What associated disorders should primary care clinicians be alert for in patients with Parkinson disease?

Although the diagnosis and treatment of Parkinson disease is tricky enough to warrant subspecialty consultation and follow-up, affected patients frequent primary care practice for a host of related problems. A recent "Top Paper" contains diagnostic and therapeutic "pearls" that can facilitate caregivers' roles in a debilitating disease with increasing prevalence. ¹

1. Select "non-motor" features may predate parkinsonian motor problems (such as tremor) and help with initial diagnosis.
Impaired olfaction, disorders in rapid eye movement sleep, constipation, and depression are in this group. The presence of these features—especially when they occur in combination—should raise suspicion of Parkinson disease.

2. Remember that not all patients with "parkinsonism" have Parkinson disease.
Parkinsonism is implied when tremor, rigidity, and postural instability are present. On follow-up, inconsistencies noted in the primary care office may change the diagnosis of Parkinson disease to supranuclear palsy (if difficulty in swallowing is an early complication or gaze paresis is detected) or multiple system atrophy (postural hypotension).

3. Although the focus of primary outcomes of treatment is on tremor/gait, many other symptoms and signs should be inquired about.
Because depression commonly accompanies Parkinson disease, it is wise to make liberal use of depression scales in this population. Compulsive behaviors, including gambling, are bothersome to both patient and family. Sleep disorders—ie, insomnia, restless legs, vivid and, at times, "acted out" dreams—should be addressed. Taste can be disturbed in addition to smell. The incidence of seborrhea is also increased.

4. Before referral to a neurologist or movement disorders specialist, do not attempt a therapeutic trial—it may mask important diagnostic findings.

5. Copy the treatment algorithm in the article.
The algorithm follows a path in which you choose from various drug classes, weighing the pros and cons of efficacy and adverse events, and offers practical warnings to share with your patients. There is also information about which medications may aggravate symptoms of dementia. Psychosis management with clozapine is outlined.

THE BOTTOM LINE
The article contains many more practical points that are all rated according to evidence-based medicine criteria. For example, modafinil and melatonin should not be used for excessive daytime sleepiness in patients with Parkinson disease. So, the bottom line is that even though the authors document how important consultation is, both to the diagnosis and the management of Parkinson disease, many associated and extremely bothersome problems require vigilance by primary care providers.

References: REFERENCE:

Dr Rutecki reports that he has no relevant financial relationships to disclose.

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