologist, Full Professor of Clinical Neuroscience Geneva University Hospitals Clinical neurologist, Full Professor of Clinical Neuroscience at the University of Geneva, Switzerland, and Director of the Memory Clinic of the Geneva University Hospital

Former Scientific Director at the National Alzheimer's Centre in Brescia, Italy. Author of over 700 scientific papers listed in PubMed, imaging editor for Neurobiology of Aging, and founding editorial board member of The Lancet Neurology. Has led national and international projects funded by the European Commission, IMI, the Alzheimer's Association, Italian and Swiss Ministry of Health, and industry. Chairman of Alzheimer's Imaging Consortium at International Conference on Alzheimer's Disease in 2010 and 2011. Honorary member of the Austrian Neurological Society and of the French Society of Neurology, he has received the Investigator Award Winner of European Academy of Neurology in 2016.



Phyllis Barkman Ferrell

Global Head of External Engagement for Alzheimer's Disease and Neurodegeneration Eli Lilly

Phyllis Ferrell is the Global Head of External Engagement for Alzheimer's disease at Eli Lilly & Company. She also currently serves on secondment as the Director of the Davos Alzheimer's Collaborative Healthcare System Preparedness initiative. Phyllis has a BA in Economics from DePauw University and an MBA from Stanford University. Phyllis is a current member of the World Dementia Council, a steering committee member of the Milken Institute Center for Aging Alliance for Dementia Care, and a strategic reviewer for the Alzheimer's Disease Drug Discovery Foundation Diagnostics Accelerator. Phyllis is also on the Boards of Directors for Alzheimer's Research UK EDoN, Gates Ventures Alzheimer's Disease Data Initiative, the Indiana Chapter of the Alzheimer's Association, and the Indianapolis 500 Festival. Phyllis is a founding member of Women Against Alzheimer's and Women of Impact Boone County; co-chair of the Women's Leadership Council and the alumna sponsor of the Women in Economics and Business Program at DePauw University. Phyllis is passionate about Alzheimer's advocacy and brain health so that other boys don't have to grow up without their grandfathers' presence as her sons did.



Jetske van der Schaar

PdD Researcher University of Amsterdam

Jetske van der Schaar is a PdD candidate at Alzheimer Center Amsterdam, where she focuses on medical ethical aspects in early stages of Alzheimer's Disease and other dementias. She's a member of the advisory board for the National Dementia Strategy of the Dutch Ministry of Health, Welfare and Sport. In addition, she's an passionate advocate for patient and public involvement in research, wrote a book about the personal impact of familial Alzheimer's Disease, which was published by Prometheus, and presents a podcast on scientific progress for a broad audience.



Discussion transcript



Professor Philip Scheltens, chair of World Dementia Council, Professor Emeritus at Amsterdam University Medical Centers and head of the EQT Life Sciences Dementia Fund

Ok! Friends and colleagues we are going to start again. I do hope you had a good lunch and we will try to make the post-prandial sort of dip as little as possible by engaging you immediately in a very, very important topic for which we also have invited, I think, an important panel.

This session is called A Timely Diagnosis. Note, it's not called an early diagnosis. This might seem irrelevant but it's really important. It's not about as early as possible, it's about as timely as possible. So, we are going to discuss several elements that constitute such a timely diagnosis and we have invited a panel that actually constitutes people working in research, working in the clinic, advocacy, doing a PhD on the diagnosis. And so I welcome the panel and I will just sort of invite them to the stage while you massively applaud from them.

- **Fiona Carragher**, Director of Research and Influence in Alzheimer's Society
- **Professor Giovanni Frisoni** is a clinical neurologist working at the Clinical Neuroscience in the Geneva University Hospital
- **Phyllis Ferrell**, Head of Global External Engagement at Lilly
- And we have **Jetske van der Schaar** she's a PdD student actually working on the ethics of disclosing diagnosis



So as usual we'll ask the panellists to introduce the topic with a few lines, more than a few lines, but not too long, to see what their stance is on this particular topic. So ,can I just go from the left to the right?



Fiona Carragher, Chief Research and Policy Officer Alzheimer's Society

So thank you Philip. I want to talk from the perspective of patient advocacy organization and pick up on an earlier comment about a sense of urgency because I think we have to recognise whilst there is a huge amount of hope and optimism coming there is the stark reality of the here and now for people affected by dementia.

Here in England our diagnosis rate has not recovered post-COVID. We are down to about 62% with some regions of the country as low as 52%. We currently have significant issues around diagnosis- we know that diagnosis is often late and that many are really struggling to get the accurate diagnosis they need. That is for a whole set of reasons; staffing issues, waiting lists and neuroimaging capacity. The bottom line is that currently people are getting diagnosed in the later stages of disease, not getting the care and support that they need, personalised to enable them to live independently in their own homes, often ending up in hospital for avoidable reasons such as falls or dehydration, and then in crisis having to find an alternative home. For many, we are hearing day in day out, that this is the reality.

The other piece I thought was really helpful to bring to this conversation is what do people affected by dementia want? We undertook a survey of over 1,000 people at the end of 2021, so before the Lecanemab announcement. And what we found was that 91% said that they saw a benefit of having that diagnosis. So even without a disease modifying therapy, the vast majority of people wanted to know. And the reason that they wanted to know is it enabled them to plan for the future, get the practical care and support they and their family needed. It also gave a real sense of relief about knowing what on earth was going on with them.

