

 <p>The National VA Parkinson's Disease Consortium</p> <p>Parkinson's Disease Research, Education and Clinical Center (PADRECC)</p>	<p>eCommuniqué</p>
<p>Welcome to this research bulletin of the National VA Parkinson's Disease Consortium. The eCommuniqué highlights information about Parkinson's disease (PD) and is provided as a service to members of the national Consortium, other colleagues, and community leaders interested in PD.</p>	

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Initial Pharmacotherapy in Veterans with Parkinson's Disease (PD)

This study analyzed characteristics of 530 veterans and VA prescribing providers in these areas: neurology (movement disorder specialists - MDS and non-MDS), geriatrics, primary care, mental health, and others. The average age of initiating PD therapy was 74.6 years with a diagnosis of dementia being present in 17%. The frequency of initial therapies included: levodopa (LD) - 75.1%, dopamine agonists (DAs) -10.2%, amantadine- 6.4%, selegiline -1.3%, and usually a combination of LD and DA- 5.6%. The neurologists (including MDS) were more likely to prescribe a DA than a non-MDS neurologist. Primary care doctors initially prescribed LD and the majority of anticholinergics were prescribed by mental health providers. Although younger patients seeing a MDS were likely to receive a DA initially, those patients comprised only 20 percent of the total. The authors conclude that veterans may not be receiving therapy that could delay the onset of motor symptoms and that initial therapy is strongly influenced by the provider's specialty - usually those without PD expertise. Authors Dr. Swartztrauber and Dr. Brodsky are neurologists at the Portland/Seattle (Northwest) PADRECC.

Neurology 2006; 66; 1425-1426. <http://www.neurology.org/cgi/content/full/66/9/1425>

FDA Approves Use of Rasagiline

In May 2006, the Food and Drug Administration (FDA) approved rasagiline (Azilect), a new molecular entity, for the treatment of PD. The drug is a monoamine oxidase-type-B (MAO-B) inhibitor that blocks the breakdown of dopamine – a chemical necessary to control movement and coordination. The safety and effectiveness of rasagiline was demonstrated in three 18-26 weeks controlled clinical trials. One of the studies compared the effects of rasagiline with patients on placebo and the other two studies compared the effects of rasagiline plus placebo with rasagiline plus levodopa. In this latter group, those who received rasagiline and levodopa had better motor function and mobility than rasagiline with placebo. *US Food & Drug Administration: FDA News.*

<http://www.fda.gov/bbs/topics/NEWS/2006/NEW01373.html>

Palliative Care in PD: Implications for Nursing

This article takes the model of palliative care and adapts it to the care of patients with PD specifically, The Parkinson's Disease Model of Care (PDMC). This PDMC model assists the neuroscience nurse in planning individual care for patients with PD throughout the trajectory of their illness from diagnosis through bereavement. The model emphasizes advance care planning and guides the nurse in providing relief from suffering for patients with PD and their families. Ms. Bunting-Perry, author, is the Assistant Clinical Director of the Philadelphia PADRECC. *J Neurosci Nurs. 2006 Apr; 38(2): 106-13.*

http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=pubmed&dopt=Abstract&list_uids=16681291&query=hl=1&itool=pubmed_docsum

Practice Parameters for Parkinson Disease: The Process

The Quality Standards Subcommittee (QSS) of the American Academy of Neurology (AAN) recently developed a series of Practice Parameters regarding the treatment of PD. The process involved the asking of questions using prespecified criteria and the assembling of a group of clinical specialists and general neurologists, experienced in evidence-based reviews, who conducted relevant literature searches. Selected articles in the final list were updated and ranked - the quality of the research (I-IV) with I the highest and the quality of the evidence used for the recommendation (A-U) with A the highest. This editorial praises the Practice Parameters for PD, noting, however, that limitations may exist due to deficits in basic knowledge and the quality of the reviews and the evidence. Identifying future research and issues for clinical practice will be strengthened by these parameters. (*Editorial*) *Neurology* 2006;66: 966-967.

<http://www.neurology.org/cgi/content/full/66/7/966>.

