EDITORIAL

More to Dementia than AD

by Kenneth Rockwood, MD, MPA, FRCPC

From the past, when the term Alzheimer's disease (AD) was underused, to the present, when it has become part of the popular lexicon (*i.e.*, "don't mind my forgetting your name, it's just my Alzheimer's acting up"), it is useful to remember that there is more to dementia than AD. This point is well illustrated by this issue of the *Canadian Alzheimer Disease Review*.

Dr. Ron Keren reminds us of the central importance of dementia with Lewy bodies (DLB; page 4). DLB is a disorder in which there are things that we ought to do (*i.e.,* cholinesterase inhibition) and things that we ought not to do (*i.e.,* prematurely treating with antipsychotic medications) when encountering hallucinations in an elderly person, especially one with no prior history of a psychiatric disorder. Indeed, the benefits of cholinesterase inhibition can be so dramatic, and the effects of antipsychotic medications (through the neuroleptic sensitivity syndrome) so catastrophic, that elderly patients with hallucinations should probably be suspected of having DLB until proven otherwise.

Dr. Sultan Darvesh takes us through what can be the torturous characterization of frontotemporal lobar degeneration (FTD; page 12). He usefully proposes three subtypes, although he recognizes that even this will not fit the full spectrum of this fascinating group of disorders. FTD is clinically and pathologically heterogeneous and, depending on the pattern of degeneration, patients can fit competing profiles. On one hand, patients can be withdrawn, with little initiative and slow motor behaviour. On the other hand, they can be loud, garrulous, disinhibited and hyperactive. Dr. Darvesh is appropriately cautious about pharmacotherapy, although in my experience—and here, in the absence of data from controlled trials, I use full editorial license—selective serotonin reuptake inhibitors, especially citalopram or sertraline, commonly give good responses.

Also in this issue, Dr. France Cloutier reminds us that our everyday experience can be helpful in understanding disease expression in our patients (page 17). She describes her experience, as a native francophone Quebecer, of doing a post-doctoral fellowship in English—with me, actually. She is too modest to point out that she won the AstraZeneca/CIHR prize as the top awardee in the Alzheimer Society of Canada competition, in which she was granted her post-doctoral fellowship and, while I can attest that it did not appear frustrating from the outside, I can readily imagine the frustration she felt struggling with a relatively unfamiliar language. Last year, I gave a lecture in Montreal on delirium, a topic about which I care deeply, to a group of francophone colleagues. Having gotten through the first several slides in French, I had to beg their indulgence and switch to English. As I told them, I cared about my subject and I could not stand talking like a child.

In the latest instalment of her remarkable series on reflections as a caregiver, Roberta Bedard also shows us how our own experiences can help us at least ask the right questions about AD (page 20). How is it that patients can have moments when facial recognition, language and judgment suddenly come together after each has apparently been lost? These questions challenge how we have understood disease progression in dementia.

But these are important questions to ask. DLB was a clinical diagnosis before it was a neuropathological one, and FTD challenges us in what is now its apparent heterogeneity. These dementias teach us the value of careful clinical observation, and will do so for some time yet, as they will never be entirely susceptible to animal modeling. The losses that they represent often reflect the assets that we most cherish as humans, reminding us of our special privilege to care for these people.