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Resting-state global functional connectivity as a biomarker of cognitive reserve in mild cognitive impairment

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Resting-state global functional connectivity as a biomarker of cognitive reserve in mild cognitive impairment --Manuscript Draft--

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diagnostic biomarker of brain changes underlying CR is not available yet. Our aim was to develop a fully-automated approach applied to fMRI to produce a biomarker associated with CR in subjects at increased risk of AD. We computed resting-state global functional connectivity (GFC), i.e. the average connectivity strength, for each voxel within the cognitive control network, which may sustain CR due to its central role in higher cognitive function. In a training sample including 43 mild cognitive impairment (MCI) subjects and 24 healthy controls (HC), we found that MCI subjects with high CR (> median of years of education, CR+) showed increased frequency of high GFC values compared to MCI CR- and HC. A summary index capturing such a surplus frequency of high GFC was computed (called GFC reserve (GFC-R) index). GFC-R discriminated MCI CR+ vs MCI CR-, with the area under the ROC = 0.84. Cross-validation in an independently recruited test sample of 23 MCI subjects showed that higher levels of the GFC-R index predicted higher years of education and an alternative questionnaire-based proxy of CR (CRlq score), controlled for memory performance, gray matter of the cognitive control network, age, and gender. In conclusion, the GFC-R index that captures GFC changes within the cognitive control network provides a biomarker candidate of functional brain changes of CR in patients at increased risk of AD.

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Regular Article

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6
7 cognitive impairment.
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37 * Data used in preparation of this article were obtained from the Alzheimer's Disease
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39 Neuroimaging Initiative (ADNI) database (adni.loni.usc.edu). As such, the
40
41 investigators within the ADNI contributed to the design and implementation of ADNI
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43 and/or provided data but did not participate in analysis or writing of this report. A
44
45 complete listing of ADNI investigators can be found at: [http://adni.loni.usc.edu/wp-](http://adni.loni.usc.edu/wp-content/uploads/how_to_apply/ADNI_Acknowledgement_List.pdf)
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ABSTRACT:

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2 Cognitive reserve (CR) shows protective effects in Alzheimer's-disease (AD) and reduces the
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4 risk of dementia. Despite the clinical significance of CR, a clinically useful diagnostic
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7
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13
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16 training sample including 43 mild cognitive impairment (MCI) subjects and 24 healthy
17
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24 reserve (GFC-R) index). GFC-R discriminated MCI CR+ vs MCI CR-, with the area under
25
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36 biomarker candidate of functional brain changes of CR in patients at increased risk of AD.
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1
2 **INTRODUCTION:**
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4 Cognitive reserve (CR) refers to the ability to cognitively perform relatively well in the
5 presence of brain pathology (Stern, 2002, 2009). Life-time experiences - such as education
6 and occupational attainment – or IQ are commonly used as proxy measures of CR (Stern,
7 2009). In Alzheimer's disease (AD), higher levels of such CR proxies are associated with
8 higher cognitive performance relative to the level of brain damage, such as measured by
9 cerebral FDG-PET hypometabolism or impaired blood flow (Bastin et al., 2012; Boots et al.,
10 2015; Ewers et al., 2014; Scarmeas et al., 2003; Stern, Alexander, Prohovnik, & Mayeux,
11 1992; Stern et al., 1995), grey matter atrophy (Bastin et al., 2012; Boots et al., 2015), white
12 matter damage (Brickman et al., 2011), and primary pathologies including amyloid-beta ($A\beta$)
13 and tau (Rentz et al., 2010; Vemuri et al., 2015; Vemuri et al., 2011). These results suggest
14 that higher levels of CR as measured by education and other proxies are associated with a
15 higher ability to cope with brain pathology in AD.
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33 Compensatory functional brain changes that may underlie CR have been investigated in a
34 number of task-related fMRI studies (Stern et al., 2005; Stern et al., 2008) or resting state
35 fMRI studies in HC subjects (Arenaza-Urquijo et al., 2013). Task-related fMRI studies in
36 MCI and AD revealed an association between increased CR proxies (education, occupation)
37 and higher brain activation (Bosch et al., 2010; Solé-Padullés et al., 2009). However, task-
38 fMRI is often difficult to perform for cognitively impaired patients, and may thus not be
39 suitable for clinical use to assess CR in AD. From a clinical point of view, a major question is
40 whether simple measures of basic brain function are indicative of CR, and thus could be used
41 as a marker of CR-related brain changes in AD. The need of a biomarker of CR-related brain
42 changes is urgent in view of a growing number of clinical trials that target protective brain
43 mechanisms in AD, such as cognitive training or meditation (Buschert et al., 2011; Reijnders,
44 van Heugten, & van Boxtel, 2013; Schultz et al., 2015; Wells et al., 2013).
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1 The overall goal of the current study was to develop a neuroimaging-based diagnostic
2 biomarker of functional brain changes underlying CR in subjects with mild cognitive
3 impairment (MCI). We focused on resting-state global functional connectivity (GFC, also
4 known as weighted degree centrality) within the cognitive control network as a measure of
5 functional brain processes of CR. The cognitive control network includes major brain hubs
6 with high GFC (Cole, Pathak, & Schneider, 2010), where greater GFC has been previously
7 associated with higher IQ, i.e. a proxy of CR, in young subjects. In the current study, CR was
8 measured by the proxy of years of education, which is the best validated CR proxy measure to
9 date in AD (Stern, 2012).

10
11 Using a cross-validation approach, we compared the frequency distribution of GFC values
12 within the cognitive control network between MCI subjects with high CR (more years of
13 education) to MCI with low CR (lower years of education) and HC groups. A newly
14 developed summary index that detects GFC frequency differences between MCI subjects with
15 low and MCI subjects with high CR, henceforth called GFC reserve (GFC-R) index, was
16 tested as a predictor of years of education in an independent validation sample of MCI
17 subjects. We hypothesized firstly that MCI subjects with more years of education show an
18 increased number of relatively high GFC values within the cognitive control network
19 compared to MCI subjects with less years of education. Secondly, we hypothesized that
20 higher levels of the GFC-R index are predictive of more years of education and a second
21 questionnaire based CR proxy in the validation sample of MCI subjects.

METHODS:

Subjects:

We included two independent samples each of amnesic MCI and HC subjects to cross-validate our findings. The training sample included 24 amyloid-PET negative ($A\beta^-$) HC subjects and 43 Amyloid-PET positive ($A\beta^+$) patients with amnesic MCI. Amyloid PET status was defined based on pre-established cut-off values of global [^{18}F] AV-45 PET standardized uptake value ratio (for $A\beta^-$ = global AV-45 PET SUVR < 1.11) (Landau et al., 2013). All data were downloaded from the Alzheimer's Disease Neuroimaging Initiative (ADNI) database, freely accessible for researchers (<http://adni.loni.usc.edu/>). ADNI was launched in 2003 as a public-private partnership, led by Principal Investigator Michael W. Weiner, MD. The primary goal of ADNI has been to test whether serial MRI, PET, other biological markers, and clinical and neuropsychological assessment can be combined to measure and predict the progression of MCI and early AD (www.adni-info.org).

The test sample comprised 32 HC subjects as well as 23 subjects with amnesic MCI, recruited between 2014 and 2015 at the memory clinic of the Institute for Stroke and Dementia Research (ISD) at the Klinikum der Universitaet Muenchen in Germany.

For the ISD study, the inclusion criteria were defined as follows: 1) age > 60 years, 2) no signs of depression, 3) no presence or history of neurological or psychiatric disorders (except for MCI), 4) no presence or history of alcohol or drug abuse, 5) no diabetes mellitus, 6) no MRI contraindications. All subjects underwent structural MRI, resting-state fMRI and cognitive testing using the CERAD-Plus test battery (Luck, 2009). A subject was defined as HC, when reporting no subjective memory complaints and scoring within 1.5 standard deviations (SD) of the age, gender and education adjusted norms in all subtests of the CERAD-Plus battery (Luck, 2009). MCI was diagnosed according to the Petersen criteria (Petersen, 2004), when scoring 1.5 SD below the age, gender and education adjusted norms in at least one of the learning or recall subtests of the CERAD-Plus battery.

