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## **A $\beta$ -related memory decline in *APOE* $\epsilon$ 4 non-carriers: Implications for Alzheimer's disease**

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## Abstract

**Objectives:** As the absence of A $\beta$  related memory decline in apolipoprotein E (*APOE*)  $\epsilon$ 4 non-carriers may be due to the relative brevity of previous studies, we aimed to characterize A $\beta$  related cognitive decline over 72-months in *APOE*  $\epsilon$ 4 carriers and non-carriers who were cognitively normal (CN).

**Methods:** CN older adults (n=423) underwent A $\beta$  imaging, and *APOE* genotyping. Participants completed comprehensive neuropsychological testing at baseline 18-, 36-, 54- and 72-month assessments.

**Results:** Relative to A $\beta$ - CN  $\epsilon$ 4 non-carriers, both A $\beta$ + CN  $\epsilon$ 4 carriers and non-carriers showed significantly increased decline in measures of memory, language, and executive function as well as higher rates of progression to a clinical classification of mild cognitive impairment (MCI). Memory decline was greater in A $\beta$ + CN  $\epsilon$ 4 carriers than in A $\beta$ + CN  $\epsilon$ 4 non-carriers. No cognitive decline was evident in A $\beta$ - CN  $\epsilon$ 4 carriers.

**Conclusions:** In CN older adults, A $\beta$ + is associated with memory decline in  $\epsilon$ 4 non-carriers; however, the rate of this decline is much slower than that observed in  $\epsilon$ 4 carriers. These data indicate that the processes by which  $\epsilon$ 4 carriage increases the rate of A $\beta$ -related cognitive decline occur in the preclinical stage of AD.

## Introduction

In cognitively normal (CN) older adults, both high amyloid ( $A\beta+$ ) and carriage of the apolipoprotein E (*APOE*)  $\epsilon 4$  allele increase risk for cognitive decline and dementia of the Alzheimer's type (DAT),<sup>1-3</sup> although the interaction between  $A\beta+$  and  $\epsilon 4$  carriage in the preclinical stages of AD is not understood. Clinical studies show substantial cognitive decline over 54 months in  $A\beta+$  CN  $\epsilon 4$  carriers, particularly in episodic memory, compared to  $A\beta-$  CN  $\epsilon 4$  non-carriers. However, cognitive decline has not been observed in  $A\beta+$  CN  $\epsilon 4$  non-carriers<sup>4-6</sup> suggesting that in preclinical AD,  $A\beta$  related cognitive decline is delayed in the absence of  $\epsilon 4$ . This hypothesis is consistent with observations from epidemiological studies that in the absence of *APOE*  $\epsilon 4$ , the average age at which dementia is classified clinically is delayed by approximately 8 years.<sup>7, 8</sup> However, the nature and length of any such delay in preclinical AD is unknown.

This study aimed to characterize the rate of  $A\beta$ -related cognitive decline over 72-months in CN older adults who were  $\epsilon 4$  carriers and non-carriers. We hypothesized that compared to  $A\beta-$  CN  $\epsilon 4$  non-carriers and  $A\beta+$  CN  $\epsilon 4$  non-carriers,  $A\beta+$  CN  $\epsilon 4$  carriers would show greater cognitive decline and higher rates of progression to mild cognitive impairment (MCI) over 72-months.

## Methods

### Participants

Cognitively normal (CN) older adults (n=767) volunteered to participate in the Australian Imaging, Biomarkers and Lifestyle (AIBL) Study, for which details of the recruitment and classification of cognitive health has been previously detailed.<sup>9, 10</sup> Briefly, participants were excluded from AIBL if they had a previous confirmed

diagnosis of schizophrenia; Parkinson's disease; sleep apnea; depression (e.g., Geriatric Depression Score [GDS] of 6 or greater); cancer (except basal cell skin carcinoma) in the last two years; symptomatic stroke or uncontrolled diabetes, or current alcohol use exceeded four standard drinks per day for men or two per day for women. This study focused on a sub-sample of CN older adults (n=423) who had undergone A $\beta$  neuroimaging with positron emission tomography (PET) and *APOE* genotyping. The demographic and clinical characteristics of the total and PET subsample are shown and compared in Table 1.

