

A Unifying Hypothesis of Alzheimer's Disease. III. Risk Factors

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Normal ageing and Alzheimer's disease (AD) have many features in common and, in many respects, both conditions only differ by quantitative criteria. A variety of genetic, medical and environmental factors modulate the ageing-related processes leading the brain into the devastation of AD. In accordance with the concept that AD is a metabolic disease, these risk factors deteriorate the homeostasis of the Ca^{2+} -energy-redox triangle and disrupt the cerebral reserve capacity under metabolic stress. The major genetic risk factors (APP and presenilin mutations, Down's syndrome, apolipoprotein E4) are associated with a compromise of the homeostatic triangle. The pathophysiological processes leading to this vulnerability remain elusive at present, while mitochondrial mutations can be plausibly integrated into the metabolic scenario. The metabolic leitmotif is particularly evident with medical risk factors which are associated with an impaired cerebral perfusion, such as cerebrovascular diseases including stroke, cardiovascular diseases, hypo- and hypertension. Traumatic brain injury represents another example due to the persistent metabolic stress following the acute event. Thyroid diseases have detrimental sequela for cerebral metabolism as well. Furthermore, major depression and presumably chronic stress endanger susceptible brain areas mediated by a host of hormonal imbalances, particularly the HPA-axis dysregulation. Sociocultural and lifestyle factors like education, physical activity, diet and smoking may also modulate the individual risk affecting both reserve capacity and vulnerability. The pathophysiological relevance of trace metals, including aluminum and iron, is highly controversial; at any rate, they may adversely affect cellular defences, antioxidant competence in particular. The relative contribution of these factors, however, is as individual as the pattern of the factors. In familial AD, the genetic factors clearly drive the sequence of events. A strong interaction of fat metabolism and apoE polymorphism is suggested by intercultural epidemiological findings. In cultures, less plagued by the 'blessings' of the 'cafeteria diet-sedentary' Western lifestyle, apoE4 appears to be not a risk factor for AD. This intriguing evidence suggests that, analogous to cardiovascular diseases, apoE4 requires a hyperlipidaemic lifestyle to manifest as AD risk factor. Overall, the etiology of AD is a key paradigm for a gene-environment interaction. Copyright © 2000 John Wiley & Sons, Ltd.

KEY WORDS — Alzheimer's disease; risk factors; Down's syndrome; APP; presenilin; apolipoprotein E; traumatic brain injury; cerebrovascular disease; cardiovascular disease; hypertension; major depression; stress; education; diet; smoking; physical activity; trace metals

THE RISK FACTORS

Various genetic and environmental risk factors have been identified. Case-controlled and community-based studies suggest that a variety of factors contribute to the clinical manifestation of AD, particularly late-onset AD. In the aetiology of AD a paradigmatic gene-environment interaction is manifested.

GENETICS

Many epidemiological studies have shown that a positive family history is a consistent risk factor for

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AD (Heyman *et al.*, 1984; Mendez *et al.*, 1992). This led to the early notion that AD has a genetic underpinning. So far, mutations in three genes have been identified as causally related to familial early-onset AD (EOAD). These three genes explain most of the highly penetrant EOAD. However, overall these gene mutations represent less than 10 per cent of all AD cases.

Mutations of the amyloid precursor protein gene on chromosome 21

The interest of geneticists in the chromosome 21 (C21) was fuelled by two factors: (i) subjects with Down's syndrome are trisomic for all or part of

C21, and, aged over 35 years, regularly develop AD-like neuropathology, (ii) APP, the mother protein of A β , is encoded by a gene which maps to C21 (Robakis *et al.*, 1987; St George-Hyslop *et al.*, 1987; Tanzi *et al.*, 1987). As result of a meticulous search, allelic heterogeneous mutations in the APP gene just distal to the C-terminus and at the N-terminus of the A β domain that cosegregate with the AD phenotype have been identified (Chartier-Harlin *et al.*, 1991; Goate *et al.*, 1991; Murrell *et al.*, 1991). Though mutations in the gene for APP account for only a small fraction of cases of early-onset FAD, totalling some 20 families worldwide (Hardy, 1997), the heuristic value of these findings was eminent, indicating that A β is involved in the etiology of AD.

Pathophysiologically, the mutant APP familial diseases exhibit the AD-typic pattern of an impaired Ca²⁺–energy–redox triangle. Carriers of APP mutations have a parietotemporal glucose hypometabolism even in asymptomatic individuals (Kennedy *et al.*, 1955). Abnormalities of glucose metabolism (Sorbi *et al.*, 1995) and Ca²⁺ homeostasis (Tatebayashi *et al.*, 1995; Gibson *et al.*, 1997) are also found in non-neuronal cells. Intriguingly, some APP mutations alter the signalling-function of APP with regard to G_o activation (Okamoto *et al.*, 1996) (a regulator of Ca²⁺ channels) which may mediate their pro-apoptotic actions (Yamatsuji *et al.*, 1996; Giambarella *et al.*, 1997). α -ketoglutarate dehydrogenase activity in brains and fibroblasts is reduced similar to sporadic cases (Gibson *et al.*, 1998), corroborating that the pathophysiological processes of familial and sporadic cases share common pathways. APP mutations found in familial AD caused an impaired neuronal plasticity with defective neurite extension and synaptic transmission and thus may already give rise to deficits during brain development (Li *et al.*, 1997; Hsia *et al.*, 1999).

The histopathological changes in EOAD are the ones typical for AD brains, including the cytoskeletal pathology (Ghetti *et al.*, 1992; Lantos *et al.*, 1992; Nochlin *et al.*, 1993). The mutations result in alternative processing of APP (Haass *et al.*, 1994) in both the secretory and endocytic pathways (Felsenstein *et al.*, 1994; Matsumoto, 1994; Perez *et al.*, 1996) and increase A β production of neurons (Citron *et al.*, 1992, Cai *et al.*, 1993) and peripheral cells (Citron *et al.*, 1994). The A β 42 variant is preferentially produced by mutant APP-transfected cells (Suzuki *et al.*, 1994; Maruyama *et al.*, 1996), deposited in the brains (Kalaria *et al.*, 1996;

Tamaoka *et al.*, 1998) and increased in familial AD plasma (Kosaka *et al.*, 1997).

Transgenic mice expressing mutant APP mimic some of the prominent behavioural and pathological features of AD (reviewed by Hsiao, 1998; Price *et al.*, 1998). This model disease leads to cognitive impairment (Hsiao *et al.*, 1996; Moechars *et al.*, 1999), abnormal synaptic transmission and impaired long-term potentiation (Chapman *et al.*, 1999; Moechars *et al.*, 1999), increased brain levels of A β , particularly A β 42, and decreased levels of sAPP (Hsiao *et al.*, 1996; Johnson-Wood *et al.*, 1997; Moechars *et al.*, 1999), mitochondrial dysfunction (Talpade *et al.*, 1998), and increased oxidative stress (Pappolla *et al.*, 1998). Cerebrovascular dysregulation is associated with an increased susceptibility to ischemic brain damage (Zhang *et al.*, 1997). Alzheimer's disease-like pathology (Games *et al.*, 1995; Sturchler-Pierrat *et al.*, 1997) includes A β deposition (Hsiao *et al.*, 1996; Johnson-Wood *et al.*, 1997), neuron loss (LaFerla *et al.*, 1996; Calhoun *et al.*, 1998), necrosis and apoptosis (LaFerla *et al.*, 1996; Masliah *et al.*, 1996a; Moechars *et al.*, 1996), gliosis and neuritic dystrophy (LaFerla *et al.*, 1996; Masliah *et al.*, 1996a; Moechars *et al.*, 1996), microglial activation and clustering within plaques (Games *et al.*, 1995; Frautschy *et al.*, 1998). Expression of mutant APP in cultured cells causes G protein-mediated apoptosis (Giambarella *et al.*, 1997).

Mutations of presenilin 1 on chromosome 14 and presenilin 2 on chromosome 1

Chromosomes 14 and 1 harbour loci of genetic mutations, which in an almost fully penetrant fashion cause familial AD with age of onset frequently in the 40s (Hardy, 1997; Mattson *et al.*, 1998). The genes encode transmembrane proteins which were called presenilins (PS) (Levy-Lahad *et al.*, 1995; Rogaev *et al.*, 1995; Sherrington *et al.*, 1995). PS mutations account for approximately half of the early-onset familial AD cases (Campion *et al.*, 1995; Gomez-Isla *et al.*, 1997; Cruts *et al.*, 1998). So far a multitude of mutations, with one exception, missense mutations, were identified (Cruts and Van Broeckhoven, 1998). However, one of the mutations which was thought to be causally related to AD was later identified as a non-pathogenic polymorphism (Mattila *et al.*, 1998). The ApoE allele does not appear to modify the age of onset (Lendon *et al.*, 1997).

Though our knowledge about the physiological

role of PS is still fragmentary, a rough pattern is gradually emerging, (Mattson *et al.*, 1998). Widely expressed in the nervous system, PS have a role in neuronal differentiation (Capell *et al.*, 1977; Hartmann *et al.*, 1997; Shen *et al.*, 1997; Tokuhiko *et al.*, 1998), synaptic plasticity (Parent *et al.*, 1999), cell survival (Shen *et al.*, 1997) and apoptosis (Deng *et al.*, 1996; Wolozin *et al.*, 1996; Kim T-W *et al.*, 1997). PS-1 and -2 are located in the endoplasmic reticulum (ER), Golgi complex and in vesicular structures of the somatodendritic compartment of neurons, predominantly AD-vulnerable regions (Cook *et al.*, 1996; Kovacs *et al.*, 1996; Page *et al.*, 1996; Capell *et al.*, 1997; Culvenor *et al.*, 1997) and are expressed in a coordinated fashion (Thinakaran *et al.*, 1997). In addition to cooperational roles of the PS, opposing roles cannot be ruled out (Mattson *et al.*, 1998). PS are processed endoproteolytically into two fragments (Mercken *et al.*, 1996; Thinakaran *et al.*, 1996). The cleavage is developmentally regulated (Capell *et al.*, 1997; Hartmann *et al.*, 1997), but is not necessarily altered by a PS-1 mutation (Mercken *et al.*, 1996; Okochi *et al.*, 1997). As a 7 transmembrane-spanning receptor-like protein (Dewji and Singer, 1997), PS modulate neuronal excitability, Ca^{2+} homeostasis and transduction signalling (see below), are upregulated by a variety of metabolic stressors such as ischemia, injury, AD, and trisomy 21 (Cribbs *et al.*, 1996; Ikeda *et al.*, 1998; Tanimukai *et al.*, 1998) and appear to protect against these (Giannakopoulos *et al.*, 1997). For instance, PS-1 expression, although decreased in the AD hippocampus (Takami *et al.*, 1997), is increased in the fraction of NFT-free but decreased in NFT-containing neurons (Giannakopoulos *et al.*, 1997). Downregulation of PS-1 expression results in reduced growth and increases susceptibility to apoptosis (Roperch *et al.*, 1998). Moreover, PS directly interact with APP, presumably in the ER and Golgi (Waragai *et al.*, 1997; Weidemann *et al.*, 1997; Xia *et al.*, 1997), increase the secretion of sAPP (Marambaud *et al.*, 1998) and are required for proper γ -secretase processing of APP (Xia *et al.*, 1998). Thus, PS1 deficiency decreases the turnover of the membrane-associated APP and causes carboxyl-terminal fragments of APP to accumulate (De Strooper *et al.*, 1998; Xia *et al.*, 1998). Another interaction involves intercellular binding of membrane-bound APP and PS, which results in cell-cell adhesion and subsequent, intracellular signalling through tyrosine phosphorylation cascades (Dewji and Singer, 1998).

Presence of the mutant PS-1 gene is associated

with reduced perfusion and glucose metabolism of the temporoparietal and cingulate region in affected individuals before and after the development of clinical symptoms (Kennedy *et al.*, 1995; Johnson *et al.*, 1998). Brains of mutant PS-1 carriers exhibit a massively increased $A\beta$ load and even severe cerebellar pathology (Lemere *et al.*, 1996; Mann *et al.*, 1996; Tamaoka *et al.*, 1998). Plasma levels of $A\beta$ also were found to be increased (Scheuner *et al.*, 1996). Compatible with a role of PS in differentiation and neuronal plasticity, in transgenic mice mutant PS-1 impairs the neuronal ability to differentiate (Furukawa *et al.*, 1998; Tokuhiko *et al.*, 1998), reduces neurite outgrowth (Furukawa *et al.*, 1998; Dowjat *et al.*, 1999) and alters long-term synaptic plasticity in CA1 hippocampus (Parent *et al.*, 1999).

Mutant PS-1 and PS-2 cause a significant increase of APP expression in fibroblasts (Querfurth *et al.*, 1995), decrease sAPP production and secretion (Ancolio *et al.*, 1997; Marambaud *et al.*, 1998), increase total $A\beta$ and $A\beta_{42}$ intracellular accumulation and secretion in transfected cells and transgenic mice (Borchelt *et al.*, 1996; Duff *et al.*, 1996; Citron *et al.*, 1997; Xia *et al.*, 1998) in an age-dependent manner (Duff *et al.*, 1996; Oyama *et al.*, 1998). Expression of the full-length mutant is required for this capacity, indicating the cooperative interaction of the PS fragments (Tomita *et al.*, 1998). Mutant PS also decreased basal ChAT activity in cultured neuronal cells (Pedersen *et al.*, 1997).

PS have a role in the regulation of apoptosis which may be modulated by their proteolytic cleavage (Kim T-W *et al.*, 1997; Vito *et al.*, 1997). Generation of PS-1 and -2 C-terminal fragments delays apoptosis (Vito *et al.*, 1997; Vezina *et al.*, 1998). PS-1 and -2 mutations, on the other hand, increase cellular vulnerability to apoptosis (Deng *et al.*, 1996; Wolozin *et al.*, 1996; Guo *et al.*, 1998).

Abnormalities of Ca^{2+} regulation, ion channels, signal transduction pathways, oxidative metabolism and antioxidant status were documented in fibroblasts and lymphoblasts of AD patients carrying mutant PS genes (Ito *et al.*, 1994; Gibson *et al.*, 1996; Latorraca *et al.*, 1998). The role of PS in neuronal Ca^{2+} homeostasis may be mediated by intrinsic Ca^{2+} channel properties suggested by homologies to Ca^{2+} channel domains (Sherrington *et al.*, 1995), by binding and regulating the activity of a G_o protein (Smine *et al.*, 1998), thus modulating Ca^{2+} currents (Hille, 1994), and by upregulating K^+ channel currents (Malin *et al.*, 1998). PS-1 over-

expression potentiates Ca^{2+} responses (Paul *et al.*, 1997). A missense PS-1 mutation impairs this activity with putative profound sequelae for neuronal excitability (Malin *et al.*, 1998). Presenilin-1 mutations alter Ca^{2+} signalling, perturb Ca^{2+} homeostasis and mitochondrial function, enhance oxyradical production in cultured cell lines and synaptosomes and sensitize neurons to apoptosis (Furukawa *et al.*, 1998; Guo *et al.*, 1998; Begley *et al.*, 1999). Both Ca^{2+} influx and release from ER are involved in the pro-apoptotic action of mutant PS-1 (Guo *et al.*, 1998). The mutant PS-induced events highlight the importance of the ER Ca^{2+} homeostasis (Meldolesi and Pozzan, 1998) for the cellular vulnerability in conditions of energetic stress (Mattson *et al.*, 1998). This role is corroborated by findings that expression of ER stress proteins, including calreticulin which inhibits the intracellular Ca^{2+} rise, protect from oxidative stress (Liu H. *et al.*, 1998), that depletion of the ER Ca^{2+} store prevents neuronal injury and death (Waters *et al.*, 1997) and that inhibition of ER Ca^{2+} -ATPase can induce apoptosis (Kaneko and Tsukamoto, 1994). The reciprocal association of ER cytochrome c reductase activity, with cholinergic dysfunction and positive correlation with neurofibrillary tangles pathology in AD (Zubenko *et al.*, 1990), points at interrelationships of distinct pathophysiological events. Furthermore, the pathophysiological relevance of the compromise of ER Ca^{2+} homeostasis in ageing is emphasized (Heininger, 1999a). It is speculated that PS, via their K^+ channel and G_o protein regulating properties, fulfil important functions in Ca^{2+} homeostasis and signalling and by disruption of these physiologic functions in mutant PS vital neuronal metabolic processes are impaired, resulting in abnormal neuronal plasticity and susceptibility to neurodegeneration.

Down's Syndrome

Down's Syndrome (DS), the most frequent of congenital birth defects, is the consequence of triplication of chromosome 21 (Lejeune *et al.*, 1959). The genetic defect results in developmental anomalies, mental retardation and accelerated ageing, the developmental arrest characterized by reduced brain weight and deficient neuro- and synaptogenesis (Wisniewski *et al.*, 1984; de la Monte and Hedley-Whyte, 1990).

