

Welcome to the Cutting Edge Health Podcast with Jane Rogers, where we discuss science to help prevent cognitive decline.

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**[00:00:01] Jane Rogers:** Welcome to the *Cutting Edge Health: Preventing Cognitive Decline* podcast. I'm Jane Rogers. Welcome back. Today's guest is Dr. Mitch Clionsky. He hails from Massachusetts, and he is a neuropsychologist. He has treated, in his career, more than 30,000 patients, and his specialty is preventing cognitive decline. What he shared with me on this podcast, there were many interesting pearls, things I didn't know, and I really appreciated his time. Dr. Clionsky, thank you for joining us today. How are you?

**[00:00:34] Dr. Mitch Clionsky:** I'm great. I'm really excited to be talking with you, Jane.

**[00:00:37] Jane:** Yes, I'm excited too. I'm excited because you published a book, and it is aimed straight at the audience that I have the pleasure to communicate with, and that is *Using Your Head to Save Your Brain*. That's the title. Tell us in a nutshell, what is this about? Then, I'd love to tear it apart with you, so that you can share all of these pearls in the book, or as many as you can in these 45 minutes with this audience, so that you can help them to live in cognitive health.

**[00:01:05] Dr. Mitch:** The first part of the title is *Dementia Prevention: Using Your Head to Save Your Brain*, and that's really what it's all about. There are a couple of key points that we'll probably hit today. The first one being that dementia is a progressive neurological disease, so it's not an imaginary thing, and it's not something that's a psychiatric disorder. It's something that's caused by a change in how our brains are structured and how they function.

The second thing we'll talk about is that not all dementias are Alzheimer's disease. In fact, Alzheimer's is only one of the various types of dementia, and there are a variety of others that are equally, or in some ways, even more important. The third thing is that it is not an inevitability for someone who has a relative with Alzheimer's or other dementias.

In fact, the large-scale research that we cite in our book, which has been really gold standard research, shows that anywhere from 40% to 60% of dementias can be prevented. You split the difference, come up with one out of two cases of dementia can be prevented if we understand what we're doing, if we understand the complexity of it, if we figure out where we need to make some changes in our life and our health, and we do something about it.

This is not a passive process. It's not just, "Oh, I hope it works out well," because probably it won't. This is more of a, "I've got to look at myself, reflect on where I am." We provide a tool for doing that, and then say, "I'm willing to continue to change and to grow as I age."

**[00:02:56] Jane:** In your experience, I know you have a vibrant practice in Massachusetts, you and your wife, who's an MD, and you're a PhD neuropsychologist, and I'm sure that people come in, and you just want to grab them, and shake them and say, "I can fix you, I can help you, If you will engage, if you'll get an advocate to help you do this." Maybe if they can't do it themselves. Do you find that a lot—people, when they come to you, they're just so motivated that they do make the change that is necessary?

**[00:03:25] Dr. Mitch:** No, unfortunately, a lot of them aren't so motivated. A lot of them are dragged in by family members or referred by their doctor. One of the first questions I always asked is, "What brought you here?" Occasionally someone says, "Well, it was the bus." [laughs] That's always a concerning question to be answered.

Most of them will say, "Well, I think I'm fine, but my kids are worried," or "My spouse is worried," or "My doctor did a quick test, and thought that there was something wrong, and so they sent me." What I really like is to get people much earlier than that. In fact, our audience really for the book is to apply the things we learned from treating patients, into treating people before they have to be our patients.

For some of the people, they recognize that there's something that's going on. They just want to know what it is and what they can do. Other people, you tell them there's a problem here, and here's what the areas are, and here's what may make a difference. They don't do much of anything. This guy I saw yesterday, as a matter of fact, I said to him, "You're back for your second visit. This is six months later. We found that you are having some cognitive problems. You have what we call mild cognitive impairment, which means it wasn't really still normal for you, based on your age and your background, but it hadn't declined to the point where it was truly a dementia, where you had lost enough function that we call it a dementia. I suggested that you get a couple of these tests, including a home sleep study, because we're finding more and more how important something called sleep apnea is in this area." I said, "Did you do that?" He said, "No". I said, "Well, tell me why. It's painless. It's only one night. Your doctor is happy to order, in fact, was happy to order it, sending his notes you weren't interested."

