

## Question & Answer (Q&A): Diagnosis and Treatment of Parkinson's Disease (PD) Webinar

*Webinar participants asked these questions during the Q&A portion of the third webinar in the 2017 Geriatric-Competent Care webinar series, Diagnosis and Treatment of Parkinson's Disease. Please note, the responses in this document have been edited for clarity. The webinar recording, slides, and transcript can be found on the Resources for Integrated Care website:*

[https://www.resourcesforintegratedcare.com/GeriatricCompetentCare/2017\\_GCC\\_Webinar\\_Series/Parkinsons](https://www.resourcesforintegratedcare.com/GeriatricCompetentCare/2017_GCC_Webinar_Series/Parkinsons)

### Featured Webinar Speakers:

- Liana Rosenthal, MD, Director, Clinical Core of the Morris K. Udall Centers of Excellence for Parkinson's Disease Research, Johns Hopkins University School of Medicine, Baltimore, Maryland
- Gregory Pontone, MD, Director, Parkinson's Disease Neuropsychiatric Clinic, Morris K. Udall Centers of Excellence for Parkinson's Disease Research, Johns Hopkins University School of Medicine, Baltimore, Maryland
- Arita McCoy, RN, BSN, Nurse Coordinator, Morris K. Udall Centers of Excellence for Parkinson's Disease Research, Johns Hopkins University School of Medicine, Baltimore, Maryland

### Q1: How can you tell the difference between PD and Lewy Body dementia?

**Dr. Liana Rosenthal:** The pathology of PD is Lewy Bodies, and the pathology of Lewy Body dementia is also Lewy Bodies. Most providers believe that dementia with Lewy Bodies and PD with dementia are actually a continuum. We often think about this in terms of which features are more prominent. With Lewy Body dementia, often times individuals experience hallucinations early in their disease and moderate to severe cognitive impairment in addition to Parkinsonism. The official definition of Lewy Body dementia is moderate to severe cognitive impairment within one year of onset of the motor features of Parkinsonism. These people have dementia with Lewy Bodies.

People who develop significant and cognitive impairment more than one year after developing motor problems have PD with dementia. The official cut off is the one year mark, but that is dependent on the individual's history, which is not always clear.

### Q2: What do Lewy Bodies look like?

**Dr. Liana Rosenthal:** Lewy Bodies are a collection of proteins inside the neuron. It is an abnormal, circular glob within the neuron that can be found within the substantia nigra where the dopamine-making cells are located. They can also be found within the cortex, which we believe is what causes the cognitive changes.

**Q3: Is there any evidence of non-pharmacological treatments such as acupuncture?**

**Dr. Liana Rosenthal:** There is evidence supporting exercise as a non-pharmacological treatment. A recent meta-analysis showed benefits of acupuncture as complementary to traditional medication management, but it has not been studied extensively.<sup>1</sup>

**Q4: How you can balance orthostatic hypotension and need for treatment?**

**Dr. Liana Rosenthal:** This is a challenge, and I usually err on the side of treating the individual's PD motor symptoms except in extreme situations, such as, the individual is having syncope or pre-syncope. There is no need to just treat the numbers; it is okay if orthostasis exists as long as it is not symptomatic. Behavioral and diet modifications often help significantly with orthostasis. These modifications include increased fluid intake, consumption of salt tabs, increased salt in the diet, and also thigh-high stockings (though difficult to put on). Medication management can also help.

**Q5: How can we best facilitate improved provider collaboration in treating PD?**

**Arita McCoy:** Some providers may find collaboration difficult. In general, it is best to reach out personally to other members of the healthcare team; a direct connection is the most effective means for facilitating the transfer of information, such as notes and other materials. It takes effort and work, but once the connection is made, it is advantageous.

**Q6: Can a psychologist be part of the care team?**

**Arita McCoy:** Care teams will vary depending on the needs of each individual, but they can include psychologists along with neurologists and/or movement disorder specialists, primary care providers, nurses, social workers, physical therapists, occupational therapists, and other providers that assist with care.

The Johns Hopkins University School of Medicine (JHUSOM) provides one example of a psychologist on a care team. JHUSOM's medical and psychological team focuses on individuals who have cognitive dysfunction or cognitive abnormalities. As a result, the care team is better able to determine the scope of the individual's deficits and provide targeted guidance. JHUSOM's medical and psychological team also helps determine surgical candidacy to ensure that individuals' cognitive dysfunction or mood issues would not worsen as a result of treatment.