1 For the training sample (ADNI), details about the inclusion can be found online
2 (<https://adni.loni.usc.edu/wp-content/uploads/2008/07/adni2-procedures-manual.pdf>). Similar
3
4 to the diagnosis of MCI in the ISD sample, MCI was diagnosed in ADNI according to the
5
6 Petersen criteria (Petersen, 2004).
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10 11 **Cognitive reserve and neuropsychological assessment:**

12 The number of years of formal education was used as a proxy for CR in both samples. In the
13
14 test sample (ISD) we additionally used the cognitive reserve index questionnaire (Nucci,
15
16 Mapelli, & Mondini, 2012) as a second proxy of CR. The CRIq is a standardized
17
18 questionnaire based measure for the assessment of CR that combines information about
19
20 education, working activity and leisure time. For neuropsychological assessments, memory
21
22 performance was assessed using memory tests that were comparable between the ADNI and
23
24 the ISD sample. As a measure of episodic memory performance, the total score of the
25
26 CERAD word list learning tests was assessed in the ISD sample (Luck, 2009), and the total
27
28 score of the Rey Auditory Verbal Learning Test (RAVLT) in the ADNI sample (Schoenberg
29
30 et al., 2006). Both tests are designed as list-learning paradigms in which the patient is read a
31
32 list of words by the examiner in several trials (CERAD: 10 words in 3 trials; RAVLT: 15
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34 words in 15 trials) and is asked to recall as many words from the list as possible after each
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36 trial. The total score reflects the number of words correctly remembered cumulated across
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38 trials.
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51 **Standard protocol approvals and patient consent:**

52 The study at the ISD was approved by the ethics committee of the Ludwig Maximilian
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54 University of Munich and was conducted in accordance with the Declaration of Helsinki. All
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56 study participants provided written, informed consent to the study. For the ADNI-sample
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58 ethical approval was obtained by the ADNI investigators.
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2 **MRI acquisition:**
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4 *Training sample (ADNI):*
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7 All MRI scans were performed on Philips 3T MRI scanners, using an 8-channel head matrix
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9 coil. High-resolution T1-weighted scans were acquired using a 3D MP-RAGE sequence, with
10
11 whole brain coverage and a voxel resolution of $1 \times 1 \times 1.2$ mm. Resting state-fMRI images
12
13 were acquired using a single shot T2*-weighted EPI sequence collecting 140 volumes, with a
14
15 TR of 3000 ms, a flip angle of 80° and 3.3 mm isotropic voxel resolution. Prior to the resting-
16
17 state scan, subjects were instructed to keep their eyes open.
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24 *Test sample (ISD):*
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27 All MRI scans were performed on a Siemens Verio 3T MRI scanner using a 32-channel head
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29 coil. For each subject a structural image was obtained using a high-resolution 3D MPRAGE
30
31 T1-weighted sequence with 1 mm isotropic voxel resolution. Functional resting-state images
32
33 were acquired using a T2*-weighted echo-planar imaging (EPI) pulse sequence collecting 180
34
35 volumes with a TR = 2580 ms, flip angle = 80° and 3.5 mm isotropic voxel resolution. Prior
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37 to the resting-state scan the subjects were instructed to keep their eyes closed and not to fall
38
39 asleep during the scanning procedure. Using the same field of view as the functional resting-
40
41 state images, field maps were acquired (TE = 7.38/4.92 ms, TR = 675 ms) to correct for
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43 susceptibility artifacts and inhomogeneity of the magnetic field during preprocessing of the
44
45 resting-state data.
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53 **Spatial normalization of MRI scans:**
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56 The spatial normalization of the MRI scans was done separately for both samples, following
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58 the same protocol of image processing based on SPM 12 (Wellcome Trust Centre for
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60 Neuroimaging, University College London, United Kingdom: www.fil.ion.ucl.ac.uk/spm).
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1 T1-weighted images were segmented into probabilistic maps of grey matter, white matter and
2 cerebrospinal fluid maps through the SPM's new-segment approach (Ashburner & Friston,
3
4 2005). Next, the spatial normalization parameters were estimated using a high-dimensional
5
6 diffeomorphic registration algorithm to warp each subjects' grey matter map to a group-
7
8 specific grey matter template that was defined in an iterative procedure, as implemented in
9
10 SPM's DARTEL toolbox (Ashburner, 2007). Subsequently, the group-specific template was
11
12 registered to the MNI template in order to estimate the affine transformation parameters.
13
14 Next, the non-linear (DARTEL flow-fields) and the affine transformation parameters were
15
16 combined and applied to the segmented grey matter maps, so that all grey matter images were
17
18 spatially normalized to the MNI space. The spatially-normalized grey matter maps were
19
20 averaged and binarized at a voxel value > 0.3 to create a group-specific grey matter mask for
21
22 later fMRI functional connectivity analyses. Similarly, we averaged and binarized the
23
24 spatially-normalized white-matter (binarized at threshold > 0.9) and cerebrospinal-fluid
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26 (binarized at threshold > 0.7) that were used during preprocessing of the resting-state fMRI
27
28 data. For later extraction of grey matter volume, we created spatially normalized grey matter
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30 maps for each subject, that were smoothed with a 8-mm full-width at half-maximum
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32 (FWHM) Gaussian kernel and modulated to preserve the volume of the images.
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43 **Preprocessing of resting-state fMRI:**

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45 The preprocessing of both samples was done separately, but following the same protocol. All
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47 volumes were realigned to the first volume to correct for motion, coregistered to native-space
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49 T1-weighted images and smoothed using an 8 mm FWHM Gaussian kernel. None of the
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51 subjects' motion parameters exceeded 2 mm translations or 2 degrees rotations. Unique to the
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53 ISD-sample, there was additional slice-timing and field map correction. Next, the DARTEL
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55 flow-fields and affine registration parameters that were estimated during preprocessing of the
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57 T1-weighted images were combined and applied to all resting-state fMRI volumes to spatially
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1 normalize the images to MNI space. The spatially normalized fMRI images were further
2 detrended and band-pass filtered, using a frequency band of 0.01-0.08 Hz. In a second step we
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4 regressed out the 6 motion parameters (3 translations, 3 rotations) and the BOLD signal
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6 averaged across the white matter and cerebrospinal fluid masks that were created during
7
8 preprocessing of the T1-weighted images.
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11 **Assessment of GFC:**

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14 For each subject, GFC was determined based on the preprocessed and spatially normalized
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16 resting-state fMRI scans. For each voxel in the grey matter, the GFC was determined by
17
18 computing seed-based Pearson-Moment correlations of the BOLD signal changes between the
19
20 seed voxel and each of the other voxels within the grey matter (as defined by the customized
21
22 grey matter mask). For each seed voxel, only Pearson-Moment correlation coefficients with r
23
24 > 0 were retained, Fisher z -transformed and averaged across the voxels within the grey-
25
26 matter-mask space to obtain the GFC coefficient. This resulted in a 3D brain map of GFC
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28 coefficients for each subject. Note that we included only positive correlation coefficients for
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30 computing the GFC, because positive and negative correlations may cancel each other out
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32 when averaging the correlation coefficients.
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43 **Spatial maps of resting-state networks:**

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45 The cognitive control network covers the anterior cingulate cortex, dorsolateral prefrontal
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47 cortex, anterior insular cortex, dorsal premotor cortex and posterior parietal cortex (Cole,
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49 Bassett, Power, Braver, & Petersen, 2014; Cole et al., 2013; Cole & Schneider, 2007). For the
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51 current study, we determined the spatial boundaries of the cognitive control network based on
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53 an a-priori conducted meta-analysis in order to avoid a sample specific bias in the spatial
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55 definition of the network. The meta-analysis was conducted using NeuroSynth, a web-based
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57 tool for fully automated detection of brain activation coordinates from published task-fMRI
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1 data (<http://www.neurosynth.org>). By entering a search term in the NeuroSynth database,
2 brain activation associated with the search term entered is analyzed across studies, yielding a
3 probabilistic map of brain activation related to that term (Yarkoni, Poldrack, Nichols, Van
4 Essen, & Wager, 2011). For the current study, we used “cognitive control” as a search term,
5 yielding a z-scored probability map based on 428 task-fMRI studies (as of September 14,
6 2015). In order to obtain a reliable map of the cognitive control network we applied a false
7 discovery rate corrected p-threshold of $p(\text{FDR}) < 0.01$ (see Fig. 1). The spatial map of the
8 cognitive control network was additionally masked with the group-specific grey matter masks
9 for each sample separately in order to restrict all further analyses to voxels that had a high
10 likelihood of falling within the grey matter. We performed control analyses on 7 major brain
11 networks (Yeo et al., 2011), to test whether a relationship between CR and GFC was specific
12 to the cognitive control network. Accordingly, we downloaded the 7 network parcellations
13 that are freely available online
14 (ftp://surfer.nmr.mgh.harvard.edu/pub/data/Yeo_JNeurophysiol11_MNI152.zip). Again, all 7
15 networks were additionally masked with the group specific grey matter masks for each
16 sample. To control for potentially confounding effects of brain atrophy, we extracted the grey
17 matter volume within the network masks for each subject, applied to the modulated smoothed
18 and normalized grey matter images that were created during the preprocessing of structural
19 MRI images.