DS is the most common genetic cause of AD. DS is associated with a high incidence of AD with similar prevalence rates to those in normals, but

occurring 30–40 years earlier (Lai and Williams, 1989; Visser *et al.*, 1997; Holland *et al.*, 1998). Intellectual deterioration is present in approximately one third of patients at the age of 35 and in 50 per cent in the fifth decade of life with fully-fledged dementia (Fenner *et al.*, 1987; Brugge *et al.*, 1994; Devenny *et al.*, 1996; Oliver *et al.*, 1998) paralleled by a slowing of the electroencephalogram (Soininen *et al.*, 1993). In contrast, the typical neuropathological features of AD, SP and NFT are regularly present in the brains of individuals with DS aged over 35 years (reviewed by Mann, 1993). Thus, in comparison to AD patients, significant differences exist in the correlation of SP density and neuronal loss, atrophy and dementia (Wisniewski and Rabe, 1986; Mann *et al.*, 1987; Oliver *et al.*, 1998). AD pathology may precede, while dementia and brain atrophy follow and correlate closely (Schapiro *et al.*, 1989; Pearlson *et al.*, 1990). This phenomenon will be further discussed in part 4 of this series. Similar to AD, middle-aged DS individuals with apoE4 have more impaired and more rapidly declining intellectual functions (Alexander *et al.*, 1997b; Del Bo *et al.*, 1997) and an increased risk of developing AD earlier, while apoE2 seems to protect DS individuals from AD (Prasher *et al.*, 1997; Schupf *et al.*, 1998; Tyrrell *et al.*, 1998). DS individuals exhibit a range of disordered processes of brain metabolism and homeostasis, which put the neurons under metabolic stress during the whole lifespan. While younger DS individuals show either normal or increased values for regional cerebral glucose utilization (Schwartz *et al.*, 1983; Schapiro *et al.*, 1990) and blood flow (Risberg, 1980), an AD-like pattern of reduced cerebral glucose metabolism and blood flow can be detected in DS subjects with AD and often in elderly DS individuals without dementia (Melamed *et al.*, 1987; Schapiro *et al.*, 1988; Azari *et al.*, 1994). Typically, older DS subjects show low glucose metabolism during brain stimulation prior to the evolution of dementia (Pietrini *et al.*, 1997). Elderly DS individuals display reduced neuronal counts in cortex, hippocampus, basal forebrain, locus coeruleus, raphe and ventral tegmentum (reviewed by Mann, 1993). Similarly, changes of neurotransmitter markers for cholinergic, noradrenergic, serotonergic, glutamatergic and GABAergic neurons are equivalent to the changes seen in AD (reviewed by Mann, 1993). These can be detected already in middle-aged DS individuals (Casanova *et al.*, 1985; Godridge *et al.*, 1987; Reynolds and Warner, 1988), including a degeneration of basal forebrain neurons (Casanova

et al., 1985). In fifth decade DS subjects, degradation and/or rapid synthesis of brain cell membranes may occur prior to neuronal loss and degeneration (Murata *et al.*, 1993). Deficiencies of mitochondrial enzymatic activities were demonstrated in DS platelets (Prince J. *et al.*, 1994). DS individuals show increased systemic levels of biomarkers of oxidative stress (Jovanovic *et al.*, 1988) and neurons display *in vitro* increased oxygen species and apoptosis (Busciglio and Yankner, 1995). Glycation end products indicating oxidative stress could be detected already in foetal DS brains (Odetti *et al.*, 1998). The cerebral metabolic stress may be aggravated by a hypothyroid state. Notably, increased TSH levels indicating a cerebral thyroid hormone shortage predict a poorer cognitive performance (Bhaumik *et al.*, 1991), while autoimmune thyroiditis is a common finding in DS subjects and appears to be more pronounced in individuals affected by AD (Percy *et al.*, 1990).

As a consequence of the extra C21, expression of APP is increased in ageing Down's Syndrome brains (Rumble *et al.*, 1989; Oyama *et al.*, 1994; Arai *et al.*, 1997), cortical cultures (Yankner *et al.*, 1998), lymphocytes and fibroblasts (Govoni *et al.*, 1996; Pallister *et al.*, 1997) and serum (Rumble *et al.*, 1989). In contrast to controls, plasma levels of A β are increased (Tokuda *et al.*, 1997), soluble A β is present in DS brains during the whole lifespan (Teller *et al.*, 1996) and, hence, A β deposition could be detected in parahippocampal structures as early as in 8 year-old DS patients (Leverenz and Raskind, 1998). A β 42 deposition precedes and is more abundant, while A β 40 is only detectable when first signs of neurodegeneration emerge (Iwatsubo *et al.*, 1995; Kalara *et al.*, 1996). This gene dosage effect is also present in transgenic mice where the level of neuronal expression of human APP determined the neuroprotective/neurotoxic equilibrium, particularly, in the context of secondary neural injuries (Mucke *et al.*, 1996). *In vitro*, overexpression of APP has been demonstrated to induce neuronal degeneration and intracellular accumulation of APP derivatives (Yoshikawa *et al.*, 1992). In DS cortical cultures, levels of secreted sAPP and A β were reduced, while intracellular A β accumulated *in vitro* and *in vivo* (Yankner *et al.*, 1998). Overexpression of S-100 β that localizes to C21 may also contribute to the accelerated brain ageing and impaired neuronal plasticity (Jørgensen *et al.*, 1990; Whitaker-Azmitia *et al.*, 1997). A decreased neuronal connectivity and synaptogenesis, which manifests as functional disruption of neural circuits, may

already be apparent in children and progress in non-demented DS subjects in their thirties (Ferrer and Gullotta, 1990), Takashima *et al.*, 1994). Finally, a precocious immunosenescent status of DS patients may condition the cerebral milieu for the AD-like acute phase response (Griffin *et al.*, 1989; Mehta *et al.*, 1993; Oka and Takashima, 1997).

Trisomy 16 (TS16) is the mouse correlate of human DS. A partial TS16 mouse (the full TS16 mouse is not viable) shows developmental delay, abnormal behaviour compatible with mental retardation, septohippocampal cholinergic degeneration and astrogliosis (Holtzman *et al.*, 1996). TS16 cell lines demonstrate aberrant APP processing and cytoskeleton abnormalities (Williams *et al.*, 1998) and show decreased glutathione levels and increased vulnerability (Bambrick *et al.*, 1995; Stabel-Burrow *et al.*, 1997). Intriguingly, TS16 astroglia elicited a cholinergic deficit when co-cultured with normal neurons from euploid littermates (Nelson *et al.*, 1997).

Mutations of mitochondrial DNA

Epidemiological studies suggest an increased risk of late-onset AD in offspring of mothers with AD compared to those of fathers with AD (Heyman *et al.*, 1983; Farrer *et al.*, 1991; Duara *et al.*, 1993; Edland *et al.*, 1996), a finding consistent with maternal transmission patterns in AD. Moreover, advanced maternal age at birth may constitute an independent risk in the offspring (Cohen *et al.*, 1982; Rocca *et al.*, 1991). Mutations in mtDNA were suspected to be causally related since mtDNA is maternally inherited in a non-Mendelian way (Giles *et al.*, 1980). Since mtDNA partly encodes four out of five complexes in the oxidative phosphorylation pathway, mutations in mtDNA may result in defective energy homeostasis (Mattson, 1997). A mutation identified as increased in AD patients affects a mitochondrial tRNA gene (Schoffner *et al.*, 1993; Hutchin and Cortopassi, 1995; Egensperger *et al.*, 1997). This is not a highly penetrant mutation (Tysoe *et al.*, 1996) and therefore may have been missed by another group (Wragg *et al.*, 1995). Possible consequences for mitochondrial protein synthesis, particularly for complex I (NADH dehydrogenase), have been suggested (Hutchin and Cortopassi, 1995). An increased sensitivity of cells bearing a variety of mtDNA mutations to Ca²⁺-dependent oxidant stress was shown (Wong and Cortopassi, 1997). Another

report recently demonstrated an increased frequency of a mtDNA 5 kb deletion in AD temporal cortex (Hamblet and Castora, 1997). This type of deletion has been shown previously to be associated with Kearns–Sayre syndrome, a mitochondrial disorder which affects different organ systems. However, as with other mtDNA changes the inherited versus acquired nature remains elusive. mtDNA is exposed to high levels of ROS, but has poor repair mechanism, so that during ageing mtDNA point and length mutations accumulate. The increased oxidative stress associated with AD (Heininger, 1999b) may result in a higher frequency of mutations. A recently reported link between heritable mutations in mtDNA encoding cytochrome oxidases and late-onset AD (Davis *et al.*, 1997) could not be confirmed by others (Hutchin *et al.*, 1997) and appears to be an artifact (Hirano *et al.*, 1997; Wallace *et al.*, 1997). Mitochondrial function may also be affected by mutations of nuclear DNA coding for mitochondrial proteins. A polymorphism of the nuclear gene (on chromosome 14) coding for dihydrolipoyl succinyltransferase (DLST), a core component of the α -ketoglutarate dehydrogenase complex, may be an independent risk factor for late onset AD (Nakano *et al.*, 1997; Sheu *et al.*, 1999a) and appears to be additive to apoE4 (Sheu *et al.*, 1999a). It has been claimed that up to 50 per cent of chromosome 14-related early-onset familial AD cases may be due to the DLST polymorphism (Sheu and Blass, 1999). Another DLST genotype, on the other hand, may protect against AD (Sheu *et al.*, 1999b). An intriguing finding associated mothers who gave birth to a DS child at a relatively young age (<35 years) with an increased risk for AD (Schupf *et al.*, 1994). Another link was suggested for the birth of a DS child and earlier onset of AD in the mother (Heston *et al.*, 1981). Causal relationships may be due to a shared susceptibility for an accelerated ageing process (Emanuel *et al.*, 1972; Brook *et al.*, 1984; Tarin *et al.*, 1998) or a maternal balanced chromosome rearrangement which predisposes to the trisomy syndrome, but does not give rise to an unfavourable phenotypic effect.

Apolipoprotein E

Apolipoprotein (apo) E, a 34 kDa molecular weight protein, is the product of a single gene on chromosome 19. It exists in three different alleles, ϵ 2, ϵ 3, ϵ 4, coding for proteins apoE2, apoE3, apoE4, respectively, differing from each other by one or

two amino acids, only. Apo E plays a critical role in lipid metabolism through its systemic function in chylomicron and very low density lipoprotein (VLDL) transport. In the individual organs, it acts by redistributing lipids between areas of excess and demand for proliferation and repair. In the brain, apoE is synthesized and secreted primarily by astrocytes and microglia (Pitas *et al.*, 1987; Nakai *et al.*, 1996; Stone *et al.*, 1997) and upregulated following neuronal injury and reinnervation (Poirier *et al.*, 1993a). Within the damaged area, apoE scavenges cholesterol and phospholipids from cellular debris and recycles it for membrane remodelling associated with neurite sprouting and synaptic replacement (Poirier *et al.*, 1993a). ApoE appears to be necessary for astrocytic lipoprotein secretion (Fagan *et al.*, 1998). Moreover, apoE is involved in synaptic integrity, stabilizes the neuronal cytoskeleton, regulates interactions between neurons and extracellular matrix and modulates intracellular Ca^{2+} levels (Masliah *et al.*, 1996b; Holtzman and Fagan, 1998). The crucial importance of these mechanisms for neuronal development and networking was highlighted by the findings that apoE-deficient mice display severe learning deficits (Oitzl *et al.*, 1997a), and age-dependent reduction of synapses, a complete disruption of the dendritic cytoskeleton (Masliah *et al.*, 1995), and a disturbed transbilayer distribution of cholesterol and lipid structure of synaptic membranes (Igbavboa *et al.*, 1997). The associated compromised synaptic plasticity (Krugers *et al.*, 1997; Holtzman and Fagan, 1998) can be ameliorated by apoE infusions (Masliah *et al.*, 1996c) and, in a slice culture, by cholesterol (Teter *et al.*, 1998). In transgenic mice produced by transfer of either apoE3 or apoE4 genes to an apoE knockout background, apoE3 and, to a lower extent apoE4, could ameliorate these neuropathologic changes *in vivo* (Vienbergs *et al.*, 1999) and in a hippocampal slice culture (Teter *et al.*, 1998). Evidence suggests that apoE is a stress protein (Einstein *et al.*, 1995; Maquire *et al.*, 1996) which is expressed after acute brain injury due to global hypoxia/ischemia, hypoglycaemia and status epilepticus (Nicoll *et al.*, 1996).

Recent findings have demonstrated a significant association between the ϵ 4 allele and late onset familial and sporadic AD (Corder *et al.*, 1993; Saunders *et al.*, 1993; Poirier *et al.*, 1993b, Rebeck *et al.*, 1993). The ϵ 4 allele increases the risk and lowers the age of onset distribution, so that patients with an ϵ 4 allele develop AD at an earlier age (Hyman *et al.*, 1996; Blacker *et al.*, 1997). In a population-

based incidence study, apoE4 homozygotes had a more than 10-fold higher risk of dementia compared with E3 homozygotes, and around 20 per cent of dementia cases were attributable to apoE4 (Slooter *et al.*, 1998). ApoE4 may also reduce the age of onset of AD in individuals with DS (Schupf *et al.*, 1996; Prasher *et al.*, 1997). On the other hand, the $\epsilon 2$ allele appears to lower the risk and increase the age of onset distribution.

A multitude of mechanistic pathways may jointly contribute to the isoform-specific pathogenic effects of ApoE4:

- ApoE4 accelerates the rate of cognitive decline in nondemented individuals (Reed *et al.*, 1994; Helkala *et al.*, 1995; Blesa *et al.*, 1996; Jonker *et al.*, 1998).
- Clinically normal apoE4 subjects in their 50s and 60s exhibit significant reductions of brain metabolic rates for glucose (Small *et al.*, 1995; Reiman *et al.*, 1996). In AD, however, apoE4 does not appear to be associated with a lower glucose utilization (Corder *et al.*, 1997; Higuchi *et al.*, 1997; Hirono *et al.*, 1998).
- ApoE4 promotes incipient AD pathology in nondemented elderly (Warzok *et al.*, 1998). Remarkably, initial neurofibrillary changes can be found in apoE4 individuals as early as in their 30s (Ghebremedhin *et al.*, 1998).
- AD patients with ApoE4 may have a lower brain atrophy in relation to their cognitive status, which was thought to indicate an ApoE4-dependent process which induces neuronal dysfunction before overt brain tissue loss becomes manifest (Yasuda *et al.*, 1998).
- ApoE4 may predispose AD patients to particularly low regional cerebral perfusion (Lehtovirta *et al.*, 1998).
- ApoE4 may be associated with reduced cholinergic function in normal and AD brains (Soininen *et al.*, 1995; Beffert and Poirier, 1996; Allen *et al.*, 1997, not confirmed by Svensson *et al.*, 1997; Jørgensen and Mogensen, 1997), and was reported to be associated with a more pronounced loss of metabolic activity of cholinergic nucleus basalis neurons (Salehi *et al.*, 1998).
- ApoE4 increases amyloid load in the AD brain (e.g. Rebeck *et al.*, 1993; Schmechel *et al.*, 1993; Beffert and Poirier, 1996; Hyman *et al.*, 1996) and DS brain (Hyman *et al.*, 1995). This phenomenon may be related to an isoform-specific binding of apoE4 and A β . ApoE4 binds less efficiently to A β than apoE2 and 3 (LaDu *et al.*, 1994; Zhou *et al.*, 1996; Aleshkov *et al.*, 1997) and hence may accelerate A β fibrillization (Wisniewski *et al.*, 1994), and fail to exert the protective actions of ApoE3 to A β toxicity (Jordan *et al.*, 1998), respectively.
- ApoE4 inhibits or fails to support neurite outgrowth (Nathan *et al.*, 1994) by a receptor-mediated effect (DeMattos *et al.*, 1998) and this effect may be mediated by blockade of microtubule formation (Pitas, 1996). In the presence of a lipid source, expression of human apoE4 blocks, while apoE3 increases neurite outgrowth from murine neuroblastoma cells (Bellosta *et al.*, 1995).
- ApoE4 binds to microtubule-associated proteins less avidly than apoE3, which may result in isoform-specific effects on PHF and NFT formation (Strittmatter *et al.*, 1994; Huang *et al.*, 1994; Fleming *et al.*, 1996) which, however, do not appear to result in quantitative differences in the AD brains (Hyman *et al.*, 1996).
- ApoE4 aggravates the abnormalities of membrane phospholipid metabolism in AD brains (Klunk *et al.*, 1998).
- ApoE4-complexed A β is readily sequestered by capillaries and taken up by the brain *in vivo*, while complexes with ApoE2 or 3 have negligible effects (Martel *et al.*, 1997).
- Apo E isoform specifically has antioxidant activity, apoE4 being less potent than E3 and E2 (Miyata and Smith, 1996), thus rendering CSF more susceptible to oxidative stress (Beisiegel *et al.*, 1997).
- ApoE complexed with A β enhances A β -induced Ca²⁺ increases in neurons and astrocytes through P/Q type Ca²⁺ channels and this effect is isoform-specific, E4 being significantly more effective than E3 (Wustenberg *et al.*, 1997; Muller *et al.*, 1998). Similarly, an ApoE fragment, which is also found in human brain, isoform-specifically elevated cytoplasmic Ca²⁺ in cortical and hippocampal cultured neurons both by mobilization of intracellular and influx of extracellular Ca²⁺ (Marques *et al.*, 1996; Wang and Gruenstein, 1997; Tolar *et al.*, 1997). Addition of protease inhibitors attenuated the neurotoxicity of apoE since the proteolytic fragment was more neurotoxic than full-length apoE (Marques *et al.*, 1997).
- Finally, ApoE also may have impacts on immunological processes. Isoform-specifically, apoE enhances complement activation by A β (McGeer *et al.*, 1997). ApoE genotype appears to be an important determinant of microglial activity:

ApoE4 gene dose significantly increased the number of scattered microglial cells (Saitoh *et al.*, 1997) and markers of microglial activation in AD brains (Egensperger *et al.*, 1998). On the other hand, apoE3 but not apoE4 blocked activation of microglia by APP metabolites (Barger and Harmon, 1997). ApoE may also modulate the specific immune defence as evidenced by the findings that apoE4 is a risk factor for herpes simplex virus (HSV) type 1 infection (Itzhaki *et al.*, 1997) and that ageing and stressed apoE-deficient mice have increased levels of autoantibodies to neuronal antigens (Zhou *et al.*, 1999).

