Emerging role of vascular burden in AT(N) classification in individuals with Alzheimer’s and concomitant cerebrovascular burdens

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ABSTRACT

Objectives Alzheimer’s disease (AD) is characterised by amyloid-beta accumulation (A), tau aggregation (T) and neurodegeneration (N). Vascular (V) burden has been found concomitantly with AD pathology and has synergistic effects on cognitive decline with AD biomarkers. We determined whether cognitive trajectories of AT(N) categories differed according to vascular (V) burden.

Methods We prospectively recruited 205 participants and classified them into groups based on the AT(N) system using neuroimaging markers. Abnormal V markers were identified based on the presence of severe white matter hyperintensities.

Results In A+ category, compared with the frequency of Alzheimer’s pathological change category (A+T–), the frequency of AD category (A+T+) was significantly lower in V+ group (31.8%) than in V– group (64.4%) (p=0.004). Each AT(N) biomarker was predictive of cognitive decline in the V+ group as well as in the V– group (p<0.001). Additionally, the V+ group showed more severe cognitive trajectories than the V– group in the non-Alzheimer’s pathological changes (A–T+, A–N+; p=0.002) and Alzheimer’s pathological changes (p<0.001) categories.

Conclusion The distribution and longitudinal outcomes of AT(N) system differed according to vascular burdens, suggesting the importance of incorporating a V biomarker into the AT(N) system.

WHAT IS ALREADY KNOWN ON THIS TOPIC

⇒ Cerebral small vessel disease vascular (V), which is one of most important cause of cognitive impairments, has an additive or synergistic effect on cognitive impairments with Alzheimer’s disease (AD) markers.

WHAT THIS STUDY ADDS

⇒ Our study indicated that the distribution of AT(N) classification varied depending on the presence of V, and cognitive decline trajectories of the AT(N) system were more exacerbated in the presence of V.

HOW THIS STUDY MIGHT AFFECT RESEARCH, PRACTICE OR POLICY

⇒ Our findings suggest the possibility that the V biomarker could be incorporated into the AT(N) system. Combination therapies targeting both V and AD burdens may more effectively preserve clinical functions than single-target therapies in clinical practice.

INTRODUCTION

Based on Alzheimer’s disease (AD) pathological features, which can be assessed using β-amyloid (Aβ) accumulation (A), tau (T) and neurodegeneration (N) biomarkers, the National Institute on Aging-Alzheimer’s Association (NIA-AA) proposed the AT(N) classification system.1 Each of the AT(N) biomarkers could be binarised into normal/abnormal (−/+), resulting in eight possible biomarker profiles, which are then grouped into four possible biomarker categories: normal AD biomarker (A–T–N–), Alzheimer’s pathological change (A+T–N– and A+T+N–), AD (A+T+N– and A+T+N+) and non-Alzheimer’s pathological change (A–T–N+ and A–T+N– and A–T+N+). If the
effects of new categories on AD pathophysiology might be demonstrated, the AT(N) system could evolve by the addition of new categories (the X component of ATX(N)) to the existing AT(N) system.2–4

AD is a heterogeneous disease with multiple contributors to its pathophysiology, including vascular dysfunction. Previous pathological studies have shown that concomitant cerebral small vessel disease (CSVD) burden is often found in participants with AD pathology.2–4 The presence of CSVD burden is also associated with impaired cognitive performance.6–8 Furthermore, CSVD burden correlates with Aβ (A) in the posterior region8 and tau (A) in the inferior temporal region.9 Eventually, our previous studies suggested that CSVD and Alzheimer’s burdens synergistically affected the cognitive impairments.2–4

In this study, we applied the AT(N) system to individuals with Alzheimer’s and concomitant CSVD burdens. First, we determined whether participants with significant CSVD burden (V+
group) could be categorised using the AT(N) system. We also investigated whether AT(N) biomarkers might be predictive of cognitive decline in the V+ group as well as in the V− group. Finally, we determined whether cognitive decline trajectories among each AT(N) category based on biomarker profiles might be more prominent in the V+ group than in the V− group.

