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The new Alzheimer's drugs: what families need to know

Lecanemab (Leqembi) and donanemab (Kisunla) are the first treatments shown to slow Alzheimer's rather than just ease symptoms. That's genuinely historic. It's also far more modest, and far more restricted, than the headlines suggest.

What they do

Both are monoclonal antibodies given by infusion. They bind to amyloid plaques in the brain and let the immune system clear them. On brain scans the plaques really do disappear. In the pivotal trials, decline over 18 months was slowed by roughly a quarter to a third compared with placebo.

Put in family terms: the person still declines, but may hold on to a stage of independence for a few extra months. Whether that difference is noticeable at the kitchen table — rather than on a rating scale — is honestly still debated among specialists. Be wary of anyone who tells you it's a cure, and equally wary of anyone who tells you it's worthless.

Who can have them

- Early-stage disease only — mild cognitive impairment or mild Alzheimer's dementia. They are not given in moderate or advanced dementia, and there is no evidence they help at that stage.
- Confirmed Alzheimer's biology, via amyloid PET, lumbar puncture or an approved blood biomarker test.
- Genetic testing for APOE4. Two copies of APOE4 carries a much higher risk of brain swelling and bleeding, and many clinicians will advise against treatment.
- No anticoagulants (blood thinners) and no history of significant brain bleeds.

- Someone able to get to an infusion centre every two to four weeks, plus repeat MRI scans throughout the first year.

The risks, plainly

- ARIA — amyloid-related imaging abnormalities: brain swelling or small bleeds. It affects a meaningful minority of people. Most cases cause no symptoms and are picked up on the monitoring MRIs, but a small number are serious and deaths have occurred.
- Infusion reactions — chills, fever, nausea, headache, usually early in treatment.
- The monitoring burden itself: regular MRIs, clinic visits, and the anxiety that goes with them.
- It does not stop the disease. Amyloid is cleared; the person still has Alzheimer's and still declines, just measurably more slowly in trials.

Can you actually get them?

UK

Both have been licensed as safe and effective by the MHRA, but NICE has concluded the benefit is too small for the cost to be funded on the NHS. In practice that means private treatment only, at a cost of tens of thousands of pounds a year once infusions, scans and monitoring are counted — and very few UK centres offer it. Decisions are reviewed periodically, so ask your memory clinic what the current position is.

US

Both are FDA-approved and Medicare covers them for eligible patients when a clinician participates in a registry. Lecanemab now also has a monthly maintenance option and a once-weekly under-the-skin injection route for maintenance dosing. You'll need a neurologist and an infusion centre within reasonable travel distance.

Questions to take to the specialist

1. Is my relative early enough in the disease for this to be considered at all?
2. What's their APOE4 status, and how does that change the risk for them specifically?
3. How many MRIs, over how long, and where would they be done?
4. What would make you stop treatment?

5. If this isn't an option, what clinical trials are recruiting nearby?

The thing that's easy to miss

For the large majority of families reading this, these drugs won't be available or won't be appropriate — and that is not the same as having no options. Treating hearing loss, controlling blood pressure and cholesterol, staying socially connected, exercise, good sleep and reviewing anticholinergic medications all have real evidence behind them, cost little, and can be started this month. That's the next guide.

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General guidance for family carers, not medical advice. Licensing, funding and eligibility change often — confirm current details with the treating clinician.

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