ApoE isoform-specific effects are not specific for AD. Repeatedly (e.g. Myers *et al.*, 1996; Hofman *et al.*, 1997; Katzman *et al.*, 1997; Marin *et al.*, 1998), but compared to AD less consistently (e.g. Pirttila *et al.*, 1996), apoE4 was also suggested as risk factor for vascular dementia, with the larger studies confirming the association. ApoE4 is associated with an increased risk for cardiovascular morbidity and mortality, also in AD patients (Kosunen *et al.*, 1995; Olichney *et al.*, 1997). ApoE4 genotype modulates the risk for a variety of dementing illnesses and may confer an increased risk for dementia after stroke (Kokmen *et al.*, 1996; Slooter *et al.*, 1997), dementia associated with normal pressure hydrocephalus (Nacmias *et al.*, 1997), for both earlier onset and manifestation of frontal lobe dementia (Minthon *et al.*, 1997; Stevens *et al.*, 1997), for traumatic encephalopathy associated with boxing (Jordan *et al.*, 1997), cognitive decline after cardiac operations (Tardiff *et al.*, 1997), senile plaques in temporal lobe epilepsy (Gouras *et al.*, 1997), HIV-related dementia (Corder *et al.*, 1998), worse outcome after traumatic brain injury (Teasdale *et al.*, 1997; Friedman *et al.*, 1999), mortality after intracerebral hemorrhage (Alberts *et al.*, 1995) and cerebrovascular disease in end-stage renal disease patients (Lim *et al.*, 1997). In Creutzfeldt-Jakob disease (CJD) apoE4 is reported to be a risk factor (Amouyel *et al.*, 1994), while in sporadic amyotrophic lateral sclerosis (ALS) apoE4 was related to an earlier onset, and more severe clinical presentation and prognosis (Moulard *et al.*, 1996). Similarly, apoE4 may be associated with an earlier onset and apoE2 with a later onset of Parkinson's disease (Zareparsari *et al.*, 1997). In general, the apoE4 genotype is associated with an increased vulnerability to and an impaired recovery from a variety of brain injuries (Roses and Saunders, 1997). In apoE ϵ 4 carriers, this increased disposition to

neuronal degeneration was highlighted by the finding of a reduced hippocampal volume as early as in their 40s (Tohgi *et al.*, 1997) and the occurrence of neurofibrillary changes as early as in their 30s (Ghebremedhin *et al.*, 1998).

ApoE, as cholesterol carrier, modulates the production of steroid hormones by which it is regulated itself (Reyland *et al.*, 1991). ApoE regulates glucocorticoid (GC) synthesis (Hammami *et al.*, 1991), but for the time being it can only be speculated about an ApoE isoform-specific regulation of GC production. Remarkably, apoE deficient mice showed a blunted initial stress response with lower GC levels (Gordon *et al.*, 1996; Zhou *et al.*, 1998), but higher baseline levels and stronger GC response upon repetitive stress (Zhou *et al.*, 1998). The complex interrelationship between the two risk factors stress/GC (see below) and apoE is epitomized by the finding that lack of apoE in knockout mice induces a cognitive deficit but protects heterozygous mice from stress-related cognitive impairment and improves cognitive performance in stressed homozygous mice (Grootendorst *et al.*, 1998). ApoE isoform modulates the relative, gender-related risk for familial and sporadic AD (Poirier *et al.*, 1993b; Payami *et al.*, 1996), and the protective action of oestrogen replacement (van Duijn *et al.*, 1996). On the other hand, apoE expression is regulated by oestrogen (Srivastava *et al.*, 1996). ApoE polymorphism-mediated alterations of the steroid hormone balance may underly in part the immunological and metabolic phenomena observed in ageing and AD.

Gender

Repeatedly, gender-specific differences in the prevalence/incidence and remaining lifetime risk of AD have been reported, the life expectancy-corrected incidence in women being higher (Silverman *et al.*, 1994; Seshadri *et al.*, 1997; Gao *et al.*, 1998). In DS, women may also exhibit both a higher incidence of clinical AD and a severe phenotypic expression of AD pathology (Raghavan *et al.*, 1994). According to another study, male DS patients may have an increased risk of AD (Schupf *et al.*, 1998). As multifactorial as the etiopathogenesis of AD may be the determinants of a different sex-related risk. Discussion of these factors clearly deserves a broader frame (Heininger, in preparation). Here, only some general principles will be covered briefly. After correction for selective survival due to a different life expectancy, different odds ratios to contract AD

may be due to a variety of putative pathophysiological variables with sometimes opposite trends on risk status such as X chromosome-associated allelic associations (Zubenko *et al.*, 1998b), susceptibility to apoE genotype (Payami *et al.*, 1996; Martinez *et al.*, 1998, but see Combarros *et al.*, 1998a), cerebral perfusion (Akiyama *et al.*, 1997; Jones *et al.*, 1998), stress responsivity (Seeman *et al.*, 1995; Kiecolt-Glaser *et al.*, 1997), association of hormonal status and memory performance (Oxenkrug *et al.*, 1989; Seeman *et al.*, 1997), education, and life style. Of high relevance is a different time course of ageing-related hormonal decline, being gradual in men and more abrupt in women (Lamberts *et al.*, 1997). Endocrinologically and metabolically, the menopause elicits a drastic change (Richardson, 1993; Spencer *et al.*, 1997), affecting not only gonadal but also thyroid, somatotrophic and adrenal hormone levels substantially (Bottiglioni *et al.*, 1983; Van Cauter *et al.*, 1996; Bernardi *et al.*, 1998). Thus, reproductive senescence predicts cognitive decline in aged female monkeys (Roberts *et al.*, 1997). These changes may be accelerated by surgically-induced menopause, as suggested in humans (Nappi *et al.*, 1999) and rodents (Gibbs, 1998), resulting in an increased incidence and earlier onset of AD (Hong-Goka and Chang, 1997; Nee and Lippa, 1999). As confounding factor, the response of neurons to gonadal steroid deprivation and replacement appears to be sexually dimorphic (Miranda *et al.*, 1999).

Other genetic influences

Other genetic factors, though actually less well defined, have been reported to modulate the risk for AD.

A polymorphism in the regulatory region of the apoE gene may be associated with an increased risk of AD independent of the apoE4 allele (Bullido *et al.*, 1998; Lambert *et al.*, 1998). A polymorphism in exon 3 of the low-density lipoprotein receptor-related protein (LRP) gene is a risk factor for late-onset AD, again independent of apoE4-associated risk (Kang *et al.*, 1997; Hollenbach *et al.*, 1998). Since LRP is an apoE receptor, this association as well as another with a lipoprotein lipase mutation (Baum *et al.*, 1999) points further at an abnormality of lipoprotein metabolism in AD. A deletion in the gene of α_2 -macroglobulin, another ligand of the LRP, may also bear a risk for the manifestation of the disease (Blacker *et al.*, 1998). A dinucleotide microsatellite allele flanking the α_1 -antichymo-

trypsin gene may modulate the apoE-related risk (Morgan *et al.*, 1997). Another apolipoprotein, CI, has been reported to confer an increased risk with its A allele (Poduslo *et al.*, 1998).

In keeping with the role of immune mechanisms in the pathophysiology of AD, antigens of the HLA immune recognition system may also modulate the risk. Earlier onset of age is associated with the HLA-A2 allele (Payami *et al.*, 1997; Combarros *et al.*, 1998b; Ballerini *et al.*, 1999). In the absence of apoE4, antigens DR1, 2, or 3 may increase the risk while DR4 or 6 may lower the risk for AD (Curran *et al.*, 1997).

Transferrin C2, a variant of the iron transport protein, appears to be weakly associated with AD, emphasizing the role of oxidative stress in the pathophysiology of the disease (van Rensburg *et al.*, 1995; Namekata *et al.*, 1997).

Other genetic associations include the short variant of the polymorphism within the promoter region of the serotonin transporter gene (Oliveira *et al.*, 1998) and a missense mutation of the neurotrophin-3 gene, which was reported to be more frequent in Japanese AD patients than controls (Kunugi *et al.*, 1998). Frameshift mutations due to inaccurate interpretation of intact genetic information, failure of the RNA surveillance system and translation into +1 proteins have been shown for APP and ubiquitin-B (van Leeuwen *et al.*, 1998). This type of mutation, however, appears to be a more general feature of ageing (Evans *et al.*, 1995).

Additional genomic associations can be expected. A complete genomic screen in families affected with late-onset AD revealed an additional locus on chromosome 12 associated with an increased risk for AD (Pericak-Vance *et al.*, 1997). Further allelic associations were detected in a systemic survey of the human genome (Zubenko *et al.*, 1998a).

MEDICAL RISK FACTORS

Between the genetic and environmental risk factors, the medical risk factors occupy an intermediate position, since often they are already the composite result of genetic and environmental factors.

Traumatic brain injury

Though inconsistent in individual studies (Gentleman and Roberts 1991; Mayeux *et al.*, 1993; Katzman and Kawas, 1994; Kondo *et al.*, 1994; Rasmusson *et al.*, 1995), a meta-analysis found

traumatic brain injury (TBI) to be associated with an increased risk of AD (Mortimer *et al.*, 1991). Closed head injury in young adulthood may predict cognitive impairment 50 years later and be associated with a higher AD incidence (Havlik *et al.*, 1998). TBI with loss of consciousness >5 min within the preceding 30 years was associated with AD (Schofield *et al.*, 1997a). Evidence suggests that the risk is highest for head injuries that occurred after age 70 (Mayeux *et al.*, 1993) and, in elderly 70 years or older, major head injuries predicted an accelerated cognitive decline (Luukinen *et al.*, 1999). Similarly, in individuals with the apoE4 genotype the TBI-related risk may be increased (Mayeux *et al.*, 1995; Nicoll *et al.*, 1995) which, however, was not confirmed by another study (O'Meara *et al.*, 1997). Dementia pugilistica following repeated head blows during boxing shares many behavioural, neurophysiological, neurochemical and pathomorphological features of AD (reviewed by Mendez 1995).

TBI may predispose for AD either by reducing the brain reserve in a single event and/or by inducing a long-term process altering neuronal circuitry, excitability and metabolism. TBI is almost invariably associated with neuronal metabolic stress following secondary ischemia (Jenkins *et al.*, 1989; Siesjo *et al.*, 1995; Martin N.A. *et al.*, 1997), cortical spreading depression (Hossmann, 1996; Mayevsky *et al.*, 1996), and resulting excitotoxic exposure (Faden *et al.*, 1989; Yamikami and McIntosh, 1989; Nilsson *et al.*, 1990). These pathophysiological cascades result in regional brain and mitochondrial Ca²⁺ elevation, oxidative stress, dysfunction of oxidative phosphorylation and ATP decrease (Nadler *et al.*, 1995; Awasthi *et al.*, 1997; Xiong *et al.*, 1997). Neuronal and axonal injury-induced metabolic stress is associated with increased APP expression as part of an acute phase response to the TBI (Gentleman *et al.*, 1993; Pierce *et al.*, 1996). Activation of invading monocytes/macrophages and resident microglial cells occurs with interleukin-1 α expression which is correlated with neuronal APP upregulation (Griffin *et al.*, 1994; Holmin *et al.*, 1998). Deposits of A β were found in the brains of some 30 per cent of patients with fatal TBI (Roberts *et al.*, 1991; Graham *et al.*, 1995). Notably, the likelihood of A β deposition and neurobehavioural deficits increased with age (Hamm *et al.*, 1992). Possibly, the trauma-associated, glucocorticoid- and prostaglandin-mediated inhibition of macrophage phagocytosis may provide the tissue milieu that is permissive to the

accumulation of amyloid deposits (Faist *et al.*, 1996; Heininger, 1999b).

TBI, of even low intensity, puts the neurons under metabolic stress with decreased glucose utilization (Hayes and Dixon 1994; Queen and Feeney, 1996) and metabolic depression (Dietrich *et al.*, 1994). The cholinergic system undergoes profound degenerative changes following TBI. In the human traumatized brain, markers of cholinergic neurotransmission are lost (Murdoch *et al.*, 1998). The loss of cholinergic forebrain neurons after TBI (Leonard *et al.*, 1994; Schmidt and Grady, 1995) leads to a disruption of the septohippocampal and basalocortical pathway (DeAngelis *et al.*, 1994; Leonard *et al.*, 1997) which is of utmost importance for cognitive processes. Thus, even in the absence of overt cognitive deficits, mild TBI animals showed an increased sensitivity to anticholinergic challenge which persisted after moderate TBI (Dixon *et al.*, 1995).

According to preclinical, clinical and radiological findings both subacute, but persisting and chronic processes may ensue which compromise neuronal circuitry and function and lay the ground for the susceptibility of TBI patients (and ischemia patients, see below) for AD. Profound and prolonged impairments of cognition occur following experimental TBI and ischemia models (Lyeth *et al.*, 1990; Volpe *et al.*, 1992; Wood *et al.*, 1993; Pierce *et al.*, 1998) and human head trauma (Prigatano and Schachter, 1991; Kay *et al.*, 1992; Carlesimo *et al.*, 1997). In animal models, TBI and even sub-threshold mechanical injury to the brain induce persistent neurofilament loss (Posmantur *et al.*, 1994) and cytoskeletal pathology (Kanayama *et al.*, 1996; Takeda *et al.*, 1997). A state of chronic stress is evidenced by chronic APP overexpression (Ciallela *et al.*, 1998). Transient ischemia, which is a routine concomitant of TBI, elicits long-term changes with hyperexcitability in rat neocortex and hippocampus due to down-regulation of inhibitory GABAergic function, disturbance of Ca²⁺ regulation (Tsubokawa *et al.*, 1992; Akaike, 1995; Luhmann *et al.*, 1995; van den Pol *et al.*, 1996; Yang and Benardo, 1997), progressive neurotransmitter receptor imbalances (Araki *et al.*, 1992), chronic depression of glucose metabolism (Beck *et al.*, 1995), and persistent microglial activation (Hsu *et al.*, 1994) resulting in long-term degenerative changes (Mudrick and Baimbridge, 1989; Onodera *et al.*, 1990; Hsu *et al.*, 1994). Similarly, a single systemic dose of the excitotoxin kainic acid induced long-term accumulation of Ca²⁺ in the rat hippo-

campus (van den Berg and Gramsbergen, 1993). Furthermore, transient ischemia leads to iron deposition in the cortex and hippocampus, followed by late-onset and persistent lipid peroxidation resulting eventually in neuronal damage (Kondo *et al.*, 1997). Thus, a chronically progressive degenerative process evolves which leads to ongoing axonal degeneration, increasing cytoskeletal abnormality (Takeda *et al.*, 1997; Pierce *et al.*, 1998), progressive loss of cortical and hippocampal tissue and reactive astrogliosis (Smith D. H. *et al.*, 1997; Pierce *et al.*, 1998). A reduction of thyroid endocrine function after head trauma may contribute to the development of brain pathology (Mocchegiani *et al.*, 1995).

Patients with even mild TBI may exhibit abnormal local cerebral metabolic rates correlating with long-term behavioural and cognitive deficits (Ruff *et al.*, 1994; Gross *et al.*, 1996). Subacutely developing hippocampal volume atrophy correlates with cognitive decline in the chronic recovery phase of TBI (Bigler *et al.*, 1997). As a consequence, TBI in young adulthood exacerbates cognitive decline in the following 30 years (Corkin *et al.*, 1989) and may facilitate the evolution of cognitive impairment and AD 50 years later (Havlik *et al.*, 1998). The no-effect threshold may be very low since, even with mild brain trauma, up to 35 per cent of victims may show cognitive sequelae (Bohnen and Jolles, 1992). Persistent abnormalities of the cholinergic system may be causally related to the cognitive deficits as suggested by the therapeutic benefit of a cholinergic agonist (Cadenas *et al.*, 1994).

