Daughterhood the Podcast

Episode #56

Preventing Dementia

with Dr Mitchell Clionsky

1:02:21

RESOURCES:

https://braindoc.com/

The Memory Orientation Screening Test MOST - https://braindoc.com/cns-neuro/the-most/

The Anticholinergic Burden Calculator - https://www.acbcalc.com/

BEERS Drug Criteria
https://gwep.usc.edu/wp-content/uploads/2023/11/AGS-2023-BEERS-Pocket-PRINTABLE.pdf

Does Benadryl Use Increase Dementia Risk?

https://www.scientificamerican.com/article/does-long-term-benadryl-use-increase-dementia-risk/

SPEAKERS
Rosanne, Dr Mitchell Clionsky

Dr Mitchell Clionsky 00:00
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Rosanne 01:02
Hello, and welcome to Daughterhood the Podcast. I am your host Rosanne Corcoran Daughterhood circle leader and primary caregiver. Daughterhood is the creation of Anne Tumlinson who has worked on the frontlines in the healthcare field for many years and has seen the multitude of challenges caregivers face. Our mission is to support and build confidence in women who are managing their parents care. Daughterhood is what happens when we put our lives on hold to take care of our parents. We recognize this care is too much for one person to handle alone. We want to help you see your efforts are not only good enough, they are actually heroic. Our podcast goal is to bring you some insight into navigating the healthcare system provide resources for you as a caregiver as well as for you as a person and help you know that you don't have to endure this on your own. Join me in Daughterhood. Dementia. While we know it's a progressive neurodevelopmental condition with over 200 types, there are still many questions of why and how it develops. Today, my guest is Mitchell Clionski, a Board Certified clinical neuropsychologist with 45 years of experience evaluating and treating patients with cognitive impairment, dementia, ADHD, and traumatic brain injury. Dr. Clionski, along with his wife and partner, Dr. Emily Clionski, have treated more than 25,000 patients with cognitive impairment. They have taken their experience and research and combined it with the most current scientific findings to create their new book, dementia prevention. Using your head to save your brain, a practical guide that empowers you to improve your brain's future. We cover a lot of topics today, our genes, common health issues, sleep, hearing our habits, and the lifestyle changes we can make to support ourselves and our brains. I hope you enjoy our conversation. Dr. Clionsky, there's so much to cover. But can you shed some light on the confusion around family history and dementia?

Dr Mitchell Clionsky 02:59
It is a complex kind of answer. Let me try to break it down into a couple pieces. There are some families that have very high rates of dementia have neurologically caused aggressive declines in how we think and behave. That's what dementia is really are. They're a neurological condition of which Alzheimer's is a big part, but not exclusively, is a lot involved with vascular factors circulation, essentially, diabetes and hypertension. Related to that is also Parkinson's disease. There's Frontotemporal dementia is happy to talk about this. Some of them like Huntington's disease, for example, have a very high genetic loading 50% of the people who have Huntington, children of Huntington's patients will have Huntington's disease and it's knowable through a genetic test. There are certain kinds of early onset Alzheimer's patterns, usually in very isolated places where there's a lot of familial headward inbreeding, but it's you know, you're married to your cousin who was also your uncle. And, you know, there's a lot of those things in places where geographically, people are sort of locked in those cases, it's very easy to see the genetic pattern and they start in their oftentimes 40s or 50s. So how do you know if you're one of those people chances are you don't have any grandparents, because they've all had dementia. And then there's the somewhat greater likelihood when you have

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parents, especially both parents, and they have a higher probability because of the number of their siblings, their brothers and sisters who also have dementia, and those can be inherited. On the other hand for most people, dementias are

Dr Mitchell Clionsky 05:00
not so much genetic, maybe 5% of the likelihood is based on who your parents were. The other important thing to know is that even if you have a higher genetic loading, and even if you actually are developing dementia, there's a lot of things you can do to reduce the progression of that, and to limit its impact on your life. So when people say, Should I get a blood test, because that's a big rage these days, everyone's talking about blood tests. And in fact, there was a company that was doing blood tests for this direct to the public Quest Diagnostics have recently pulled back on this, partly because of their there were some errors technically, I think, and also because there's real questions about what to do when you give a blood test to somebody, and there's no follow up to discuss what that means, and how do you deal with it. But there's some people really want to know that probability. My contention is, that doesn't really change very much, you still want to do everything you can to reduce your risk, whether or not you have that gene, it's not like you're going to walk faster when you're walking, or that you're going to sleep deeper when you're sleeping. There's really nothing more that you're going to do. Algae and alga really watch out not get a concussion, because I got that genetic background. That's not gonna change anything. So I'm not really I don't recommend it for my patients. And I don't recommend it for their families, either. Because I don't think it gives us much at this point in time. Now, in the future, if there are earlier interventions, medically that make a difference? Absolutely, then you can do something, it becomes actionable information. And right now, we don't have that correct. Everything that is out there right now is pretty much minimal gain, if any gain and it just kind of slows it down for maybe three to five months? Well, it depends how you look at it. Let me take break that down a little bit. There right now, the last half year, a infusion therapy bottle, a cannabis brand name is Allah cambie, where people every couple of weeks go in and get this IV infusion into their veins. And they've looked at this over 18 months, and show that it probably you can estimated maybe over the 18 months reduces the progression by about three months. And then maybe the figure that you are citing, right there are. So if we take that data, and we give it the most optimistic kind of interpretation, we would say, Well, if we did that in 18 months, maybe in three years, we would now slow it down by a half a year, and then maybe over another three years, we'd gain another half a year. But that's not been proven, we haven't actually tested it that far, we don't know, it could be that the effect becomes more pronounced that you get better results. Or conversely, it could be that the early results don't get any better or even get worse. What we're doing with that kind of a treatment is removing beta amyloid plaques, these buildups of these fibrils little fibers that form into plaques, that are sort of cholesterol like in nature. And they gum up the works essentially, and also cause a breakdown of the structure of our brain cells called neurofibrillary tangles. But now the thought is, well, if we could find it, then if we go back earlier by doing blood tests