All available neuropsychological, psychiatric and medical information for participants on all assessments were reviewed by an expert clinical panel to determine whether individuals' classification remained as CN or whether they met diagnostic classification for MCI,<sup>11, 12</sup> or AD.<sup>13</sup> Clinical classifications were blinded to data obtained from A $\beta$  imaging at all visits.

#### *Standard Protocol Approvals, Registrations, and Patient Consents*

The AIBL study was approved by the ethics committees of Austin Health, St. Vincent's Health, Hollywood Private Hospital and Edith Cowan University. These institutions also ensured compliance of all study protocols.<sup>9</sup> Informed consent was provided in writing prior to participation in any study procedure.

### **Assessments**

#### *PET neuroimaging and APOE $\epsilon$ 4 genotyping*

PET A $\beta$  imaging was conducted using one of three radioligands, that is, Pittsburgh Compound B (PiB), florbetapir or flutemetamol. The acquisition protocol for each radioligand has been detailed previously.<sup>10, 14, 15</sup> Briefly, a 30-minute acquisition



was started 40 minutes after PiB-injection, and 20-minute acquisitions were performed 50 minutes after florbetapir injection and 90 minutes after flutemetamol injection. For PiB acquisition, standardized uptake value (SUV) data for key regions of interest were summed and normalized to the cerebellar cortex SUV. This resulted in a region-to-cerebellar ratio which was termed SUV ratio (SUVR). For florbetapir, SUVR was generated using the whole cerebellum as the reference region,<sup>16</sup> and for flutemetamol, the pons was used as the reference region. Consistent with previous studies, A $\beta$  status was classified as either low (A $\beta$ -) or high (A $\beta$ +). For PiB, an SUVR threshold  $\geq 1.5$  was used.<sup>10, 15</sup> For florbetapir and flutemetamol, an SUVR threshold of  $\geq 1.1$  and  $\geq 0.62$  were employed to discriminate between A $\beta$ - and A $\beta$ +, in accord with results of phase III studies.<sup>16</sup>

An 80ml blood sample was taken from each participant, a sample of which was forwarded for DNA extraction using either QIAamp DNA blood Midi or Maxi kits (Qiagen) in accord with the protocol provided by the manufacturer. *APOE* genotype was determined through TaqMan genotyping assays (Life Technologies) for rs7412 (Assay ID: C\_\_904973\_10) and rs429358 (Assay ID: C\_\_3084793\_20) on a QuantStudio 12K-Flex real-time PCR system (Applied Biosystems) using the TaqMan GTXpress Master Mix (Life Technologies) methodology per manufacturer's instructions.

### *Neuropsychological testing*

To compute composite cognitive scores, first, each outcome measure on each neuropsychological test was standardized using the baseline mean and SD for the total CN group. Composite scores were then formed by averaging standardized scores for *episodic memory* (California Verbal Learning Test, Second Edition [CVLT-II] delayed recall, Logical Memory delayed recall and Rey Complex Figure Test delayed recall);

*executive function* (Category Fluency Fruit/Furniture Switching and Letter Fluency); *language* (Boston Naming Test and Category Fluency Animals/Boys' Names total score); and *attention* (Digit Symbol and Digit Span). We have previously detailed the rationale, development and validation for each cognitive composite score.<sup>17, 18</sup>

## **Procedure**

Upon enrolment into AIBL, all participants underwent detailed medical, psychiatric, and neuropsychological assessment. These same assessments were repeated at 18-month intervals. In this study, we report PET neuroimaging and *APOE*  $\epsilon 4$  genotyping data obtained at a single assessment, and neuropsychological data obtained at the baseline, 18-, 36-, 54- and 72-month assessments.