For more information on care teams specific to PD, please visit:

<http://www.parkinson.org/understanding-parkinsons/what-is-parkinsons/putting-your-comprehensive-care-team-together>.

**Q7: What are some of the services that neuropsychology can provide?**

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<sup>1</sup> Lee, S. & Lim, S. (2017). Clinical effectiveness of acupuncture on Parkinson disease: A PRISMA-compliant systematic review and meta-analysis. *Medicine (Baltimore)*, 96(3), e5836.

**Dr. Gregory Pontone:** Neuropsychologists can help identify and diagnose mood and cognitive syndromes, and in some cases, provide sophisticated cognitive behavioral interventions to improve mood and behavioral symptoms.

**Q8: I work for a home health agency that serves individuals with PD who do not have a depression or anxiety diagnoses but are showing manifestations of the disease. Could we add a Psych RN consult even without a formal diagnosis?**

**Dr. Gregory Pontone:** Yes, screening for depression, anxiety, and other neuropsychiatry syndromes is warranted given the high prevalence in PD. If recognized and treated early, this avoids adverse outcomes and result in improved quality of life.

**Q9: Are the Patient Health Questionnaires (PHQ-2 and PHQ-9) equally effective in screening and measuring depression and depression severity in individuals with PD?**

**Dr. Gregory Pontone:** The PHQs are usually not as effective as a depression-specific scale. There have been studies exploring this issue, but for the most part, the geriatric depression scale is the best. Other options include the self-rated inventories, such as the Beck Depression Inventory, the Hamilton Depression Rating Scale, and the clinician/nurse administered Montgomery-Asberg Depression Scale. Questionnaires that measure other non-motor symptoms or quality of life can be tricky because they are not sensitive or specific enough to measure depression.

**Q10: What is your experience with Nuplazid and PD psychosis?**

**Dr. Gregory Pontone:** I have found Nuplazid to be well tolerated and helpful for the majority of individuals. However, like other antipsychotics used in the treatment of PD, such as Clozaril and Seroquel, it takes time to work and the initial expectation should be improvement in symptoms, e.g. decreased frequency and distress, and not full resolution of psychosis.

**Q11: What makes Nuplazid better for PD psychosis than Seroquel?**

**Dr. Gregory Pontone:** Nuplazid has fewer side effects, a longer duration of action (e.g. a longer half-life), is easier to dose (does not need adjustments), and has demonstrated efficacy for PD psychosis. It is also FDA approved for this indication. For Seroquel, efficacy has not been proven, despite wide use and several clinical trials.

**Q12: Can you comment on sexually inappropriate behavior related to Sinemet?**

**Dr. Gregory Pontone:** One scenario is an impulse control disorder, which has been associated with dopamine agonists, and sometimes, but less frequently, Sinemet, where a dopamine agonist triggers something that “revs up” normal drive. In such situations, individuals tend to have sexual behaviors that are outside typical levels. It is important to determine if new medications were introduced or if there was a change in the medications that contain dopamine. Regardless, bringing the situation to the attention of a primary care physician as soon as possible is imperative because one behavioral problem, such as sexual changes, could be indicative of other behavioral problems that might be missed or are “hiding” in the shadows.

The second scenario is a major mental illness occurring in individuals with PD. One example is bipolar illness which is fairly rare, but can cause mania that results in hypersexual behaviors. The final scenario, and one that is fairly common, is the development of cognitive impairment and dementia, which results in disinhibition. The end result is sexually inappropriate behaviors or comments in inappropriate social contexts; all require different management approaches.

**Q13: What do we know about the interaction of opiates given for pain management for PD?**

**Dr. Gregory Pontone:** Opiate pain medications, similar to benzodiazepines, potentially increase the risk of falls for those with PD because of decreased functional resources. Opiates, even in non-Parkinson's conditions, frequently cause confusion, and this is more likely to occur in individuals with neurodegenerative disorders. Clinicians should use caution when prescribing opiates to individuals with PD.

However, sometimes the use of opiates is unavoidable. For instance, if an individual breaks his/her hip, they will require pain medications for a short period of time. At this point, clinicians must use their best judgment to administer the minimum amount of opiates possible for pain control, while keeping the individual engaged and in a well-lit environment to decrease the risk of hallucinations and confusion.