Longitudinal Change of Biomarkers in Cognitive Decline

Raymond Y. Lo, MD, MS; Alan E. Hubbard, PhD; Leslie M. Shaw, PhD; John Q. Trojanowskki, MD, PhD; Ronald C. Petersen, MD, PhD; Paul S. Aisen, MD; Michael W. Weiner, MD; William J. Jagust, MD; for the Alzheimer’s Disease Neuroimaging Initiative

Objective: To delineate the trajectories of Aβ42 level in cerebrospinal fluid (CSF), fludeoxyglucose F18 (FDG) uptake using positron emission tomography, and hippocampal volume using magnetic resonance imaging and their relative associations with cognitive change at different stages in aging and Alzheimer disease (AD).

Design: Cohort study.

Setting: The 59 study sites for the Alzheimer’s Disease Neuroimaging Initiative.

Participants: A total of 819 participants 55 to 90 years of age with normal cognition, mild cognitive impairment, and AD who were followed up during the period from 2005 to 2007.

Main Outcome Measures: Rates of change in level of Aβ42 in CSF, FDG uptake, hippocampal volume, and the Alzheimer Disease’s Assessment Scale–cognitive subscale scores during up to 36 months of follow-up by diagnostic group as well as prediction of cognitive change by each biomarker.

Results: Reductions in the level of Aβ42 in CSF were numerically greater in participants with normal cognition than in participants with mild cognitive impairment or AD; whereas both glucose metabolic decline and hippocampal atrophy were significantly slower in participants with normal cognition than in participants with mild cognitive impairment or AD. Positive APOE4 status accelerated hippocampal atrophic changes in participants with mild cognitive impairment or AD, but did not modify rates of change in level of Aβ42 in CSF or FDG uptake. The Alzheimer Disease’s Assessment Scale–cognitive subscale scores were related only to the baseline level of Aβ42 in CSF and the baseline FDG uptake in participants with normal cognition, which were about equally associated with change in FDG uptake and hippocampal volume in participants with mild cognitive impairment and best modeled by change in FDG uptake in participants with AD.

Conclusion: Trajectories of Aβ42 level in CSF, FDG uptake, and hippocampal volume vary across different cognitive stages. The longitudinal patterns support a hypothetical sequence of AD pathology in which amyloid deposition is an early event before hypometabolism or hippocampal atrophy, suggesting that biomarker prediction for cognitive change is stage dependent.


Using biomarkers for the early detection of Alzheimer disease (AD) is crucial for developing potential treatment. Previous studies have shown that Aβ42 and tau protein levels in cerebrospinal fluid (CSF),1 demonstrated that the burden of AD pathology was reflected by the antemortem Aβ42 level in CSF,4 the region-specific FDG uptake using PET,3 and the hippocampal volume using MRI,6 which suggests that these markers are indicative of the altered biological states in AD.

CME available online at www.jamaarchivescme.com and questions on page 1236

For editorial comment see page 1237

Although lower levels of Aβ42 in CSF are associated with the risk of incipient AD,7 CSF biomarkers appear to be relatively stable over time within individuals.8,9 Greater hippocampal atrophy rates measured by serial MRI correlated with faster cognitive decline in normal aging.
and early conversion to dementia in mild cognitive impairment (MCI) in previous studies. Several longitudinal FDG-PET studies also suggested that regional hypometabolism predicted clinical progression or conversion to AD. Because these time-varying biomarkers as well as the APOE4 allele are all associated with AD or cognitive impairment, it is conceivable that they are correlated with one another. However, very few studies have examined the dynamic change of 2 or more biomarkers simultaneously. Longitudinal comparison of biomarker change is an important approach to assess the relative importance and pathological significance of each biomarker.

In our study, we aimed to delineate the trajectories of the Aβ42 level in CSF, FDG uptake, and hippocampal volume as well as the influence of the APOE4 allele, and then evaluate their relative associations with cognitive function in participants with normal cognition (NC), MCI, or AD.

## METHODS

### STUDY POPULATION

A total of 819 research participants (229 with NC, 397 with MCI, and 193 with AD) were enrolled in the Alzheimer’s Disease Neuroimaging Initiative (ADNI) from 59 centers in the United States and Canada during the period from 2005 to 2007. Full inclusion and exclusion criteria are detailed at http://www.adni-info.org. Briefly, screening criteria for entry into our study included the Mini-Mental State Examination score, the Clinical Dementia Rating scale, and an education-adjusted cutoff score on delayed recall of 1 paragraph from the Logical Memory subtest of the Wechsler Memory Scale—Revised. All participants were recruited between the ages of 55 and 90 years and had at least 6 years of education. Participants who took specific psychoactive medications or who had other neurological disorders were excluded. After the baseline visit, subsequent visits occurred at 6- or 12-month intervals. Participants with NC or MCI were followed up for 3 years, whereas those with AD were followed up for 2 years at maximum.

