Letters to the Editor

Musical abilities may outlast other faculties in advanced dementia

SIR—It is widely recognised that musical abilities may outlast other faculties in advanced dementia, and may become almost the sole means of communication between patient and carer. It is possible that a specific neural substrate may be identified. A fuller account is in preparation jointly by myself and Raya Jones (PhD) of Cardiff University. There are two details on which we have been unable to find relevant published information, and we would be grateful for any comments from Age and Ageing readers.

The first is the frequency of incidence of persistent musicality in dementia. Positive observations may be reported more often than negative ones, but one might expect that non-musicality in dementia would be at least as common as is amusia in health, reported as 4–5%. The other question concerns the nature of the dementia; in published accounts of continuing musicality, the specific type of dementia is rarely mentioned. It may be that in the middle and late stages all dementias are behaviourally similar; but it is also possible that the diagnostic information is not made available to the mainly non-medical people involved in the immediate caring profession.

Any relevant comments will, by permission and if time allows, be mentioned in the article now in preparation.

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Methods to correct placement of a nasogastric tube: beware of the pitfalls

SIR—On 22nd February 2005, the National Patient Safety Agency issued new advice to the National Health Service on reducing harm caused by misplaced nasogastric tubes. They state that at least 11 patients have died as a result of misplaced nasogastric feeding tubes between December 2002 and December 2004. They recommend:

• pH of aspirate (stomach contents) should be measured using pH indicator strips in the range of 0–6 with half-point gradations.
• Radiography (X-rays) is recommended but should not be used routinely. Fully radio-opaque tubes with markings to enable measurement, identification and documentation of the external lengths should be used.

The following are not recommended:

• The ‘whoosh’ test which involves the use of a syringe to push a small volume of air down the nasogastric tube whilst the sounds produced are monitored with a stethoscope.
• Testing acidity/alkalinity of aspirate using blue litmus paper.
• Observing for signs of respiratory distress is often ineffective in detecting a misplaced tube.
• Monitoring for bubbling at the end of the tube is unreliable because the stomach also contains air and could falsely indicate respiratory placement
• Observing the appearance of feeding tube aspirate is unreliable because gastric contents can look similar to respiratory secretions.

Further information is available at www.npsa.nhs.uk

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Inter-rater reliability of the Barthel Index

SIR—We have read with great interest the paper of Sainsbury et al. [1] focusing on the reliability of the Barthel Index (BI) when used with older people. We have recently evaluated the inter-rater reliability of two groups, one composed of clinical nurses expert in Gerontology and the other composed of Family Medicine residents when they were faced with BI [2]. The reliability of the BI has been well documented in stroke patients [1, 3] and it seems that it may be useful even when a single training session is offered to non-health care interviewers [4]. Nevertheless, we hypothesised that a larger training period may be necessary.

One hundred community-dwelling patients were assessed during a hospital admission episode due to diverse conditions. Eighteen patients were excluded because they were able to answer only a few questions. Previously, two weeks before admission, the BI (scored 0–100) [5] was evaluated through an interview. Sequential BI was assessed by clinical nurses in Gerontology and by residents of Family Medicine who had received a brief training session on BI, and additional scoring guidelines were facilitated. Previously, in a study that had included 30 patients, an excellent