One of the stark things about this survey was that a quarter of those people took up to two years to get their diagnosis. Health system readiness is one key element of this, but there is a huge issue around stigma and awareness. We found was that the majority of people who didn't step forward for a diagnosis was because they thought their symptoms were a normal part of aging. They thought, actually, it's just I'm getting old and I can manage my symptoms; they're just about manageable. But also do you know what, I really don't want to know if there's something going on as we can't do anything about it anyway. This is the stark reality of where we are now. But when we asked, what was the reason that you came to get a diagnosis? The really sad bit is that the majority of people came in crisis. That they couldn't cope anymore, the symptoms are unmanageable, or actually we've reached a crisis point and we've ended up in hospital. So that's where we are now.

This sense of urgency is something for all of us here today because unless we make dementia a priority at the government level, at the societal level, we're going to sit in this room for the next few years being very hopeful and optimistic about the science, and I for one am very hopeful and optimistic about the science, but we've got a big piece to do, not least around awareness of dementia and tackling the fear and misconceptions about it.



Professor Philip Scheltens, chair of World Dementia Council, Professor Emeritus at Amsterdam University Medical Centers and head of the EQT Life Sciences Dementia Fund

Thank you. So it's also a timely panel, I would say. But is it, I mean, you say diagnosing later, do you mean to say that the diagnosis made in 2023 now is even later than it was a couple of years ago? Has there been no sort of advance in.



Fiona Carragher, Chief Research and Policy Officer Alzheimer's Society

I think we were improving before COVID, but what we've seen is that that diagnosis rate and the level is not recovered.



Professor Philip Scheltens, chair of World Dementia Council, Professor Emeritus at Amsterdam University Medical Centers and head of the EQT Life Sciences Dementia Fund

Thank you for the clarification. Giovanni.



Giovanni Frisoni, Clinical Neurologist, Full Professor of Clinical Neuroscience Geneva University

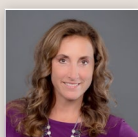
Well, you've spoiled my start, Philip. The concept of timely diagnosis should come in parallel with the concept of early diagnosis. Because in our field, we've been using and advocating both at different times. Early diagnosis is a technology-driven concept, while timely diagnosis is a patient-centred concept.

Now, in times when, therapeutical options are weak, it made sense to move from the technological-driven concept to the patient-centered. Now, with the monoclonal antibodies coming into the market, there will be an anchor, and the anchor will be the prodromal to mild. So, I'm curious to see how dementia specialists, patients, society will reorient the timely diagnosis around the anchor of the prodromal to mild stage.



Professor Philip Scheltens, chair of World Dementia Council, Professor Emeritus at Amsterdam University Medical Centers and head of the EQT Life Sciences Dementia Fund

Thank you. Phyllis.



Phyllis Barkman Ferrell, Global Head of External Engagement for Alzheimer's Disease and Neurodegeneration Eli Lilly

It's always a pleasure to be here, but it's really a pleasure to be sitting next to Giovanni because having recently visited, they're actually doing what we're trying to do at the Davos Alzheimer's Collaborative. So, I work for Eli Lilly and Company, but I'm an executive on loan to the Davos Alzheimer's Collaborative and specifically working on system preparedness. That initiative kicked off in 2020 and actually at least half of our working group is here in the room. So, if you haven't seen the paper, I highly recommend you go find, "Without a frame, there is no aim", and it actually takes this problem of health system preparedness and breaks it down into digestible bites. Because how do you eat an elephant, one bite at a time, right?

But the timely diagnosis is a really critical step that I want to make sure that we hit on this panel. And that is the framework actually breaks the diagnosis into two steps. Early detection of cognitive impairment, and then timely diagnosis or accurate diagnosis of the cause of that impairment. And I think it's really important when we think about health systems and how they operate that we split that into two steps. Because otherwise we have what we've been doing today, which is you muddy the things by combining them together. So, you expect one tool to do both steps. And that's not reality. The tools won't do that. They are different use cases. I mean, I'll build on Rhoda's statement. Digital



is the new blood isn't because digital is replacing blood. It's that digital allows for the early detection of cognitive symptoms, the same thing that blood allows for the accurate diagnosis of pathology. So, I would highly encourage us to think about taking this in two steps.

And then the one other comment I'll make, we've got 19 programmes live in 12 countries now for early detection of cognitive symptoms. And I'm here to tell you, the low-and-middle income countries are running circles around the high resource countries. And the reason for that is they're not sitting back and waiting for a drug. They're not sitting back and saying, well, I don't get paid to do that. My reimbursement rate for my time is not high enough to do that. Or I don't have a therapy, there's nothing I can do. Howard Fillit's here, I've heard him say on a panel to a room full of more people than this one, "I've spent 40 years and never found a patient that I couldn't help by identifying that cognitive impairment."

And so, I just encourage us to not wait, for whether that be the therapy with clinical meaningfulness, or the reimbursed therapeutic, or the perfect biomarker, let's make sure we do what we can do today and run with this early detection of cognitive symptoms because unrecognized cognitive impairment is a very, very difficult thing for the health system, and families, to deal with.



Professor Philip Scheltens, chair of World Dementia Council, Professor Emeritus at Amsterdam University Medical Centers and head of the EQT Life Sciences Dementia Fund

Thank you. Good. Jetske? Well, thank you.



