

Emeritus Professor David Ames  
AO BA MD BS FRCPsych FRANZCP

UoM Academic Unit for Psychiatry of Old Age

National Ageing Research Institute, Howard Florey Research  
Institute, St George's Hospital, and Epworth Camberwell  
[dames@unimelb.edu.au](mailto:dames@unimelb.edu.au)

# **Dementia and Alzheimer's disease – a psychiatrist's view**



*We heard a rumour that Ralph Fiennes  
might be on the flight*

# Conflict of interest declaration

- I have received honoraria for talks/consultancies, assistance with conference attendance, and/or financial support of research from Astra-Zeneca, Eisai, Eli Lilly, Forrest, GSK, Janssen-Cilag, Lundbeck, Novartis, Pfizer, Roche, Sandoz, Sanofi-Aventis, Servier, SmithKlineBeecham, Voyager, Wyeth **but not for 5 years** (darn it)
- Investigator on numerous AD drug trials - currently PI for Florey site for Eli Lilly Amaranth study.
- Former Editor-in-Chief *International Psychogeriatrics* 2003-11
- Member International Psychogeriatric Association, Geelong Football Club, 3 Wagner societies, der Förderverein der Osterfestspiele Salzburg, Glyndebourne Festival Society, Medical Advisory Panel of ADI and former (unpaid) medical advisor to Alzheimer's Australia



**William Beattie Smith**  
**1853 – 1921**

- Born Walker, Northumberland, England, son of a surgeon. Educated Campsie House School, Musselburgh, Scotland, and University of Edinburgh. Licentiate RCP, Edinburgh (1876), and licentiate (1876) and fellow (1879) RCS, Edinburgh, studied mental diseases under Thomas Smith Clouston, the outstanding teacher of his day. Practised Stockton-upon-Tees. 1881 he visited Australia and was appointed RMO Ararat Lunatic Asylum, then promoted to deputy medical superintendent at Yarra Bend Lunatic Asylum. In 1888 returned as medical superintendent to Ararat and developed a small wine-growing industry. In 1899 he became superintendent at the Kew Lunatic Asylum. Encouraged better conditions and treatment for patients.

- He recommended in 1887 a systematic plan of nurse teaching and insisted that attendants have uniforms. Concerned at the lack of knowledge of mental diseases among GPs, he began instruction for medical students at Kew in 1899; attendance was compulsory but there was no exam.
- He was forthright, autocratic disciplinarian who never feared to accept responsibility or to force innovations. He took offence easily, was impatient with his superiors and colleagues and caustic in his communication. In 1900 he came into conflict with the government pathologist and resigned 1902 after a disagreement with the chief secretary. He went into private practice as Melbourne's first full-time alienist. He continued to lecture to Medical Students until 1907 and to serve on a committee to advise the chief secretary, which played a part in the reform of the Lunacy Act in 1903 and 1914, when voluntary treatment was introduced sixteen years before England did so.
- Beattie Smith died, unmarried, of arteriosclerotic heart disease at his East Melbourne home on 12 December 1921, and is buried in Brighton cemetery. He left £1000 to the University of Melbourne for an annual lecture on insanity, to be named after him. By 1994 the sum had grown to \$6500. The lecture has been held since 1925.

- William Beattie Smith bequeathed "to the University of Melbourne £1000" and directed "that the annual interest on same be used to establish 'a few' annual lectures on the early treatment of insanity as I consider the practitioner and the public are in need of much education in regard to this subject."
- The income is devoted to the provision in each year of a few lectures on the early treatment of mental illness having regard to causation, pathology, symptoms, diagnosis, prognosis, therapeutics, control and prevention or any of these. Such lectures may be directed in any year wholly or in part specially to medical practitioners or specially to the public.
- 1925-2017 -114 lectures by 83 lecturers including my mentors Herbert Bower, Brian Davies, Anthony Mann and Ed Chiu and on topics relating to Old age psychiatry or dementia 2 lectures by Herbert Bower 1963 (Sociological and Psychiatric Aspects of Old Age in Western Society), and one each by Ross Anderson 1987 (The Choroid Plexus and Dementia), Ed Chiu 2002 (Silly Old Buggers: Ageing Mental Health and Society) and Henry Brodaty 2007 (The Rise and Surprise of Old Age Psychiatry)

SENILE DEMENTIA? - ISN'T THAT  
WHEN ELDERLY CLIENTS DISAGREE  
WITH YOU ABOUT WHAT'S BEST FOR THEM?



# What is dementia?

An acquired decline in higher mental function occurring in an alert patient, due to organic brain disease, producing decline in multiple higher mental functions (memory, intellect, personality) which results in significant impairment in social or occupational functioning.

Most dementia is irreversible and progressive.

Prevalence doubles every 5 years from ages 60 to 90

7 or 8 out of 10 die without dementia

Now Major Neurocognitive Disorder USA DSM5

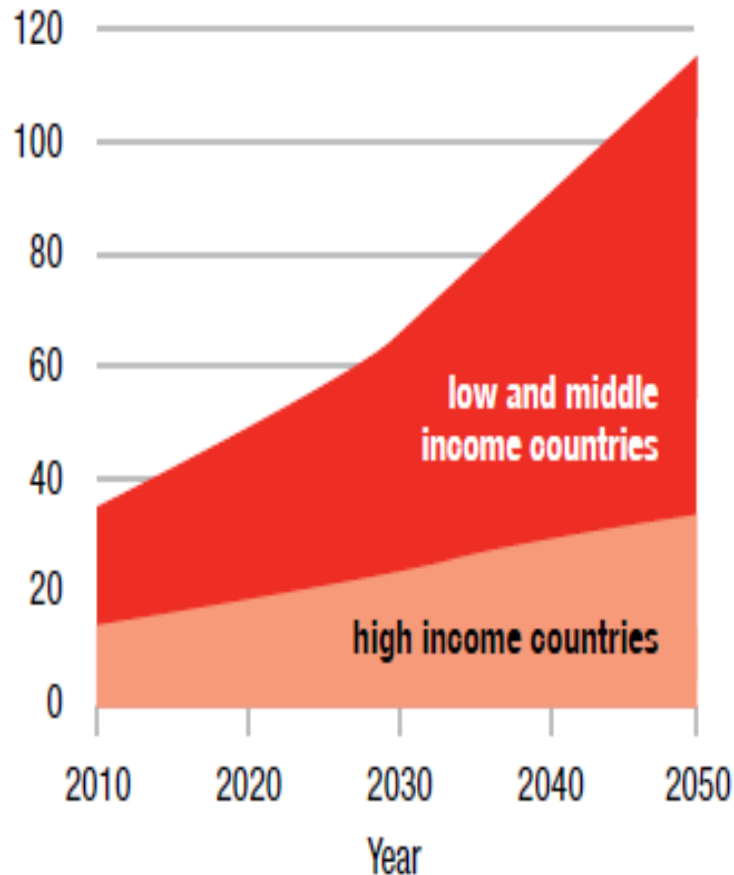
OLD MOTHER HUBBARD  
WENT TO THE CUPBOARD...



Sesq Thompson

# Growth of numbers of people with dementia

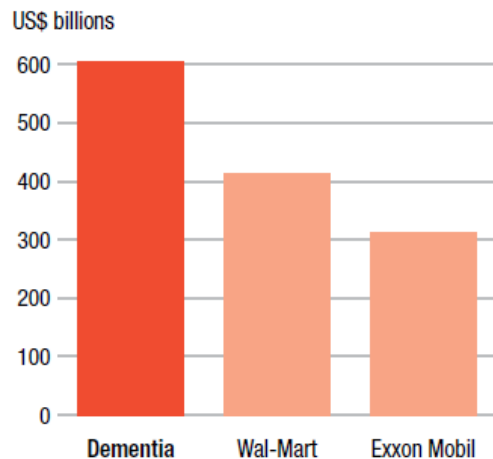
Numbers of people with dementia (millions)



- **The World Alzheimer Report (2009) estimated:**

- **35.6 million people living with dementia worldwide in 2010**
- **Increasing to 65.7 million by 2030**
- **115.4 million by 2050**