### STANDARD PROTOCOL APPROVALS, REGISTRATIONS, AND PATIENTS’ CONSENT

The study procedures were approved by the institutional review boards of all participating institutions. Written informed consent to obtain blood samples and to perform lumbar puncture, neuropsychological testing, and neuroimaging were obtained from all research participants or their representatives.

### GENETIC MARKER

Blood samples at baseline were collected, and APOE genotyping was performed at the University of Pennsylvania AD biomarker laboratory in Philadelphia. APOE4 allele carriers were participants who had at least 1 APOE4 allele.

### CSF PROTEINS

Cerebrospinal fluid samples were collected in the morning after overnight fast, shipped to the University of Pennsylvania AD biomarker laboratory, and analyzed using a standardized protocol. Levels of Aβ42, total tau, and phosphorylated tau were measured (in units of picograms per milliliter) in each of the CSF aliquots using the multiplex XMAP Luminex (Luminex Corp, Austin, Texas) platform with Innogenetics (INNO-BIA AlzBio3; Ghent, Belgium; for research use–only reagents) immunnoassay kit–based reagents. About 50% of all participants underwent lumbar puncture at baseline, after which 106 participants underwent a lumbar puncture every year for 3 years.

### FDG UPTAKE USING PET

The protocol to acquire ADNI PET data at sites nationwide is detailed at http://adni.loni.ucla.edu/research/protocols/pet-protocols/, and methods for FDG-PET analysis have been described previously. Briefly, PET images were acquired 30 to 60 minutes after injection. Images were averaged, spatially aligned, interpolated to a standard voxel size, intensity normalized, and smoothed to a common resolution of 8-mm full-width at half-maximum. The PET volumes were intensity normalized to a single region comprising the cerebellar vermis and the pons defined by the Montreal Neurological Institute template. We used predefined regions of interest to reflect glucose metabolism. Mean FDG uptake was extracted and averaged from 5 regions of interest (right and left temporal gyrus, right and left angular gyrus, and posterior cingulate gyrus) for each participant. Baseline PET images were available for 404 participants, and more than 60% of these participants were followed up for 2 additional years with repeated PET scans.

### MRI HIPPOCAMPAL VOLUME

The 1.5-T MRI protocol, which was described elsewhere, was standardized across all sites: 2 T1-weighted MRI scans, using a sagittal volumetric magnetization-prepared rapid gradient echo sequence, with an echo of 4 milliseconds, a repetition time of 9 milliseconds, a flip angle of 8°, and an acquisition matrix size of 256×256×166 in the x, y, and z dimensions with a nominal voxel size of 0.94×0.94×1.2 mm. The images were aligned, skull-stripped, and segmented. A quality-control center was designed to exclude scans with serious motion artifacts. FreeSurfer software (http://surfer.nmr.mgh.harvard.edu) was applied to obtain bilateral hippocampal volumes in units of cubic millimeters from this segmentation. Baseline MRI images were available for 811 participants, and more than 60% of these participants were followed up for 2 more years with multiple MRI scans.

### ASSESSMENT OF COGNITIVE FUNCTION

The Alzheimer’s Disease Assessment Scale–cognitive subscale (ADAS-cog) score was used as a dependent measure to examine relationships between biomarkers and cognitive change. This test contains 11 items covering language, memory, praxis, and comprehension function. The total score ranges from 0 to 70, and higher scores indicate poorer cognitive function. Baseline and multiple follow-up ADAS-cog assessments were available for all participants.

### STATISTICAL ANALYSES

Participants with 2 or more repeated measures had their data entered into the analyses. We first delineated the trajectories of different biomarkers and used repeated measures linear regression (an exchangeable, working-within-subject correlation model via a generalized estimating equation) to estimate population average rates of change in levels of CSF proteins, FDG-PET regions of interest, hippocampal volume, as well as ADAS-cog scores for participants with NC, MCI, or AD.
To account for the residual correlation due to repeated measures on the same subject, we could have also used a more parametric, mixed-model approach. However, given that our focus was on the average rate of change in biomarkers (and not on the variance components), and because we wanted to derive a robust inference (standard errors not sensitive to the specified correlation model), we chose the generalized estimating equation approach rather than a parametric maximum likelihood approach.29 Time-varying biomarkers were treated as the outcome and modeled by time and baseline age in the regression. In these models, a significant time coefficient indicated a nonzero rate of change. We also made intergroup comparisons of rates of change. In a separate analysis, we included APOE4 allele carrier status in the model to evaluate its influence on the rate of change for each biomarker, reflected by the coefficient of the interaction term ($APOE4 \times \text{time}$).