Jetske van der Schaar, PdD Researcher University of Amsterdam

Thank you. I think in addition to what has already been said, when it comes to a timely diagnosis, it's difficult to separate it from an early diagnosis. And we have to not just ask the question when to diagnose and why to diagnose, but also whom to diagnose.

Because it's very difficult to have this discussion if we don't contextualise it and are not specific to the situation at hand. It's very different when a person with concerns comes to a memory clinic and wants to know whether something is going on compared to population screening of asymptomatic individuals. Or a more extreme example, to discuss whether we need to assess biomarkers to determine whether commercial pilots are fit to fly.

Regarding the why of a diagnosis, the clinical utility is very important, and given the advancements in disease-modifying treatments, the medical actionability is increasing, and will increase rapidly in the coming years.

But we also need to take into account, as has been said before, the personal actionability. A timely diagnosis can allow people to shift their priorities, to set their affairs in order, to adopt a risk-reducing lifestyle, and also to take control over a future in which they will lose their autonomy. Now, this is personal actionability and I really believe that it's a very personal choice whether people appreciate this opportunity and want to make use of it.

Now, regarding an early diagnosis or a timely diagnosis, empirical data show that people are quite well able to understand what that means and also to cope with that emotionally. But we know little of the longer-term implications and especially the dynamics, as was mentioned before, between sharing such information and receiving support or encountering stigma or even discriminating reactions. So, we also have to take stock of our legal system and maybe adjust it to protect people from those consequences.

Now my last and I think my most important point is that we talk so easily about biomarkers and about a diagnosis, but we need to be aware that this is very, very sensitive information and people have the right to know their medical information, but they also have a right not to know that. And as this is a very personal preference, and we also need a personalised approach when it comes to a timely diagnosis. And we cannot do that if we only include professional stakeholders. I think we have to also include personal stakeholders, not just people from academia or policy makers or investors or pharmaceuticals, but also the people it concerns. And that's not just persons with dementia or their caregivers, but also persons at risk. And to make it more personal, that's all of us.



Many people don't want to think of dementia until it is too late, because they think there's nothing that can be done. But we have this window of opportunity, and I think it's very important to make the general population aware of that, because we were discussing this morning that we need to hold ourselves to a higher standard when it comes to developing tests and treatments, and we need more pressure to make those tests and treatments available to everyone. And that means we have to involve the general public and empower them because they can help to apply that pressure and create that sense of urgency. And I think they also have a right to know what is going on and the information that is available.

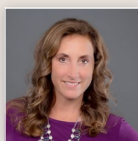
So, I'm a very strong advocate for involving the people that it concerns. And I wasn't planning to disclose this, but in addition to doing a PhD on the ethical aspects in early stages of Alzheimer's disease and other causes of dementia I am also a research participant and I have also been a caregiver of my mother until she passed away from Alzheimer's at the age of 63. And I also know I am at a very high risk of developing Alzheimer's disease. It's very important to be aware that it's not just about other people it about me and it's about you in an equal sense.

So, if you allow me the liberty to stir things up a little bit after lunch, I would invite you to reflect on the question, if those blood biomarker tests were available right now, would you take it? Would you want to know whether you are developing AD pathology. And I would like to invite you to stand up if you would like to know, or to sit down if you wouldn't, but to make it personal and feel what it what it implicates.



Professor Philip Scheltens, chair of World Dementia Council, Professor Emeritus at Amsterdam University Medical Centers and head of the EQT Life Sciences Dementia Fund

Can they raise their hand? Can you raise your hand? So those are the ones who do want to know.



Phyllis Barkman Ferrell, Global Head of External Engagement for Alzheimer's Disease and Neurodegeneration Eli Lilly

We're in a room full of believers, which is something we should think about as we wrap the day.



Professor Philip Scheltens, chair of World Dementia Council, Professor Emeritus at Amsterdam University Medical Centers and head of the EQT Life Sciences Dementia Fund

I saw on the panel there was only one. It's only you.



Giovanni Frisoni, Clinical Neurologist, Full Professor of Clinical Neuroscience Geneva University

Well, I believe that the question is a simple question, but the answer is not so easy. The vast majority of cases of Alzheimer's are sporadic, and we know that the lifetime risk is not 100%. And even if you are amyloid positive and tau positive, you may never develop the clinical phenotype of Alzheimer's disease. So, we still have to refine the measure of the risk associated with biomarker positivity in persons without cognitive impairment. This is a discussion that might be exploded: the need of population-based studies where the lifetime risk factors and biological risk factors are measured at the same time and patients are followed for decades, kind of Framingham study for dementia. But I will leave it at that.



Professor Philip Scheltens, chair of World Dementia Council, Professor Emeritus at Amsterdam University Medical Centers and head of the EQT Life Sciences Dementia Fund

Okay, that's good. Any comments from the audience at this point? Yeah, Rhoda. I mean, you have the microphone anyway!



Participant | **Rhoda Au**, Professor Anatomy and Neurobiology Boston University

I just want to mention there is a Framingham study of dementia because I happen to have been doing it for 32 years.



Professor Philip Scheltens, chair of World Dementia Council, Professor Emeritus at Amsterdam University Medical Centers and head of the EQT Life Sciences Dementia Fund

Well, it's all about awareness! Well, thank you very much. Other comments from the audience? Yes, I see the hands. John first and then you microphone, please.