# Worldwide cost of dementia

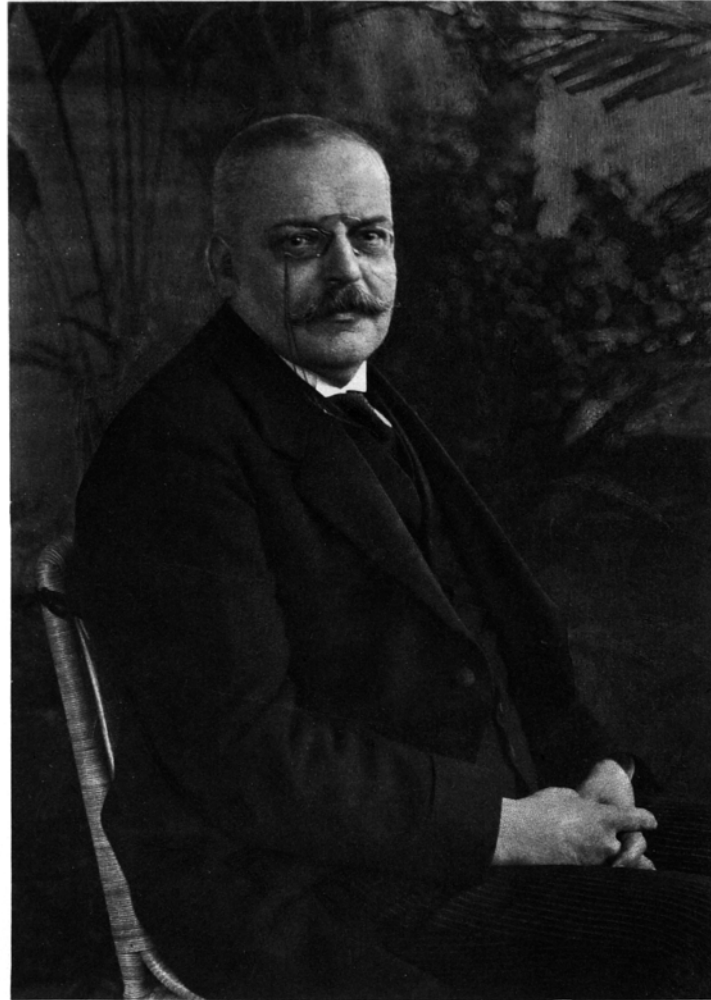


- The societal cost of dementia is enormous.
- Dementia affects every health and social care system in the world.
- The economic impact on families is insufficiently appreciated.
- The total estimated worldwide costs of dementia were US\$604 billion in 2010.
- These costs were around 1% of the world's GDP
  - 0.24% in low income**
  - 1.24% in high income**

# Mild Cognitive Impairment MCI

- Historically concept evolved since 1962 through benign senescent forgetfulness, age associated memory impairment, CIND etc
- 1.5 SD below the age & education adjusted mean on at least one neuropsychological test
- Complaint of memory impairment
- Substantially intact ADL & not demented
- Intermediate state between healthy cognition and dementia
- In clinic based studies 10-20% annual rate of AD dementia development
- One third never progress to develop dementia

# Alois Alzheimer (1864-1915)



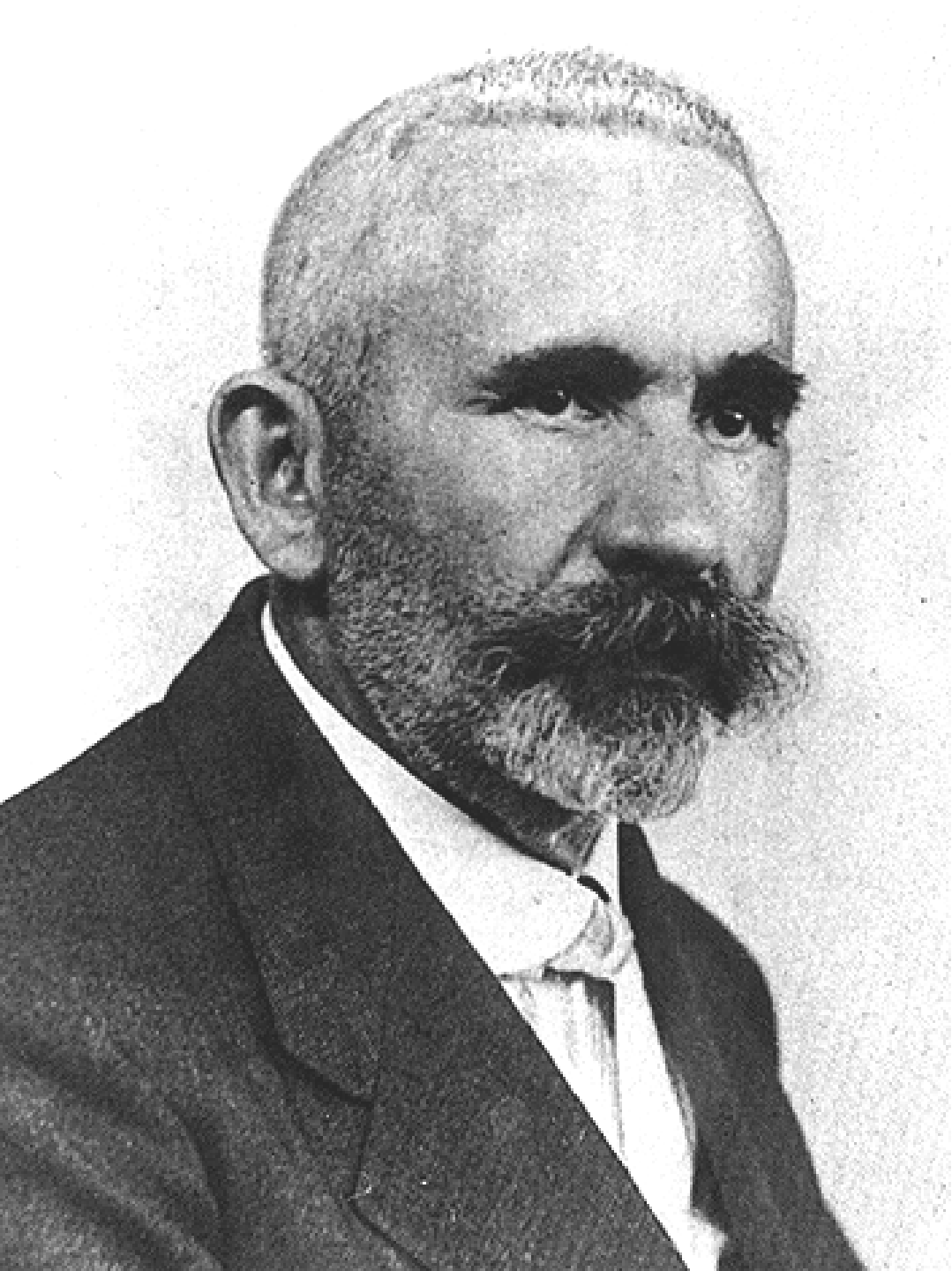
Verlag von Julius Springer, Berlin.

Hel. Meisenbach Riffarth & Co. Berlin.