Cerebral perfusion

The traditional concept assumes that AD and vascular dementia (VD) are two distinct entities. Due to epidemiological evidence that vascular risk factors which are associated with a reduced cerebral blood flow contribute to the pathophysiology of AD (Crawford, 1996, 1998) this dichotomy has come under scrutiny and has increasingly been questioned (Gold *et al.*, 1998; Stewart, 1998). The commonness of vascular abnormalities in AD (Ellis *et al.*, 1996; Buee *et al.*, 1997; see below) and the rarity of isolated cerebrovascular pathology with dementia at autopsy (Hulette *et al.*, 1997; Nolan *et al.*, 1998) highlight the dubiousness of this differentiation. Thus, it appears as if AD and VD represent theoretical concepts with heuristic value, but that the clinical reality is characterized by mixed pictures with varying proportions of respective

pathologies. Accordingly, a pathophysiological approach indicates that dementing illnesses can be regarded as a continuum with AD and VD representing two more or less abstract poles rather than distinct entities (Heininger, in preparation). A more radical concept even assumes that cerebral capillary perfusion deficits may trigger the pathophysiological AD cascade (Richardson, 1997; de la Torre, 1999).

The cerebrovascular pathology of AD

Processes related to cellular metabolic stress play a predominant role in the pathophysiology of AD. As already pointed out, the brain as the metabolically most active organ is vitally dependent on a steady supply of oxygen and oxidizable substrates. It can be expected that any shortage of this supply, related or unrelated to the AD-specific processes, would aggravate the disease-related metabolic stress and may accelerate the progression of the disease.

As early as 1938, an AD-related cerebrovascular pathology was described (Scholz, 1938). Other reports followed (reviewed by Kalaria, 1996). However, with the emphasis on the neurobiological processes and the often forced delimitation from VD, scientific interest in the vascular aspect of the disease diminished. Only recently, has this interest been revived (see vol. 826 of the *Annals of the New York Academy of Sciences*, which contains a wealth of further reading).

The cerebrovascular bed already undergoes slight changes during ageing (Kalaria, 1996; Buee *et al.*, 1997; De Jong *et al.*, 1997; Moody *et al.*, 1997). These include a decrease in vascular density, number of branches and length of microvessels, luminal narrowing, pericyte degeneration and thickening of the basement membrane. In AD, an aggravation of these changes is frequently observed with both a further decreased density of capillaries and arteriolar multiplications and with coiled, fragmented, and twisted microvessels (Perlmutter and Chui, 1990; Kalaria, 1996; Buee *et al.*, 1994, 1997; Moody *et al.*, 1997). Moreover, capillary deposits and basement membrane thickening as well as loss of endothelial mitochondria are more pronounced (De Jong *et al.*, 1997; Zarrow *et al.*, 1997). It can be assumed that these changes are associated with profound haemodynamic consequences, affecting laminar flow and passage of nutrients through the capillary wall (reviewed by de la Torre, 1997b).

AD is very frequently associated with cerebral amyloid angiopathy. Vascular amyloid contains

fibrillar A β (Glennner and Wong, 1984). The segments of blood vessels affected by amyloid angiopathy show increased blood–brain barrier permeability, which appears to be due to the disturbed vessel wall structure (Wisniewski *et al.*, 1997). Evidence suggests that A β causes the cerebral amyloid angiopathy and the degeneration of the cerebral microvasculature (Kalaria, 1997). Vascular smooth muscle cells may be the source of A β and amyloid fibrils (Frackowiak *et al.*, 1995; Wisniewski *et al.*, 1995) and may facilitate the accumulation of A β and the assembly of amyloid fibrils (Van Nostrand *et al.*, 1998).

Soluble A β is vasoactive, induces vasoconstriction *in vivo* and *in vitro* mediated by endothelin, enhances vasoconstriction induced by phenylephrine or endothelin and is toxic to endothelial cells by mechanisms involving Ca²⁺ influx and free radicals (Thomas *et al.*, 1996; Crawford *et al.*, 1998a; Paris *et al.*, 1998a). A β may also mediate an auto-amplified inflammatory cascade by upregulating cytokines, expression of adhesion molecules and activators of cellular immune reaction (CD40) in vascular cells (Suo *et al.*, 1998). These properties of A β are already evident in the pM range and require a random coil or in part β -sheet structure (Crawford *et al.*, 1998b). ApoE4 more than apoE3 may enhance the vasoactivity of A β and thus could contribute to the vascular component of AD as well (Paris *et al.*, 1998b).

Cerebrovascular diseases

Various cardiovascular and cerebrovascular diseases appear to be associated with AD. The pathophysiologic common denominators seem to be both a decreased cerebral perfusion leading to a hypometabolic state (de la Torre, 1997a), lesions reducing the reserve capacity of the brain and, as in head trauma, persistent pathophysiologic processes following the acute event (see above).

Acute and chronic cerebrovascular processes may predispose to the dementias and pave the way to AD (Pasquier and Leys, 1997). Multiple cerebral infarcts are frequently present in AD brains (Nagy *et al.*, 1997; Snowdon *et al.*, 1997; Heyman *et al.*, 1998), often without a clinical history of stroke (Heyman *et al.*, 1998). Frequently, stroke patients have reduced cognitive abilities (Tatemichi *et al.*, 1996a; Petrovitch *et al.*, 1998; Zhu *et al.*, 1998a), a faster cognitive decline (Zhu *et al.*, 1998b) and are more prone to develop dementia and also AD (Tatemichi *et al.*, 1994b; Brayne *et al.*, 1998; Pohjas-

vaara *et al.*, 1998; Zhu *et al.*, 1998a) with adverse impact for prognosis (Tatemichi *et al.*, 1994c; Desmond *et al.*, 1998). Subcortical cerebral infarction elicits global and regional cerebral glucose hypometabolism, which correlates with cognitive capacities (Kwan *et al.*, 1999). Older age at stroke onset, fewer years of education and concomitant hypoxic-ischemic disorders (e.g. seizures, cardiac arrhythmias, pneumonia) are significant covariates (Tatemichi *et al.*, 1994b; Moroney *et al.*, 1996; Pohjasvaara *et al.*, 1998). Transient ischemic attacks are also a risk factor for accelerating cerebral atrophy, cortico-subcortical perfusion decline and incident dementia (Akiyama *et al.*, 1997; Brayne *et al.*, 1998). In large survey studies, vascular factors were important risk factors for AD (Brayne *et al.*, 1997; Hofman *et al.*, 1997) and a cumulative effect of atherosclerosis, white matter lesions (WML) and apoE4 was seen (Hofman *et al.*, 1997; Skoog *et al.*, 1998a). In other retrospective analyses, cardiovascular and cerebrovascular risk factors were common among AD victims (Tiberghien *et al.*, 1993; Tariska *et al.*, 1997). Certain stroke features, e.g. dysphasia (Pohjasvaara *et al.*, 1998), and particularly lacunar infarcts localized in the basal ganglia, thalamus or deep white matter, predispose to dementia, necessitating fewer neuropathologic AD lesions for manifestation of the disease (Tatemichi *et al.*, 1993; Snowdon *et al.*, 1997). Accordingly, AD patients with cerebral infarcts or lacunar lesions display a greater overall severity of dementia (Nagy *et al.*, 1997; Snowdon *et al.*, 1997; Heyman *et al.*, 1998).

A marker for atherosclerotic disease, homocysteine (Frishman *et al.*, 1998), was found elevated among AD patients (Clarke *et al.*, 1998; Lehmann *et al.*, 1999), which further confirms the pathophysiological role of atherosclerosis in AD (Miller, 1999).

During normal ageing, cerebral atrophy and WML increase, paralleled by a decline of cerebral perfusion, particularly after age 60 (Claus *et al.*, 1996, 1998; Akiyama *et al.*, 1997; Meyer *et al.*, 1997). WML found in brain imaging studies, or at autopsy, are associated with cognitive impairments and predispose to cognitive deterioration (Pantoni and Garcia, 1997; Meyer *et al.*, 1997). WML indicate and are caused by cerebral hypoperfusion (reviewed by Pantoni and Garcia, 1997) and correlate with vascular risk factors (Amar *et al.*, 1995) and a history of stroke (Breteler *et al.*, 1994b). Although the tissue may attempt to compensate the reduced blood flow by an increased oxygen extrac-

tion (Yamaji *et al.*, 1997; Tohgi *et al.*, 1998), regions of WML denote areas of decreased levels of energy-rich phosphates (Sappey-Marinié *et al.*, 1992). WML are a frequent finding in AD — in neuropathological series up to 60 per cent of patients were affected — and are associated with a more rapid clinical progression (Brun and Englund, 1986; Wallin *et al.*, 1989a; Diaz *et al.*, 1991). Of note, WML is almost completely absent in early-onset AD, indicating the differential importance of vascular factors in early- versus late-onset AD (Wallin *et al.*, 1989a). These differences are also reflected by the pattern of membrane phospholipid changes in early- and late-onset AD (Svennerholm and Gottfrides, 1994). The pathophysiologic importance for AD of a reduced cerebrovascular perfusion was highlighted by the transient clinical improvement of a patient after receiving an omental transposition which improved cerebral blood flow (Goldsmith, 1997).

In animal models of chronic cerebral hypoperfusion induced by bilateral occlusion of common carotid arteries, certain features of WML and AD can be mimicked. Cognitive performance is reduced and sensitivity of cognitive performance to muscarinic blockade is increased (de la Torre *et al.*, 1997; Farkas *et al.*, 1999). Importantly, myelin damage appears to precede the axonal injury (Kurumatani *et al.*, 1998). After chronic cerebrovascular insufficiency in adult and aged rats energy stores are depleted, ATP turnover is increased and APP is upregulated (Plaschke *et al.*, 1997) paralleled by a decline of regional cytochrome oxidase activity that leads to neuronal apoptosis and memory impairment (Pappas *et al.*, 1996; Bennett *et al.*, 1998; de la Torre, 1998). Moreover, microvascular abnormalities reminiscent of AD-related changes occur (Farkas *et al.*, 1999). It is stressed that the pathophysiological events discussed above with regard to TBI-related ischemia also apply for cerebrovascular ischemic events, thus outlining the processes leading from acute ischemic exposure to delayed and persistent neuronal degeneration. Particularly, the hippocampus is vulnerable to these persistent degenerative changes (Hsu *et al.*, 1994).

Cardiovascular disease

Cardiovascular disease (CVD) is associated with AD, leading to a six-fold increased incidence of AD type pathology (Sparks *et al.*, 1990; Stewart, 1998). A history of myocardial infarction (MI) increases

the risk of probable AD five-fold in older women (Aronson *et al.*, 1990), while a history of heart attack is a risk factor for incident dementia (Brayne *et al.*, 1998). Importantly, the CVD-associated risk of cognitive decline is increased by apoE4 (Haan *et al.*, 1999). CVD is related to poorer cognitive performance and cognitive decline (Breteler *et al.*, 1994a; Haan *et al.*, 1999). Patients with CVD exhibit accelerated brain ageing with a pattern of hippocampal and cortical intraneuronal A β immunoreactivity strikingly similar to AD and DS (Sparks, 1996a), and increased microglial activation (Streit and Sparks, 1997), in severe cases pronounced senile plaque formation and less prevalent NFT densities (Sparks *et al.*, 1995; Soneira and Scott, 1996). MI and hypertension are significantly and independently associated with WML (Breteler *et al.*, 1994a). Atrial fibrillation is associated with cognitive impairment (Kilander *et al.*, 1999), dementia (De Pedis *et al.*, 1987) and with AD with cerebrovascular disease (Ott *et al.*, 1997). Two separate animal models of CVD show the same pattern of deficits, the severity corresponding to the decreased cardiac output (Sparks, 1996b).

Hypotension and hypertension

Both hypertension and hypotension have been related to the development of dementia including AD (reviewed by Skoog, 1997; Viitanen and Guo, 1997).

Orthostatic hypotension or low blood pressure is a common finding in organic dementia and AD (Guo *et al.*, 1996; Passant *et al.*, 1997; Pohjasvaara *et al.*, 1998; Skoog *et al.*, 1998b) which, although causing decreased regional blood flow, may not be clinically symptomatic (Passant *et al.*, 1996). Repetitive hypotensive episodes may lead to decreased perfusion pressure of the long penetrating arteries of the deep white matter, induce WML and clinically manifest as cognitive impairment (Raiha *et al.*, 1993; Dettmers *et al.*, 1997). In line with these findings, low blood pressure was associated with a reduced white matter blood flow in AD patients (Siennicki-Lantz *et al.*, 1998). Low blood pressure was associated with decreased cognitive performance 9 years later (Glynn *et al.*, 1999). In another longitudinal study, a reduction of systolic blood pressure correlated with cognitive decline (Zhu *et al.*, 1998b). In a large cohort of 85-year-olds a low diastolic and systolic blood pressure correlated with frontal and parietal cortical atrophy. Blood pressure decreased further in the

demented and correlated with dementia severity, suggesting that low blood pressure in dementia is mainly a secondary phenomenon (Skoog *et al.*, 1998b).

Midlife hypertension was found associated with both AD (Kokmen *et al.*, 1991; Kuusisto *et al.*, 1997; White *et al.*, 1998) and AD with white matter disease (Wallin *et al.*, 1989a). Due to a reduced haemodynamic reserve (Fujii *et al.*, 1990), hypertension may lead to dementia as a result of ischaemic cerebrovascular events (see above), being the most important risk factor for stroke (Strandgaard and Paulson, 1994). Independent of stroke, in prospective studies of elderly nondemented persons, hypertension was associated with excess cognitive decline (Launer *et al.*, 1995; Carmelli *et al.*, 1998; Glynn *et al.*, 1999; Haan *et al.*, 1999; Kilander *et al.*, 1999) and accelerated cortical atrophy and cortical perfusion decline (Akiyama *et al.*, 1997; Strassburger *et al.*, 1997). An animal model of hypertension demonstrated the association of cognitive deficits with degeneration of nicotinic transmission, a marker of ageing and AD (Gattu *et al.*, 1997). In longitudinal studies, systolic and diastolic blood pressure were higher in those individuals who developed dementia and AD later (Skoog *et al.*, 1996; Guo *et al.*, 1997). Notably, the manifestation of dementia appeared to be associated with a decrease in blood pressure (Skoog *et al.*, 1996) which continued to decline with increasing dementia severity (Hogan *et al.*, 1997; Skoog *et al.*, 1998b). This may be a potential source of conflicting data with regard to a blood pressure–cognition relationship (see Viitanen and Guo, 1997). Likewise, cross-sectional and retrospective studies in the elderly indicate that hypertension is associated with cognitive impairment, cognitive decline and cerebral WML (Wilkie and Eisdorfer, 1971; Elias *et al.*, 1993; Breteler *et al.*, 1994b; Strassburger *et al.*, 1997; Carmelli *et al.*, 1998; Kilander *et al.*, 1999), the latter increasing with duration of hypertension (de Leeuw *et al.*, 1998). The diastolic blood pressure appeared to be predictive of cognitive impairment on follow-up (Cacciato *et al.*, 1997). Pathophysiologically, hypertension leads to both a decreased regional glucose utilization, CBF, cerebral oxygen supply and cerebral oxygen consumption in humans and laboratory animals (Wei *et al.*, 1992; Nobili *et al.*, 1993; Fujishima *et al.*, 1995; Salerno *et al.*, 1995). Again, apoE genotype may modulate the hypertension-related risk of AD, isoform-specifically (E4 > E3, but not E2) promoting vasoconstriction (Paris *et al.*, 1998b). In

comparison with CVD patients, hypertension accentuates the occurrence of NFT indicating the metabolic stress of neurons (Sparks *et al.*, 1995). Hypertensive rats exhibit a decreased level of polyunsaturated fatty acids in synaptosomal membranes as evidence of a higher level of oxidative stress in these animals compared to normotensive controls (Wei *et al.*, 1987, see below).

Therapeutic control of blood pressure may prevent the cognitive impairment, halt the progression of WML (Fukuda and Kitani, 1995; Cacciato *et al.*, 1997), may halt or even reverse the degenerative changes of cerebral microvasculature (Harper, 1987), and reduce the incidence and progression of AD (Guo *et al.*, 1999). A recent double-blind controlled drug trial investigated the long-term treatment of hypertension with a calcium antagonist (Staessen *et al.*, 1997). After a mean follow-up of 2 years, antihypertensive therapy diminished the incidence of AD by 50 per cent (Forette *et al.*, 1998) confirming the pathophysiological role of hypertension in the manifestation of AD and its therapeutic amenability.