METHODS

Study participants

We prospectively recruited 210 participants who visited the memory clinic of the Samsung Medical Center (SMC) in South Korea and underwent tau (18F-flortaucipir (FTP)) positron emission tomography (PET) scans between May 2015 and December 2021. All participants underwent neuropsychological tests, brain MRI and Aβ (18F-florbetaben (FBB) or 18F-flutemetamol (FMMI)) PET scans. They were classified using the syndromal cognitive staging proposed by the NIA-AA Research Framework as cognitively unimpaired (CU), mild cognitive impairment (MCI) and dementia.1 CU individuals met the following criteria: (1) no medical history that is likely to affect cognitive function based on Christensen’s health screening criteria10 and (2) no objective cognitive impairment from a comprehensive neuropsychological test battery in any cognitive domains (above the −1.0 SD of age-matched and education-matched norms in memory and −1.5 SD in other cognitive domains).13 All participants with MCI met the following criteria: (1) subjective cognitive complaints by the participants or caregiver; (2) objective cognitive impairment in any cognitive domain (below −1.0 SD of age-matched and education-matched norms in memory and −1.5 SD in other cognitive domains); (3) no significant impairment in activities of daily living and (4) no dementia. The participants with dementia met the NIA-AA criteria.13

We excluded participants who had any of the following conditions: (1) white matter hyperintensities (WMH) due to aetiology other than vascular pathology, including radiation injury, multiple sclerosis, vasculitis, leukodystrophy or metabolic disorders; (2) traumatic brain injury; (3) territorial infarction; (4) brain tumour and (5) rapidly progressive dementia.

Amyloid PET imaging acquisition, analysis and Centiloid values

All participants underwent either FBB or FMM PET at SMC using a Discovery STE PET/CT scanner (GE Medical Systems, Milwaukee, Wisconsin, USA) in the three-dimensional (3D) scanning mode that examined 47 slices of 3.3 mm thickness spanning the entire brain.14 The detailed imaging acquisition protocols are described in online supplemental method 1.

PET images were coregistered on individual 3D-T1-weighted MR images that were normalised to the T1-weighted MNI-152 template using Statistical Parametric Mapping (SPM) 8. Specifically, Aβ uptakes were quantified using BeauBrain Morph of BeauBrain Healthcare, which performs fully automated image analysis of Aβ uptakes on PET images. The detailed imaging acquisition protocols and conversion equations of the standardised uptake value ratio (SUVR) into a direct comparison of Centiloid units (dcCL) are described in online supplemental method 2.

To obtain the dcCL cut-off value for Aβ positivity, we performed receiver operating characteristic (ROC) analysis using Aβ positivity based on the SUVR cut-off for each PET scan as the standard of truth. We defined Aβ positivity (A+) according to the cut-off value of the FBB or FMM PET global dcCL, which was previously computed as 25.11.15

Tau PET imaging acquisition and analysis

All FTP PET images were acquired using a Discovery STE PET/CT scanner (GE Healthcare) at the SMC (n=109) and a Biograph mCT PET/CT scanner (Siemens Medical Solutions) at Gangnam Severance Hospital (n=97). The detailed protocols are described in online supplemental method 3.

The FTP PET images were coregistered onto individual MR images using SPM V.12. For the regional SUVR analysis, we used FreeSurfer V.6.0 (http://surfer.nmr.mgh.harvard.edu) to delineate the region of interest (ROI) masks in the native space. The detailed methods are presented in online supplemental method 4. We excluded two patients because of segmentation errors during the FTP analysis.

To obtain the FTP SUVR positivity cut-off value, we performed ROC analysis as an analytical method. FTP SUVR using Braak III/IV ROI (Braak III: parahippocampal, fusiform, lingual gyrus, amygdala; Braak IV: inferior temporal cortex, middle temporal cortex, temporal pole, thalamus, caudal, rostral, isthmus, posterior cingulate, insula) was used to predict the classification of Aβ− CU (n=14) and Aβ+ AD dementia (n=53). We defined tau positivity (T+) when the FTP SUVR at Braak III/IV ROI was higher than the cut-off of 1.406.

Brain MRI acquisition

All participants underwent 3D-T1 turbo field echo images and 3D fluid-attenuated inversion recovery (FLAIR) at SMC using a 3.0T MRI scanner (Philips 3.0T Achieva; Philips Healthcare, Andover, Massachusetts, USA), as previously described.16

Measurement of hippocampal volume

We defined (N) using HV on brain MRI. Hippocampal atrophy is a well-established (N) biomarker of AD,17 which was proposed by the NIA-AA and the National Institute of Neurological Disorders and Stroke-Alzheimer Disease and Related Disorders working groups for research criteria for the diagnosis of AD.18–20

The images were processed using the CIVET anatomical pipeline (V2.1.0).21 Native MRIs were registered to the MNI-152 template by linear transformation22 and corrected for intensity non-uniformity using the N3 algorithm.23 The detailed methods for adjusted HV (HVa) measurements are available in online supplemental method 5. We excluded one patient because of a segmentation error during HV measurement. Therefore, the final study sample consisted of 205 participants.

