There were a number of questions submitted regarding Alzheimer’s and Dr. Pat Blanchette has provided additional information included below to address those.

Alzheimer's Disease: (More correctly called "Disease of the Alzheimer's Type - DAT")

Many scientists have conducted research over many years to find an easily accessible biological marker for AD in blood or urine, or even in cerebrospinal fluid. This would greatly advance the ability to enter large number of patients into research trials. To date, no such reliable marker has been found. Certainly biological markers, such as a blood test for ApoE4 and others can demonstrate a higher risk for the disease, but none predict for or diagnose the disease with enough certainty.

In fact, knowing the results of such risk studies could cause more harm than good. We all misplace or forget things at times. What if you knew you were carrying a risk factor for AD and you misplaced or forgot something? How would that affect the quality of your life? There are many people who carry risk factors, live a long life, and never develop the disease.

An easily accessible biological marker would certainly make diagnosis and research into treatments much easier and remains as an important research goal. At this point, the best biological marker is a PET scan of the brain for the presence of amyloid. However, amyloid is often present when the person is cognitively normal. A new research study, Anti-Amyloid Asymptomatic Alzheimer’s (A4) Prevention Trial, is underway to follow a group of research subjects who are cognitively normal and a PET scan has demonstrated that they have amyloid in their brains. These kinds of studies are important because they may find factors that predict for slow or rapid progression of the disease. See the link below: http://alzheimer.wustl.edu/education/berg/berg2012/Slides/Sperling.pdf

At this point, the diagnosis of Alzheimer's disease is best made by a trained physician, usually a neurologist or geriatrician, who is experienced in the diagnosis and management of Alzheimer's disease. Ordinarily, the patient will have experienced (or family or friends will have noticed) a decline in the person's cognitive abilities, usually a decline in memory for very recent events. It is typical that the patient is completely unaware that they have a problem, even when it is obvious to others. It is important that the physician take a complete history, perform a physical examination, order brain imaging (usually a CT or MRI), and perform screening cognitive testing. A neuropsychologist may assist by performing more complete neuropsychological testing when the family or close friends have noticed a decline, but the patient is normal on screening mental status tests. It is important that the clinician rule out certain factors, such as depression or medication side effects or substance use, such as alcohol, prior to making a diagnosis of DAT. In my experience, I have examined many people who were thought to have DAT, but who were suffering side effects from over-the-counter or prescribed medications and/or alcohol. As a person ages, their tolerance for alcohol declines, and the same amount of alcohol that they had been drinking for many years can cause reversible depression and cognitive decline. It is important to find these reversible causes of cognitive decline, as they could lead to accidents and injuries. Additionally, brain imaging is very helpful to rule out "silent stroke", usually seen as multiple small stokes. While the effects of the strokes may not be reversible, it may be possible to discover why the person has been having strokes and prevent them from having further strokes and further decline.

Age is an important factor in the prevalence of cognitive impairment. In the U.S. about 5% of all people 65 and over have enough cognitive impairment to be diagnosed as having dementia. This prevalence doubles every 5 years, so that at age 70 the prevalence is about 10%, at age 75 the prevalence is 20%, at age 80 the prevalence is about 40%. However, there have been too few studies of people over age 80 to know whether the prevalence would continue to double. People who survive to age 80 and above could be genetically at less risk for DAT. Since few very large studies of the prevalence of cognitive impairment have been done, prevalence estimates are derived from studies of people from widely differing parts of the country where other factors, such as the distribution of genetic risks may also differ. The estimates of prevalence over age 80 range from 40% to 50%, depending on where the studies have been done, but these are only estimates. In the U.S. about half of the
causes of dementia are Alzheimer's type. Other causes of dementia include strokes, head injury, or other rarer forms of brain disease.

Dementia, senility and Alzheimer's disease

The term "dementia" refers to a previously normal adult who has an acquired, usually irreversible, form of cognitive impairment. The term "reversible dementia" usually refers to impairments caused by depression or the effects of medications or alcohol. The term dementia is now falling out of favor and replaced by the term "cognitive impairment."

The term "senility" has fallen out of favor. Its connotation is that of cognitive impairment in an older person, but, when studied, many older persons are cognitively normal. Those who are not normal have a variety of conditions, many of them reversible.

Alzheimer's disease is more correctly named "Disease of the Alzheimer's type" (DAT) because it may actually be a cluster of brain diseases with a final common pathway involving the accumulation of amyloid, tau, neurofibrillary tangles and deficiencies of certain neurotransmitters in the brain. For ease of communication, the term "Alzheimer's disease" is usually used, but researchers and clinicians working in the field know that more than one disease process may be at work.

Lost Sense of Smell

I would suggest starting with an evaluation by an ENT (ear-nose-throat) physician (more correctly termed an otolaryngologist). If that does not yield an explanation, I would then consult a neurologist.

Subsidy for Geriatric Medicine

At one time, it was thought that payments from Medicare would be higher for physicians who were board certified in Geriatric Medicine. However, that has not happened. Further, the current government trend to population-based practices make it less likely that improvement in fee-for-service payments to geriatricians will occur. This means that the outpatient practice of geriatric medicine is not financially feasible. Done well, the care of older patients takes longer than those of younger patients. Geriatric Medicine is considered a critical shortage specialty, but few geriatricians able to sustain a private practice where most of the patients are older. However, graduates of geriatric medicine fellowship training programs are highly recruited for positions with large health care centers, the VA, and medical schools, where they mainly have teaching, consultative and research practices. A few geriatricians have entered into "concierge" practices where patients pay a certain set amount every year for their outpatient care to help defray the cost of the practice, but I am not aware of such a practice in Hawaii. The American Geriatrics Society has lobbied extensively, but unsuccessfully, for higher payments for board certified geriatricians. So geriatricians may have considerable effect on the quality of your care, but you are not likely to find one to be your primary care physician.