## **Data Analysis**

To examine relationships between group ( $A\beta^-$  CN  $\epsilon 4$  non-carrier,  $A\beta^-$  CN  $\epsilon 4$  carrier,  $A\beta^+$  CN  $\epsilon 4$  non-carrier,  $A\beta^+$  CN  $\epsilon 4$  carrier) and time (baseline, and 18, 36, 54 and 72 month follow-up) for each composite cognitive score, we conducted a series of analyses using linear mixed effects models (LMM) with an unstructured covariance matrix and maximum likelihood estimation. The linear mixed modelling approach was employed because it is robust to missing data (see Figure 1 for number of participants who withdrew from the study or had deceased), because it can model both fixed and random effects, thus accounting for multiple sources of variability, and because it provides improved estimates of random effects (within-subject coefficients) in prospective studies. For each LMM, the cognitive composite score was the dependent variable. Group, time, and the interaction between group and time were specified as fixed factors; participant was specified as a random factor; and age, and anxiety

symptoms as the only covariates. Group mean slopes were computed for each cognitive composite score to reflect estimates of the rate of cognitive change over time. Where LMMs indicated an interaction between group and time as statistically significant, estimates of slope in the A $\beta$ - CN  $\epsilon$ 4 carriers, A $\beta$ + CN  $\epsilon$ 4 non-carriers, and A $\beta$ + CN  $\epsilon$ 4 carriers were compared to that in the A $\beta$ - CN  $\epsilon$ 4 non-carriers. Differences between slopes were expressed using Cohen's *d*. To provide context for any differences in memory decline observed between study groups, a criterion for clinically-significant memory impairment was defined as performance <1.5 SD below that of A $\beta$ -  $\epsilon$ 4 non-carriers. The amount of time estimated for memory performance to reach this criterion was computed for each study group based on their LMM-derived linear functions.

## **Results**

### **Demographic and clinical characteristics**

There were no significant differences between the demographic and clinical characteristics of the total CN sample and the PET subsample, as the 95% confidence intervals for each outcome measure overlap (Table 1).

Statistically significant differences between A $\beta$ / $\epsilon$ 4 groups were observed for age and anxiety symptoms at baseline (Table 1). Consequently, age and anxiety symptoms were entered as covariates in the LMMs. Groups did not differ significantly on any other demographic or clinical characteristic at baseline.

### **Effect of A $\beta$ and $\epsilon$ 4 on cognitive change**

Table 2 provides a summary of the group mean slopes for each cognitive composite for each A $\beta$ / $\epsilon$ 4 group. Compared to A $\beta$ - CN  $\epsilon$ 4 non-carriers, A $\beta$ + CN  $\epsilon$ 4 carriers showed a significantly increased decline on all cognitive composites, and the

magnitudes of these differences were moderate-to-large (Figures 2 and 3). However, compared to A $\beta$ + CN  $\epsilon$ 4 non-carriers, A $\beta$ + CN  $\epsilon$ 4 carriers showed a significantly increased decline only on the measure of episodic memory, and the magnitude of this difference was large.

Compared to A $\beta$ - CN  $\epsilon$ 4 non-carriers, A $\beta$ + CN  $\epsilon$ 4 non-carriers also showed a faster rate of decline for the measures of episodic memory, language and executive function (Figure 3). The rate of decline in episodic memory in A $\beta$ + CN  $\epsilon$ 4 carriers indicated that the memory performance of this group would be severe enough to meet criterion for clinically-significant impairment in approximately 10 years (95%CI 6-18 years), as opposed to 27 years (95%CI 10-45 years) in A $\beta$ + CN  $\epsilon$ 4 non-carriers. Compared to A $\beta$ + CN  $\epsilon$ 4 non-carriers, A $\beta$ + CN  $\epsilon$ 4 carriers showed an increased rate of decline only for episodic memory (Figure 3). Group mean slopes of A $\beta$ - CN  $\epsilon$ 4 non-carriers and A $\beta$ - CN  $\epsilon$ 4 carriers did not differ significantly on any cognitive composite.

