EDITORIAL

Alzheimer's Disease Across the Life Course: The Earlier You Know, the More You Can Do

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Cite this article: Abdolrahmani M, Shomoossi N. Alzheimer's Disease Across the Life Course: The Earlier You Know, the More You Can Do. Int Rev Lifestyle Med. 2026;1(2):1-7.
https://doi.org/10.22034/irlm.2026.604264.1020

Article history
Received: 29 Aug 2026
Revised: 24 Sep 2026
Accepted: 01 Oct 2026

Abstract

Background and Objective: World Alzheimer's Month 2026 emphasizes the earlier recognition of Alzheimer's disease to enable timely clinical action, planning and support. This progressive neurodegenerative disorder is the most common cause of dementia. This editorial intends to overview current evidence on early diagnosis, and life-course strategies for risk reduction and multidimensional care.

Methods: The present review relies on peer-reviewed literature, international guidelines, and commission reports on Alzheimer's disease epidemiology, diagnosis, risk reduction, and major care models such as the 2024 Lancet Commission on dementia prevention, intervention, and care and World Alzheimer's Month 2026 campaign materials.

Results: The 2024 Lancet Commission identifies 14 modifiable risk factors across the life course, including limited education, hypertension, hearing loss, smoking, obesity, depression, physical inactivity, diabetes, traumatic brain injury, excessive alcohol use, social isolation, air pollution, untreated vision loss, and elevated LDL cholesterol; addressing them could prevent or delay approximately 45% of dementia cases globally. Early clinical evaluation facilitates accurate diagnosis, exclusion of reversible causes, access to therapies, and person-centered care planning. Effective management integrates pharmacological and non-pharmacological interventions, caregiver support, and attention to social determinants of health.

Conclusion: Public communication should promote awareness without encouraging indiscriminate screening or therapeutic nihilism. Health systems must ensure equitable access to assessment, support, and resources. Implementing evidence-informed and equitable strategies can reduce risk, minimize stigma, and sustain the dignity of people living with dementia.

Keywords: Alzheimer's Disease; Dementia; Early Diagnosis; Risk Factors; Life Course.

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Introduction

World Alzheimer's Month 2026 places a necessary proposition at the center of public and professional discourse: "The Earlier You Know, The More You Can Do: A Dementia Diagnosis Matters" (1). The statement is not merely a campaign slogan. It is a clinical, ethical and public-health argument for replacing silence with recognition, stigma with accurate information, and late crisis management with timely assessment and planned support. Alzheimer's disease is not an inevitable expression of ageing, nor is it a condition that concerns only the oldest members of society. It is a progressive brain disease whose biological processes may begin years before dementia becomes clinically apparent, while its consequences extend to patients, families, health professionals, social-care systems and communities (2, 3).

The editorial case for earlier knowledge must, however, be made carefully. Awareness should not become indiscriminate screening, premature labelling or the suggestion that individual lifestyle choices can fully control a biologically complex disease. Rather, the public needs a balanced message: persistent cognitive or behavioral change warrants professional evaluation; diagnosis can open access to treatment, planning and support; and health-promoting behaviors across the life course may reduce risk or delay disability, even when they cannot guarantee prevention. In this sense, World Alzheimer's Month is an opportunity to connect neuroscience with everyday health, and individual care with social responsibility.

A disease with a long course

Alzheimer's disease is the most common cause of dementia. Dementia is a clinical syndrome involving decline in cognitive abilities severe enough to interfere with daily functioning; Alzheimer's disease is a specific neurodegenerative disease that commonly causes that syndrome. The pathological process is associated with abnormal amyloid-β and tau biology, synaptic dysfunction, neuronal injury and progressive loss of brain networks. Yet biology, symptoms and functional consequences do not emerge simultaneously. The disease continuum may include a preclinical phase, a prodromal phase often represented by mild cognitive impairment, and a dementia phase with increasing loss of independence (2, 4).

Alzheimer's disease is also heterogeneous in age at onset. Alzheimer's disease with onset before age 65 years is commonly described as early-onset Alzheimer's disease (EOAD), whereas onset at 65 years or older is generally described as late-onset Alzheimer's disease (LOAD). EOAD accounts for a minority of Alzheimer's cases but can present with atypical cognitive or behavioral phenotypes and has distinct implications for diagnosis, family planning, employment and psychosocial support (5).

