



Although many of Dr. Geller's recommendations for alternative drug therapies have merit, they need to be supported by clinical trials that establish the safety and effectiveness of these treatments in elderly patients. In the meantime, physicians are well advised to introduce new medications cautiously to old patients, and to "start low and go slow" when the therapeutic dose of a drug is unknown or the patient has complex medical problems.

Our interpretation of the value of certain drugs in this group of patients varies from Dr. Geller's in some areas. There are certainly pros and cons to any group of drugs, such as antihypertensives, but we would urge careful consideration before adding some of these drugs. For example, beta-blockers can cause blood pressure drops, resulting in falls or fractures as well as in dysphoria.

Carbamazepine and valproate come with their own concerns, such as weight gain and tremor in the elderly. Patients may have received these for mood stabilization as opposed to "antiseizure" medication. Serum level issues can be bypassed in some cases by using gabapentin if kidney function is adequate and simply monitoring for side effects and clinical progress.

Neuroleptics, although not appropriate for all patients, have advanced significantly from those described in the past. For example, risperidone, now the antipsychotic most often selected in the elderly, has fewer negative cognitive effects, fewer extrapyramidal concerns, and good tolerability at low dosages. Various other newer agents such as

olanzapine and clozapine offer advantages in the agitated patient with Parkinson disease.²

Amantadine, a dopamine agonist, often causes increased psychotic behavior. The same is true for the psychostimulant methylphenidate, which is more appropriate for depression in the non-demented elderly patient.

Pseudobulbar emotional incontinence can be treated with selective serotonin reuptake inhibitors as well as tricyclic antidepressants. For the latter group secondary amines (ie, nortriptyline) are clearly preferred to the tertiary amines (ie, amitriptyline), which carry greater risk for anticholinergic confusion and orthostasis.

As Dr. Chan and Dr. Geller point out, new cholinergic agents, which slow the progression of memory loss, may promote improved judgment and resultant behavior. Although the recent treatment guidelines did not comment on cholinergic agents for agitated patients with dementia, we realize clinical studies in this area are only beginning. We look forward to the future research in this area.

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2. Alexopoulos G, Silver J, Kahn D, Frances A, Carpenter D. Treatment of agitation in older persons with dementia. *Postgrad Med* 1998; 103(Suppl) April:9-80.

CORRECTION

Two errors appeared in the article by Ana Vann, PharmD, "The herbal medicine boom: Understanding what patients are taking," which was published in the March 1998 issue of the *Cleveland Clinic Journal of Medicine*.¹

The first paragraph on page 129 incorrectly cited a survey² as saying one in three respondents took an herbal medication. In fact, one in three received some form of alternative therapy, but not necessarily an herbal medication.

The first paragraph on page 130 incorrectly cited a test from *Consumer Reports*³ as finding that 7 of 10

ginseng products contained no ginseng at all. In fact, *Consumer Reports* measured the amounts of 6 ginsenosides (the putative active ingredients in ginseng) in 10 ginseng products. Some products had 10 to 20 times as much ginsenoside as others, and one product had very little.

REFERENCES

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3. Consumers Union. Herbal roulette. *Consumer Reports* November 1995:698.