Introduction and Speaker Background

Welcome back to the Reverse Alzheimer's Summit. I'm your host, doctor Heather Sanderson, and I'm so pleased to have gotten pregnant here today. He's a board certified internal medicine doctor and completed his fellowship in geriatric medicine at the Cleveland Clinic.

He co-developed the program for brain health at the Cleveland Clinic Center for Functional Medicine, where he worked for several years before taking his current position as Chief scientific Wellness officer at Kemper Cognitive Wellness.

Based in Rocky River, Ohio. Kemper Cognitive Wellness is one of the nation's leading companies organized around prevention as well as treatment of early intervention and later stages of Alzheimer's, dementia and related conditions.

He has authored a number of peer reviewed medical articles, and hosts a popular Alzheimer's podcast called Evolving Past Alzheimer's, where I often go to learn the news and the latest in the Alzheimer's world.

Doctor Brickman, thank you so much for being here. Thanks for doing this, Heather. It's nice to be here with you. So, you know, I reached out to you not only because you host the podcast and have talked to so many of the experts in the fields, but also because you're a bit of a self-described skeptic.

And so I, I love to have conversations that sort of challenge my worldview and help me to think more critically about what's possible, about what we know, what we don't know.

And so that's where I would really like to go today, is into the frank conversation about what we know and what we don't, according to the science. I'm also curious, just to start, you've interviewed so many of the voices in this area.

What are some of the pearls and concepts that you've picked up with them that you'd like our listeners to know? Yeah, that's a good question. There is a lot, I think, much is unknown.

I think that's the most honest truth. But there is enough known where you and I and others doing this kind of work are seeing people stabilize. They're seeing people in some cases, improve.

But the the key seems to be, acting early, right? The early identification, the early where people can identify and seek treatment, for symptoms like Alzheimer's.

Early Detection and Reframing Alzheimer's

The better the results are. For so long, people are have been on this impression that there's nothing you can do about Alzheimer's. And when we speak publicly that we talk about usually talk about early identification, doing something early.

And this idea that it's no longer true, even from an evidence based medicine perspective, you don't have to get into functional medicine. You don't have to get into functional neurology.

You really just, have to follow the data. But for the last few years, there's been evidence for prevention. There's been evidence for early improvements.

And so that's that's like a game changer. So it's that's exciting because it's never been like that. The other thing and I give, doctor Dale bread and I know you've had on this, an this summit on, and we both know fairly well.

I give him a credit for clarifying and making the analogy between Alzheimer's and, cancer. Right. So redefining cognitive impairment like that, as opposed to, you know, like when we started the podcast Evolving Past Alzheimer's, we were using the word Alzheimer's.

And in our brand strategy, person said to me, she said, well, it really evokes this image of someone kind of in a nursing home against the wall with like hot cereal spilling out their mouth and completely impaired, can't recognize family members.

And that's like people's notion of Alzheimer's. And, you know, I still see people like that often. And those cases hurt our hearts every day, every week.

But it also just doesn't start there. Right? You you know, this and by, by making this analogy to cancer, you know, some it tells you cancer. You want to first know, okay, what kind of cancer is it?

You know, the treatable kind or not. If somebody says they have early stage breast cancer, most of us know that, okay, it was probably picked up on a self-exam or a mammogram or something like that.

And then there's a lot you can do and you don't have to die of it. Right. You can treat it. You could call it a cure. People are often worried that it will come back, and sometimes it does.

But there are treatment strategies around early identification and taking it out as opposed to like stage four pancreatic cancer. Which although there have been incremental improvements, it's still, you know, it's while stage four pancreatic cancer, most of us know.

Well, that's, that's tough. So the idea that someone can have Alzheimer's, but not have dementia is a novel, right? I think that's still new. And in the sort of academic medicine world, we're using terms like preclinical or prodromal, as you know, prodromal, Alzheimer's, amnestic, mild cognitive impairment.

These are all like stage 1 to 3 before you get into Alzheimer's dementia. And just the difference between dementia and general Alzheimer's would be dementia is where people have cognitive impairment that's so bad that they can no longer live on their own, right.

They're no longer sort of safe, or able to be, paying their own bills or using a phone or, you know, in as it advances, you know, being able to go to the bathroom or dress themselves or eat themselves by themselves.

So, like it really pushing the needle and sort of defining Alzheimer's as something that can happen when you're 65, 50 years old and you're starting to have I can't remember the words, I can't keep up at work like those kinds of any sort of brain inefficiencies or it doesn't mean it's Alzheimer's disease.

It may very well be sort of the beginning of the changes that ten, 15, 20 years later might show up as a loss of independence is awesome. So I think that's that's like really critical.

And I so I think that's one of the big pearls and concepts. And then I mean, we can get into specifics, but and it's good to go back to to sleep. We can talk about sleep if you want.

And you've had a doctor, Charles Whitney, on talked about this, airway and sleep and oxygen. But there's, there's so much, what we're seeing and, kind of brainwave technology and brain bioenergetics, that, have to do with sleep.

Exercise is really been the most evidence based thing. Of course, for a long time, that we know we can do, for our brain. But I think sleep now is really rising as, as sort of a rival in terms of its importance in brain function, overall mood, memory, mind function.

Almost almost at the level of the evidence we have for exercise, diet, and then really learning the skills to be able to trauma, anxiety, ability toward resilience becoming more important in mid in sort of later stages of life.