Practice Parameter: Diagnosis & Prognosis of New Onset PD

The findings were: 1) Features useful in distinguishing parkinsonian syndromes from PD include: early falls, poor response to levodopa, symmetry of motor manifestations, lack of tremor, and early autonomic dysfunction. 2) Levodopa or apomorphine challenge and olfactory testing are probably useful in distinguishing other parkinsonian syndromes from PD. 3) Predictive factors for more rapid motor progression include - nursing home placement, older age at onset of PD, associated comorbidities, presentation with rigidity

and bradykinesia, and decreased dopamine responsiveness. More research is needed in these areas. *Neurology* 2006; 66:968-975. *Report of the QSS of the AAN.*

<http://www.neurology.org/cgi/content/abstract/66/7/968>

Practice Parameter: Treatment of PD with Motor Fluctuations and Dyskinesia

The findings were: 1) To reduce off time: entacapone and rasagiline should be offered (Level A), pergolide, pramipexole, ropinirole, and tolcapone should be considered (Level B), apomorphine, cabergoline, and selegiline may be considered (Level C). 2) Evidence does not establish superiority of one medicine over another in reducing off time (Level B). Sustained release carbidopa/levodopa and bromocriptine may be disregarded to reduce off time (Level C). 3) Amantadine may be considered to reduce dyskinesia (Level C). 4) Deep brain stimulation (DBS) of the subthalamic nucleus (STN) should be considered to improve motor function and reduce off time, dyskinesia, and medication use (Level C). There is insufficient evidence to support or refute the efficacy of other DBS sites in reducing off time, dyskinesia, medication use, or to improve motor function. 5) Preoperative response to levodopa predicts better outcome after DBS of the STN.

Neurology 2006; 66:983-995. *Report of the QSS of the AAN.*

<http://www.neurology.org/cgi/content/abstract/66/7/983>

Practice Parameter: Neuroprotective Strategies and Alternative Therapies for PD

The findings were: 1) Levodopa does not appear to accelerate disease progression in a patient diagnosed with PD. 2) No treatment has been shown to be neuroprotective, 3) There is no evidence that vitamin or food additives can improve motor function. 4) Exercise may be helpful in improving motor function. 5) Speech therapy may be helpful in improving speech volume. 6) No manual therapy has been shown to be helpful in the treatment of motor symptoms. *Neurology* 2006; 66:976-982. *Report of the QSS of the AAN.*

<http://www.neurology.org/cgi/content/abstract/66/7/976>

Practice Parameters: Evaluation and Treatment of Depression, Psychosis in PD

The findings were: 1) The Beck Depression Inventory-I, Hamilton Depression Rating Scale, and Montgomery Asberg Depression Rating Scale should be considered to screen for depression in PD (Level B). The Mini-Mental State Examination and the Cambridge Cognitive Examination should be considered to screen for dementia in PD (Level B). Amitriptyline may be considered to treat depression in PD without dementia (Level C). For psychosis, clozapine should be considered (Level B), quetiapine may be considered (level C), but olanzapine should not be considered (Level B). Donepezil or rivastigmine should be considered for dementia in PD (Level B) and rivastigmine should be considered for Dementia with Lewy Bodies (Level B). More validated screening tools are needed for depression and dementia in patients with PD. *Neurology* 2006; 66:996-1002. *Report of the QSS of the AAN.*

<http://www.neurology.org/cgi/content/abstract/66/7/996>.

Dementia with Lewy Bodies: The Consortium Report

The criteria for the clinical and pathological diagnosis of dementia with Lewy bodies (DLB) has been revised incorporating new information about core clinical features and improved management methods. Distinctions are now made between *suggestive* features

of DLB (i.e. more frequent than in other dementing conditions) and *supportive* features (i.e. commonly occur but less specific). Features found on functioning neuroimaging that are given more diagnostic weighting for DLS include REM sleep behavior, severe neuroleptic sensitivity, and reduced striatal dopamine transporter activity. The authors suggest new methods for the pathologic assessment of Lewy bodies and Lewy neuritis with the pattern of regional involvement being more important than the total Lewy body count. (Dr. Duda, contributing author and neurologist, is the Co-Director of the Philadelphia PADRECC). *Neurology* 2006;66:1425-1426.
<http://www.neurology.org/cgi/content/full/65/12/1863>

