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# Standard of Care

**Announcer:**
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**Dr. Agronin:**
This is CME on ReachMD, and I'm Dr. Marc Agronin. I'm here today with my colleague Dr. Richard Isaacson.

So let's get right into today's topic. Dr. Isaacson, tell us a little bit about what's the current standard of care for treating Alzheimer's disease.

**Dr. Isaacson:**
When it comes to FDA-approved medications, there are 2 classes of medications. One are the general class of acetylcholinesterase inhibitors. Acetylcholine is a chemical in the brain, a neurochemical that's responsible for memory, and there are 3 that are currently used: donepezil used to be called the trade name Aricept, rivastigmine used to be the trade name Exelon, and then galantamine which had different trade names. But these are all now generic, but there are now several oral medications that are available as well as several patches. Donepezil now has a patch that you can wear for a week, or rivastigmine has a patch that you can wear every 24 hours.

So the take-home point with the acetylcholinesterase inhibitors, the good news is there's a lot of them. And the other news is the preponderance of evidence and the totality of evidence suggests that these drugs do have a modest benefit in terms of symptomatic improvement. Now the improvements are not large; there's modest benefit. But when it comes to comparings to placebo, there is some statistically significant improvement compared to placebo. That being said, not everybody responds, and I think that's something that needs to be thought about. There's also some side effects and maybe, Marc, you can talk about those.

When it comes to the other class of medications, it's the, actually, NMDA antagonist medication, or memantine. Memantine used to be a twice-a-day medication and now it can also be used as a combined, extended-release medication. And when it comes to the treatment of early, mild, moderate, or severe Alzheimer's, the acetylcholinesterase inhibitors are variously approved for different indications. But when it comes to memantine, that needs to be that is approved in combination therapy with cholinesterase inhibitor in combination with memantine for moderate and severe Alzheimer's alone.

So the take-home point here is we can often start with acetylcholinesterase inhibitor, start low and go slow, donepezil 5 milligrams with food, breakfast or lunch, whichever meal is larger, increase that over a couple of months to 10 milligrams if tolerated with breakfast or lunch, whichever meal is larger, really important clinical pearl from my perspective there. And then as the person progresses to moderate dementia, then the person can be added on memantine.

**Dr. Agronin:**
Great, thank you for that description of those. Always be aware of key side effects. For the acetylcholinesterase inhibitors, the most common tend to be GI related, so anything ranging from loss of appetite, nausea, vomiting, diarrhea. And we see these in sometimes between 5% and 10% of individuals. Often, that gets better after a few days. But if it's more severe than that, sometimes the person just

doesn't tolerate those.

We also have to make sure that if someone has a pre-existing bradyarrhythmia, often we get cardiology input, because theoretically, at least the medications can slow heart rate. And some people actually get nightmares on these medications. So if you're dosing it at night, and someone has noticed a change in their sleep, you can switch it to the morning.

Memantine tends to be pretty well tolerated. Some people get a little bit of a fogginess or confusion initially, and that may worry patients that they're actually getting worse when it tends to get better within a few days. And so it's important at least to let people know that ahead of time, just so they don't panic if that happens. But you know, generally, when these are combined, people tolerate them pretty well.

Just a few key takeaways in terms of do's and don'ts here. It's important that both patients and their care partners understand to keep their expectations modest. The medications don't necessarily slow the disease, they don't always make a huge difference in terms of cognition, but we know from lots of research that there is statistically significant improvement over time, and people just need to kind of keep their expectations in check. We only use one acetylcholinesterase inhibitor; we don't combine them. But we do combine it with memantine over time, that’s standard of care.

It's important not to rush titration given especially side effect issues, so we have starting doses, and we slowly over time move up to the therapeutic level, but it's important to move up to that therapeutic dose. So just an example, if you're starting donepezil 5 mg, after 4 weeks, you want to go to 10 mg and give someone that maximal benefit, rather than just kind of having them hang out at a lower dose. And then monitor for side effects. That's really key.

So but again, standard of care is to use these medications. It's just important that we engage patients and care partners in really educating them about them.

So, Dr. Isaacson, thanks again. This has been a great bite-sized discussion. Unfortunately, our time is up. Everyone, thank you for listening.

**Announcer:**
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