We then examined the relation between the change of cognitive function and the change of different biomarkers. Time-varying ADAS-cog scores were treated as the outcome of interest and modeled by time and the change in biomarkers after adjusting for baseline age and baseline biomarker value. Values of $R^2$ were calculated for each longitudinal model to represent the goodness of fit or the extent to which the marginal variance of cognitive function was explained by the model. Models differed by biomarker of interest and sample size because only a limited number of participants had all 3 biomarkers available. We conducted model comparisons by restricting participants to those with 2 biomarkers available (Aβ42 level in CSF and FDG uptake; Aβ42 level in CSF and hippocampal volume; or FDG uptake and hippocampal volume) so as to make models more comparable. All statistical analyses and graphics were performed in R version 2.11.1 (R Foundation for Statistical Computing, Vienna, Austria).

**RESULTS**

The demographic features of all participants are summarized in Table 1. The sample size declined over time, and the number of repeated measures available for longitudinal analysis varied across different biomarkers and diagnostic groups (Table 2). The Aβ42 level in CSF (measured in units of picograms per milliliter per month) appeared to decrease faster in participants with NC (−0.46 pg/mL/mo) than in participants with MCI (−0.26 pg/mL/mo) or AD (−0.29 pg/mL/mo), but intergroup differences were not significant; changes in total tau and phosphorylated tau levels in CSF for the most part were not significantly different from zero (Table 2). Brain regional glucose metabolic decline (measured in units of normalized intensity per month) was significantly slower in participants with NC (−7.4 × 10−4 normalized intensity per month) than in participants with MCI (−1.9 × 10−3 normalized intensity per month) or AD (−4.2 × 10−3 normalized intensity per month) and slower in participants with MCI than in participants with AD (Table 2). The rate of MRI hippocampal atrophy (measured in units of cubic millimeters per month) was also significantly slower in participants with NC (−2.95 mm/mo) than in participants with MCI (−5.52 mm/mo) or AD (−8.01 mm/mo) and slower in participants with MCI than in participants with AD (Table 2). Cognitive function assessed by the ADAS-cog declined (increased in ADAS-cog score) a little in participants with NC. The hypothetical average changes of these biomarkers and the ADAS-cog scores for a 75-year-old person in the 3 diagnostic groups are illustrated in our Figure.

The associations between APOE4 status and the baseline value of biomarkers were significant in the NC group for Aβ42 level in CSF and FDG uptake and in the MCI group for all 3 biomarkers (Table 3). Positive APOE4 status did not appear to modify the rate of change in the Aβ42 level in CSF or glucose metabolism in all 3 groups, but it accelerated hippocampal atrophy in the MCI and AD groups.

For participants with NC, although changes in cognitive function were not captured by any of these time-varying biomarkers, Aβ42 level in CSF ($R^2=0.12$) appeared to better explain the total variance of ADAS-cog scores over time than did FDG uptake ($R^2=0.07$) or MRI hippocampal volume ($R^2=0.03$) (Table 4). For participants with MCI, changes in cognitive function were associated with all of these biomarkers, such that cognitive decline (increase in ADAS-cog score) was associated with the decrease in the Aβ42 level in the CSF, FDG-PET regional metabolism, and MRI hippocampal volume. Cognitive function at the MCI stage was about equally well modeled by FDG uptake ($R^2=0.18$) and hippocampal volume ($R^2=0.16$). For participants with mild AD, cognitive decline was still captured by FDG uptake and hippocampal volume, but not by the Aβ42 level in CSF. The variance of the ADAS-cog score during the course of dementia seemed better modeled by FDG uptake ($R^2=0.36$) than by hippocampal volume ($R^2=0.19$). We further conducted head-to-head comparisons in sample-size matched groups (Aβ42 level in CSF vs FDG uptake; Aβ42 level in CSF vs hippocampal volume; and FDG uptake vs hippocampal volume), and their relative contributions to model cognitive decline remained largely unchanged (eTable; http://www.archneurol.com).

**COMMENT**

Annualized changes in the biomarkers of the Aβ42 level in CSF, FDG uptake, and hippocampal volume as well

---

**Table 1. Demographic Features of 819 Participants in the Alzheimer’s Disease Neuroimaging Initiative at Enrollment**

<table>
<thead>
<tr>
<th>Feature</th>
<th>NC</th>
<th>MCI</th>
<th>AD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sample size, No.</td>
<td>229</td>
<td>397</td>
<td>193</td>
</tr>
<tr>
<td>Age, mean (SD), y</td>
<td>75.1 (5.0)</td>
<td>74.0 (7.5)</td>
<td>74.6 (7.5)</td>
</tr>
<tr>
<td>Sex, No.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>119</td>
<td>256</td>
<td>102</td>
</tr>
<tr>
<td>Female</td>
<td>110</td>
<td>141</td>
<td>91</td>
</tr>
<tr>
<td>Education, mean (SD), y</td>
<td>16.0 (2.9)</td>
<td>15.7 (3.0)</td>
<td>14.7 (3.1)</td>
</tr>
<tr>
<td>MMSE score, mean (SD)</td>
<td>29.1 (1.0)</td>
<td>27.0 (1.8)</td>
<td>23.3 (2.1)</td>
</tr>
<tr>
<td>APOE4 carriers, No. (%)</td>
<td>61 (26.6)</td>
<td>212 (53.4)</td>
<td>127 (65.8)</td>
</tr>
</tbody>
</table>