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and say 10 years before someone becomes symptomatic, and if we catch the very beginnings of the beta amyloid buildup of that point before anyone's having really any symptoms. If we get rid of the beta amyloid, then we could avoid the disease later. That is really speculative. It's really unclear in my mind, and I've been doing this for 45 years, but it's really unclear in my mind that getting rid of the amyloid at that point will in fact, change the course of the disease. We don't know what causes Alzheimer's, let alone some of the other ones. Because there are these plaques doesn't necessarily mean that it's the blocks that are the problem. blocks may very well be the result of other inflammatory problems, other kinds of health changes. For all we know we could actually need those plaques and started to take them away 10 years before we're symptomatic, they actually have the opposite effect of what we're intending. On the other hand, we have had medications on the market now for the past 25 years. Three of those medicines work on a particular chemical in our brain called acetylcholine. Acetylcholine is chemical which transfers information from one nerve cell to the nerve cells around it. So it's very much involved in the making of new memories. As we get older, our levels of acetylcholine naturally declined. Well, we can't put in more acetylcholine. So what we do is instead help to support the exh vailable and existing levels of acetylcholine, because that will keep our brains working better longer. That actually does work, and especially in many cases, if it's combined with the different kinds of medication of men and teen is to be called Namenda. And if we can get people on a combination of those two medications, many of my patients are no different five years later than when they walked in the door. And I consider that in an aging population to be a really good outcome.

Rosanne 10:57
That's a win.

Dr Mitchell Clionsky 10:58
So we've had this for a long time, but people got confused because taking these it's acetylcholine medications, medications like Aricept, otherwise prescribed as Donepezil. Exelon which is now prescribed as Rivastigmine,, Razadine which is prescribed as Galantamine don't make you better by themselves. And because they don't make you better. Oftentimes, people conclude that they don't have much benefit. Well, in a condition that by its very nature gets worse over time. No news is good news. So I'm very pro existing medications, because I see it all the time, where people come in and I see them every six months or every year, and over a course of time, they're very stable. That's a good outcome.

Rosanne 11:49
That is a good outcome. And that's with the combo of the Aricept and Namenda.

Dr Mitchell Clionsky 11:53
Yes.

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Rosanne 11:54
Okay. That's very interesting.

Dr Mitchell Clionsky 11:56
One of the other things that we found is if you can discover other conditions, medical conditions, or lifestyle problems and improve those, sometimes people get better by about 15% and stay better over a much longer period of time. So my wife, the psychiatrist, Emily Clionsky, and I did a study back in the early was 2010, is when we started the study, we eventually presented at the American Academy of Neurology, in Philadelphia in 2014. In the study, we followed 750 people, patients of ours, all of whom were seen by me for testing. I'm a neuro psychologist. So my primary role is to perform cognitive tests, along with my postdocs and my testing assistants. At that point in time, I was seeing anywhere from 1000 to 1200 people a year, I've cut down in my later years, I only see about six to 700 people a year now, but it's still a darn lot. It's a lot of people. And our goal is to test their abilities to pay attention, their abilities to learn and remember new information, short term memory, to solve problems, to think abstractly, to basically create an inventory of their cognitive abilities. They take stock of their thinking skills. Well, we followed all of these people, the 700 people for two years, at six month intervals. Half of those people were patients that Emily did not see in her practice. They were big, followed by a neurologist and primary care doctors in the community. The other half she was seeing as their primary dementia doctors, and these were people who ranged anywhere from having mild cognitive impairment, which is a level below their normal level, but not yet to the point of dementia, that they were just having inefficiencies, greater difficulty and thinking. But it said they're really at risk for decline. So he started with people at that level anywhere down to a level of mild to moderate dementia is of all types and has Alzheimer's and vascular and lots of combinations of these. Big difference was her group got a lot more attention. They got blood tests for things that their traditional doctors were not testing. They had overnight sleep studies that looked at their oxygen levels and the number of times they stopped breathing during the night. They were put on usually combined treatment with the chonlinestrase medicines. And Namenda purple also were the people from my group were there but mostly I was getting the doctors to do that part of it. But Emily's focus was fixing all the underlying medical conditions as well as treating them with the medicines. And what we found out was that six months into this per half of the sample was about 15% better. My half of the sample was slightly worse than when they first started just slightly, six months after that we're now about a year, the group was still 15%. Better, my group was now a step down, there were about 10%. Worse. These were significant statistically, from the very first six months, the year after that. So two years out from the starting point, there was even more rapid change and difference because her group was the same, my group got significantly worse because they were just being treated mostly by the medications. When we looked at the data, subsequent to our presentation at the Academy, we started drilling down on where was this

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coming from? What we discovered was that the biggest part of what made the difference was the fact that she was treating the sleep apnea, as well as prescribing the medications. So her patients were getting more oxygen to their brain. I believe that sleep apnea and oxygen are actually the secret sauce for a lot of this. And it's amazing to me that none of the current drug companies are actually testing anyone in their study groups to see who's got sleep apnea. They're just ignoring this whole factor.

Rosanne 16:09
Yeah. And believe me, when I finished your book, I was like, I'm getting a sleep study.

Dr Mitchell Clionsky 16:14
Did you end up doing it?

Rosanne 16:16
Not yet? Well, not yet. You know, that's the that's the flip side of everything, right? You have to call to make the appointment, and you have to wait for your appointment, and you have to have that consultation for your appointment, then you have to make the appointment for the sleep. So we'll get there. But

Dr Mitchell Clionsky 16:29
It's like an Odyssey unnecessarily, you can actually go to a website and order a home sleep study today. It'll be there in a couple of days. It'll be then read by a Board Certified sleep medicine doctor, and it'll cost 200 250 bucks to do this. Yeah, it can be done under our insurance system. But usually it's thought

Rosanne 16:50
it's no, like, let's not be crazy now. Right? We don't want to we don't want to support these things.