To develop the cut-off for HV, we applied machine learning K-means clustering methods, which have been widely used in previous studies24 25 due to its efficiency and simplicity.26 The detailed methods are available in online supplemental method 6. As the K-means revealed a cut-off value of −0.363 cm³, HVs below the cut-off was defined as abnormal (N+).

Assessment of CSVD scores

The WMH visual rating scale proposed by the Clinical Research Center for Dementia of South Korea was used to investigate WMH in the deep subcortical and periventricular regions on FLAIR images.27 28 Details of measurement of WMH volume and rating of lacunes and microbleeds are described in online supplemental method 7.

We defined V+ as severe levels of WMH visual rating scales based on our classification system for ischaemia.19 This classification system distinguished the presence of vascular risk factors (hypertension, diabetes and history of stroke) and the severity of CSVD markers including WMH volume, number of lacunes and
Table 1 Baseline characteristics of participants according to AT(N) category and CSVD burden

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>Normal AD biomarker</th>
<th>Non-Alzheimer’s pathological change</th>
<th>Alzheimer’s pathological change</th>
<th>AD</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>V−</td>
<td>V+</td>
<td>V−</td>
<td>V+</td>
</tr>
<tr>
<td>No</td>
<td>205</td>
<td>21</td>
<td>12</td>
<td>15</td>
<td>17</td>
</tr>
<tr>
<td>Age, years, mean (SD)</td>
<td>74.1±8.6</td>
<td>73.4±5.2</td>
<td>70.2±6.5</td>
<td>78.1±7.8</td>
<td>80.0±5.5</td>
</tr>
<tr>
<td>Sex, female, n (%)</td>
<td>129</td>
<td>15</td>
<td>5</td>
<td>9 (60.0)</td>
<td>14 (82.4)</td>
</tr>
<tr>
<td>Education, years, mean (SD)</td>
<td>10.2±5.3</td>
<td>10.7±5.8</td>
<td>6.1±5.5</td>
<td>9.1±6.2</td>
<td>9.7±5.0</td>
</tr>
<tr>
<td>ε4 carrier, n (%)</td>
<td>89</td>
<td>4 (19.0)</td>
<td>4 (33.3)</td>
<td>7 (46.7)</td>
<td>3 (17.6)</td>
</tr>
<tr>
<td>HV volume (mm³), mean (SD)</td>
<td>2424.1±582.3</td>
<td>2978.7±330.6</td>
<td>3180.8±428.7</td>
<td>2174.3±522.2</td>
<td>2240.2±443.3</td>
</tr>
<tr>
<td>WMH volume (mm³), mean (SD)</td>
<td>21 923±23648.2</td>
<td>54 915.8±21601.9</td>
<td>58 084±3 17443.7</td>
<td>12 297.6±11 221.2</td>
<td>848±3299.2</td>
</tr>
<tr>
<td>Baseline CDR-SOB, median (IQR)</td>
<td>2.0±0.5</td>
<td>0.5 (0.5–0.5)</td>
<td>1.5 (0.5–1.5)</td>
<td>1.7 (0.5–3.5)</td>
<td>1.5 (0.5–2.0)</td>
</tr>
</tbody>
</table>

To compare the distributions of the AT(N) framework according to the V biomarker, the Chi-squared test was used for categorical variables and the Kruskal-Wallis test was used for continuous variables. The alpha level was set at 0.05 for all statistical tests. The results suggest that participants with V biomarker have more severe cognitive impairment. We also observed a significant interaction effect between V biomarker and time interval, indicating that V biomarker affects longitudinal CDR-SOB scores, which are useful for determining staging severity and widely used in clinical trials of AD modifying agents. For the follow-up observation, we used clinical dementia rating sum of box (CDR-SOB) scores, which are useful for determining staging severity and widely used in clinical trials of AD modifying agents.
To investigate the multiple CSVD markers including WMH volume, number of lacunes and number of microbleeds on longitudinal cognitive changes, separate LME models were performed for each of the CSVD markers. Specifically, we analyzed the equation of the LME model for each CSVD marker within the four AT(N) biomarker categories as follows:

\[
\text{CDR-SOB} = \text{age} + \text{sex} + \text{education} + A\beta + \text{dcCL} + \text{FTP SUVR} + \text{Braak III/IV ROI} + \text{HV CSVD marker} + (t) + \text{CSVD marker} \times (t).
\]

Statistical analyses were conducted using STATA V.15 (StataCorp), and a \( p < 0.05 \) was considered statistically significant for all analyses.