Abbreviations: AD, Alzheimer disease; ADNI, Alzheimer’s Disease Neuroimaging Initiative; MCI, mild cognitive impairment; MMSE, Mini-Mental State Examination; NC, normal cognition.
as cognitive function during the first 12 months of follow-up in ADNI have been reported.30 We extended the follow-up study to up to 36 months and found evidence of significant change in the biomarkers of Aβ42 level, glucose metabolism, and hippocampal volume in all 3 groups of participants: NC, MCI, and AD. These biomarker trajectories showed that rates of change in the Aβ42 level were not different among the groups, but changes in glucose metabolism and hippocampal volume accelerated as cognitive function deteriorated. For participants with NC, cognitive change was not related to change in any of the biomarkers, although a model that included the APOE4 gene on Aβ42 level in CSF captured more variance than models that contained other biomarkers. The lack of association between cognitive change and biomarker dynamics in participants with NC may be due to only a subtle functional difference at this stage or to the limitation of our cognitive measurement tool. For participants with MCI, a baseline Aβ42 level in CSF and a baseline FDG uptake (but not a baseline hippocampal volume) in participants with NC, whereas in participants with MCI or AD, the presence of APOE4 accelerated hippocampal atrophy (but not the Aβ42 level in CSF or FDG uptake). The influence of the APOE4 gene on Aβ42 level in CSF and FDG-PET regional metabolism appeared to begin earlier than on hippocampal atrophy. There is evidence from pathological examinations and amyloid PET imaging showing that the APOE4 gene increases the risk of AD through Aβ accumulation in the brain.34,35 Therefore, the effect of APOE4 on biomarkers at different stages may reflect the pathological sequence led by the pivotal event in AD, β-amyloid deposition.

The decrease in the Aβ42 level in CSF as an early event shown in our biomarker trajectories and the influence of APOE4 on hippocampal atrophy that occurred after Aβ42 deposition in CSF and FDG uptake both imply that the FDG-PET marker changes after Aβ42 deposition in CSF but before hippocampal atrophy. Our study supports the hypothetical model of the AD pathological cascade proposed by Jack et al,36 in which brain Aβ deposition heralds the onset of the entire AD pathological process and is followed by regional synaptic dysfunction or glucose hypometabolism that eventually culminates in cell loss or brain atrophy.

One of the unique features in our study is that we have follow-up information on the biomarkers of the Aβ42 level in CSF, FDG uptake, and hippocampal volume from our study participants, as well as ADAS-cog scores, to address the dynamics of the pathological course of AD. These biomarker dynamics have been examined by the ADNI
using a cross-sectional approach; however, to translate cross-sectional results into actual patterns of change requires a strong assumption that all participants follow the same pattern of disease progression from normal all the way to dementia. We understand that this assumption may hold true for participants who developed MCI and for participants with AD, but it is unlikely for participants with NC who did not develop MCI. Nearly half of the participants with MCI developed AD during follow-up, but very few people changed from NC to MCI or AD in the ADNI. Participants with NC may be a very different group of people from those who used to be cognitively normal but currently have MCI or AD. Ideally, the longitudinal change of biomarkers could have been better delineated had our study continued with follow-up that was long enough to observe the same group of participants with NC transitioning to MCI and AD. Limited by this design, we might be observing biomarker dynamics in aging but not necessarily disease progression in AD; therefore, we should be conservative about making inferences from participants who remained cognitively intact.

Previous longitudinal CSF studies showed that the decrease in the Aβ42 level correlated with cognitive decline in a healthy elderly population but that the decrease might be too slight to detect later in the disease course, which suggests that the level of Aβ42 in CSF might stabilize long before symptomatic dementia. These longitudinal CSF studies were, however, limited by at most 2 repeated measures and relatively small sample sizes. Our longitudinal study of CSF biomarkers is based on up to 3 repeated measures, which is the minimum number of time points allowing us to evaluate the variance of change. A baseline measure and 1 follow-up measure can only generate 1 single slope or change for each individual, and therefore there is no variance of slope to evaluate. The 2-point difference may result from either

Figure. Hypothetical longitudinal changes in the Aβ42 level in cerebrospinal fluid (CSF), fludeoxyglucose F18 (FDG) uptake using positron emission tomography, hippocampal volume using magnetic resonance imaging, and Alzheimer Disease’s Assessment Scale–cognitive subscale (ADAS-cog) score for a 75-year-old person at different cognitive states. AD indicates Alzheimer disease; MCI, mild cognitive impairment; and NC, normal cognition.
actual change or simply measurement error. In addition, if CSF biomarker measurement error exists, which is very likely for all laboratory tests, the magnitude of difference can be subject to the “regression toward the mean” effect. In other words, the more the baseline value deviates from the population mean, the larger the change is likely to be.