### **Effect of A $\beta$ and $\epsilon$ 4 on rates of disease progression**

At the 72-month assessment, the rate of clinical reclassification from CN to MCI/AD was significantly greater for A $\beta$ + CNs (18%) than for A $\beta$ - CNs (6%),  $\chi^2=9.91$ ,  $p<.001$ , Cramér's  $V=.17$  (Figure 1). However, while the rate of clinical reclassification from CN to MCI/AD was greater in A $\beta$ + CN  $\epsilon$ 4 carriers (22%) than A $\beta$ + CN  $\epsilon$ 4 non-carriers (15%), this difference was not large enough to reach statistical significance,  $\chi^2=0.49$ ,  $p=.49$ , Cramér's  $V=.09$ .

## **Discussion**

The hypothesis that A $\beta$ + CN  $\epsilon$ 4 carriers would show an increased rate of cognitive decline and greater rates of progression to MCI/AD compared to A $\beta$ - CN  $\epsilon$ 4

non-carriers and A $\beta$ + CN  $\epsilon$ 4 non-carriers was supported. Compared to A $\beta$ - CN non-carriers, A $\beta$ + CN  $\epsilon$ 4 carriers showed decline in all cognitive domains, although this was greatest for episodic memory (Figures 2-3). Compared to A $\beta$ + CN  $\epsilon$ 4 non-carriers, A $\beta$ + CN  $\epsilon$ 4 carriers also showed a faster rate of decline in episodic memory, which was, by convention also large in magnitude (Table 2, Figure 2). The exacerbation of A $\beta$ -related memory decline by  $\epsilon$ 4 is both consistent with, and extends, the results of previous analyses of AIBL data over shorter periods<sup>5,6</sup> and also from other cohorts,<sup>4</sup> that  $\epsilon$ 4 carriage increases the rate of A $\beta$ -related memory decline over 18 to 54-months. It is also consistent with animal studies which show that in the presence of A $\beta$ +, the apoE4 isoform causes cognitive impairment. No such impairment is observed in the presence of the apoE3 isoform.<sup>8,19</sup> The current results also characterize the much slower rate of development of A $\beta$ -related memory decline in CN older adults who do not carry the *APOE*  $\epsilon$ 4 allele. Previous analyses of data from A $\beta$ + CN older adults in AIBL conducted over shorter periods (e.g., 36 months) have observed that A $\beta$ -related cognitive decline is restricted to episodic memory.<sup>17</sup> In the current study, cognitive decline in A $\beta$ + CN older adults extended to executive function, language and attention, albeit with more subtle trajectories (Table 2). We believe that the detection of A $\beta$ -related decline in domains beyond memory, observed in the current study, was due to the larger sample size in this study and that individuals had been assessed over a much longer time interval than previously. In this context, the observation that exacerbation of A $\beta$ -related cognitive decline by *APOE*  $\epsilon$ 4 was specific to episodic memory confirms the centrality of episodic memory dysfunction to early AD. It is also consistent with previous studies which also observed that A $\beta$ -related cognitive decline in preclinical AD occurs only for *APOE*  $\epsilon$ 4 carriers and only for episodic memory.<sup>4,5</sup> We believe that with

a longer study period, A $\beta$ -related decline in cognitive functions other than memory will become evident in A $\beta$ + CN  $\epsilon$ 4 non-carriers.