He said, "I guess I'm just stubborn." I looked at him. I said, "Well, let's see how that's working out for you." It turns out that this time, unfortunately, his cognitive abilities had declined somewhat compared to where he was. I engaged him again and said, "I asked you the question, how's that working out for you? I have to tell you, it's not working out so well. You really can't afford to be stubborn at this point. You have to embrace the idea that you change as you age or else life changes on you. Here's what I want you to do this time."

This time he was finally ready to hear it. I hope that we can improve his thinking and get him back to where he was. If nothing else, I think we'll go far to helping him not to get worse. I see those kinds of things all the time, where they don't know me that well. They come in; I spend half an hour to an hour talking with them. We do three hours of testing.

I can't expect that just because I have a doctorate degree and just because, at this point, I've treated about 30,000 people over the course of my career, that they're going to necessarily say, "Well, he knows what he's doing," but they've got to listen to somebody. I hope it's somebody who knows what they're doing.

**[00:06:31] Jane:** You mentioned sleep apnea. If you are having the deficit in nocturnal oxygenation, your brain cells are going to die. It's a huge problem.

**[00:06:39] Dr. Mitch:** Not going to. They already have to some degree. Yes, this is a big issue. For those people who are not all that familiar, sleep apnea is a condition whereby you stop breathing more than five times per hour, or your oxygen level declines by 4% more than five times an hour, or the combination of those two while you're asleep. Many people with sleep apnea snore. They think that that's the equivalent, but it's not.

There are people with snoring who don't have sleep apnea, and people with sleep apnea who don't snore because you need to get air down your airway in order to make that sound that's caused by the air rushing over your soft palate. If you're completely closed down, you're not going to be snoring. You're going to be chortling. You're going to go [chortling sound] like that, and wake yourself up, and then fall back to sleep again, and then go through that multiple times per hour.

Getting up to go to the bathroom multiple times during the night is actually a sign of sleep apnea. Falling asleep in the easy chair, watching TV, reading a book, going to the play, and finding that you're sleeping through most of the first act, is oftentimes associated with sleep apnea. Feeling tired, feeling like you have to pound down a couple cups of coffee in the morning just to get out of bed and wake up are all signs.

The true test is a sleep study, where you actually can measure those things. If you have this condition, by the way, the most recent research coming out just a couple of months ago showed that, from the general population, if you're age 58 or older, your chances of having sleep apnea are 50%.

**[00:08:29] Jane:** I didn't know that.

**[00:08:31] Dr. Mitch:** Well, this is brand new. It came out of a consortium of places like the Framingham Heart Study, Mayo Clinic, places that bring in people from the general population every three to five years. Then they give them a battery of different kinds of tests, usually heart-related tests, some memory-related tests, and then they bring them

back every three to five years and retest them, so they can see how illnesses develop over time.

Well, this time, this group formed a consortium, and they gave every single person, 6,000 adults, a one night in their own bed sleep study. The results were staggering that 50% of them had diagnosable sleep apnea. What's crazy about this is that not only does it increase your risk for dementia and cognitive decline, but also strokes, heart attacks, erectile dysfunction. Gout is associated with it of all things. I know.

You wonder, "Wow, how's it related to all the oxygen?" Turns out to be a really key element to how our bodies work. If not enough air gets down your lungs, not enough oxygen can get pulled out of your lungs, make its way up to your blood vessels, to your brain, and get to those very tips of your brain. Not only does your brain get deprived of oxygen and nutrients, but you don't make enough of an energy molecule called adenosine triphosphate, otherwise known as ATP, and there's a system in our brain called the glymphatic system.

