LETTERS TO THE EDITOR

It was found that the ADDTC criteria were more sensitive than the NINDS-AIREN criteria in that there was closer agreement between the ADDTC criteria and their own, which, however, are not clearly specified beyond the use of the HIS. The NINDS-AIREN criteria failed to diagnose VaD in cases where there were no focal neurological signs following small strokes, or where the temporal relationship between the stroke and cognitive decline was unclear. It could be argued that a clinical diagnosis of VaD in these cases would not, in fact, be justified.

We agree that the NINDS-AIREN criteria are relatively narrow and that the definition of dementia is arguably too restrictive. This would be anticipated given that they are research criteria, in contrast to the ADDTC criteria which are intended for clinical work. We suggest, however, that the ADDTC criteria are too sensitive. The definition of dementia is vague and open to interpretation, and the ability to diagnose VaD on the strength of non-temporally related strokes only must increase the risk of over-diagnosis. A further drawback of both sets of criteria is the emphasis on what is effectively multi-infarct, cortical, dementia. Validated criteria for the diagnosis of Binswanger’s disease exist [5], yet leukoaraiosis in association with cognitive deficit and neurological signs would only merit a ‘possible’ diagnosis with both NINDS-AIREN and ADDTC criteria.

There is a strong chance that VaD will be inappropriately diagnosed whenever emphasis is placed on a history of strokes without due consideration of their likely clinical or pathological significance [6]. However the diagnosis of VaD assumes that cerebrovascular pathology has a primary causative role in the dementing process, so a ‘definitive’ diagnosis using rigid criteria would lead inevitably to an underestimation of the dementing process, so a ‘definitive’ diagnosis using rigid criteria would lead inevitably to an underestimation of the dementing process, so a ‘definitive’ diagnosis using rigid criteria would lead inevitably to an underestimation of the dementing process, so a ‘definitive’ diagnosis using rigid criteria would lead inevitably to an underestimation of the dementing process, so a ‘definitive’ diagnosis using rigid criteria would lead inevitably to an underestimation of the dementing process, so a ‘definitive’ diagnosis using rigid criteria would lead inevitably to an underestimation of the dementing process, so a ‘definitive’ diagnosis using rigid criteria would lead inevitably to an underestimation of VaD. Conversely, a chance of slowing the progression of the disease may lead to patients and family placing pressure on the clinician to err on the side of diagnosing AD in cases of genuine doubt.

Neither set of criteria appears to be completely satisfactory, particularly without pathological validation or clarification of the exact relationship between evidence of cerebrovascular disease and cognitive decline. The flexible clinical approach described by Amar et al. employing the principles of the HIS, if not the scale itself, seems to strike the right balance between sensitivity and specificity. The NINDS-AIREN and ADDTC criteria have not so far demonstrated an overwhelming advantage over this.

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