Oh, sorry, Howard.



Participant | **Howard Fillit**, Co-Founder and Chief Science Officer Alzheimer's Drug Discovery Foundation (ADDF)

Well, I just thought we should entertain a discussion about whether we're talking about screening populations, or I have the sense that we're really talking about sort of case finding in a physician model where somebody comes in with a memory complaint.



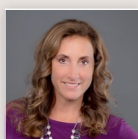
Professor Philip Scheltens, chair of World Dementia Council, Professor Emeritus at Amsterdam University Medical Centers and head of the EQT Life Sciences Dementia Fund

I agree.



Participant | **Howard Fillit**, Co-Founder and Chief Science Officer Alzheimer's Drug Discovery Foundation (ADDF)

And I think those are two very different types of consideration and the U.S. Preventive Service's task force is still giving screening for cognitive impairment a C recommendation. I think that's really prevented progress in the field tremendously.



Phyllis Barkman Ferrell, Global Head of External Engagement for Alzheimer's Disease and Neurodegeneration Eli Lilly

Yeah, you know Howard, it's interesting. We saw in the U.S. specifically this exact issue. So, we've got two major sites that are running early detection of cognitive impairment with a digital cognitive assessment tool. And what we learned, and this was pretty specific to the US, we'll see when the data comes in from the other countries whether it landed the same way, but screening provoked a reaction



in primary care that was emotional. And I have a commercial background, so I was like, let's get underneath that. Because the first thing they'll say is, well, the US Preventative Services Task Force, da-da-da-da-da. But what we found was that was a bit of a smokescreen. And what we found is that primary care physicians in the US are remunerated based on their ability to screen for a whole variety of things. And they actually get rated red, yellow, green. And you can only get green if it's 100%.

So as soon as you said the word screening to the primary care physician, their immediate reaction is, I'm going to fail because I can't ever do something a hundred percent of the time. And so as soon as we shifted that language to case-finding, we got a dramatically different reaction, even though we actually didn't change the steps in the protocol at all. It was just purely this, they get paid, whether they're red, yellow, green. Imagine if every day you came to work or once a month, a report went out to your entire organisation and it rated you red, yellow, or green on these quality metrics, and your pay was associated with that. So, it did create this emotional reaction.

And the thing about case finding then is it gave them the degrees of freedom to say, how do I do this? Now, our annual Medicare wellness visit still gives everyone 65 and over the right to timely detection. It happens 4% of the time in the US. So, we still have legislation that allows us to do it, but it was just very interesting that when you just shifted language a little bit, what a big difference you had in terms of acceptance and behaviour change.



Professor Philip Scheltens, chair of World Dementia Council, Professor Emeritus at Amsterdam University Medical Centers and head of the EQT Life Sciences Dementia Fund

So let's try to stay with the case finding then. The diagnosis timely when patients come to the clinic, and then also without a treatment yet available. That's how important that is. Fiona made that point as well, and Jetske also. So, let's stay with that. So, but I see hands, I see John, I see you, and you. So, three people on this side.



Participant | **John Harrison**, Chief Scientific Officer Scottish Brain Sciences

Thanks. It's really a question for Fiona, but given the international representation, there might be sort of wider lessons. It's not through lack of effort or engagement on our parts to shift the dial on the numbers that you gave us, and I think the last time there was a survey done of Alzheimer's disease understanding one in four people didn't know it was a brain disorder even. So, it seems like we have a very low baseline to rise from.



After 10 years on for the G8 summit and a year on from the declaration we will in England have a dementia strategy it feels like political inaction is the fundamental cause of our problems. What do we do as a community to shift the dial if we can't engage with government to get things changed? Is that a fair reflection, and if so what might we do about that?



Fiona Carragher, Chief Research and Policy Officer Alzheimer's Society

So, I think from a UK perspective it is a fair reflection. We were expecting a 10-year dementia strategy in England that was announced at Alzheimer's Society's conference last May. There has been, if anyone's not noticed, a little bit of political turmoil in the UK over the past nine months, but it means that what we now have is a major condition strategy of which dementia is one of six conditions. So, I think there is real political challenge with this. I think what I would say is that we need to unite as a community and we need to be really quite simple in our message actually.

And I think there's something around the public awareness piece. I mean, I was quite shocked by those figures in some ways that we haven't changed the dial, but most people think this is just about natural bit of aging. So, we've started to do some awareness campaigns with "It's not called getting old, it's called getting ill". And it has had some cut through, but there's some real challenge because in some ways we need to portray the harsh reality of what dementia is, of what dementia can be for families. And that's very difficult. And I think Lenny picked this up at the beginning, about how do we have a narrative of hope, but actually for the vast majority of people now, it's not going to change. It is still a progressive neurological condition. So, there's something for me about us all together kind of simplifying the message that has hope but actually also the stark reality that if we don't do something now we're not going to be able to cope with it in the future.



Giovanni Frisoni, Clinical Neurologist, Full Professor of Clinical Neuroscience Geneva University

May I try to redirect attention to a danger that we may be facing in the near future? I am a strong advocate of early detection. Those who know my history know what I mean by that.

But I feel that the danger we may be facing in the future comes from patients who come to observation in many memory clinics in Western high-income countries with subjective cognitive decline. They are people generally very highly educated that perceive some changes in their memory and cognitive performance, and they're deeply unsatisfied by that because they would love at 60 years their brain to work as it used to work at 30 years. And the numbers of them presenting are more and more.

