Letters to the Editor

may be no history of diarrhoeal illness. Coeliac disease [5] has been diagnosed even in 93-year-old patients.

We believe the above-mentioned study should have excluded possible causes of malabsorption in these patients.

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Outcome of elderly patients requiring ventilatory support

SIR—We were very interested to read the article by Meinders et al. [1] on the outcome of elderly patients receiving mechanical ventilation. In their retrospective study of 181 patients aged over 70 years receiving mechanical ventilation for at least 3 days, the authors showed that mortality during hospitalization in an intensive care unit was associated with cardiac arrest on admission and shock during hospitalization.

We focused on the same subjects in a retrospective study [2] involving 110 patients aged 70 years and over admitted consecutively to our intensive care unit over a period of 12 months, who received artificial ventilation for the first time for at least 24 h. The aim of our study was to determine predictors of mortality during admission to intensive care and 6, 12 and 18 months after discharge. The mean age was 78±0.5 years (range 70–95 years). Median duration of hospitalisation and artificial ventilation were both 12.5 days. Mortality during admission and 6, 12 and 18 months after discharge was 38, 60, 63 and 67%, respectively. Multivariate analysis revealed that the factors predictive of mortality during hospitalization were shock on admission and recourse to invasive therapy during admission (dialysis, pulmonary arterial catheter). The factors predictive of mortality 6 months after discharge were shock on admission, previous impaired health status and being married. The same results held true after 6 months.

Meinders and co-worker’s results [1] are similar to ours in several respects. They also highlight the essential role of the seriousness of the patient’s general state at admission to hospital on outcome during hospitalization. They confirm that age is not an adverse prognostic factor for patients aged over 70 years. The medical history in itself has no predictive role, although its effect on patient performance, as evaluated by the Knaus classification, plays a role in outcome during the first 6 months after discharge [2-4].

We found no adverse influence of cardiac arrest at admission, which involved only five of our patients. Moreover, in contrast to the study of Meinders et al. (in which there were no survivors among their eight patients aged 85 years and over), in our study 50% of the 14 patients in the same age-range were discharged from hospital, and three of them were still alive 18 months later.

The agreement and differences in results emphasize the need for prospective studies. We are currently undertaking such a study in our hospital.

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Early post-stroke parasitic delusions

SIR—In his excellent review [1], Harvey mentions vascular dementia as one of the causes of parasitic delusions. This is encouraging, since these delusions have been described mostly in the psychiatric and dermatological literature but rarely in geriatric journals. We recently encountered this unusual delusional disorder in two cognitively preserved patients following the onset of a right hemispheric stroke, with a rapid and complete clinical response to neuroleptics.

Case 1. A 78-year-old man, with a history of ischaemic heart disease and hypertension, presented with acute onset of left-sided hemiparesis. The patient had no previous psychiatric disorder and had no cognitive deficits (MMSE 29/30). CT showed a right frontal lobe infarction. Three weeks later the patient
started to complain about small worm-like creatures in his stool that were continuously multiplying in the anal region. Rectal examination and repeated stool specimen were normal. He was treated with perphenazine 12 mg/day and stopped complaining of the problem 2 weeks later. Treatment was discontinued after 3 months.

Case 2. A 76-year-old women had coronary bypass surgery that was complicated by mild residual hemiparesis. A few days later she started to feel 'small ants' crawling over her scalp and entering her ears. The patient was cognitively preserved and had no history of psychiatric disorder. A true infestation was ruled out, and a CT revealed a right-sided temporoparietal stroke. This patient was also treated by perphenazine 20 mg/day with complete and rapid remission of symptoms. Treatment was discontinued 7 months later without a relapse.

The phenomenon of parasitic delusions is infrequent and is considered as a type of monosymptomatic hypochondriac psychosis, with the patient focusing on a single delusion. Its onset shortly after acute stroke is rare but has not been described previously and is therefore of particular interest. As mentioned by Harvey, parasitic delusions have been described in association with various chronic neurological disorders rather than following acute stroke. Both our patients had sustained a right hemisphere stroke which may be causal or in agreement with our knowledge about the possible relationship between delusional states and particular anatomical structures [2].

A difficulty in these cognitively preserved patients was the reluctance to accept the psychiatric origin of the complaints and to be treated by neuroleptics rather than anti-parasitic agents. However, both patients responded favorably to perphenazine and did not relapse during 3 and 7 months follow-up.

We believe that acute cerebral infarction should be added to the list of organic conditions associated with parasitic delusions.

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Xerostomia: a symptom which acts like a disease

SIR—I read the excellent review article by Ettinger [1] with interest, but was concerned about the omission of HIV/AIDS, its drug treatment and xerostomia.

Some late middle-aged 55–60-year-old individuals are getting older whilst on antiretroviral therapy, notably didanosine (Videx), a reverse transcriptase nucleoside inhibitor used in combination with other antiretrovirals in the treatment of HIV/AIDS—a unusual cause of xerostomia [2, 3, 4].

Carers for the young elderly so often ignore to enquire of sexual history, previously sexually transmissible infections, and previous IVDU or even transfusion of infected blood (products)—as reflected by the omission of this topic in the review—with the consequence that causal factors may be missed.

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Author’s reply

SIR—I thank Dr Harry for his comments. I have had limited experience with persons using didanosine. I am happy that Dr Harry pointed out that we need to be more aware of the problems associated with sexually transmitted infections in older adults.

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Assessment of well-being

SIR—We were interested to note in Coleman, Philp and Mullee’s comparison of measures of well-being [1] their finding that the Geriatric Depression Scale (GDS) and the Philadelphia Geriatric Centre Morale Scale (PGCMS) yielded similar patient profiles. Their results from acute and rehabilitation elderly care wards mirrors our findings in two continuing-care wards, using in addition the Memorial University of Newfoundland Scale of Happiness (MUNSH) [2]. In our study [3], in which all three instruments were administered to 30 patients (mean age 83, range 62–93), there was a high degree of correlation between the three scales.

The Spearman’s rank correlation coefficients were −0.83 (GDS-15 and PGCMS), −0.77 (GDS-15 and MUNSH) and 0.74 (PGCMS and MUNSH). Median values were: GDS 5, PGCMS 9 (both comparable to...