The glymphatic system's purpose is to flush out the byproducts of daily thinking activity. While our brain is working while we're awake, our brain cells are actually creating waste, like filling up your trash can. If you don't empty your trash can every night, after a while, there's going to be a lot of trash building up in your office. The glymphatic system is really important, and it doesn't work well if you don't get enough oxygen. There are all kinds of reasons why getting enough air down your lungs, makes a lot of sense.

**[00:10:53] Jane:** Sometimes I hear about people who suspect they have sleep apnea. They don't like what can be done about it. They don't want to wear a CPAP machine, and who would? It's bulky. Now, they have oral appliances that you can put in your mouth and change it, so that your throat is opened up, you have a better airway, and it's not as intrusive, but it doesn't work for some people.

**[00:11:16] Dr. Mitch:** It's also not as successful. There's one head-to-head study which looked at people with sleep apnea who used either the oral appliance first or the CPAP first, and then they switched after a couple months, and they took a look at the effectiveness at lowering their levels of sleep apnea, what they call the Apnea-Hypopnea Index, sort of miles per gallon. It's one of those kind of averages.

What they found was the oral appliance worked, but only half as well as the CPAP. What we found is that, if we can help people to number one, understand the importance of this, number two, using behavioral psychology, help them reframe the problem so they see why this is beneficial, and then give them a simple desensitization technique, they can get used to using the CPAP.

We've taken groups of people with mild to moderate dementia, and their spouses, and in a matter of four sessions, half-hour sessions, reached 70% to 80% adherence, meeting the Medicare standards, which is twice the usual adherence rate. The studies tell us that only 40% of people who get a CPAP machine actually end up using it long enough for it to make a difference.

The reason is they don't get enough instruction, they don't get enough appropriate motivation and technique. How do I know this? Because I've been on a CPAP machine for the last 18 years, every night. I've been through all of the normal resistances. Number one, it'll make me feel old and sick to have this breathing thing on my face. Number two, I won't be sexy.

**[00:13:05] Jane:** [laughs]

**[00:13:06] Dr. Mitch:** That's the biggest one for a lot of people. I know this because my patients tell me this, and I tell them, "Well, number one, the first part is that what you're going to find is that you can rethink your way into being okay with this concept. I'll tell you what I did, which is silly, but when I was getting used to this, I was struggling with the same issue. It was about the time that the movie *Top Gun* came out. I imagined myself being in the cockpit, strapping on my mask, so I got enough oxygen. When I got up at a certain altitude, I didn't fall asleep and crash the plane. [chuckles] I'm like Tom Cruise, ready to take off down the runway." That was helpful.

**[00:13:52] Jane:** He's sexy. Exactly.

**[00:13:54] Dr. Mitch:** Exactly.

**[00:13:54] Jane:** It's okay.

**[00:13:55] Dr. Mitch:** The second thing was, if you're putting the CPAP on before you have sex, unless you're into a little kink, you're not doing it right. You wait till after, and after nobody cares. That's the reality. Afterwards, nobody cares.

**[00:14:12] Jane:** Yes. Interesting.

**[00:14:14] Dr. Mitch:** That works around a lot of that kind of thing. People smile and they laugh. Then we're ready to start the process of getting them used to doing this, so that when they do it, they can be really successful, and feel better, and think better. The research tells us that if you get a group...this is done by a very prominent researcher named Ancoli-Israel. That's her hyphenated last name.

Dr. Ancoli-Israel did a really interesting study with women who had mild cognitive impairment, and also had sleep apnea. Half of them used CPAP, and the other half did

not. She looked at them months to a few years later and found out that there's a far different rate of progression to dementia. Very few of the people who use the CPAP got worse. Many of the people who had the sleep apnea but didn't treat it did get worse and ended up with a dementia after that period of time. There's a lot of research showing why that is on a cellular and molecular level. Oxygen, it's a critical piece of the puzzle.

**[00:15:22] Jane:** Thank you for that. That was an important conversation. Dr. Clionsky, think of some other things that are in your book and that you counsel all those patients about, if they're wanting to stay healthy cognitively longer. What's another topic?

