ON-LINE APPENDIX

APOE ϵ 4

APOE ε 4 is the strongest known common genetic risk factor for sporadic AD. *APOE* ε 4 increases the age-specific risk of developing AD in a dose-dependent manner compared with noncarriers, at least through ages $85-90$ years,^{1,2} and lowers the age of onset by up to 4–6 years for ε 4 homozygotes relative to noncarriers.^{1,3,4} Thus, ε 4 status may be of importance diagnostically in the clinic, but it may also be important if medications are developed that affect carriers and noncarriers differently. Though it is not thought to increase synthesis of monomeric $A\beta_{1-42}$ (A β) in the brain,5,6 4 nevertheless increases the burden of synaptotoxic oligomeric $A\beta$ ⁷⁻⁹ particularly near synapses, and this is hypothesized to facilitate its higher potency in producing AD. Several studies have examined the effects of ε 4 on rates of hippocampal volume loss,10-12 with a few also assessing the effects of $A\beta$,¹³⁻¹⁶ but results have been inconsistent, and the effects across the diagnostic spectrum on cognitive rates of decline and rates of volume loss in multiple brain regions have not been well understood.

In follow-up analyses, we examined whether ε 4 interacted with age to affect rates of structural or clinical decline in each diagnostic group, that is, the additional effect of an age \times ε 4 interaction implemented with an extra term $\rm{b_{Age APOE}A_iE_i t_{ij}}$ in Equation 1, and, separately, whether ε 4 interacted with sex to affect the rates of structural or clinical decline, by including an extra term b_{APOESex}E_iS_it_{ij} in Equation 1.

Interactions Among **APOE** *4, Age, and Sex on Rates of Decline*

For HC and MCI cohorts, there were no significant ε 4 \times age, ε 4 \times sex, or sex \times age interactions on rates of structural or clinical decline.

In the AD cohort, the ε 4 \times age interaction was significant only for the entorhinal cortex, for which $b_{\text{AgeAPOE}} = -0.1\% / year^2$ $(SE = 0.05, P = .041)$, indicating that the slowing in rate of decline with advancing age is attenuated in ε 4 carriers compared with noncarriers. With the interaction term in the model, the sex effect remained significant, $b_{\text{sex}} = -0.57\%$ /year $(SE = 0.22, P = .009)$, and the direct age effect also remained significant, $b_{Age} = 0.11\% / year^2$ (SE = 0.04, *P* = .006), but the direct ε 4 effect remained insignificant, $b_{\rm APOE} = -0.36\%$ /year $(SE = 0.25, P = .15).$

There were no significant ε 4 \times age interactions on cognitive measures, except for ADAS-Cog in MCI converters to AD for which $b_{AgeAPOE} = 0.28/year^2$ (SE = 0.10, *P* = .006). With the interaction term in the model, the sex effect remained significant, $b_{\text{sex}} = 1.55/\text{year}$ (SE = 0.51, *P* = .002), but the direct ε 4 effect showed only a trend toward significance, $b_{\text{APOE}} = -1.06$ /year $(SE = 0.57, P = .063).$

A significant ε 4 \times sex effect was found only for ADAS-Cog in the AD cohort, for which $b_{APOESex} = 4.80$ /year (SE = 1.87, *P* = .011), indicating faster decline for women who are ε 4 carriers compared with all others. With this term in the model, the direct *APOE* ε 4 term remained insignificant, $b_{\text{APOE}} = -1.05\%$ /year $(SE = 1.31, P = .42)$, but the direct sex term approached significance, $b_{\text{sex}} = -2.96/\text{year}$ (SE = 1.60, *P* = .064).

Rates of Decline for MCI-to-AD Converters

Because MCI is a heterogeneous condition, not necessarily prodromal AD, and *APOE* ε 4 may have a selection effect for participants who are on an AD trajectory, we carried out an additional analysis restricted to MCI participants who converted to AD while being followed in the ADNI study.

On-line Table 1 shows the effects of age, *APOE* ε 4 status, and sex on atrophy rates and clinical decline in the subset of MCI participants who converted to AD. The b_{APOE} term was found to be significant for the amygdala, inferior parietal cortex, and middle temporal cortex, approaching significance for the entorhinal cortex ($P = .060$) and the whole brain ($P = .064$); the b_{Sex} term was significant for the amygdala, entorhinal cortex, medial orbito-frontal cortex, and ADAS-Cog, approaching significance for the whole brain $(P = .063)$.