Previously, we have expressed the relevance of A $\beta$ -related memory decline in CN older adults as the time required for a declining memory trajectory to reach a level of clinically-significant memory impairment, that is, memory impairment that would warrant consideration of a diagnosis of MCI.<sup>12</sup> In this study, clinically significant memory impairment was defined as performance that is less than 1.5 standard deviations from matched controls (Figure 2 dashed horizontal line).<sup>5</sup> Extrapolation of the rates of memory decline in this study suggest that the A $\beta$ + CN  $\epsilon$ 4 carriers would develop clinically-significant memory impairment approximately 10 years after their first assessment (Figure 2; see Table 1 for baseline demographic characteristics of this group). In contrast, A $\beta$ + CN  $\epsilon$ 4 non-carriers would require 27 years to reach the same criterion. Consistent with these estimates of a relatively slow decline in cognition, only 18% of the A $\beta$ + CN group were classified as having met clinical criteria for MCI or AD over the study period of 72-months, and this proportion was only slightly greater in  $\epsilon$ 4 carriers (22%) than in non-carriers (15%) (Figure 1). These data reflect the subtlety of A $\beta$ -related cognitive decline observed in current preclinical AD groups and suggest that study over even longer intervals may be required to determine the effect of *APOE*  $\epsilon$ 4 carriage on clinical progression in A $\beta$ + CN older adults.

There is increasing evidence from both human and animal studies that the apoE4 isoform affects risk for AD by disrupting A $\beta$  clearance relative to the other apoE isoforms (i.e., apoE3 and apoE2).<sup>7, 8, 20, 21</sup> Further, apoE4 itself has also been implicated directly in neurodegeneration and reduced synaptic integrity,<sup>22</sup> such that even a modest increase in apoE4 levels can increase A $\beta$  accumulation and exacerbate synaptic loss

around plaques.<sup>23</sup> However, it is not clear whether the processes by which apoE4 affects risk for AD are through an increase in neurotoxicity, loss in neuroprotective function, or combination of both.<sup>21</sup> While the processes by which apoE4 increases risk for AD may occur independently of A $\beta$ , it is also likely that A $\beta$  oligomers can further impair the physiological functions of apoE in promoting synaptic and neuronal integrity.<sup>24</sup> Thus, the absence of the *APOE*  $\epsilon$ 4 allele may afford some level of protection against AD-related neurodegeneration even when the amyloid cascade has begun (i.e., A $\beta$  accumulation). The substantial delay in A $\beta$ -related memory impairment observed in the current CN group suggests that understanding and manipulating the biological processes by which apoE4 exacerbates A $\beta$  toxicity could provide important insight into the pathogenesis of AD and perhaps even a basis for the development of pharmacotherapies to reduce this toxicity and its clinical consequences. The observation in the current study that  $\epsilon$ 4 carriage accounted for more than 18% of additional variance in A $\beta$ -related cognitive decline suggests strongly that clinical trials of preclinical AD should consider stratification of their A $\beta$ + samples according to *APOE*  $\epsilon$ 4 carriage.

While the risk for AD and high levels of A $\beta$  posed by *APOE*  $\epsilon$ 4 carriage have now been documented consistently,<sup>10,25</sup> the results of this study suggest that in the absence of A $\beta$ , *APOE*  $\epsilon$ 4 carriage does not increase risk for cognitive decline. Despite the comparatively large sample, the long period of investigation and the sensitive neuropsychological tasks used, we observed no effect of  $\epsilon$ 4 carriage on cognitive decline independent of A $\beta$ +. All aspects of cognitive function remained stable in A $\beta$ - CN  $\epsilon$ 4 carriers, and the rate of change of A $\beta$ - CN  $\epsilon$ 4 carriers over the 72-month test-retest period was indistinguishable from that of A $\beta$ - CN  $\epsilon$ 4 non-carriers (Figure 2 and Table 2). The observation that in A $\beta$ -,  $\epsilon$ 4 carriage is not associated with any cognitive decline has

been reported previously in the AIBL and other cohorts of CN older adults whose A $\beta$  status is known.<sup>4-6</sup> While a series of large and well-designed prospective studies have shown that carriage of the *APOE*  $\epsilon$ 4 allele is associated with increased decline in cognitive function, a major limitation of these studies has been that the A $\beta$  status of their samples was unknown.<sup>26</sup> It is therefore likely that the decline in cognitive function observed previously in  $\epsilon$ 4 carriers reflected the effects of both A $\beta$ + and  $\epsilon$ 4 carriage, rather than any independent effect of  $\epsilon$ 4 by itself.

