Letters to the Editor

able to make a firm diagnosis and commence anti-convulsant therapy.

On reviewing the literature, we were unable to find any other reports of mobile phone evidence being presented to geriatricians by patients, or relatives, which have aided diagnosis. The most similar report we found was that of a rheumatologist being given a video phone clip demonstrating an urticarial rash in a patient with systemic lupus erythematosus (SLE) [1]. Surprisingly, we found no reports of patients showing dermatologists images of rashes.

However, video phones have been used in some small studies to transmit clinical photographs or radiological investigations. Perhaps most applicable to geriatrics, so far, was a small study using video phones to transmit images of leg ulcers for assessment by remote clinicians [2]. Mobile phone technology has also been used to transmit ECG data and video footage of ambulance patients in transit to formulate an initial diagnosis and prioritise review on arrival [3].

Descriptions of ‘fits, faints and funny turns’ are vital in diagnosis. Video phone clips showing such incidents may be increasingly provided as evidence by relatives at follow-up as the technology has become more commonplace. However, mobile phones are increasingly used to send radiological, cardiological or clinical images between clinicians, allowing opinions, and thus care, to be timelier.

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Comparative analysis of mortality in patients with Alzheimer’s disease treated with donepezil and galantamine

SIR—We read with interest, López-Pousa et al.’s article ‘Comparative analysis of mortality in patients with Alzheimer’s disease treated with donepezil or galantamine’ [1]. This is interesting information providing data on the real world clinical effects of AChEIs, that have been the subject of controversy regarding its benefit/risk ratio [2, 3]. The authors conclude that the duration and the dose of donepezil or galantamine are not related to an increase in mortality. Some points should be discussed in order to clarify the data leading to such a conclusion.

Regarding mortality, the primary aim of the study, the authors compare the mortality rates irrespective of the follow-up time. We believe that a true time-to-event analysis, using, e.g. Kaplan-Meier or Cox proportional hazard methods, would yield the most correct results. Additionally, the death rate was estimated taking into account the deaths occurring in patients who continued the AChEI as well as those occurring in patients who abandoned the AChEI, mimicking an ITT (intention to treat) analysis. As the aim of the study is to compare mortality among patients treated with these two AChEIs, the survival time analysis should applied only be to the cohort of patients who continue treatment either with donepezil (16 deceased among 163 patients continuing treatment) or galantamine (13 deceased among 116 continuing treatment). On the other hand, the total number of donepezil treated patients in Table 1 of the original publication is 197 instead of 202 as it appears in the text and in Figure 1 of the original publication. This discrepancy should be reviewed and taken into consideration whenever a survival time analysis is performed.

Conflict of interest

We declare that we have no conflict of interest.

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