And then the other thing that's also really important. And the key is to start, and we can talk about more of that if you want. It's just, the idea of paying attention to our ability to pay attention, executive function skills, things like ADHD, procrastination, poor organizational skills, new sort of executive skills.

Have a number of patients that right now are in their late 60s, early 70s and have kind of like undiagnosed or unidentified ADHD, and they have maybe a child or grandchild that has it.

And then when we start to talk about it, they never kind of get it treated. And, and so this is something we're starting to work with more and starting to pay more attention to, no pun intended to, and seeing if we can do something about that.

Sleep, Exercise, and Lifestyle Foundations

And as we do something about that, we anticipate beginning to see improvements because early Alzheimer's in animals, like in test animals, really looks like ADHD in flies and in mice.

And it turns out in human beings a little bit, too, in some kind of human beings. So it looks like that because of how we think the frontal lobe of the brain, the front parts of the brain that really control our ability to stay organized and, and focused, in some people, not everybody with Alzheimer's really can take a hit early and then everything else like the memory problems, etc.

will follow. I love what you just said, and if I can just sort of summarize one of the big goals of this summit of just putting the work in to make this happen is to change the narrative that if you are noticing cognitive decline, tell someone, get resources, find information that can help you reverse that because there are things that you can do.

We don't have to. The old narrative has been that there's nothing that can be done, so don't tell anyone. It's really embarrassing. There's nobody should know.

You know, I still talk to spouses who are covering for their, partner who is suffering with cognitive decline. And really, the opposite opposite should be happening.

We should be telling as many people who can get us help as possible, getting the intervention started early and the other piece that I thought was so important that you just said is the foundational piece of it.

Throughout this summit, we're talking about testing that's exciting. And interventions that are exciting and technology that's exciting. And there's a lot to be learned there.

And yet what we know with certainty is that it's these basic foundational sleep diet, exercise, stress management pieces that are so critical that all of that other technology, all of that other the icing on the cake, it's not as necessary as these foundational pieces that are relatively inexpensive.

So anyone listening that feels a little overwhelmed by how much we can do, just go back to the basics and just to tweak that a little bit. So I totally agree with what you said, and maybe to even amplify what you said or add to what you said.

Just take sleep as an example. You can take exercise, food or all of these things even, you know, sort of stress or stress responses. But just take sleep for, for example.

So, a lot of people have undiagnosed problems with either, you know, the two common to sleep issues are going to be in some at least United States are going to be insomnia and obstructive sleep apnea.

And, you know, this idea that you have to be snoring and the and the, blinds and the shades and the windows have to be shaking and the house has to be shaking to have obese. Yes.

Yeah. Or obese. Right. All those things don't don't, don't, don't have to be again, you may have had another guest

that I haven't heard yet. Talk about this.

A lot of dentists that are talking about this, there's some agents that are talking about this. There's a couple of neurologists that are talking about this.

There's some pulmonologists that are talking about this. But, there are a number of other conditions other than sleep apnea that can both interrupt your body's ability to get oxygen, but also interrupt the brain's efficiency.

So, like, when we see things, brainwaves on EEG, sometimes, just like I'll have people close their eyes for ten minutes while we're collecting EEG, doing a brain map, and you'll see people sort of doze off and people's arousal, meaning their ability to kind of reorient to, to awakens alert state where they can pay attention, create memories, etc., is impaired.

Right? And that's not only in people with Alzheimer's. This is people with kind of like subjective problems, subjective cognitive impairment, sort of the early so-called Alzheimer's.

Right. So stage one, stage two, before they get in really bad and people are really concerned. And this is like you said, people sweep that under the rug.

So we'll sometimes send people to a sleep doctor. I'm not a sleep doctor. And there are people that know more about sleep than I ever will. But sometimes they'll do the evaluation.

Maybe they'll get a poly, some ngram, or a home sleep test and it'll say mild sleep apnea. And the doctors will say, you know, sleep time to say, let's just sleep on your side.

It's not a big deal. Like it's no big deal. It's kind of waved off. And that's where we kind of have to pause and say, this approach is different, right?

We want to be more aggressive about the lifestyle stuff because like you said, it moves the needle as much, if not better than many other things. So starting with like a more aggressive approach to lifestyle, right.

You don't have to have 100% perfect diet, but it's going to be pretty good. You know, just kind of walking, and gardening may not be enough exercise, right?

It has to be lifestyle done. Right in a way, as you know, that's going to move the needle. I know, I know, you know all this. But, you know, we're talking to the public.

And of course, you know, and I love that, you know what we're asking even dentists, right. This comes up over and over again. It's like, no, we're not asking you to do the minimum.

We're looking for optimization, which is really the theme of functional medicine. And when we look at the alternative, right, of just kind of pushing things under the rug and not addressing them, then they start to accumulate.

And this is what manifests as chronic disease. And so this is reorienting to let's be aggressive about our prevention and our treatment when things are early on.

Don't wait. Yeah, totally. And just another thing, sometimes it helps people hear this that you'll say, oh my, my I went to the same doctor like you said, Doctor Bergmann.

He or she said it was just mild and, you know, I don't have to do anything about it. I said, okay, well, this is mild means just be having mild brain damage every night.

It's my opinion just fine. Right? Just have mild brain damage night after night. And when you say it like that, it's like a whole different thing, right?