The relationship between these pathologies and clinical expression is not symmetrical. Amyloid accumulation is an early feature of the Alzheimer's biological continuum, whereas tau pathology, particularly its neocortical spread, tracks more closely with neurodegeneration and clinical severity. The 2024 Alzheimer's Association criteria distinguish early-changing phosphorylated tau biomarkers from later-changing tau PET and other tau measures, emphasizing that different tau biomarkers carry different diagnostic and prognostic information. Thus, a positive amyloid biomarker should not be interpreted as equivalent to evidence of advanced tau-mediated neurodegeneration (4, 6).

The duration of these stages varies substantially according to age, sex, genetic factors including APOE genotype, comorbidity and other individual characteristics (2). This variability matters clinically: a person with subtle memory

concerns may remain functionally independent for years, while another may deteriorate more rapidly. It also matters socially, because a diagnosis should initiate an individualized conversation rather than impose a predetermined timeline. Alzheimer's disease is a medical condition, but the experience of living with it is shaped by relationships, housing, income, education, culture, health-care access and the availability of trained caregivers.

Pathological change may begin 15–20 years before symptoms, yet amyloid positivity in a cognitively unimpaired person is a risk state, not a certainty of future dementia. Current debate over whether such individuals should be described as having Alzheimer's disease has direct consequences for how "earlier knowledge" is communicated. The campaign's message is best understood as timely diagnosis of symptomatic people, not biomarker testing of the asymptomatic public (2, 7, 8)

The global burden is expected to increase as populations age. In the United States alone, an estimated 7.4 million adults aged 65 years or older were living with clinical Alzheimer's dementia in 2026, although estimates differ according to diagnostic definitions and methods (3). Globally, approximately 57 million people were living with dementia in 2021, more than 60% of them in low- and middle-income countries, with nearly 10 million new cases each year (7). Population ageing can increase the absolute number of affected people even when age-specific incidence declines. Historical reductions in some dementia incidence rates have been associated with improved education and better prevention or treatment of vascular risk factors, illustrating why population health and brain health cannot be separated (3, 7).

Recognizing change without panic

The earliest clinically meaningful signs are often gradual and easy to rationalize. Repeated questions, difficulty retaining recent conversations, missed appointments, problems managing finances or medications, getting lost in familiar settings, and difficulty completing previously familiar tasks should not automatically be attributed to normal ageing. Changes in language, judgement, mood, sleep, personality or social engagement may also be relevant. Subjective cognitive decline (i.e., the person's perception that memory or thinking is worsening) can be an early signal, but it can also arise from depression, anxiety, sleep disorders, medication effects or other treatable conditions (3).

This is why awareness must be paired with assessment, not self-diagnosis. A clinical evaluation may include a history from the individual and someone who knows them well, cognitive testing, neurological examination, medication review, laboratory investigations and, when indicated, structural or molecular imaging. The purpose is not only to determine whether Alzheimer's disease is present, but also to identify reversible or contributing conditions and distinguish it from other causes of cognitive impairment. Persistent symptoms that affect daily life should prompt a conversation with a qualified health professional. Blood-based biomarkers, particularly plasma p-tau217, are beginning to make biological confirmation more accessible, although they are intended to support rather than replace clinical evaluation in symptomatic people (6, 9).

The 2026 campaign's emphasis on diagnosis is particularly important because underdiagnosis is common, especially when symptoms are mild. Delayed recognition can postpone access to treatment and supportive services, reduce the time available for care planning, and increase the likelihood that decisions will be made during a crisis (3). Earlier knowledge can help individuals express preferences, review finances and legal arrangements, address driving and medication safety, organize family responsibilities, and connect with community

resources while the person can still participate meaningfully in decisions.

Earlier diagnosis should nevertheless be accompanied by psychological and social support. A large English case-control study found no significant increase in suicide risk across people with dementia overall, but identified substantially higher risk among people diagnosed before age 65 years and during the first three months after diagnosis; the highest relative risk occurred in those diagnosed before 65 and within three months of diagnosis. These findings do not establish that the diagnosis itself causes suicidal behavior, but they indicate that timely diagnosis should be coupled with attention to psychological wellbeing and suicide-risk assessment in vulnerable groups (10).

