Introduction

The various etiological hypotheses for Alzheimer’s disease (AD) need to be tested in patients using designs and outcomes that are appropriate. This chapter reviews the principles of symptomatic treatment versus disease modification, the natural history of AD, and designs to slow down its progression. It should be noted that the diagnosis of AD implies first a diagnosis of dementia, followed by an assessment of its etiology. The accuracy of the clinical diagnosis of AD is in the order of 85% once dementia is clinically detected, but less than 50% in the predementia stage of amnestic mild cognitive impairment (aMCI) using clinicopathological correlations (Petersen et al., 2006).

Symptomatic Treatment Versus Disease Stabilization

The main thrust of therapeutic research in AD has so far been directed at improvement of symptoms, using cholinesterase inhibitors (ChEI) and the NMDA receptor antagonist memantine. The initial expectations were primarily a cognitive enhancement effect, but these drugs improve cognition only transiently, stabilize activities of daily living (ADL), and delay emergence or improve existing behavioral and psychological symptoms of dementia (BPSD), such as apathy, agitation, and hallucinations. Although the improvement above baseline is small, these results are clinically meaningful in a neurodegenerative condition that leads to death within 3–8 years after the onset of symptoms (Winblad et al., 2001).

The current interest is in disease modification. A delay of progression from no or minimal symptoms to diagnosable dementia would have an obvious value from a public health point of view, and delaying progression from mild AD to more advanced stages would also be considered important, even if there were no symptomatic improvement. Delaying progression in severe stage would obviously not be considered appropriate, although much more can be done to improve symptoms and quality of life at that
stage. The study design currently favored by pharmaceutical sponsors and regulators to prove disease modification is a fixed time comparison of decline of clinical outcomes and rate of brain atrophy. Another study design is survival to a clinically important disease milestone, which may offer more clinical applicability and allow for pharmacoeconomic estimates. A combined approach (fixed time measures and survival-to-clinical events) may be possible (Andrieu, Rascol, Lang, Grandjean, & Vellas, 2006).

It should be noted that a sustained symptomatic therapeutic effect (akin to levodopa in Parkinson’s disease) would stabilize progression of disease without modification of the underlying pathophysiology. There are thus different perspectives on symptomatic versus disease stabilization for regulators approving a label versus users (patients, caregivers, clinicians, and third-party payers).

Natural History of Alzheimer’s Disease

The natural history of AD can be broadly considered as a presymptomatic stage during which a number of pathological events take place over many years, an early symptomatic or prodromal stage (aMCI) with cognitive and at times neuropsychiatric manifestations, and symptomatic mild, moderate, and severe stages. Hoping for reversibility of pathological changes, the early stages of AD can be targeted for disease modification, requiring different trial designs and outcomes (Table 1).

Disease milestones have been defined in AD (Table 2). Some of these can be a target for treatment, with considerable face validity and potential impact.

<table>
<thead>
<tr>
<th>Stage</th>
<th>Population</th>
<th>Trial design</th>
<th>Primary outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Presymptomatic</td>
<td>Healthy elderly</td>
<td>Survival over 5–7 years</td>
<td>Incident dementia</td>
</tr>
<tr>
<td>Prodromal</td>
<td>Amnestic MCI</td>
<td>Survival over 2–3 years</td>
<td>Progression to dementia</td>
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<td>Mild dementia</td>
<td>AD in the community</td>
<td>Parallel groups over 18 months</td>
<td>Cognition and global impression of change</td>
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*Table 1. Examples of trial design and outcomes for disease modification at early stages of AD.*

<table>
<thead>
<tr>
<th>Milestone</th>
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<tr>
<td>Emergence of cognitive symptoms</td>
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<tr>
<td>Conversion from aMCI to diagnosable dementia</td>
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<tr>
<td>Loss of instrumental ADL</td>
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<tr>
<td>Emergence of BPSD</td>
</tr>
<tr>
<td>Nursing home placement</td>
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<tr>
<td>Loss of self-care ADL</td>
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<tr>
<td>Death</td>
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</tbody>
</table>

*Table 2. Clinical milestones in AD.*
on care (Galasko, Edland, et al., 1995). For example, if the studies in aMCI using ChEI had demonstrated a sustained delay in progression to dementia, such patients would have been actively treated with these drugs worldwide. Delaying loss of autonomy for self-care and even death in moderate-to-severe stages of AD using α-tocopherol in only one study performed by the Alzheimer disease cooperative study group (Sano et al., 1997) has influenced clinical practice to use vitamin E in all stages of AD, at least in the USA, until a meta-analysis showed higher mortality associated with vitamin E at doses of 400 IU per day or higher (Miller & Pastor-Barriuso, 2005). Delaying the loss of autonomy for ADL or the emergence of some of the BPSD could reduce the burden of the caregiver and delay the need for nursing home placement.