**RESULTS**

**Study participants**

Detailed characteristics of the 205 participants are described in table 1. The age of the participants was 74.1±8.6 (mean±SD) years, and the proportions of female and apolipoprotein E ε4 carriers were 62.9% and 43.4%, respectively. The frequencies of A+, T+, N+ and V+ were 68.3, 42.0, 64.4 and 24.9%, respectively.

**Figure 1** Distribution of participants according to AT(N) category and CSVD burden in (A) A– and (B) A+ groups. \( p \) values were generated by the \( \chi^2 \) tests for the distribution of AT(N) categories and CSVD burden. A, \( \beta \)-amyloid; AD, Alzheimer’s disease; N, neurodegeneration; V, cerebral small vessel disease.

**Effects of each AT(N) biomarker on cognitive decline in the V– and V+ groups**

In the V– group, the A+, T+ and N+ groups showed steeper increases in CDR-SOB than those in the A– (\( p < 0.001 \)), T– (\( p < 0.001 \)) and N– (\( p < 0.001 \)) groups (figure 2A). In the V+ group, the A+, T+ and N+ groups also showed steeper increases in CDR-SOB than those in the A– (\( p = 0.001 \)), T– (\( p < 0.001 \)) and N– (\( p < 0.001 \)) groups (figure 2B).

In both the V– and V+ groups, the A+ and T+ groups showed worse performances in visuospatial, language, memory and frontal/executive domains than those in the A– (\( p < 0.05 \) for all comparisons) and T– (\( p < 0.05 \) for all comparisons) groups (online supplemental table 1).

**Effects of V biomarker on cognitive decline in AT(N) categories**

**Figure 3** shows the effects of the V biomarker on CDR-SOB changes in AT(N) categories. The V biomarker had effects on CDR-SOB changes in the non-Alzheimer’s pathological change category (\( p < 0.001 \)) and Alzheimer’s pathological change category (\( p < 0.001 \)). That is, in the non-Alzheimer’s pathological change and Alzheimer’s pathological change categories, cognitive decline developed over time, and their impact was higher in the V+ group than in the V– group. In the AD category, the V+ group tended to show a faster decline in CDR-SOB than the V– group, but the difference was insignificant (\( p = 0.137 \)).

The V biomarker had effects on changes of visuospatial and memory functions in the non-Alzheimer’s pathological change and the Alzheimer’s pathological change categories (\( p < 0.05 \) for all comparisons) and changes of memory function in the AD category (\( p = 0.008 \)) (online supplemental table 2).

The WMH volume (continuous variable) affected on CDR-SOB changes over time in the non-Alzheimer’s pathological change category (\( p = 0.047 \)) and Alzheimer’s pathological change category (\( p = 0.001 \)) (online supplemental table 3).
DISCUSSION

In this study, we applied the AT(N) system to a prospectively designed cohort of participants with Alzheimer’s and concomitant CSVD burdens. These participants underwent non-invasive Aβ and tau PET imaging and structural MRI to assess AT(N) biomarkers. Our major findings were as follows: First, within the Alzheimer’s continuum (A+), compared with the frequency of the Alzheimer’s pathological change (A+T−), the frequency of AD (A+T+) was lower in the V+ group than in the V− group. Second, each AT(N) biomarker independently acted as a predictor of cognitive decline in the V+ group as well as in the V− group, showing the prognostic value of the AT(N) system in the V+ group. Finally, cognitive decline trajectories of Alzheimer’s pathological change (A+T−) were exacerbated in the V+ group. Taken together, our findings suggest that CSVD burden might influence the earlier stages of Alzheimer’s pathophysiology, synergistically contributing to the development of cognitive decline. Furthermore, this study suggests the potential of incorporating the V biomarker into the existing AT(N) system in participants with Alzheimer’s and concomitant CSVD burdens.