We've called them subjective cognitive decline. And what is the danger? The danger is that if we do a sufficiently deep cognitive assessment with your tools, John, or any other sufficiently sophisticated cognitive tool, we may find minor impairment in some and label them as mild cognitive impairment. And if we test them, blood or CSF amyloid biomarkers and they come out positive what do we call them? We call them prodromal. And when Lecanemab is available what will we do? We will treat them. But maybe their low performance on cognitive tests is not a cognitive impairment associated with the amyloid cascade.

So, over-diagnosis is the danger that I see that we should be aware of and that we should be very careful not to fall into. Because we will be immediately pointed at by payers and decision makers as those who over-diagnose to promote drug use. And this is a trap that we should not fall into.



Participant | **Ruth McKernan**, Venture Partner SV Ventures

So, there are 141 different entities in clinical trials for dementia. And my question really for the panel is, does timely diagnosis also include the opportunity for people to engage in those studies if they choose to? And most clinical trials in dementia don't even complete or read out because they are so difficult to do.

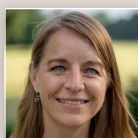


Phyllis Barkman Ferrell, Global Head of External Engagement for Alzheimer's Disease and Neurodegeneration Eli Lilly

So, I get very passionate about this topic. I was doing the Solanezumab study and I came from a marketing background, as I mentioned, and someone came running up and said "we did it". And we did it meant we recruited a thousand people in the US in 18 months. And I thought, "There are five million people in this country with this disease, why are we celebrating that it took us 18 months to find a thousand people?" And when you peeled back the onion, what you found was this broken healthcare system underneath where people were diagnosed too late if they were diagnosed at all, and often not even told about their diagnosis.

I am tired of getting phone calls from my friends who have said, something's wrong with my mum, where do I go? They call, they said it's going to take me nine months for her to see this neurologist. Nine months later they tell me, they told me my mum has Alzheimer's disease and she's too late for a clinical trial.

We've taken that choice away from someone. Now, clinical research isn't for everyone, but for people who want to do it, our systems shouldn't be working against them. And I have yet, in a clinical trial (and we've run a lot of them), had anyone come to me and say, "I wish I had enrolled in that clinical trial later." They all say, "I wish I'd done that sooner. I finally felt like I was fighting against a disease that was taking everything from me."



Jetske van der Schaar | PdD Researcher University of Amsterdam

I think the difficulty is also in the magnitude of the numbers of people and also all the emotions involved, because Alzheimer's disease is one of the most feared conditions of older people.

And at the same time it is one of the conditions that most people want to find a remedy for.

There's a hesitance to to inform the general population of the process of Alzheimer's disease and how it starts developing decades before one has symptoms. And the result of this is that people, when they realise something might be wrong, are too late.

This hesitancy of informing people also has to do with the lack of medical utility or the lack of personal actionability. So I think it's a very good point that you raise, that it's very important to be able to enrol in a clinical trial because it does give actionability and it does give people a purpose. And if I speak for myself, it makes so much sense to me to be a research participant. It's a world of difference to be passive and having everything overcome you or take an active stance and to contribute to science and do this for perhaps the generations after us. And we have to offer people this opportunity because research also shows many people want to participate in research and to help advance the development of treatment.

So, I really think we should involve the population and the full potential and what we can do together to empower the people and to help give them an opportunity to help advance the case.



Fiona Carragher, Chief Research and Policy Officer Alzheimer's Society

This is such a good point. Such a good point. What people affected by dementia tell us is that they absolutely want to have that choice and they haven't got it. What I would say goes back to this point about stories and messaging, because since the announcement of Lecanemab, we have been inundated through our Joint Dementia Research helpline which we run at Alzheimer's Society. We've had to double the numbers of staff to run it. So, there is absolutely appetite out there, but it is, I think, a beholden on us to get that story and that message out there.



Professor Philip Scheltens, chair of World Dementia Council, Professor Emeritus at Amsterdam University Medical Centers and head of the EQT Life Sciences Dementia Fund

Thank you for raising it. I would just add that it's usually not the patients who don't come, but the physicians that hold them back.



Participant | **Patrick Holford**, CEO Food for the Brain Foundation

The issue of whether or not I want to know, I want a timely diagnosis, depends entirely on whether I can do something about it. Now in 2013 at the G8 summit we had a statement made of 113 leading experts in this field that homocysteine was an exquisite biomarker and was lowerable, in other words disease modifying with B vitamins. And this research which is all randomised controlled trials has produced up to 73% less brain shrinkage, up to 73% less brain shrinkage. Now what we learn is that the homocysteine-lowering B vitamins only work in people who have sufficient omega-3 and we now have four replicated studies that have put these two factors together. So, we, at our charity, we are just a very small tiny charity, have tested 400,000 people on a clinical cognitive function test early because changes occur 40 years before a diagnosis. We're now introducing blood testing for homocysteine and omega-3, because there is something that you can do about it. That's the point. There are markers that we already have that you can do something about



Professor Philip Scheltens, chair of World Dementia Council, Professor Emeritus at Amsterdam University Medical Centers and head of the EQT Life Sciences Dementia Fund

Thank you very much. Comments from the panel?



