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Letter to the Editor

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Demographic, Social, and Clinical Profiles of Patients Initiating Lecanemab in Clinical Practice: A Single-Center Experience in Korea

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Dear Editor,

Alzheimer's disease (AD) is a leading cause of dementia worldwide, and the development of disease-modifying therapies targeting amyloid pathology has reshaped the therapeutic landscape of AD.[1,2] Lecanemab demonstrated modest but statistically significant slowing of cognitive decline in patients with early AD and has since entered routine clinical use in several countries, including Korea.[3,4] However, its implementation requires biweekly infusions and repeated clinical monitoring, including magnetic resonance imaging, resulting in substantial financial burden.[4] These requirements may influence access to treatment. Emerging real-world data from Western healthcare systems suggest that early uptake of lecanemab may be concentrated among socioeconomically advantaged populations.[5] To date, comparable data from Asian healthcare systems remain limited. Accordingly, we described the demographic characteristics, social determinants of health (SDOH), and baseline clinical profiles of patients initiating lecanemab at a single tertiary center in Korea.

We recruited consecutive patients initiating lecanemab in routine clinical practice at a tertiary hospital in Seoul, Korea between the initiation of lecanemab treatment at our institution in January 2025 and September 2025. Eligible participants were patients who received at least one lecanemab infusion and met national eligibility criteria for early AD with biomarker-confirmed amyloid pathology.[6] Data were collected at treatment initiation and from neuropsychological assessments conducted within three months after treatment initiation, during which additional social information was also obtained. Variables included demographic characteristics (age, sex), SDOH (education, employment status, region of residence, marital status, and caregiver accompaniment), and clinical measures. Clinical variables included *APOE* ε4 carrier status, Clinical Dementia Rating (CDR),[7] Korean Mini-Mental State Examination (MMSE)-2,[8] and the Seoul Cognitive Status Test (SCST),[9] a tablet-based cognitive battery assessing five domains (attention, language, visuospatial, memory, and executive function) with z-scores standardized to internal norms.

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The authors have no financial conflicts of interest.

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A total of 118 patients were included in the descriptive analysis. Seventy patients (59.3%) were *APOE* ε4 carriers, 83.1% of patients were classified as global CDR 0.5, and the mean MMSE score was 24.3±3.0. Baseline cognitive performance on the SCST showed the greatest impairment in the memory domain (mean z-score=−2.66), with milder deficits in attention (−0.61), language (−1.02), executive (−1.04), and visuospatial (−1.04) domains. Of these, 79 (66.9%) were female. Patients aged ≤74 years accounted for 60.2%, including 15.3% aged ≤64 years and 44.9% aged 65–74 years. Most patients had relatively high educational attainment, with 59.3% reporting >12 years of education, while smaller proportions had 10–12 years (21.2%), 7–9 years (6.8%), or ≤6 years (12.7%) of education. The majority had a history of employment (90.7%), and 28.8% were currently employed. Regarding region of residence, 79.7% of patients lived in the capital metropolitan region, and 20.3% lived in provincial areas. A total of 100% of patients had ever been married, of whom 81.4% were currently married. Caregivers were most commonly spouses (49.2%) or adult children (39.8%), and only a small proportion of patients were unaccompanied. Demographic, SDOH, and clinical characteristics are summarized (**Table 1**).

This study describes the demographic, social, and clinical characteristics of patients initiating lecanemab in real-world practice in Korea. Patients were predominantly aged ≤74 years and were largely at an early disease stage, consistent with current indications for

Table 1. Baseline demographic, social, and clinical characteristics of patients initiating lecanemab (n=118)

Characteristics	Values
Female sex	79 (66.9)
Age group (yr)	
≤64	18 (15.3)
65–74	53 (44.9)
75–84	44 (37.3)
≥85	3 (2.5)
Education (yr)	
≤6	15 (12.7)
7–9	8 (6.8)
10–12	25 (21.2)
>12	70 (59.3)
Employment history	
Ever employed (lifetime)	107 (90.7)
Currently employed (at baseline)	34 (28.8)
Region of residence	
Capital metropolitan region	94 (79.7)
Provincial areas	24 (20.3)
Marital status	
Married (current)	96 (81.4)
Widowed	18 (15.3)
Divorced/separated	4 (3.4)
Never married	0 (0.0)
Accompanying caregiver at infusion visits	
Spouse	58 (49.2)
Adult child	47 (39.8)
Other (e.g., sibling/friend)	5 (4.2)
None	8 (6.8)
CDR	
0.5	98 (83.1)
1.0	20 (16.9)
APOE ε4 carrier status	70 (59.3)
K-MMSE-2	24.3±3.0

Values are presented as mean ± standard deviation or number (%).
CDR: Clinical Dementia Rating, K-MMSE-2: Korean Mini-Mental State Examination-2.

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lecanemab use.[4,6] Baseline cognitive performance showed the greatest impairment in memory, with milder deficits across other domains, consistent with the characteristic cognitive profile of early AD.[10,11] Patients had relatively high educational attainment and high rates of lifetime employment and were predominantly concentrated in the capital metropolitan region. Most patients were married and accompanied by a caregiver, most commonly a spouse or adult child, which may reflect the availability of social support during treatment. Prior reports from Western healthcare systems have described similar patterns, in which early uptake of lecanemab tends to occur among individuals with more favorable socioeconomic conditions.[5] In line with these observations, our findings may suggest that real-world access to lecanemab could be influenced not only by clinical eligibility but also by underlying social and economic resources. However, direct comparisons should be interpreted cautiously given differences in healthcare systems and sociocultural contexts. This study has several limitations, including its single-center design in the capital metropolitan area and its reliance on descriptive analysis without comparison with untreated patients. In addition, we lacked detailed socioeconomic data (e.g., household income level, insurance status, and occupational class), which limited our ability to fully characterize the socioeconomic profile of patients accessing lecanemab and to explore potential variations in access across socioeconomic groups. Since these results merely suggest possible correlations between SDOH indicators and accessing lecanemab, they should not be interpreted as causal relationships. Nevertheless, these findings provide an initial real-world characterization of patients receiving lecanemab and may serve as a reference for future evaluations of how social factors influence access to disease-modifying therapies as they become more widely implemented.

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