**[00:15:37] Dr. Mitch:** What'd you say? What'd you say?

**[00:15:39] Jane:** Okay. [laughs]

**[00:15:39] Dr. Mitch:** What'd you say? It's your hearing. It turns out that subtle hearing loss is actually a significant cause for the development of dementia, as well as depression. One of the things about dementia prevention is it's not just one thing. It's a whole lot of things, and they're all interrelated. When you look at hearing loss, you're looking first at the physiological parts of it.

If you examine the brains of people who have subtle or greater hearing loss using a technique called volumetric magnetic resonance imaging, MRI, what you find out is that the thickness of the cortex, the surface of the brain in the auditory association areas, is thinner in people with hearing loss than people without it. If you look at a related field using a different kind of MRI called functional MRI or fMRI that looks at the connectivity of different parts of your brain, you'll find that one of the background resting state networks called the salience network is downregulated.

In other words, you're not paying attention and finding things interesting enough to be focused on them, and therefore, take in and hold onto that information. More importantly, if we can identify people with hearing loss and get them to wear hearing aids, that means you put them in the morning and you wear the hearing aids all day. You don't treat them like the crown jewels and just bring them out for special occasions.

If you can get people to do this, number one, their cognitive scores improve. Number two, their rate of decline goes down, and so they remain healthier in their mind longer. They also have a much better time. They now find things to be funny that they didn't think were funny before because they missed the subtleties of the joke. They're now more involved socially because it's more rewarding.

They're not withdrawn. They're doing more things. They're stimulating their brain more. All those things are connected in a way which makes for a better outcome. It's just a piece of the puzzle. For some people, it's a really important extra piece.

**[00:17:58] Jane:** Hearing aids aren't sexy. That's what I keep hearing. [chuckles]

**[00:18:02] Dr. Mitch:** [chuckles] They are these days.

**[00:18:02] Jane:** I think they are.

**[00:18:04] Dr. Mitch:** Now, these days, you can hardly even tell someone's wearing them. That's the beauty. They're really good. They're self-charging at night, so you don't mess with batteries the way you used to. More like you're wearing ear pods or something. They really, really work. In fact, they're so good now that you can adjust them to different environments.

You have a different setting when you're in a movie theater than in a restaurant, than when you're talking to somebody one-to-one.

**[00:18:28] Jane:** Listening to music.

**[00:18:29] Dr. Mitch:** Yes. You can even answer your phone on them if you want to do that.

**[00:18:33] Jane:** Okay. We've talked about sleep apnea. We've talked about hearing. What's your third one?

**[00:18:38] Dr. Mitch:** Here's something that's not in the book. It's the F-word. The F-word was taught to me by my dental hygienist. We talked about gingivitis and its effect on gum disease, increasing your risk of dementia. The F-word is "floss".

**[00:18:53] Jane:** Oh, I wondered.

**[00:18:54] Dr. Mitch:** It's a very important word. I love getting people's attention. I love using things like that because, immediately, you start, "What? What do you say? F-word?" I believe in using the F-word every day.

**[00:19:07] Jane:** That's a good thing.

**[00:19:08] Dr. Mitch:** I encourage my patients to use the F-word. Floss. Don't just brush, but take care of your gums because as you get older, most people lose gum. They lose the protection, the wetness of their mouth. Their mouths get dried out and their gums recede, and they're much more prone to infections. In fact, any infection as you get older increases your risk of cognitive decline.

You want to get vaccinated. You want to avoid getting the flu. You want to avoid getting pneumonia. You certainly want to avoid getting COVID because all of those things can accelerate any disease process that affects our brain. We don't recover so well in our 70s

than in our 40s. We certainly don't recover as well in our 80s as we did in our 40s. The older we get, the more important those kinds of preventative measures are.