We used the ADAS-cog score to monitor cognitive function and mapped the change of biomarkers to the ADAS-cog score as a way to assess the extent to which pathological markers correlated with clinical progression over time. There is no gold standard for measurement of cognitive function, particularly when our outcome of interest includes multiple stages of AD from normal to overt dementia. We noticed that ADAS-cog scores in participants with NC even improved over time, and we recognized that the possible learning effect might hinder us from using the ADAS-cog to track cognitive change among healthy elderly people. Nevertheless, ADAS-cog is still the standard tool in many clinical trials to assess AD, which allows our results to be more interpretable across different studies.

There are several limitations in our study. First, research participants in the ADNI were volunteers and from clinics, not from the general population. Although they all met the inclusion and exclusion criteria for NC, amnestic MCI, or mild AD, they were not newly diagnosed or incident cases. Within the same diagnostic group, participants were enrolled in our study at different stages in the disease course. Baseline evaluation did not adequately reflect their clinical states when they first had the disease. Therefore, we want to be clear that our target population is patients who come to the clinic rather than the general community; and we applied a generalized estimating equation approach to avoid the unverifiable assumption about their biological states at the beginning of cognitive impairment. Second, not all ADNI research participants underwent all biomarker examinations, especially lumbar puncture for CSF. Like many longitudinal studies, we had substantial missing data for biomarkers during the 36-month follow-up period. Although a generalized estimating equation approach can handle missing time points within individuals, there is no way that we can recover the actual biomarker profiles for those individuals who did not end up being in the analyses. The differences in sample size, particularly the smaller samples of individuals with longitudinal CSF samples compared with the other biomarkers, may limit our ability to draw inferences about the rela-

---

**Table 3. Influence of APOE4 Gene on Biomarkers Among Participants in the Alzheimer’s Disease Neuroimaging Initiative**

<table>
<thead>
<tr>
<th>Biomarker</th>
<th>NC (n=36)</th>
<th>MCI (n=54)</th>
<th>AD (n=16)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>2.45</td>
<td>0.30</td>
<td>0.92 b</td>
</tr>
<tr>
<td>Time</td>
<td>−0.38 b</td>
<td>−0.36 c</td>
<td>−0.41</td>
</tr>
<tr>
<td>APOE4</td>
<td>−52.34 c</td>
<td>−46.24 d</td>
<td>−0.71</td>
</tr>
<tr>
<td>APOE4 × time</td>
<td>−0.32</td>
<td>0.20</td>
<td>0.15</td>
</tr>
</tbody>
</table>

**Table 4. Goodness of Fit of Regression Analyses Modeling Cognitive Change by Biomarkers**

<table>
<thead>
<tr>
<th>GEE Model</th>
<th>NC (n=36)</th>
<th>MCI (n=54)</th>
<th>AD (n=16)</th>
</tr>
</thead>
<tbody>
<tr>
<td>CSF Aβ model</td>
<td>0.12</td>
<td>0.12</td>
<td>0.26</td>
</tr>
<tr>
<td>Age</td>
<td>0.06</td>
<td>−0.01</td>
<td>−0.12</td>
</tr>
<tr>
<td>Time</td>
<td>−0.02</td>
<td>0.05</td>
<td>0.43 b</td>
</tr>
<tr>
<td>Baseline</td>
<td>−0.02 c</td>
<td>−0.03 c</td>
<td>0.12</td>
</tr>
<tr>
<td>Change</td>
<td>−0.02</td>
<td>−0.08 d</td>
<td>−0.15</td>
</tr>
</tbody>
</table>

**Abbreviations:** AD, Alzheimer disease; ADNI, Alzheimer’s Disease Neuroimaging Initiative; CSF, cerebrospinal fluid; FDG, fludeoxyglucose F18; GEE, generalized estimating equation; MRI, magnetic resonance imaging; NC, normal cognition; PET, positron emission tomography.

---

a Time-varying biomarkers were modeled by baseline age, time, APOE4 status, and interaction between APOE4 and time using a generalized estimating equation approach. Coefficients of the interaction term (APOE4 × time) represented the influence of APOE4 on rates of change. Sample sizes were limited to subjects with 2 or more repeated measures during the 3-year follow-up period.

b P < .05.
c P < .01.
d P < .001.