Figure 2  Distinctive cognitive trajectories according to each AT(N) biomarker in V− (A) and V+ (B) groups. Linear mixed effects models were performed in V− (A) and V+ (B) groups in order to investigate the effects of the presence of A, T or N biomarkers (binarised by each cut-off) on longitudinal cognitive changes over time in V− and V+ groups. Each p value is for two-way interaction term of each pathological burden (presence of A, T or N biomarkers) and time interval on longitudinal cognition changes in V− and V+ groups. A, β-amyloid; CDR-SOB, clinical dementia rating sum of boxes scores; N, neurodegeneration; PET, positron emission tomography; T, tau; V, cerebral small vessel disease.
Our first major finding was that, within the Alzheimer’s continuum, compared with the frequency of Alzheimer’s pathological change, the frequency of AD was lower in the V+ group than in the V− group. Our findings were consistent with the result of a previous study by our group showing that 25% of A+ subcortical vascular cognitive impairment were categorised as A+T+, while 70% of A+AD-related cognitive impairment were categorised as A+T+0.7 Considering that T biomarkers were highly correlated with cognitive impairment, our findings suggest that CSVD burden may have a tau-independent effect on cognitive impairment. In addition, considering that Alzheimer’s pathological change represents the earlier form of the Alzheimer’s continuum than AD, our findings leave the potential that CSVD burdens might have an influence mainly on the earlier stages of Alzheimer’s pathophysiology.

Our second major finding was that each AT(N) biomarker was independently predictive of cognitive decline in the V+ group as well as in the V− group. Recently, there has been emerging evidence for the prognostic value of the AT(N) system.30–32 In this regard, the practical value of the AT(N) system extends from a research framework for diagnosis to prognostic evaluation and therapeutic decision-making. Considering our new findings on the effects of AT(N) biomarkers on cognitive decline in the V+ group, it is reasonable to expect that the AT(N) system can not only have diagnostic added value but also have important relevance for determining the prognosis of cognitive evolution in individuals with Alzheimer’s disease and concomitant V burden. Our results could, therefore, encourage further investigation into the potential of the AT(N) system as a prognostic tool for Alzheimer’s and concomitant non-Alzheimer’s pathologic changes.

Our final major finding was that the cognitive decline trajectories of Alzheimer’s pathological changes were exacerbated in the V+ group. Our findings could be supported by previous findings from our group showing that Aβ deposition and V burden synergistically affect cognitive impairments.22–24 These findings might be related to several hypotheses, including alterations in microvascular integrity, the neuroinflammatory cascade and blood–brain barrier disruption.31–33 However, the whole-group analysis did not show the exacerbation of cognitive decline trajectories of AD in the V+ group. Considering that the effects of V burden on cognitive decline were more prominent in Alzheimer’s pathological change than in AD, it is possible that V burden might have an influence on the earlier stages of Alzheimer’s pathophysiology, synergistically contributing to the development of cognitive decline. Therefore, our findings suggest that combination therapies targeting both V and AD burdens, especially in the earlier process of Alzheimer’s pathophysiology, may more effectively preserve cognitive functions than single-target therapies. Furthermore, we found that, in the non-Alzheimer’s pathological change group, cognitive decline was more prominent in the V+ group than in the V− group.

The NIA-AA research framework suggested the possibility of adding the V biomarker to the existing AT(N) system and expanding AT(N) to the ATV(N) system.4 In order to develop the ATV(N) system, efforts to prove the influence of V biomarker on AT(N) at the multiomics level and to develop and validate new V biomarker are needed. Nonetheless, considering our findings on the effects of V biomarker on the cognitive trajectory of the AT(N) system, we suggest the possibility that the ATV(N) system may enhance the understanding of the heterogeneous pathophysiology and improve the prediction of the prognosis of individuals with Alzheimer’s and concomitant V burdens.