When considering the results of this study, an important caveat is that the AIBL study, like many other natural history early AD cohorts,<sup>27, 28</sup> is not a population-based sample. In AIBL, few CN older adults had existing or untreated medical, neurological or psychiatric illnesses and most participants were highly educated. As such, it will be important for the results of the current study to be replicated in other early AD cohorts, especially in study groups whose ascertainment has been based on epidemiological principles (e.g., the Mayo Clinic Study of Aging).<sup>29</sup> A second caveat is that participants underwent neuroimaging at varying timepoints after their baseline assessment, with the median delay between neuropsychological testing and A $\beta$  neuroimaging 3 years. However, as current empirical models of AD have shown that the rate of A $\beta$  accumulation is very slow, particularly in the preclinical stage of the disease,<sup>3, 30</sup> it is unlikely that individuals classified as A $\beta$ + at the 36-month assessment were A $\beta$ - at the baseline assessment. To test this assumption, the main statistical models were re-computed with the time lag between baseline neuropsychological assessment and PET scan entered as a covariate. This reanalysis revealed no statistically significant effect for the time lag (Supplementary Table 1). Further, estimates of slopes for each A $\beta$ / $\epsilon$ 4 group also did not change substantially. We now await the completion of sequential amyloid scans in the entire AIBL CN cohort so as to appreciate, more accurately, the relationship



between cognitive change and A $\beta$  accumulation in  $\epsilon$ 4 carriers and non-carriers. Nonetheless, it will be prudent for future studies to determine whether individuals who transition from A $\beta$ - to A $\beta$ + show a different cognitive profile to those who remain A $\beta$ - or A $\beta$ + across a study period. However, our current data suggest that the additive effect of A $\beta$ + and  $\epsilon$ 4 on cognitive decline in preclinical AD may make an ideal target for pharmaceutical therapies that mitigate A $\beta$ -related neurodegeneration, or from the interaction between A $\beta$ + and  $\epsilon$ 4. They further support the hypothesis that reducing the toxic effects of apoE4 or restoring the neuroprotective functions of apoE isoforms in promoting synaptic plasticity and reducing neuroinflammation may be viable therapeutic strategies for the future.<sup>21</sup>

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Table 1. Demographic and clinical characteristics.