20 **Generation of GFC index related to CR (GFC-R index):**

21 *Study design*

22 Our aim was to develop a summary index to quantify GFC frequency changes within the
23 cognitive control network that were associated with the CR proxy years of education in
24 patients with MCI. In brief, the ADNI sample served as a training sample to create the GFC-R
25 index that is related to our CR proxy *education*. Subsequently, we tested the validity of this

1 GFC based index as a predictor of the CR proxy years of education and the CR-questionnaire
2 (CRIq) composite score in the ISD sample, which served as an independent test sample. A
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4 Flow diagram illustrating the individual steps to create the GFC-reserve index is shown in Fig
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10 11 *Dichotomization of subjects according to CR*

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13 The HC and MCI groups were each dichotomized into groups of low and high CR (CR- vs
14 CR+), split at the median of years of education within the entire sample. The groups were
15
16 dichotomized separately within the ISD (CR+: > median education = 13) and the ADNI
17
18 sample (CR+: > median education = 16).
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26 *Histogram Analysis of GFC*

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28 For each diagnostic group (MCI vs. HC) within the CR+ and CR- subjects, we plotted a
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30 histogram of the GFC frequencies across voxels of the cognitive control network (Figure 2A
31
32 & B). Visual inspection of the histograms in the training sample (ADNI) revealed, that the
33
34 GFC histogram of the MCI CR- subjects showed an overall shift to the left of the HC
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36 subjects, with a decreased frequency of relatively high GFC values, but an increase of lower
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38 GFC values compared to the HC CR- group (Figure 2B). Conversely, the GFC histogram of
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40 the MCI CR+ subjects showed a shift to the right of the HC CR+ group.
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46 In a next step, we binned the GFC voxel values for each subject at intervals of 0.01 from $z = 0$
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48 to $z = 0.6$ resulting in a total of 60 bins, each containing the number of voxels (i.e. the GFC
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50 frequency) falling within that bin. To quantify changes in GFC frequency in MCI with respect
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52 to the HC group, we bin-wise subtracted each MCI CR+ subject's GFC frequencies from the
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54 averaged GFC frequencies in the HC CR+ group. The analogous subtraction was done for the
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56 MCI CR-, where each MCI subject's histogram was subtracted from the average histogram of
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1 the HC CR- group. Thus, for each MCI CR group, alterations of GFC frequencies (called
2 GFC-Diff, Figure 2C) were obtained according to the following equation.
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$$6 \quad GFC-Diff_{ijk} = GFC \text{ frequency}(MCI)_{ijk} - \text{Mean GFC frequency}(HC)_{ik} \text{ (Eq. 1)}$$

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11 where, i = CR group (CR + or CR-), j = MCI subject, k = GFC bin (1-60).
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17 In bins where a MCI subject had a higher GFC frequency than the HC group, GFC-Diff
18 values were positive (green shaded area in Figures 2C-E). Conversely, in bins where a MCI
19 subject showed a lower GFC frequency compared to the HC group, the GFC-Diff score was
20 negative (red shaded area in Figures 2C-2E). To identify GFC bins where MCI CR+ and MCI
21 CR- subjects showed different GFC frequency changes, we compared GFC-Diff scores
22 between the CR groups for each of the 60 bins, using two-sample t-tests with the significance
23 threshold being $\alpha = 0.05$ for each t-test (Figure 2D). We did not correct for multiple testing at
24 this stage, since the analysis was an intermediate step, exclusively done in order to select bins
25 where MCI CR- and MCI CR+ groups differed in terms of GFC-Diff.
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39 The results of the t-tests showed that GFC-Diff scores were greater (i.e. more positive) in
40 MCI CR+ compared to MCI CR- in the range from 0.34 to 0.5, suggesting that MCI CR+ had
41 significantly increased frequencies of relatively high GFC values (henceforth referred to as
42 $GFC-Diff_{CR+>CR-}$) relative to MCI CR- subjects. In contrast, GFC-Diff scores were increased
43 in MCI CR- compared to MCI CR+ subjects in a range from 0.2 to 0.26, suggesting that MCI
44 CR- subjects had a higher frequency of relatively low GFC values (henceforth referred to as
45 $GFC-Diff_{CR+<CR-}$) compared to MCI CR+ subjects. In order to create a subject-specific
46 summary score of GFC frequency differences indicative of CR+ status, we subtracted the sum
47 of GFC-Diff values in the $GFC-Diff_{CR+<CR-}$ from the sum of GFC-Diff values in the $GFC-$
48 $Diff_{CR+>CR-}$. Finally, this differences was divided this difference by the total number of voxels
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2 in the cognitive control network mask to standardize it to a range between -1 and 1 (Figure 2E
3 & F, Eq. 2).

$$4 \quad 5 \quad 6 \quad 7 \quad 8 \quad 9 \quad GFC-R\ index_j = \frac{\sum GFC-Diff_{CR+>CR-} - \sum GFC-Diff_{CR+<CR-}}{\text{Number of voxels in mask}} \quad (Eq. 2)$$

10 where j = subject

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16 This coefficient was then used as our GFC-R index. A negative GFC-R index indicates an
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18 increased GFC frequency in $GFC-Diff_{CR+<CR-}$ and a simultaneous decrease in $GFC-Diff_{CR+>CR-}$
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20 , i.e. a MCI CR- characteristic pattern. Conversely a positive GFC-reserve indicates an
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22 increased GFC frequency in $GFC-Diff_{CR+>CR-}$ and a decreased frequency in $GFC-Diff_{CR+<CR-}$,
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24 a pattern that was typically seen in MCI CR+.

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27 All steps described above were conducted also for the test sample (ISD). Supplementary
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29 Figure 1 is showing – equivalent to Figure 2B - the distribution of GFC voxels averaged
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31 across subjects within CR and diagnostic (MCI vs. HC) groups. When conducting the t-tests
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33 to compare the GFC-Diff values between MCI CR+ and MCI CR-, we found $GFC-Diff_{CR+<CR-}$
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35 in a range from 0.2-0.22 (vs. 0.2-0.26 in the training sample) and the $GFC-Diff_{CR+>CR-}$ in a
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37 range from 0.29-0.41 (vs. 0.34-0.5 in the training sample). The $GFC-Diff_{CR+<CR-}$ fully
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39 overlapped between both samples, whereas the $GFC-Diff_{CR+>CR-}$ only partly overlapped. For
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41 our validation analysis, we used the $GFC-Diff_{CR+>CR-}$ and $GFC-Diff_{CR+<CR-}$ ranges derived
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43 from the training sample to compute the GFC-R index in the test sample. All above delineated
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45 steps were conducted accordingly for 7 major brain networks derived from a previous
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47 publication to control whether a relationship between CR and GFC was specific for the
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49 cognitive control network. Again, $GFC-Diff_{CR+>CR-}$ and $GFC-Diff_{CR+<CR-}$ ranges were assessed
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51 in the training sample and used to create the GFC-R index in the test sample. The histogram
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53 analysis was conducted fully-automated using in-house MATLAB scripts.
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2 **Statistical Analysis:**
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4 Demographic variables were compared between groups using t-tests for continuous variables
5 and χ^2 -test for gender.
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9 In order to test whether the GFC-R index differed between MCI CR+ vs. MCI CR- groups in
10 the training sample, we conducted an ANCOVA, with group as the predictor, and age, gender,
11 the global AV45 uptake, the grey matter volume within the cognitive control network and the
12 learning score of the RAVLT as covariates. To evaluate how accurately the GFC-R index
13 classified between MCI CR+ and MCI CR- subjects we performed a Receiver Operating
14 Characteristic (ROC) Curve analysis. Prediction accuracy was quantified using the area under
15 the curve (AUC). The 95% Confidence interval (CI) for each ROC was computed with 2000
16 stratified bootstrap replicates for each ROC analysis. Equivalent models were run in the test
17 sample, with the exception of AV45 PET uptake, which was not available in the ISD test
18 sample.
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34 Lastly, we tested whether the GFC-R index predicted the CR proxies (years of education,
35 CRIq) in the MCI subjects of the test sample (pooled across CR+ and CR-). To this end we
36 conducted a multiple regression analysis, with the GFC-R index as a predictor of years of
37 education or the CRIq, controlled for age, gender, the learning score of the CERAD and the
38 total grey matter volume within the cognitive control network. For the ADNI sample, the
39 association between the continuous AV-45 PET measure and GFC-R was tested in the MCI
40 subjects (who were by definition of the inclusion criteria all AV-45 PET positive). We
41 conducted a linear regression analysis, with AV45 uptake as independent variable and the
42 GFC-R index as dependent variable, and age, gender, the RAVLT learning score and grey
43 matter volume as covariates. Next, we tested whether our findings on the GFC-R for the
44 prediction of years of education were specific for the cognitive control network. Thus, the
45 regression analyses on GFC-R were repeated for each GFC-R index derived on the GFC
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1 frequencies in one of 7 major functional brain networks (i.e. Default Mode Network (DMN),
2 Visual Network, Somatomotor Network, Dorsal Attention Network (DAN), Ventral Attention
3 Network (VAN), Limbic Network, Frontoparietal Network (FPAN)) (Yeo et al., 2011).
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6 All statistical analyses were conducted using the statistical software package *R* (*R*
7 Development Core Team, 2013). Linear models were computed using the `lm` command in *R*.
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9 Linear model assumptions (skewness, kurtosis, heteroscedasticity) were tested using the
10 `gvlma` function implemented in *R*. For all models reported, no significant ($\alpha = 0.05$)
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RESULTS:

Demographics, cognitive measures and the mean GFC-reserve index values for the training and test sample are depicted in table 1.

GFC Distribution:

Figure 3 shows the spatial distribution of significant GFC values in the brain displayed in percentiles for the training (ADNI) and the test sample (ISD). We found a high spatial correspondence of significant GFC values between both samples with a correlation coefficient of $r = 0.84$, $p < 0.001$. The highest GFC values were observed predominantly within the frontal cortex, lateral parietal cortex, and areas of the medial brain surface. Those brain areas are known to be part of the DMN and the cognitive control network as reported previously (Cole et al., 2010).

The GFC-reserve index is decreased in MCI CR- as compared to MCI CR+:

MCI CR- showed significantly lower GFC-R index values than the MCI CR+ subjects in the training sample ($F(6,36) = 16.82$, $p = 0.0002$; see Figure 4A) and the test sample ($F(5,17) = 7.93$, $p = 0.0119$). In an exploratory regression analysis, we tested the association between the

1 global AV45 uptake and the GFC-R index of the cognitive control network with age, gender,
2 grey matter volume of the cognitive control network and the RAVLT learning score as
3 covariates. The model showed no relationship between AV45 and the GFC-R index ($t(37) = -$
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5 0.1482, $p = 0.54$).
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10 11 **ROC analysis:**

12 Using a ROC analysis, we evaluated how accurate the GFC-reserve index discriminated
13 between MCI CR+ and MCI CR- subjects (Figure 4B). The AUC was 0.840 with the 95% CI
14 ranging between 0.72 and 0.95 within the training sample. Similarly, in the test sample, we
15 found a AUC of 0.79 with the CI ranging from 0.60-0.99.
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26 **The GFC-reserve index is a predictor of CR proxies in the ISD test sample:**

27 Using linear regression, we tested whether the GFC-R index predicted CR proxies in the test
28 sample, when controlling for age, gender, the word list learning score of the CERAD battery
29 and grey matter volume of the cognitive control network. For years of education, the
30 regression model was significant ($F(5,17) = 12.63$, $p = 0.00003$) with an adjusted R^2 of 0.72,
31 showing that a higher GFC-R index significantly predicted higher years of education ($t(17) =$
32 2.232, $p = 0.039$). For the CRIq score, a higher GFC-R index predicted a higher CRIq score
33 ($t(17) = 2.638$, $p = 0.173$, overall model fit: $F(5,17) = 4.422$, $p = 0.009$, adjusted R^2 0.44). The
34 relationship between the GFC-R index and the CR proxies is illustrated in Figure 5. When
35 testing the Pearson-moment correlation between the GFC-R index and our CR proxies, the
36 correlation was significant for both years of education ($r = 0.46$, $p = 0.026$) and the CRIq ($r =$
37 0.6, $p = 0.0024$).
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58 **Control analyses in other brain networks:**

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1 In order to test, whether our findings on the prediction of years of education by GFC-R index
2 were specific for the cognitive control network, we repeated the regression analysis for GFC-
3 R index derived from each of seven other major cortical networks (Yeo et al., 2011). For none
4 of the other networks, the GFC-R index predicted years of education or the CRIq ($p > 0.05$,
5 table 2). This suggests that the relationship between GFC changes and education is specific
6 for the cognitive control network.
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DISCUSSION:

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2 The first major finding of the current study was that MCI subjects with high CR (as measured
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4 by years of education) had an increased frequency of high GFC values within the cognitive
5
6 control network compared to MCI subjects with lower years of education. Secondly, a newly
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8 derived summary measure of abnormal GFC frequencies within the cognitive control
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10 network, the GFC-R index, was associated with more years of education and a higher CR_{Iq}
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12 score, a composite measure of CR, in an independent cross-validation sample of MCI
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14 patients. The predictive value of GFC-R index was independent of demographic variables
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16 including age and gender, episodic memory performance or grey matter volume of the
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18 cognitive control network. These results suggest that the GFC-R index constitutes a
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20 biomarker candidate of CR-related functional brain changes in MCI.
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26 For our first major finding, MCI CR₊ showed a right-ward shift of the GFC histogram to that
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28 in HC CR₊, i.e. MCI CR₊ showed an increased frequency of relatively high GFC values. In
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30 contrast, there was a left-ward shift of the GFC histogram in the MCI CR₋ group, i.e. an
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32 increased frequency of lower GFC values. A previous study on GFC changes in MCI reported
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34 decreased GFC in the frontal, parietal, and temporal cortices in MCI (J. Wang et al., 2013).
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36 That latter study, however, did not assess the impact of years of education on GFC
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38 differences. Our results extend those previous results showing that the levels of CR are an
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40 important modifying factor, where MCI CR₋ subjects show a decrease in GFC but MCI CR₊
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42 subjects show an increase in GFC within the cognitive control network.
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49 The increase in the frequency of high GFC values in MCI CR₊ may reflect either pre-existing
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51 high levels of GFC before the development of MCI or, alternatively, a compensatory increase
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53 in GFC during the development of MCI. Previous studies showed that higher IQ is associated
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55 with higher GFC within the left frontal core region of the cognitive control network in young
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57 subjects (Cole, Yarkoni, Repovs, Anticevic, & Braver, 2012). Given that years of education
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59 and IQ are correlated (Matarazzo & Hermann, 1984), it is possible that MCI CR₊ subjects
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1 had already higher levels of GFC before disease onset, thus possessing higher brain reserve.
2 However, the fact that MCI CR+ subjects showed abnormally increased frequency of high
3 GFC values when compared to HC CR+, i.e. at similarly high levels of education, suggests a
4 compensatory increase of GFC in MCI. Such an interpretation of compensatory increase of
5 GFC in MCI is consistent with several previous studies showing increased resting-state
6 functional connectivity in MCI and AD compared to HC (K. Wang et al., 2007), that is
7 attributable to higher levels of education (Bozzali et al., 2015). In summary, the MCI CR+
8 subjects show increased frequency of high GFC values within the cognitive control network,
9 which probably reflects compensatory changes in MCI.
10

