

Asia-Pacific's Alzheimer's Bottleneck Is Triage, Not Treatment

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As amyloid-targeting therapies expand across Asia-Pacific, the real challenge is building diagnostic pathways that can identify, triage and prioritise the right patients before specialist capacity becomes the limiting factor.



Amyloid-targeting therapies have arrived across Asia-Pacific faster than the infrastructure needed to decide who should receive them. Lecanemab was approved in Japan in September 2023 and in China in January 2024, with approvals following in South Korea, Singapore, Hong Kong and elsewhere. The scientific achievement is real. The operational problem it creates is regional, and it is not primarily about treatment.

The bottleneck is the specialist appointment

More than 240 million people aged 65 and over live in the Western Pacific, a figure projected to double by 2050. Alzheimer's Disease International has estimated the region's dementia population will roughly triple between 2015 and mid-century. Reviews of regional readiness identify the same constraints in nearly every country: the cost of therapy, limited PET and infusion capacity, a shortage of specialists, and low awareness that delays presentation.

Two findings illustrate where the pressure actually falls. Among 2,726 patients presenting with cognitive decline at a Seoul memory clinic, only 9.1 per cent met appropriate-use criteria for Lecanemab — under a quarter of those who were amyloid-positive. At a Tokyo dementia centre, 82 per cent of patients started on therapy had been referred by general practitioners.

Primary care is already the front door, but most patients who come through it will not be treatment candidates. And every one of them currently consumes a specialist evaluation to establish that.

What a blood test is being asked to do

Blood-based biomarkers are often presented as the answer to this capacity problem, and they can be — but only if they answer the right question. A test that reports amyloid status alone tells a physician whether one specific pathology is present. It says nothing about the majority of symptomatic patients in whom it is absent, who remain symptomatic, undiagnosed, and still queued for a specialist.

Alzheimer's is not a single biological process. Amyloid deposition, tau pathology, neurodegeneration and neuroinflammation advance on partly independent timelines, and each is now measurable in plasma. A multi-analyte panel spanning those axes does something a single marker cannot: when the amyloid result is negative, markers of neuronal injury can indicate that something else is driving the symptoms — vascular disease, or another neurodegenerative process entirely — and that the patient needs a different investigation rather than a memory clinic slot.

Triage is the capacity intervention

This reframes what diagnostics contribute in systems that cannot build PET capacity quickly. The value is not only in confirming candidates for therapy. It is in identifying, early and in primary care, the larger group who are not — something a multi-analyte panel can do and a single-marker test cannot — and directing them somewhere useful rather than into a queue.

The objection is that broader testing will generate demand health systems cannot absorb, but the opposite is closer to true. Testing that can only say yes or no to amyloid sends every ambiguous patient downstream, while multi-analyte testing that distinguishes between causes is what protects scarce specialist capacity for the patients who most need it.

Asia-Pacific will face the steepest dementia burden of any region this century, and the therapeutic advances underway to address it are genuine. Whether they reach patients will depend less on the drugs themselves than on how early, and how accurately, health systems can sort the people arriving at their clinic doors.

Dr David Wilson, Vice President, Clinical Strategy, Quanterix, USA