Abstract

As we are better characterizing the phenotypes of the various dementias, diagnosis is moving more to “rule in” rather than “rule out”. No longer is Alzheimer’s disease diagnosed only by excluding other causes of neurodegeneration - it can be ruled in by the typical clinical features as well as hippocampal atrophy on MRI and the pattern of hypometabolism on FDG-PET or levels of biomarkers in CSF. Similarly, as we better understand the correlation between clinical presentation, pathology and genetics of the FTLD spectrum, we are now able to rule in this diagnosis. Overlap syndromes are also being better characterized - eg AD/ DLB and AD with vascular cognitive impairment. Atypical presentations of the more common dementias continue to pose difficulty, but are also being better diagnosed - these include frontal variant AD (FvAD) and logopenic aphasia, a language-onset AD.

It is disappointing that a quarter of a century after the first publication on effective AD therapy we still only have 4 marketed drugs for all the dementias, but there is a huge pipeline of new therapies being developed, targeting the various pathological and genetic processes we are increasingly identifying in the dementias. As with any other major clinical area - eg cancer - it may take decades but it is likely that therapies that target the disease process itself will soon be developed and marketed. Whilst most research activity is directed towards AD, there is increasing research into therapies for FTLD and the other more common dementias. Therapies are likely to be more effective if used earlier, and new diagnostic criteria for prodromal AD facilitate the identification of these early stages, underlying the close relationship between advances in diagnosis and therapies for the dementias.