**[00:20:02] Jane:** Including a flu shot.

**[00:20:03] Dr. Mitch:** Including a flu shot. Yes.

**[00:20:05] Jane:** You don't want to get sick, so--

**[00:20:06] Dr. Mitch:** You don't want to fall. That's the other thing.

**[00:20:09] Jane:** You don't want to fall. How about muscle mass, and how that correlates with brain function?

**[00:20:14] Dr. Mitch:** It has to do with strength. All this comes, basically, using our bodies. Exercise turns out to be the one thing that everyone agrees is good for our bodies. You never find any argument about that. When I ask people about exercise, nobody ever says, "Oh, it's bad for you." I've never had anyone say that over the years. They all have reasons why either they don't, they can't, they're not up to it, they're not interested in it, the time.

I tell them to examine their butt. It's another one of those things that always gets their attention. I say, "I want you to examine your but." They look at me, and I say, "No, not the butt you're sitting on. The 'but' that comes in the sentence, 'I would exercise, but.'" Whatever comes after that is the thing we have to attack from a behavioral, cognitive behavioral perspective, and change that approach.

"I don't have the time." Great. Here's a simple formula. Take a 10-minute brisk walk. It's only 10 minutes. Do it three times a day. You can squeeze it into all those places that you would have sat down and looked at your cell phone, or that you would have done something else. Those 10 minutes of brief walking every day at a rapid enough pace. You get the heart rate up, but you're still able to talk. You're able to get breath. Doing that three times a day gives you 210 minutes of exercise a week.

**[00:21:46] Jane:** Great.

**[00:21:46] Dr. Mitch:** If you're doing it briskly, you're walking 9 or 10 miles. Now, you're also building up the muscles in your legs, reducing your chance of falling and having a hip fracture, or hitting your head so you have a bleed inside your brain. All those things are connected. Plus, you're getting more oxygen to your heart and up to your brain.

**[00:22:07] Jane:** That doesn't mean just going out and walking your dog.

**[00:22:09] Dr. Mitch:** Part of it--



**[00:22:10] Jane:** I see so many people just walking their dogs, but that's often not brisk enough to really help.

**[00:22:16] Dr. Mitch:** It's like golf—which I don't play, by the way—but you play it where it lays. I will take people for wherever they are right now and say, "Fine". I've got a dog and having a dog is a great thing for your cognitive health, and for your social life, and everything.

**[00:22:31] Jane:** It is.

**[00:22:32] Dr. Mitch:** There's his walk. Then there's my walk in addition to that. Take your dog out for a walk. That'll get you moving. That's a good start. Then take a faster walk for yourself. You start with, if you can only walk 10 minutes, if you can't do that, walk 5 minutes. Start now rather than later. Don't wait for it to be a better day. Don't wait for yourself to be in a better mood.

You'll focus better after your walk. You'll feel more energized after you walk. It's actually paradoxical. The more that you put out an energy on that walk, actually, the more energy you'll have later on.

**[00:23:09] Jane:** One of the things that I heard recently, Dr. Dale Bredesen, who was one of the leading researchers in how to prevent Alzheimer's pretty early on, he really feels now that mold is playing like a 50% or 60% role in developing dementia of some sort. What do you think about mold and its toxins in your brain?

**[00:23:29] Dr. Mitch:** I've not read the research on mold and dementia. I caution people that there are a lot of fads out there that someone has a theory about, whether it's diet, or supplements, or toxins of various types. One of the things that Emily and I paid a lot of attention to when we put together this book was we wanted to only look at very well-established research, not something that was speculative, because there's a lot of speculative things out there.

You see these all the time on your feed, on your phone, where it's this diet of raspberries, pomegranates, blueberries, leafy vegetables, as if those things by themselves are enough. In many ways, they're dangerous. Not because they themselves are bad, but because they give people the false idea that, "Oh, that's enough. I've had my 12 blueberries. I've done that, so therefore, I'm cool."

If that were the case, we'd have already fixed this problem. There wouldn't be much dementia in this world. There'd be half as much if that was really all that successful. It isn't. I don't know, particularly, the theory on mold, but I want to see the research. I want to see it replicated. I want to see it extended to large groups of people. I want to have it really accepted. Then we can include it.