Effects of **APOE** *4 and Sex on Baseline CSF and Clinical Measures*

There was insufficient power to assess ε 4 \times sex interactions on biomarker levels in the HC and AD groups (On-line Table 7 shows the number of participants in each category), but they could be explored in the MCI group, in which a trend toward significance was found for CSF A β concentrations ($P = .08$, Online Table 5*B*) and τ concentrations (*P* = .12). For A*β* concentrations, subsequent analysis showed that the ε 4 effect occurred only in men, with ε 4 carriers having significantly lower values than noncarriers ($P = 3 \times 10^{-7}$, On-line Table 6*A*); in women, A β concentrations were comparably lower for both carriers and noncarriers ($P = .498$); there was, however, only a trend toward a sex effect in ε 4 noncarriers (lower concentrations for women, $P =$.105), whereas carriers had similarly low concentrations ($P =$.91). Thus, results in MCI suggest a potential interaction between sex and ε 4 status on CSF A β concentration, in which ε 4-negative status does not confer the same advantage to women as it does to men. For τ concentrations, although the interaction effect was not significant, subsequent analysis showed that whereas there was a significant ε 4 effect in both sexes (carriers had higher values, $P =$.025 for men and $P = .014$ for women, On-line Table 6*A*), the sex effect occurred only in ε 4 carriers, in whom women had significantly higher concentrations than men ($P = .036$, On-line Table 6*B*, a pattern that also occurred in AD; $P = .019$); in noncarriers, τ concentrations were similarly low for both men and women $(P = .955)$.

Interaction effects of ε 4 \times sex were found in AD for ADAS-Cog and MMSE, and in MCI for MMSE, only (On-line Table 5*B*). Subsequent analysis showed that there was an ε 4 effect in AD for ADAS-Cog in men only, with carriers performing worse than noncarriers (On-line Table 6*A*). In women, there was no difference in performance on this measure as a function of ε 4 status: both groups performed comparably to men with an ε 4 allele. There was a sex effect in AD for MMSE for ε 4 noncarriers only, with women performing more poorly. In MCI, women with ε 4 performed more poorly than the other 3 groups (On-line Table 6*B*).

ADNI Database

Data used in the preparation of this article were obtained from the ADNI database (adni.loni.ucla.edu). The ADNI was launched in

2003 by the National Institute on Aging, the National Institute of Biomedical Imaging and Bioengineering, the Food and Drug Administration, private pharmaceutical companies, and nonprofit organizations as a \$60 million, 5-year public-private partnership. The primary goal of the ADNI has been to test whether serial MRI, PET, other biologic markers, and clinical and neuropsychological assessment can be combined to measure the progression of MCI and early AD. Determination of sensitive and specific markers of very early AD progression is intended to aid researchers and clinicians to develop new treatments and monitor their effectiveness as well as lessen the time and cost of clinical trials.

The Principal Investigator of this initiative is Michael W. Weiner, MD, VA Medical Center and University of California– San Francisco. ADNI is the result of efforts of many co-investigators from a broad range of academic institutions and private corporations, and subjects have been recruited from more than 50 sites across the United States and Canada. The initial goal of the ADNI was to recruit 800 adults, ages 55–90, to participate in the research, approximately 200 cognitively normal older individuals to be followed for 3 years, 400 people with MCI to be followed for 3 years, and 200 people with early AD to be followed for 2 years. For up-to-date information, see www.adni-info.org.

Participants

The ADNI general eligibility criteria have been described elsewhere.¹⁷ Briefly, participants are not depressed, have a modified Hachinski score of \leq 4, and have a study partner able to provide an independent evaluation of functioning. HC participants have a CDR of 0. Participants with MCI have a subjective memory complaint, objective memory loss measured by education-adjusted scores on Wechsler Memory Scale Logical Memory II, a CDR of 0.5, preserved activities of daily living, and absence of dementia. Participants with AD have a CDR of 0.5 or 1.0 and meet National Institute of Neurological Disorders and Stroke and Alzheimer's Disease and Related Disorders Association criteria for probable AD.