Symptomatic domains in dementia include cognition, ADL, and behavior. One can even add a domain of changes in mobility, since patients with AD will manifest some features of parkinsonism late in the course of disease. In most patients, early changes in mood and anxiety precede the formal diagnosis of AD, with spontaneous improvement as insight is lost about the disease. Cognitive and functional (ADL) decline are relatively linear over time, whereas BPSD and caregiver burden peak midway into the disease course and improve through the severe stage (Gauthier, Thal, & Rossor, 2001). These natural fluctuations in the intensity of individual symptomatic domains through the stages of AD have an impact into trial design and outcomes (Table 3). It should be noted that decline is faster in the moderate stage, which may be related to the sensitivity of measurement scales or to the natural progression of AD.

### Table 3. Symptoms through the stages of AD and relevant outcomes.

<table>
<thead>
<tr>
<th>Stage</th>
<th>Prominent symptoms</th>
<th>Types of outcomes</th>
<th>Examples of scales</th>
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<tbody>
<tr>
<td>aMCI</td>
<td>Cognitive decline</td>
<td>Cognition</td>
<td>ADAS-cog</td>
</tr>
<tr>
<td>Mild</td>
<td>Cognitive decline</td>
<td>Cognition</td>
<td>ADAS-cog, ADCS-ADL, DAD</td>
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<tr>
<td>Moderate</td>
<td>Instrumental ADL</td>
<td>Instrumental ADL</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Cognitive and ADL</td>
<td>Cognition</td>
<td>ADAS-cog</td>
</tr>
<tr>
<td></td>
<td>decline more rapid</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Severe</td>
<td>BPSD emerge</td>
<td>Behavior</td>
<td>NPI</td>
</tr>
<tr>
<td></td>
<td>Cognitive decline</td>
<td>Cognition</td>
<td>SIB</td>
</tr>
<tr>
<td></td>
<td>Self-care ADL</td>
<td>Basic ADL</td>
<td>ADCS-ADL sev</td>
</tr>
<tr>
<td></td>
<td>BPSD abating</td>
<td>Behavior</td>
<td>NPI</td>
</tr>
<tr>
<td></td>
<td>Parkinsonism emerging</td>
<td>Parkinsonism</td>
<td>UPDRS</td>
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ADAS-cog Alzheimer disease assessment scale-cognitive subscale (Rosen, Mohs, & Davis, 1984), ADCS-ADL Alzheimer disease cooperative study-ADL scale (Galasko, Bennett et al., 1997), DAD Disability assessment in dementia (Gélinas, Gauthier, McIntyre, & Gauthier, 1999), NPI neuropsychiatric inventory (Cummings et al., 1994), SIB severe impairment battery (Panisset, Roudier, Saxton, & Boller, 1994)

UPDRS, United Parkinson Disease Rating Scale (Fahn, Elton, & Members of the UPDRS development committee, 1987)
Symptomatic Clinical Trials Using ChEI and Memantine

The modern treatment for AD was initiated by the report that tacrine improved some aspects of cognition and daily life. The follow-up confirmatory studies used crossover and parallel group designs. The FDA published guidelines (Leber, 1990) that influenced greatly the choice of outcomes for proof of efficacy of drugs, which improve the symptoms of AD: a cognitive performance-based scale such as the ADAS-cog (Alzheimer Disease Assessment Scale-cognitive subscale) and an interview-based impression of change became the primary outcomes for the symptomatic treatment of mild-to-moderate AD, defined operationally as scores between 10 and 26 on the Mini-Mental State Examination (MMSE; Folstein, Folstein, & McHugh, 1975). Unfortunately, these FDA guidelines caution against the pseudospecificity of measurable benefits on BPSD delayed research in this important symptomatic domain. In the past few years, regulatory agencies have been more open to ADL and behavior as important outcomes.

The following study designs have been used in the proof of efficacy for ChEI: parallel groups over 3–12 months, and survival to a predefined clinical endpoint over 1 year or longer.

The parallel groups offer the possibility of short-term (minimum of 3 months) studies comparing the efficacy of different doses of the drug versus placebo. The primary analysis is done on outcomes at the end of the study, using the “last observation carried forward” (LOCF) or “intent to treat” (ITT) to compensate for missing values in case of dropouts. Although LOCF/ITT has been favored by regulatory bodies, there is increasing support for primary analysis to be done using observed cases (OC), e.g., completers in studies of 12 months or longer duration (Sampaio, 2006). For practical purpose, both types of analyses are performed.

Survival studies with ChEI have targeted primarily loss of ADL, and have successfully demonstrated a delay in the loss of autonomy for patients on active drug compared to placebo. Parallel group studies of 6 months duration ranging from mild-to-severe AD (MMSE 26/30 to 1/30) have also established that ADL are stable on treatment with ChEI, but with no improvement of instrumental ADL (so called tutoring effect).