Because. What do you mean? I might have been like this for 20 or 30 years now. I got to do something about it. Like nobody wants mild and nobody wants any kind of brain damage.

So calling it mild brain damage sometimes is a little bit, even though it's hyperbole, kind of. But sometimes it gives people a perspective that that changes their, their, what they heard from the from the sleep doctor.

That's helpful. I'm going to borrow that, if you don't mind. Yeah, sure. So you also recently interviewed, doctor Marwin Sabar. You'll have to say his name for me.

You said. Exactly. And so, I was really impressed by this because, again, we want to kind of poke holes in our worldview so that we make sure we're getting as close to right as possible. Right.

The stakes are so high. There's so many people suffering. So we never want to make false claims. And although the claim that there's nothing you can do is clearly false, there's also a claim that, you know, dementia can be reversed.

And we want to make sure that and that's our entire conversation on the summit. We want to make sure that that's accurate too. And if there's any if there's any sort of question about that, that we're picking this through the the potential holes in that, then we're understanding where they are and how we can really optimize what we know to be true.

So there is a conversation that you had with him about Adam the new at Academy Lab, the Biogen product that was recently FDA approved. And there are arguments on both sides about why this was done or shouldn't have been done, perhaps.

And, I noticed that the Cleveland Clinic, where you studied and did your fellowship has decided to not offer it and then wanted you to speak to some of the controversy and some of the discussion around this.

As you know, as a society, we consider spending lots of money to intervene in this way with people. Yeah, yeah. So I mean, Doctor Sebo is, you know, he's a leader at the Cleveland Clinic.

He's been a leader in the Alzheimer's community for a long time, and he's basically dedicated his entire career for at least 20 to 25 years. As a neurologist, as a geriatric neurologist, in large part just to solve the Alzheimer's problem.

Right. And he's a very, you know, he's a proponent and involved in a lot of, medication, drug studies. But he's also been pretty outspoken even going back to 2019 and 2020 about lifestyle and lifestyle interventions.

To to some degree, he's sort of been interested in the kind of work we're doing. You and I are doing. But he, you know, he's doing it from, standpoint of sort of the, the, the resources and rigors of, of academic medicine and currently at Cleveland Clinic.

Debating Aduhelm and Amyloid-Targeted Therapy

So it's a different kind of perspective, but it's important perspective. You know, I worked kind of in the line of fire at the Cleveland Clinic for several years.

And, it's a different kind of expectation there, right? You can't just do what you want and say and say things. You have to show evidence or do a study and, that's good.

And like you're saying, that's a that's a good thing. I thought that the perspective that he brought, I've just about brought on Andrew Helm and he was I mean, one to me is one of the most outspoken proponents of, as you Homer education lab.

And it's approval because of what it represents to patients and kind of the field. We need a win. Right. And while I

don't personally agree, with, the approval, if somebody could pay for it cash and wanted to try it, I don't think.

And they were early enough on, you know, the evidence, of course, suggested that it would, if it helps, if it helps, then that was sort of a big if, if it's helpful at all in slowing things down.

It would be kind of an needed to be given early, right? Mild cognitive impairment or very early Alzheimer's. And who knows, maybe it's even more helpful to somebody earlier stage.

The idea that there will be better medications, especially these monoclonal antibodies, seems to be pretty clear, although the field's been saying that for a while.

So the the advantage and I spoke to some of my, you know, old colleagues at Cleveland Clinic and they were very proud that they were, not going to be prescribing education and sort of wait until better medications would come along.

And, you know, a lot of these people have a lot of skepticism around what we're doing, the kind of it's sort of a functional medicine approach, if you will.

But they but they're sort of taking notice, at least what we're doing in general wellness, they're not objecting in some cases, especially those that kind of know me and know the, company where we work at Kemper, like they're, you know, we have a decent, decent reputation that we are trying not to be unscrupulous and overly hyping, results and telling people it's work like you talked about before with all the lifestyle stuff.

But, I think in general, the what was good about education and education is that it it raised some awareness about things that that you and I and doctor Dale Bredesen and our came in and, David Perlmutter and some of the other like people and Rick and Richard Isaacson and if you can go on and on, have been saying for a while, which is we have to be looking earlier.

Right. It's time to take care of cancer. Is not stage four right? It's earlier. You want to get it as early as possible? Some kind of like we started off on this.

I think the ag catch up conversation sort of help that kind of boil to the top a little bit, in the sense that it wasn't helpful or it wasn't seemed to be helpful later.

In fact, they only took people in the study that were, earlier because they've done many, many, many trials on people that are later stage. And while we still I still work with those folks on a day to day basis, these particular medications don't seem to be helpful.

So act early. And now it also raises awareness that seek identification early. And if something can be done, it's probably early. And oh, by the way, we're starting to have a conversation that there's something that could be done even in mainstream medicine.

Right. Sort of common practice medicine that you may be able to do something about Alzheimer's. So all of those things are good for people that are either worried about going through the suffering of Alzheimer's, or someone they care about is going to that all of those things are positives.

Whether or not you agree with AG, approval or not, I don't think it's feasible. I don't think it's tenable, and I don't think it's probably worth it. But I wouldn't stop a patient of mine most likely if they had the science and sort of met the conditions that the medications, seem that they might work on or slow things down.

And I don't think I would stop them. I would actually be very curious when they combine kind of a functional medicine approach with the medication, what that would look like, and if that would make the response to medication even better.