	CN total sample (n=767)	PET subsample (n=423)	CN A $\beta$ - non- $\epsilon$ 4 (n=262)	CN A $\beta$ - $\epsilon$ 4 (n=64)	CN A $\beta$ + non- $\epsilon$ 4 (n=46)	CN A $\beta$ + $\epsilon$ 4 (n=51)	<i>p</i>
% Female	439 (57%)	231 (55%)	142 (54%)	37 (58%)	23 (50%)	29 (57%)	.854
[95% CI]	[52-62%]	[49-61%]					
% APOE $\epsilon$ 4	207 (27%)	115 (27%)	-	-	-	-	-
[95% CI]	[21-33%]	[19-35%]					
Age Mean (SD)	70.03 (7.00)	69.39 (6.60)	<b>68.59 (6.03)</b>	<b>66.97 (5.47)</b>	<b>75.02 (7.37)</b>	<b>71.45 (6.82)</b>	<b>.000</b>
[95% CI]	(69.53-70.53)	(68.76-70.02)					
Premorbid IQ Mean (SD)	108.28 (7.27)	108.66 (7.08)	108.44 (6.94)	107.56 (7.59)	110.63 (7.62)	109.37 (6.43)	.118
[95%CI]	[107.77-108.79]	[107.99, 109.33]					
GDS Mean (SD)	0.98 (1.39)	0.87 (1.33)	0.91 (1.38)	0.98 (1.49)	0.61 (1.08)	0.73 (1.08)	.406
[95% CI]	[0.88-1.08]	[0.74, 1.00]					
HADS-D Mean (SD)	2.58 (2.24)	2.62 (2.32)	2.57 (2.24)	2.77 (2.04)	2.02 (1.69)	3.22 (3.24)	.080
[95% CI]	[2.42, 2.74]	[2.40, 2.84]					
HADS-A Mean (SD)	4.30(2.95)	4.28 (2.85)	<b>4.29 (2.84)</b>	<b>4.13 (2.89)</b>	<b>3.42 (1.97)</b>	<b>5.18 (3.31)</b>	<b>.025</b>
[95% CI]	[4.09, 4.51]	[4.01, 4.55]					
MACQ Mean (SD)	25.19 (4.32)	25.21 (4.41)	24.79 (4.32)	25.98 (3.86)	25.71 (4.87)	26.01 (4.96)	.110
[95% CI]	[24.88, 25.50]	[24.79, 25.63]					
CDR Mean (SD)	0.03 (0.12)	0.03 (0.13)	0.03 (0.11)	0.04 (0.14)	0.07 (0.20)	0.02 (0.10)	.187
[95% CI]	[0.02, 0.04]	[0.02, 0.04]					
CDR sum of boxes Mean (SD)	0.03 (0.15)	0.03 (0.15)	0.03 (0.16)	0.04 (0.14)	0.04 (0.14)	0.02 (0.10)	.852
[95% CI]	[0.02, 0.04]	[0.02, 0.04]					
MMSE Mean (SD)	28.86 (1.19)	28.92 (1.16)	28.97 (1.13)	28.90 (1.21)	28.85 (1.25)	28.75 (1.18)	.627
[95% CI]	[28.78, 28.94]	[28.81, 29.03]					

Note: CN = cognitively normal older adults; APOE = apolipoprotein E; GDS = Geriatric Depression Scale; HADS = Hospital Anxiety and Depression Scale; MACQ = Memory Complaints Questionnaire; CDR = Clinical Dementia Rating scale; MMSE = Mini Mental State Examination

Table 2. Effect of A $\beta$  and  $\epsilon$ 4 on each cognitive composite score over 72-months in CN older adults

	Episodic Memory		Executive Function		Language		Attention	
	(df) F	<i>p</i>	(df) F	<i>p</i>	(df) F	<i>p</i>	(df) F	<i>p</i>
Age	(1,418) 41.75	.000	(1,419) 31.87	.000	(1,423) 25.74	.000	(1,421) 65.49	.000
Anxiety	(1,415) 0.69	.408	(1,412) 0.33	.569	(1,419) 1.64	.201	(1,418) 1.92	.167
Group	(3,421) 0.47	.701	(3,426) 2.52	.057	(3,425) 1.78	.150	(3,427) 4.28	.005
Time	(1,360) 11.78	.000	(1,392) 33.32	.000	(1,331) 30.61	.000	(1,404) 41.67	.000
Group x Time	(3,356) 19.42	.000	(3,386) 3.89	.009	(3,327) 6.45	.000	(3,401) 4.96	.002
	Mean Slope	SD	Mean Slope	SD	Mean Slope	SD	Mean Slope	SD
CN A $\beta$ - $\epsilon$ 4- (n=262)	0.024	0.161	-0.048	0.173	-0.022	0.157	-0.045	0.176
CN A $\beta$ - $\epsilon$ 4+ (n=64)	0.044	0.131	-0.008	0.141	-0.006	0.128	-0.015	0.143
CN A $\beta$ + $\epsilon$ 4- (n=46)	-0.043	0.129	-0.100	0.139	-0.086	0.126	-0.115	0.139
CN A $\beta$ + $\epsilon$ 4+ (n=51)	-0.173	0.134	-0.112	0.139	-0.120	0.131	-0.123	0.143