Dr Mitchell Clionsky 16:56
Give people care. I mean, really do it.

Rosanne 16:58
Yeah. Yeah. And that I, when I read that, I was like, Oh, my goodness, because you know, there are times when you wake up and you feel like did I sleep and for caregivers, sleep is a premium. Sleep isn't guaranteed. Good sleep is never guaranteed. And it's it's hard. And then to think well, now I have to go get a sleep study, I'm never gonna get a sleep study, I'm lucky I can get out when I get out. Having that ability to get it at home would be great.

Dr Mitchell Clionsky 17:25

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And they're just as accurate. By and large. There are some particular kinds of sleep conditions where after the home sleep study, they want you to come into a lab, because they want to figure out exactly what kind of sleep apnea you have, and what's the best way to treat it. But as a starting point, if I ruled the world, at age 50, everyone would start getting colonoscopy, all the women would get mammograms, and everybody would get home sleep study. Since we published the book, just about three or four months ago, there was a very interesting study that was done looking at 6000 People from the general population who are middle aged or older. This was done through a consortium of the kinds of study centers, like the Framingham Heart Study, were in Framingham, Massachusetts, they've been doing this for years, they bring in a cohort of people middle aged or older, they give them a whole bunch of different tests. And then they follow them every three to five years with additional tests. Well, it turns out, there's like six or seven places like that in the country, which all banded together, and then gave every single one of their people 6000 of their newest enrollees with one night's sleep study.

18:44
Out of the 6000 people 50% had sleep apnea. That's how common it is. And yet, the rate of diagnosis is so much lower than that, because we're still back in the age of thinking, you have to be a male, you have to be fat, you have to store terribly, and you have to sit down in front of the TV and fall asleep immediately, in order for us to give you a sleep study. And that's what that console is all about. It's a stupid console that determines whether or not you're going to get the test, but they're not going to really make the determination unless you get the test. So why are we doing this consult? I don't get it.

Rosanne 19:20
I don't either. It's infuriating. But then is the only way if you have sleep apnea to wear the mask.

Dr Mitchell Clionsky 19:26
It is the best way. So this is interesting point because it was talking about with somebody else the other day, and I had to go back and pull up four studies on this. So the most effective treatment, the thing that will reduce your level of sleep apnea down to less than one or two events per hour, rather than being five to 30 or 40, depending on the severity is continuous positive airway pressure. CPAP CPAP works by the principle that air is a fluid. And that if you air under pressure, and you put it so that you're breathing it under pressure, it keeps your throat open and keeps your airway open, so it doesn't collapse or become obstructed. As you say, whether you have a garden hose that collapses, when you don't have water running through it, you're on the water, suddenly, it's a fully functional OHS. The same thing happens with air regular room air that's put under pressure goes through this flexible tube to a mask. Now, over the course of years, by the way, I'll tell you, I've been on a CPAP every night for the last 18 years. And I've seen so many people who have used this, I know a lot about it through experience of various natures, the technique has gotten better, the machines have gotten

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lighter and quieter to the point where you could hardly even hear them now. So you don't have to worry about keeping your bed partner awake. They also have a variety of different masks that are much smaller and more efficient than we used to have. There's some commercials you may have seen on TV for a technique or device called Inspire. It'll tell you it's a surgical implantation, like a pacemaker for your throat, that it's only approved for moderate to severe sleep apnea. So these are people who are basically not breathing 20 or more times per hour. They also don't tell you that that little device that looks like it's the remote control for your bedroom fan, that just sort of lay on top of your chest or next to you while your sleep is only the outside part. Thats not the inside part. We find that if we can get people to approach this in a more positive kind of way, we give them a lot of support early in the process, that not only do they get used to this, but it really works for them. And it's something they don't want to give up later on. There's another type of device, it's called a mandibular advancement device, it's a dental type of thing that moves your jaw forward. And for people who absolutely cannot and will not use the CPAP. I'll tell them to go and get one of these dental devices. The reason I'm not so excited to hop on top of this is that it's only half as effective as the CPAP. So if you have somebody who's got more than 10 events per hour where they stopped breathing, or their oxygen level drops by 4% instead of a ticking you down like the CPAP will to about two events per hour, this will take you down to about five or six. But you still got sleep apnea, because anything over five is sleep apnea.

Rosanne 22:46
Yeah.

Dr Mitchell Clionsky 22:46
And the rationalization that's given is that, well, we can't get people to use CPAP well enough, so they only use it maybe 40% of the time. Therefore, even though this is only half as good if they're using it all the time that nets out at the same point. I believe that we're making a mistake by approaching it that way, I think we should be spending much more time explaining to people why this is important. Helping them to get comfortable using it, essentially, how will we look for anything that's new and different. And that you have to just sort of figure it out and use it on a regular basis. But I think our energies would be far better spent putting it into something that really works well then say, well, this is almost as good, let's use this because you're more likely to use it.

Rosanne 23:33
And does like lifting your bed up help at all. Will that help?

Dr Mitchell Clionsky 23:37
Yep, I have people usually buy a bed wedge, because they can put something under the head of their bed, under the legs of that part of the bed. And that'll help a little bit getting a foam bed

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wedge. Or if they really want to spend a lot of money getting a TempurPedic bed wedge is more support on their back. That will help. Both of those are better than just using pillows. Because unfortunately, if you're sleeping on your back with a couple of pillows under your head, you're probably doing something to your neck that you don't want to do, right? The reason that this can be of some help is that the gravitational force of direct gravity forcing scraped down is going to more likely collapse your airway. Whereas if you're on an angle, the gravitational force is a little less direct. Okay. It's not usually enough by itself, but it can be a bridging technique.