The strength of our study is that participants were recruited using a standardised diagnostic protocol, including Aβ and tau PET and brain MRI, to assess AT(N) biomarkers. However, this study had some limitations. First, we used A and T biomarkers on PET and N and V biomarkers on MRI instead of performing pathological confirmation. Although the system was developed for the categorisation of living individuals, there is a possibility that our participants were misclassified into A, T, V and N biomarker groups. Second, there exist numerous methods for classifying A, T, V and N abnormality, and a consensus within the field remains elusive; however, this limitation might be mitigated by the fact that the method to obtain the cut-off value for each biomarker abnormality has been widely used in other studies.15–17 Third, in terms of the ‘V’ biomarker, we need a clearer definition of V+ to develop the ATV(N) framework. Additionally, there may be alternative definitions, particularly ones that incorporate multiple CSVD markers besides WMH. Nonetheless, we deemed it appropriate to define ‘V+’ using severe WMH since this classification system has been well validated. Fourth, the tau PET data were acquired on two different PET scanners, either at SMC or Gangnam Severance. However, such variability was minimised by analysing the tau PET data centrally at the SMC with a uniform pipeline. Finally, we recruited participants with either a high Aβ burden or a high V burden, which may limit the generalisability to the community-based population. Nevertheless, our findings related to the effects of V burden on cognitive trajectories of AT(N) categories support the importance of interventions targeting both AD and V burden to attenuate disease progression in participants with Alzheimer’s and concomitant V burdens if these treatments become a clinical reality in the future. Our idea of CSVD burden influencing the earlier stages of Alzheimer’s pathophysiology requires further evidence from longitudinal studies examining the cognitive trajectories of V+ and V− individuals as they progress along the Alzheimer’s continuum.
In conclusion, our study showed that the V burden affected the cognitive decline trajectories across the AT(N) system, suggesting the possibility that the V biomarker could be incorporated into the AT(N) system to gain a better understanding of AD pathophysiology and help reduce modifiable risks.

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Contributors MYC, HJ and SWS devised the project and the main conceptual ideas. SHM, JYC, KRIN, B-HB and S-ML led the data collection. SHM, JYC, KRIN, B-HB and S-ML developed the design of methodology. MYC and JPX analyzed the data and investigated the findings of the work. MYC and HJK drafted the manuscript and HJ and SWS reviewed and edited the manuscript. S-ML, MW, CDC and DLN supervised the work. All authors discussed the results and contributed to the final manuscript. HJ and SWS are guarantors.

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Competing interests None declared.

Patient consent for publication Not applicable.

Ethics approval This study involves human participants and this study was approved by the Institutional Review Board of Samsung Medical Center (IRB No: 2018-10-120). Written informed consent for participating in the study and publication was obtained from participants and their caregivers. Participants gave informed consent to participate in the study before taking part.

Provenance and peer review Not commissioned; externally peer reviewed.

Data availability statement Data are available on reasonable request. Data will be made available to qualified investigators on reasonable request to the corresponding authors and approval from the contributing institutions.
Cognitive neurology


Supplementary Methods

Supplementary Method 1. Protocols of amyloid PET imaging acquisition

For amyloid PET imaging acquisition, CT images were acquired using a 16-slice helical CT (140 keV, 80 mA; 3.75mm section width) for attenuation correction. According to the protocols proposed by the ligand manufacturers, a 20-min emission PET scan with dynamic mode (consisting of 4×5 min frames) was performed 90 min after injection of a mean dose of 311.5 MBq of FBB or 185 MBq of FMM. 3D PET images were reconstructed in a 128×128×48 matrix with a voxel size of 2.00×2.00×3.27 mm³ using the ordered-subsets expectation-maximization (OSEM) algorithm (FBB iterations = 4 and subset = 20; FMM iterations = 4 and subset = 20).

Supplementary Method 2. Methods of conversion equations to Centiloid units

In our previous study, we directly converted the standardized uptake value ratio (SUVR) of the FBB or FMM CTX VOI into a direct comparison of Centiloid units (dcCL) using the dcCL conversion equation.¹ Cerebral cortex segmentation was derived from the segmentation method on the SPM8 and automatic anatomical labeling template. The whole-cerebellum mask was downloaded from the Global Alzheimer’s Association Interactive Network website (http://www.gaain.org). No corrections were applied to the PET images for brain atrophy or partial-volume effects. FBB-FMM cortical target region volume of interest-derived SUVR was converted to dcCL with transformation equation derived from previous studies of FBB (dcCL\textsubscript{FBB} = 151.42 × dcSUVR\textsubscript{FBB} − 142.24) and FMM (dcCL\textsubscript{FMM} = 148.52 × dcSUVR\textsubscript{FMM} − 137.09).¹

Supplementary Method 3. Protocols of Tau PET imaging acquisition

FTP PET images were acquired for 20-min at 80 min after intravenous bolus
injections of approximately 280 MBq $^{18}$F-flortaucipir. Three-dimensional PET images were reconstructed in a $128\times128\times47$ matrix with $2.00\times2.00\times3.27$ mm$^3$ voxel size at Samsung Medical Center (SMC) and in a $256\times256\times223$ matrix with $1.591\times1.591\times1.00$ mm$^3$ voxel size at Gangnam Severance Hospital, using the OSEM algorithm (iteration = 6 and subset = 16).