---

©2011 American Medical Association. All rights reserved.
tive changes in these biomarkers. Participants whose data were used in the analyses might be different from those whose data were not included or who dropped out; we do not know whether this is informative censoring or random missing data. Nevertheless, we focused on the relative rates of change or associations with cognitive change but not true rates. The calculated biomarker values would be biased by informative censoring, but the interrelationship among these biomarkers might not be affected.

In sum, longitudinal patterns of biomarkers suggest that $A\beta$42 level in CSF, FDG uptake using PET, and hippocampal volume using MRI capture AD pathological states sequentially and that their predictive values for cognitive decline depend on the stage of the disease. Repeated measurement of these candidate biomarkers provides a potential approach for early diagnosis of AD.

Accepted for Publication: March 25, 2011.
Published Online: June 13, 2011. doi:10.1001/archneurol.2011.123

Author Affiliations: Division of Epidemiology (Drs Lo, Hubbard, and Jagust) and Helen Wills Neuroscience Institute (Dr Jagust), University of California, Berkeley, Department of Neurosciences, University of California, San Diego, La Jolla (Dr Aisen), and Center for Imaging of Neurodegenerative Diseases, San Francisco Veterans Affairs Medical Center and Departments of Radiology, Medicine, Psychiatry, and Neurology, University of California, San Francisco (Dr Weiner); Department of Pathology and Laboratory Medicine and Institute on Aging, University of Pennsylvania School of Medicine, Philadelphia (Drs Shaw and Trojanowski); and Department of Neurology, Mayo Clinic, Rochester, Minnesota (Dr Petersen).

Correspondence: Raymond Y. Lo, MD, MS, Division of Epidemiology, University of California, Berkeley, 118 Barker Hall MC3190, Berkeley, CA 94720-3190 (rlo@berkeley.edu).

Author Contributions: Study concept and design: Lo, Trojanowski, Weiner, and Jagust. Acquisition of data: Trojanowski and Weiner. Analysis and interpretation of data: Lo, Hubbard, Shaw, Trojanowski, Petersen, Aisen, Weiner, and Jagust. Drafting of the manuscript: Lo. Critical revision of the manuscript for important intellectual content: Lo, Hubbard, Shaw, Trojanowski, Petersen, Aisen, Weiner, and Jagust. Obtained funding: Weiner and Jagust. Administrative, technical, and material support: Shaw, Trojanowski, Aisen, Weiner, and Jagust. Study supervision: Jagust.