Rosanne 24:33
It's very interesting. And it's, you know, it all goes back to the it's not just one thing with dementia. It's not just we're going to do this and it's going to be fixed. There's so many different variables. And can we talk about some of the conditions that affect you know, high blood pressure, high cholesterol, sedentary lifestyles, smoking, drinking, like what are the things that we can control, that we could try to change and help ourselves?

Dr Mitchell Clionsky 25:00
A great question. And you're right, in midlife, particularly diabetes, and hypertension, are two of the major drivers of later life dementia. They're secondary, in many cases, to obesity, and lack of exercise, and smoking. So those factors all work together. So if you're going to change something, and you can quit smoking, that's going to help a lot. If you're going to exercise. And by that, I mean, you know, 30 minutes of walking the day is great. And especially, it can be done by breaking it up into smaller segments, I instruct people to take a 10 minute walk three times a day, because they can do that. And it's less likely they're going to resist it, because it's only 10 minutes. Right? If you can get people to get out and it's cumulative, they won't hurt themselves. So we get them moving, we get them to stop smoking. And then we can say, Okay, let's take a look at what you're eating. Not so much from the fact of are you eating the certain fruits? Or berries? Or is it the green leafy vegetables, or whatever? Is it fish rather than beef? To be honest, the research doesn't show that that makes a big difference. People We're Americans, we like to eat our way into health, I don't quite understand it. But it really is true. If you can open the dementia prevention restaurant, I'm sure it would be a hit. I'm probably wasting my time reading books, I should be opening a restaurant. The problem is that stuff doesn't work particularly well. But the amount you eat can make a difference. Because like it or not, your body was designed for a certain size, and not to shame anyone, but simply to say that's the way you're built. That's what your body is designed for. If you carry more weight than your body is designed to carry, your body is not going to react very well, it's going to have problems. And that's where you get into the sugar levels being too high, the blood pressure being too high, the fatigue, because you're carrying around a backpack, essentially, all day long. So you're not going to want to go out and do anything you want to lie down, not socialize, not interaction on the TV and space out. Well, that's not going to be good for your brain. So

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that's really important. And one of the things that most people don't know is that hearing loss is a cause for dementia.

Rosanne 27:31
Yep, that was my next question.

Dr Mitchell Clionsky 27:32
Getting your hearing test. So how do you know if you need a hearing test? Well, if you're seven years old, there's about a 70% chance that you've got hearing loss. Realistically, yeah. So you probably should get a test it but if you're cranking up the volume on the TV, you've decided everyone in your world mumbles now, probably should get your hearing tested because it may not be them as much as you. I love the story about the guy who calls the doctor and asks, you know, I think my wife is losing her hearing. Can I bring her in and the doctor says, well, here I gotta test for you don't have to bring her in. Says really is yeah, you start about 20 feet away what her back is turn and ask her what's for dinner? If she doesn't answer, no, five feet closer, if she doesn't answer go five feet closer. Eventually you'll figure out how close you have to get for her to answer. So he says great. I love that idea. So that day is wife's working in the kitchen. He stands 25 feet away and says Honey, what's for dinner? No response. He walks closer, repeats the question. He walks closer repeats quested finally standing right behind her. And he says honey what's for dinner? She looks around says for the fifth time already. We're having chicken. So you never know who's got the hearing loss. Sometimes it's both of you.

Rosanne 28:51
It was definitely not her.

Dr Mitchell Clionsky 28:53
So I tell people get your hearing tested but no, some place where they're not also a private place trying to sell you hearing aids. You want someone who the opinion you can objectively believe in because they've got no stake. They got a horse in the race as we say.

Rosanne 29:10
Right. Is that in your nose and throat doctor?

Dr Mitchell Clionsky 29:12
Actually you'll I send people to Costco

Rosanne 29:16
Do you?

Dr Mitchell Clionsky 29:17

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I do.

Rosanne 29:19
Well if they need them then they're cheaper there too. Yeah.

Dr Mitchell Clionsky 29:21
They actually are the cheapest and best hearing aids. I hope that people are listening aren't saying well, my brother's audiologist they're taking business away. I may be but the reason I do that was because my patients kept coming in see me and raving about their hearing aids. And I thought this is the strangest thing people are saying I love my hearing aids these to hate them. Right and they'd also you'll never guess where I got the it was always Costco. So at this point, I find that if you want to go someplace else wonderful. Get your hearing tested. If you have no place else that you know of. It's free if you're a member of Costco, you just have to make an appointment. And they really do sell very high quality hearing aids.

Rosanne 30:05
Well, and that was the big the big thing that happened last year when the hearing aids were able to be sold over the counter now.

Dr Mitchell Clionsky 30:12
Yes.

Rosanne 30:12
For the people that that you know that it is cost prohibitive for they can still get these hearing aids that that would help. Because I don't think people realize it's the quickest way to dementia. And people just don't want to I'm not wearing it. It doesn't, you know, I don't want people to see that I have hearing aids. And it's like, no, it's the bigger picture here.

Dr Mitchell Clionsky 30:31
But also these days, they're so small. Yeah, unless you're really looking in someone's ear. And if you're that close, you know the well enough so that you can do this. But if you're that close, you can't see them. That's the maze. If you're a woman, you hardly ever see them because they're under your hair. Yeah, yeah. If you're a man, you could sometimes see them. But if you've got gray hair, the little wires that come down, look about the same color as your hair. And you know, people say I think I'm old. And I say them, you know what really makes you look old. They say what I say exactly what? What? That really makes the look old. Yeah, if you're hearing better, you're going to seem younger and more with it, jokes are going to make more sense, you're going to laugh more, you're going to interact better with other people if nothing else happens. But it turns out, there's actually a physical change in the brain in several different areas that occurs when people have hearing loss, their brains do not get stimulated.

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And so parts of the surface of their brain actually get thinner. And the other thing that happens, we found out through a technique called functional magnetic resonance imaging fMRI is that one of the background networks that connects different parts of our brain is called the salience network. So it's something salient, it means it's meaningful. When people have hearing loss, their salience network gets down regulated, and they get pulled back and withdrawn. And they're not finding things interesting enough to actually hold on to and pay attention to. So we want to change that we want them to have interest in the world around them, we want the connections between their auditory Association cortex on the surface of their brain, connect with the central memory areas, because that's going to help reduce the risk of decline. So that's why plus they come back to see me their test scores are better.