When I saw the price tag right, this $56,000 a year, with my experience at Marana and, you know, my experience

with patients, I couldn't help but think with $56,000 a year per dementia patient, what we could do with that?

I mean, we could build parks in people's neighborhoods who don't have them. We could, you know, get food, good high quality food delivered to people we could do.

I mean, you could get physical therapists or more, you know, somebody to coach more, exercise, all of these things that we already know. We could put those funneled those resources into what we do know about the lifestyle that most seniors are not living, or a lot of them are not living, and probably move the needle a lot more.

But there's another piece to this out-of-home conversation and that. Is that it? It, the target is beta amyloid plaques. And it seems to me that there's a big question mark in this conversation about whether or not beta amyloid plaques are really the culprit, because we've seen that there are, you know, centenarians who die and have perfect cognitive function, who have tons of plaque buildup.

We've also seen that there are people who don't have a ton of plaque buildup who have dementia. And sometimes we call this something other than Alzheimer's.

But to what degree do you think medications that directly target the destruction, essentially, of beta amyloid plaques or tau proteins will be the sort of the continued trajectory?

Or do we need to kind of take a step back and go, maybe that's not as big of a deal as we thought. Well, I mean, you know, one thing I think Marlin made clear in the, in the, in the review, was that if you don't implicate amyloid data, at least to some degree in Alzheimer's, then you really probably haven't seen enough Alzheimer's.

And so, you know, to me, there's no question that amyloid is playing a role in many, many cases of Alzheimer's. Right? There are all kinds of paradoxes or things that are unexplained because we don't fully understand, Alzheimer's disease.

Neurofibrillary tau tangles. You know, the idea of with zinc finger fingers, there's a whole group, a whole cadre of, doctors thinking about, mitochondrial function and vascular implications to hit hypotheses.

Glidewell talking about blood sugar problems unrelated to amyloid, necessarily, sort of like on and on. Physical trauma, emotional trauma, early brain, biogenic, sort of a brain bioenergy failure, on a network level.

So there are a lot of descriptions of what's happening. And with Alzheimer's and probably like you, we take the holistic approach of, you know, how many things can we look at, both from, what happened to this individual through the their life course and then or the things that we can specifically measure, that will target the problem, more specifically infections, toxins, etc., all of the hormones, these are all, I think, like open questions.

I'm not, married to the idea that amyloid beta is the is the be all and end all. And I don't think in the end, even with like a drug only approach, which is of course, the, Western world, particularly American business model for medicine, you know, drug it.

Or I mean, I talked to a leading, a ketogenic, researcher, was working with ketosis. And, you know, his whole interest in ketosis is to be able to drug it, right?

To put it, make it into a drug. And, that's the business model.

Multifactorial Dementia and Personalized Treatment

That's how, large health care systems really make money as procedures, medications. And you it can be more efficient that way. I love what you said about parks and exercise, I mean, and access to good clean food.

I mean, those are so important. So important. Even, when our, when our mark came in, my boss at the Cleveland Clinic spoke to the, surgeon general at the time.

I mean, that was one of his big initiatives. Was, was access to clean food and meditation for everybody. It was it was amazing. So, couldn't agree more.

I'm not married to amyloid beta. Have to treat all the causes, at least ones that are known. And then there's probably, I suspect, many things that we still don't know.

But I do think at the end, even if we come to a drug cocktail early stage, if it's a drug cocktail or it's, some kind of neurosurgical implant or device that's implanted in the brain, it'll probably target multiple signals rather than just amyloid.

So you also bring up a good point about how multifactorial dementia is. And this feels well-established, that there's not one thing that causes dementia, that it's a bunch of things.

And so this is in a situation like strep throat where there's a bacteria in your throat causing a bunch of pain and you want to treat it yesterday. And here's one pill, an antibiotic, and you take it for several days and it goes away.

That is not the model here. And so as you've mentioned, the business model around medicine is very much geared in towards single toward single interventions and the the gold standard of research.

And how we know what we know is a double blind, placebo controlled trial. Now in the case of something that is multifactorial and individualized, where two people can have different pathways that they take to get to the same diagnosis and Doctor Peterson does a good job of just describing his kind of six pathways or six types.

And they're not mutually exclusive, right. You can have all six types, or you can have 1 or 2. And so when we think about a disease where we know that that's the process.

The double blind, placebo controlled trials are no longer adequate to answer the question what works and what doesn't? And so we start having these conversations with people who really value that type of of trial.

And they point to the science. But the science and the way that we've designed the way science works doesn't meet the need of the current complex chronic disease landscape that we have in the Western world.

So what do we do? Yeah. Well, I mean, I think part of the, you know, as I became aware of functional medicine and the work of Doctor Branson, I was in my geriatrics fellowship at the Cleveland Clinic and, was sort of already convinced to some degree that, like, we needed to do more than one thing.

Right? Because that's what you saw with healthy people. They were doing more than one thing. People that would be diseases and sort of keep them at bay.

Either they were just lucky or they were doing more than one thing. And then when you kind of got into it, even back then in 2014, when we kind of looked around the world at what was working, there were people and organizations and serious researchers, mostly in Europe, France and Finland, doing what we called multi-domain trials there.

And I gave a grand rounds with this, as a fellow to the internal medicine department there. And it was interesting to see their response because I wasn't talking about functional medicine.

