GUEST EDITORIAL

Revised NIA-AA criteria for the diagnosis of Alzheimer’s disease: a step forward but not yet ready for widespread clinical use

In clinical medicine, diagnostic criteria are not only useful everyday tools for the practicing physician, but also represent a conceptual concentrate of the understanding of the etiology and pathophysiology of diseases at a given point in time. Although different sets of diagnostic criteria for Alzheimer’s disease (AD) have been developed, the most widely used and best validated by clinico-pathological study to date are the NINCDS-ADRDA (National Institute of Neurological and Communicative Disorders and Stroke – Alzheimer’s Disease and Related Disorders Association) criteria which were published in 1984 (McKhann et al., 1984). These criteria are largely based on the exclusion of other conditions that may cause dementia and can be succinctly but fairly summarized as defining AD as an “acquired progressive cognitive, behavioral, and functional impairment with no other obvious cause”. Clearly, the NINCDS-ADRDA criteria were etiology- and pathophysiology-agnostic in that they failed to point at any specific etiology, not even a degenerative one. They were also developed before other important causes of dementia, such as dementia with Lewy bodies, fronto-temporal dementia and subcortical vascular dementia had been fully described and characterized. The recent publication of a substantially revised version of these criteria (Sperling et al. 2011; Albert et al., 2011; McKhann et al., 2011), heralded by a largely European initiative four years ago (Dubois et al., 2007) has been greeted with great interest by the field. The newly proposed criteria reflect the substantial insights on disease pathophysiology gained over the last decades, especially regarding the molecular pathology of AD and the time course of such pathology in relation to clinical symptoms and disease.

The conceptual framework

Longitudinal studies in patients with cognitive impairment of variable severity (from absent to moderate dementia) have led to the widely held view, rooted in the amyloid cascade hypothesis, that the pathophysiological process of AD (AD-P) starts at least ten years before the onset of even the mildest clinical symptoms (Figure 1) and that AD-P can be characterized by imaging and cerebrospinal fluid (CSF) biomarkers. Clinical symptoms usually – but not invariably – consist of amnestic and/or non-amnestic cognitive impairment, which do not impair functional abilities for a few years (mild cognitive impairment – MCI). With ongoing progression, cognitive impairment leads to disability and dementia within 5 to 7 years (2 to 3 years on average), and death usually ensues after 7–10 more years, though the disease course can be highly variable. Thus, by the time patients develop cognitive symptoms, the brain has been suffering amyloid-associated damage for many years. The practical consequence is that it is fully sensible to expect that patients with MCI due to AD-P will show an AD-like profile of biomarkers, consistent with the increased prevalence of AD-like changes that have been demonstrated in MCI cases over the past decade.

The molecular pathology of AD has been found to consist of cerebral β-amyloidosis and neurodegeneration (synaptic failure and neuronal loss), pathologically hallmarked by the classical extracellular senile plaques of amyloid β1–42 and intracellular neurofibrillary tangles of hyper-phosphorilated tau (HP-τ) protein, respectively. While the biological mechanisms linking the deposition of amyloid β1–42 into plaques to accumulation of HP-τ into tangles are uncertain, the prevalent view posits that β-amyloidosis is the primary phenomenon, and neurodegeneration then follows (the “dynamic biomarkers” hypothesis) (Jack et al., 2010). It is fair to acknowledge, however, that models alternative to the amyloidocentric hypothesis also exist. Recently, Braak and Del Tredici have proposed that the disease might start as tangles (or, rather, as “pre-tangles”) in proximal axons of the noradrenergic locus ceruleus, and that via a prion-like transmission (neuron-to-neuron and tran-synaptic transport of tau protein aggregates), pathology spreads to the entorhinal cortex, and from here to the hippocampus and the rest of the neocortex (Braak and Del Tredici, 2011). This hypothesis will need to be tested in future studies.

The revised criteria, now more succinctly called NIA-AA (National Institute on Aging and Alzheimer’s Association), build on the above...
scientific knowledge and propose the recognition of three stages of AD of increasing cognitive and functional severity: the preclinical, the MCI, and the dementia stage (Table 1). AD-P can be detected with markers of brain $\beta$-amyloidosis and neuronal injury (Table 2) at any one of the three stages. It should be noted that four of the six biomarkers with the best evidence of validity are imaging-based, and that two techniques (PET and CSF studies) allow assessment of both biomarkers of brain $\beta$-amyloidosis and neurodegeneration. This is relevant in view of the practical application of the criteria.