Finally, the blood oxygen transportation capacity is an important variable, which together with the perfusion rate determines the total amount of oxygen delivered to the brain. A decrease of this capacity by anaemia also is associated with an increased risk for dementia (Beard *et al.*, 1997).

Thyroid disease

Heyman *et al.* (1984) were the first to suggest thyroid disease and hypothyroidism as risk factors for AD in a case-control study. This could not be confirmed by others (Amaducci *et al.*, 1986). In the EURODEM meta-analysis of 11 case-control studies, the risk ratio for hypothyroidism was marginally increased (Breteler *et al.*, 1991). Furthermore, an elevated TSH, indicative of a hypothyroid state, was associated with an increased odds ratio for dementia in a community-based study (Ganguli *et al.*, 1996). Patients with sporadic AD present higher titers for autoantibodies indicating autoimmune thyroid disease (Genovesi *et al.*, 1996). Familial AD kindreds display a significant co-segregation between the presence of thyroid autoantibodies and the development of AD (Ewins *et al.*, 1991). Similarly, in DS patients, a pattern of abnormal thyroid function is common, often associated with autoimmune thyroiditis (Murdoch *et al.*, 1977) and more pronounced in patients with AD manifestations (Percy *et al.*, 1990). Cognitive

dysfunction in patients with hypothyroidism is common, particularly in older individuals (Whybrow *et al.*, 1969; Jain, 1972; Osterweil *et al.*, 1992) and may not be reversible upon therapy (Clarfield, 1988).

Hypothyroidism impairs mitochondrial respiration (Popovici *et al.*, 1980; Dembri *et al.*, 1983), reduces the activity of enzymes of the TCA cycle and ATP content (Glushakova *et al.*, 1976), decreases the rate of glycolysis (Dimitriadis *et al.*, 1989), renders mitochondrial function more vulnerable to Ca^{2+} overload (Thomas *et al.*, 1987) and reduces the fluidity particularly of mitochondrial membranes (Tacconi *et al.*, 1991). Neurobiologically, hypothyroidism causes impairment of signal transduction processes, lysosomal dysfunction, dysregulation of neurotransmitter and energy metabolism (Iriuchijima *et al.*, 1991; Sinha *et al.*, 1994), reduces slow axonal transport (Stein *et al.*, 1991) and causes brain region-specific biochemical dysfunction (Ahmed *et al.*, 1993). Thyroid hormones (TH) regulate NGF content and expression of low affinity NGF receptors in adult brain (Calza *et al.*, 1997) and, consequently, neurotrophin receptors were decreased in the hypothyretic rat brain (Alvarez-Dolado *et al.*, 1994). Persistent reduction in choline acetyltransferase activity in the basal forebrain of the rat was detected after thyroid deficiency during early life (Patel *et al.*, 1987). Given the central role of TH in cholesterol metabolism (Ness, 1991), hypothyroidism may also affect AD development by promoting another risk factor, hypercholesterolaemia (see below).

Hyperthyroidism may also lead to impaired brain mitochondrial energy metabolism, uncoupling of oxidative phosphorylation (Popovici *et al.*, 1980), oxidative stress related to the elevated respiratory rate (Satav and Katyare, 1982; Fernandez and Videla, 1993), reduced mitochondrial Ca^{2+} loading capacity, increased mitochondrial Ca^{2+} cycling (Imberti *et al.*, 1994) and finally, to mitochondrial permeability transition (Castilho *et al.*, 1998). Both hypo- and hyperthyroidism induce low density lipoprotein oxidation (Costanini *et al.*, 1998) and may also increase the tissue susceptibility to oxidative challenge, possibly through impairment of the antioxidant capacity (Venditti *et al.*, 1997). These abnormalities of energy metabolism may underly the reported reduction in hippocampal dendritic spine density in hyperthyroid animals (Gould *et al.*, 1991).

Given the profound effects of thyroid dysfunction on brain tropism and metabolism (Hein-

inger, 1999a), the lack of a stronger association between AD and thyroid disease is hard to reconcile with the mounting evidence that a metabolic deficit plays a key role in the pathophysiology of AD. A possible explanation for this discrepancy may come from an inappropriate definition of hypothyroidism in the aged. In the elderly, subclinical hypothyroidism, characterized by normal free T4 levels and elevated TSH levels, is not uncommon (Drinka and Nolten, 1988). These individuals, though not considered as clinically hypothyroid, have an increased risk to become demented (Ganguli *et al.*, 1996) and thus may disguise a stronger thyroid disease/AD relationship. Moreover, the systemic indices give an insufficient picture of the tissue TH state, particularly in the brain. For instance, in the aged even minimal elevations in serum TSH levels are associated with cardiac dysfunctions (Cooper *et al.*, 1984; Forfar *et al.*, 1985) which can be corrected after normalisation of TSH levels (Ridgway *et al.*, 1981; Cooper *et al.*, 1984). High serum cholesterol and an abnormal pattern of lipoproteins may be sensitive indicators of the tissue level hypothyroid state (Kung *et al.*, 1995; Michalopoulou *et al.*, 1998). The pattern of therapeutic response of lipid levels to T4 replacement suggests that in the aged individual the 'set point' of hypothalamic-pituitary-thyroid function may be even in the low normal TSH level range (Franklyn *et al.*, 1993; Michalopoulou *et al.*, 1998). Thus, since the hypothalamic-pituitary leg of the axis is hypo-responsive (Stahelin *et al.*, 1982; Cizza *et al.*, 1992) already a normal and the more an elevated TSH level may indicate an increased TRH drive and thus hypothyroid CNS state in normal ageing. Finally, as another indicator of suboptimal cerebral TH supply, increased CSF transthyretin levels suggest a compensatory upregulation to counteract the decreased transport of TH to the brain in ageing (Mooradian, 1990).

Depression

The findings from individual case-control studies (e.g. Kokmen *et al.*, 1991) were confirmed by the EURODEM Group meta-analysis suggesting a history of late-onset depression as risk factor, increasing the risk for AD independently of family history (Jorm *et al.*, 1991; Van Duijn *et al.*, 1994). A twin study indicated late-life depression as a risk factor for AD as large as two apoE $\epsilon 4$ alleles (Steffens *et al.*, 1997). In addition, a population-based, prospective study suggested early-onset depression as

another risk factor for dementia (Palsson *et al.*, 1999). A retrospective follow-up study over 11 years identified depressive symptoms in a very high proportion of patients as initial manifestations (Evenhuis, 1997).

A variety of neurobiological, endocrinological and immunological events related to the manifestation of major depression (MD) may predispose the CNS for AD. Mild to moderate depression may result in decline of specific cognitive abilities (Boone *et al.*, 1994; Bassuk *et al.*, 1998). This effect appears to be modulated by education, higher education being a protective factor (Palsson *et al.*, 1999). MD is associated with ventricular dilation (Jacoby *et al.*, 1983; Shima *et al.*, 1984; Kellner *et al.*, 1986; Schlegel *et al.*, 1989) which correlates with cognitive impairment and depressive symptomatology (Kellner *et al.*, 1986; Schlegel *et al.*, 1989). Moreover, correlating with the duration and age of onset of MD, the hippocampus is atrophic (Axelson *et al.*, 1993; Sheline *et al.*, 1996). Patients with late-onset MD show a significantly lower whole brain volume, lower tissue density, higher CSF volume and higher ventricle–brain ratio, suggesting a higher degree of central atrophy than in normal aged controls (Jacoby *et al.*, 1983; Shima *et al.*, 1984; Pantel *et al.*, 1997) and also in comparison to aged patients with early-onset MD (Dahabra *et al.*, 1998). Notably, both late-onset minor and major depression were associated with prefrontal atrophy which correlated with illness severity (Kumar *et al.*, 1998). Other imaging studies detected reduced fronto–temporo–parietal perfusion and increased abnormalities of deep white matter in late onset MD (Lesser *et al.*, 1994; Awata *et al.*, 1998; Ebmeier *et al.*, 1998; Greenwald *et al.*, 1998). These WML were associated with cognition deficits and worse antidepressant response (Hickie *et al.*, 1995; Leuchter *et al.*, 1997; Simpson *et al.*, 1997; Awata *et al.*, 1998). Conversely, the CBF abnormalities were found reversible after successful treatment (Bench *et al.*, 1995; Bonne and Krausz, 1997). Finally, brain functional imaging techniques demonstrated a fronto–temporo–parietal glucose hypometabolism in depressive states (Kumar *et al.*, 1993; Biver *et al.*, 1994; Mayberg, 1994).

Depression is associated with a variety of neuroendocrinological disturbances (reviewed by Nemeroff and Krishnan, 1991; Holsboer, 1995; Plotsky *et al.*, 1995). The HPA axis is dysregulated with elevated plasma cortisol levels which normalize after remission (Steiger and Holsboer, 1997). The dexamethasone suppression test (DST) indi-

cates an impaired HPA axis feedback. Of note, ventricular enlargement and hippocampal atrophy correlated with plasma cortisol, but not impaired DST (Kellner *et al.*, 1983; Schlegel *et al.*, 1989; Axelson *et al.*, 1993), while in elderly depressives the latter correlated with the cognitive impairment (Siegel *et al.*, 1989). Likewise, the hypothalamic–pituitary–thyroid axis is hypofunctional (reviewed by Prange *et al.*, 1987; Holsboer, 1995). The TSH response to TRH is often blunted, the nocturnal TSH rise absent, transthyretin is reduced in CSF (Hatterer *et al.*, 1993; Gorman *et al.*, 1997) and euthyroid sick syndrome may be present. Importantly, the peripheral TSH levels are inversely correlated to the global and regional CBF and glucose metabolism (Marangell *et al.*, 1997). Other hormonal abnormalities are present which are equally reminiscent of AD-related changes (Heininger, 1999b): (1) nocturnal melatonin levels are reduced in patients with MD and related disorders (Claustral *et al.*, 1984; Brown *et al.*, 1987; Kennedy *et al.*, 1989); (2) seven studies documented decreased CSF somatostatin levels (reviewed by Rubinow *et al.*, 1992); (3) insulin resistance is a routine finding (Winokur *et al.*, 1988).

The incidence and severity of the MD-related HPA-axis dysregulation increases with age (Asnis *et al.*, 1981; Nelson *et al.*, 1984). Moreover, the ability for compensatory changes decreases. Thus, in comparison to normal controls, depressed children and adolescents have increased nocturnal melatonin levels (Shafii *et al.*, 1996), while in adult and aged depressed these levels are decreased putatively due to CRF-mediated inhibition of melatonin release (Kellner *et al.*, 1997). The pattern of endocrinological alterations which has been suggested to be causally related to the MD-related cognitive disturbances (Reus, 1984; Rubinow *et al.*, 1984) indicates that the neurons of elderly depressed patients are under metabolic stress. Indeed, in patients with affective disorders, blood cells show a compromise of calcium homeostasis and signalling (and, as a corollary, of energy and antioxidant homeostasis, see Heininger, 1999a), which led to the formulation of the calcium hypothesis of depression (reviewed by Dubovsky, 1994; Heininger *et al.*, 1998).

Not surprisingly, these endocrinological abnormalities have profound effects on the immune system of depressed individuals (reviewed by Irwin, 1995). The cellular immune responsiveness is blunted (Darko *et al.*, 1988). On the other hand, the innate immune system is activated, including an acute phase response with increased plasma levels of

complement components, α -1-antichymotrypsin, α -2-macroglobulin (Song *et al.*, 1994a), IL-1 and macrophage activation (Maes *et al.*, 1993; McAdams and Leonard, 1993).

Finally, the pathophysiological and putative aetiological relationships between stress (see below) and MD are manifold (reviewed by Akil and Morano, 1995; Post *et al.*, 1995) and may represent a common detrimental pathway into AD manifestation.

PSYCHOSOCIAL AND LIFESTYLE RISK FACTORS

Psychosocial stress

Stressful life events may be another risk factor for AD (Henderson *et al.*, 1992; Shen, 1992; Bratsun, 1998; Zie *et al.*, 1998). Early clinical observations already indicated the relevance of psychological and social adjustment deficiencies (Wang, 1977). Indirect evidence for the pathophysiological role of lifelong stress exposures may be suggested by the premorbid behaviour of social withdrawal. AD patients reportedly exhibit an increased incidence of personality disorders and premorbid personality traits such as psychosocial inactivity, social introversion, pessimism, submissive behaviour and lack of active coping behaviour (Kokmen *et al.*, 1991; Kondo *et al.*, 1994; Bauer *et al.*, 1995; Motomura *et al.*, 1996; Malinchoc *et al.*, 1997). The intriguing finding of an association of AD with marital status, single individuals having an excess risk (Bickel and Cooper, 1994; Helmer *et al.*, 1999), may have a similar basis due to the premorbid personality and behaviours of singles.

AD patients exhibit also biological variables indicating a role of stress exposure and responsivity in the pathophysiology of AD (see Heininger, 1999b). Corticotropin-releasing factor (CRF) and arginine vasopressin neurons in the paraventricular nucleus of the hypothalamus are involved in the regulation of stress responses. These neurons are activated in ageing and AD (Lucassen *et al.*, 1993, 1994; Raadsheer *et al.*, 1995) and in both chronic stress (Makino *et al.*, 1995; Nakase *et al.*, 1998; Scott and Dinan, 1998) and depression (Raadsheer *et al.*, 1995; Scott and Dinan, 1998), suggesting a continuum of pathophysiological processes (Heinrichs, 1999).

Contemporary stress research emphasizes the importance of the individual appraisal of the

stressor. The degree to which the individual can cope with or defend against the stressor determines the individual stress hormone profile and development of stress pathologies (Virgin and Sapolsky, 1997; Bookwala and Schulz, 1998). This variability of coping responses to given stressors, however, makes detection of associations of psychosocial stress exposures with disease risks a cumbersome undertaking. The individual stress vulnerability is modulated very early in life as result of a gene-environment interaction (Bouchard, 1994; Plomin *et al.*, 1994; Heim *et al.*, 1997). In experimental animals, prenatal and postnatal stress increase HPA-axis responsivity, prolong stress-induced corticosterone secretion in later life (Maccari *et al.*, 1995) and impair cognitive performance in vulnerable animals (Lyons *et al.*, 1997; Oitzl *et al.*, 1997b). On the other hand, postnatal maternal care and neonatal handling reduce HPA reactivity, improve cognitive performance and protect the hippocampus from age-related dysfunction and neuronal loss (Meaney *et al.*, 1988; Mohammed *et al.*, 1993; Sapolsky 1993; Liu *et al.*, 1997).

A variety of conditions associated with elevated GC levels such as chronic stress, depression (see above) and Cushing's syndrome have detrimental sequelae for human brain function and structure (Sapolsky, 1996; Keenan and Kuhn, 1999). Exposure to physiologic stress level GC induces impaired memory performance in healthy human adults (Newcomer *et al.*, 1994; Wolkowitz, 1994). In normal aged, GC levels correlate negatively with intellectual performance (Lupien *et al.*, 1994; Seeman *et al.*, 1995, 1997; Kelly *et al.*, 1996) and hippocampal volume (Lupien *et al.*, 1998). Longitudinal and cross-sectional studies indicate a memory-deteriorating effect of chronic GC in humans, elderly individuals being particularly susceptible (Keenan *et al.*, 1996). War veterans with post-traumatic stress disorder or political prisoners who have been tortured suffer from memory deficits (Sutker *et al.*, 1991; Bremner *et al.*, 1993; Basoglu *et al.*, 1994). Cushing's syndrome is associated with memory impairment, hippocampal atrophy and decreased brain glucose utilization (Starkman *et al.*, 1992; Mauri *et al.*, 1993; Brunetti *et al.*, 1988). Importantly, the pattern of cognitive impairment suggests premature cognitive ageing (Forget *et al.*, 1996), increases with age and tends to improve after surgical treatment (Mauri *et al.*, 1993). Chronic life stress renders more vulnerable to acute stressful events resulting in an exaggerated sympathetic, neuroendocrine and immune responsivity (Pike *et al.*,

1997). Monkeys in their natural habitat which experience chronic subordination stress and social isolation exhibit hypercortisolism (Sapolsky 1995; Sapolsky *et al.*, 1997). A history of low rank pronounced an ageing-related social withdrawal (Veenema *et al.*, 1997), a behaviour which has been reported to be associated with AD in humans (see above).