11 For our second major finding, we could show in a cross-validation approach that higher levels
12 of the GFC-R index are predictive of higher levels of education and CRIq in MCI and could
13 well separate high vs. low education groups in MCI as shown by the ROC analysis, with an
14 AUC of 0.79. Note however that sensitivity and specificity is not of primary clinical
15 significance in the context of CR, which is likely to be continuously distributed. More
16 importantly, the GFC-R index significantly predicted the level of CR proxies in the validation
17 sample. The point prediction is difficult but clinically important as previous studies showed
18 that with each additional year of education, the onset of dementia is delayed by 0.21 years
19 (Hall et al., 2007) and the risk of AD dementia is reduced (Sando et al., 2008; Stern et al.,
20 1994). A critical test in the future will be whether the GFC-R index predicts slower cognitive
21 decline in subjects with preclinical AD or MCI as has been reported for years of education as
22 a proxy of CR (Soldan et al., 2015). The advantage of using fMRI based CR biomarkers such
23 as GFC-R in such prediction models is that GFC-R could be used as a measure to track CR
24 changes over time. CR may be reduced as the disease progresses since brain pathology may
25 eventually use up the reserve (Members et al., 2010). In contrast, proxies of CR such as
26 education or occupational attainment are time-invariant.
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1 We found that only the GFC-R index derived from GFC values within the cognitive control
2 network but not within any of the other major resting-state networks was predictive of years
3 of education or CRIq. These results suggest that frequency changes of GFC specifically
4 within the cognitive control network are related to CR. These results are broadly consistent
5 with previous findings showing that higher GFC of brain regions in the cognitive control
6 network but not the default mode network were predictive of higher IQ in healthy subjects
7 (Cole et al., 2012). A possible explanation includes that the cognitive control network has a
8 unique role in the brain, such that it is highly connected with the other networks and may
9 orchestrate the activation of other networks during cognitive tasks (Cole, Repovs, &
10 Anticevic, 2014; Cole et al., 2013). Brain regions with increased connectedness in the brain
11 have previously shown to be more resilient to targeted attacks as shown in graph theoretical
12 analysis of resting state fMRI (Achard, Salvador, Whitcher, Suckling, & Bullmore, 2006).
13 Higher GFC of the cognitive control network may enable to more flexibly activate different
14 networks during cognitive processing (Cole et al., 2013), which in neurodegenerative disease
15 may render a more flexible coping with local damage of specific neural networks, thus
16 increasing CR. This will need to be tested in future combined resting-state and task-related
17 fMRI studies.

18 We used years of education as our primary outcome measure, i.e. the gold standard, since
19 educational attainment has been recommended as the best validated indicator of cognitive
20 reserve (Stern, 2012). Years of education has been tested as a CR proxy in numerous studies
21 in AD (for review see (Stern, 2012)) and is robustly associated with reduced risk of AD
22 dementia across studies (Meng & D'Arcy, 2012; Valenzuela & Sachdev, 2006). Alternative
23 proxy measures of CR include assessments such as occupational attainment, premorbid IQ or
24 leisure activities. Since we used international cross-validation samples, equivalent measures
25 of such variables were not available in both samples in the current study. However, we found
26 a positive association between the GFC-R index and the CRIq (Nucci et al., 2012) an

1 alternative CR proxy that takes into account education, working and leisure activities,
2 supporting criterion validity of the GFC-R index.
3

4 A promising alternative marker of CR has been recently proposed, consisting of the residual
5 episodic memory variability after accounting for brain atrophy and demographic variables
6 (Reed et al., 2010; Zahodne et al., 2015; Zahodne et al., 2013). Such a measure captures well
7 CR as the discrepancy between the level of cognitive performance and brain pathology, but is
8 non-informative about any structural or functional brain changes that may underlie CR. The
9 current biomarker captures functional brain changes of CR and would thus be complimentary
10 to such memory-variance based marker or any of the standard proxy measures of CR.
11

12 For the interpretation of the current results several caveats need to be taken into account. It is
13 important to note that the GFC-R index is not a biomarker candidate of CR *per se*, rather it is
14 a biomarker of functional brain changes that underlie CR. Ideally, the primary outcome
15 parameter for the validation of the current biomarker constitute specific functional
16 mechanisms that cause CR. Although several task fMRI studies have attempted to extract
17 specific functional brain changes of CR in subjects with MCI and AD, no core mechanism,
18 however, has yet emerged (for review see (Barulli & Stern, 2013)). Thus, more work is
19 needed to disentangle the functional brain processes that underlie CR, which could then
20 provide a point of reference for the validation of functional biomarkers of CR. Still, years of
21 education has been validated in numerous studies as a marker of CR and may thus constitute
22 the best primary outcome as a reference measures for the validation of functional biomarkers
23 of CR at this point.
24

25 It should be also taken into account that the reliability of GFC assessment is an important
26 factor for the utility of GFC-R as a biomarker. Previous studies showed that GFC exhibits a
27 fair to excellent test-retest reliability and its retest reliability ranks among the highest of
28 resting state fMRI functional connectivity measures (Liao et al., 2013; J. H. Wang et al.,
29 2011). Multicenter variability of resting state fMRI is an active field of research and needs
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1 still to be established for the various connectivity indices including that of GFC. However,
2 the current cross-validation of the GFC-R between completely different samples using
3 different scanners and acquisition protocols suggest robustness of the current findings (Feis et
4 al., 2015). Summary indices that average across large number of voxels may be more robust
5 to multicenter variability that measures focusing on small ROIs (Ewers et al., 2006). Still, the
6 test-retest and multicenter variability of the GFC-R index needs to be established in future
7 studies.
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10 A strength of the current approach is the fully automated way to extract GFC frequency
11 changes based on resting state fMRI. Thus, functional MRI data can be assessed without
12 reliance on a task and data processing can be done without manual intervention, which
13 provides a high attractiveness to be used in clinical praxis. Possible clinical applications of the
14 GFC-R index as diagnostic biomarker candidate include the use outcome measure in clinical
15 trials such as cognitive training, physical training that target compensatory brain mechanisms
16 (Suo et al., 2016). Secondly, the GFC-R index could be used to track changes in CR during
17 the progression of the disease. Future longitudinal studies may address these next steps.
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1
2 **Conflict of Interest Statement:**
3

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5

6
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8

9
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11

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13

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22
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24

25
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27

28
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30

31
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33

34
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56 The authors declare that they have no conflict of interest
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Figure legends:

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2 *Fig. 1:* Meta-analytical activation map across 428 task-fMRI studies that were associated with
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4 search term “cognitive control” (FDR-corrected at $p < 0.01$) in NeuroSynth, projected on a
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6 brain surface. Colors indicate z-scores.
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11 *Fig. 2:* Analysis flow diagram, illustrating the steps of GFC-R index computation. (A) Voxel-
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13 wise GFC is computed based on preprocessed resting-state fMRI for each subject and masked
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15 with the binarized cognitive control network map. (B) The GFC frequency distribution within
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17 the cognitive control network is plotted for groups split by diagnosis (HC & MCI) and CR
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19 status (CR- & CR+). (C) GFC within the cognitive control network is binned in intervals of
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21 0.01 for each subject. Within each CR group, the difference in GFC differences (GFC-Diff)
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23 between each MCI subject and the average GFC within the HCs group is computed.
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25 Colored areas indicate whether MCI subjects showed lower (red) or higher (green) GFC
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27 frequency than the HC subjects. (D) GFC-Diff scores are compared between MCI CR+ and
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29 MCI CR- groups via bin-wise two-sample t-tests. (E) GFC-Diff scores are summed up across
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31 the selected bins for each MCI subject. In order to create a subject-specific summary score of
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33 GFC frequency differences indicative of CR+ status, the sum of GFC-Diff values in the GFC-
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35 Diff_{CR+<CR-} was subtracted from the sum of GFC-Diff values in the GFC-Diff_{CR+>CR-}. (F) This
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37 differences was divided by the total number of voxels in the cognitive control network mask
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39 to standardize it to a range between -1 and 1 to derive the GFC-R index for each MCI subject.
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51 *Fig. 3:* Distribution of significant GFC values in the brain. T-values of voxel wise one-sample
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53 t-tests of the GFC among the pooled HC and MCI subjects (FWE corrected at the voxel level
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55 at $\alpha = 0.001$) were converted to percentiles to facilitate visual group comparison between
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57 both samples.
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Fig. 4: (A) Boxplots of the GFC-R index split by CR group for the training and the test sample. MCI CR- subjects show significantly lower GFC-CR values as MCI CR+ subjects in both samples. (B) shows the ROC curves with the specificity on the x- and the sensitivity on the y-axis. AUC = Area under the curve, * = $p < 0.05$, ** = $p < 0.001$

Fig. 5: Scatterplot for the relationship between the GFC-R index and the CR proxies (years of education & CRIq) in the test sample.