*Alzheimer*



**Figure:** Auguste D, June 18, 1902 at asylum for the insane and epileptics in Frankfurt on Main

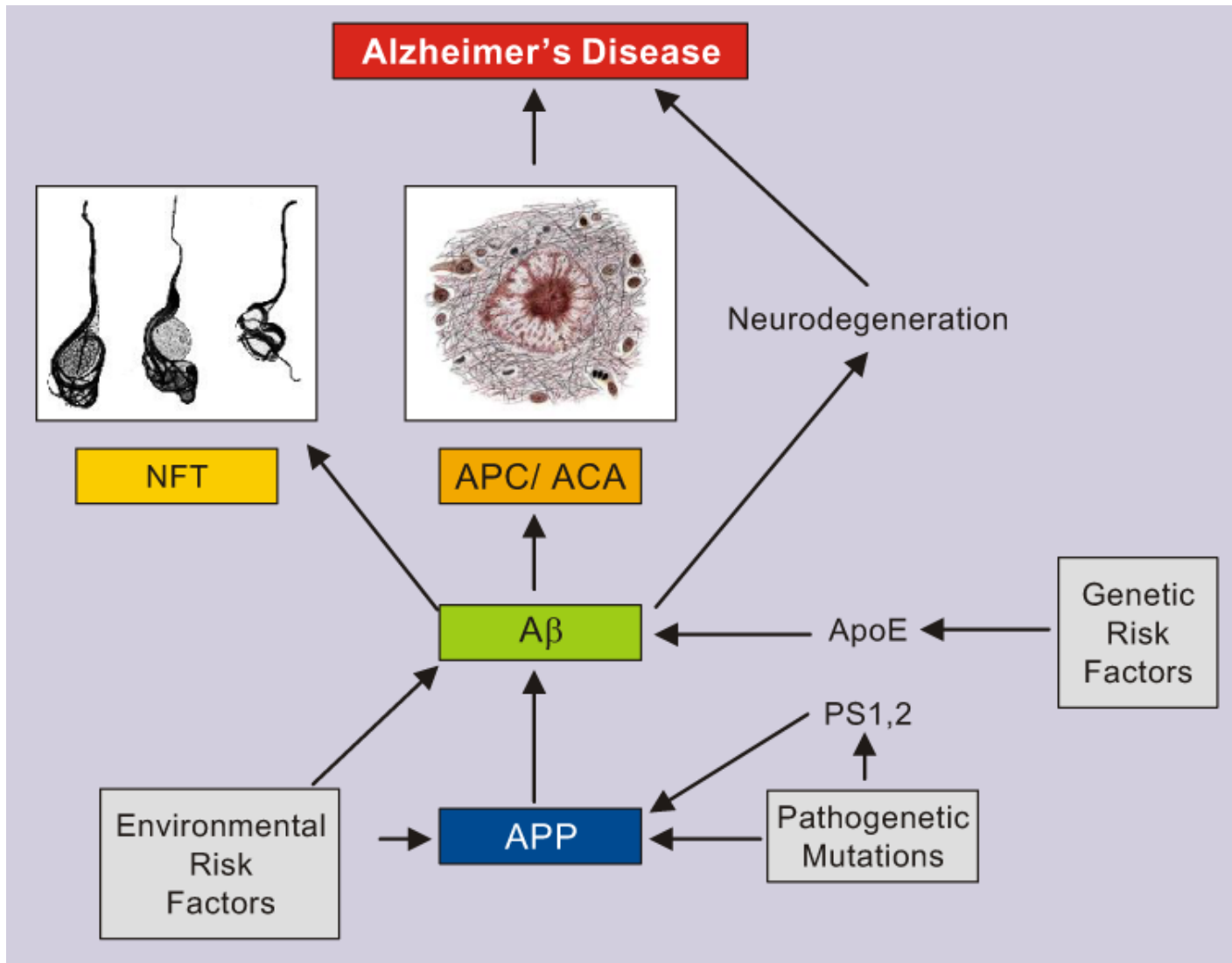


Emil Kraepelin

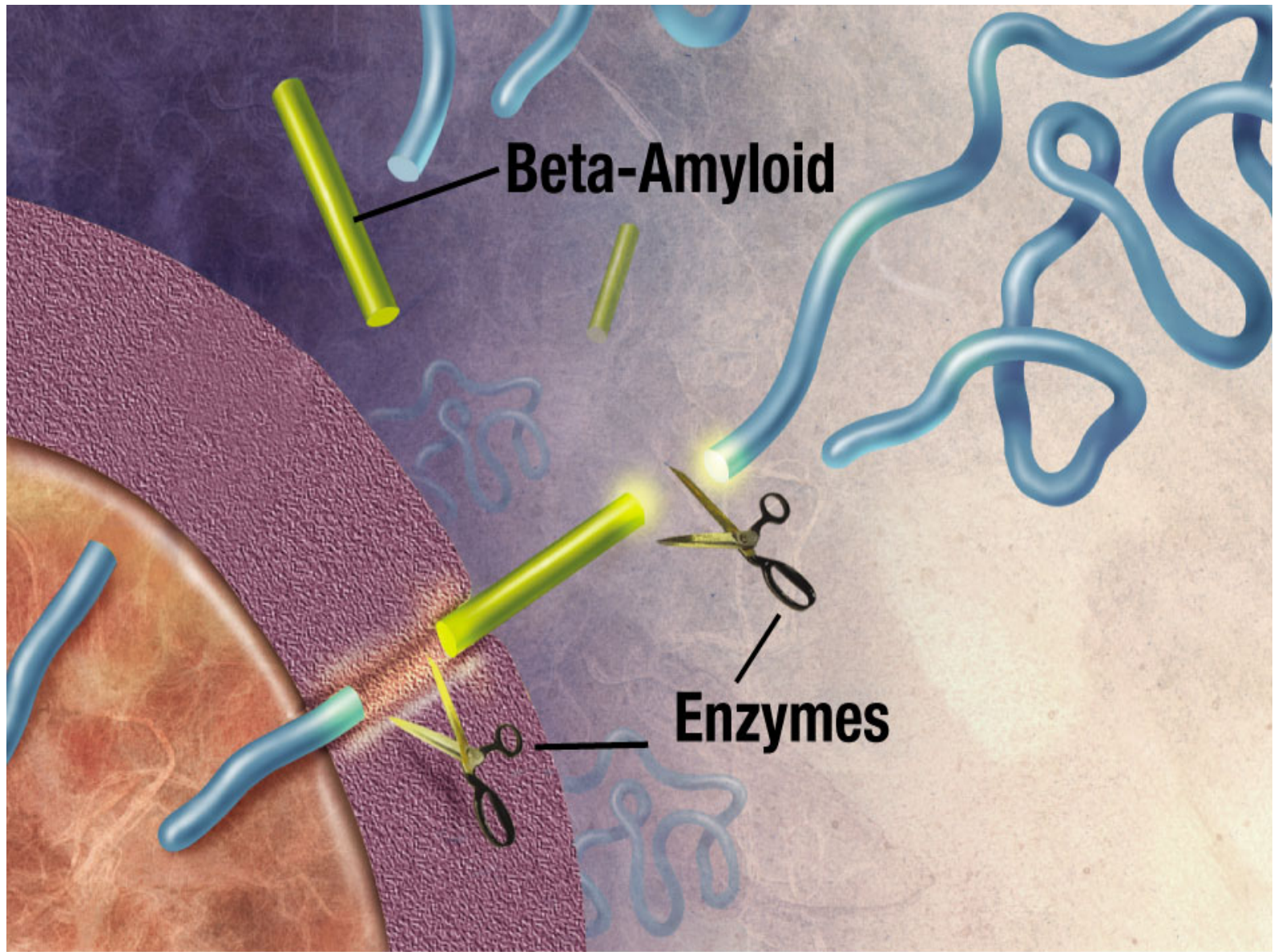
# Alzheimer's disease

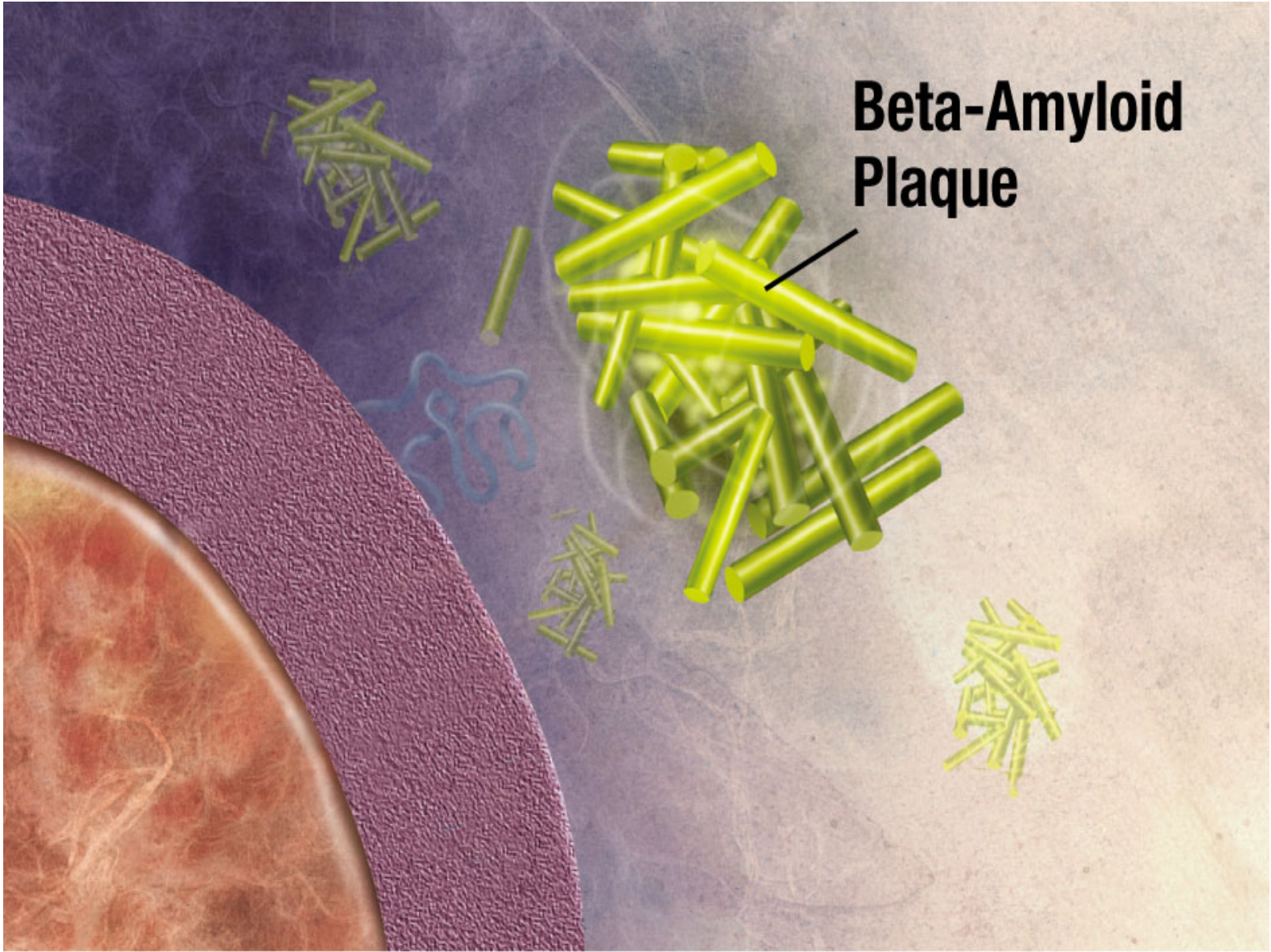
- Causes or contributes to 50-80% of all dementias
- Characterised by insidious onset and slow steady progression of deficits – 30 year incubation
- Initially new learning is affected, later praxis, language and some frontal functions will deteriorate
- Pathological hallmarks are plaques (amyloid) between cells and tangles (tau) within neurons
- Appears related to breakdown of amyloid precursor protein leading to amyloid production
- Main risk factors are unmodifiable – age, family history, APOE  $\epsilon$ 4, female sex, but potentially modifiable may include head injury and vascular risk factors – maybe depression and hearing impairment too
- No perfect diagnostic test (even amyloid imaging imperfect); clinical diagnosis correlates 80-90% with autopsy findings in experienced hands
- Typical course 7-10 years from onset of dementia to death

