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## Carers' Assessment of Patients on Donepezil—How Reliable?

Dear Editor,

Evans *et al.* (2000) in their recent paper on donepezil raise a number of interesting points. Their preliminary results are quite similar to ours in Warrington with an almost identical rate of non responders. However, our results in responders were a little different in the first 12 months of treatment. After 18 months on donepezil there was no appreciable difference between those on treatment compared to the expected rate of natural decline without treatment (Fig. 1). Evans *et al.* (2000) make a subtle comment that support, counselling and regular reviews of patients as well as carers may have contributed to the subjective reporting of behavioural as well as cognitive improvement in patients on donepezil.

Patients with a diagnosis of Alzheimer's are generally cared for at home by a carer, usually a spouse or relative. As the disease progresses, this places increasing demands on carers which often leads patients into institutionalised care. From our experience in Warrington since 1997, most carers, at least during the first few months of treatment, would often use statements such as 'they are more like their old selves' and 'they seem much happier' to describe patients' response to donepezil.

Therefore carers' perception of the disease are important in reducing levels of carer stress. The reduction therefore in caregiver stress would hopefully lead to delayed institutionalised care. The average cost of moving a patient into institutionalised care has been estimated at £20,688 per year to the public (Holmes *et al.*, 1998) compared to £1200 per year for daily dose of 5 mg of donepezil. It follows that increased caregiver satisfaction would have enormous economic implications.

In Warrington Cognitive Monitoring Clinic (CMC) we survey periodically, using self administered questionnaire, carers' assessment of patients' response to treatment. This consists of a Likert scale from marked improvement to deterioration and the following were asked about: overall opinion, short term memory, long term memory, concentration and memory, mood, emotional reaction, communication, spontaneity, day to day activities, reading, watching TV, sleep, anxiety, interests in old hobbies, meeting others and driving. A space was also provided for additional comments.

We compared the clinical changes as documented by the clinician based on Clinical Global Impression CGI, MMSE scores, Functional Activity Questionnaire and Bristol ADL with

Table 1. Clinician and carers' overall assessment of donepezil treatment

General impression: Response to donepezil:	First 12 months on donepezil Assessment		Second 12 months on donepezil Assessment	
	Clinicians	Carers	Clinicians	Carers
	Rate of change		Rate of change	
Improved	23%	21%	0%	0%
Mild decline	25%	16%	15%	10%
Moderate decline	29%	40%	30%	37%
Significant decline	23%	23%	55%	53%

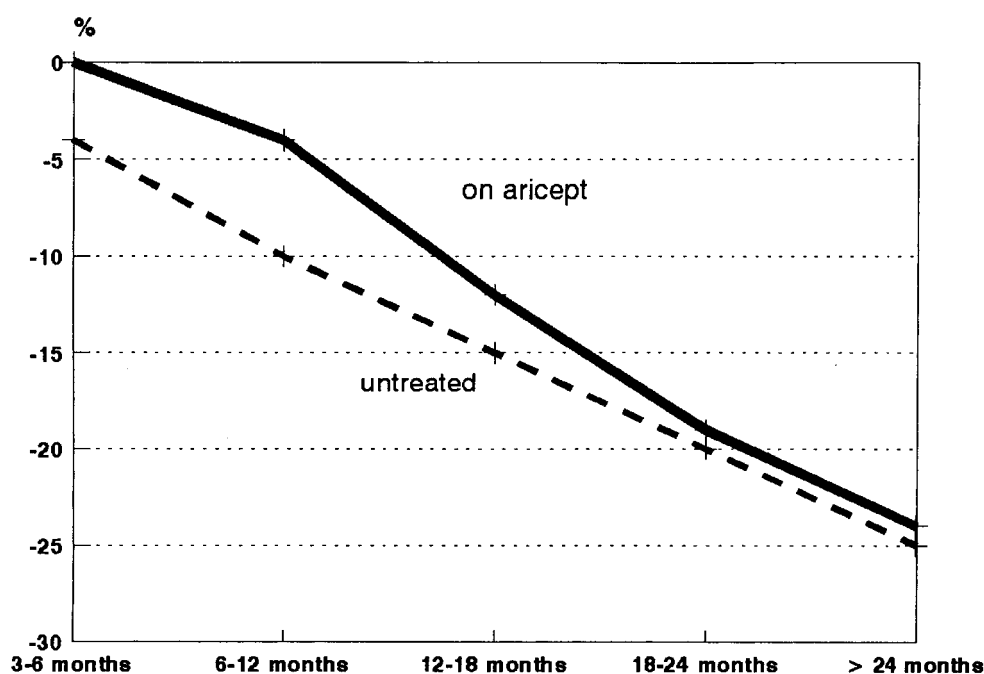


Figure 1. Comparative rate of decline in Folstein score (mean) in treated and untreated AD cases within 2 years at Warrington Cognitive Monitoring Clinic 1997-1999

carers' overall assessment of outcome at the first and second 12 months on donepezil and the results are shown in Table 1.

As can be seen from the results in Table 1, the carers' impression agrees with clinical impression. This, we feel, is an interesting result and suggests that asking the carers for their opinion is as valid as carrying out more complicated and time-consuming measurements. At the very least it shows that, despite the expected bias and subjectivity, carers' views are an important part of the monitoring of patients on donepezil.

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Dear Editor,

I read with interest the recent paper on screening instruments for cognitive impairment in older south Asians (Rait *et al.*, 2000). The GMS/AGECAT semi-structured interview was conducted with appropriate interpreters and was used as the gold standard in the absence of other gold standards. The Leicester study of elderly Gujaratis is cited to illustrate that a clinical diagnosis by a psychiatrist with a Gujarati background may have limitations as they may not be familiar with dementia (Lindesay *et al.*, 1997). Clinical observations by Gujarati speaking psychogeriatricians report similar diagnostic difficulties (Shah, 1999). One way to resolve such uncertainty is to re-evaluate study subjects with dementia after a sufficiently long interval from the first evaluation. If the initial diagnosis of dementia was accurate then a clear decline over time will be demonstrated by the clinical assessment. Subjects with dementia in the Leicester sample were followed-up by a Gujarati psychogeriatrician at a median interval of 27 months and clear evidence of decline in cognition was demonstrated in most subjects (Shah *et al.*, 1998). There were only two cases of dementia in the Gujarati group in the current study and thus such a longitudinal follow-up may not be productive unless a few more emergent incident

cases can arise at follow-up, in which case the predictive value of the initial AMT and MMSE scores can be examined. Such longitudinal confirmation of initial diagnosis can strengthen the use of unevaluated instruments through translators as gold standard.

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