**Supplementary Method 4. Tau PET regional SUVR analysis**

To measure FTP PET regional SUVR, we used FreeSurfer 6.0 (http://surfer.nmr.mgh.harvard.edu) to delineate the region of interest (ROI) masks after coregistration with corresponding MR using SPM12. The cerebellar gray matter was used as the reference region. The region-based voxel-wise correction method was used for partial volume correction and was performed using the PETPVC toolbox for tau PET images. Therefore, we measured the partial volume effect–corrected regional SUVR for the following 25 cortical regions: inferior, middle, and superior frontal; orbitofrontal; paracentral; precentral; inferior and superior parietal; postcentral; precuneus; supramarginal; medial and lateral occipital; lingual; insula; inferior, middle, and superior temporal; fusiform; entorhinal; parahippocampal; anterior and posterior cingulate; amygdala; and hippocampus. Finally, we created bilateral Braak stage ROIs.

**Supplementary Method 5. Measurement of adjusted hippocampal volume**

To measure hippocampal volume (HV), we used an automated hippocampus segmentation method using a graph cut algorithm combined with an atlas-based segmentation and morphological opening as described in an earlier study. We averaged right and left hippocampal volumes and adjusted them for intracranial volume (ICV) by calculating the residual from a linear regression of HV versus intracranial volume among 366 Aβ–cognitively unimpaired (CU) participants in an independent SMC cohort, as in previous
Adjusted HV (HVa) can be interpreted as the deviation in cubic millimeters of a participant’s hippocampal volume from what is expected given their ICV. We excluded one patient because of a segmentation error during hippocampal volume measurement. Therefore, the final study sample consisted of 205 participants.

**Supplementary Method 6. Development of the cutoff for HV**

In order to develop the cutoff for HV, we applied machine learning K-means clustering methods using the HVa of 1,453 participants in an independent SMC imaging registry comprising participants with CU, amnestic mild cognitive impairment, and Alzheimer’s disease (AD) dementia. We restricted our analysis to two clusters. Each participant was assigned a probability of belonging to either Cluster A (low hippocampal volume) or Cluster B (high hippocampal volume). The cut-off value corresponds to the 10th percentile of Cluster B (higher hippocampal volume).

**Supplementary Method 7. Measurement of WMH volume and rating of lacunes and microbleeds**

We quantified white matter hyperintensities (WMH) volume (in mm$^3$) on fluid-attenuated inversion recovery (FLAIR) images using an automated method. Lacunes were defined as small lesions ($\leq 15$ mm and $\geq 3$ mm in diameter) with low signal on T1-weighted images, high signal on T2-weighted images, and a perilesional halo on 80 axial slices of FLAIR images, as proposed by Wardlaw et al. Cerebral microbleeds were defined as lesions $\leq 10$ mm in diameter on 20 T2* GRE-MRI axial slides using criteria proposed by Wardlaw et al.
**Supplementary Method 8.** A standardized neuropsychological test battery

The Seoul Neuropsychological Screening Battery 2nd edition is a standardized neuropsychological battery widely used in South Korea.\(^9\) Five cognitive domains were evaluated: attention (digit span task forward/backward); visuospatial function (Rey-Osterrieth Complex Figure Test (RCFT)); language (the Korean version of the Boston Naming Test); memory (delayed recall scores of the Seoul Verbal Learning Test and RCFT); and frontal/executive function (Controlled oral word association test and Stoop test).
Supplementary References