I was it was an internist doing a geriatrics fellowship, and we were talking about multi-domain therapies and the effectiveness of those. So a lot of people heard of the finger trial map.

T m a p. T a trial. I mean, these were all multi-domain interventions, and we're just like, there's a this notion that we have to do more things. You don't get pushback anymore from cardiologists.

That diet's important from endocrinologists, you know, can important. You don't get pushback from endocrinologists. People actually take care of diabetes and other conditions like that.

Diet, exercise, sleep are important, but you don't get that. But we still get that kind of pushback from oncologists. Like diet doesn't matter. I had a story.

This is unbelievable. We have I have sort of a a friend, who is a physician and an epidemiologist. His wife is, PhD level, therapist. And so they're very bright.

And, after you got Covid right early on, right before we were all sort of wearing masks, he had, you know, probable Covid and all the symptoms had really bad brain fog.

He's in his late 60s, has a Parkinson's runs in his family, in first degree relative. And he started having cognitive changes and he started having like, trouble with walking right, which is classic in Parkinson's.

And, was obviously very concerned, very concerned. And, you know, he kind of was trying to figure out what to do. Went to a movement disorder specialist who I know, who's a very good doctor, very smart like everybody else, probably smarter than me.

And he went through the diagnosis, sort of the diagnostic process, you know, diagnosed thousands of people with, Parkinson's or sort of related movement disorders.

And he told this guy who is an educated physician, researcher. He said, well, you know, I'm not sure if you have Parkinson's, come back in 6 to 12 months, that I can kind of tell you for sure if you get worse.

Right. And that just that was like, okay, all right. I guess, you know, that's sort of just the limitations of medicine. So then he said, well, what about, like nutritional strategies and, yeah.

Yeah, nothing. So this guy's smart. So he went and started googling. I just started doing the research and like immediately you come up with all kinds of, research how nutrition can improve.

So he fixed is tied up a little bit. And he was already doing pretty well, but he was fixed up his diet. We talked we talked about brain training. So he was interested, likes chess.

So he started getting back into chess and a lot of his brain fog cleared. Typically, there's a little bit of a workup done in neurology. You know, like a thyroid. Rule out some infections.

We'll get like a B12 level that wasn't done here. But to be fair, was the kind of the middle and beginning of Covid. So I'm going to be a little bit sensitive to the neurologist because, you know, we all I mean, we've all missed stuff.

We've all failed to follow through on something in our careers. But, he ended up going to his primary care doctor and so that he had sort of below red line B12.

So not like a sort of low, but in a normal range it was abnormally low, according to everybody. And then he started reading, reminding himself what he learned in medical school, about B12 and reading about B12 is like, oh my gosh, if it goes on a long time, it can be permanent.

But just started taking B12 and then went on some shots and started to notice sort of even more improvement. Right? So it's like he went to one of the best places in the world that you could get a diagnosis.

He listened to the doctor, and if he just did the recommendations, he would be waiting to see the doctor, like for a year and then go back to sort of make the pronouncement of Parkinson's.

But he didn't because, you know, he's proactive. And those are the people that we see that are succeeding, that are sort of saying, okay, well, I'm going to go to the I want to go to the regular doctor first.

And I always I mean, people shouldn't skip going to a neuropsychologists like I always refer people back. Why wouldn't you do the standard of care? First of all, insurance pays for it and you get some good information.

The problem is, when we get these these messages that are that are just not up to date where, oh, you nutrition doesn't matter. Oh like so that's that's the disconnect.

So that story to me is very, very powerful because he, he this guy is having improvements, though he's still wanting to have more. He still has some struggles, but just with the few things that he does.

And this is a very sort of evidence based family. Wife writes evidence based guidelines. There's sort of national level, evidence based guidelines. But but he's open and curious enough, and he just kind of called me and we had an hour conversation about, take a guess, sleep.

You know, all the other things mitochondrial function, etc.. And so he's he's kind of like pursuing that is his own pace. It's like these are we see these things over and over and over again, over and over again.

How interesting. And I think that's where it happens. Right, is when when you get a diagnosis or someone in your family gets a diagnosis and you start to really put the effort in, okay, what are some of the options?

What's impressive about him is he's not back to 100%. It sounds like, and it's been a year and a half or so, but his doctor was expecting in 6 to 12 months that he would progress.

And he's gotten some improvement. Right. So that sounds like a success. And certainly around the narrative of Alzheimer's, Parkinson's, a lot of these neurodegenerative disorders is the expectation from neurology or a lot of conventional medicine is progression of disease.

And our expectation is reversal. And we're not going to get at 100% of the time, and we're not going to get it without some significant effort. But we can see that it's possible.

And that is what I want people to understand is that there is a chance of reversal. And so what does a balanced perspective look like in this area right now?

What do you suggesting that your patients do you know how far do you take it. Do you give them the entire list. Do you say these are the things that move the needle the most?

Do what you can? I think that we all need to allow ourselves a little bit of grace because it's it can feel overwhelming. It can become a full time job.

It can take a fortune to do it all. But what is a balanced approach look like? Yeah. So, so just to not to I will answer the question. I do think reversal needs to be defined and clarify for, for people because, you know, improvements, reimbursement, return of function.

You know, we have someone working with now just at a, podcast one she's, you know, she's pretty advanced by scores, who's still kind of living independently, pretty much.

