



Editorial

From Biomarker to Bedside: Integrated Care as the Real Innovation in Alzheimer's Disease

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For decades, clinicians treating Alzheimer's disease could offer accurate diagnosis, symptomatic drugs, and compassionate support, but nothing that altered the course of the disease. This, however, has changed. Two phase 3 trials showed that anti-amyloid monoclonal antibodies slow clinical decline in early symptomatic Alzheimer's disease: lecanemab in CLARITY AD [1] and donanemab in TRAILBLAZER-ALZ 2 [2]. On 4 February 2026, Swissmedic authorised donanemab for early Alzheimer's disease, with treatment limited to 18 months [3,4]. At the same time, blood-based biomarkers such as plasma p-tau217 are beginning to make biological diagnosis possible outside specialised centres [5]. Both advances are real, and both are modest in effect. Their value to patients will depend less on the molecules than on how we organise care around them.

The central challenge is integration, and three fields each hold part of the answer. Neurology brings biomarker interpretation, imaging and the management of amyloid-related imaging abnormalities (ARIAs). Eligibility, APOE genotyping, MRI monitoring, and how to respond to ARIA all need well-defined processes and neuroradiology support [1,2,6].

Geriatric psychiatry brings attention to factors that are often overlooked in the excitement over new drugs. Depression, anxiety, apathy, and early behavioural changes are often the first signs of neurodegeneration, and they shape how well a patient tolerates treatment. They also call for careful assessment of capacity and consent. Many older patients have several illnesses and take many medications, so many will not be eligible for antibody therapy. Their care must not be neglected as resources move towards infusion units. Telling someone they have a biological disease with a probabilistic outlook, sometimes before marked symptoms appear, also requires psychological skill and ethical care.

Integrated care, including primary care, links these fields into one pathway. Recent European recommendations describe a stepwise model: clinical evaluation in primary care, followed by specialist assessment and biomarker confirmation [6]. The first clinical practice guideline on blood-based biomarkers restricts their use to specialised memory care. It allows triage with tests of at least 90% sensitivity and 75% specificity, and confirmation only with tests that reach at least 90% for both [5]. Used this way, blood tests could make access fairer. Used without clear thresholds and follow-up capacity, they could overwhelm memory clinics.

The research agenda follows from this. We need real-world Swiss registry data on effectiveness, ARIA, and treatment discontinuation. We need validation of blood-based biomarkers in older patients with multiple illnesses, including those with kidney disease and mixed pathology. Outcome measures should consider neuropsychiatric symptoms, quality of life, and caregiver burden, not only cognitive scores. Health-economic studies should inform reimbursement and address regional fairness across cantons. Finally,



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research on prevention and combination therapy should target modifiable risk factors alongside amyloid, tau and inflammation.

The Swiss Archives of Neurology, Psychiatry and Psychotherapy is relevant to this conversation because its readership already spans the three fields that now have to work as one. We invite submissions on care pathways, biomarker implementation, neuropsychiatric aspects of disease-modifying therapy, and early real-world experience. The coming years will show whether the new treatments become a meaningful advance or a privilege for a few. That outcome depends on us.

Conflicts of Interest: The author declares no conflict of interest.

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