Fiona Carragher, Chief Research and Policy Officer Alzheimer's Society

I didn't want to comment particularly about the specific biomarker, but having been a diagnostician in the NHS for a very long time it is difficult to get a biomarker from the brilliant labs like Charlotte Teunissen, or in the UK DRI, into routine clinical practice.

So, I think this group here today cannot underestimate how the kind of implementation, evaluation, and adoption piece, real world, of having high through put diagnostic testing is going to take us a long time as well, because we've tried to do it in other conditions, and it's been very challenging to do.



Participant | **Steve Salloway**, Martin M. Zucker Professor of Psychiatry and Human Behavior, Professor of Neurology Kent Hospital Rhode Island

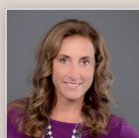
I want to pick up on Giovanni's comment and give my view of what is likely to happen in the US. I'll just take the US as a case example, if things move forward, is that we're going to see a transformation in early diagnosis. I think it's going to start, like you're saying, with the anchor of early AD. If there's a disease-modifying treatment, depending on how many drugs are available, it will be direct to consumer advertising. As you're saying, the patient community is going to be very receptive to this. The blood tests are going to help us make that early diagnosis. It will start with this early AD.



If that's successful, which I think it will be, if the momentum is gained from that, then things like what Phyllis is doing, other demonstration projects, will help address how can this be used in primary care? Once we have the anchor with early AD with a treatment, we'll then move to early diagnosis in primary care with first a clinical assessment, followed by a confirmation with a blood test.

And then the third piece is what we talked about this morning is brain health and what Jetske is talking about. If you're at risk, do you want to find out? And I think that's not going to come right away.

First hopefully we'll start with early AD, then we'll start with better diagnosis in primary and specialty care, and then eventually, hopefully not too far away, will be brain health and people at risk.



Phyllis Barkman Ferrell, Global Head of External Engagement for Alzheimer's Disease and Neurodegeneration Eli Lilly

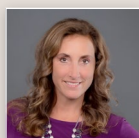
Steve, I agree with you stepwise, the only thing I might tweak on that a little bit is that people are going into their primary care physicians first. And what we know from Soeren Mattke's work is that if we don't actually identify the people who really need to move from primary care to specialty, we create a massive unnecessary bottleneck. And this is where I think this digital technology is key. Anything that we can do where the use case is such that it only passes forward false positives but all the true negatives get jettisoned out, it's better for our health system because you can actually clear that first step and really only send to your specialist the folks that really need to be there.

Because otherwise what ends up happening is the people who get care, are the ones who know the expert. By the way this is the other thing that happens, there's a nine-month wait, "Phyllis will you just call Steve? Sure I'll text Steve. Steve will you see my friend?" Okay this is great for some people, except this is why white affluent educated people are the ones that are getting through the system. So, I just would make sure that we don't throw out that first step in primary care of letting the right people go to the specialty, and then, of course, the specialist does the additional cognitive assessment or the blood test or the advanced pathology.



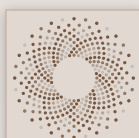
Participant | **Steve Salloway**, Martin M. Zucker Professor of Psychiatry and Human Behavior, Professor of Neurology Kent Hospital Rhode Island

I agree that, maybe I misstated, primary care is a partner in this first step. The anchor is the early AD.



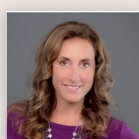
Phyllis Barkman Ferrell, Global Head of External Engagement for Alzheimer's Disease and Neurodegeneration Eli Lilly

Agreed.



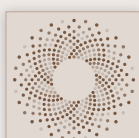
Participant | **Steve Salloway**, Martin M. Zucker Professor of Psychiatry and Human Behavior, Professor of Neurology Kent Hospital Rhode Island

It won't start in specialty care. It's going to start in primary care with a referral to specialty care. There's one more thing I was going to say about this. What's the last thing you said?



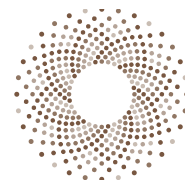
Phyllis Barkman Ferrell, Global Head of External Engagement for Alzheimer's Disease and Neurodegeneration Eli Lilly

That I text you when I need someone to see you. (laughs)



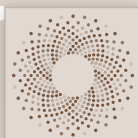
Participant | **Steve Salloway**, Martin M. Zucker Professor of Psychiatry and Human Behavior, Professor of Neurology Kent Hospital Rhode Island

Oh yeah, no, no, thank you.



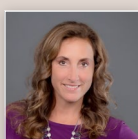
Professor Philip Scheltens, chair of World Dementia Council, Professor Emeritus at Amsterdam University Medical Centers and head of the EQT Life Sciences Dementia Fund

So we now discover that she's texting you all the time.



Participant | **Steve Salloway**, Martin M. Zucker Professor of Psychiatry and Human Behavior, Professor of Neurology Kent Hospital Rhode Island

I need that prompt. So, no, this is critical, the workforce. Now we're going to get better at early diagnosis in primary care they need some place to go for care, for additional care. And I think that advanced practice providers, additional clinical help can really expand that capacity. That's how we have...



Phyllis Barkman Ferrell, Global Head of External Engagement for Alzheimer's Disease and Neurodegeneration Eli Lilly

Allied health professionals.



Participant

Yes. Nurses, potentially. Dementia nurses.



Professor Philip Scheltens, chair of World Dementia Council, Professor Emeritus at Amsterdam University Medical Centers and head of the EQT Life Sciences Dementia Fund

But you need the sensitivity of the test to rule out the ones who don't have it. Yes, you. Please. Ryoji.



