Dear Colleague:

Do you want to ensure the best management of your patients with Parkinson's disease? If so, consider these key points from our CME-certified OfficePerspectives activity, “Understanding Parkinson’s Disease: Early Diagnosis, Treatment Options, and Complications”:

• Beyond the 4 major motor symptoms of Parkinson’s disease (PD)—resting tremor, rigidity, slowness or bradykinesia, and postural instability—clinicians should also look for non-motor symptoms such as constipation, sleep disorders, including REM behavior disorder and excessive daytime somnolence, depression, and anxiety.

• Clinicians should pay attention to the timing of symptom occurrence: while features such as balance difficulty or cognitive problems can occur in PD, they tend to do so later in the course of the disease. An early appearance should raise a red flag as to whether PD is the correct diagnosis.

• Approximately one-third of PD patients do not have a tremor, presenting with the akinetic-rigid variant. Others may present with a tremor outside of the hand (eg, the foot) or other symptoms that may look parkinsonian but need to be confirmed. For instance, when examining an older individual who is having a gait problem, the clinician needs to consider whether the problem is a Parkinson’s gait problem or an orthopedic gait problem.

• PD remains primarily a clinical diagnosis, but newer technologies are evolving that may assist with the diagnosis. For example, dopamine transporter imaging (DaTscan), which measures DAT binding at striatal presynaptic terminals, may demonstrate reduced levels that are associated with the loss of neuronal activity that characterizes PD—or may display normal levels in an individual with a psychogenic or drug-induced form of Parkinson's disease or other tremor disorders such as essential tremor. Genetic testing, on the other hand, is not often used in PD diagnosis unless a patient is at risk due to family history or may be exhibiting early onset of the disease.

• Patient education and support should begin at diagnosis and continue indefinitely with the acknowledgement that PD is a chronic disease. In addition to support, education, and follow-up from the office, clinicians can encourage patients to find in-person and reputable online sources and support groups that meet their needs (age, interests, etc).

• Lifestyle choices to increase general health and strength, such as sustained exercise, proper diet, and appropriate sleep habits, should be encouraged: a patient in good physical condition will be better able to tolerate a disease like PD that affects movement and balance.

• Treatment of symptoms may better improve a patient’s quality of life if the focus is on the issue of greatest impact to the patient. Thus, if a patient is highly bothered by anxiety and far less by a tremor, managing the anxiety will likely be the better course of action. Keeping treatment as simple as possible, for as long as possible, also helps reduce potential side effects and complications.
• There is no universal consensus regarding the timing of starting treatment for a patient's motor symptoms, particularly as there is little clear-cut evidence that any currently available treatments slow progression. However, some studies have demonstrated better outcomes in terms of movement and quality of life when treatment is started rather than being delayed. Such a decision should be patient-specific, and consider how personal circumstances may be impacted by complications of, and response to, the agent.

• Most clinicians agree that whatever and whenever medication is prescribed, it should start at a low dose and be slowly titrated to find the most effective dose. As the disease progresses, method of delivery—for example, a once-a-day oral medication, daily patch, or infusion gel—may help patient adherence.

• Complications with medications may emerge with disease progression. When adjusting dose strength and intervals does not adequately address problems like wearing off and medication-induced dyskinesia, interventional therapies, including deep brain stimulation and pump-based therapies, can offer significant improvement in appropriately selected candidates.

• Although levodopa/carbidopa may not be the initial treatment option for a patient, it is considered the gold standard of treatment for PD. Clinicians need to be aware, however, that patients often fear initiation of levodopa as a signal of disease worsening, or grow concerned about the potential motor complications it can induce, rather than accepting its needed efficacy at that point in their disease.

Management of Parkinson's disease requires a long-term relationship between practitioner and patient—and the patient's management plan. As clinicians, it is incumbent upon us to stay current with our patients and with advances in therapeutic strategies to help our patients stay healthy.

Yours sincerely,

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