In adult life, exposure to acute and chronic social and psychological stressors worsens cognitive performance in laboratory animals (McEwen and Sapolsky, 1995; Blanchard *et al.*, 1995), increases GC levels and impairs hippocampal function and dendritic morphology (Uno *et al.*, 1989; McEwen *et al.*, 1992; McEwen and Magarinos, 1997). Electrophysiologically, chronic stress or GC accelerate the development of a pattern of ageing-like changes (Landfield *et al.*, 1978; Kerr *et al.*, 1989; Talmi *et al.*, 1993). The stress or ageing-related changes can be prevented by inhibition of GC synthesis and chronic GC receptor blockade (Bodnoff *et al.*, 1995; Magarinos and McEwen, 1995; Talmi *et al.*, 1996) and mimicked by long-term exposure to GC (Sapolsky *et al.*, 1985; Bodnoff *et al.*, 1995; Endo *et al.*, 1996). The intensity of behavioural and neuroendocrine responses to stressful stimuli determines the rate of ageing and life-span of inbred rodent strains (Gilad and Gilad, 1995). GC, stress and ageing set in motion a vicious cycle leading to a downregulation of hippocampal GC receptors which results in the loss of hippocampal feedback inhibition of HPA-axis activity, increased and/or prolonged GC levels, and hippocampal metabolic endangerment (Sapolsky *et al.*, 1984; Zoli *et al.*, 1991; Sapolsky, 1993; Bennett *et al.*, 1996). Mechanistically, GC-elicited glutamate excitotoxicity may be causally involved. Modulatory actions include enhancement of glutamate release and reduction of glutamate reuptake (Armanini *et al.*, 1990; Gilad *et al.*, 1990; Moghaddam *et al.*, 1994; Stein-Behrens *et al.*, 1994; Magarinos and McEwen, 1995). Serotonergic mechanisms may equally play a role (Watanabe *et al.*, 1992; Luine *et al.*, 1993). Importantly, the recovery of GC levels from stress is impaired (Sapolsky *et al.*, 1983) and the morphological and electrophysiological effects of stress and GC appear to be more pronounced in aged animals (Kerr *et al.*, 1989; Bodnoff *et al.*, 1995).

There are multiple, reciprocal relationships between the cholinergic system and the HPA axis. Hippocampal injection of a muscarinic antagonist enhances the HPA axis responsiveness to stress while depletion of hypothalamic ACh resulted in an

impaired adaptation to chronic intermittent stress (Ramade and Bayle, 1989; Bhatnagar *et al.*, 1997). Conversely, acute stress activates the cholinergic system (Gilad, 1987; Kaufer *et al.*, 1998a). Intermediate-term stress elicits mixed responses characterized by decreased choline uptake but an upregulation of muscarinic binding sites (Finkelstein *et al.*, 1985; Gonzalez and Pazos, 1992). Chronic GC leads to the degeneration of cholinergic neurons in the medial septal area (Tizabi *et al.*, 1989), which may underly the chronic stress-induced enhanced sensitivity to muscarinic antagonists (Kaufer *et al.*, 1998b). An increased stress responsivity is associated with a premature degeneration of the cholinergic septohippocampal pathway and shorter life span (Gilad *et al.*, 1987). Furthermore, chronic GC administration decreases nicotine sensitivity and brain nicotinic receptor binding in mice, the hippocampal, hypothalamic and frontal cortical regions being particularly sensitive (Pauly *et al.*, 1990; Pauly and Collins, 1993). GC also render cholinergic neurons more susceptible to other neurotoxic agents (Hortnagl *et al.*, 1993). The glutamatergic system, known to be activated by GC, may participate in the mediation of the degenerative effects (Michel and Agid, 1995). The neurobiological effects are paralleled by behavioural changes. Ten days' stress induced cholinergic hypersensitivity and resistance to scopolamine-induced amnesia, while 30 days' stress resulted in cholinergic hyposensitivity and learning deficits (Zerbib and Laborit, 1990).

Stress also antagonizes the neurotrophin system. Immobilization and cold stress unbalanced the expression of neurotrophins and their receptors in the rat brain (Foreman *et al.*, 1993; Ueyama *et al.*, 1997). While NGF increased in the cortex and hippocampus, the low-affinity receptor density decreased in the basal forebrain and hippocampus (Foreman *et al.*, 1993; Aloe *et al.*, 1994). The equally disruptive effects of physiological stress level GC on neurotrophin levels and signal transduction has been discussed earlier (Heininger, 1999a).

Stress may also interact with hormonal activities of other endocrinological axes. Lower postmenopausal oestrogen levels are associated with stress variables as are oestrogen levels during the menstrual cycle and chronic stress may even lead to infertility in women and impotence in men (Selye, 1976; Ballinger, 1990). In young animals the stress-related neurobiological changes could be aggravated by castration and prevented by testosterone

(Mizoguchi *et al.*, 1992; Levy *et al.*, 1994). Moreover, oestrogen treatment reversed the ageing-related loss of HPA axis feedback inhibition (Ferrini *et al.*, 1999) corroborating the importance of protective gonadal hormones (Goodman *et al.*, 1996; Heininger, 1999a). Furthermore, chronic stress may decrease the activity of the hypothalamic–pituitary–thyroid axis, a feature which may be attenuated in ageing (Bauer *et al.*, 1994; Cizza *et al.*, 1995), possibly due to the restricted functional capacity of the axis (Cizza *et al.*, 1992). Insulin-like growth factor 1 (IGF-1) is suppressed in socially subordinate male baboons (Sapolsky and Spencer, 1997) and the GC-mediated suppression of astroglial IGF-1 expression may play a role in the age-related decline of axonal sprouting (Ye *et al.*, 1997; Woods *et al.*, 1998). Finally, neuropeptide Y mRNA has been found suppressed following acute stress (Thorsell *et al.*, 1998). As an implication of these hormonal alterations psychosocial stressors may increase the vulnerability of cellular antioxidant systems to pathological conditions (Tolakis and Godin, 1995). Chronic stress may be directly involved in AD-specific processes in that GC and stress impair the Ca^{2+} –energy–redox triangle (Heininger, 1999a) and enhance $\text{A}\beta$ production (Liu J. *et al.*, 1996, 1998).

Stressful events have profound effects on immune parameters (Apanius, 1998; Elenkov *et al.*, 1999), depending on the time course of exposures and responses. Chronic stressors decrease lymphocytes and their proliferative response, natural killer cells, monocytes and their phagocytosis (Song *et al.*, 1994b; Kanno *et al.*, 1997) and induce an acute phase-like pattern of cytokine elevations, including IL-1, IL-6 and TNF α (Zhou *et al.*, 1993; Chancellor-Freeland *et al.*, 1995; Connor and Leonard, 1998), cytokines which stimulate the HPA axis (Sweep *et al.*, 1992; Zhou *et al.*, 1993; Raber *et al.*, 1997). Again, the stress-related effects are more pronounced and prolonged in aged rodents (Odio *et al.*, 1987; Lorens *et al.*, 1990; Kanno *et al.*, 1997).

Chronic stress may also affect the vascular component of AD pathophysiology. Acute psychological stress elevates persistently total and lipoprotein-associated cholesterol levels (Servatius *et al.*, 1993; Muldoon *et al.*, 1995) and psychosocial stress factors were associated with an atherogenic serum lipid profile (Vitaliano *et al.*, 1995). Thus, together with an atherogenic lipid profile, an increased stress response predicted a higher progression of cardiovascular atherosclerosis (Barnett *et al.*, 1997). It is speculated that epidemiological

studies may underestimate these relationships, since subjects with these risk factors are also at risk to contract other life-threatening diseases such as cancer (Baltrusch *et al.*, 1988) or arteriosclerosis (Ely, 1995) which may prevent them from reaching the age to manifest AD.

Lack of education and of life-long cognitive activity

Epidemiology suggests that low education is a risk factor for accelerated memory decline and dementia (Evans *et al.*, 1993; Kondo *et al.*, 1994; Stern *et al.*, 1994; Ott *et al.*, 1995; Brayne *et al.*, 1997; Zhu *et al.*, 1998b; Lyketsos *et al.*, 1999). A diagnostic bias, however, related to the sensitivity of the psychometric instruments and the uniformity of threshold values for low and high educated has to be taken into account (Fratiglioni *et al.*, 1998; Geerlings *et al.*, 1999). A low occupational challenge as further risk factor for AD highlights the equal importance of life-long mental activity as a protective factor (Fratiglioni *et al.*, 1993; Stern *et al.*, 1994; Bonaiuto *et al.*, 1995; Jorm *et al.*, 1998). Conversely, pre-morbid interests and activities were found reduced in patients with Alzheimer's disease as compared to age- and sex-matched controls (Shen, 1992; Friedland *et al.*, 1997).

According to a 'use it or lose it' concept, a lifetime use of the brain by continuing education and learning appears to build up a brain reserve capacity which protects against the losses of ageing and eventual contraction of AD (Swaab, 1991; Timiras, 1995; Mortimer, 1997) and even may prevent cognitive impairment despite a widespread AD pathology (Katzman *et al.*, 1998; Davis *et al.*, 1999). Hence in AD patients with the same level of cognitive impairment, educated individuals exhibit a reduced cerebral metabolism compared with less educated individuals. On the other hand, comparing patients with the same abnormality of cerebral metabolism, the educated have more preserved intellectual abilities (Alexander *et al.*, 1997a). Even during AD the verbal competence, in contrast to non-verbal capacities, differentiates between patients with low and high education (Filley and Cullum, 1997). An intriguing finding supports the reserve capacity concept: head circumference and direct brain volume measurements by MRI identified a small brain volume as a risk factor for AD (Mori *et al.*, 1997; Schofield *et al.*, 1997b). Education, on the other hand, increases brain size (Coffey *et al.*, 1999). An interaction between low education and low socioeconomic

rank may confound the reported association of education and AD (Evans *et al.*, 1997; Mortimer *et al.*, 1998, see above). Since poorer education in general leads to lower socioeconomic status, social subordination stress may be a cofactor strengthening the association of low education with cognitive ageing and, finally, AD (Mortimer *et al.*, 1998). Conversely, individuals at risk for AD are protected independently by higher education and socioeconomic status/lower subordination stress against manifesting the disease (Mortimer *et al.*, 1998). Intriguingly, both neuronal activity and stress exposure/coping ability may affect the same neuroendocrinological substrate. Environmental enrichment in adulthood, like neonatal-handling, resulted in a higher hippocampal GC receptor expression, thus promoting the hippocampal feedback inhibition of HPA-axis activity (Mohammed *et al.*, 1993).

These data are extended by findings that both enriched early experience at weaning, training in adulthood and even in senescence result in changes of cortical thickness, size of synaptic contacts and number of dendritic spines and branching compatible with an enhanced use-induced plasticity (Diamond *et al.*, 1985; Van Gool *et al.*, 1987; Rosenzweig and Bennett, 1996). In rodents, environmental enrichment and neuronal activity upregulate growth factors NGF, BDNF and NT-3 (Lindholm *et al.*, 1994; Lauterborn *et al.*, 1996; Pham *et al.*, 1997). Learning and sensorimotor stimulation also increase somatostatin levels in rat brain (Nilsson *et al.*, 1995). Neurotrophins act preferentially on active neurons which, for their part, upregulate neurotrophin receptor expression (Tongiorgi *et al.*, 1997). Importantly, the joint action of neurotrophins and electrical activity is required to promote dendritic arborization in brain cortex (McAllister *et al.*, 1996). Moreover, the activity-dependent secretion of neurotrophins generates further secretion of neurotrophins, thus establishing a positive feedback mechanism which reinforces and stabilizes synaptic connections (Canossa *et al.*, 1997). The neuronal trophic response to activation is supported by astroglial, highly potent activity-dependent neurotrophic factors (ADNF) (Gozes and Brenneman, 1996; Bassan *et al.*, 1999). Thus, environmental enrichment increases the density of dendritic contacts (Bogdanovic *et al.*, 1998), promotes neuronal survival in senescent animals (Kempermann *et al.*, 1998) and prevents the ageing-related loss of synaptic connections observed in sensorially deprived controls (Saito *et al.*, 1994).

An interesting *in vitro* model shed light on the interrelation of use-dependent neuronal plasticity and Ca^{2+} homeostasis (Nelson *et al.*, 1990). Previous electric stimulation enhanced and strengthened synaptic connectivity between nerve cells and was able to render the neuronal network resistant against the deleterious action of increased calcium levels.

Lack of physical activity

Lack of physical activity has been identified as a risk factor for AD in a prospective study of 7 years' duration (Yoshitake *et al.*, 1995; Fujishima *et al.*, 1998). Other case-control studies, using retrospective questionnaires, indicated a reduced pre-morbid physical activity level in dementia and AD patients (Li *et al.*, 1991; Henderson *et al.*, 1992; Kondo *et al.*, 1994; Friedland *et al.*, 1997). A variety of features of physical activity (discussed in part 5 of this series) links these intriguing epidemiological findings to the pathophysiological processes of AD.

Diet

Dietary cholesterol clearly can be defined as risk factor for AD which is modulated by apoE polymorphism. In a prospective study, a high intake of saturated fat and cholesterol was associated with an increased risk of dementia, while fish consumption, an important source of polyunsaturated fatty acids protected against dementia and AD (Kalmijn *et al.*, 1997). Another study suggested an increased daily intake of kcal as risk factor (Petot *et al.*, 1998). Mean total cholesterol and low-density lipoprotein cholesterol levels are significantly higher in AD patients than in elderly controls (Lehtonen and Luutonen, 1986; Giubilei *et al.*, 1990; Czech *et al.*, 1994; Kuo *et al.*, 1998; Sulkava *et al.*, 1998) which correlates with apoE4 status (Czech *et al.*, 1994; Sulkava *et al.*, 1998). Brain cholesterol was also found elevated in AD frontal cortex and in CVD (Sparks, 1997b). The high incidence of hyperlipaemia was equal in individuals with VD and AD (54 per cent versus 56 per cent) (Deplanque *et al.*, 1998) arguing for shared pathophysiological pathways (Heininger in preparation). Dietary fat not only increases cholesterol and triglyceride levels in the serum, but also in the brain (Oner *et al.*, 1991). Higher intake of saturated and monounsaturated fatty acids and cholesterol is associated with worse cognitive function (Ortega *et al.*, 1997) while a diet low in fatty acids and high in fibre is associated with

better cognitive performance and lower mortality (Huijbregts *et al.*, 1998). Serum cholesterol levels correlate negatively with cognitive performance in elderly (Desmond *et al.*, 1993; Orengo *et al.*, 1996). In aged individuals plasma cholesterol correlates with the presence of white matter lesions (Breteler *et al.*, 1994b) and hyperlipidemia is a risk factor for accelerated cerebral atrophy and cortical perfusion decline (Akiyama *et al.*, 1997).

Dietary fat can alter membrane lipid composition in rat brain and liver, even without directly affecting serum cholesterol levels (Divakaran and Venkataraman, 1997; Kessler *et al.*, 1985; Huertas *et al.*, 1992; Kelly *et al.*, 1995). Ageing, on the other hand, is associated with profound increases of plasmalemmal, mitochondrial and microsomal membrane cholesterol content and of membrane cholesterol/phospholipid mole ratio in a variety of organs and cell types (Grinna, 1977; Rivnay *et al.*, 1979; Nagy *et al.*, 1983; Kessler *et al.*, 1985; Sugawa *et al.*, 1996). Importantly, the asymmetry of cholesterol distribution between exofacial and cytofacial leaflet of synaptic plasma membranes is increasingly lost with ageing (Igbavboa *et al.*, 1996). These changes correspond to the reduced membrane fluidity and Na^+, K^+ -ATPase activity and increased age-dependent susceptibility to lipid peroxidation (Rivnay *et al.*, 1979; Nagy *et al.*, 1983; Kessler *et al.*, 1985; Viani *et al.*, 1991; Mecocci *et al.*, 1997). Evidence suggests that the decrease in membrane fluidity and a concomitant inhibition of $\text{Ca}^{2+} + \text{Mg}^{2+}$ -ATPase activity depend both on cholesterol content and on increased lipid peroxidation products (North and Fleischer, 1983; Viani *et al.*, 1991; Choi and Yu, 1995; Wood *et al.*, 1995).

Changes in plasmalemmal cholesterol content have substantial consequences for cellular Ca^{2+} and energy homeostasis. Enrichment of cholesterol and its oxidized derivatives in membranes greatly enhance basal and stimulated Ca^{2+} influx and decrease $\text{Ca}^{2+} + \text{Mg}^{2+}$ -ATPase activity which jointly result in increased cytosolic Ca^{2+} levels in a variety of cell types (Boissonneault and Heiniger, 1985; Gleason *et al.*, 1991; Kutryk *et al.*, 1991; Wood *et al.*, 1995). Moreover, activities of liver and heart mitochondrial Ca^{2+} transport, cytochrome oxidases, ATPases, electron transport chain, and adenine nucleotide translocase are decreased, leading to reduced oxidative phosphorylation and a reduced pool of exchangeable adenine nucleotides (ATP and ADP) (Divakaran and Venkataraman, 1977; Rogers *et al.*, 1980; Cunningham *et al.*, 1981;

Kopeikina-Tsiboukidou and Deliconstantinos, 1983; Kim *et al.*, 1998; Echegoyen *et al.*, 1993). These changes can also be elicited by diets. A high cholesterol-containing diet decreased mitochondrial cytochrome oxidase activity in the monkey liver (Cunningham *et al.*, 1981) depressed mitochondrial respiration in rat liver (Rogers *et al.*, 1980), lowered coenzyme Q10 and increased hydroperoxides in rabbit hepatocyte mitochondria (Ramirez-Tortosa *et al.*, 1997), and partially uncoupled respiration and decreased Ca^{2+} -stimulated respiration in swine myocardial mitochondria (Morrison *et al.*, 1997). An atherogenic diet leads to a 50 per cent decrease in brain Ca^{2+} ATPase activity (Oner *et al.*, 1991). Oxidative stress may accentuate these changes, indicated by the finding that membrane hydroperoxides correlated inversely with mitochondrial coenzyme Q levels (Ramirez-Tortosa *et al.*, 1997). Finally, neurotransmitter transport and receptor-mediated signal transduction is impaired by increasing synaptic cholesterol content, the cholinergic stimulation being particularly vulnerable (Crews *et al.*, 1983; Kelly *et al.*, 1995; Sugawa *et al.*, 1996; Denisova *et al.*, 1998). Cholesterol and oxysterol can modulate receptor function by two distinct mechanisms, by changes of membrane fluidity and/or specific molecular interactions (Gimpl *et al.*, 1997). Notably, young animals are relatively resistant to such changes (Kelly *et al.*, 1995; Denisova *et al.*, 1998).