Rosanne 32:35
Really?

Dr Mitchell Clionsky 32:35
Really.

Rosanne 32:36
I believe it. How could they not be?

Dr Mitchell Clionsky 32:38
Well it's more meaningful. People typically understand the social implications. They say, Well, I get it, you're more social. I said, Yeah, that's true. And you're also less depressed. chronic depression is also a risk factor. And the things people do to deal with their chronic depression, they sometimes drink too much alcohol as a way of medicating themselves against their depression. They also of course, miss out on a lot of the activities that would keep them cognitively engaged. Some of them get really anxious, and then they start taking benzodiazepines, Valium, librium, Lorazepam, Xanax, all these different short acting, anti anxiety medications, that if you take them frantically, in other words, for more than 90 days, you actually increase your risk, or dementia. When when I saw just this morning, takes three times a day, a benzodiazepine, she's been doing it for years. I understand she's really depressed and anxious. But this is not the way that's best going to help her with this. It's just going to calm her. There's something to be said for being calm, but not in this way that clouds her thinking.

Rosanne 33:55
Right. And that's part of the that's part of the challenge here because we know that dementia affects women more than men. And we know that when it comes to caregiving, women, men caregive, not saying that, primarily it's women. So here we are women at midlife, and we're not sleeping, because we're caregiving or we're in menopause, which again, is that wild, uh we

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don't know. I mean, it's 2024 and nobody can tell us what the best thing to do with menopause is. Are we taking hormones? Are we not taking hormones, are hormones going to increase your risk? Like the big study that came out in 2023 from Denmark that said, it increases your risk of dementia by 24%. And then we have no no, it's really fine, but you can take it. Okay, so we're in this stew and then when we go to our doctors our doctors say you're just stressed or you're just anxious, and then you get the benzos so then you're in this midlife of menopause, sleeplessness, high blood pressure, obesity, depression and anxiety, which isn't being treated, because we're being patted on the head, and given these benzos, which then affect our cognition, which also makes us feel more depressed and more anxious, because we're, oh, my goodness, I'm not, I'm forgetting why I came in this room. What do we do? How do we do this?

Dr Mitchell Clionsky 35:20
You are right. And it's very complex. And you have to figure out where you can intervene. So one of the things you can do, no matter how busy you are, you can squeeze in a 10 minute walk, and do it a couple times a day. If you're caring for somebody, guess what they probably also need the exercise, you can start to look for other sources of help for the person you're caring for. One of the things I see time and again, in my practice is people who are great children, it's almost like they're too good at being a caregiving child, because they believe that it's their duty to do it all. And consequently, they don't take care of themselves. And I reach, bringing in other assistance, even if you could do it at that point. Because you number one, you want your parent or loved one to get used to also receiving care from someone else. Number two, you're going to need time to recharge and take care of yourself. Because if you go down, the whole house of cards goes tumbling along with you. So you got to do some self care along the way you need a break, you need to be able to go and do something else and talk to some other people or take a class if you wanted to. Or just take a walk or just take a nap or whatever it is that play cards with somebody for a half an hour, that gives you some time away, that's a more normal kind of life. Because caregiving goes on and on and on and on. In many cases, and you're working so hard to keep that person you're caring for healthy, that it makes it go even further than if it had the natural course because you're taking really good care of that person.

Rosanne 37:12
Right.

Dr Mitchell Clionsky 37:12
So the question is, Who do you have to ask to help you out? How do you say, Nope, this is more than I can do by myself. Or it's more than I really should do for myself, because people can really in the short run, especially to wait too much. But it's not a sprint, it is a marathon. It's a you got to pace yourself. And so I really work hard at getting, you know, other people involved. Yeah, there's that brother who lives such a such a way to talk to mom on the phone,

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he needs to actually take mom for a couple of weeks, he needs to come in and visit more often and give you a spell. He needs to make some adjustments, because you need to share this more. So you got to look around and you have to sick and I get some agencies involved? Or do I have the means to also bring in some people where I can afford or mom can afford to pay for some help? And she might say I don't want anyone else. You have to say, you know, I would love to have me full time to but so do my kids. So does my husband. So do my friends.

Rosanne 38:21
Yeah.

Dr Mitchell Clionsky 38:21
So it's a tough thing, though. But it really is true, what you're pointing out is absolutely correct.

Rosanne 38:27
And it's it's so hard to because then okay, we make it to the doctor. And and some of these things. I didn't know beta blockers can affect your cognition. So like, how are you supposed to navigate these things in a positive way for yourself that you're still taking care of the condition that you have? What you're navigating, you're you're trying to advocate for yourself with your own doctor and say, I don't think this is gonna work for me. Is there something else?

Dr Mitchell Clionsky 38:57
Complicated by the fact that you may not even see your doctor.

Rosanne 39:01
Right.

Dr Mitchell Clionsky 39:01
Or the amount of time you may see your doctor may be so limited, that you had two other problems, which are a little more pressing at the time. And by the time you get to the third one doctor says, Well, I'm sorry, I gotta see somebody else.

Rosanne 39:15
Right.