# The amyloidocentric theory of Alzheimer's disease









**Beta-Amyloid  
Plaque**

# Compelling evidence for the A $\beta$ theory of AD

- A $\beta$  is the major macromolecule in the AD plaque
- Mutations in APP and gamma-secretase (PS1, PS2) cause AD
- Correlations of AD with PiB-PET and CSF A beta<sub>42</sub> (↓)
- Pathologic lesions of AD occur in Down's Syndrome (APP triplication)
- Zn / Cu interactions with A beta explain the selective topography of AD in the excitatory glutamatergic system
- ApoE polymorphism – the only major genetic risk factor - may act through A $\beta$  clearance pathway
- Preliminary evidence of 1-2% loss of clearance capacity of A $\beta$  in sporadic AD (Bateman)
- Preliminary evidence that therapeutic targeting of A $\beta$  is effective (e.g. aducanumab)
- **Alternate theories not developed**

# Creation of academic posts in Old Age Psychiatry 1989-1990 – Chiu, Ames, O'Connor

- So what have we been doing about it since then?
- Services including Memory Clinic
- Assessment instruments
- Treatment studies
- Carers
- BPSD/Neuropsychiatric symptoms
- Biomarkers including imaging and genetics
- AIBL study
- Diet and Lifestyle
- Lancet Dementia Commission
- Education and training
- The future

# Research on Services

- **AMES D, FLYNN E & HARRIGAN S.** (1994) Prevalence of psychiatric disorders among inpatients of an acute geriatric hospital. Australian Journal on Ageing, 13: 8-11.
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# Dementia in the General Hospital

- **Psychiatric disorders among elderly patients in a general hospital.**  
[Ames D](#), [Tuckwell V](#).
- Of 495 enrolled patients, 204 were aged over 65 years; 167 could be interviewed; 18% showed evidence of organic mental impairment, 27% were depressed and 2% had other psychiatric disorders. Some mental state findings were recorded on admission for only 25% of patients, 52% of patients were prescribed hypnotic or psychotropic drugs and 30% of the psychiatric disorders identified by the survey were mentioned in the discharge summary.
- Screening for psychiatric disorders in this setting was not routine. The frequency of such disorders makes it desirable to conduct prospective evaluation of the use of brief cognitive and depression screening instruments on admission to hospital.

- March 1988 Melbourne's first Memory Clinic founded by Leon Flicker & David Ames, support from NARI and UoM Dept Psychiatry
- First 100 patients - mean age 75.5 years and 75 were women: 74 met DSM-III-R criteria for dementia and a further 13 had other organic brain syndromes.
- Of the next 577 patients seen mean age was 72.9 years and 60.8% were female. Over 40% fulfilled ICD-10 diagnostic criteria for dementia in Alzheimer's disease. A further 24% had another dementing illness.
- Clinic formed model for statewide CADMS clinics introduced in 1998

# Memory Clinics

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An Australian Government Initiative

STV



Helping Australians with dementia,  
and their carers

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Plus 2 Lazabemide studies, and studies of efficacy of Milameline, Rasagaline, Servier compound for MCI (poison), Xaliproden, Rosiglitazone, Memantine, Lilly Xsecretase inhibitor, Dimebon, Lundbeck compound and Amaranth  $\beta$ -secretase inhibitor in AD/MCI.

# Carers

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*'Some people feel they've entered a dark, claustrophobic place from which there's no escape. They feel like a trapped rat. Hope you're not one of those.'*

# Imaging Research Phase 1

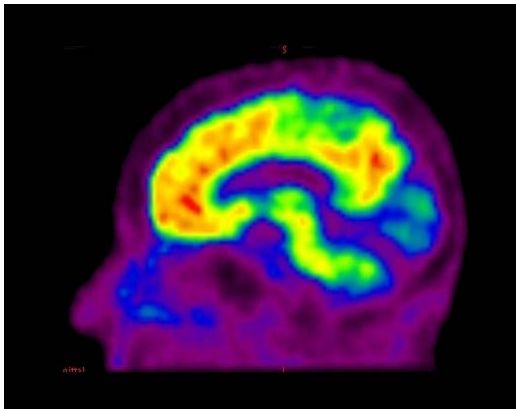
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# The Australian Imaging, Biomarkers and Lifestyle Flagship Study of Ageing – an example of Australian research on Alzheimer’s disease



# AIBL: Two site collaborative study 2006-2018 – CSIRO \$3M initiative 2005

Study is conducted at two sites: Perth (40%) and Melbourne (60%).

CSIRO Preventative Health Flagship  
University of Melbourne  
Neurosciences Australia Ltd (NSA)  
Edith Cowan University (ECU)  
Mental Health Research Institute (MHRI)  
National Ageing Research Institute (NARI)  
Austin Health  
University of WA (UWA)  
CogState Ltd.  
Charles Gairdner Hospital  
Alzheimer's Australia  
Macquarie University





## The Australian Imaging Biomarkers and Lifestyle Study of Ageing

**Commenced 2006**

**Amyloid PET + MRI with follow-up in 288 of the 1112 original  
participants.**

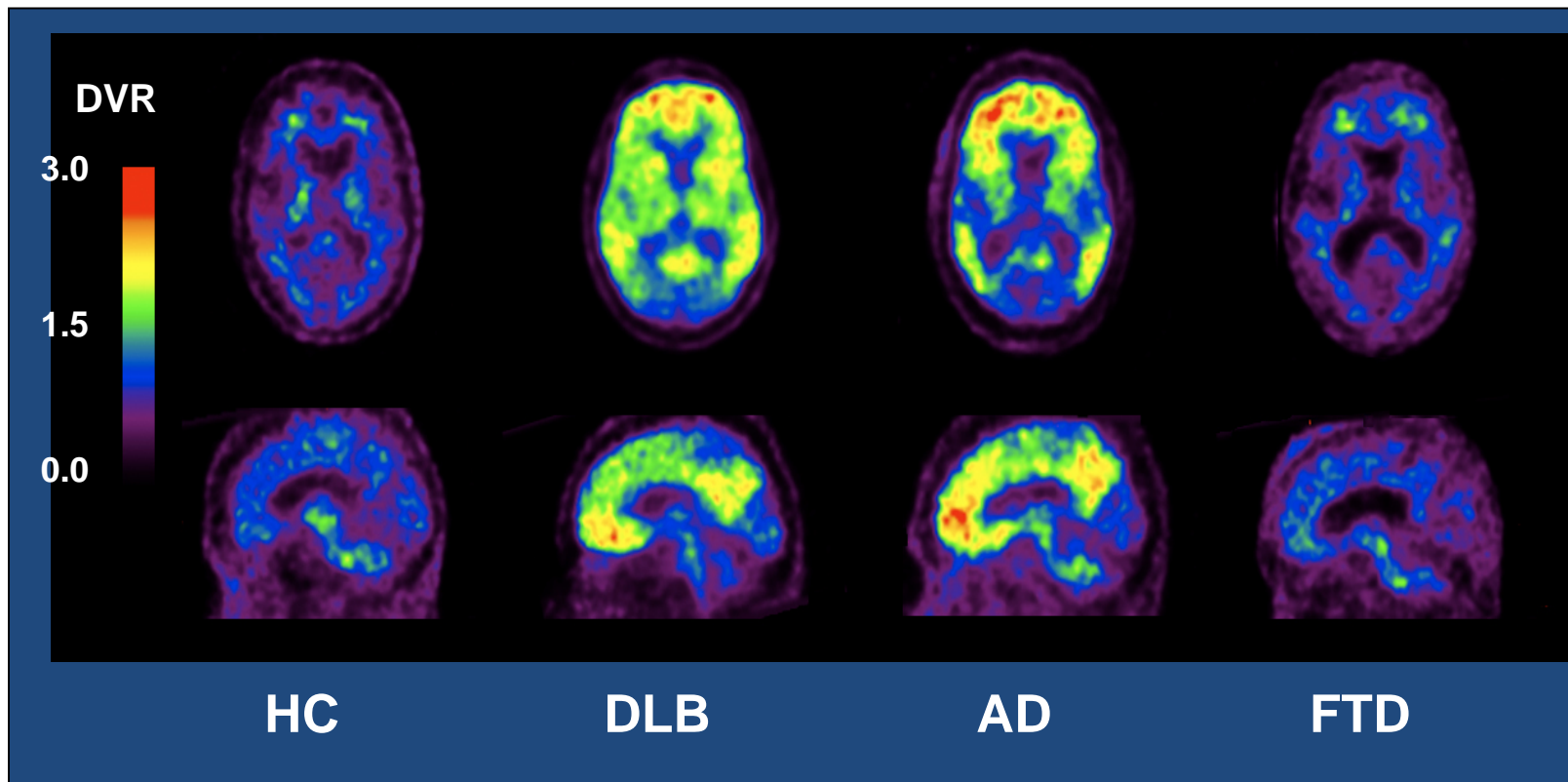
**Now in 1,515 of 2,135 participants (November 2017)**



