as well as ginkgo, nicergoline, and nimodipine. Memantine is licensed with restrictions only for moderate to severe dementia—and was withdrawn from the market in France because of its lack of effectiveness (4).

We worry that healthcare provision for older people will not improve if prescribing behavior changes as a result of the PRISCUS List without satisfactory proof of benefit for the suggested alternatives.

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Conflict of interest statement
The authors declare that no conflict of interest exists.

In Reply:

Ebersbach and Warnecke point out the classification of MAO-B inhibitors as "potentially inadequate medication" (PIM) and the naming of ropinirole as an alternative. The cited study included patients with newly diagnosed Parkinson syndrome and investigated the efficacy and tolerability of levodopa, a dopamine agonist, or a MAO-B inhibitor as initial medication (1). Treatment cessation was rarest in patients treated with levodopa (2%), highly significantly less than in those treated with a dopamine agonist (28%) or a MAO-B inhibitor (23%); the difference between the latter two did not reach significance.

The FORTA classification also prefers ropinirole and rotigotine (patch) as label B(eneficial) treatment) for elderly patients over rasagiline (C-areful) and selegiline (D-on't) (2).

When comparing the adverse effect profile of ropinirole (and rotigotine) with piribedil or pramipexole we wish to mention the explanation of adverse effects in the prescribing information or Micromedex®. Piribedil and pramipexole were also labeled by experts as C in the FORTA List.

As regards amantadine in the named restricted indication we agree with our colleagues' assessment; the suggested alternatives apply for more general use and it goes without saying that they require critical evaluation in the individual case.

As regards the comments by Egidi et al, we have to clarify that in the consensus process it was unfortunately not possible to coordinate all comments and alternative suggestions. The focus was on considering potential harms, less on weighing up benefits against harms, which obviously has to be undertaken in the individual case.

We agree with our correspondents that non-pharmacological measures have to be consistently listed as alternatives for all sedatives—this is included in the longer online version of the article.

As regards the effectiveness of DPP-4 inhibitors in elderly patients, the evidence is really limited. When emphasizing their safety, the study data are actually supportive of DPP-4 inhibitors (3). The cited systematic review and resulting GRADE tables were available to the experts.

The German National Disease Management Guideline on Unipolar Depression (NDGM) also mentions the anticholinergic potential of tricyclic antidepressants as an argument for exercising restraint in elderly patients. The US Beers List classifies tricyclics because of the anticholinergic characteristics generally as "to be avoided" (4). Tricyclics and selective serotonin reuptake inhibitors similarly increase the risk of suicide, and when selecting the antidepressant the risk of falls has to be balanced against other adverse effects. Further alternatives are listed in the long version.

We understand the point in recommending memantine. Memantine as well as cholinesterase inhibitors are named in the long online version.

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