Financial Disclosure: Dr Shaw has received funding for travel and speaker honoraria from Pfizer; serves on the editorial board of the journal Therapeutic Drug Monitoring; may potentially receive revenue for patent pending (application number 10/192,193): O-methylated rapamycin derivatives for alleviation and inhibition of lymphoproliferative disorders, licensed by the University of Pennsylvania to Novartis; receives royalties from publication of Applied Pharmacokinetics and Pharmacodynamics: Principles of Therapeutic Drug Monitoring (Wolters Kluwer/Lippincott Williams & Wilkins, 2005); receives research support from the National Institutes of Health (NIH) (grant AG024904 [co-principal investigator [co-PI], Biomarker Core Laboratory]); and receives board of directors’ compensation and holds stock options in Salix Biomedical. Dr Trojanowski has received funding for travel and honoraria from Takeda to attend numerous conferences not funded by industry; serves as an associate editor of the journal Alzheimer’s & Dementia; may accrue revenue on patents regarding Modified Avidin-Biotin Technique, Method of Stabilizing Microtubules to Treat Alzheimer’s Disease, Method of Detecting Abnormally Phosphorylated Tau, Method of Screening for Alzheimer’s Disease or Disease Associated with the Accumulation of Paired Helical Filaments, Compositions and Methods for Producing and Using Homogeneous Neuronal Cell Transplants, Rat Comprising Straight Filaments in Its Brain, Compositions and Methods for Producing and Using Homogeneous Neuronal Cell Transplants to Treat Neurodegenerative Disorders and Brain and Spinal Cord Injuries, Diagnostic Methods for Alzheimer’s Disease by Detection of Multiple MRNAs, Methods and Compositions for Determining Lipid Peroxidation Levels in Oxidant Stress Syndromes and Diseases, Compositions and Methods for Producing and Using Homogenous Neuronal Cell Transplants, Method of Identifying, Diagnosing and Treatment $\alpha$-synuclein Positive Neurodegenerative Disorders, Mutation-specific Functional Impairments in Distinct Tau Isoforms of Hereditary Frontotemporal Dementia and Parkinsonism Linked to Chromosome-17: Genotype Predicts Pheno- type, Microtubule Stabilizing Therapies for Neurodegenerative Disorders, and Treatment of Alzheimer’s and Related Diseases with an Antibody; and receives research support from the NIH National Institute on Aging (NIA) and National Institute of Neurological Disorders and Stroke (grants P01 AG 09215-20 [PI], P30 AG 10124-18 [PI], P01 AG 17586-10 [project 4 leader], 1P01 AG-19724-07 [core C leader], U01 AG 024904-05 [co-PI, Biomarker Core Laboratory], P50 NS053488-02 [PI], U01 AG029213-01 [coinvestigator], RC2NS069368 [PI], RC1AG035427 [PI], and P30AG036468 [PI] and from the Marrian S. Ware Alzheimer Program. Dr Petersen serves on scientific advisory boards for Pfizer, Janssen Alzheimer Immunotherapy, Elan, and GE Healthcare; receives royalties from the publication of Mild Cognitive Impairment (Oxford University Press, 2003); and receives research support from the NHI/NIA (grants U01 AG 06786 [PI], P50 AG 16574 [PI], U01 AG 024904 [subcontract PI], and R01 AG11378 [coinvestigator]). Dr Aisen serves on a scientific advisory board for NeuroPhage; serves as a consultant to Elan, Wyeth, Eisai, Neurochem, Schering-Plough, Bristol-Myers Squibb, Eli Lilly, NeuroPhage, Merck, Roche, Amgen, Genentech, Abbott, Pfizer, Novartis, and Medivation; receives research support from Pfizer, Baxter, Neuro-Hitech, Abbott, Martek, and the NIH/ NIA (grants U01 AG10483 [PI], U01 AG024904 [coordinating center director], R01-AG030048 [PI], and R01-AG16381 [coinvestigator]); and has received stock options from Medivation and NeuroPhage. Dr Weiner serves on scientific advisory boards for Bayer Schering Pharma, Eli Lilly, CoMentis, Neurochem, Eisai, Avid, Aegis Therapies, Genentech, Allergan, Lippincott Williams & Wilkins, Bristol-Myers Squibb, Forest Laboratories, Pfizer, McKinsey & Company, Mitsubishi Tanabe Pharma.
Dick Tract, PhD (Cognitive Neurology—St. Joseph’s, Ontario, site investigator); Charles Bernick, MD (Cleveland Clinic Lou Ruvo Center for Brain Health, Cleveland, Ohio, site investigator); Donna Munic, PhD (Cleveland Clinic Lou Ruvo Center for Brain Health, site investigator); Chuan-Kuo Wu, MD, PhD (Northwestern University, Chicago, Illinois, site investigator); Nancy Johnson, PhD (Northwestern University, site investigator); Marsel Mesulam, MD (Northwestern University, site investigator); Carl Sadowsky, MD (Premiere Research Institute [Palm Beach Neurology], Palm Beach, Florida, site investigator); Walter Martinez, MD (Premiere Research Institute [Palm Beach Neurology], site investigator); Teresa Villena, MD (Premiere Research Institute [Palm Beach Neurology], site investigator); Scott Turner, MD (Georgetown University Medical Center, Washington, DC, site investigator); Kathleen B. Johnson, ANP (Georgetown University Medical Center, site investigator); Kelly E. Behan, BA (Georgetown University Medical Center, site investigator); Reisa A. Sperling, MD (Brigham and Women’s Hospital, Boston, Massachusetts, site investigator); Dorene M. Rentz, PsyD (Brigham and Women’s Hospital, site investigator); Keith A. Johnson, MD (Brigham and Women’s Hospital, site investigator); Allyson Rosen, PhD (Stanford University, Palo Alto, California, site investigator); Jared Tinklenberg, MD (Stanford University, site investigator); Wes Ashford, MD, PhD (Stanford University, site investigator); Marwan Sabbagh, MD, FAAN, CCRI (Sun Health Research Institute, Sun City, Arizona, site investigator); Donald Connor, PhD (Sun Health Research Institute, site investigator); Sandra Jacobson, MD (Sun Health Research Institute, site investigator); Ronald Killiany, PhD (Boston University, site investigator); Alexander Norbash, MD (Boston University, site investigator); Anil Nair, MD (Boston University, site investigator); Thomas O. Obisesan, MD, MPH (Howard University, Washington, DC, site investigator); Annapurna Jayam-Trouth, MD (Howard University, site investigator); Paul Wang, PhD (Howard University, site investigator); Alan Lerner, MD (Case Western Reserve University, Cleveland, Ohio, site investigator); Leon Hudson, MPH (Case Western Reserve University, site investigator); Paula Ogrocki, PhD (Case Western Reserve University, site investigator); Charles DeCarli, MD (University of California, Davis-Sacramento, site investigator); Evan Fletcher, PhD (University of California, Davis-Sacramento, site investigator); Owen Carmichael, PhD (University of California, Davis-Sacramento, site investigator); Smita Kuttur, MD (Neurological Care of Central New York, site investigator); Seema Mirje, MBBS (Neurological Care of Central New York, site investigator); Michael Borrie, MD (Parkwood Hospital, London, Ontario, Canada, site investigator); T-Y. Lee, PhD (Parkwood Hospital, site investigator); Rob Bartha, PhD (Parkwood Hospital, site investigator); Sterling Johnson, PhD (University of Wisconsin, Madison, site investigator); Sanjay Asthana, MD (University of Wisconsin, site investigator); Cynthia M. Carlsson, MD (University of Wisconsin, site investigator); Steven G. Potkin, MD (University of California, Irvine [Brain Imaging Center], site investigator); Dana Nguyen, PhD (University of California, Irvine [Brain Imaging Center], site investigator); Pierre Tariot, MD (Banner Alzheimer Institute, site investigator); Adam Fleisher, MD (Banner Alzheimer Institute, site investigator); Stephanie Reeder, BA (Banner Alzheimer Institute, site investigator); Veronica Bates, MD (Dent Neurologic Institute, Buffalo, New York, site investigator); Horacio Capote, MD (Dent Neurologic Institute, site investigator); Michelle Ramkia, PhD (Dent Neurologic Institute, site investigator); Barry A. Hendin, MD (Dent Neurologic Institute, site investigator); Douglas W. Scharre, MD (Ohio State University, Columbus, site investigator); Maria Kataki, MD, PhD (Ohio State University, site investigator); Earl A. Zimmerman, MD (Albany Medical College, New York, site investigator); Dzintra Celmins, MD (Albany Medical College, site investigator); Alice D. Brown, FNP (Albany Medical College, site investigator); Sam Gandy, MD, PhD (Thomas Jefferson University, Philadelphia, Pennsylvania, site investigator); Marjorie E. Marenberg, MD (Thomas Jefferson University, site investigator); Barry W. Rovner, MD (Thomas Jefferson University, site investigator); Godfrey Pearson, MD (Hartford Hospital, Olin Neuropsychiatry Research Center), Karen Blank, MD (Hartford Hospital, Olin Neuropsychiatry Research Center), and Robert B. Santulli, MD (Dartmouth-Hitchcock Medical Center, Lebanon, New Hampshire, site investigator); Karen Anderson, RN (Dartmouth-Hitchcock Medical Center, site investigator); Jessica Engler, PhD (Dartmouth-Hitchcock Medical Center, site investigator); Jeffrey D. Williamson, MD, MHS (Wake Forest University Health Sciences, Greensboro, North Carolina, site investigator); Kaycee M. Sink, MD, MS (Wake Forest University Health Sciences, site investigator); Franklin Watkins, MD (Wake Forest University Health Sciences, site investigator); Brian R. Ott, MD (Rhode Island Hospital, Providence, site investigator); Chang-Kuo Wu, MD, PhD (Rhode Island Hospital, site investigator); Ronald Cohen, PhD (Rhode Island Hospital, site investigator); Stephen Salloway, MD, MS (Butler Hospital, Providence, Rhode Island, site investigator); Paul Malloy, PhD (Butler Hospital, site investigator); Stephen Correia, PhD (Butler Hospital, site investigator); Howard J. Rosen, MD (University of California, San Francisco, site investigator); Bruce L. Miller, MD (University of California, San Francisco, site investigator); and Jacobo Mintzer, MD (Medical University South Carolina, Charleston, site investigator).