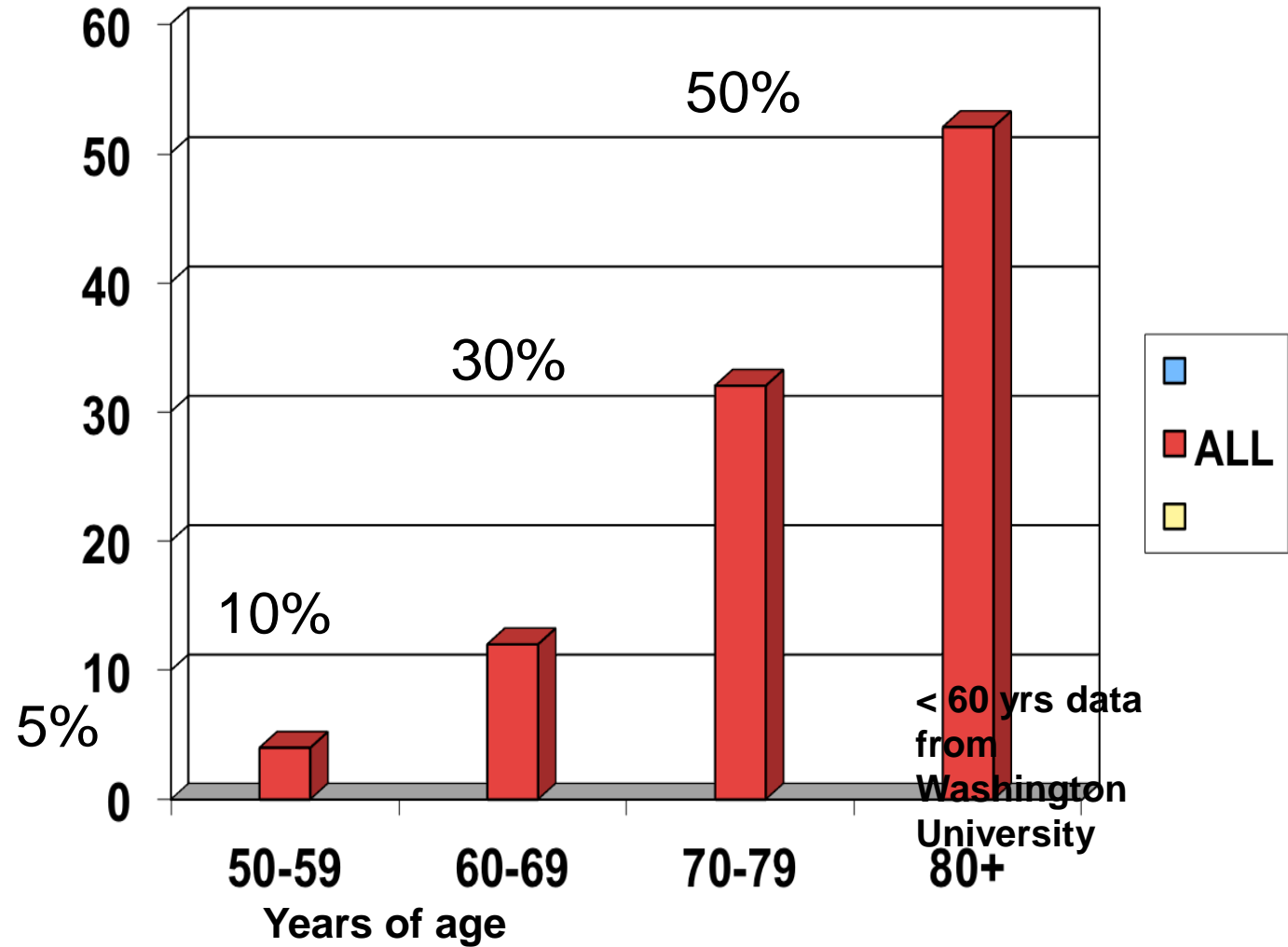
## Imaging Beta-amyloid Burden in Aging and Dementia

Beta-amyloid PET inventors: **Chet Mathis, William Klunk** (*University of Pittsburgh*)

*First Publication 2004.*



# % of healthy population who have plaques



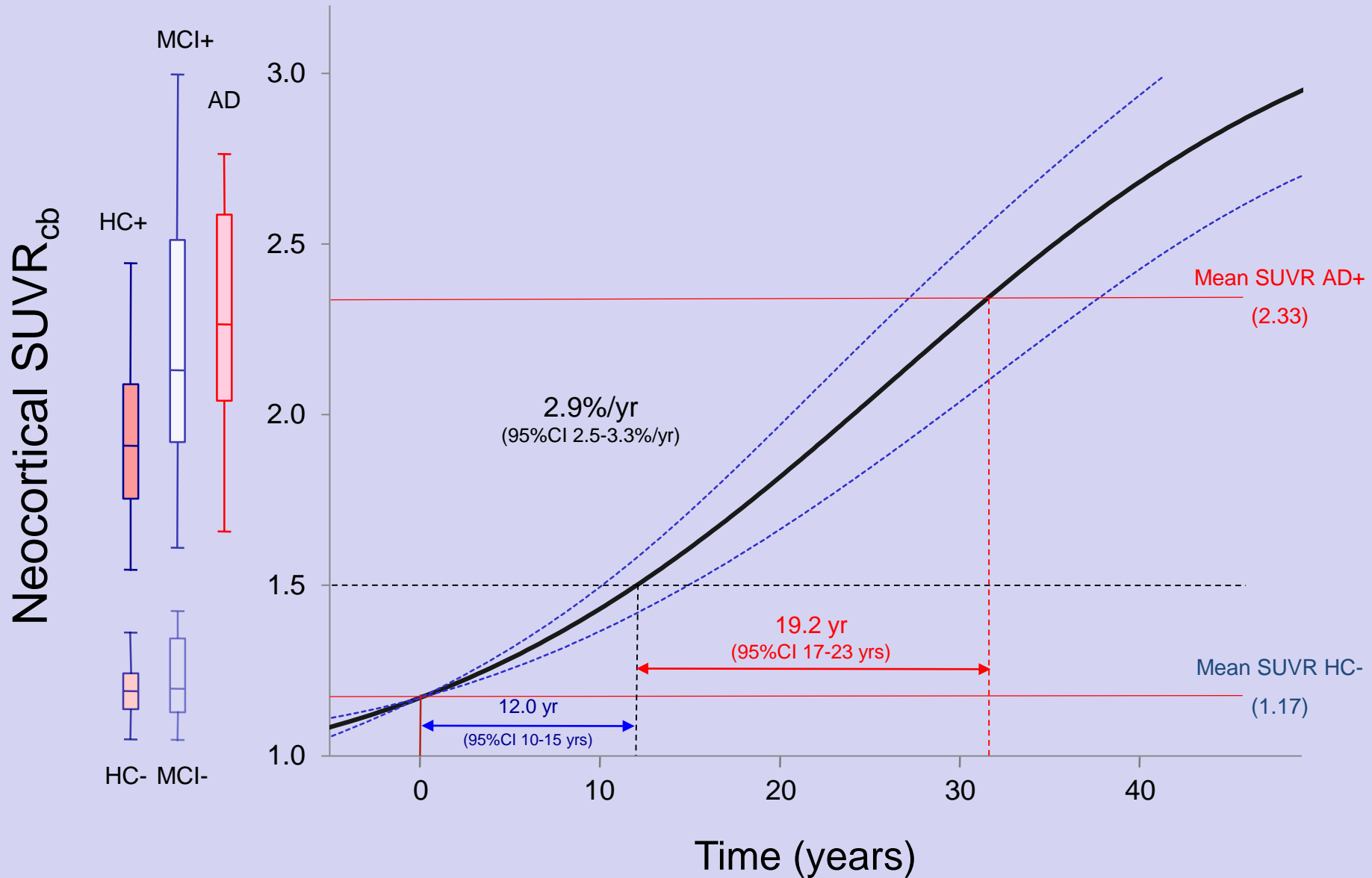
## Achievements of A $\beta$ PET imaging

- Improved diagnosis of AD vs FTD
- Earlier diagnosis of AD in MCI phase (“Prodromal” AD)
- Opened a broad window (15 years) for preclinical intervention
- Improved subject selection for therapeutic trials
- Measures effectiveness of anti-A $\beta$  agents
- Permits the study of AD related pathology in non-demented persons and its relationship to genetic and potentially modifiable environmental factors.

