Welcome to the Geriatric Section of the American Academy of Neurology!

To those of you who are active section members, I want to thank you all for supporting my election as Chair of this incredibly important and unique section of the AAN.

For those of you that are new to the section, do not know me personally, or are not familiar with my work, I pledge to represent our combined interests in the neurologic welfare of the aging population. I believe I can do justice to this appointment on the basis of my past experiences, credentials, and vision of reinforcing the relevance of this section and integrating our work with overlapping sections of the ANN, particularly, Behavioral Neurology, Movement Disorders and Stroke/Vascular Neurology. My CV is attached for your review, and hopefully, your approval.

RELEVANCE

We are all aware of the explosive population growth in the aging population. Those over the age of 85 years are the most rapidly expanding proportion of the population. With such growth, comes increasing burden of neurologic disease that may preferentially affect the aging population. A major focus of the Geriatric section of the AAN over the years has been the issue of cognitive decline and dementia. Current practice parameters in this are over a decade outdated, and predate the development and FDA approval for use of diagnostic biomarkers in the diagnosis of Alzheimer’s disease. Yet we are in a new era, where such diagnostic capabilities are available to all practicing medicine currently. Despite these advances, no guidelines or practice parameters exist to help the neurologist who is in practice but may not specialize in geriatric neurology. Such guidelines and practice parameters are needed to guide the field. Geriatric Neurology needs to take a leading position in establishing such guidelines in conjunction with other AAN Sections such as Behavioral Neurology. It is a travesty that there are active clinical trials in the areas of mild cognitive impairment of the Alzheimer type and in preclinical AD, diagnoses determined through the use of such biomarkers and yet no guidance has come forth from the AAN on such clinical entities or the appropriate use of biomarkers to identify degenerative disease states in clinical practice. The future is unfolding and when we envision the scope of the problem, it is not an impending disaster or epidemic, it is a crisis that is upon us now. I have not yet seen a full description of the scope of the problem put forth, and so I will put this forth now.

Over 5 million Americans suffer from AD currently of the 39 million over the age of 65 years. Another 6 million suffer from MCI. Of the remaining cognitively intact population, one-in-three have preclinical AD that can be detected through the use of clinically available biomarkers today. Summing these groups, it is easy to understand that 25 of the 39 million seniors in the US are affected biologically by AD changes.
Recognition of this simple fact drives home the reality that if a disease modifying treatment is proven over the next few years (the ADCS A4 trial already includes FDA registration for solanezumab in preclinical AD), the field will be inundated with a five-fold increase in geriatric patients seeking appropriate diagnosis and potential treatment for AD at the preclinical, MCI, or dementia stage of AD. Preparing for this day is something we must address today. Geriatric and Behavioral Neurology Section members cannot manage the 25 million that will be demanding care, but we can lead the fight with guidance and established practice parameters that will allow providers across the continuum of care to join forces with us in this struggle.

INTEGRATION

The scope of the Geriatric Section includes interests in many subspecialties of neurology that are increasing in prevalent disease as the population continues to age. Areas of specific integration for the Geriatric section include Behavioral Neurology, Movement Disorders, and Stroke/Vascular Neurology. Among these AAN Sections, most neurologists have selected their affiliation as primary (Stroke/Vascular 87%, Movement 72%, and Behavioral 59%) and only a subset of members have selected a secondary and or tertiary Section affiliation, including Geriatric Neurology. The exception to this is the Geriatric section that has only 28% membership as solo affiliate, and 72% as secondary and tertiary membership. This is unique among AAN sections with 434 of 592 members sharing AAN section affiliation with Behavioral Neurology, Movement Disorders, and Stroke/Vascular Neurology.
It is clear that while the relevance of the Geriatric Section of the AAN remains a priority in regards to meeting neurologic health care needs currently and in the immediate future, Geriatric Neurology initiatives need to be accomplished in the setting of AAN sections affiliated through mutual membership.

**ISSUES FACING OUR SECTION CURRENTLY**

Primary issues that the Geriatric section must confront immediately include:

1) Revising practice parameters that were written in 1999 and 2001 in regards to diagnosis of dementia and MCI to reflect the current state-of-the-art diagnosis and care for persons suffering from memory decline in the geriatric population.
2) Establishment of a practice parameter regarding diagnosis of preclinical AD in the clinical as opposed to research setting. (this is important for guidance of non-specialists practicing geriatric care)
3) Increasing engagement in geriatric neurology for those in training currently and those already in practice, given the potential for catastrophic escalation in patient numbers seeking care in the near future.
4) Threat of loss of our UCNS accreditation as a subspecialty in Neurology

At the heart of these issues lies education, advocacy, and reimbursement that make the scenario of enhanced geriatric neurologic care possible for all.

While research initiatives and funding opportunities have been vital components of the Geriatric Neurology Section initiatives over the past decades, other organizations and interests are better positioned to lead these roles such as the NIA, AA, AFAR, and NAPA, among others. While we will remain strong advocates of such research oriented organizations, our priorities as a Section of the AAN should lie in the area of promoting and advancing diagnosis and care in the clinical setting at this time.

As always, I open encourage open discussion of our agenda and issues on an ongoing basis. Please stay engaged and make your voice heard!

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