And, you know, she's feeling back to herself after several months and the program and, you know, her story continues to evolve. So up, down, up and down.

But for many months, it was sort of up right uptick. And it wasn't really anything. Magical that we did. Right. Like there wasn't anything that we did that was kind of like magical.

Like we weren't bringing her in for IV's at this point. Anything. It was just, getting engaged, and trying to have people if you if you're fortunate enough to have people around you that care about you that can kind of hold you accountable, that's like part of a balanced perspective.

Doing this alone, I do. I've talked to people that are doing it, doing this alone. We're talking to a group of people next month that are trying to do this alone.

Sometimes you're living alone with dementia. They're typically younger because, as you know, this diagnosis is starting to happen younger and younger, like the 35 to 64 age range, is like jumping, jumping up in terms of diagnosis.

Infections, Toxins, and Immune Resilience

Maybe it's because we're looking for things earlier and we're getting better about the diagnostics, but a balanced approach really goes back to the first thing that we started to we're talking about like typically it's hard for me to add anything, even if it's, it's sort of monetarily good for the practice that I work for.

If people can't do the basic things right, like starting to exercise, changing their diet, ideally, maybe, depends on the risk, depends on the person, and it depends on what you we're talking about before, like kind of what kind of Alzheimer's they have.

Because it does seem like there's multiple sort of personalities or kinds of Alzheimer's. And that's just not doctor Dale. Brett isn't talking about that.

You know, a clinic clinic. We did deep phenotyping work to sort of describe what the Alzheimer's look like. Richard Isaacson, at Cornell, we'll talk about sort of personalities of Alzheimer's.

So there's different, different kinds, right. Not all kinds of Alzheimer's look the same. But like getting people in ketosis, if it's appropriate, exercising with some measure of intensity and trying to add, like, a cognitive load, some, some type of cognitive tasking, learning, you know, sort of brain training, if you will, addressing oxygen issues like, like a huge deal, sleep and oxygen issues.

And then, like. The other key that we see, is hooking into. Why do you want to fight this? Why? This is not easy, right? It can be costly. And it can be, at least in part, like you're saying.

It's at least a part time job. Why do you want to do this? And that's sometimes a difficult, that's sometimes a difficult conversation, because I'm sure, like you have what we see a lot is, a spouse or a child of someone who is suffering as being the bringing my patient in saying, mom, you have to do this.

And no one's looking at me like, who said I want to do this? Right? And so that that sort of presents us with an ethical, sort of an ethical challenge.

Like, what are what are, what are we doing this for? Right. What are we doing this for. So I think purpose is, is huge and and we try to talk about those things.

We maybe talk about things like goals or we say in different language. But to start, I think about the, the, we start with that exercise, sleep, issues purpose.

And then, then we sort of move quickly into mitochondrial optimization. And, maybe oxygen therapies. Neuromodulation. We do look we sort of look a little bit at toxins, infections, although I'm, I still have my, doubts about the diagnostics around that a little bit.

But we, you know, so we sort of, we, we wade through depending on how advanced someone is or how engaged someone is. Right. But if somebody can engage in sort of changing a diet that really help to to start them up on tons and tons of supplements or tons and tons of, you know, like whatever else it's going to be, start hormone replacement therapy.

If there's any risk of hormone therapy at all. It's certainly to be higher. And someone who has inflammation because they're not exercising enough and they're not eating well. Right.

So we're maybe introducing a risk that we unnecessarily not that we've never done it. Not that there may not be a time and an individual, but as sort of a general piece of advice.

I think that's, that's the beginning of the balanced perspective. And then wading into some of the kind of deeper layers, functional medicine sort of diagnostics and layers, or soon thereafter, soon thereafter, once you get people started with the core stuff.

One of my favorite mentors has always said, you can't out supplement a shitty diet, right? Totally. So start there. I'm curious about the infection. So like, you just speak a little bit to that and you're kind of skepticism around it or what you do.

It seems to me like pigeons to Valis, the herpes viruses. Certainly the Lyme skyrockets that there is a pretty clear connection between them and amyloid plaques.

We know amyloid plaques are antimicrobial, so to speak, to that that section of this conversation a little bit. So, so so you mentioned a couple, you know, HSV one maybe HSV two.

It should be six of these herpes families viruses. No doubt implicated. Like if we're going to follow evidence, we definitely have to follow the evidence for those devils and some other dental infections, periodontal disease.

So we're pretty quick to refer for that to identify and refer for those. Right. In terms of infections or viruses we look for, I would put I'll probably put Covid up there now although we don't have long term data.

But the association with Parkinson's in particular, and the anatomy of where in the anatomy of where Covid seemed to attack some of the Japanese studies we're talking about this last year.

Where Ace2 or Ace2, receptors are right in the same areas, classic sort of hippocampal areas and frontotemporal areas in the brain, are impacted not always, but sometimes Alzheimer's.

So those those I think I'm much more quick, the dental referrals very quick, because it's, because the data is good. It's when we get into some of these other things, Lyme disease or Lyme related or co-infections.

CMV, I've seen bar, right, like where there's much less data and the treatments aren't clear. That's where I think I get, I get, My, my questions are raised as to how do we know?

And then we have to say, okay, what are we going to treat with. We treat with verbal therapy, okay. And we know that IRBs are safe. Something like a buena IRB or something like that.