Diagnosis should therefore be communicated as information that enables action, not as a verdict that erases identity. People living with Alzheimer's disease continue to have preferences, emotions, relationships, histories and capacities. The language used by clinicians, families and the media can either reinforce stigma or support dignity. Public education should correct the myth that dementia is simply "senility," while avoiding another harmful misconception: that a diagnosis means there is nothing useful left to do.

Lifestyle across the life course

A lifestyle-oriented approach to Alzheimer's disease begins long before old age. The 2024 Lancet Commission identified 14 potentially modifiable risk factors across the life course: lower educational attainment in early life; hearing loss, high LDL cholesterol, depression, traumatic brain injury, physical inactivity, diabetes, smoking, hypertension, obesity and excessive alcohol use in midlife; and social isolation, air pollution and untreated vision loss in later life. Collectively, addressing these factors could theoretically prevent or delay approximately 45% of dementia cases globally, although the estimate is a population-level opportunity rather than a guarantee for any individual (11).

In early life, education and cognitive development contribute to cognitive reserve (i.e., the capacity to tolerate pathology while maintaining function). This does not mean that formal education alone protects everyone, or that people with limited educational opportunities are responsible for later disease. It means that equitable access to high-quality education is a dementia-prevention policy as well as a social good. Lifelong learning, mentally stimulating work and meaningful hobbies may continue to support cognitive resilience, especially when combined with physical and social activity.

Midlife is a critical period for prevention because vascular and metabolic exposures can accumulate silently over decades. Regular measurement and treatment of blood pressure, diabetes and LDL cholesterol, together with smoking cessation, weight management, healthier eating, adequate sleep and reduced harmful alcohol use, should be framed as brain–heart health rather than as a narrow dementia prescription. Physical activity is similarly central: walking, aerobic exercise, resistance training and balance activities can be adapted to age, ability and health status. The goal is sustainable participation, not an unrealistic ideal of perfect behavior. Evidence from multidomain interventions suggests that combining dietary guidance, physical activity, cognitive training and vascular risk monitoring may help maintain cognitive functioning in older adults at increased risk (12).

Head protection deserves greater attention. Traumatic brain injury is associated with later neurological consequences, making seat-belt use, helmet use, fall prevention, occupational safety and sport-specific protection important throughout life (11). Hearing and vision should also be treated as components of cognitive and social health. Untreated

sensory loss can increase communication difficulty, withdrawal and cognitive load; assessment and appropriate aids may help preserve participation and independence.

In later life, prevention and care remain active projects. Social connection, purposeful roles, safe movement, good nutrition, sleep regularity and treatment of depression are relevant even after cognitive symptoms begin. Lifestyle interventions should not be presented as substitutes for clinical care, nor should they be imposed without considering frailty, pain, poverty, cultural preferences or caregiver capacity. The best plan is individualized, achievable and reviewed over time.

Treatment is multidimensional

There is currently no single cure that reverses Alzheimer's disease. Management combines medication, risk-factor treatment, rehabilitation, environmental adaptation, psychosocial support and caregiver education. Symptomatic medicines may be prescribed for selected patients to support cognition or manage associated symptoms, while newer disease-modifying approaches may be considered for appropriate individuals with early Alzheimer's disease under specialist assessment. Cholinesterase inhibitors and memantine may provide modest symptomatic benefit for selected patients. Anti-amyloid monoclonal antibodies, including lecanemab and donanemab, have shown modest slowing of decline in early symptomatic Alzheimer's disease; lecanemab reduced decline on the CDR-SB by approximately 27% over 18 months in CLARITY-AD. These therapies require biomarker confirmation of amyloid pathology, MRI monitoring for amyloid-related imaging abnormalities (ARIA), and careful consideration of APOE ε4 status, which increases ARIA risk (10, 13). Because eligibility is limited to the earliest symptomatic stages, delayed diagnosis can mean lost access to these options. Treatment decisions require discussion of diagnostic certainty, expected benefit, adverse effects, comorbidities, monitoring requirements, cost and the patient's values. Public communication should resist both therapeutic nihilism and exaggerated promises. Treatment decisions require discussion of diagnostic certainty, expected benefit, adverse effects, comorbidities, monitoring requirements, cost and the patient's values. Public communication should resist both therapeutic nihilism and exaggerated promises.