Supplementary Fig. 1: Shown is the distribution of GFC voxels averaged across subjects within CR (CR+ vs. CR-) and diagnostic (MCI vs. HC) groups for the test sample. The graphs are equivalent to Figure 2B of the main manuscript.

Tables:

Table 1: Demographics and neuropsychological characteristics of the study samples subjects split by Diagnosis and CR group

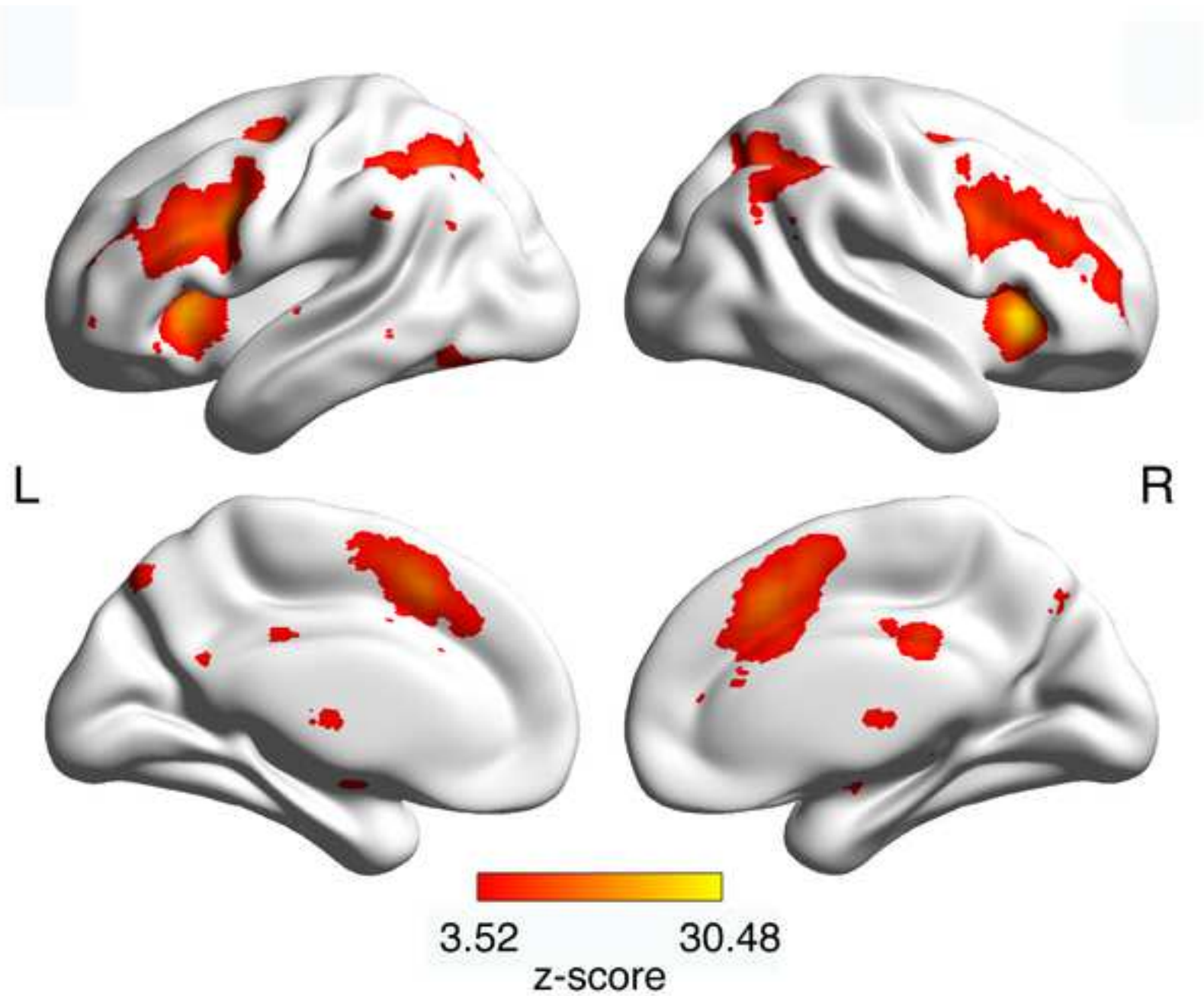
Training sample (ADNI)				
	HC CR- (<i>n</i> = 13)	HC CR+ (<i>n</i> = 11)	MCI CR- (<i>n</i> = 24)	MCI CR+ (<i>n</i> = 19)
Age (years) ²	75.12 ± 5.85	74.30 ± 7.56	74.90 ± 5.87	69.10 ± 6.16
Gender (female/male)	3/10	5/6	14/10	12/7
Education ^{1,3}	15.15 ± 1.41	18.64 ± 1.12	14.17 ± 1.58	18.58 ± 1.02
Global AV45 Uptake	0.99 ± 0.45	0.98 ± 0.04	1.4 ± 0.18	1.37 ± 0.15
MMSE ^{2,3}	29.12 ± 0.91	27.91 ± 1.45	26.71 ± 1.63	28.16 ± 1.34
RAVLT Learning ¹	45 ± 13.46	43.74 ± 7.81	31.71 ± 9.40	38.70 ± 8.91
Test sample (ISD)				
	HC CR- (<i>n</i> = 17)	HC CR+ (<i>n</i> = 15)	MCI CR- (<i>n</i> = 13)	MCI CR+ (<i>n</i> = 10)
Age (years)	70.17 ± 3.94	72.52 ± 6.33	77.02 ± 3.63	73.87 ± 4.23
Gender ⁴ (female/male)	13/4	5/10	11/2	8/2
Education ^{1,3}	11.59 ± 1.33	16.6 ± 2.1	10.92 ± 1.98	17.1 ± 2.08
MMSE ¹	29.53 ± 0.87	29.33 ± 0.72	25.15 ± 1.52	27.9 ± 2.33
CERAD Word List Learning ¹	23 2.6	24.07 3.24	13.3 2.84	18.9 3.14

- 1) MCI CR+ > MCI CR-
- 2) MCI CR+ < MCI CR-
- 3) HC CR+ > HC CR-
- 4) HC CR+ < HC CR-

Table 2: Control analyses of the GFC-R index as a predictor of CR proxies in major brain networks

