NICE and dementia treatment guidance

Sir,

Now that the National Institute for Health and Clinical Excellence (NICE) has given its guidance on management of dementia patients with anticholinesterase inhibitor drugs the world of dementia is reeling with a mixture of reactions and opinions.

Geriatricians have been caught between the General Medical Council on one hand reminding us that the duties of a doctor are to one's patient in the first instance, and the NICE guidance on the other. The patient suffering from dementia is in the middle (this includes the carer and relatives as well as social services).

The most important issue that arises from this guidance is the categorization of dementia into mild, moderately severe and severe by the use of an assessment tool such as the Mini Mental State Examination (MMSE). This is not an exact science and its results can vary widely even in the same patient at different times of the day. Results also depend on the patient's level of education and whether the patient is English speaking, visually impaired or physically incapable of writing.

Although these drugs do have some memory-enhancing effects there other important effects such as behavioural modifications which help to control patients with dementia who may otherwise need other antipsychotics. The patients we see as geriatricians have co-morbid states, especially cardiovascular and cerebrovascular conditions.

The cost-effectiveness argument is not valid – these patients have a terminal illness like cancer and yet like-for-like expenditure for a patient with lung cancer, for example, is not comparable.

It is with the above concerns that we, as practicing physicians, feel constrained to provide our patients with the only treatment available to them at the moment and many are finding it difficult to differentiate between the arbitrary lines which have been drawn for us.

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Testing for suxamethonium apnoea

Sir,

Prolonged block after administration of suxamethonium is known to occur as a result of genetic or acquired conditions affecting plasma cholinesterase, also known as butyrylcholinesterase or pseudocholinesterase. The dibucaine number indicates the percentage inhibition of this enzyme but makes no assessment of the quantity of the enzyme in the plasma (Peck and Williams, 2002) which is more relevant after scoline apnoea. The authors could find little information on the subject from standard anaesthetic textbooks or even the suxamethonium data sheet.

A survey of consultants and trainees revealed that the majority had no experience of investigating patients for scoline apnoea. The majority knew a blood sample was needed, but did not know which specimen bottle to send it in. Although half knew where to send the samples for analysis none knew the importance of timing of the blood sample. Almost all of them did not know where exactly to get the information from.

After an extensive literature search the authors found that the timing of the sample is important. Although it is suggested that one should wait for 4–6 weeks after exposure to suxamethonium before taking any bloods for testing, there is no consensus on the time period. Samples collected during scoline-induced apnoea are not suitable for measurement of activity as the presence of the drug leads to anomalously low activity and erroneous inhibitor numbers (Goodall, 2004). If patients are treated with fresh frozen plasma then a period of at least 6 weeks should be allowed before sample is collected (Goodall, 2004).

There is no universally recommended reference method. There could be four different substrates at three different temperatures with different reagents. There is also reporting inconsistency with many not using SI units (U/litre) (Peck and Williams, 2002).

Information about the enzyme, type of specimen, specimen bottle, volume of the sample, laboratory providing service and contact telephone numbers can be found on www.assayfinder.com. This is a useful resource for those managing patients with suxamethonium apnoea.

Suxamethonium apnoea is a rare condition which can have serious consequences for the patient and his/her family including prolonged ventilation and intensive care unit stay. There is currently no universally accepted method for testing for scoline apnoea. The authors suggest that there should be a common regional or national procedure for testing of scoline apnoea which can be followed easily and automatically.

The duties of the anaesthetist should extend well after the anaesthetic and operation is over and include discussion with the patient and the spouse and/or other family members about the nature and genetics of pseudocholinesterase deficiency, implications for future anaesthetics, the need to test other family members and the need for a medic alert bracelet. The incident should be written up in the patient's notes and a copy given to the patient and the GP.

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