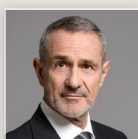
Participant | **Ryoji Noritake**, Director Health and Global Policy Institute (HGPI)

Thank you. My question is about dementia-friendly society. So, for the timely diagnosis, people need to feel hope, but also feel adequate concerns about dementia. It's not part of aging, but it's a disease. But on the other hand, there's an inevitability that we focusing on dementia-friendly society, dementia-friendly design, which is nothing wrong with that. We do believe, I personally believe in dementia-friendly society should be built, but there's an inevitability because we do not have the treatment. But how we can reframe this dementia-friendly concept? We advocated dementia-friendly society, dementia-friendly design for years, but we in cancer, in cardiovascular, we never call it cancer-friendly society. Cardiovascular dementia, cardiovascular-friendly society, how can we reframe the phrase to keep the moment of the dementia friendly society but to attract the adequate concern in a way. Thank you.



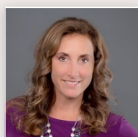
Professor Philip Scheltens, chair of World Dementia Council, Professor Emeritus at Amsterdam University Medical Centers and head of the EQT Life Sciences Dementia Fund

Good point. Thank you very much. Any other panel?



Giovanni Frisoni, Clinical Neurologist, Full Professor of Clinical Neuroscience Geneva University

Do we really need that? The dream is a world without Alzheimer's disease. I think that the next step is prevention, is secondary prevention in persons without cognitive impairment. And hopefully, we will get rid of the need of having a dementia-friendly society, because it will be a preventable disease, such as stroke, such as myocardial infarction.



Phyllis Barkman Ferrell, Global Head of External Engagement for Alzheimer's Disease and Neurodegeneration Eli Lilly

Are we allowed to argue up here? (laughing)



Professor Philip Scheltens, chair of World Dementia Council, Professor Emeritus at Amsterdam University Medical Centers and head of the EQT Life Sciences Dementia Fund

Of course, of course.



Giovanni Frisoni, Clinical Neurologist, Full Professor of Clinical Neuroscience Geneva University

But let me make a further step. Going back to the issue of the Framingham study for dementia, if we go down the road of secondary prevention, we will need accurate estimates of the risk associated with the different risk factors.

If we don't know the amount of risk associated with hypertension and to amyloidosis or tauopathy associated, is it 1.2, is it 7, is it 25, we cannot develop any secondary prevention programme.

It is true that we have a number of studies that allow us to estimate the weight of the different risk factors. We have studies on the dementia risk associated with lifestyle risk factors, studies on genetic risk factors such as amyloidosis, tau, atrophy, and vascular changes. However, what is missing is a study measuring all of these risk factors lifestyle, genetic and biological at the same time and with a long follow-up, and estimate the weight of each risk factor adjusted for all others. This is a gap of knowledge that we need to fill if we want to develop secondary prevention programmes for dementia and cognitive impairment.



Professor Philip Scheltens, chair of World Dementia Council, Professor Emeritus at Amsterdam University Medical Centers and head of the EQT Life Sciences Dementia Fund

Fiona so you wanted to argue?



Fiona Carragher, Chief Research and Policy Officer Alzheimer's Society

I think that the point I would make is we still will need really good personalised care for the foreseeable future. Most people with dementia tell us that they want to live independently in their own home, they want to be in a community that they call home, doing the things that they love that gives them meaning in life. So, whether that's badged as dementia-friendly or dementia-inclusive, that is going to still be the reality that we need to have in place at the same time as the system readiness for these breakthrough diagnostics and treatments. So, I think we can't lose sight of that because essentially that is the quality of life. That's what gives meaning in life.



Phyllis Barkman Ferrell, Global Head of External Engagement for Alzheimer's Disease and Neurodegeneration Eli Lilly

I would love to get rid of the word dementia I mean, Harry Potter used dementors, demented. I mean, why are we using this label anymore? It forces us into a late-stage mindset, which we've all been talking about is the problem, right? Everyone thinks when you say, even Alzheimer's disease, but certainly when you say dementia, you're talking about a syndrome, and you're actually really confusing a field that's already confused. I think a lot of the things that happen in the dementia-friendly societies are actually pro-aging.

My mum doesn't have cognitive impairment, but she's very frail. She would do very, very well with some of the things that are done around dementia-friendly societies, dementia-friendly shopping, things like that, but she doesn't want to go during dementia-friendly hour. But she'd be very happy to go during pro-aging hour or longevity hour and so I think anything we can do to stop saying that this is a syndrome that you can't do anything about and it's actually a series of diseases and let's call it what it is based on the pathology but let's be pro-aging and let's make sure we have societies that are pro-aging.



Jetske van der Schaar, PdD Researcher University of Amsterdam

And I also think we do want to have dementia friendly society because it affects our identity it is not just about our body but it's about our mind it's about who we are. And in addition to what you just said, I think most people don't know the difference between dementia and Alzheimer's disease, let alone MCI or a prodromal diagnosis. It's all one big blur. And I think the image is people in their final stages. So again, I think it's important to also educate the population on what all these terms involve, how the disease develops, and also to frame it differently.



