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Correspondence

Sir: Bullock (1998) provides an excellent review of current drug treatments for Alzheimer's disease. I would like to comment on three points following on from his article.

First of all, Bullock makes the pertinent point that as many as 80% of patients on acetylcholinesterase inhibitors (ACHEIs) show an improvement in non-cognitive symptoms while 40% show improvements in cognitive symptoms. This corresponds well with my clinical impressions of the very limited number of patients on ACHEIs that I have seen. However, reliable and easy measures of non-cognitive change have been lacking. McKeith (1998) noted that activities of daily living (ADL) measures were so unreliable when evaluating antidementia drugs for a license that they were effectively dropped. Harvey (1997) has pointed out that current ADL scales were developed for physical problems and are largely insensitive to change in dementia. Myronuk (1998) commented that the apparent obsession with cognitive measures from regulatory authorities is obscuring the apparently greater improvement seen in non-cognitive features which not only leads to promising drugs being abandoned but also prevents ACHEIs from being funded.

My second point is that there is an unfortunate impression given by the title of the article that ACHEIs are only effective in Alzheimer's disease. There have been suggestions (McKeith, 1997) that Lewy body disease will respond well to these drugs. So far my best result with donepezil has been with such a case. We should be aware of how limited our experience of using donepezil with non-Alzheimer's dementias is and not be afraid of trying to treat such cases, as long as the patient is aware that this is an experiment.

Finally, Bullock is right to point out that the adoption of this drug will have a wide impact on services, the pattern of dementia care and carers. I hope the article will spur more of us to speak out for these new drugs. Sceptics like Melzer (1998) argue that the benefit is not convincing. People who are actually using it know that this is not the case. Patchy or token funding is not equitable and we need to speak out for a fair share of health resources on behalf of a vulnerable group of people who largely cannot speak for themselves.

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Author's reply: I thank Dr Aquilina for his comments and respond to them.

The current position with the ADL scales is much as stated. However, the Bayer–ADL (Heinmarsh *et al*, 1998) scale has been developed over the past few years, and is thought to be sensitive to decline, as measured by the Functional Assessment Staging Tool (FAST; Reisberg, 1986). Whether it is sensitive to change when treatment is given needs to be evaluated. It does not suffer from gender or culture bias, a more common problem. The scale is currently being validated for UK use, and I think may give useful information to prescribers about non-cognitive symptoms, along with scales for behavioural symptoms, for example the Neuropsychiatric Inventory (Cummings *et al*, 1994).

I can only apologise for giving a false impression about the overall use of ACHEIs. The narrower title of the paper was the topic on which I was asked to write. There is a lot of evidence that dementia with Lewy bodies (LBD) responds well to the ACHEIs. For example, the tacrine studies at the Institute of Psychiatry had post-mortem follow-up showing the patients with LBD did well (Eagger *et al*, 1991). At this time there are studies ongoing with ACHEIs in LBD and vascular dementia, and Dr Aquilina is right in suggesting these cases may respond as well. However, in the current climate with a lack of resources, use outside of licence, although interesting, needs to be performed with caution.