Correspondence

The Editors will be pleased to receive and consider for publication correspondence containing information of interest to physicians or commenting on issues of the day. Letters ordinarily should not exceed 600 words and must be typewritten, double-spaced, and submitted in duplicate (the original typescript and one copy). Authors will be given the opportunity to review the editing of their correspondence before publication.

A Safer Blood Supply

To THE EDITOR: The editorial by Dr Paul Bunn in the May issue calls attention to the desirability of testing the blood supply for the presence of HTLV-I infection.[1]

Your readers would probably appreciate knowing that HTLV-I testing has been part of the routine for insuring the safety of the blood supply for the past several months for all blood issued in the United States.

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REFERENCE

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The Increased Rate of Fractures of the Hip and Spine in Alzheimer's Patients

To THE EDITOR: It was suspected that patients with Alzheimer's disease would experience an increased rate of fractures of the hip and spine.

Method

A computer printout of women patients over the age of 60 with either a primary or secondary diagnosis of Alzheimer's disease was obtained. The medical records of these patients were then reviewed. There were 20 patients in this study with Alzheimer's disease. For a control, the records of 60 patients who were matched for age, race, and sex were similarly reviewed.

Results

In the 20 patients with Alzheimer's disease, 10 (50%) were found who had fractures of either the hip or spine. Of the 60 persons in the control group, 12 (20%) had fractures. A *P* value was obtained of less than .001.

Discussion

It appears that there is a significant correlation between Alzheimer's disease and fractures of the hip and spine as compared with controls. This correlates with results of a 1986 study by Buchner and Larson.[1] Patients with Alzheimer's disease need to be protected. The reason for this association may be more significant. This relationship can have only two logical explanations. Either Alzheimer's disease caused an increased rate of fractures, or osteoporosis, which predisposes to this type of fracture, and Alzheimer's disease have a common origin. In support of the former explanation, patients with Alzheimer's disease could have a poorer diet, less exercise, or otherwise have increased rates of osteoporosis.[2,3] They may simply fall more frequently. If Alzheimer's disease increased the frequency of fractures or the rate of the development of osteoporosis, these patients must sustain the fractures at a younger age than the control group with the same fractures. To determine if this was in fact the case, we compared the average ages of the Alzheimer's group who had fractures of the hip and spine with the control group, who had similar fractures. The average ages were 77.6 and 77.1, respectively. There was no significant difference. Alzheimer's disease does not appear to have increased the fracture rate or accelerated the development of osteoporosis. These observations are not inconsistent with the hypothesis that Alzheimer's disease and osteoporosis are derived from a mutual agent.

If this conclusion is correct, it follows that the therapy for osteoporosis should be efficacious in treating Alzheimer's disease.[4] Aside from the theoretical explanation of the etiology, treating Alzheimer's patients for osteoporosis can be justified on the basis of the association with fractures.

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2. Parfitt AM: Dietary risk factors for age-related bone loss and fractures. Lancet 1983; 2:1181-1185

3. Seeman E, Riggs BL: Dietary prevention of bone loss in the elderly. Geriatrics 1981; 36:71-79

4. Riggs LB, Seeman E, Hodgson SF, et al: Effect of the fluoride/calcium regimen on vertebral fracture occurrence in postmenopausal osteoporosis—Comparison with conventional therapy. N Engl J Med 1982; 306:446-450

Lyme Disease in Northern California

To THE EDITOR: A recent article in the journal indicated that the vector of Lyme disease inhabits the entire West Coast.[1] In northern California fear of Lyme disease is rampant because of an increased number of case reports and the drama of the news media. People visualize infected ticks perched on bushes and grass waiting to infect all passersby. As this disease becomes more widely recognized throughout the West, fear of Lyme disease will spread. This fear is quite false based on current data, medical literature, and expert opinion. As physicians we must educate our patients about this disease and quiet their fears.

The offending spirochete, *Borrelia burgdorferi,* is transmitted in the West by the deer tick, *Ixodes (Ixodes) pacificus.* It occurs year round, with a major peak in summer and a second lesser peak in winter. Lyme disease occurs in stages of active and silent disease. The illness usually begins with a skin rash, erythema chronicum migrans, and may be followed by cardiac, neurologic, or joint problems. Laboratory tests may be helpful but are not standardized or totally reli-