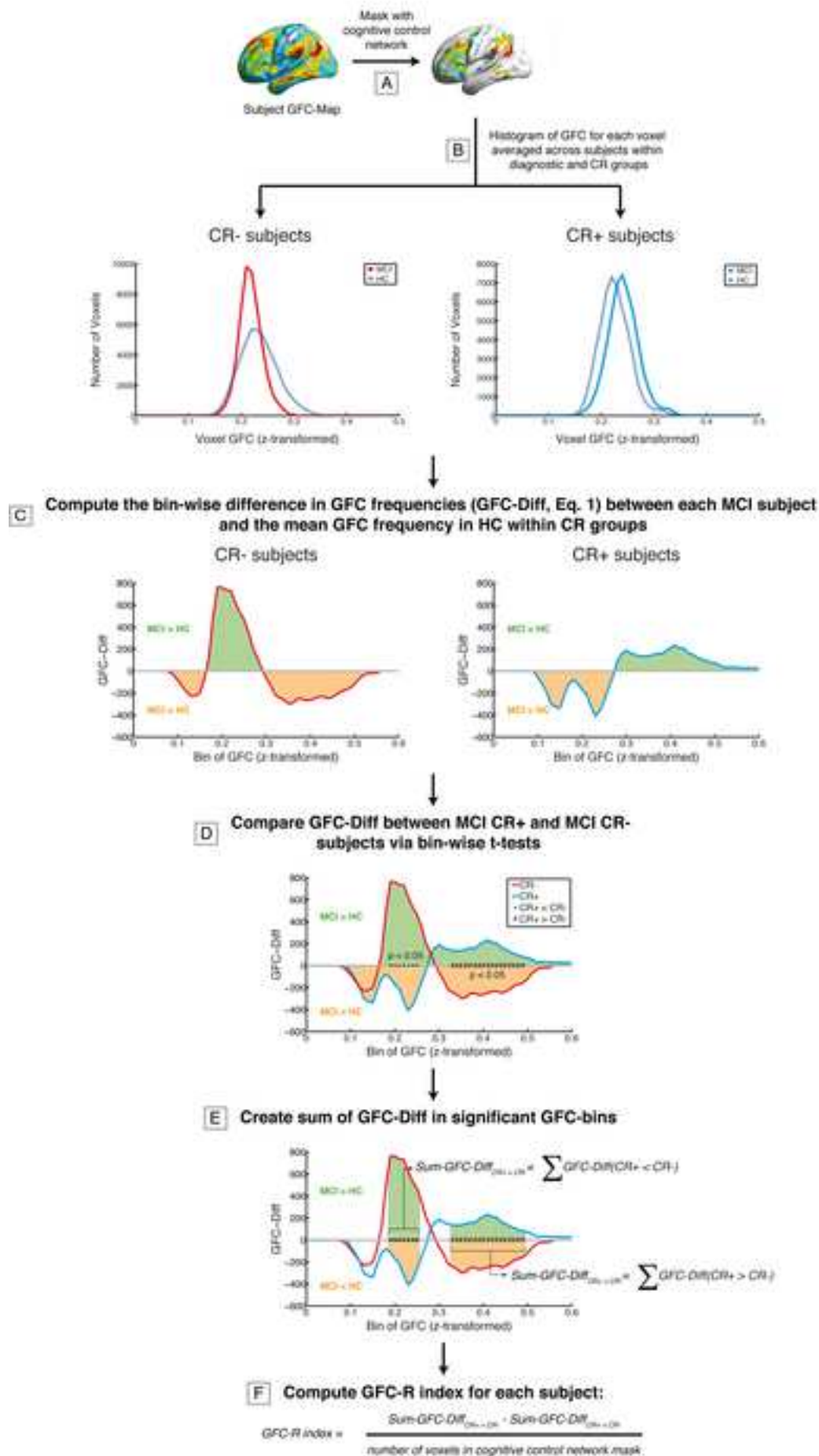
Training sample (ADNI)			Test sample (ISD)			
Functional Network	GFC-Diff		GFC-CR as a predictor of education in MCI CR+ and CR- pooled ¹		GFC-CR as a predictor of CRi _q in MCI CR+ and CR- pooled ¹	
	CR+<CR-	CR+>CR-	T	p	T	p
Cognitive Control	0.2-0.26	0.34-0.5	2.232	0.039	2.638	0.017
Default Mode	0.2-0.27	0.37-0.52	0.663	0.516	1.365	0.190
Dorsal Attention	0.22-0.28	0.41-0.51	0.981	0.341	0.948	0.356
Ventral Attention	0.19-0.23	0.3-0.5	0.927	0.367	1.820	0.087
Frontoparietal	0.2-0.27	0.35-0.52	1.258	0.225	1.656	0.116
Limbic	0.25	0.36-0.46	0.566	0.579	0.562	0.582
Visual	0.22-0.28	0.43-0.53	0.256	0.801	1.571	0.135
Somatomotor	0.21-0.28	0.32-0.46	1.2526	0.227	0.849	0.408

1) Models controlled for age, gender, grey matter volume of the tested network, CERAD Word list learning score

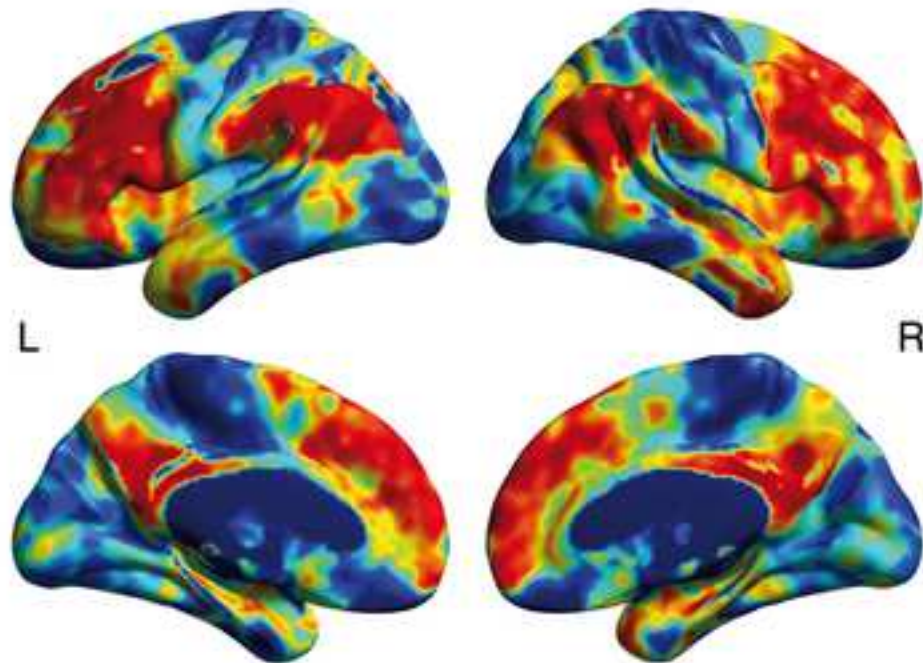


Meta-analysis: fMRI activation - cognitive control

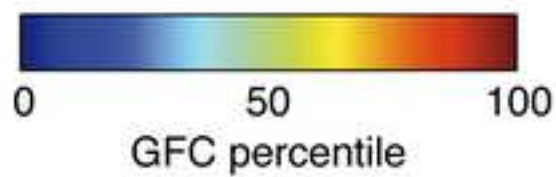
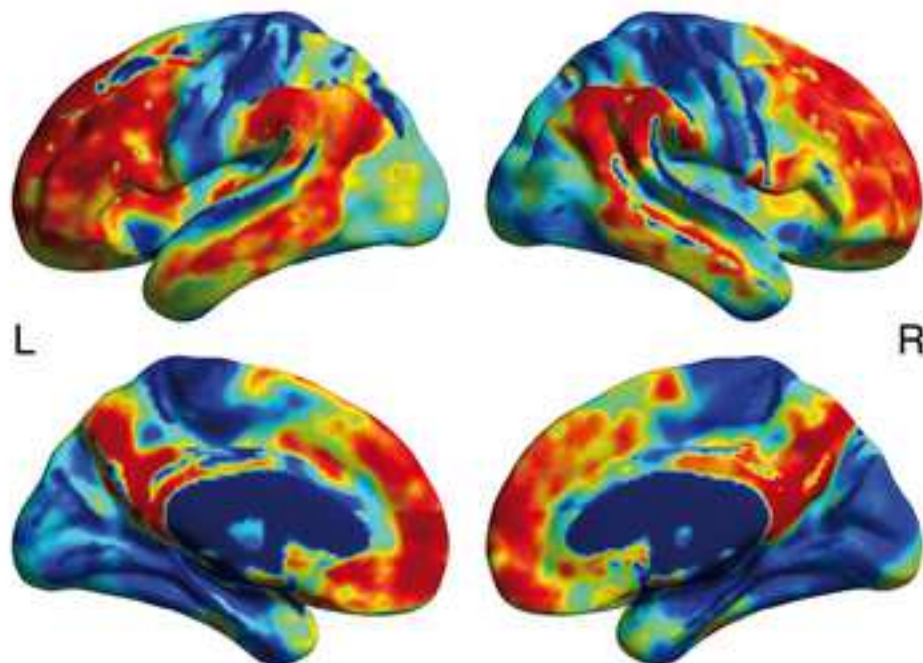
Analysis flow diagram (training sample)