Dr Mitchell Clionsky 39:16
Yep. You're talking about systematic systemic problems in the health care system. I'm hoping that doing positive things for your health, in general, reduces some of the need for some of the medications that are so easily prescribed. You know, there's a big push to deprescribe some things that especially are anticholinergic, right. What I think about is the people who are having constellation of problems, each of which adds to this. Number one, they have trouble falling

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asleep. So they take an over the counter sleep medication, some of the PM at the end of it that contains diphenhydramine, otherwise known as Benadryl, they also have allergies. So they're takin some medicines to dry themselves up, chances are those are also anticholinergic. They're probably also in midlife or later experiencing more frequent urination than they would like. The doctor says, Oh, I got something here that will tighten up your bladder, guess what? It's anticholinergic and reduces the levels of acetylcholine in your brain, which previously, as we're talking about, we're trying to maintain with those medicines that we use for cognitive decline. And then you have the ones that you probably need to take, but could be perhaps switch to something else. So for example, there may be a heart medicine, there may be an antidepressant, there may be something else that you're taking, which is good for you. But it adds to the other things you're taking. And that's we get into the concept of anticholinergic burden, where it's not just one, it's not just two, you'll look at it, it's four or five things you're taking all of which combined, space you out, make it hard for you to think we don't know that necessarily, that will cause you to have dementia at a higher rate. But we do know that you'll feel like you do, because you can't find words, and you can't remember what you're planning on doing. And finding where you left your keys is now a half hour project. So that part of figuring out what you're taking and that's why we have connection in our book online, and also on our website to an anticholinergic burden calculator, where you can very easily type in whatever you're taking both things that are prescribed, and things that you buy on your own and it will give you a score that's an accurate score of how anticholinergic is this thing. And you add that up, they'll give you a better idea of what you're taking, and where there may be some opportunities to change things.

Rosanne 41:50
And that's on your website.

Dr Mitchell Clionsky 41:52
That is yes it's on BrainDoc.com Of course, you want to do this with your doctors getting back to the thing you asked before is what happens when you have a doctor who is not responsive?

Rosanne 42:01
Yeah.

Dr Mitchell Clionsky 42:02
I think you need to find another doctor actually hate to say it, because it's real hard to do that. But there's only so much you're going to persuade your doctor, maybe they'll read the book, maybe give a book I had, it's this fantasy that we're going to put a copy of our book into the hands of every medical student in the United States to get how do we raise enough money to even at the discounted rate, give 80,000 doctors a book, that'll give them insight into oh, here's some things that are within my control that I wasn't really paying attention to. Because, you

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know, they didn't teach much about dementia, when I went to medical school. And even in my continuing education, I don't get a lot of training in dementia. Turns out that something like 40% of the doctors out there are not even comfortable identifying or treating dementia, the chances are almost 50/50, your doctor may say, Oh, don't worry about that. Rosanne, everybody your age has that problem. It's pretty normal. That's no big deal.

Rosanne 43:06
Right. Which is what they do when we go with our parents. And they say, Oh, it's nothing. Oh, it's just aging. And and you're like, No, it's this is not aging. And this is, these are things that need to be addressed. But they don't want whether by training, or they just don't they don't have it to be able to say, oh, we'll do this, this and this.

Dr Mitchell Clionsky 43:23
Right.

Rosanne 43:24
It's very frustrating. And it's it's hard because we're trying and you know, there's no guarantee when it comes to dementia. I think everybody knows that. And while I was reading your book, I was like, Well, boy, this is rough. And then I and then I got to that section of okay, you can do these things. And it did make me feel hopeful. And like I said, I'm gonna get a sleep study. But it did make me feel hopeful, because of some of the control that we can take back and at least try and at least do something to try to help yourself.

Dr Mitchell Clionsky 43:57
Well, here's what's really cool about it, is that I agree with you it is an optimistic message, which is great because I'm a light one candle rather than curse, the darkness kind of guy. The fact that the interrelatedness of so many of these different factors causes them to be worse, also can work in the other direction. That if you begin to change one or two things, let's suppose getting back to exercise, or to a sleep study where you get supposed to get sleep study. Turns out you have sleep apnea, you really embrace treating that. Now a couple really cool things happen. Number one, you sleep more continuously. You don't get up two or three times go to the bathroom during the night. You get into deeper sleep. Because you're getting more oxygen to your brain, your brains glymphatic system is able to flush out the toxins that have built up during the day while you were thinking so that your brain mean is clearer and you feel better when you wake up. Now, because you have more energy, you say, you know, I can sneak out for 10 more minutes walk before mom wakes up or before my husband gets up or before any of these things happen. So I start doing this, and I don't feel so hungry. I don't feel like I have to have a Hershey bar in order to put my energy in the afternoon because of fatigue. So I can avoid that now your weight starts to normalize more, and your sugar levels are more

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stable. So that one intervention makes as this fall out effect. Yeah. And that's what we're looking for starting someplace.

Rosanne 45:33
And that even if you're caregiving, you can try to supplement something even, you know, what did we talked about? We talked about the Mediterranean dash diets. Just trying to incorporate something because it just kind of makes you feel better. And it makes you feel like, okay, you know, I feel a little bit better when I have this instead of having, you know, a scotch and soda and a candy bar.

Dr Mitchell Clionsky 46:00
Don't rain on our parade here Rosanne.

Rosanne 46:03
I'm sorry. I'm sorry. I think about that part you have in the book where the woman said to you she has a vodka and Seltzer every night to relax, and you're like, Okay, and how big is the glass? Like its a 16 ounce glass of vodka and Seltzer. I'm thinking you're going to be a little woozy there.

Dr Mitchell Clionsky 46:20
But it's only one.

Rosanne 46:24
But it's only one, just one.

Dr Mitchell Clionsky 46:24
I once went to a restaurant where they showed us how they could take this one particular wine glass and put an entire bottle of wine into it. I thought, well, that's really great. Except hopefully you're not serving that to people like that they weren't

Rosanne 46:38
Holy cow. Yeah.

Dr Mitchell Clionsky 46:39
But yeah, it's deceiving. We actually posted something on our LinkedIn account, where we put three standard glasses of wine into a wine glass. And it looks like what a lot of people drink, but it's actually three standard servings was nine ounces of wine.

Rosanne 46:54

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Wow. Well, and that's, and that's part of it, like, you know, we're, we're just going along and portion sizes have gotten bigger. You know, drink sizes have gotten like everything has just gotten bigger. And I don't know if if we're realizing that.

