Chapter 33

Differential Patient Response to Ergoloid Mesylates According to Current Etiopathic Notions of Dementia

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Summary

Data obtained from 1165 patients treated from 3 to 12 months in 21 double-blind studies with ergoloid mesylates (Hydergine, Sandoz) reveal a differential patient response based upon current etiopathic notions of dementia. Patients who were classified as having degenerative/idiopathic dementia derived the most benefit from ergoloid mesylates following 3 months of treatment.

Patients presumed to have multi-infarct dementia based on historical evidence of at least one cerebrovascular accident were also improved significantly with ergoloid mesylates but somewhat less on an overall symptom-by-symptom basis. Patients with evidence of cardiopulmonary dysfunction demonstrated less consistent improvement. Ergoloid mesylates had no demonstratable effect on specific target symptoms of dementia associated with systemic/metabolic or neurological disease. Less consistent results emerged from analyses for the 6 and 12 month evaluations compared to the 3 month assessment period.

Introduction

Among the numerous methodological problems encountered in evaluating any therapeutic agent in the elderly is the tendency to utilize a nonspecific
diagnosis such as organic brain syndrome in characterizing patients entered into clinical trials (Prien, 1972). Physicians commonly attribute the varied cognitive, emotional, and social problems of the elderly to chronic brain disease without regard to specific etiology. It has been widely assumed that many of the symptoms associated with aging have been caused by arteriosclerotic cerebrovascular disease. There is, however, considerable evidence that refutes this contention (Wells, 1978a; Seltzer and Sherwin, 1978; Paulson and Perrine, 1968).

Attempts at distinguishing chronic brain disorders based on clinical–pathological data have provided an impetus for modifying traditional diagnostic methods (Tomlinson, Blessed, and Roth, 1970). It has been suggested that the term cerebral vascular insufficiency be restricted only to conditions manifested by focal neurological signs (Obrist, 1972). The terms multi-infarct dementia (MID) and primary degenerative dementia have been distinguished on the basis of pathology, clinical findings, and patient history (Fisher, 1968; Hachinski and Lassen, 1974). Both the presenile and senile forms of Alzheimer’s disease (SDAT) can be considered on the basis of similar pathology to be synonymous with idiopathic/degenerative dementia (Blessed, Tomlinson, and Roth, 1968). This has resulted in various refinements in the psychiatric nomenclature and are reflected in the American Psychiatric Association’s DSM III classification which delineates only progressive idiopathic dementia and multi-infarct dementia as senile, non-drug-induced forms of organic mental disorder (Spitzer, 1980).

While these disorders are generally considered irreversible, it has been estimated that approximately 15% of patients with symptoms of dementia will have reversible conditions, and that another 20–25% will require specific therapeutic intervention (Wells, 1977). There are numerous medical conditions and chronic disease states including endocrine, cardiovascular, systemic, metabolic, and neurological disorders which give rise to the dementia syndrome (Wells, 1978b). It thus becomes critical to consider seriously such conditions in the evaluation of any elderly patient with symptoms of organic brain disease.

Over the past 15 years, ergoloid mesylates has been extensively evaluated in clinical studies in the United States and abroad for the treatment of symptoms associated with “cerebrovascular insufficiency”, “cerebral arteriosclerosis”, “senile deterioration,” and “organic brain syndrome” (Bazo, 1973; Rosen, 1975; Rehman, 1973; McConnachie, 1973; Thibault, 1974; Banen, 1972; Rao and Norris, 1972; Jennings, 1972; Triboletti and Ferri, 1969; Ditch, Kelly, and Resnick, 1971; Gerin, 1969; Roubicek, Geiger, and Abt, 1972; Nelson, 1975; Einspruch, 1976; Hollister, 1955; Popkin, 1956; Gaitz, Varner, and Overall, 1977). The use of such descriptive labels without the application of more precise diagnostic inclusion criteria has caused some criticism of these investigations (Hughes, Williams, and Currier, 1976).