MRI Processing

We preprocessed all MRI scans with the use of image correction procedures for site-specific distortion effects updated for recent scanner changes.¹⁸ We quantified anatomical regional change in serial MRI with the use of Quarc,^{19,20} a recently developed method from our laboratory. The longitudinal outcome measure of change with respect to baseline was calculated by directly registering each follow-up scan to the baseline scan. To evaluate baseline ROI measurements, we used a structural MRI postprocessing technique that automatically delineates subcortical²¹ and cortical²² ROIs. We analyzed data from all available time points that passed local quality control (total $= 2244$). The number of follow-up scans was reduced by approximately 15% primarily as the result of motion artifacts, change in scanner model, or change in radiofrequency coil, as described in Holland et al.¹⁸

Methodologic bias in image registration, leading to artifactually elevated effect sizes and reduced sample size estimates, remains a concern in the structural neuroimaging literature.²⁰ Several robust approaches to reducing or eliminating bias have been developed.^{23,24} Our explicitly inverse-consistent approach¹⁹ essentially eliminates potential bias by combining forward and reverse image registrations and has been assessed vis-à-vis other approaches.²⁰

ACKNOWLEDGMENTS

Data collection and sharing for this project was funded by the Alzheimer's Disease Neuroimaging Initiative (National Institutes of Health Grant U01 AG024904). ADNI is funded by the National Institute on Aging, the National Institute of Biomedical Imaging and Bioengineering, and through generous contributions from the following: Abbott; Alzheimer's Association; Alzheimer's Drug Discovery Foundation; Amorfix Life Sciences, Ltd; AstraZeneca; Bayer HealthCare; BioClinica, Inc; Biogen Idec, Inc; Bristol-Myers Squibb Company; Eisai, Inc; Elan Pharmaceuticals, Inc; Eli Lilly and Company; F. Hoffmann-La Roche, Ltd, and its affiliated company, Genentech, Inc; GE Healthcare; Innogenetics, N.V.; IXICO Ltd; Janssen Alzheimer Immunotherapy Research & Development, LLC; Johnson & Johnson Pharmaceutical Research & Development LLC.; Medpace, Inc; Merck & Co, Inc; Meso Scale Diagnostics, LLC; Novartis Pharmaceuticals Corporation; Pfizer, Inc; Servier; Synarc Inc; and Takeda Pharmaceutical Company. The Canadian Institutes of Health Research is providing funds to support ADNI clinical sites in Canada. Private sector contributions are facilitated by the Foundation for the National Institutes of Health (www.fnih.org). The grantee organization is the Northern California Institute for Research and Education, and the study is coordinated by the Alzheimer's Disease Cooperative Study at the University of California, San Diego. ADNI data are disseminated by the Laboratory for Neuro Imaging at the University of California, Los Angeles. This research was also supported by NIH grants P30 AG010129 and K01 AG030514.

ON-LINE REFERENCES

- 1. Sando SB, Melquist S, Cannon A, et al. **APOE epsilon 4 lowers age at onset and is a high risk factor for Alzheimer's disease; a case control study from central Norway.** *BMC Neurol* 2008;8:9
- 2. Khachaturian AS, Corcoran CD, Mayer LS, et al. **Apolipoprotein E epsilon4 count affects age at onset of Alzheimer disease, but not lifetime susceptibility: the Cache County Study.***Arch Gen Psychiatry* 2004;61:518 –24
- 3. Corder EH, Saunders AM, Strittmatter WJ, et al. **Apolipoprotein E, survival in Alzheimer's disease patients, and the competing risks of death and Alzheimer's disease.** *Neurology* 1995;45:1323–28
- 4. Kwon OD, Khaleeq A, Chan W, et al. **Apolipoprotein E polymorphism and age at onset of Alzheimer's disease in a quadriethnic sample.** *Dement Geriatr Cogn Disord* 2010;30:486 –91
- 5. Mawuenyega KG, Sigurdson W, Ovod V, et al. **Decreased clearance of CNS beta-amyloid in Alzheimer's disease.** *Science* 2010;330:1774
- 6. Castellano JM, Kim J, Stewart FR, et al. **Human apoE isoforms differentially regulate brain amyloid-beta peptide clearance.** *Sci Transl Med* 2011;3:89ra57
- 7. Prince JA, Zetterberg H, Andreasen N, et al. **APOE epsilon4 allele is associated with reduced cerebrospinal fluid levels of Abeta42.** *Neurology* 2004;62:2116 –18
- 8. Morris JC, Roe CM, Xiong C, et al. **APOE predicts amyloid-beta but not tau Alzheimer pathology in cognitively normal aging.***Ann Neurol* 2010;67:122–31
- 9. Koffie RM, Hashimoto T, Tai HC, et al. **Apolipoprotein E4 effects in Alzheimer's disease are mediated by synaptotoxic oligomeric amyloid-beta.** *Brain* 2012;135:2155–68
- 10. Morra JH, Tu Z, Apostolova LG, et al. **Automated mapping of hippocampal atrophy in 1-year repeatMRI data from 490 subjects with**