The most difficult domain to study, although very significant clinically, has been behavior. The availability of BPSD scales such as the NPI (neuropsychiatric inventory) has not yet allowed unequivocal demonstration of benefit in severe stages of AD in nursing home settings. New methods of analysis of behavior have been proposed (Gauthier et al., 2002; Gauthier, Wirth, & Möbius, 2005), and will likely be more successful in defining categories of BPSD symptoms most responsive to ChEI (anxiety, hallucinations), memantine (agitation), and other treatments.

Memantine a new therapeutic class has been found to be effective in a range of studies using parallel groups in moderate-to-severe AD (Doody, Winblad, & Jelic, 2004). Scales, such as the SIB (severe impairment battery),
the ADCS-ADL (Alzheimer disease cooperative study-ADL scale) modified for severe stage, and the NPI, appropriate for this stage of disease have been used and accepted by the FDA and other regulatory agencies. Of great importance is the novel design of adding memantine or placebo to a stable dose of a ChEI, which has been used successfully (Tariot et al., 2004), paving the way to a number of studies where novel drugs or placebo are added to standard treatment.

Disease-Modification Studies

In the early days of designing protocols to demonstrate slowing of AD progression, the randomized start design was considered promising (Bodick et al., 1997) but failed in the propentofylline drug development program (Whitehouse et al., 1998). Current studies use parallel groups over 18 months in mild AD, requiring the addition of the novel drug or a placebo to standard symptomatic treatments. The outcomes selected have demonstrated relatively linear changes over time such as the clinical dementia rating-sum of boxes (CDR-SB; Hughes, Berg, Danziger, Coben, & Martin 1982), the ADAS-cog, the ADCS-ADL, and the DAD. Cognitive measures usually consist of one scale, such as the ADAS-cog, but could be a z-score transformation of a number of well-validated tests (Visser, 2006). The latter may be required in very early AD, where there is limited impairment in recent memory and executive tasks (Nadkarni & Black, 2006). The clinical measures are supplemented by volumetric brain measurements using magnetic resonance imaging at the beginning and end of treatment (Scheltens & Barkhof, 2006). Other biomarkers can be monitored as supportive evidence for a biological effect on disease progression (Lovestone, 2006).

Although this design appears promising, there are uncertainties and limitations. For instance, the difference in the rate of brain atrophy may be absent or opposite to expectations, with accelerated atrophy in the actively treated group, as was seen in one of the immunotherapy studies. The planned analysis for differences in mean changes at 18 months relative to baseline, or differences in slopes of decline using nonlinear models may satisfy regulatory requirements, but may not convince third-party payers and users. Demonstration of a delay in reaching clinical milestones (such as loss of instrumental ADL present at baseline, delaying emergence of BPSD not present at baseline, delaying transition from CDR global stage 1 [mild] to 2 [moderate]) would greatly improve the translation of randomized clinical trials to clinical practice, particularly if frail (real world) populations were enrolled in phase III (Ferruci, Guralnick, & Studentski, 2004).

One of the difficult issues in disease modification strategies is the decision of the stage of disease where the proposed drug is most likely to work. On this proof of concept, phase II/III efficacy and safety study hinges the entire future of a given drug. For example, numerous attempts at treating patients
with AD in mild-to-moderate stages using nonsteroidal anti-inflammatory drugs (NSAID) have failed, despite the weight of evidence from epidemiological research and the biological plausibility of an inflammatory component to AD pathology (McGeer, Schulzer, & McGeer, 1996). It may be that treatment with NSAID in the presymptomatic or in the prodromal stages of AD would be a more appropriate time from a pathophysiology point of view, or that doses tested so far were too low. On the other hand, studies in these stages of AD require 3–5 years, a very long time for a proof of concept. Alternatively, patients groups at very high risk of progression could be considered, such as presenilin mutation carriers, or aMCI carrying the apoE4 genotype with hippocampal atrophy (Pennanen et al., 2006).

The prototype of trial designs to establish the safety and efficacy of preventive therapies in asymptomatic populations is the ongoing 7-year survival study comparing *Ginkgo biloba* to placebo in elderly subjects, with incident dementia as primary endpoint (Touchon, Portet, & Gauthier, 2006). Variations of this design may be possible by enriching the study population with different levels of risk, such as a positive family history of AD or selected gene markers, although it should be remembered that any enrichment of a study population will limit the applicability of findings to the population as a whole. Nevertheless, there is building evidence that pharmacogenomics will play a major role in matching disease-modifying drugs to individual patients, so much so that ethical considerations to pharmacogenomics profiling are under study (Issa, 2003).

**Conclusions**

We are fortunate that many etiological hypotheses for AD have been formulated and are amenable to study in human populations. A concerted effort among basic scientists, clinical trialists, and regulators is necessary to select the best study design for the appropriate stage of disease in order to prove efficacy. There is also a need to take into account the applicability of findings for the population as a whole in terms of safety and cost benefit.

**References**


Pharmacological Mechanisms in Alzheimer's Therapeutics
Cuello, C. (Ed.)
2007, XX, 324 p. 35 illus., Hardcover