The Progression of Benign Hallucinations in PD

Benign hallucinations associated with dopaminergic treatment for Parkinson's disease, have been studied in 48 patients with PD at Rush University. Over the period of 2 years, just 2 of the 48 patients continued to have benign hallucinations without requiring a decrease in their dopaminergic medications or an addition of neuroleptic agents. Most patients progressed from a score of 2 (benign hallucinations, insight retained) to a score of 3 (loss of insight) or 4 (delusions) on the thought disorder of the Unified Parkinson Disease Rating Scale (UPDRS). The researchers suggest that the term "benign" is misleading because of the serious consequences of the progression of hallucinations. .
Arch Neurol. 2006 May;63(5):713-6.
http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=pubmed&dopt=Abstract&list_uids=16682540&query_hl=1&itool=pubmed_docsum

National VA Parkinson's Disease Consortium Conference

The National VA PD Consortium Conference will be held Sept. 21-22 in Philadelphia. A core group of approximately 45 VA movement disorder specialists and neurologists, representing geographical areas of responsibility for each PADRECC, have been invited to meet and discuss the establishment of Consortium Centers. These Centers will ensure accessibility and continuity of specialized care for veterans afflicted by Parkinson's disease and related disorders throughout the VA Healthcare System. The Consortium Executive Committee has planned a dynamic and interactive program that encourages innovation and collaboration in the development of these Centers.

A Capsule....of Information

~**Rasagiline and Aging** - A study that examined age effects on adverse events from the use of rasagiline showed no statistical interaction between age and rasagiline exposure. This finding suggests that rasagiline does not require special safety precautions for elderly patients with PD. <http://www.neurology.org/cgi/content/abstract/66/9/1427?etoc>

~**Successful Aging** - 500 independently living Americans, ages 60 to 98, were studied and rated their own degree of successful aging as 8.4 on a ten point scale of 1 to 10 (with 10 being 'most successful'). Fewer than 10 percent of the participants would have met the standards proposed by professionals with expertise in successful aging. Since self-perception for successful aging may be more important than disease and disability, researchers may need to focus more on the attitudes of the seniors themselves.
<http://www.seniorjournal.com/NEWS/Aging/5-12-12-AgingMindOverMatter.htm>

~Stress and Hospitalized Spouses - The stress of having a hospitalized spouse, especially for psychiatric illnesses and dementia, may raise the risk for illness and death in the healthy spouse. In a study published in the NEJM, researchers studied the records of more than ½ million couples enrolled in Medicare. Having a spouse hospitalized for a serious illness is about ¼ as tough on the healthy spouse as having that spouse die.

<http://www.nursingknowledge.org/Portal/main.aspx?pageid=56&contentid=69327>

~Future Programs

2006

July 6-8 NPF Young-Onset Parkinson Network Conf. – Washington, DC
Sept. 14-15 WE MOVE Movt. Disorder Patient Summit: - Washington DC
Sept. 21-22 PADRECC Consortium Conference – Philadelphia, PA
Oct. 13-15 AAN Fall Conference - Washington, DC
Oct. 20 Movt. Disorders Soc. Dystonia Conf. - Milwaukee, WI
Oct. 28-Nov.2 Movt. Disorders Soc. 10th Internatl. Congress - Kyoto, Japan

2007

Jan. 12-13 AAN Winter Conference - Lake Buena Vista, FL
April 28-May 5 AAN Annual Meeting – Boston, MA
June 3-7 Movt. Disorders Soc. Internatl. Congress – Istanbul, Turkey

The National PD Consortium

Mission statement: ...to support the provision of optimal care and education for veteran patients diagnosed with Parkinson's disease and related movement disorders through advocacy, scientific inquiry and enhanced clinical expertise.

Coordinating Center:

Philadelphia VA Medical Center

ATTN: Rebecca Martine, APRN, CS, BC (Phone: 215-823-5934)

email: Rebecca.Martine@med.va.gov

National Consortium Leadership:

Rebecca Martine, APRN, CS, BC (Chairperson)

Jeff Bronstein, MD, PhD (Co-Chairperson)

Dawn McHale (Consortium Coordinator)

Mark Baron, MD (Research Committee Chairperson)

Eric Cheng, MD (Communications Committee Chairperson)

Gretchen Glenn, LSW/Naomi Nelson, PhD (Education Comm. Co-Chairs)

PADRECC Website: <http://www.parkinsons.va.gov>

Editors:

Naomi D. Nelson, PhD, Co-Associate Director of Education, Houston PADRECC

Eugene C. Lai, MD, PhD, Director, Houston PADRECC

To unsubscribe: contact.naomi.nelson@med.va.gov