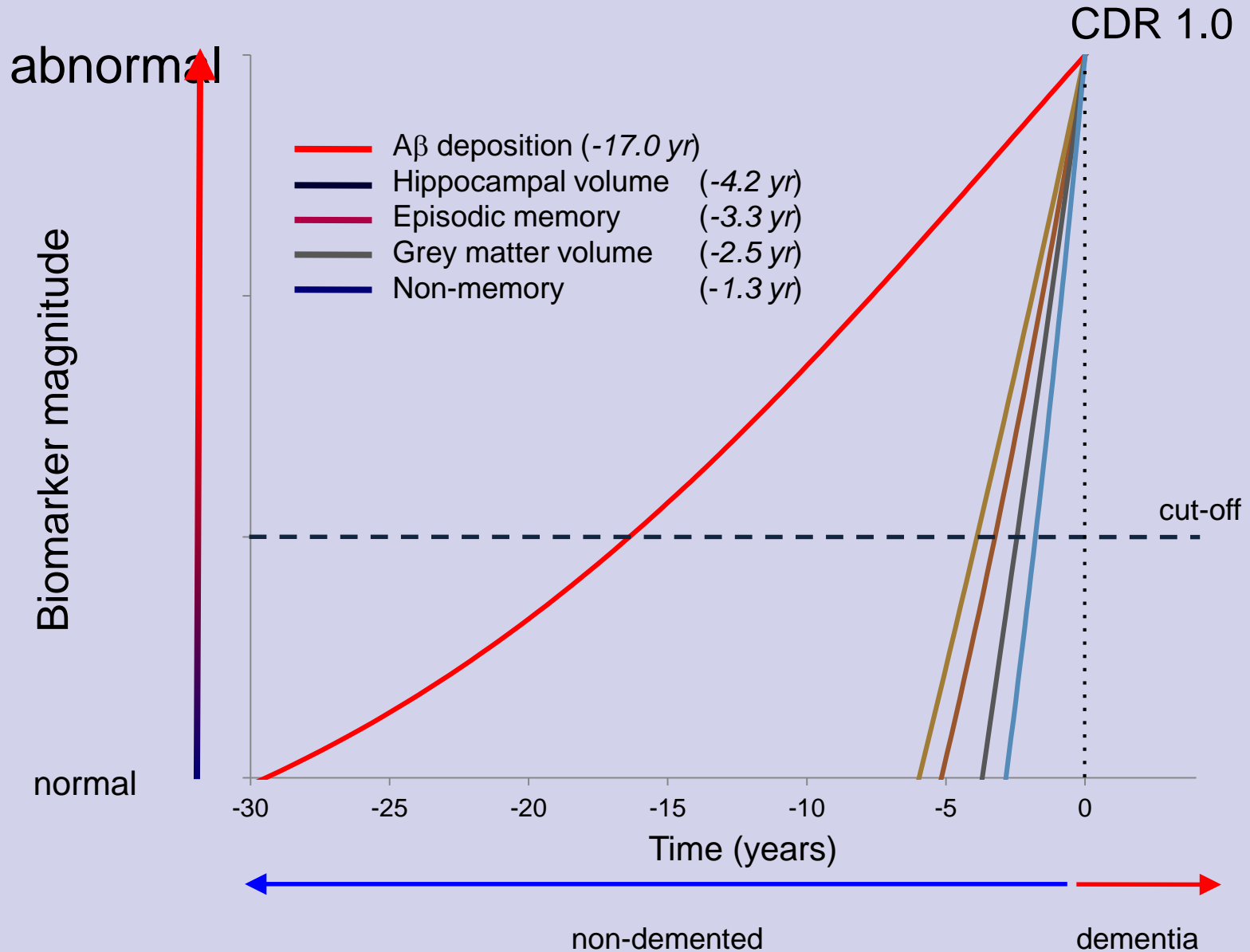
# Prediction of Progression: MCI to AD (at 36 months follow-up)

	<i>ACCURACY</i>	<i>Odds Ratio</i>	<i>NPV</i>
PiB+ve (SUVR >1.5)	0.80	25	0.93
ApoE $\epsilon$ 4+	0.76	10	0.80
Composite Memory (<2.0)	0.70	6	0.81
Hippocampal atrophy	0.68	5	0.75
PiB+ve plus Hippo atrophy	0.89	>100	1.00

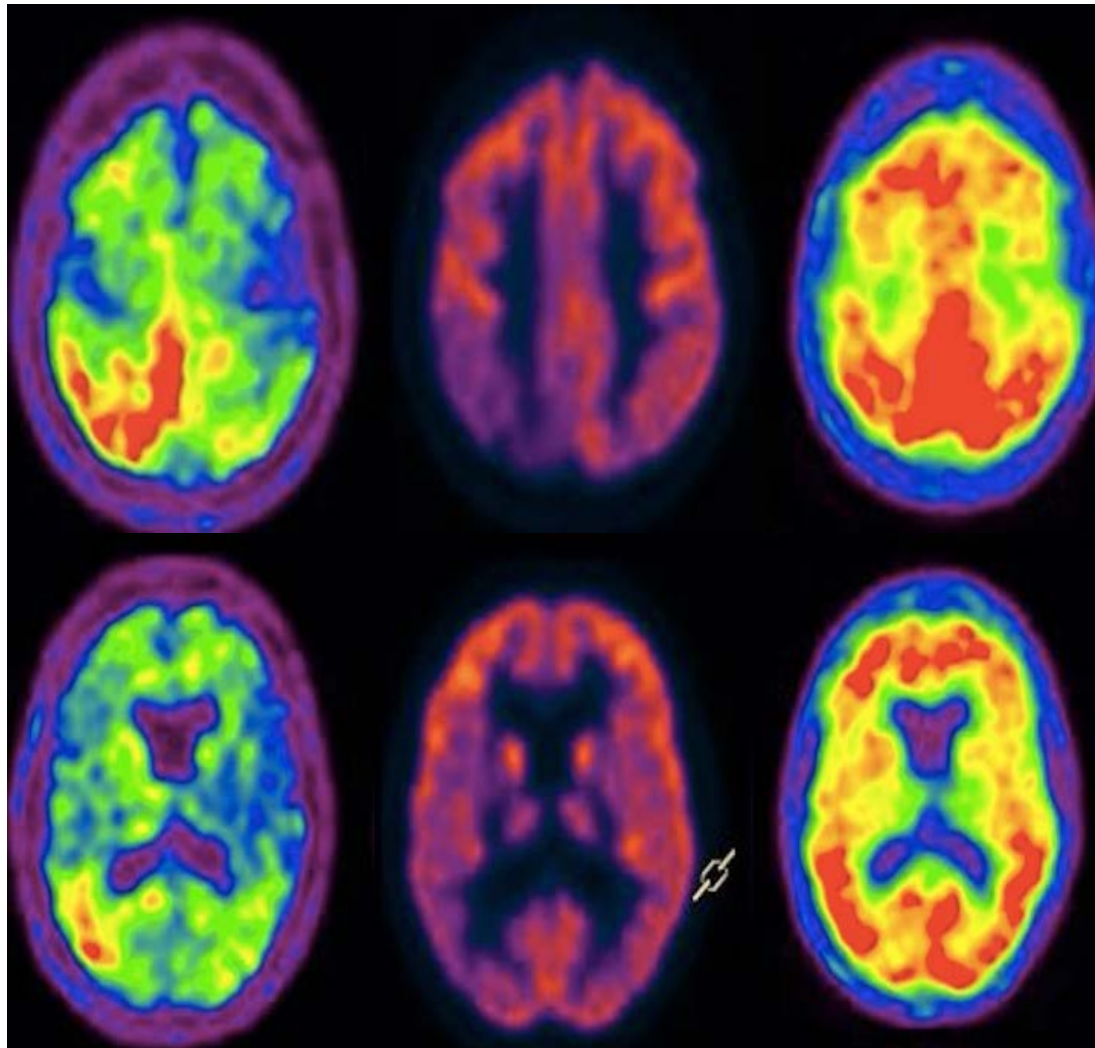
# AIBL: A $\beta$ deposition over time



# Relationship between “abnormality” and CDR of 1.0



Tau deposition corresponds to reduced regional perfusion and metabolism while amyloid is diffuse



Tau PET

rCBF PET

Amyloid PET

# AIBL Publications in peer-reviewed journals to November 2017

- 2007 – 4
- 2008 – 1
- 2009 – 8
- 2010 – 8
- 2011 – 16
- 2012 – 21
- 2013 – 37
- 2014 - 31
- 2015 - 31
- 2016 – 25
- 2017 - 30
- 2018 - 10 to date
- Total – at least 206