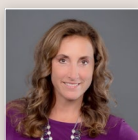
Professor Philip Scheltens, chair of World Dementia Council, Professor Emeritus at Amsterdam University Medical Centers and head of the EQT Life Sciences Dementia Fund

One last question from the audience there. We have to take the time.



Participant | **Kousuke Wada**, Director for Dementia Strategy, Division of Dementia Policy and Community-Based Long-Term Care Promotion, Health and Welfare Bureau for the Elderly, MHLW Ministry of Health, Labour and Welfare (MHLW)

Thank you for allowing me. My name is Kosuke Wada from Japanese Government. Thank you for inviting me to the UK it is good to be here after a long absence. I like to ask you all, again, the importance of timely and early diagnosis for non-Alzheimer's disease. I'd like to ask you again. This is an important point, I think. Thank you.



Phyllis Barkman Ferrell, Global Head of External Engagement for Alzheimer's Disease and Neurodegeneration Eli Lilly

Yeah, I think the question is the value of early detection. And I think, once again, I would split between the early detection of cognitive impairment, Phil mentioned the use case we're talking about here is cognitively impaired people who are sitting in a doctor's office today with unrecognised cognitive impairment, which probably means they're not following their doctor's directions very well on things like diabetes control. And if you'll humour me for one second, I will tell you about my friend, Teresa.

So, I was at my son's basketball game. I'm in the United States of America, one of the wealthiest countries in the world, and my friend Teresa came to me crying. She said, can we talk? I said, what happened? She said the police called. They found my mum wandering last night. Teresa is an emergency room nurse. She owns her own home. She pays a mortgage. She's a single mum. We would call her upper middle class. In the U.S., she has three days to find her mother a Medicare bed because three days is what the hospital will allow her to stay. She now has to decide, does she work? If she



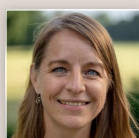
doesn't work, she doesn't get paid, doesn't make her mortgage, doesn't take care of her kids, she's a single mum. Or does she care for her mother, how does she find a place, Medicare beds aren't available overnight. Mark McClellan said on the first panel today, this is a system problem. Her mum did not go to bed without Alzheimer's disease dementia and wake up with it. That was probably three to four years that Teresa could have been figuring out the best situation for her family. It could have been a clinical trial, it could have been healthy lifestyle behaviours, it could have just been making sure her mum had a voice in her plan. And I sit in the one of the wealthiest countries in the world. And Teresa works in the health system. How does this happen?

And so, what's the value of early detection? Let's catch this cognitive impairment. Let's let people make personal choices about what their families need. And then when we have the opportunity to use therapies that are pathology-based. We get them the accurate diagnosis of the pathology. But it's shameful that any of us are sitting back and waiting for a drug before we actually make sure that Teresa has what her family needs.



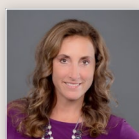
Professor Philip Scheltens, chair of World Dementia Council, Professor Emeritus at Amsterdam University Medical Centers and head of the EQT Life Sciences Dementia Fund

Thank you very much. I think we have to wrap up this panel. So, as I usually do, one last sentence, one last word for the audience. Jetske



Jetske van der Schaar, PDD Researcher University of Amsterdam

Yeah, I think it's important to stress we talk about the diagnosis as if one goes to a clinic and gets a positive diagnosis. Yes, this is Alzheimer's disease. But I also think there's great value in excluding Alzheimer's disease, especially when people have concerns and are worried, they are developing dementia. To reassure them and exclude this option.



Phyllis Barkman Ferrell, Global Head of External Engagement for Alzheimer's Disease and Neurodegeneration Eli Lilly

Just that the power of this meeting is in the individuals in this room and if we just stay here and talk about it with each other we've lost the power of this room. So, I would just ask that each of us walk out of here after this meeting and decide what are we going to do differently, because the power is the influence that's in this room.



Professor Philip Scheltens, chair of World Dementia Council, Professor Emeritus at Amsterdam University Medical Centers and head of the EQT Life Sciences Dementia Fund

Hear hear.



Giovanni Frisoni, Clinical Neurologist, Full Professor of Clinical Neuroscience Geneva University

Well, my tagline is from the point of view of a physician, of someone who is in a memory clinic. My tagline is that we must provide the possibility of the earliest possible diagnosis, which is timely for the patient, but not too early. And be very strict to use the future disease-modifying drugs according to indications.



Fiona Carragher, Chief Research and Policy Officer Alzheimer's Society

And I think that, as I said, from a patient advocacy perspective, the diagnosis is the first really, really important step for the individual and their families and carers around them. And if we get this right, they should be able to have that early and what's right for them, get the opportunity to get into clinical trials, get those disease modifying therapies as and when they come, but also have that really good personalised care and support around them, with the options for as they deteriorate potentially in the future into what really good care looks like. Because I think that's going to be when dementia no longer devastates lives.



Professor Philip Scheltens, chair of World Dementia Council, Professor Emeritus at Amsterdam University Medical Centers and head of the EQT Life Sciences Dementia Fund

Thank you very much. I think they all deserve a round of applause.

Thank you. Thank you. This was really, really very important part of the discussion. It's by no means it has ended, of course. It's just scratching on the surface of the topic.

The World Dementia Council (WDC) is an international charity. It consists of senior experts and leaders drawn from research, academia, industry, governments and NGOs in both high-income and low- and middle-income countries, including two leaders with a personal dementia diagnosis. The WDC has an executive team based in London, UK.

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