Non-pharmacological interventions are not secondary to "real" treatment. Cognitive stimulation, occupational therapy, structured routines, physical activity, social engagement, sleep support, communication strategies and meaningful activities can improve daily functioning and quality of life. Management of pain, constipation, infection, sensory impairment and medication burden may prevent avoidable distress. A familiar environment, clear communication and opportunities for choice can reduce confusion and support autonomy.

Behavioral and psychological symptoms (including anxiety, depression, agitation, apathy, sleep disturbance and resistance to care) should be understood as clinical experiences and possible forms of communication. Before using medication, clinicians and caregivers should consider unmet needs such as pain, fear, overstimulation, loneliness, hunger, fatigue or an unfamiliar environment. Medication may sometimes be necessary, but it should be prescribed cautiously, monitored and integrated into a broader person-centered plan.

Mental health must be considered for both the patient and the caregiver. A person with Alzheimer's disease may experience grief, fear, frustration and loss of confidence, particularly when they recognize changes in their abilities. Preserving routine, respect, social contact and opportunities for participation can protect emotional

wellbeing. Caregivers may face chronic stress, sleep disruption, depression, financial strain and anticipatory grief. Asking about caregiver wellbeing, offering respite and involving family members in education are clinical necessities, not optional courtesies. Dementia-care recommendations emphasize person-centered, coordinated support that attends to safety, function, communication, quality of life and the needs of care partners (7, 14).

From awareness to implementation

The most effective World Alzheimer's Day message is not simply "learn the symptoms." It is "learn, notice, ask, assess, plan and support." Families should be encouraged to document changes, accompany a relative to an appointment when appropriate, bring a medication list, and ask what investigations and follow-up are needed. Clinicians should create environments in which cognitive concerns can be raised without humiliation, and health systems should make assessment and post-diagnostic support accessible beyond specialist centers.

Public health communication must also address social determinants. Education, income, housing, transport, neighborhood safety, air quality, access to nutritious food, social inclusion and health-care availability influence the feasibility of healthy choices and timely diagnosis. A prevention message that ignores these conditions risks widening inequalities by placing responsibility solely on individuals. Brain-health policy should therefore combine clinical services with tobacco control, cardiovascular prevention, injury prevention, sensory-health programs, educational opportunity, age-friendly communities and caregiver support.

Researchers and journals have a complementary responsibility. Studies should report outcomes that matter to patients and families, including quality of life, independence, caregiver burden, equity and implementation feasibility. Research on risk reduction should communicate uncertainty honestly and avoid implying that association proves individual prevention. Digital tools, biomarkers and emerging treatments are valuable, but they must be evaluated for accessibility, safety, cultural validity and real-world benefit.

Conclusion

Alzheimer's disease will remain a major challenge for medicine and society, but inevitability is not the appropriate public narrative. The life-course evidence supports action at multiple stages: invest in education, protect hearing and vision, prevent head injury, move regularly, control vascular and metabolic risks, avoid tobacco, moderate alcohol, treat depression, maintain social connection and seek medical advice when cognitive changes persist. These actions benefit overall health even when they do not prevent Alzheimer's disease.

The theme of World Alzheimer's Month 2026 asks us to understand diagnosis as a gateway to possibility. Earlier knowledge can help a person and family access appropriate treatment, plan care, reduce avoidable crises and replace blame with compassion. It can help professionals see the whole patient rather than a list of deficits, and it can help communities build services around dignity rather than exclusion.

The central task is not to promise a world without Alzheimer's disease. It is to create a world in which risk is reduced where possible, symptoms are recognized without stigma, diagnosis is timely and accurate, treatment is multidimensional, caregivers are supported, and people living with dementia remain visible members of society. The earlier we know, the more we can do; but what we do must be evidence-informed, equitable and humane.

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