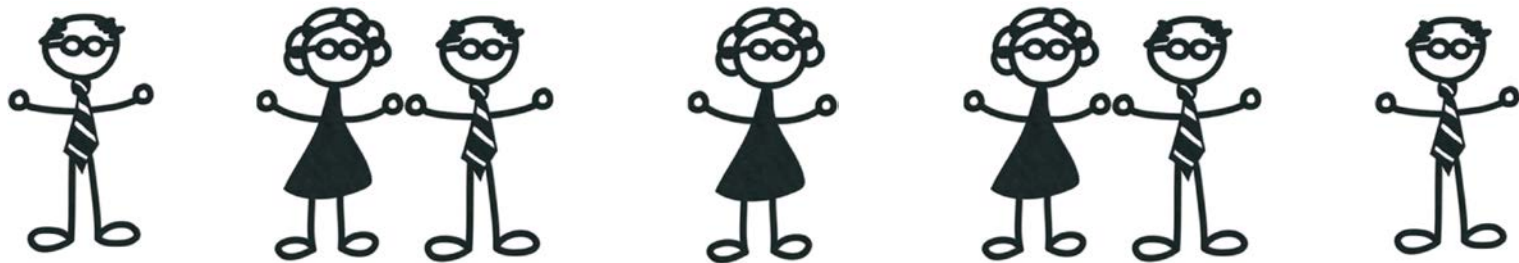
# Key Publications

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- BROWN B, *et al.* (2016) The relationship between sleep quality and brain amyloid burden. *Sleep*, 39: 1063-1068. doi: 10.5665/sleep.5756.
- HARRINGTON K *et al.* (2017) Using robust normative data to investigate the neuropsychology of cognitive aging. *Archives of Clinical Neuropsychology*, 32: 142-154. doi: 10.1093/arclin/acw106. **This paper won the 2017 Nelson Butters Award for Research Contributions to Clinical Neuropsychology, presented by the National Academy of Neuropsychology for the best paper of the year in the journal *Archives of Clinical Neuropsychology*. This was the second year in a row that these authors won the award.**
- PEDRINI S *et al.* (2017). A blood-based biomarker panel indicates IL-10 and IL-12/23040 are jointly associated as predictors of  $\beta$ -amyloid load in an AD cohort. *Scientific Report*, in press, accepted 26/9/17.



# AIBL Collective Remembering Project

Prof Amanda Barnier, Macquarie University



# Memory and collaboration

- We believe that through relationships with other people we develop expert “remembering systems” that have cognitive payoffs, such as the ability to recall more information with another person than if we recalled alone
- However, most attempts to demonstrate this in the lab have actually shown the opposite. That is, people typically recall less with another person than if they did this individually. We call this “collaborative inhibition”



# Memory and collaboration over a lifetime

- One explanation for collaborative inhibition is that the groups tested (typically young university students) have not had the time, nor the intimacy, to develop the specific knowledge and strategies that *facilitate* the memory of their partner
- One group we believe this would not apply to is **long-married couples**. With the help of **AIBL** we sought to investigate whether such couples did help each other recall more information



# Real example of how hearing difficulty influences performance

**Husband:** Scotland. Ireland. England. France. Germany.

Luxembourg. Norway. Holland. Um. Sweden.

**Wife:** *I'm having terrible trouble hearing you.*

...

**Husband:** Greenland.

**Wife:** *Hmm?*

**Husband:** Greenland I said.

**Wife:** *Speak up!*

**Husband:** Greenland! Turkey. No Turkey.

That's not part of Europe. Belgium.

**Wife:** *Norway. Sweden. Finland.*

**Husband:** Scotland.

**Wife:** *I don't think we said Wales. Jutland.*

**Husband:** *Hmm? Did you say Denmark?*

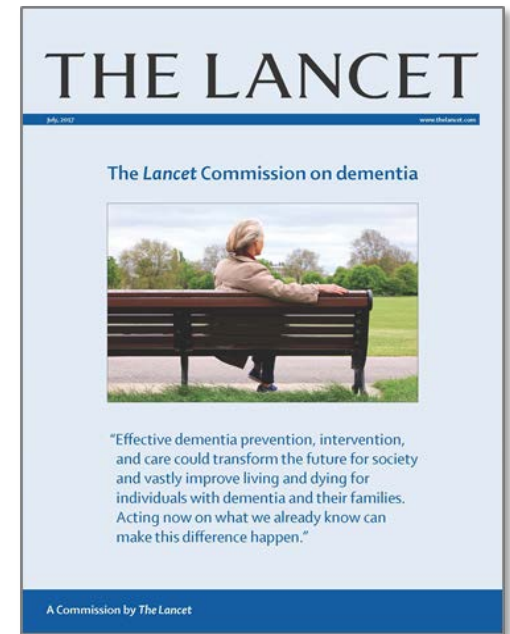


# Diet and Lifestyle

- Nicola Lautenschlager et al.
- FABS 2008 MCI & SCD - exercise helps cognition (a bit)
- FABS 2 AD - subjects' health benefited but cognition did not
- **AIBL Active** - Changes in body mass, composition & distribution resulting from increased PA are positive health benefits for this target group
  - Imaging results to come
- **Physical Activity Guidelines for SCD and MCI**  
[www.unimelb.edu.au](http://www.unimelb.edu.au) go to medicine and select psychiatry then to AUPOA
- Belinda Brown et al.
  - Mediterranean diet – associated with better cognition – cause or effect?

Lancet commission

# Dementia prevention, intervention, and care



## Gill Livingston

Andrew Sommerlad, Vasiliki Orgeta, Sergi G Costafreda, Jonathan Huntley, David Ames, Clive Ballard, Sube Banerjee, Alistair Burns, Jiska Cohen-Mansfield, Claudia Cooper, Nick Fox, Laura N Gitlin, Robert Howard, Helen C Kales, Eric Larson, Karen Ritchie, Kenneth Rockwood, Elizabeth L Sampson, Quincy Samus, Lon S Schneider, Geir Selbæk, Linda Teri, Naaheed Mukadam

Partners **UCL, AS, ESRC, ARUK**

# Key areas

- Prevention
- Intervention
- Care

# 10 Key headline messages

- **The number of PWD is increasing globally**
- **Be ambitious about prevention**
- **Treat cognitive symptoms**
- **Individualise dementia care**
- **Care for family carers**
- **Plan for the future**
- **Protect PWD**
- **Manage neuropsychiatric symptoms**
- **Consider end of life**
- **Technology**

# Teaching

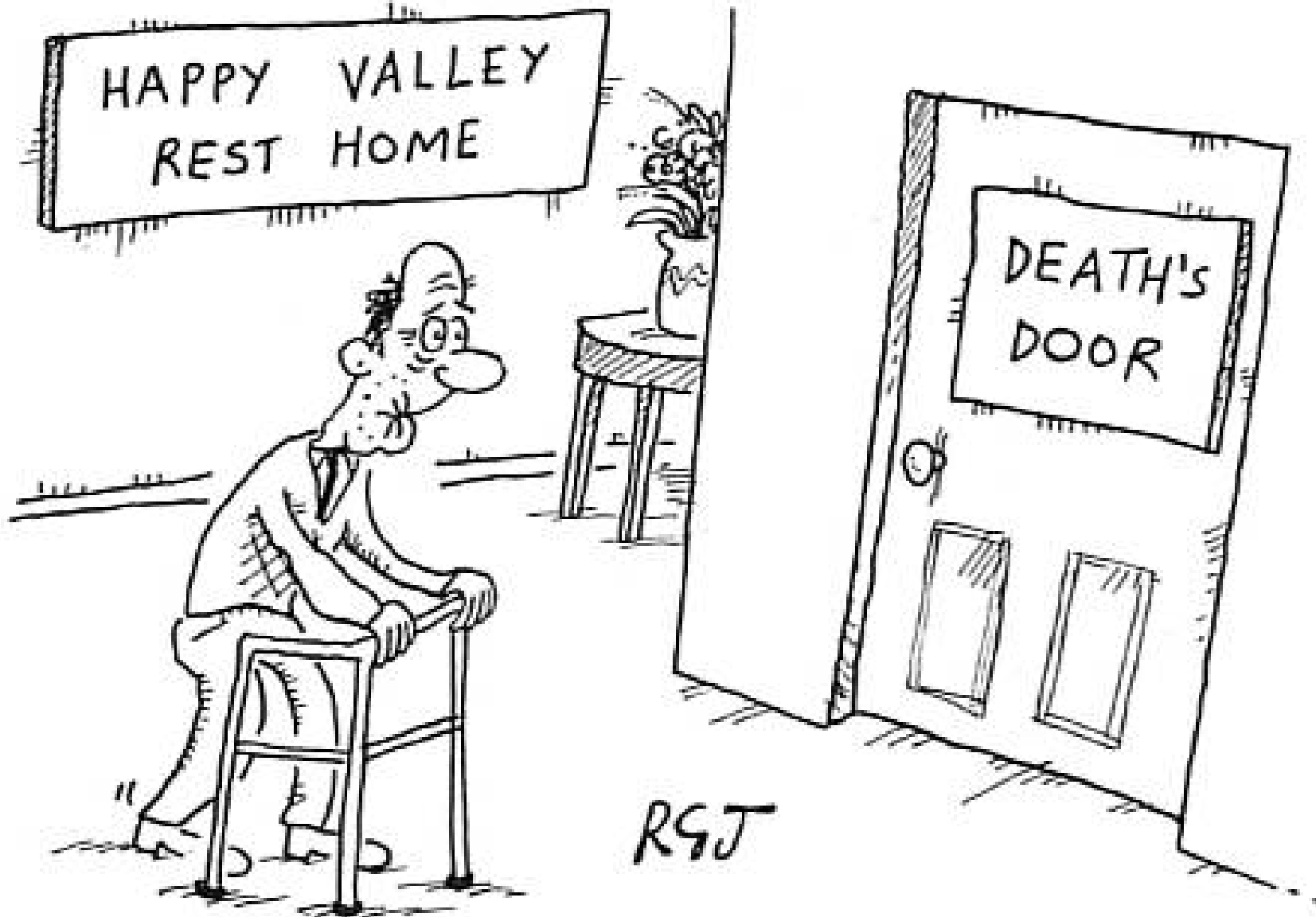
- Nursing and allied health
- Medical students
- Psychiatry trainees
- PhD supervision
- Other postgraduate and public education