Dr Mitchell Clionsky 47:09
Probably not. We don't measure a lot of that stuff. You know, people measure when they're baking, but they oftentimes don't measure in other areas, and they just pour, right. And that's, and I joke with people about it all the time. I said, do you actually take your whiskey and put it through a shot glass? Or do you pour like your neuro psychologist pours? And they always laugh and they look at me and say yeah, I know we gotta use a shot glass otherwise, we're gonna be drinking a lot more than we think we are.

Rosanne 47:34
Well, yeah, true. Now, what do you say about those, you know, we see the commercials all the time, my memory got better when I took are there these quick fixes for our memory out there?

Dr Mitchell Clionsky 47:45
That's what's known as placebo effect. Otherwise known as Dumbo is feather. Remember the old Walt Disney cartoon with Dumbo the Flying Elephant and he had this feather in his trunk that allowed him to fly and Jiminy Cricket, who is up in his hat, how to talk to Matt about when the feather dropped out of his trunk One day, while he was flying, it says it's not the feathered Dumbo, it's you, you're the one who's causing this. So there's a lot of things that people do that make them feel better. And because they're doing something and here's the interesting thing, it actually does cause endogenous changes in our brain. In other words, you take to Tylenol because you have a headache, before it even hits your stomach, your brain is already sending out endocannabinoids. It turns out, it works on the cannabinoid receptor sites in your brain since the marijuana works on. And these are self propagating kinds of chemicals. And because we're used to getting a good response from the Tylenol, we actually begin to secrete those things helping us to reduce the pain. Well, for a lot of people, there's a very powerful effect to taking something which they think is going to help them if it's expensive, the effect works better. What a setup. And it also works by the way, if you tell the person that there's actually no science behind it, it still works. That's what's so amazing about this. It's called placebo, there's a negative effect to called the no SIBO effect, where people sometimes and you may know their friends like this, I see patients like this, where they tell me I nibble a little bit of this pill that my doctor prescribed because if I take it even though it's lower dose, I have horrible side effects, and completely sensitive to every medicine that anyone is ever given me. That just doesn't exist. That person's not like that, except that they've made themselves like that. And so they've taken it down to a dose that so small that it has no effect, because that's the only one they can tolerate. Right. So the question for us as feeding professionals is, how do we use this in a positive way being respectful to people and saying, you know, I tell people, you know, do

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you really want to spend 60 $70 a month on this thing, which, you know, maybe jellyfish do have it together. But the evidence is that people don't remember better as a result of taking this for us, you see the commercials is my other pet peeve where they say, I take this product that they've taken all these fruits and all these vegetables, they freeze dried them and crammed them into little pills and pause, I am active, and I take this and I want to stay active. I will keep taking this. And they can say that, because they're just saying what they're intending to do. But it gives a false impression that it's those pills, those capsules that are actually causing their good health.

Rosanne 50:44
Right.

Dr Mitchell Clionsky 50:45
They're not. But they're, they got lots of people who enjoy this. They think that there's one thing I can do. The negative part of this whole message, though, is that that's enough. And it is, that's where people take the wrong turn, because they think well, I don't have to really pay attention to this or that the other thing because I'm taking my three fruits by three vegetable today, right? That will do it.

Rosanne 51:09
No. Are there any that you do, Are there any supplements or vitamins supplements that you like? I mean, we hear a lot about vitamin B and we vitamin D and that kind of thing. Is there anything that that you like?

Dr Mitchell Clionsky 51:22
If you're deficient? Yes.

Rosanne 51:25
Okay.

Dr Mitchell Clionsky 51:25
Your vitamin B deficient taking a B supplement. Really great idea. If your vitamin D is, even in the low end of normal, you probably will benefit from supplementing it. But you gotta be careful, you don't take too much. But this is not the kind of stuff where you just stop by the vitamin counter in the pharmacy and say, Oh, it's alphabet soup time, I'll take B to D and A, C and E. And pretty soon I've got enough of the Alpha could write my name with my vitamins.

Rosanne 51:57
Right.

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Dr Mitchell Clionsky 51:57
That's the unless you need them what's most likely to happen, assuming that you don't overdose on it is that as most likely just go right through your body and out the other end, and you've become a very expensive processing plant for the vitamins.

Rosanne 52:12
Okay, and what's too much vitamin D?

Dr Mitchell Clionsky 52:14
You want to be at about 50 to 60 or 70 nanograms per milliliter, you don't want to be up in the range of 90 to 100. That's when you start getting problems with your calcium and other areas. This is not my area of great expertise but I know enough about it that I know that people can get themselves into trouble at those levels. But also, if you're just at the lower end, 25 to 30, or 35 nanograms per milliliter that may not be optimal for your brain, or even your pain levels. It's amazing what can happen with some of the aches and pains. If you have normal levels of vitamin D, you get those in the normal range of times as aches and pains improve.

Rosanne 52:55
That's great to know. And that again, comes back to asking your doctor for that blood test.

Dr Mitchell Clionsky 52:59
Right.

Rosanne 53:00
So when we go to the doctor, and we say we may have a problem, we think we have a problem with our memory, or we have someone who we think has a problem with their memory. Again, it's it's difficult to breach that but you have developed a memory screening test.

Dr Mitchell Clionsky 53:15
Yes.

Rosanne 53:16
That we can take and then keep it for a year or take it to the doctor and put it as part of our chart. Can you how do people? How did you develop that? And how can we access that?