### The operationalization

In agreement with the theoretical framework of dynamic biomarkers (Jack et al., 2010), the preclinical stage is broken down into three sub-stages (Table 1) according to (i) the presence of brain amyloidosis only, (ii) brain amyloidosis with neurodegeneration, or (iii) brain amyloidosis with neurodegeneration and mild cognitive deficits not severe enough to qualify as MCI. Future prospective studies on representative samples of the general population will need to provide verification of this sequence of events. However, the detection of AD-P in the preclinical stage is not recommended in a clinical setting (Sperling et al., 2011) as it is currently impossible to predict the proportion of persons with AD-P but with no or extremely mild cognitive symptoms who will subsequently develop MCI or dementia nor, importantly, when they will do so.

The new criteria for the mild cognitive impairment (MCI) (Albert et al., 2011) and dementia stages (McKhann et al., 2011) are potentially applicable in the clinic. The detection or exclusion of AD-P in a patient with MCI (Albert...
et al., 2011) (Table 1) can increase the confidence that the cognitive impairment is or is not due to AD and as such will or will not deteriorate in a matter of a few years leading to dementia. Similarly, the detection or exclusion of AD-P in a patient satisfying the traditional NINCDS-ADRDA criteria for “probable AD dementia” (McKhann et al., 2011) can increase the confidence that the syndrome is due or not due to AD, which can be of clinical relevance in a significant proportion of cases where the differential diagnosis with non-AD dementias (e.g. dementia with Lewy bodies, frontotemporal degeneration, vascular dementia) is unclear on clinical grounds alone. Information provided by biomarkers is weighted according to two criteria: positivity/negativity of biomarkers, and fitting the theoretical dynamic biomarkers framework. Indeed, conflicting positivity/negativity of biomarkers (e.g. a negative amyloid biomarker in the presence of a positive neurodegeneration biomarker) is regarded as uninformative as if biomarkers information is not available.

An editorial accompanying publication of the revised criteria (Jack et al., 2011) states that “in both the MCI and AD dementia criteria, clinical diagnoses are paramount and biomarkers are complementary”. While stressing the relevance of history-taking and that the physical and neurological exam is a deontological must to anyone who is a physician, it is also fair to acknowledge that the availability of biomarkers to ascertain AD-P clearly downgrades the clinical “diagnoses” of AD dementia and MCI to clinical syndromes with multiple possible etiologies. In the case of probable AD dementia, the most frequent etiology by far is indeed AD, but in the case of MCI the AD etiology is only between a half and two thirds of all cases, the remaining having either non-AD neurodegenerative diseases (rarely) or an unidentified cause most likely more related to the “normal” aging process (more frequently). It is not hard to imagine that, when biomarkers become available for routine use, the clinical criteria for AD dementia and MCI may be more loosely interpreted to increase their sensitivity, leaving to biomarkers the role of enhancing etiologic specificity.

**Limiting factors for widespread use in the clinic**

Clearly, the most pressing question for the practicing physician is whether the revised criteria are ready for use in their routine clinics. Here, the NIA-AA task force seems to have mixed feelings, possibly reflecting uncertainty in the community at large. While the revised criteria for AD dementia explicitly state that they “do not advocate the use of AD biomarker tests for routine diagnostic purposes at the present time”, those of MCI due to AD state that the criteria “are designed to stimulate the application of biomarkers in clinical and research settings”. While in theory biomarkers may have differential utility at different disease stages, the authors fail to provide clues that might help explain the different approaches.

We believe that several clinical and scientific factors currently limit widespread clinical adoption of the revised criteria. It is essential that the new criteria are fully validated in clinical-pathological series, as was the case for the NINCDS-ADRDA criteria. While initial clinical-pathological validation of individual markers has been undertaken under the pressure of the Food and Drugs Administration (FDA) for regulatory purposes (Clark et al., 2011), studies will need to be undertaken including multiple biomarkers.

Research must further define the most efficient and effective diagnostic combination of biomarkers.
The current formulation of the criteria requires positivity on at least one marker of amyloidosis and one of neurodegeneration, so a minimum of one lumbar tap with assessment of Aβ42 and t might be sufficient. Alternatively, positron emission tomography (PET) imaging with FDG and an amyloid ligand might equally be effective but more acceptable to some patients – though substantially more expensive. On the other hand, the combination of medial temporal atrophy together with CSF Aβ42 might be the least expensive. Clearly, cost-effectiveness considerations will play a key role for widespread use.

Standardized procedures for biomarker assessment will need to be developed. Most biomarkers currently suffer from poor reproducibility across laboratories (Mattson et al., 2010; Frisoni and Jack, 2011). In the case of hippocampal volume, despite high intra-laboratory reproducibility, normal hippocampal volume figures can vary 2.5-fold (Geuze et al., 2005). This has so far prevented the definition of universally accepted norms and individually applicable normality thresholds. Current efforts are ongoing to develop standard operating procedures for the collection and measurement of biomarkers (Mattson et al., 2010; Frisoni and Jack, 2011) that will allow widespread use of the criteria in clinical settings. Other uncertain issues include how the contribution of mixed pathologies (e.g. Lewy bodies or cerebrovascular disease) should be assessed, the effect of age on the penetrance of AD-P, and the interpretation of biomarker results when these are conflicting.

