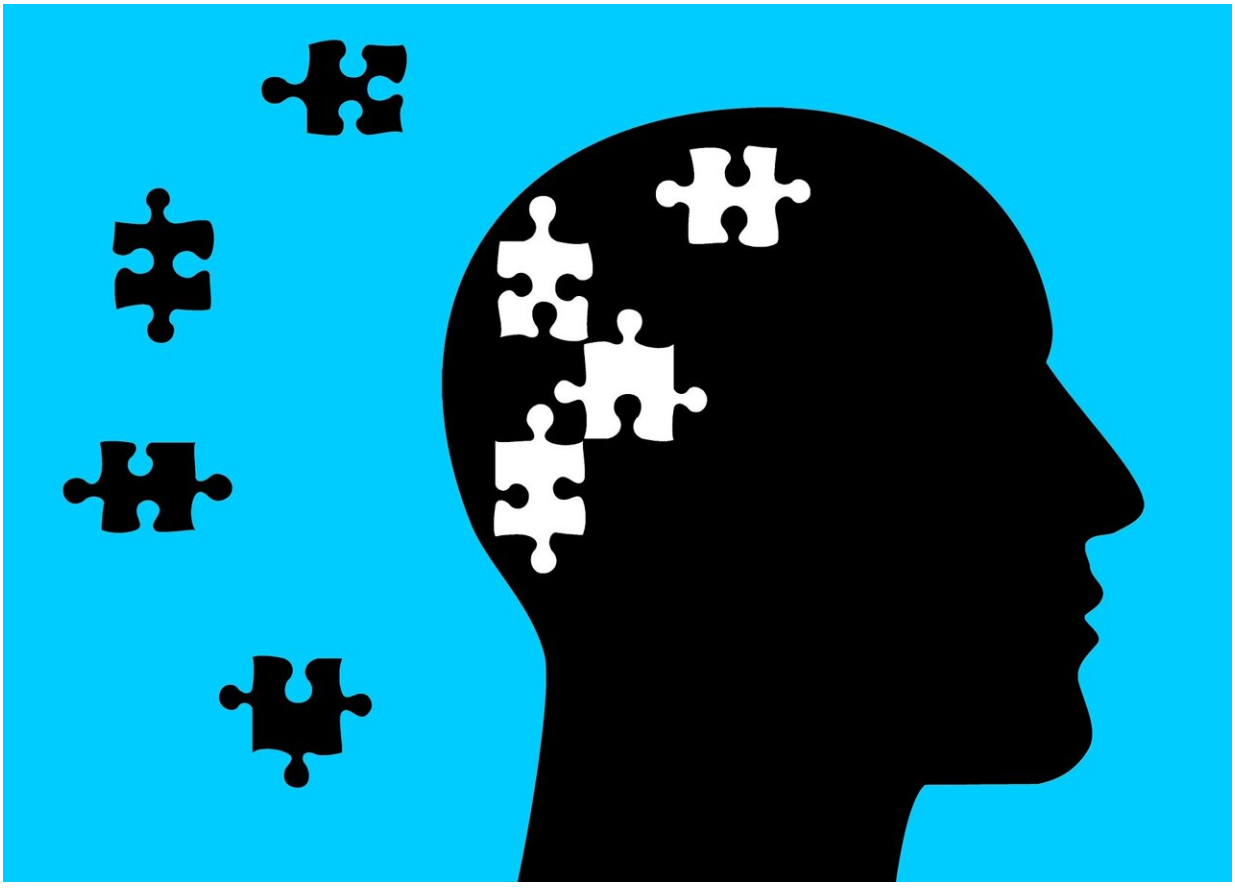
A new drug could slow Alzheimer's: But can patients get it?

June 17 2024, by Lisa Jarvis, Bloomberg Opinion



Credit: Pixabay/CC0 Public Domain

It's welcome news for Alzheimer's patients and their families: A Food and Drug Administration advisory panel unanimously recommended

approval for Eli Lilly & Co.'s treatment donanemab. If given the agency's green light later this year, it would be the second drug to target amyloid plaques in the brain, which have been associated with the memory-destroying disease.

Still, this month's expert panel served as a reminder of the challenge of getting these drugs to the people that will most benefit, as well as the many open questions about how best to use them.

In weighing Lilly's data for donanemab, the FDA's advisers didn't focus much on whether the drug worked—experts all agreed that the data are compelling that it can slow the disease's progression. They spent most of their time discussing for whom it worked and how it should be used.

Those are gnarly questions for a field already grappling with this new class of drugs. As I explained last year, when Biogen and Eisai's Leqembi became the first anti-amyloid drug to receive full FDA approval, these therapies require careful, complex coordination among medical providers.

Patients need amyloid PET scans to confirm their disease, genotyping to understand if they are at added risk of side effects, regular infusions of the treatment, and frequent MRIs to monitor for swelling or bleeding in the brain.

And although Alzheimer's specialists have worked hard to create the infrastructure to identify and treat appropriate patients, the rollout is still very much a work in progress.

"We need to figure out a more scalable way" to make treatment accessible to more people, says Eric Reiman, executive director of the Banner Alzheimer's Institute.

There are practical challenges to replicating Lilly's smart approach to its clinical study.

Drug developers have a long and storied history of enrolling the wrong patients in Alzheimer's clinical trials—in the early days, they included people who had general dementia, but not the specific disease we call Alzheimer's; more recently, their results were muddied by people whose disease was too advanced to meaningfully improve with a drug, or ones whose disease was too early and cognitive decline too slow to show a clear benefit from treatment.

Lilly was looking for people between those two groups—patients who were earlyish in their disease, but far enough along to have measurably worsening symptoms. To find that population, the company used specialized brain imaging to confirm the presence of amyloid and tau, two telltale proteins connected to Alzheimer's disease that, together, have been associated with a likelihood for cognitive decline.

But what helped prove the drug's efficacy also creates a quandary for its use in doctors' offices. While amyloid imaging is increasingly available in the US, tau imaging is not. And the study did not have much data on people with no or very low levels of tau, calling into question whether donanemab should be used in those patients.

In the end, the FDA's advisers felt that all patients, regardless of tau levels, would benefit from donanemab. They also were clear that requiring tau testing in order to prescribe the drug would further raise the already high barriers to access. The FDA should heed both of those recommendations when drawing up guidelines for donanemab's use.

Lilly also studied what would happen if people stopped taking the drug after amyloid was cleared out of their brains, opening the door to treating people for a limited period rather than a lifetime. In theory,

giving less of a likely expensive drug in an overburdened system would be a big win for patients, insurers and the health care system.

But while their results were promising—patients who took a placebo after their amyloid was reduced continued to see slower progression of their disease—the study has yet to clarify how the approach would work in practice. For example, when and how often does a patient need special imaging to determine that their brain is clear of amyloid? How often will imaging be needed to catch when plaques come creeping back? And how many courses of therapy can resolve that?

Beyond those unknowns, the approach also contrasts with the way Biogen and Eisai's Leqembi is used. That treatment currently is given indefinitely.

Longer-term data on both drugs will eventually help sort out which of these two approaches makes the most sense. Yet even without that, having both on the market should widen access for a patient population that has waited far too long for better treatments. That's worth celebrating.