Dr Mitchell Clionsky 53:26
Well, the development took 20 years. And this took place. Initially, in my practice, as more and more of the time. We were testing people, very extensive batteries, tests, and then giving them what were the quick tests of the day. Most commonly the mini mental state exam, started back

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in 1975, by a very brilliant psychiatrist by the name of Marshall fullsteam. And what we kept finding was that there was this group of people who did not do well in their tests, but perfectly normal scores on their MMSE. There many mental states. They said, why is that and we realized that the active ingredients of the MMSE were only a couple of little parts of it. And so we took those parts and extracted them. We added some other tests, including clock drawing test, which you may be familiar with, because it's routinely done by neurologists and even some primary care doctors. We edited a couple other memory components and we created a test called the memory orientation screening test the most. It's a five minute test. And then we were originally developing it paper and pencil, but then we got the idea to put it on an iPad so that it could be given reliably and it could be done at a doctor's office. And not only could it be administered by an assistant this way, but then at the end the score would not only show you what you did, where your level was, but would also print out a page or two recommendations for the doctor, they'd have a treatment plan based on the score that they could then choose from. Well, it was so good that we then went into partnership with a company called Quest Diagnostics. And they bought the rights for the test, which was wonderful. They renamed it. And for five years, he had the exclusive rights during which time we stopped by virtue of our contract promoting this. And at this point, we're a couple generations behind in the programming for the most quest decided not to stay in the testing business. So the rights are back with us. So one of our jobs for 2024 is revitalizing this test, and also trying to come up with a version of it, that you could do at home with your mom. Because if you have that kind of tool, you can then get a pretty accurate idea of how she's doing without having to rely on just that intuitive sense of peace. He forgot my name yesterday. But today, she seems with it, should I be worried or not? This is something that's more reliable over time, that doesn't change so much from day to day. So that's what we're going to be working on, you know, we're being out a year on the book, or we were thinking about redoing it or up, it's up quite yet, there hasn't been enough new research that it makes sense to come up with a new edition of it. But we're gonna turn our attention to more diagnostic stuff in 2024, hopefully have that out with within a couple months from now, so that people could get this and use this. Anybody is looking to follow up with this stay tuned to our website, because that's what will be the beginning to announce it. If there is anybody in your listening audience who happens to work for a large corporation, and would like to partner on this, that would be ideal, because it's very time consuming to do this kind of thing. And while we have a lot of data, we don't have the, there's there's not 20 of us.

Rosanne 57:07
Right, right, right. Yep. No, that's great. Now, though, I mean, the work that you've done, you can tell that there's a lot of research, there's a lot of education, there's a lot of heart, in this book, and in what you're trying to convey. And and it's really great. I mean, thank you for that. It's, it's, it's hopeful. And it it because dementia is tough, dementia is rough, and we start to look at it and think oh, well, we're all just gonna get this, you know?

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Dr Mitchell Clionsky 57:37
Right. And we know that one out of two cases are preventable. And the person who really should thank is my mom, for a couple of different reasons. Number one, when she came down with dementia, part of me realized that as bad as this was, I was going to learn something from it, that was going to help me to be a better doctor. So she taught me a lot about life that her life taught me a lot about dementia, unfortunately, or fortunately, depending on your perspective. The other thing was something she used to say to me when I was really little. And she claimed it was an old Yiddish expression. But to be honest, I've never found anyone else who knows this expression. The expression though, was if you can't get over the table, get under the table. I said to her MA, what does that mean? She said, Oh, that means that find a different way to do it, figure it out. Don't just accept something for what it is. And that is really been a guiding principle and one that I like to put out there. Because I think that one of the big challenges of living is adapting to things that happen. And a lot of people stop adapting once they reach midlife. They think that they're sort of done. And that that's all there is. And so it happens, whatever happens happens, it's not true, that if you don't keep changing, if you don't keep growing, you're not going to succeed. And so that's really the passion that I feel is how do I take on the next chapter of my life? And those of the people around me, if you take that attitude, I really think you work out better in the end.

Rosanne 59:18
I love that. It's very true. And I do I think that we do we do get caught in that, well, just how it's going to be. And it doesn't necessarily have to be that way. You know, we all come up in these family systems, right? So this is what we do. This is what we eat. This is how we live. These are the things that we do is is it more lifestyle, or is it more genetic? And that's that balance, right?

Dr Mitchell Clionsky 59:44
It's both. It can't be anything but both. And but we don't have control over the genes. Right? That's the important thing. It's sort of way it's right. I tell people it's like you do a sculpture out of marble to some degree you arevlimited by the veins in the marble the imperfections that exist in the stone as its quarried. That's where you start? Well, if you say, Well, gee, I was gonna make a tabletop out of this, but there's this curve in this. Now you have to say, Well, I'm gonna have to look for a different thing to make my tabletop probably. But I could take this and turn it into that. And that's where you start with where it is genetically. You say, I don't really make the best of what I've dealt as a hands, so to speak card hand. How do I make the best out of this statue? What do I chip away at that I want to work on? That's the job.

Rosanne 1:00:35
That's great. That's, that's hope right. That's hope

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Dr Mitchell Clionsky 1:00:38
It is. Yes.

Rosanne 1:00:40
That's hope. Do you have any other advice or anything that you would like to say to someone who is listening?

Dr Mitchell Clionsky 1:00:47
I want to say thank you to caregivers out there because, you know, it's mostly underpaid or unpaid, and sometimes, unfortunately, thankless. kind of job. So for me, I say thank you, because you're holding it together.

Rosanne 1:01:07
A big thank you to Dr. Mitchell Clionsky for being my guest today. For more information about Dr. Clionsky, including his book and all of the resources he mentioned today, visit his website, BrainDoc B R A I N D O C.com. I hope you enjoyed our podcast today, head over to Daughterhood.org and click on the podcast section for shownotes including the full transcript and links to any resources and information from today's episode. You can find and review us on Apple podcasts or anywhere you listen to your podcasts. We are also on Facebook, Twitter, and Instagram at Daughterhood the Podcast. Leave me a message and let me know what issues you may be facing and we'd like to hear more about or even if you just want to say hi, I'd love to hear from you. Also a very special thank you to Susan Rowe for our theme music, the instrumental version of her beautiful song Mamas Eyes from her album Lessons In Love. I hope you found what you were looking for today, information, inspiration or even just a little company. This is Rosanne Corcoran. I hope you'll join me next time in Daughterhood.

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