### Supplementary table 1. Detailed cognitive trajectories according to each AT(N) biomarker in the V− and V+ groups

<table>
<thead>
<tr>
<th>Biomarker</th>
<th>Attention</th>
<th>Language</th>
<th>Visuospatial</th>
<th>Memory</th>
<th>Frontal/executive function</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>V−</td>
<td>V+</td>
<td>V−</td>
<td>V+</td>
<td>V−</td>
</tr>
<tr>
<td>A</td>
<td>-0.071</td>
<td>0.233</td>
<td>-0.105</td>
<td>0.001</td>
<td>-0.489</td>
</tr>
<tr>
<td></td>
<td>0.059</td>
<td>(0.060)</td>
<td>(0.279)</td>
<td>(0.230)</td>
<td>(0.225)</td>
</tr>
<tr>
<td>T</td>
<td>-0.348</td>
<td>-0.261</td>
<td>-2.241</td>
<td>0.001</td>
<td>-2.057</td>
</tr>
<tr>
<td></td>
<td>0.075</td>
<td>(0.112)</td>
<td>(0.356)</td>
<td>(0.427)</td>
<td>(0.278)</td>
</tr>
<tr>
<td>N</td>
<td>0.013</td>
<td>-0.035</td>
<td>-0.829</td>
<td>0.003</td>
<td>-0.209</td>
</tr>
<tr>
<td></td>
<td>0.059</td>
<td>(0.053)</td>
<td>(0.278)</td>
<td>(0.207)</td>
<td>(0.225)</td>
</tr>
</tbody>
</table>

*Effects of each pathologic burden (presence of A, T, or N biomarkers) on longitudinal cognitive changes obtained from linear mixed effects models.

Abbreviations: A, β-amyloid; T, tau; N, neurodegeneration; V, cerebral small vessel disease.
**Supplementary table 2.** Effects of V biomarker on detailed cognitive trajectories in each AT(N) framework category

<table>
<thead>
<tr>
<th></th>
<th>Normal AD biomarker</th>
<th>Non-AD pathologic change</th>
<th>Alzheimer's pathologic change</th>
<th>Alzheimer's disease</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>coefficient</td>
<td>coefficient</td>
<td>coefficient</td>
<td>coefficient</td>
</tr>
<tr>
<td></td>
<td>(standard error)</td>
<td>(standard error)</td>
<td>(standard error)</td>
<td>(standard error)</td>
</tr>
<tr>
<td></td>
<td>p-value</td>
<td>p-value</td>
<td>p-value</td>
<td>p-value</td>
</tr>
<tr>
<td>Attention</td>
<td>-0.093 (0.046)</td>
<td>0.043</td>
<td>-0.156 (0.066)</td>
<td>0.018</td>
</tr>
<tr>
<td>Language</td>
<td>-0.280 (0.157)</td>
<td>0.075</td>
<td>-0.204 (0.254)</td>
<td>0.422</td>
</tr>
<tr>
<td>Visuospatial</td>
<td>0.067 (0.215)</td>
<td>0.755</td>
<td>-0.655 (0.278)</td>
<td>0.018</td>
</tr>
<tr>
<td>Memory</td>
<td>-0.013 (0.203)</td>
<td>0.948</td>
<td>-0.432 (0.192)</td>
<td>0.025</td>
</tr>
<tr>
<td>Frontal/executive function</td>
<td>-1.126 (0.856)</td>
<td>0.188</td>
<td>-1.284 (1.071)</td>
<td>0.231</td>
</tr>
</tbody>
</table>

*aEffects of the presence of V biomarker on longitudinal cognitive changes obtained from linear mixed effects models.

Abbreviations: A, β-amyloid; T, tau; N, neurodegeneration; V, cerebral small vessel disease
**Supplementary table 3.** Effects of different CSVD markers on CDR-SOB changes in each AT(N) category

<table>
<thead>
<tr>
<th></th>
<th>Normal AD biomarker</th>
<th>Non-AD pathologic change</th>
<th>Alzheimer’s pathologic change</th>
<th>Alzheimer's disease</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>coefficient (standard error)</td>
<td>p-value</td>
<td>coefficient (standard error)</td>
<td>p-value</td>
</tr>
<tr>
<td>WMH_volume (mm³)</td>
<td>&lt; 0.001 (&lt; 0.001)</td>
<td>0.156</td>
<td>&lt; 0.001 (&lt; 0.001)</td>
<td>0.047</td>
</tr>
<tr>
<td>Numbers of lacunes</td>
<td>0.010 (0.008)</td>
<td>0.203</td>
<td>0.045 (0.023)</td>
<td>0.504</td>
</tr>
<tr>
<td>Numbers of microbleeds</td>
<td>0.003 (0.002)</td>
<td>0.142</td>
<td>0.009 (0.003)</td>
<td>0.072</td>
</tr>
</tbody>
</table>

*aEffects of the presence of V biomarker on longitudinal cognitive changes obtained from linear mixed effects models.

Abbreviations: AD, Alzheimer's Disease; WMH, white matter hyperintensities.