Chief Complaint: Memory Loss

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One of the most common complaints among elders is memory loss. It can be an annoyance in some and a harbinger of Alzheimer's in others. In either case, the prospect of losing one's memory is among the most horrifying fates one can imagine. Unfortunately, treatments for Alzheimer's disease, the most common form of memory loss in elders, are lacking. The few medications available have only modest effects in a subset of individuals and do not slow disease progression. This situation leads to frustration on the part of the family, the patient and the physician. We are trained to offer treatments for disease and for many conditions associated with memory impairment we have little to offer. Too often the state of affairs leads to physician nihilism. It is our view that reversing this nihilism—while at the same time being realistic about the daunting challenge of the problem—is more crucial now than ever as the baby boomer population bubble moves into the age of risk for Alzheimer's disease and the problem of dementia in our communities begins to soar.

Two changes in our thinking could help.

(1) Focus on reducing the risk for developing Alzheimer's disease. Targeting the at-risk population with risk reduction measures is likely to have the greatest impact on the disease short of a cure. Although implementing interventions that reduce risk will not necessarily prevent the disease, they can diminish the chances of getting it or delay its onset. Even a modest push back in the age of Alzheimer's disease onset would have an enormous impact on the medical care burden we now face. Risk reduction measures are simple to enumerate, but challenging to implement. We know what they are. Established cardiovascular risk factors are also risk factors for Alzheimer's disease. In addition to keeping blood pressure, LDL, and glucose in the normal range, general wellness measures may also forestall the disease. Those measures for which there is reasonable data include the value of exercise, nutrition, cognitive challenges, stress reduction, and avoiding social isolation.

(2) Once a person has Alzheimer's disease we need to focus on quality of life. Although not a topic that the pharmaceutical industry tends to discuss, research intended to reverse or even slow the progression of Alzheimer's disease once it has advanced to frank dementia is no longer on big pharma's agenda. The task is just too daunting. Instead, pipeline drugs now are focused on treating the very earliest stages of the disease called mild cognitive impairment (MCI), or pre-symptomatic disease in genetically at-

> risk populations. One conclusion from this reality is that the physician's role may be minimized after the diagnosis is made, and the role for ancillary services including social services becomes crucial. Secondly, we need to calibrate expectations for our patients carefully—neither rob them of hope, nor falsely promise. Instead, we need to consider what constitutes quality of life for people in each stage of this inexorably advancing scourge. Finally, to make a significant impact on Alzheimer morbidity we need to intervene before the disease strikes by implementing risk reduction measures broadly across the community.

The biggest obstacle we face in implementing risk reduction measures is adherence. As a neurologist and family physician, we can recall countless cases in which a patient with a seizure disorder who clearly benefited from anti-epileptic medication simply did not take the medication. How much more challenging is achieving adherence for health measures such as regular exercise and good nutrition when sedentary activities and tempting desserts surround us. Sometimes, even motivated individuals may find adherence difficult. For example, one's established exercise regimen is quashed by a knee injury or another physical ailment. Or how to prepare nutritionally sound meals that are also tasty may be elusive for those used to cooking with gobs of butter and salt. However, more often the problem is behavioral: we know what to do, but actually practicing healthy behavior is difficult.

The threat of Alzheimer's disease is so pervasive—upwards of 40% of the population will suffer from the disease at age 85 and an even higher percentage will have some degree of cognitive decline—that we need a community-wide response. Our communities band together admirably when disasters strike and the looming Alzheimer epidemic is an impending disaster in slow motion. Of course the list of so-called 'impending disasters' from environmental to economic collapse is long, and each vies for our attention. But few of them have such a straight forward 'work-around' solution that does not carry an extravagant price tag.

Until a cure for Alzheimer's disease emerges, the establishment of community-based centers that focus on cognitive health could make a significant dent in the problem. Detrimental health practices such as smoking or poor nutrition or a myriad of other unhealthy behaviors are generally acquired, reinforced, and sustained within social networks. Recent data has shown how smoking cessation travels through a social network (*N Engl J Med* 2008:358;2249-2258) and clearly demonstrates that the networks which link us as a community can be harnessed for health goals. Community-based "brain shops" that are engaging and comfortable and lack the stigma of disease are potentially a powerful inroad to behavioral change. Increasingly, we recognize that the mind is a source of lifelong pleasure—sometimes with physical decline, the mind may become the only source of pleasure—and protecting this resource is paramount.

In Santa Barbara we are testing the utility of a center which helps people maintain a healthy brain. The center is called CFIT (Cognitive Fitness and Innovative Therapies-- www.sbcfit.org). CFIT is designed to provide risk-reduction measures for successful aging to those at risk for age-related cognitive decline or those who suffer from mild cognitive impairment. The programs at CFIT are intended to add value to the existing medical and community services. Importantly, CFIT entry requires that the client have a physician in the community and all suggestions made at CFIT are communicated to the physician of record for implementation. In this manner we are working with the SB medical community to address cognitive decline in elders and prevention in everyone.

On Wednesday August 4th 2010 we will be hosting a doctor's luncheon at CFIT from 12:30 -1:30 PM and we welcome you, our physician colleagues, to tour the facility and join us in a discussion regarding the challenges, and hopes for prevention, of cognitive decline.

Doctors Luncheon Location: The Center for Cognitive Fitness & Innovative Therapies (CFIT)

2409 De La Vina Street (behind Cottage Rehabilitation Hospital)

Free Valet Parking is Available at CRH

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