within an hour or two of tetracyclines (except doxycycline and minocycline).

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Treatment for aging brains

Anyone who has tried to compete with children in the seemingly simple task of picking up pairs of cards from an upturned pack realises that the speed of response deteriorates with age. Few psychological tests are standardised for use with the aged. Many depend on speed of response, and old people are less likely to guess. Is speed to be the only gauge? Cohen and Faulknor concluded that older adults are impaired when greater processing is required. That, however, depends on the test. My mother completes the daily crossword in five to 10 minutes, while I usually fail to finish it. Is my comparative failure a measure of lack of practice or impaired processing of the test?

Doctors do themselves and their patients an injustice if they believe that a failing memory is a sign of old age: in examining the elderly we may not find what we expect to find? Because we see old age as a problem, do we report only negative findings? If a patient has lost memory the first question should be “is anything that I am prescribing causing it?” The doctor should suspect all drugs. Digoxin, barbiturates, short and long acting benzodiazepines, tricyclic antidepressants, antihistamines, diuretics, indomethacin, and recently naproxen and ibuprofen, septrin, cimetidine, the anti-Parkinsonian drugs levodopa, bromocriptine, and benzhexol, and tranquillizers may all cause confusion. The list is endless: indeed, it is surprising that the medicated aged pass any mental tests at all. If one or another doctor is not causing the problem, then alcohol excess should be considered. A recent onset of heavy drinking suggests depression.

Some 5-10% of patients presenting with impaired cognition may have depressive pseudodementia. Patients with confusion and depression respond to questioning with “don’t knows” or emotional distress, while demented patients respond uncritically. All doctors should beware of falling into the trap of “falling” a patient on direct questioning about the time and place if he or she has had no opportunity to learn the facts. Then by a thorough history, clinical examination, and appropriate investigations the doctor should search for the potentially treatable: subnutrition with vitamin deficiency, hypothyroidism, hyperglycaemia, hyponatraemia, hypercalcaemia, vitamin B12 deficiency, and hydrocephalus. A fluctuating clinical course with focal neurological signs and islands of preserved mental function suggests multi-infarct dementia. Hypertension may indicateBinswanger’s disease, encephalopathy affecting the white matter.

In the absence of a specific diagnosis, what treatment is possible? A recent study in Southampton found that the decrement in the consolidation of new learning was prevented by an oral form of probacne bound to haemoptophrin (Geriatricum-Schwarzhaupt KH.) in 335 healthy elderly volunteers. The study compared the effect over two years of 50 mg KH once daily with placebo in a double blind trial. On three measures—two neuromuscular (incon-"