Then the question is, do you abate the mold? Do you avoid living in places with it? Do you wear a mold filter of some sort when you're in places like that? I don't know. I'm looking for stuff that people can use. Recently, there was something that was published that said people who grow up in underprivileged neighborhoods have a higher risk of dementia.

I thought, "Well, that's an interesting fact. What are we going to say? 'Hey, move out of that underprivileged neighborhood. What do you do and live in there? Everyone's poor. Move up to the east side. Everything's better.'"

**[00:25:32] Jane:** It's not an option.

**[00:25:32] Dr. Mitch:** That's not going to happen. That's not doable. How does that help you? It's interesting from a scientific perspective because then you get into people who live there are more exposed to pollutants. People who live there, oftentimes, have lower educational levels. They don't have as much money to buy better foods. There are a lot of reasons why those things are correlated. We're looking for what you can use to make a change in yourself that's going to reduce your risk now. That's really the focus.

**[00:26:01] Jane:** Where are you with diet? A lot of things that I'm hearing, and I went to a very interesting longevity conference, because if we can stay healthy longer, we're going to prevent the diseases of aging, like the dementias to a large extent. It seems like a plant-based diet in some form, possibly, with some meat, so not completely vegetarian. A plant-based diet has some efficacy. What are you reading?

**[00:26:26] Dr. Mitch:** Well, I'm reading that diets like the Mediterranean diet, and the MIND diet, which is a combination of the Mediterranean and the NASH diet, are better than the worst diets. That's what the literature tells us. Are they better than the average diet is the question. The answer is no. Statistically, they're not. If you have a horrible diet, if you're spending most of your time through the drive-through lane and you're eating a lot of junk food, then going on a plant-based MIND diet with a lot of olive oil instead of butter and things like that is better for you.

I have no quibble with people eating better. Again, that's not going to make the difference for most Americans in terms of their risk of dementia. If it did, we would have fixed this already. Nobody who is upper middle class or more economically intact so their level of diet is much better would ever have dementia. Yet we do. We're Americans. We like to eat our way into better health. It's a fascination for us.

At the beginning of going through all the research on this, Emily and I looked into it. We thought, "Okay, chocolate. Everyone loves chocolate. Red wine. My goodness, we could put together workshops, and have people eat chocolate over raspberries and

strawberries, and drink red wine. It'll be wonderful. We'll have a lot of fun, and we'll really reduce the risk of dementia."

Then we started looking at the real research on it. We discovered, "Yes, it's nice. It's not enough." It really doesn't make enough of a difference. I have a sort of a personal peeve. That's why you won't find really much of anything in our book about diet. There are tons of books on diet and dementia. Have a blast. Read about them. Unfortunately, that's not where we're going because the evidence just does not support it making a big enough difference, and I'm into results.

**[00:28:26] Jane:** Where are you with supplementation? What supplementation do you think does serve us well? Either meds or supplements?

**[00:28:35] Dr. Mitch:** Here's the deal on supplements. There's a lot of it. It's a billion-dollar industry. None of it is FDA-approved. There's no regulation on exactly what goes into it. Usually, the ingredients in the supplements seem to have an association with better health, and with greater longevity, and all kinds of good things, especially in animal studies.

Number one, because they're not regulated, you really don't know how much of that you're getting. Number two, suppose you take it. You don't know how much of it is getting through your digestive system into your bloodstream. What are the peak blood levels is a question that's usually not answerable. Number three, suppose it gets into your bloodstream at high levels.

Now the question is, how much makes its way from the blood to your brain? How much crosses the blood-brain barrier? That's where really the rubber meets the road because you could have wonderful levels of B12 and B9, for example, in your bloodstream. If you've got elevations in homocysteine levels, which are, by the way, really testable easily by a good internal medicine doctor, that's going to block the B9 and B12 from getting to your brain, so you're not going to get the benefit.