# The Future

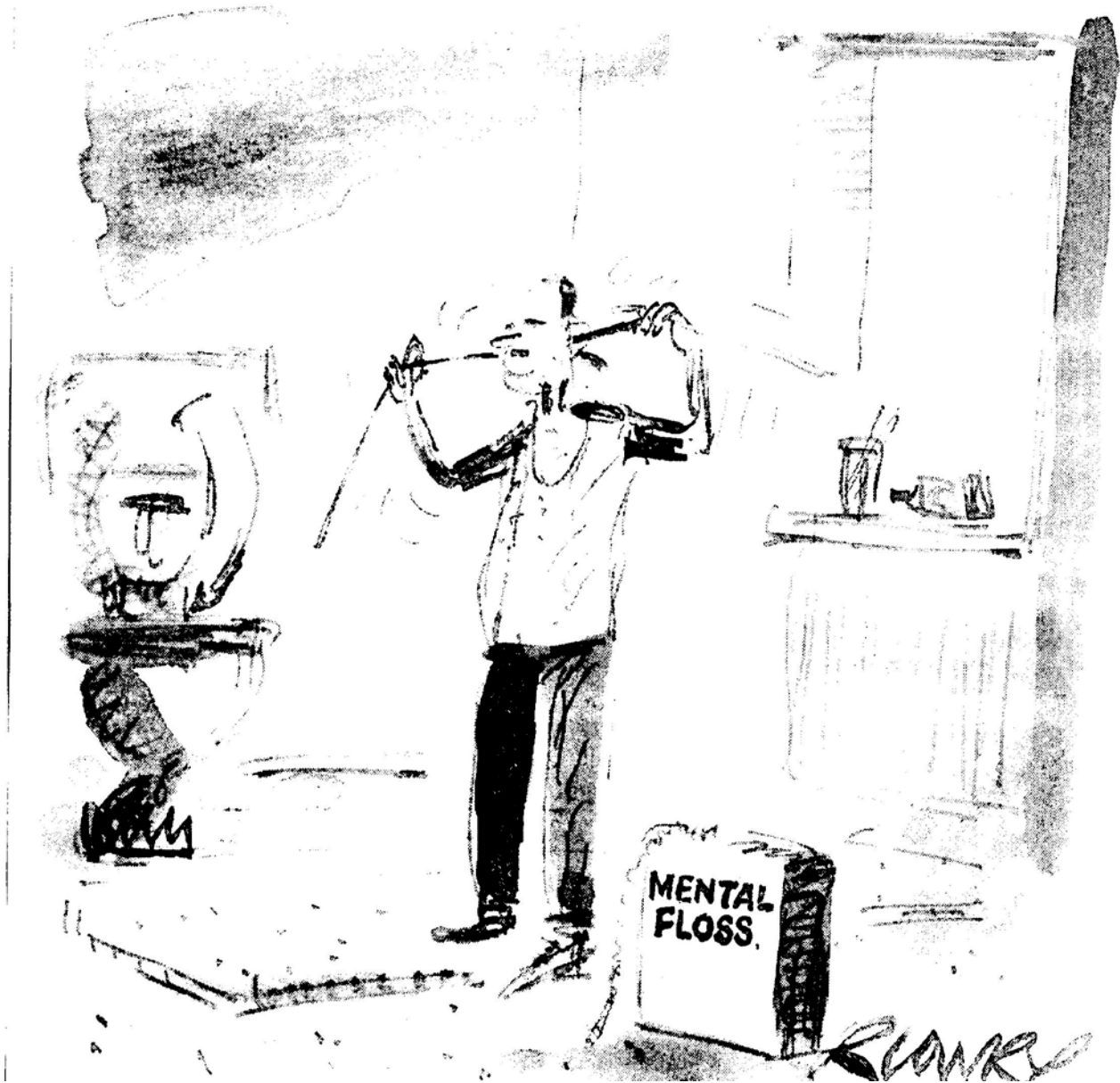
HAPPY VALLEY  
REST HOME

DEATH'S  
DOOR

RSJ







# Current Trials For Alzheimer's Disease:

- Symptomatic Treatment
- Anti-amyloid (antibodies, BACE-1 inhibitors)
- Anti-tau

Across the preclinical, prodromal and AD dementia spectrum

# Are we already winning?

- Age-specific prevalence of dementia reported to be falling in some populations
  - 2005 Duke, USA – prevalence of severe cognitive impairment fell between 1982 and 1999
  - 2013 Cognitive Function and Ageing Study (CFAS, UK)
    - 2 cohorts of >65 year-olds assessed 20 years apart (1990-93, 2008-11)
    - 24% decrease in prevalence of dementia (Odds Ratio 0.7 [95% C.I. 0.6-0.9, p=0.003] in the later cohort
  - 2013 Christensen et al (Denmark)
    - Compared individuals born in 1905 (at age 93, n=2262), to those born in 1915 (at age 95, n=1584).
    - More recent (1915) cohort scored higher on cognitive tasks and ADL scores (plus more lived longer)
  - 2015 PAQUID Cohort, Bordeaux, France
    - 2 cohorts aged >65y, 1988-89 (n = 1,469) and 1999-2000 (n = 2,104)
    - 40% decline in dementia incidence between two cohorts
  - 2016 Framingham cohort
    - 5,205 persons aged >60y assessed each decade from 1975 to present
      - Reduction in dementia incidence by 22%, 28%, 44% respectively
      - Despite increases in BMI, Diabetes, and population ageing
      - Findings not completely explained by trends to better VRF management
      - Risk reduction only observed in those with at least High School Diploma

UNITED STATES OF AMERICA  
**MARINE ONE**  
December 15, 2014



Welcome

Aboard



# Thank you

- **Schoolteachers**

- Amelia Greenfield
- Mervyn Callaghan
- Ian Collier
- Michael Collins Persse
- Tommy Garnett
- Dick Johnson

- **University Teacher**

- Herbert Bower

- **Mentors**

- Ed Chiu
- Brian Davies
- Nori Graham
- Anthony Mann
- Bruce Singh

- **Collaborators**

- Nick Allen
- Deborah Ashby
- Kerryn Bennetts
- Nick Bradfield
- Henry Brodaty
- Rachel Buckley
- Sam Burnham
- Alistair Burns
- Ashley Bush
- Esther Cerin
- Gael Chételat
- Terry Chong
- Michael Connors
- Liz Cyarto
- David Darby
- Patricia Desmond

- Briony Dow
- Colleen Doyle
- Kathryn Ellis
- Leon Flicker
- Chris Fowler
- Steve Gibson
- Anita Goh
- Suzy Harrigan
- Karra Harrington
- Anne Hassett
- Rob Helme
- Di Kirby
- Glynda Kinsella
- Nicola Lautenschlager
- Simon Laws
- Tim Layton
- Raymond Levy
- Yen Ying Lim
- Dina LoGiudice
- Samantha Loi
- Lance Macaulay
- Ralph Martins
- Paul Maruff
- Colin Masters
- Maree Mastwyk
- Eileen Moore
- Kirsten Moore
- John O'Brien
- Daniel O'Connor
- Debra O'Connor
- Kerryn Pike
- Margaret Pozzebon
- Stephanie Rainey-Smith
- Alan Rembach
- Craig Ritchie
- Jo Robertson
- Chris Rowe

- Perminder Sachdev
- Olivier Salvado
- Greg Savage
- Issy Schweitzer
- David Scott
- Ajit Shah
- John Snowdon
- Cassandra Szoeker
- Brian Tress
- Julian Trollor
- Virginia Tuckwell
- Victor Villemagne
- Alissa Westphal
- Siegfried Weyerer
- Michael Woodward

- **Clinical Colleagues**

- Francine Moss
- Anne Unkenstein

- **Secretaries**

- Yvonne Liddicoat
- Marilyn Kemp
- Roz Seath
- Lynette Bon

- **Patients and Research Participants**

- **Family**

- Gordon Ames
- Joan Ames
- Eleanor Flynn
- Elizabeth Ames
- Jennifer Ames
- Phil Ames
- Paul Rogers