Reduction of mitochondrial bioenergetics and aberrations of cholesterol metabolism reinforce each other. Underutilized citrates due to inhibited decarboxylation are degraded to acetyl CoA which are the source for all endogenous cholesterol, thus driving *de novo* steroid synthesis (Tanner, 1995). Autochthon *de novo* synthesis is the overwhelming source of brain cholesterol in a variety of mammals, including man (Spady and Dietschy, 1983; Turley *et al.*, 1996) and is insensitive to feedback inhibition by the endproduct (Zhang *et al.*, 1994). Thus, the increased brain membrane cholesterol may depend in part at least not on dietary cholesterol but on the mitochondrial ageing process itself (Choi and Yu, 1995). Dietary cholesterol, on the other hand, affects brain cholesterol metabolism. Hypercholesterolemia accelerates brain ageing with increased brain cholesterol levels, increased oxidative stress (Sparks, 1997a,b) and microglial activation in rabbits (Streit and Sparks, 1977).

In AD brains membrane defects, characterized by decreased phospholipids and precursors and

increased degradation products have been documented, suggesting an increased phospholipid degradation (Nitsch *et al.*, 1992). Mitochondrial membrane fluidity was reduced, putatively secondary to oxidative stress (Mecocci *et al.*, 1996a). In contrast to ageing, the membranes in affected AD brain regions, but not from regions not affected, show a decreased cholesterol/phospholipid mole ratio, leading to a reduced membrane bilayer width (Wallin *et al.*, 1989b; Mason *et al.*, 1993). Membrane bilayer stability is decreased in AD mid-temporal cortex, but not cerebellum (Ginsberg *et al.*, 1993).

What may be the mechanisms transforming the excess cholesterol content of ageing membranes into the cholesterol deficit in AD membranes? Lipid peroxidation alters the membranes' lipid composition (Viani *et al.*, 1991). Oxidative stress as well as ageing results in a decreased membrane fluidity and increased cholesterol/phospholipid ratio (Ghosh *et al.*, 1993; Urano *et al.*, 1997). The increase in cholesterol may be a cellular defence mechanism to protect the membranes from oxidative damage (Subramanian *et al.*, 1993; Jacobsen-Borin *et al.*, 1994; Joseph *et al.*, 1997). Cholesterol is a weak antioxidant and stabilizer of membrane structure (Gutteridge, 1978; Jacobsson-Borin *et al.*, 1994; Vatassery *et al.*, 1995, 1997; Denisova *et al.*, 1997; Joseph *et al.*, 1997). It is suggested that cholesterol is part of the hierarchical antioxidant system (including melatonin, ascorbate, ubiquinol, vitamin E, thiols like glutathione and polyunsaturated fatty acids) which protect cells from the detrimental actions of oxyradicals (Vatassery *et al.*, 1995; Denisova *et al.*, 1997; Joseph *et al.*, 1997; Urano *et al.*, 1997). Cholesterol is protected by the first line antioxidants (Urano *et al.*, 1997). When this system gets under stress and deficient, cholesterol is oxidized and may get mobilized (Huertas *et al.*, 1992), indicating that membrane cholesterol exchanges with exogenous pools when lipid peroxidation occurs. Thus, when oxidative stress is extensive enough, it finally may result in decreased mitochondrial and microsomal membrane cholesterol content (Huertas *et al.*, 1992) and increased brain synaptic plasma membrane fluidity (van Rensburg *et al.*, 1994; Wood *et al.*, 1995). Quantitatively different degrees of the same pathophysiological process, oxidative stress leading to lipid peroxidation, may therefore induce opposite effects on the target variable, the isoprenoid content of biomembranes. Likewise, mobilization of cholesterol by A β may contribute to the AD-related

increase in membrane fluidity (Wood *et al.*, 1998).

Finally, based on fragmentary evidence, a potential link between APP and cholesterol metabolism and function is outlined. The metabolism of both APP and cholesterol is coupled and influences each other. Brain APP metabolites can be modulated by dietary cholesterol, an effect which needs the presence of apoE (Howland *et al.*, 1998). Cholesterol increases cellular APP levels, decreases metabolism and release of sAPP (Bodovitz and Klein, 1996; Racchi *et al.*, 1997) and enhances amyloidogenic A β production (Mizuno *et al.*, 1998) and amyloid deposition (Sparks, 1997a). A reduced sAPP metabolism is also achieved by lipoproteins (Nadeau *et al.*, 1998). Furthermore, both a disturbed membrane cholesterol and sphingomyelin distribution increase A β production (Urmoneit *et al.*, 1998), while a depletion of cholesterol inhibits A β generation in hippocampal neurons (Simons *et al.*, 1998). On the other hand, A β decreases the synthesis of various lipids, particularly cholesterol and phospholipids (Koudinova *et al.*, 1996; Walters and Austen, 1998). Moreover, A β inhibits cholesterol esterification (Koudinov *et al.*, 1996a; Liu Y *et al.*, 1998), which may be causal to the decreased plasma cholesterol esterification rate in AD and DS (Lacko *et al.*, 1983; Knebl *et al.*, 1994). Serum LDL and total cholesterol levels correlate with brain A β N-42 content in AD patients, again indicating a link between lipid and APP metabolism (Kuo *et al.*, 1998). Thus, cholesterol may induce the generation of its own carrier protein and A β and cholesterol may interact in a feedback-cycle, whereby A β production is upregulated by cholesterol and down-regulates cholesterol synthesis. It is speculated that APP and A β , in conjunction with apolipoproteins, may serve as lipid transport proteins to direct lipids, particularly cholesterol to cholesterol domains at synaptic sites and stabilize these structures. APP is developmentally regulated and correlated with synaptogenesis (Moya *et al.*, 1994; Morimoto *et al.*, 1998) and is localized at synaptic plasma membranes (Shigematsu *et al.*, 1992; Shimokawa *et al.*, 1993). During synaptogenesis cholesterol is enriched in synaptic structures (Surchev *et al.*, 1995; Schroeder *et al.*, 1995), presumably to stabilize the synaptic formation and reduce lateral shifts of structural components. A β is highly lipophilic and as such is secreted, for instance, by hepatoma cells as an apolipoprotein in association with lipoproteins, transthyretin, phospholipids, triglycerides and cholesterol (Koudinov and Koudinova, 1997). In the plasma and CSF, A β is associated with both

the apolipoproteins and lipids of high density lipoproteins (Koudinov *et al.*, 1996b, 1998b; LaDu *et al.*, 1998). $A\beta$ has markedly higher binding affinity for cholesterol than for phosphatidylcholine or fatty acids (Avdulov *et al.*, 1997). This capacity may endow APP as integral constituent of synapses a stabilizing, synaptic domain building property. In fact, $A\beta$ increases the free cholesterol content of membranes (Liu Y. *et al.*, 1998). Putatively due to this interaction, cholesterol protects neurons from the disruption of Ca^{2+} homeostasis and neurotoxicity effected by $A\beta$ *in vitro* (Hartmann *et al.*, 1994; Zhou and Richardson, 1996) and hence chronic implants in young and old rat brain of cholesterol- or lipid-embedded $A\beta$ are not neurotoxic *in vivo* (Clemens and Stephenson, 1992).

Diet may also have effects on activities of hormonal feedback axes. High fat and carbohydrate consumption can elevate basal and stress-induced HPA activity in young and elderly individuals (Tannenbaum *et al.*, 1996, 1997a). In rats, free fatty acids activate the HPA axis as well (Widmaier *et al.*, 1995, Tannenbaum *et al.*, 1997b) and reduce plasma corticosteroid binding globulin (Haourigui *et al.*, 1994), resulting in an overall increase of free GC. Finally, dietary fats and proteins appear to have modulatory effects on the inflammatory acute phase response (reviewed by Hellerstein, 1989) and may thus also affect the immune system component of AD pathophysiology.

Intake of several vitamins have been related to the incidence of cognitive decline and dementia. In a longitudinal and cross-sectional study of 22 years' duration, plasma vitamin A and C levels correlated significantly with various variables of cognitive performance (Perrig *et al.*, 1997). A cross-sectional study suggested a correlation between serum vitamin E level and memory performance (Perkins *et al.*, 1999). A prospective study with a mean 4.3 years' follow-up period indicated a protective effect of high-dose vitamins E and C supplement (Morris *et al.*, 1998). A low vitamin C intake was found associated with poorer cognitive performance (Gale *et al.*, 1996). A cross-sectional study reported reduced plasma levels of vitamins A, C and E in AD patients (Foy *et al.*, 1999). AD patients had lower serum folate and vitamin B₁₂ levels (Clarke *et al.*, 1998). In addition, low folate levels were related to worse cognitive performance, a higher incidence of stroke and dementia (Fioravanti *et al.*, 1997; Ebly *et al.*, 1998; Hassing *et al.*, 1999). Elderlies taking a diet containing more carbohydrate, fibre and vitamins (folate, vitamins C, E,

and β -carotenes) show a better cognitive capacity (Ortega *et al.*, 1997). Dietary intake of antioxidants such as vitamins A, C and E may be protective against loss of cognitive function (Masaki *et al.*, 1994; Jama *et al.*, 1996; Paleologos *et al.*, 1998, but see Mendelsohn *et al.*, 1998) and the development of AD (Petot *et al.*, 1998). *In vitro*, antioxidant vitamins can attenuate $A\beta$ cytotoxicity (Yallampalli *et al.*, 1998). Reduced vitamin B₁₂ levels may be secondary, since they were also found in familial AD (McCaddon and Kelly, 1994). Thiamine (vitamin B₁) deficiency has a role in the aetiology of Wernicke's encephalopathy of chronic alcoholics, elicits in animals an impaired cerebral oxidative metabolism (reviewed by Hazell *et al.*, 1998) and may be associated with an increased incidence of AD (Peppersack *et al.*, 1999). Further mode of actions linking molecular events with preventive effects will be discussed in part 5 of this series.

Further intriguing evidence associated moderate alcohol drinking with a better cognitive performance (Carmelli *et al.*, 1999) and lower incidence of AD (Orgogozo *et al.*, 1997).

Smoking

In a population-based study, smoking was negatively associated with prevalent AD, over a 3-year follow-up, however, the risk of incident AD was equal between smokers and non-smokers (Wang *et al.*, 1999). A meta-analysis of 19 case-control studies (Lee, 1994) showed a strong protective effect of smoking against contracting AD, a finding which was confirmed by later studies (Van Duijn *et al.*, 1995; Callahan *et al.*, 1996; Hillier and Salib, 1997). In keeping with this notion, neuropathologic studies suggested a diminution of senile plaques and neurofibrillary changes in brains of smokers (Perry and Perry, 1993; Ulrich *et al.*, 1997). However, this effect may be specific for AD only, whereas smoking may be a risk factor for VD (Shaji *et al.*, 1996). Smoking may even carry the risk of an overall increase of dementing illnesses (Prince M. *et al.*, 1994; Cobb *et al.*, 1995; Ott *et al.*, 1998; Carmelli *et al.*, 1999), particularly in the presence of another risk factor for atherosclerotic disease, hypertension (Prince M. *et al.*, 1994). Moreover, there may be a dose effect, other case-control studies suggesting heavy smoking as a risk factor for AD (Shalat *et al.*, 1987; Joya-Pardo *et al.*, 1991; Ott *et al.*, 1998; Merchant *et al.*, 1999). Accordingly, in one case-control study light smoking protected from AD and stronger smoking increased the risk (Wang *et al.*,

1997), while a longitudinal study suggested a decreased risk among former smokers (Merchant *et al.*, 1999). Smoking is associated with premature menopause (Nilsson *et al.*, 1997), but since early menopause is associated with a significantly increased risk of AD (van Duijn *et al.*, 1994) this could further confound the epidemiological evidence. The argument that the putative smoking effect may be due to a selective survival bias — representing a 'survival of the fittest' selection — (Riggs, 1993) was questioned (Van Duijn *et al.*, 1995). Mortality, classification (AD or VD) and selection biases make an evaluation of the association smoking-AD problematic. The inconsistent epidemiological association of smoking and AD may be driven both by the neurobiological benefits of nicotine and the cerebrovascular sequelae of smoking.

The epidemiological data suggesting a protective effect of smoking may have a neurobiological basis. The cholinergic system is thought to play an important role in cognition (reviewed by Warburton, 1991; Levin and Simon, 1998). Acute or chronic nicotine or nicotine-agonists improve learning and cognitive performance in young and aged animals (Meguro *et al.*, 1994; Arendash *et al.*, 1995; Buccafusco *et al.*, 1996) and human smokers and non-smokers (Pritchard *et al.*, 1992; Hasenfratz and Battig, 1994; Algan *et al.*, 1997). Both an enhanced attention, information processing and storage may contribute to these effects (Warburton, 1991). Aged smokers may evade the ageing-related diminution of interhemispheric electrophysiological coherence (Knott and Harr, 1997). Nicotine enhances hippocampal synaptic transmission (Gray *et al.*, 1996) and glutamatergic transmission by a presynaptic mechanism (Radcliffe and Dani, 1998) and potentiates evoked single cell activity in aged rat prefrontal cortex (Huitron-Resendiz *et al.*, 1997). Nicotinic agonists upregulate nicotinic receptors (Benwell *et al.*, 1988; Wonnacott, 1990; Yang and Buccafusco, 1994) and chronic nicotine, if initiated before normal age-related decline, even promoted the retention of nicotinic receptor expression in rat hippocampus (Rogers *et al.*, 1998). Moreover, nicotine protects neurons against various excitotoxic stressors (Shimohama *et al.*, 1996; Kihara *et al.*, 1997; Zamani *et al.*, 1997) and NGF deprivation (Yamashita and Nakamura, 1996) and attenuated apoptosis in several non-neural cells through a protein kinase C-dependent mechanism (Wright *et al.*, 1993). The upregulation of various constituents of the neurotrophic factor system such as IGF-1 (Kito

et al., 1997), fibroblast growth factor-2 (Kratz *et al.*, 1997) and NGF receptor (Terry and Clarke, 1994; Buccafusco *et al.*, 1996) expression may contribute to the neuroprotective action.

AD brains display a substantial loss of nicotinic cholinergic receptors at autopsy (Shimohama *et al.*, 1986; Whitehouse *et al.*, 1986; Nordberg and Winblad, 1986) and *in vivo* (Nordberg *et al.*, 1995). Experimentally, lesioning of the cholinergic basal forebrain cells causes degeneration of their target cells in the hippocampus and cortex (Arendash *et al.*, 1987; Nanri *et al.*, 1997). Administration of nicotine can prevent the cell loss and associated cognitive deficit (Decker *et al.*, 1992; Nanri *et al.*, 1997). Accordingly, smokers may exhibit an improved cognitive performance (Letenneur *et al.*, 1994) and postmortem had a higher density of hippocampal and brain nicotinic binding sites and choline acetyltransferase (Benwell *et al.*, 1988; Perry *et al.*, 1996) than non-smoking controls. This protective potential may be related to the modulation of APP metabolism by promoting the secretory pathway (Kim S. H. *et al.*, 1997) and the blocking of A β toxicity (Kihara *et al.*, 1997; Kim S. H. *et al.*, 1997; Miao *et al.*, 1997). Thus, although smoking, due to inherent detrimental effects such as atherosclerosis and premature menopause, is not a feasible protectant against AD, nicotine or nicotinic agonists may have a potential as therapeutic opportunities in AD (Jones *et al.*, 1992; Court and Perry, 1994; Parks *et al.*, 1996). In fact, a small trial with 4 weeks of transcutaneous nicotine treatment suggested an improvement of attentional performance in AD patients (White and Levin, 1999).

ENVIRONMENTAL AGENTS

Numerous trace elements, including aluminum (Al), cadmium (Cd), copper (Cu), iron (Fe), lead (Pb), mercury (Hg), selenium (Se), and zinc (Zn) have been reported to be imbalanced in AD. A comprehensive coverage of this issue is provided by recent reviews (Markesbery and Ehmann, 1994; Olanow and Arendash, 1994).