\*Note: All models have been adjusted for age and the Hospital Anxiety and Depression Scale (HADS) Anxiety subscale score; Group indicates group membership as A $\beta$ -  $\epsilon$ 4-, A $\beta$ -  $\epsilon$ 4+, A $\beta$ +  $\epsilon$ 4- or A $\beta$ +  $\epsilon$ 4+

\*\*Note: CN = Cognitively normal;  $\epsilon$ 4- =  $\epsilon$ 4 non-carriers;  $\epsilon$ 4+ =  $\epsilon$ 4 carriers

Supplementary Table 1. Effect of A $\beta$  and  $\epsilon$ 4 on each cognitive composite score over 72-months in CN older adults, after accounting for time lag between baseline neuropsychological assessment and PET scan

	Episodic Memory		Executive Function		Language		Attention	
	(df) F	<i>p</i>	(df) F	<i>p</i>	(df) F	<i>p</i>	(df) F	<i>p</i>
Age	(1,417) 38.85	.000	(1,417) 27.52	.000	(1,421) 21.50	.000	(1,420) 58.53	.000
Anxiety	(1,415) 0.68	.409	(1,412) 0.35	.552	(1,419) 1.71	.191	(1,418) 1.95	.163
Scan Time Lag	(1,416) 0.00	.983	(1,410) 0.64	.426	(1,418) 0.91	.342	(1,418) 0.30	.584
Group	(3,422) 0.47	.703	(3,428) 2.40	.067	(3,427) 1.74	.159	(3,429) 4.05	.007
Time	(1,360) 11.78	.001	(1,392) 33.54	.000	(1,331) 30.67	.000	(1,404) 41.74	.000
Group x Time	(3,356) 19.42	.000	(3,386) 3.92	.009	(3,327) 6.47	.000	(3,401) 4.97	.002
	Mean Slope	SD	Mean Slope	SD	Mean Slope	SD	Mean Slope	SD
CN A $\beta$ - $\epsilon$ 4- (n=262)	0.024	0.161	-0.049	0.173	-0.022	0.157	-0.046	0.176
CN A $\beta$ - $\epsilon$ 4+ (n=64)	0.044	0.131	-0.008	0.141	-0.006	0.128	-0.015	0.143
CN A $\beta$ + $\epsilon$ 4- (n=46)	-0.043	0.129	-0.101	0.139	-0.086	0.126	-0.115	0.139
CN A $\beta$ + $\epsilon$ 4+ (n=51)	-0.173	0.134	-0.112	0.143	-0.120	0.131	-0.123	0.143

\*Note: All models have been adjusted for age, amount of time lag between baseline neuropsychological assessment and PET scan, and the Hospital Anxiety and Depression Scale (HADS) Anxiety subscale score; Group indicates group membership as A $\beta$ -  $\epsilon$ 4-, A $\beta$ -  $\epsilon$ 4+, A $\beta$ +  $\epsilon$ 4- or A $\beta$ +  $\epsilon$ 4+

\*\*Note: CN = Cognitively normal;  $\epsilon$ 4- =  $\epsilon$ 4 non-carriers;  $\epsilon$ 4+ =  $\epsilon$ 4 carriers



## Figure Captions

Figure 1. Clinical classification and disease progression of CN A $\beta$ - and CN A $\beta$ + participants over 72 months.

Figure 2. Trajectories of Episodic Memory change over 72 months.

Dotted line indicates 1.5 SD decline for clinically-significant memory impairment. Error bars represent the 95% confidence intervals of the difference in the rate of cognitive change.

Figure 3. Magnitude of difference (Cohen's *d*) in the rate of cognitive change over 72 months.

Magnitude of difference (Cohen's *d*) in the rate of change in each cognitive composite score between CN A $\beta$ -  $\epsilon$ 4 carriers, CN A $\beta$ +  $\epsilon$ 4 non-carriers, and CN A $\beta$ +  $\epsilon$ 4 carriers relative to CN A $\beta$ -  $\epsilon$ 4 non-carriers (represented by "0" line). Error bars represent the 95% confidence intervals of the difference in the rate of cognitive change.







