# KISS: Parkinson's Disease

**Based on NICE 2019, NG127 & NICE July 2017 and BMJ 2017;358;j1951**

**Diagnosis:**

- Diagnosis depends on the presence of **bradykinesia** plus **one of rigidity, rest tremor** or **postural instability** (click here for full diagnostic criteria).
- Refer all suspected cases early and **untreated** for specialist diagnostic confirmation.
- All patients who drive must inform the DVLA (click here for DVLA notification link).

**Non-pharmacological management:**

- Exercise - **physical activity** has been shown to be very important in reducing motor and non-motor symptoms; consider referring to **physio** especially if balance or motor problems.
- Consider referral to **Occupational Therapy** if difficulty with activities of daily living & to **Speech & Language therapy** if problems with communication, swallowing or saliva.
- Patient information and support: lots of good information from Parkinson's UK.

**Drug treatment of motor symptoms:**

- All drugs are for symptomatic benefit and none influence the long-term progression.
- Initiation and alteration of all drugs should be done under specialist supervision.
- **First-line drugs**:
  - **Levodopa** - better for motor symptoms with fewer adverse effects but higher long-term motor complications.
  - **Dopamine agonists** (non-ergot derived e.g. pramipexole, ropinirole) - less good for motor symptoms but fewer motor complications, but higher adverse effects.
  - **MAO-B inhibitors** - less good for motor symptoms but fewer motor complications, but higher adverse effects).
- **Adjuvant** therapy: consider adding dopamine agonist, MAO-B inhibitor or COMT inhibitor to levodopa if dyskinesia or motor fluctuations despite optimal levodopa therapy.
- **Impulse control disorders** (e.g. hypersexuality, gambling, binge eating) can occur with any dopamineric therapy, but particularly dopamine agonists; warn patients and family about this potential complication as can be distressing.
  - If it occurs seek specialist advice, but we should not alter/stop medications without advice - medications usually need to be slowly reduced due to risk of dopamine withdrawal.

**Non-motor symptom treatment** (review potential causative/contributory drugs in all cases):

- Day time sleepiness, particularly associated with dopamine agonists; consider **modafinil.**
- Rapid eye movement sleep disorder - consider **clonazepam** or **melatonin.**
- Orthostatic hypotension: meds review important; consider **midodrine** or **fludrocortisone.**
- Depression (CKS 2018) - can be difficult to diagnose as features may be wrongly attributed to the PD; consider **CBT**; best evidence for **TCAs** but use may be limited by side effects (cognitive impairment and falls) so **SSRIs** may be more appropriate.
- Psychosis: don't treat if well tolerated; consider **quetiapine** or clozapine (specialist only).
- Dementia: consider **cholinesterase inhibitor** or **memantine.**
- Drooling: refer to **speech & language therapy** or consider **glycopyrronium bromide.**

**Palliative care** - consider referring at any stage to consider end of life care.