Okay. Those seem reasonably safe. That seems like a reasonable thing to do. Are the tests good like we have? What are we missing? Herpes viruses because we're using, like, you know, yeah.

Like we're using, you know, globulin tests. Are we missing Lyme? Everybody agrees that the Lyme tests know for whether it's for, really serious or any Lyme related infections.

The most of the tests that we have are highly inaccurate. It's just the best that we have. So, that's where I'm saying it, like it's people sometimes misunderstand me.

Like, I don't believe that these things are implicated. That's not necessarily true. I mean, I mean, McDonald's sort of demonstrated, that if you look under at the brain of people that have Alzheimer's disease, you'll see more repeats, at least in 100 or so individuals who looked at, okay, so that's data.

But how do we test for that? How do we know, like what's the best treatment. And so those things still need to be worked out. And I'm willing to wade through that with my patients.

And have frank conversations. But sometimes it can feel confusing to them because they just want to know, do I have it? I need to treat it for how long? Right?

They want a clear answer. And, to me, the honest answer is we're not sure. So let's talk about it and then we'll

wade through it together. And, for people that are already doing the work, like, yeah, I'm like, that's my commitment to them.

Even though it's not the standard of care. I know you you've probably practiced kind of the same way. It's just the, the the, the, I think sometimes think that the the the clarity and certainty that we, that we know people want and that we ourselves want, we sort of convince ourselves that it's there.

And that's where that tricky sort of hope versus hype. And that's where it gets tricky. Because in the meantime, we all have a life that we need to, to, to, to sort of continue to live.

We have families. We have businesses. Right. So, so we need to sort of like keep things rolling. And I and I, I hesitate whether to talk about that publicly, but like, I know everybody's thinking about it, every single person, whether they're mainstream doctor, their, functionaries and doctor or, do something completely different.

They're always asking themselves like, okay, what level of certainty do we have here? And so I just feel like having, more honest conversations about what we know and what is more experimental is, is the best way to go.

And, and we still like, like everybody else. So we see some of these remarkable, remarkable recoveries. And then we also are starting to ask ourselves, like, so what are the characteristics of people that are not not improving?

Right. And I'm a natural born skeptic and I'm the son of a doctor and a lawyer who sues doctors and hospitals. And, they would tell you I was by like this when I was six years old.

Okay. But it's, you know, it's served me and it's also I hopefully serve patients, but, sometimes it gets you into, like, you're neither here nor there, right?

Either you're not there. The Covid is this really phenomenal illustrator of this phenomenon, right? That, different people respond very differently to viruses, bacteria, these infections that some people succumb, some people, in fact, lose their lives.

Other people are asymptomatic. And so what's the difference? Right. This is sort of host versus pathogen conversation in medicine that it's been going on for 100 more than 100 years.

And when we think about like, my hope is that Covid bill will sort of open up the conversation around Lyme and the co-infections around EBV and the co-infections and things that, whether they're functional medicines or integrative or naturopathic or whatever kind of these alternative doctors have favorites.

Kind of what you'll see is that everybody who goes to that doctors diagnosed with EBV or everybody who goes to that, doctors diagnosed with Lyme, and that maybe what we can do is start to have a conversation about where is the interface.

And not that we don't, but even more so where's the interface between okay, right. There's a lot of ubiquitous infections out in the environment. What is the host doing and what can the host do to best protect themselves so that these these infections don't become opportunistic and start to create complex, chronic disease?

What are the things that set people apart and is it genetic? Is it it's probably like dementia. Multifactorial, right. There's a piece of it that's genetic.

There's a piece of it that's nutritional. There's a piece of it that may be toxic. It's a piece of it that might be stress and that we can start to unravel this.

And although it feels a bit overwhelming sometimes, there are things that we do know and that we can start to eliminate. And there are conversations that we can have with people who are ambitious about getting well and willing to do the work.

Yeah. And I that's I think maybe really, maybe the most important. But it's a very, maybe the most important point. But it's certainly top 2 or 3, which is, you know, strengthening our organism.

And that goes back to the first thing we started talking about diet, exercise, sleep, stress, environment, cognitive stimulation. And I know you've created environment.

Marama. That sort of trying to optimize for that. We've done a similar thing in terms of a kind of a program, to rehabilitate sort of the term that started showing up in the literature, in 2017.

Three involvement in cognitive enablement for people with dementia. So we're very proud of the small amount of pilot data we have for for that. And we're sort of extending that environment, here in Cleveland and like the that's what you got.

We want to like make the soil better. We want to improve people's overall. Sort of like neurochemistry, electrophysiology so that all of these toxins, all of the infections that we all encounter, sort of on a day to day basis, our bodies can, can fight it.

Right. So I, I was, you know, I've been hearing about this since before I went to medical school. I was sort of fascinated by the psycho neuro immunology stuff.

In undergrad and, and sort of followed data points a long time, but I, I became a little bit more convinced of things when, about 2 to 3 years ago, when I really started seeing, like, how much of the, of neuroinflammation was related to the immune system within the nervous system.

Right. And this sort of, tethering of the nervous system and the immune system. And it seems to me right now that if you can rehabilitate an immune system enough by just sort of removing, just going back to basic functional medicine principles, typical sort of rules of like removing what shouldn't be there and giving the body sort of pressing the levers of wellness, if you will, based on things that are measurable or things that are just common sense that are known and driving that like people don't have maybe as much susceptibility to mold or infection.