The one relatively straightforward set of criteria for AD has been replaced by three significantly more complicated sets. There will undoubtedly be issues not only regarding basic training in use of the criteria, but around how these are operationalized, and about reliability, not just of the biomarkers measurement but how these are integrated with clinical and demographic information to make a diagnosis. With increasing age, there is a decreasing relation between AD-P and clinical symptoms (Frisoni et al., 2007; Bouwman et al., 2009), and AD in the elderly is probably a more complex and even more heterogeneous condition than in younger patients. Considering that 75% of persons with dementia are aged over 75 years, it will be important to include a representative group of elderly patients in future studies of imaging and CSF biomarkers.

Communicating the various messages that these criteria bring to patients, carers, and society at large will require significant discussion among all involved stakeholders. New ethical problems arise when delivering to individuals a diagnosis that may cause anxiety and depression to both patients and relatives, in the absence of approved treatments. What will these individuals’ reactions be, and how will we meet them? How might such early diagnosis impact on health and other insurance coverage? How will secular trends (Rocca et al., 2011) affect the whole scenario? These key issues are already being debated in the literature (Porteri et al., 2010).

Ready or not ready for clinical use?

The above shortcomings, however, do not preclude the use of the revised criteria under specific circumstances (Frisoni et al., 2011). Uncertainties about the most efficient biomarker combination may restrict their use to those specialized centers with the ability to assess a large spectrum of biomarkers reliably and with good normative data. As with the diagnosis of any disease, the individual clinician will need to integrate the results of the biomarker analysis with clinical data in order to reach a final diagnosis.

A few European centers have found that the concept underlying the revised criteria for the diagnosis of MCI due to AD, i.e. the use of combined amyloid and neurodegeneration biomarkers, was applicable to the routine clinical population and was reasonably sensitive and specific to predict the development of incident dementia (Galluzzi et al., 2010; Bouwman et al., 2010). These results will undoubtedly encourage more centers to adopt a similar approach. Importantly, regulatory agencies such as the European Medicines Agency have indicated their interest in recommending the use of biomarkers for the selection of early AD cases to be enrolled in clinical trials and as markers of disease modification (Committee for Medicinal Products for Human Use, 2008; Hampel et al., 2010). Scientific societies have become increasingly aware of the potential of AD biomarkers and are consequently considering their adoption into clinical guidelines (Hort et al., 2010).

Clearly, the current lack of effective disease-modifying therapies will detract severely from their widespread clinical use. Their practical usefulness, and indeed, the value of the criteria – when validated – lies largely on improving patients’ and families’ knowledge. Even in the apparently pointless situation of the prediction of AD in asymptomatic young or middle-aged adults who might carry a pathogenic mutation, it has been shown that most individuals demonstrate effective coping skills and find the testing to be beneficial (Steinburt et al., 2001). Many countries struggle to offer a basic assessment and diagnosis to those with established dementia, and even the routine use of
routine structural imaging has been hotly debated in this journal (O’Brien, 2007), so the prospect of global use of several sophisticated biomarkers in some stretched healthcare systems might be a very distant and arguably unachievable prospect. Also, in high-income countries, the judgment on the opportunity to use health resources to provide mere patient knowledge will need to be made by politicians and healthcare decision-makers. The population prevalence of MCI might range between 1% and 3% of the general population (Fisk et al., 2003), and from a societal perspective, such a large group of individuals at risk of developing AD places an extra burden on healthcare systems. Do health systems have sufficient resources? What will be the cost for society?

Everyone’s hope is that ultimately one of the many disease-modifying drugs currently under trial (Mangialasche et al., 2010) will show uncontroversial effectiveness. If so, then undoubtedly the field will need to have valid and reliable diagnostic criteria for AD that are fit for the purpose of delivering such treatments at the earliest possible opportunity to maximize benefit.

**Conflict of interest declaration**

GBF has acted as a consultant for Lilly, BMS, Bayer, Lundbeck, Elan, Astra Zeneca, Pfizer, Taurx, Wyeth, and has received unrestricted grants from Wyeth Int.l, Lilly Int.l, and Lundbeck Italia.

BW is/has been a member (on a consultancy basis) of the Scientific Advisory Boards for most companies with anti-dementia drugs: Merz Pharmaceuticals, Lundbeck Inc., Medivation, Inc., BMS, GSK, Janssen, Novartis, Pfizer Inc, Wyeth Int., l, Ely-Lilly. BW has been asked to comment on the revised criteria in Swedish for Lakartidningen (a journal for Swedish physicians).

JOB has acted as a consultant for GE Healthcare and Bayer healthcare and received honoraria for lectures from Pfizer, Novartis, Eisai, Lundbeck and Shire Pharmaceuticals.

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