

result is that neither Alzheimer's research nor research in less-developed countries is properly supported.

What needs to be done? The most important improvement would be clarity and openness in the grant systems with three types of grant. The first should be aimed at building centres of excellence for Alzheimer's research. The second should be the introduction of a grant similar to the US R01 system of investigator-initiated grants. These first two grants should be allocated on a simple peer-review system and should be the major system for funding European research, with review committees based only on talent and not on nationality. The third should be targeted grants aimed at developing countries and should, in the first instance, be twinning types of grants with the major centres. This system would ensure better spending on Alzheimer's research and more honesty in the review process than at present. If European research on Alzheimer's disease is to prosper, and if the brain drain is to be halted, these changes need to be made.

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Zolpidem in Parkinson's disease

SIR—Antonio Daniele and colleagues (April 26, p 1222–23)¹ report that the hypnotic drug zolpidem may be efficacious in the treatment of some patients with Parkinson's disease. We are concerned about the interpretation of their results. They report significant improvement in a small number of severely impaired patients and suggest that zolpidem could be helpful in a subpopulation of Parkinsonian patients. There are important safety and efficacy issues about the use of zolpidem in this disease, and a methodological issue may reduce the validity of their conclusions, based on a placebo-controlled study in ten patients.

Zolpidem is a flexible, effective, and acceptably safe drug for the management of insomnia.² In contrast to existing hypnotics this non-benzodiazepine (BZD) drug, exhibits in vivo and in vitro preferential binding to a specific BZD-receptor subtype.³ There is little information available about the value of GABA (γ -aminobutyric acid) ergic compounds in the treatment of Parkinson's disease, and they certainly do not represent the treatment of choice.⁴ Patients with this disease do not seem to be homogeneous in respect of either changes in the nigrostriatal

dopaminergic system or response to therapy. An individual patient's response to treatment varies considerable over time, and it is generally recommended that drug therapy should be adapted to the stage of the disease, the predominant symptoms, and the patient's needs.

Zolpidem is not indicated for Parkinson's disease. Extensive trials with this drug as a hypnotic and nine years of clinical experience have shown that increasing the dose above 10 mg dose provides no substantially greater efficacy and may even be associated with a greater risk of side-effects.⁵

Daniele and colleagues give few details to allow assessment of the impact of zolpidem, administered during the day and at doses up to 40 mg (four times the maximum recommended in the elderly), in their at-risk population. Drowsiness, an expected pharmacological effect of a hypnotic, occurred in four patients, but Daniele et al did not mention the risk of falls which is generally associated with drowsiness and which would be very serious to patients with Parkinson's disease.

Without more extensive data on the benefits and risks of zolpidem in Parkinson's disease, its usefulness is not assessable, and we cannot recommend it in this disease.

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Injury to diabetic feet by thumb tacks

SIR—Many have had the experience of a thumb tack being stuck to the sole of one's shoe and the clicking sound thus produced when walking on a firm surface. We report two patients with diabetes in whom attention was drawn to injury of the foot by investigation of a

ticking sound while walking.

A 62-year-old Asian woman was admitted with cellulitis of the left foot. She had noticed a ticking sound while walking on a tiled floor. She found that there was swelling, redness, and pus surrounding an embedded thumb tack at the base of the 4th toe. She had been diabetic for 15 years, was recently converted to insulin for secondary responsiveness to oral hypoglycaemic agents, and had had a cataract extraction 1 month earlier. At presentation, she had painless swelling and induration of the lateral aspect of the left foot. A puncture wound was noted at the base of the 4th toe. She had no pain sensation and could not feel crude touch bilaterally up to the mid leg. Vibration sense was also impaired distally. Foot pulses were easily palpable. She had only received informal instructions about foot care from her practitioner. She wore footwear outside, but walked barefoot indoors at her home.

A 54-year-old Asian woman was admitted with cellulitis of the right heel. Her husband had noted a ticking sound while she was walking on their terrazo (polished stone) floor. Inspection revealed redness and warmth. Despite intravenous antibiotics, surgical drainage of deep plantar infection was necessary. She had been diabetic for 8 years. She had complete loss of pain sensation in both her feet and legs. Pedal pulses were strong.

Infection resulting from unrecognised trauma to neuropathic diabetic feet is a common cause of lower limb loss.¹ In developing countries, walking barefooted is a major predisposing factor for trauma and infection. This practice, together with failure to routinely inspect feet, means that patients often present at a stage of advanced limb-threatening sepsis.^{2,3} Our patients recognised the dangers of walking barefooted and heeded advice about use of appropriate footwear outside the house, but neglected such advice while indoors. Both patients had an injury that could have gone unrecognised but for the ticking thumb tack.

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