So I, I agree with you. And then there was a more recent, pieces of information came came came my way. That's been around for a while. There's a she's sort of an emeritus professor at University of Texas San Antonio for Miller, and she's really her and now the group that sort of picked up sort of her proteges, that have picked up, are really doing the work to show connections to toxins and triggers, including mold and, derangement in immune system.

Right. Whether it's so clear that mold causes Alzheimer's, a not I don't it's not I'm not certain about it, but I've seen people that seem to get worse when they're in moldy environments.

If you talk to your brothers in or cantaloupes or and Hathaway and people that just completed the trial. And now you've spoken about the trial, and I'll, I'll add my anecdotal information as of yet, but we'll publish it next year.

Research Needs and Closing Remarks

But certainly I see a connection between mold and dementia, and then also getting rid of it and improvement, which is expensive. So we try to get again that the testing a rough try to get an indoor environmental professional in there and to examine people's houses.

We know air pollution is linked to Alzheimer's and Parkinson's things. And so I agree with you in terms of how do we improve the organism. And then improve our general ability to try to detoxify.

And then the specifics of doing that, like the hard work of doing a study and publishing, that's going to be the thing that that, will convince the neurologic community, the public at large instead of, you know, my patients going and saying, yeah, it's for the neurologists who want to read to see.

And she said, well, that has nothing to do with it, right? Like, okay, like, what am I going to do about that? What can

I show them now? So people are like, you know, people are doing some of the hard work to, to sort of, to, to make this point, to find out, you know, is it true?

How true is it? When is it true? And, you know, who do we need to act on? So I, I have a sense, yeah, that this is this is a real thing. But to say it's proven yet is I think it's, it's it's premature.

And some of the diagnostic tools that we have our, probably not ideal. So I think that's some of this sort of skepticism or cynicism that some people have.

It's where my own skepticism lies. But we still, again, we still look for it. We still, work with it and try to treat it, even with the skepticism. Because.

Because it's all hands on deck, as you know, with these folks. Because we need to do everything we can and support them in every way we can so that they can get better.

And so many of them do, as you know. So we just do our best with what we know now. And as we know more and we know better, we do better. So I would love to hear from you.

In an ideal world, what would the research look like? Like what would be published? Or how would a study be designed to help you feel like less of a skeptic?

And then I want to make sure before we go, that everyone knows where they can find out more about your podcast, your clinic, and then also, whatever else you have to offer. Yeah.

So the question about the research, you know, where does it needs to go? I mean, it's sort of what we were saying before, usually the research is done in sort of bits and pieces and threads.

Right? So first, like Claudia miller was the first thing that her work and the work of her group was the first thing that sort of was really convincing to me on a sort of a mechanistic level of how mode might trigger the immune system.

Right. Because I've read a lot. But this, this was this was sort of qualitatively different. And I even though she's been around for a while, I hadn't seen a lot of the people that I look to and learn from.

According to her, although they might have and I just wasn't it didn't sort of put it together yet. I know a couple of people that I contacted after the fact said, oh, yeah, she's she's a giant.

But, but it was a recent paper by the, her group that was really, had turning to me. And so you kind of need the same thing with Lyme, but in order to do that, we need better diagnostics.

So, like, first we need good diagnostic tools. And my main issue is with the testing. It's sort of the testing itself. It's less question about whether or not it's playing a role in this sort of multifactorial issue.

But so less questions about that. But how do we how do we know with certainty to be able to make a recommendation to someone that they should spend $35,000 reviewing their home or leave the house that they've been in for 45 years?

That's a that's a hard thing to know without a pretty good level of certainty. We're starting to be able to answer the people that are committed. As you know, are willing to do it.

But but to me, I'm not an indoor environmental professional. I don't think that a lot of the sort of urine and blood tests that we have our are foolproof.

And so we like to have a home inspected by someone that knows what they're doing, and then we can make better recommendations. And so we're starting to see that with our people.

And, that feels more legitimate. Then, then a urine test that I don't know whether I can trust the results of because of everything I've seen, everything I've done, everything I've read, and every expert I've talked to, you know, so, so that so we need to sort of, like, do the tests, validate the tests, see if treating the problems improve either as sort of a one off basis or as a complex of things.

But when you're treating a complex, I do think that the, you know, when I was at Cleveland Clinic, there are technologies that are starting to, allow us to, to do systems interventions.

So doing multiple interventions and usually used using drug trials use 3 or 4 drugs that say in brain, certain kinds of brain cancer. It was when I first became aware of this a few years ago, that can sort of attribute different kinds of improvements to the different aspects of the treatment.

So I think those are coming. We're a little bit, far away from that in the functional and world, but those kinds of treatments and technologies that allow us to sort of assess for, well, how much was it this and how much was it that, those are coming, those are the kinds of things that would be really, really persuasive.

And if we have those, this kind of medicine will be mainstream medicine. It's I mean, it's it's very exciting. We're a Kemper County Wellness in Cleveland, Ohio.

The podcast is evolving past Alzheimer's. And, I'd love to hear from me. Thank you so much for taking the time for having this conversation with me. I always learn something when I chat with you, and I'm just so grateful that you are part of the team that's changing the narrative around this.

And I feel just really grateful to call you a colleague and to have gotten to have this conversation and share it with all of our listeners. Thank you. Thank you.

I feel the same about you, Heather. Thanks for having us on.