Alzheimer's disease, mild cognitive impairment, and elderly controls. *Neuroimage* 2009;45:S3–15

- 11. Wolz R, Heckemann RA, Aljabar P, et al. **Measurement of hippocampal atrophy using 4D graph-cut segmentation: application to ADNI.** *Neuroimage* 2010;52:109 –18
- 12. Risacher SL, Shen L, West JD, et al. **Longitudinal MRI atrophy biomarkers: relationship to conversion in the ADNI cohort.** *Neurobiol Aging* 2010;31:1401–18
- 13. Schuff N, Woerner N, Boreta L, et al. **MRI of hippocampal volume loss in early Alzheimer's disease in relation to ApoE genotype and biomarkers.** *Brain* 2009;132:1067–77
- 14. Tosun D, Schuff N, Truran-Sacrey D, et al. **Relations between brain tissue loss, CSF biomarkers, and the ApoE genetic profile: a longitudinal MRI study.** *Neurobiol Aging* 2010;31:1340 –54
- 15. Desikan RS, McEvoy LK, Holland D, et al. **Apolipoprotein E 4 does not modulate amyloid-beta-associated neurodegeneration in preclinical Alzheimer disease.** *AJNR Am J Neuroradiol* 2013;34:505–10
- 16. Chiang GC, Insel PS, Tosun D, et al. **Impact of apolipoprotein E4 cerebrospinal fluid beta-amyloid interaction on hippocampal volume loss over 1 year in mild cognitive impairment.** *Alzheimers Dement* 2011;7:514 –20
- 17. Petersen RC, Aisen PS, Beckett LA, et al. **Alzheimer's Disease Neu-**

roimaging Initiative (ADNI): clinical characterization. *Neurology* 2010;74:201–09

- 18. Holland D, Brewer JB, Hagler DJ, et al. **Subregional neuroanatomical change as a biomarker for Alzheimer's disease.** *Proc Natl Acad Sci USA* 2009;106:20954 –59
- 19. Holland D, Dale AM. **Nonlinear registration of longitudinal images and measurement of change in regions of interest.** *Med Image Anal* 2011;15:489 –97
- 20. Holland D, McEvoy LK, Dale AM. **Unbiased comparison of sample size estimates from longitudinal structural measures in ADNI.** *Hum Brain Mapp* 2012;33:2586 –602
- 21. Fischl B, Salat DH, Busa E, et al. **Whole brain segmentation: automated labeling of neuroanatomical structures in the human brain.** *Neuron* 2002;33:341–55
- 22. Desikan RS, Segonne F, Fischl B, et al. **An automated labeling system for subdividing the human cerebral cortex on MRI scans into gyral based regions of interest.** *Neuroimage* 2006;31:968 –80
- 23. Reuter M, Schmansky NJ, Rosas HD, et al. **Within-subject template estimation for unbiased longitudinal image analysis.** *Neuroimage* 2012;61:1402–18
- 24. Leung KK, Ridgway GR, Ourselin S, et al. **Consistent multi-timepoint brain atrophy estimation from the boundary shift integral.** *Neuroimage* 2012;59:3995–4005

ON-LINE FIG 1. Baseline cognitive performance, measured with CDR-SB, ADAS-Cog, and MMSE, by ε 4 status (left) and sex (right) for the HC, MCI, and AD cohorts. *Significant differences. Also see On-line Table 5*A*.