A putative role of Al in AD has gained widespread attention but has remained controversial despite intense scientific efforts (Savory *et al.*, 1996). Since the first report of an elevated bulk brain Al content in AD (Crapper *et al.*, 1973, 1976), a multitude of studies both confirmed (e.g. Trapp *et al.*, 1978; Ward and Mason, 1987; Corrigan *et al.*, 1993) and refuted (McDermott *et al.*, 1979; Jacobs *et al.*, 1989; Dedman *et al.*, 1992; Bjertness *et al.*, 1996)

these initial findings. Microprobe studies suggested increased Al in the nuclei or tangle portion of NFT bearing neurons (Perl and Brody, 1980; Good *et al.*, 1992; Yumoto *et al.*, 1996) which could not be confirmed by others (Jacobs *et al.*, 1989; Chafi *et al.*, 1991; Lovell *et al.*, 1993; Makjanic *et al.*, 1998). The content of Al in senile plaques is similarly controversial (Candy *et al.*, 1986; Lansberg *et al.*, 1992). A role for transferrin in the cerebral uptake of Al has been proposed (Roskams and Connor, 1990) but this was dismissed in a study comparing transferrin Al content *in situ* in AD and control brains (Dedman *et al.*, 1992). Plasma Al levels were also found increased (Basun *et al.*, 1991).

The public health implications of this issue are related to the environmental exposure to Al in drinking water (McLachlan, 1995). A significant increase in the risk of AD was reportedly associated with an elevated Al content ($> 111 \mu\text{g/l}$) in drinking water in comparison with districts with lower Al ($< 10 \mu\text{g/l}$) exposure (Martyn *et al.*, 1989). In one instance, a regional clustering of dementia mortality was ascribed to a high concentration of Al in the drinking water (Frecker, 1991). Supportive findings were obtained in some (Flaten, 1990; Neri and Hewitt, 1991; McLachlan *et al.*, 1996) but not in all further studies (Wood *et al.*, 1988; Wettstein *et al.*, 1991). Confounding factors may be pH, fluoride, Ca^{2+} , and silica content of water, the latter three and neutral pH potentially reducing the risk (Birchall *et al.*, 1989; Edwardson *et al.*, 1993; Forbes and Agwani, 1994; Jacqmin *et al.*, 1994). In a series of papers, increased exposure to Al from drinking water (reviewed by Forbes *et al.*, 1995) and occupational exposure to Al (Rifat *et al.*, 1990; Bast-Petersen *et al.*, 1994) were associated with impaired cognitive functions. However, in a radiotracer study, the total uptake of Al from drinking water was determined to be less than 1 per cent of the typical daily uptake from food (Priest *et al.*, 1998).

The brain is dependent on a steady supply of Fe for normal function (Gerlach *et al.*, 1994). Since free Fe is toxic, its bioavailability has to be controlled stringently. Consistently, iron levels have been found elevated in hippocampus, nucleus basalis, and cortex of AD brains (Andorn *et al.*, 1990; Jellinger *et al.*, 1990; Dedman *et al.*, 1992; Richardson *et al.*, 1992) but lower in AD plasma (Basun *et al.*, 1991). Importantly, loosely bound Fe which is responsible for free radical reactions *in vivo* is elevated (Kala *et al.*, 1996) and redox-active Fe and an iron regulatory protein were documented in association with SP and NFT (Smith M. A. *et al.*,

1997). The role of iron transport proteins in the brain accumulation of iron has been indicated (Qian and Wang, 1998). Expression of lactotransferrin, an iron scavenger, was greatly up-regulated in effected AD brain regions (Kawamata *et al.*, 1993; Leveugle *et al.*, 1994). Ferritin, which binds and inactivates extracellular iron, similarly increased in AD brains, associated with reactive microglia and NFT (Grundke-Iqbal *et al.*, 1990; Jellinger *et al.*, 1990; Dedman *et al.*, 1992) and was found almost 10 times higher in the cerebrospinal fluid of patients with AD (Kuiper *et al.*, 1994; Robinson *et al.*, 1997). Both alterations can be regarded as a cellular defence mechanism (Focht *et al.*, 1997). Moreover, Fe binding protein p97 levels are elevated in AD patients' sera (Kennard *et al.*, 1996) and are associated with reactive microglia in AD brains (Jefferies *et al.*, 1996), while the Fe transport protein transferrin is increased in AD frontal cortex (Loeffler *et al.*, 1995). The transferrin C2 subtype, which has an increased frequency in malfunctions which are associated with formation of free radicals, was found to be increased in AD patients (van Rensburg *et al.*, 1995; Namekata *et al.*, 1997; Van Landeghem *et al.*, 1998). Of note, ageing-related changes of Fe homeostasis include increase of total rat brain Fe and possibly ferritin (Roskams and Connor, 1994). Since Fe accumulates in dependence of energy and oxidative stress (Romslo, 1975; Fujimoto *et al.*, 1982; Castelnau *et al.*, 1998), these alterations of Fe homeostasis indicate a status of cellular stress and damage (Ceccarelli *et al.*, 1995; Wang *et al.*, 1995).

Zn fulfils important functions in neuronal transmission, as a component of catalytic sites of enzymes, as an antioxidant and in a structural capacity (Bettger, 1993; Cuajungco and Lees, 1997). Significant increases and imbalances of Zn in the AD brain tissue and in areas of severe AD histopathology associated with senile plaques have been reported (Thompson *et al.*, 1988; Deibel *et al.*, 1996; Cornett *et al.*, 1998; Lovell *et al.*, 1998). Normal (Hershey *et al.*, 1984; Ehmann *et al.*, 1986) and reduced levels were reported as well (Ward and Mason, 1987). In subcellular compartments of AD brains, Zn was decreased in the nuclear fraction (Wenstrup *et al.*, 1990). These changes, although inconsistent, may indicate oxidative stress, since Zn is readily released from its transport protein under oxidative stress (Maret, 1995), but can reduce oxidative stress by displacing redox-active transition metals such as Fe and Cu and, by binding to thiol groups, protect these from oxidation (Bettger, 1993;

Cuajungco and Lees, 1997). In AD patients, an altered Zn homeostasis was also documented in plasma evidenced by a decreased activity of a carrier peptide (Licastro *et al.*, 1996).

A possible pathophysiological role of Cu deficiency in AD was suggested by Hartmann and Evenson (1992). Cu was reportedly decreased in AD hippocampus (Deibel *et al.*, 1996), but elevated in the rim of senile plaques compared with AD neuropil (Lovell *et al.*, 1998). Ceruloplasmin, the Cu transport protein with both antioxidant and oxidant properties (Fox *et al.*, 1995) was found depleted in the AD temporal gyrus (Connor *et al.*, 1993) but increased in the hippocampus and frontal cortex (Loeffler *et al.*, 1996), and increased in AD CSF (Loeffler *et al.*, 1994), indicating an acute phase-type response.

Childhood exposure to Pb was suggested as a risk factor for AD (Prince, 1998). Pb may be a predictor of cognitive performance, with high blood and bone levels associated with impaired cognition (Payton *et al.*, 1998).

Hg was reported to be increased in AD cortex, nucleus basalis and amygdala and in subcellular fractions of the temporal lobe (Ehmann *et al.*, 1986; Thompson *et al.*, 1988; Wenstrup *et al.*, 1990; Cornett *et al.*, 1998). Hg levels were also found increased in AD patients' blood (Basun *et al.*, 1991; Hock *et al.*, 1998). Potential mechanisms of Hg neurotoxic actions and their putative role in AD have been discussed (Markesbery and Ehmann, 1994). For instance, Hg may induce signal transduction deficits as encountered in AD (Pendergrass *et al.*, 1997). Dental amalgam, for instance, is a potential source of Hg (Hahn *et al.*, 1990) and brain Hg levels correlated with the number of amalgam restorations (Eggleston and Nylander, 1987). The number of amalgam fillings, however, was not found associated with a lower cognitive performance (Saxe *et al.*, 1995). Environmental sources other than dental amalgam are suspected (Hock *et al.*, 1998), although not identified.

Se has an important role in the regulation of the general redox balance as part of the antioxidant enzymes Se-glutathione peroxidases (Ursini and Bindoli, 1987; Bettger 1993). Se was found reduced in AD brains (Ward and Mason, 1987; Wenstrup *et al.*, 1990).

Modes of neurotoxic actions of trace elements may include modulation of Ca^{2+} homeostasis (Nicotera and Rossi, 1993), induction or enhancement of oxygen radical formation and augmentation of $\text{A}\beta$ aggregation. Cellular Ca^{2+} homeostasis may be

disrupted by ions of Al (Anghileri and Thouvenot, 1998; Gandolfi *et al.*, 1998), Cr (Anghileri and Thouvenot, 1998), Cu, Fe (Richardson *et al.*, 1992; Anghileri and Thouvenot, 1998), Hg (Nicotera and Rossi, 1993; Marty and Atchison, 1998), and Pb (Hegg and Miletic, 1997). Oxidative stress is a general toxic mechanism of a variety of transition metal ions (Stohs and Bagchi, 1995). For instance, it can be induced by Fe (Halliwell and Gutteridge, 1992; Bondy *et al.*, 1998), Cd (Kumar *et al.*, 1996; Sarkar *et al.*, 1997), Cu (Multhaup, 1997; Bondy *et al.*, 1998), Hg (Lund *et al.*, 1993; Hussain *et al.*, 1997) and Mn (Halliwell, 1984), while Al (Gutteridge *et al.*, 1985; Bondy *et al.*, 1998) may not be able to catalyse the free radical formation but enhance the formation elicited by other trace elements. Similarly, the pro-oxidant action of Cd may be mediated by Fe (Casalino *et al.*, 1997). $\text{A}\beta$ may enhance the trace metal-induced ROS formation (Bondy *et al.*, 1998; Dikalov *et al.*, 1999). Cd, Fe, Hg, and Zn may modulate sAPP formation, presumably at the α -secretase level (Bush *et al.*, 1994b; Bodovitz *et al.*, 1995; Smedman *et al.*, 1997; Hock *et al.*, 1998) and facilitate $\text{A}\beta$ toxicity *in vitro* (Schubert and Chevion, 1995). Moreover, Al, Cu, Fe, and Zn were shown to promote $\text{A}\beta$ aggregation (Mantyh *et al.*, 1993; Bush *et al.*, 1994a; Atwood *et al.*, 1998). Finally Al and Pb may contribute to the neurofibrillary pathology (Nikowitz, 1975; Abdel-Ghany *et al.*, 1993).

GENETIC DISPOSITION OR ENVIRONMENT?

The composite risk to develop AD is characterized by an interaction of genetic and environmental factors (van Duijn *et al.*, 1994). The allocation of hierarchical positions has been attempted, rating the risk factors according to their pathophysiological relevance. Twin studies suggest both genetic and environmental risk factors in varying proportions in late-onset AD (Nee *et al.*, 1987; Rapoport *et al.*, 1991; Breitner *et al.*, 1995; Lannfelt *et al.*, 1995; Raiha *et al.*, 1996; Gatz *et al.*, 1997). The modulating role of environmental factors is highlighted by the finding that some monozygotic twin pairs have remained discordant for AD for up to 20 years (Breitner *et al.*, 1995). Twin pairs discordant for AD differed in the level of schooling, a higher level carrying a reduced risk (Raiha *et al.*, 1988). In late-onset familial AD, the influence of non-genetic factors may be even greater and the degree of heterogeneity larger (Lopez-Alberola *et*

al., 1997). However, these studies, carried out in a shared cultural environment, are inadequate to remove environmental factors due to cultural lifestyles like diet. Clues for such influences could be provided by comparison of epidemiological data from studies in different ethnic groups living in the same environment (Treves *et al.*, 1986; Maestre *et al.*, 1995; Tang *et al.*, 1996; Farrer *et al.*, 1997) and from groups with the same ethnic background but differing cultural environments (Hendrie *et al.*, 1995a,b; Osuntokun *et al.*, 1995a; Kalaria *et al.*, 1997; Hall *et al.*, 1998; Holder and Warren, 1998). The relatively low prevalence of AD in developing countries may have ethnic and/or environmental causes (Ogunniyi and Osuntokun, 1991; Chandra *et al.*, 1998; Hall *et al.*, 1998; Liu HC *et al.*, 1998). In sporadic AD, studies consistently confirm the biological relevance of the association between apoE4 allele and risk of AD across various ethnic origins living in Western culture environments. However, the association seems stronger in Japanese and weaker in American Africans than in Caucasians (Maestre *et al.*, 1995; Tang *et al.*, 1996; Farrer *et al.*, 1997). In contrast, ethnically similar populations living in different environments such as African Americans and Nigerian Africans exhibit not only different AD prevalences (Hendrie *et al.*, 1995b; Hall *et al.*, 1998), but also differ grossly in the association of AD with apoE4 (Osuntokun *et al.*, 1995a; Hendrie *et al.*, 1995a). Similarly, another study suggested that apoE4 is not associated with AD among East Africans (Kalaria *et al.*, 1977; Sayi *et al.*, 1997). Notably, brains from non-demented elderly East Africans exhibited a number of AD pathomorphological hallmarks quantitatively and qualitatively similar to specimens from elderly US controls (Ogeng'o *et al.*, 1996), while brains from elderly Nigerians lacked these changes (Osuntokun *et al.*, 1995b). Other not yet identified genetic determinants may account for these differences. The low incidence of AD in African populations contrasts with the high frequency of apoE4 in sub-Saharan African populations which may be as high as 40 per cent and is therefore considered the ancestral apoE isotype (Zekraoui *et al.*, 1997). A possible link reconciling these diverse findings comes from the assessment of lipid metabolism. In a Nigerian population the total serum cholesterol values were found low compared to African American and other Western populations (Kesteloot *et al.*, 1989). In a population of South African bushmen a particularly high frequency of the apoE4 allele was not associated with higher plasma cholesterol levels

(Sandholzer *et al.*, 1995). It was suggested (Sandholzer *et al.*, 1995) that only if exposed to a Western lifestyle with its hypercholesterolaemic diet (Finchan *et al.*, 1987) and lack of physical exercise inherent individual susceptibilities may manifest as burden to develop late-onset disorders such as atherosclerosis and AD (Kamboh *et al.*, 1995). The same conclusion is suggested from studies investigating the prevalence of AD in Old Order Amish, a conservative Christian group in North America, which shuns the modern Western lifestyle. Here, a reduced prevalence of cognitive impairment and AD (Johnson *et al.*, 1997) does not appear to be due to a reduced apoE4 frequency (Pericak-Vance *et al.*, 1996; Holder and Warren, 1998). In this population, which has also a lower cardiovascular mortality (Hamman *et al.*, 1981), a low serum cholesterol, despite a diet high in total and unsaturated fat and cholesterol, is thought to be due to vigorous physical activity (Glick *et al.*, 1998). It is inferred that these examples highlight the interdependence of genetic and environmental prerequisites: apoE4 confers a risk of AD if coincident with increased cholesterol levels (Czech *et al.*, 1994; Jarvik *et al.*, 1995; Chandra and Pandav, 1998; Sulkava *et al.*, 1998) due to certain environmental factors such as high dietary fat intake, psychosocial stressors and lack of physical activity. The cross-cultural epidemiological data clearly relativate the multiple pathophysiological and clinical abnormalities elicited by apoE4 (see above), as of minor functional relevance in an organism which lacks abundant cholesterol supply. Another intriguing genetic-environmental link associated apoE4 with HSV1 infection (Itzhaki *et al.*, 1997; Matsui *et al.*, 1998). Neither factor alone increased the risk for AD, however, the combination strongly correlated with AD brain pathology (Itzhaki *et al.*, 1997). However, evidence suggests that the expression of HSV DNA may be simply an indicator of an underlying immune response deficit related to an HPA axis dysfunction (Dobbs *et al.*, 1993; Sawiris *et al.*, 1994; Noisakran *et al.*, 1998). The finding that apoE4 is also a risk factor for herpes labialis (Lin *et al.*, 1998) may further hint at an association of apoE genotype and immune dysfunction, possibly secondary to an HPA axis dysregulation.

In the familial type AD, genetic factors clearly are of primary importance though even here a less than 100 per cent penetrance (Rossor *et al.*, 1996) and a wide variation in age at onset (Bird *et al.*, 1996; Lopera *et al.*, 1997) point at additional genetic and environmental modulators. These genetic fac-

tors were indicated by an Israeli study showing a significantly higher incidence of early-onset AD in European or American immigrants, than in African or Asian immigrants (Treves *et al.*, 1986). On the other hand, in late-onset FAD, a high degree of phenotypic heterogeneity within families which was even more pronounced between families, was attributed to non-genetic influences (Lopez-Alberola *et al.*, 1997).

In an individual patient a unique combination of genetic, biographic and sociocultural factors may act together causing the many etiologies/one pathogenesis riddle of AD. However, above all these aetiological considerations, the overwhelming importance of ageing as the most significant risk factor should be borne in mind.

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