randomised controlled trial, while studying the role of selective decontamination of the oral cavity, post stroke.

In the remaining three patients who had a normal swallow, but in whom *E. sakazakii* was found in the oral cavity, two received active SDD gel and one placebo, with no evidence of a pneumonia process or septicemia. In the report of See and colleagues [1], the bacterium was resistant to cephalexin. In our 10 oral isolates, all except one was resistant to ampicillin, one was resistant to tobramycin, three to colistin, four to cefotaxime, four to trimethopin and three to ciprofloxacin. In the case report, the 75-year-old woman deteriorated after an initial clinical response, with the authors surmising that the organism had developed cephalexin resistance. In one of our patients, in whom *E. sakazakii* was isolated on four separate occasions, we found that the antibiotic sensitivities altered, probably as a result of the SDD gel.

We would like to speculate that the patient may have had oral colonisation with *E. sakazakii*, which subsequently resulted in a pneumonia complicated by a splenic abscess. We agree with the authors that *E. sakazakii* should not be treated with a cephalexin and that *E. sakazakii* must be considered in older individuals who fail to respond to traditional antibiotic administration.

We hope that, by highlighting a possible pathogenesis of the *E. sakazakii* splenic abscess, clinicians caring for older individuals with impaired oral hygiene and abnormal swallow or immunosuppression due to age, disease or treatment, will consider *E. sakazakii* as an aetiologic agent if early treatment fails to result in a clinical response.

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**Integrated services for people with dementia**

**SIR** — We discussed the thought-provoking editorial ‘Can we afford not to have integrated dementia services?’ from Roger Bullock, Steve Iliffe and Peter Passmore [1] at a recent meeting of the West Midlands Memory Clinic Network [2].

Colleagues from several disciplines working in Memory Services across the West Midlands felt alarmed by the drift of the arguments presented by these respected colleagues. We would caution against adopting their conclusion that: ‘There is need to stop providing dementia services across multiple agencies.’

Their assertion that ‘... there are no integrated dementia services in the United Kingdom...’ is false. We all work in integrated services which engage with appropriate resources across a range of agencies. This, we believe to be entirely appropriate. The alternative which Bullock et al. espouse is a segregated or exclusive service—setting apart people with dementia as a special or sub-population who will receive all their needs as subservient to their dementia label.

Contrast this with the direction of services for people with life-long learning disability, where the thrust is all toward ‘normalisation’ to ensure that individuals receive a proper share of expert help from across the complex range of health and social care [3]. This leaves the experts in learning disability (or dementia) to work effectively to inform, educate and support all parties to gain optimal care for every individual. We commend this approach and hope that it will be advanced through initiatives which the government is contemplating in response to the several reports published recently, and quoted helpfully by Bullock et al.

The need is to improve the quality and capacity of services for people with dementia across multiple agencies.

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**Acetylcholinesterase inhibitors and cardiovascular disease**

**SIR** — We read with interest Malone et al.’s research letter on cholinesterase inhibitors and cardiovascular disease [1]. It comes as no surprise that there is wide variation in the prescribing of cognitive enhancers to people with cardiovascular co-morbidity. They rightly state the need for consensus guidelines for prescribing to this group of patients.

Rowland et al. [2] have recently published a proposed guideline in Advances in Psychiatric Treatment to aid the
management of cardiovascular risk in patients receiving cholinesterase inhibitors. This protocol is based on the findings that serious adverse events are rare and the major cardiovascular risks of cognitive enhancers are arrhythmias, notably heart block and sinus bradycardia. They suggest an evidence-based yet pragmatic approach to managing cardiovascular risk based on pulse rate and vigilance for sycopy or seizures. They suggest there are no ‘high-risk’ groups who should have targeted screening or special treatment when considering prescribing cognitive enhancers.

Although Malone et al. state the need for a clinical guideline, they do not suggest its contents apart from the proposal that a pre-treatment ECG should be mandatory. This is not recommended in the Rowland et al. protocol for good reasons. ECGs have proven to be poor predictors of cardiac events. Psychiatrists may not have the skills to correctly interpret ECGs and appropriate physician input would, in many centres, be impractical for large numbers of ECGs. There would also be significant cost involved for routine ECG screening and limited resources may be best spent elsewhere.

Further clinical guidelines for prescribing cholinesterase inhibitors are welcome and Rowland et al.’s protocol appears clinically useful. Mandatory pre-treatment ECGs, however, would seem unjustified and unhelpful.

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