 $\sf ON-LINE\,FIG\,2.$ Top row shows baseline CSF A $\beta_{\rm L42}$ values for HC, MCI, and AD participants, with respect to age, categorized by *APOE &*4 status (upper row) and sex (lower row). Open circles with error bars are means for successive 5-year age ranges; closed circles represent individual participants. Lines are generalized linear model fits to the data. The linear fits show that regardless of diagnosis, *APOE* $e4^+$ had consistently lower .
CSF Aβ than APOE ε4 - . For the HC and MCI APOE ε4 ⁺ participants, the linear fits suggest an increase in Aβ burden with age (lower CSF Aβ),
becoming independent of age for the AD cohort. For the APOE ε4 - HCs, Aβ bur burden appeared to be greater for younger compared with older *APOE ɛ4* $^+$ MCI participants, but the positive slope (l.8 pg/[mL year], SE = 1.2) was not significantly different from zero (P = .15). The negative slope is also not significant (–0.9 pg/[mL year], SE = 0.7), but the difference between slopes approaches significance: $P = .058$.

ON-LINE FIG 3. See On-line Fig 1, but for baseline CSF p- τ . The negative p- τ slope for AD APOE $\varepsilon 4^+$ (-1.2 pg/[mL year], SE = 0.4) is significant: P = .01.

ON-LINE FIG 4. See On-line Fig 1, but for baseline CSF τ .

On-line Table 1: Direct effects of age, *APOE* **4, and sex on rates of change in individuals with MCI who converted to dementia within the 3-year follow-up period**

Measure	b_0	D_{Cog}	b_{Edu}	b_{Age} (SE; P)	b_{APOE} (SE; P)	b_{Sex} (SE; P)
Hippocampus	$-2.43^{\rm a}$	$-0.09a$	-0.01	0.01(.03; 0.8)	-0.22 (.33; .5)	-0.41 (.31; .2)
Amygdala	-2.10°	$-0.09a$	-0.04	0.03 (.03; .2)	-0.99 ^a (.33; .003)	-1.07 ^a (.31; 5 \times 10 ⁻⁴)
Entorhinal	-2.27 ^a	-0.03	0.00	0.05° (.02; .026)	-0.47 (.25; .060)	-0.77 ^a (.23; .001)
Inferior parietal	-1.15°	$-0.06a$	0.02	0.06° (.02; .002)	-0.57 ^a (.24; .017)	-0.30 (.22; .2)
Middle temporal	-1.80°	$-0.09a$	0.03	0.08^a (.02; .002)	-0.64 ^a (.28; .023)	-0.39 (.26; .1)
Med-orbito-frontal	-0.77 ^a	-0.03	0.05	0.01(.02; .5)	-0.13 (.19; .5)	-0.46° (.17; .008)
Whole brain	-0.82 ^a	-0.02	0.02	0.02 (.01; .070)	-0.25 (.13; .064)	-0.23 (.12; .063)
CDR-SB	1.21^a		-0.02	0.01(0.01; .3)	0.09 (.17; .6)	0.23 (.16; .1)
ADAS-Cog	2.53 ^a		0.01	$-0.01(0.05; .8)$	-0.58 (.56; .3)	$1.41a$ (.52; .007)
MMSE	-1.72 ^a		0.01	0.03(0.03; .3)	-0.11 (.30; .7)	-0.20 (.29; .5)

Note:— b-Values are coefficients in Equation 1; for structural measures, units are annual thickness or volume change as a percentage of baseline size (%/year), and for cognitive measures they are annual score change, per ADAS-Cog unit in the case of b_{Cog}, and per year in the case of b_{Edu} and b_{Age}. Med-orbito-frontal indicates medial orbito-frontal cortex.

ROIs: N = 110; mean age = 75.77 years; mean ADAS-Cog = 13.06; mean years education = 15.66. Clinical: N = 139; mean age = 76.23 years; mean years education = 15.63. SE indicates standard error. $P=P$ value for significance of $\mathsf{b}{-}\mathsf{coeff}$ cients.

^a Values significant at $P \leq .05$.

On-line Table 2*A*: **Direct effects of age,** *APOE* **4, and sex on rates of change in HC participants with CSF data**

Note:—See On-line Table 1 for units and key.

^a Values significant at $P \leq .05$.

b Number of participants in ROI analyses/number in clinical analyses.

On-line Table 2*B*: **Direct effects of age,** *APOE* **4, and sex on rates of change in participants with MCI with CSF data**

Note:—See On-line Table 1 for units and key.

^a Values significant at $P \leq .05$.

b Number of participants in ROI analyses/number in clinical analyses.