Funding/Support: Data collection and sharing for this project was funded by ADNI (NIH grant U01 AG024904), which is funded by the NIA and the National Institute of Biomedical Imaging and Bioengineering, and through generous contributions from the following: Abbott, AstraZeneca, Bayer Schering Pharma, Bristol-Myers Squibb, Eisai Global Clinical Development, Elan, Genentech, GE Healthcare, GlaxoSmithKline, Innogenetics, Johnson and Johnson, Eli Lilly, Medpace, Merck, Novartis, Pfizer, F. Hoffman-La Roche, Schering-Plough, Synarc, as well as nonprofit partners the Alzheimer’s Association and Alzheimer’s Drug Discovery Foundation, with participation from the US Food and Drug Administration. Private sector contributions to ADNI are facilitated by the Foundation for the National Institutes of Health (http://www.fnih.org/). The grantee organization is the Northern California Institute for Research and Education, and our study is coordinated by the Alzheimer’s Disease Cooperative Study at the University of California, San Diego. The ADNI data are disseminated by the Laboratory for Neuro Imaging at the University of California, Los Angeles. This research was also supported by NIH grants.
P30 AG01029 and K01 AG030514 and the Dana Foundation.


Additional Information: Data used in the preparation of this article were obtained from the ADNI database (http://www.loni.ucla.edu/ADNI). As such, the investigators in the ADNI contributed to the design and implementation of the ADNI or provided data but did not participate in the analysis or writing of this article.

REFERENCES