Most of what we're doing with most supplements that are available without a prescription is we are digesting them and we are eliminating them. They're expensive. People love them because they're available, they feel like they're doing something, and they exert a very strong placebo effect. The placebo is the expectation that something is good for you, so therefore, you feel better. It's a very powerful effect.

In fact, one study found that about 40% effect, "Wow, I feel better now. My depression is better, my health is better," simply because it is an expectation. Here's something even more important. The more expensive the placebo, the more effectively it works.

**[00:30:43] Jane:** [laughs] Of course.

**[00:30:44] Dr. Mitch:** Believe me, I would love for these things to work. I would love to be the spokesperson for some of these companies so I can make a little money on saying, "Hey, I've written the book on dementia prevention, and I take this supplement." We don't do any of that for a good reason. It actually isn't evidence-based, and that's where we are in this—evidence-based science.

**[00:31:04] Jane:** Do you take any prescription meds then that directly try to impact the pace of your aging?

**[00:31:09] Dr. Mitch:** The only thing that I do that is not directly from a prescription point of view is I take metformin and I don't have diabetes.

**[00:31:17] Jane:** So do I.

**[00:31:18] Dr. Mitch:** Because there is some interesting stuff out there about longevity, and by keeping your blood sugar levels. I'm not endorsing people doing this. I'm simply telling you what I do based on the research. When I go to my doctor, he says, "You've got diabetes." I said, "No, I don't have diabetes." "Well, you're on metformin." I say, "I know I'm on metformin. Here's why I'm on the metformin. Don't you remember we actually had this discussion a year ago?" "Oh, yes, you're right." [chuckles]

We go through this literally every year. I'm moderate with the amount I take. My hemoglobin A1C levels are in the mid-5 range.

**[00:31:56] Jane:** Good.

**[00:31:56] Dr. Mitch:** 5.5, 5.6, which I think is really healthy because even pre-diabetes, which is hemoglobin A1C levels in the 6s, increases your risk of dementia by about 50%. You're over 7, and now you're talking about a doubling of your risk. A lot of cardiac stuff is really related. Diabetes is actually, in addition to being a metabolic disorder, is also a cardiac-affecting illness.

**[00:32:24] Jane:** I went on it. I take it every day and a half for the last couple of years for the same reason that you do. I have a similar reaction sometimes in a doctor's office. "You have diabetes?" No. I took it because my insulin and glucose, my hemoglobin A1C, those were all fine. My HOMA-IR was off. HOMA-IR is insulin plus glucose divided by 400-something, and I'm not exactly sure what that number is.

You want that number to be under 2. If it's not under 2, it shows that your body is trying to process the sugars correctly, but it's not succeeding. Mine was like a 3. That was, to my doctor that put me on it, was a red flag that said, "You know what? You look like you're okay, but you're really not."

**[00:33:06] Dr. Mitch:** [laughs]

**[00:33:07] Jane:** If you want cognitive health, you need to consider doing this. It was a good decision.

**[00:33:12] Dr. Mitch:** I think it's really important to have a doctor who pays attention to the research. See, one of the things with dementia is there are no dementiologists. Pretty crazy idea when you think about it. There's no dementiologists. You have neurologists who do some dementia as part of their practice, but they also take care of people for seizures and strokes, multiple sclerosis.

You have psychiatrists, like Emily, who do dementia work, but psychiatrists also do depression, anxiety, bipolar disorder, schizophrenia, OCD. You've got neuropsychologists like me who measure cognitive function and are in a position to recommend a lot of things. They won't let me order a blood test or a scan. They won't let me prescribe a medication in Massachusetts where I practice.

You've got endocrinologists who are really up to date on things like diabetes, which influences this, but they don't even think about dementia. Sleep medicine, there's some of the people who pay a little bit of attention to it, but not a lot. Exercise physiologists who are off in a different place. Cardiologists, you've got all these different ologists. Where are the dementiologists? That's the question.

**[00:34:24] Jane:** Right before we're headed into such a big epidemic of dementia, we're missing the boat. You're right.