On-line Table 2*C*: **Direct effects of age,** *APOE* **4, and sex on rates of change in participants with AD with CSF data**

Note:—See On-line Table 1 for units and key.

^a Values significant at $P \leq .05$.

 b Number of participants in ROI analyses/number in clinical analyses.</sup>

On-line Table 3*A*: **Direct effects of age,** *APOE* **4, sex, and A**- **on rates of change in HC**

Note:—See On-line Table 1 for units and key.

^a Values significant at $P \leq .05$.

b Number of participants in ROI analyses/number in clinical analyses.

On-line Table 3*B*: **Direct effects of age,** *APOE* **4, sex, and A**- **on rates of change in MCI**

Note:—See On-line Table 1 for units and key.

^a Values significant at $P \leq .05$.

b Number of participants in ROI analyses/number in clinical analyses.

On-line Table 3*C*: **Direct effects of age,** *APOE* **4, sex, and A**- **on rates of change in AD**

Note:—See On-line Table 1 for units and key.

^a Values significant at $P \leq .05$.

b Number of participants in ROI analyses/number in clinical analyses.

On-line Table 4*A*: **Direct effects of age,** *APOE* **4, sex, A**-**, and p- on rates of change in HC**

Note:—See On-line Table 1 for units and key.

^a Values significant at $P \leq .05$.

b Number of participants in ROI analyses/number in clinical analyses.

On-line Table 4*B*: **Direct effects of age,** *APOE* **4, sex, A**-**, and p- on rates of change in MCI**

Note:—See On-line Table 1 for units and key.

^a Values significant at $P \leq .05$.

b Number of participants in ROI analyses/number in clinical analyses.

On-line Table 4*C*: **Direct effects of age,** *APOE* **4, sex, A**-**, and p- on rates of change in AD**

Note:—See On-line Table 1 for units and key.

^a Values significant at $P \leq .05$.

b Number of participants in ROI analyses/number in clinical analyses.

Note:—Units are pg/mL for CSF values. All values for *APOE* 4 effects (left half of table) are covaried for age and sex; all values for sex effects (right half of table) are covaried for age and *APOE*; clinical values are additionally covaried for education.

SE indicates standard error; $P = P$ value for paired comparisons (significance of the effect, ie, the difference in the expected values).

^a Differences significant at $P < .05$. See print Fig 3 and On-line Fig 1. Numbers of participants are in On-line Table 7.

On-line Table 5*B*: **Expected baseline CSF and cognitive values for each cohort: Direct and interaction effects of** *APOE* **and sex**

Note:—See On-line Table 5*A* for units and key.

^a Differences significant at $P < .05$.

Along with the direct effects, $\varepsilon 4 \times$ sex effects are additionally modeled; $p-value$ for $\varepsilon 4 \times$ sex gives the significance of the interaction term alone.

Note:—This table shows the results of modeling the effects of *APOE* 4 on baseline values, independently in men and in women. Units are pg/mL for CSF values. All values are covaried for age; clinical values are additionally covaried for education.

SE indicates standard error; $P = P$ value for paired comparisons (significance of the effect, ie, the difference in the expected values).

^a Differences significant at $P < .05$.

Numbers of participants are shown in On-line Table 7.

On-line Table 6*B*: **Baseline CSF and cognitive values:** *APOE* **4 and** *APOE* **4 sex effects**

Note:—See On-line Table 6A for units and key. This table shows the results of modeling the effects of sex on baseline values, independently in *eA* noncarriers and in carriers. ^a Differences significant at $P < .05$.

On-line Table 7: Number of participants with baseline CSF and cognitive data

		Male	Female		
	ϵ 4	ϵ 4 ⁺	ϵ 4	ϵ 4 ⁺	
CSF ^a					
HC	39	16	45	9	
MCI	58 ^c	61 ^d	20	35	
AD	13	35 ^e	8	24 ^f	
$\mathsf{Cog}^{\rm b}$					
HC	84	30	79	29	
MCI	106	122	54	66	
AD	24 ^g	60	23	49	

^aCSF: Aβ, p-τ, and τ<mark>.</mark>
^b Cog: CDR-SB, ADAS-Cog, and MMSE.

^{c–f} For π ^c57, ^d60, ^e34, ^f23.
⁸ For ADAS-Cog: 23.