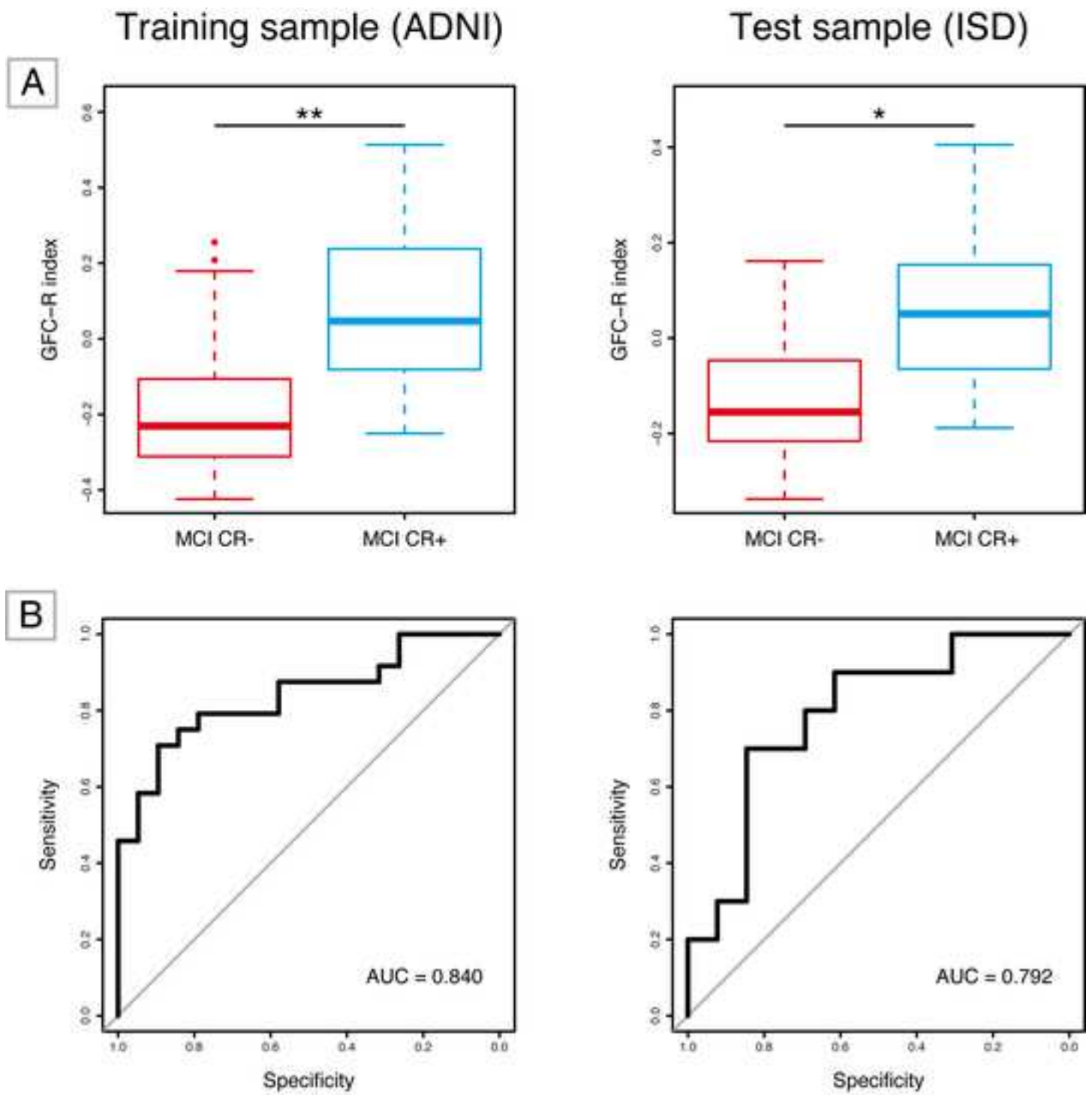


Training sample (ADNI)

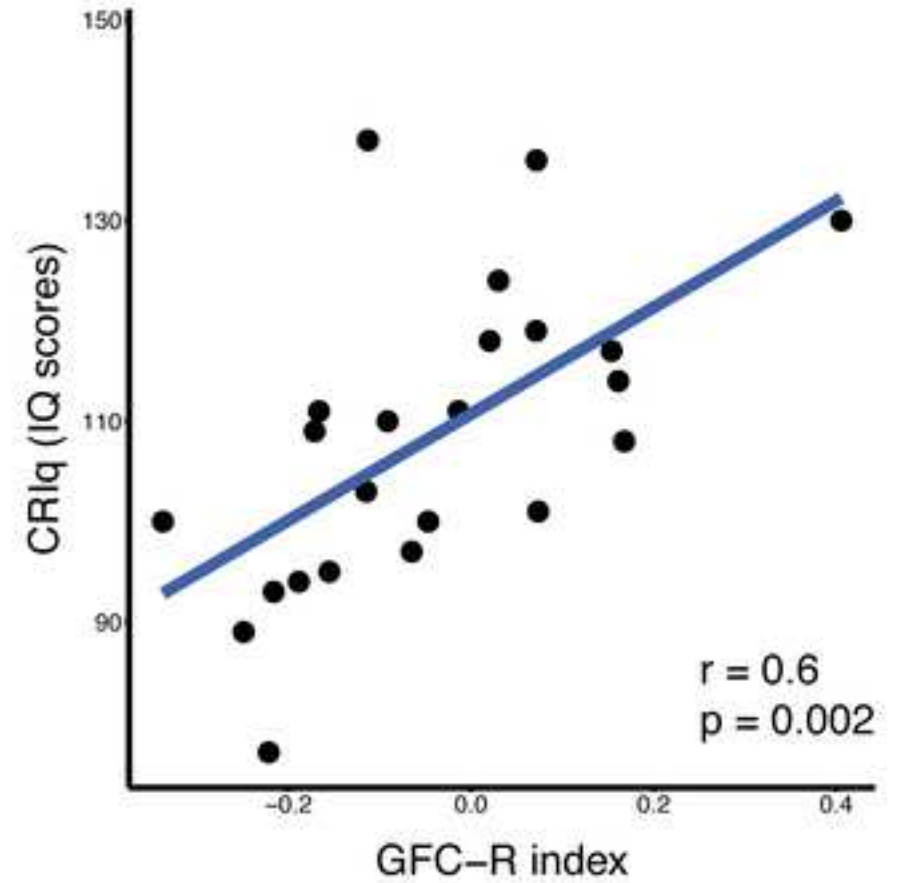
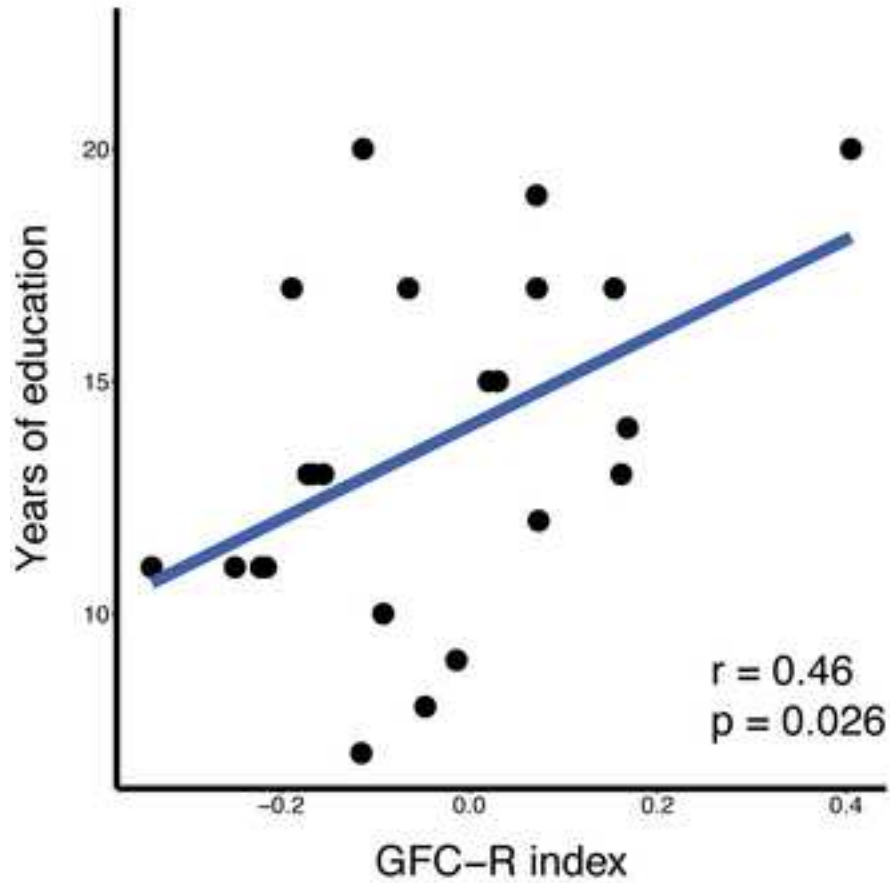


Test sample (ISD)





Test sample (ISD)



Test sample (ISD)