**[00:34:31] Dr. Mitch:** We need to redefine this area, and probably create a subspecialty of either internal medicine or geriatrics, although I think maybe internal medicine, because I want people to start before they're in the geriatricians' age group. I want them to start in their 20s, their 30s, their 40s, because the earlier you start, the more effective you're going to be in the long run.

Just by doing things like controlling cholesterol, you're much more effective as you're managing your lipids better in your 20s and 30s, and continue, than if you start in your 50s and 60s. While you can catch up to some extent, and it's never too late to start, it's always better to start earlier.

**[00:35:18] Jane:** Convincing people in that earlier decade, 30s to 40s, I have a son in that demographic, and I don't think he's especially interested right now. It doesn't seem like something he needs to worry about. "Mom, thank you very much." That is the age they should start thinking about it.

**[00:35:34] Dr. Mitch:** They should. If they have a parent or a grandparent who's had dementia, you're starting to see them be a little more concerned because they've seen it up close and personal. Anyone I've seen who's a child of someone like myself, my mom had dementia.

**[00:35:50] Jane:** She did?

**[00:35:51] Dr. Mitch:** She did. Despite all I knew about it and had practiced for years and years before she had it, there was only so much I could do once it began. I knew a lot less than I know now. Part of the reason why we wrote the book is because I want other people to avoid becoming like Muriel, like my mom. I certainly don't want my kids to end up being like I had to be in taking care of her.

There's a real personal mission to this, as well as a scholarly and professional mission. Thank goodness, they all come together. There are things we can do if we really take a look at it.

**[00:36:31] Jane:** Very well put. My parents both passed with Alzheimer's, and I'm doing this because of them. It could have been prevented. You, in many ways, are doing the same thing. Look how many people you've helped, Mitch. 30,000 people have come through your practice.

**[00:36:45] Dr. Mitch:** Yes, it's an amazing number.

**[00:36:47] Jane:** It is.

**[00:36:49] Dr. Mitch:** [laughs] I look back and think, "Wow."

**[00:36:50] Jane:** [chuckles] Is there anything else that you would like to talk about before we call it a day?

**[00:36:57] Dr. Mitch:** I'd like people to know that if they go up to our website, [braindoc.com](http://braindoc.com), that there is a free downloadable dementia prevention checklist that they could fill out to give themselves an idea of where they are, in terms of their own status, where they're on target, where they're near target, and where, unfortunately, they have work to do because they're off target.

This is a way of taking an inventory because the more you know about what the real factors are, the more then you're able to make a difference. Also, I'd like them to know that even if they can't afford our book, it is available in a couple hundred libraries around the country. If you can't get it in your library, your library could probably borrow it from another library.

There's no reason for not taking the time to read it, or to download the audiobook and listen to it, so you can figure out where you are. I mean, we don't know the essence of everything. I don't pretend to. I think that there's more real information translated for people, so that they can feel like they're actually having a conversation with us. That's the idea. Take the real science, translate it into terms that people understand, and then give them tools to be able to make a change. That's where it's critical.

**[00:38:19] Jane:** The book is *Dementia Prevention: Using Your Head to Save Your Brain*. Dr. Clionsky, where can folks get a hold of you?

**[00:38:28] Dr. Mitch:** Braindoc.com is the easiest way. There's a link if someone wants to send us a question. There's a link to do that. If they just want to read about it. There's a lot of different-- There's a bunch of other podcasts. Most of them are not as good as this one, I'll tell you.

**[00:38:43] Jane:** Oh, bless you. Thank you very much.

**[00:38:45] Dr. Mitch:** There's a lot of them on there because I really feel like it's important for people to understand and to have access to this information.

**[00:38:54] Jane:** It is. This has been such a joy. Thank you for your time.

**[00:38:58] Dr. Mitch:** It's been my pleasure.

**[00:39:00] Jane:** Oh, have a great day.

[music]

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**[00:39:38] [END OF AUDIO]**

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