Early Tx of Dementia Helpful in Parkinson's

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MIAMI BEACH — Early and aggressive treatment of dementia in people with Parkinson's disease could optimize outcomes and quality of life for patients and their caregivers, growing evidence suggests.

Approximately one-third of people with Parkinson's disease experience dementia. "We know there is such high risk for dementia in this population. We need to be proactive," Dr. David J. Burn said at the World Federation of Neurology World Congress on Parkinson's Disease and Related Disorders.

Hallucinations are a major concern. These can arise when mild cognitive impairment, common in people with Parkinson's disease, progresses to dementia.

"There is some reluctance to give the diagnosis. You have to be sure in your mind the dementia exists," Dr. Burn said. "But giving this in a reasonable way might reassure people with hallucinations they are not going mad." A definitive diagnosis can provide a sense of relief to patients and family members.

"Giving a positive diagnosis is still something that is not terribly well done," said Dr. Burn, professor of movement disorder neurology at Newcastle (U.K.) University, Newcastle-Upon-Tyne.

Current patient age is the dominant risk factor for dementia in Parkinson's disease. Cognitive impairments (attention, executive functioning, visuospatial perception, and memory) and behavioral effects (apathy, mood) are clinical features often associated with this classic "dysexecutive visuoperceptual" dementia. "There is a high psychiatric burden in that dementia, which is important in management of the disease."

General and specific diagnostic instruments can be helpful in this population, such as the Mini-Mental State Examination or the Mini-Mental Parkinson. Dr. Burn recommended the Neuropsychiatric Inventory-4. "It is a fairly quick thing to administer to the caregiver and can be administered with the Caregiver Distress Scale. It is quite a neat, compact way of assessing a lot quite quickly."

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"What we sometimes forget is why we are actually using them," Dr. Burn said. "This is an important point. Never forget that just because the scale generates a number, we would never feel comfortable the number is robust. Always follow-up with an interview with the patient and the informant—that is essential."

Fluctuation in symptoms is among the diagnostic challenges, Dr. Burn said. "They can have good hours/days versus bad hours/days—can have widely different values on neurologic testing. These fluctuations may be the biggest determinant of [impact on] activities of daily living in the setting of Parkinson's disease dementia."

Other confounding factors can further complicate diagnosis, including an insidious onset, slow progression, motor effects of Parkinson's disease, and whether the impairment is the result of cognitive dysfunction, he said.

Multiple medications have been studied for efficacy in this comorbid population. These include clozapine (Clozaril), quetiapine (Seroquel), memantine (Namenda), rivastigmine (Exelon), and donepezil (Aricept). However, the level of evidence to support a particular agent varies in the literature, and many drugs have side effects that need to be considered. Cholinesterase inhibitors can have effects on the heart, including reports of hospital visits for syncope and bradycardia, for example.

"Most of us when we diagnose Parkinson's disease dementia would reach for a cholinesterase inhibitor if patients are symptomatic," Dr. Burn said. "You need to push the dose to the maximum," he advised.

Keep in mind patients do not always respond to the first agent, so a switch to a different agent in this class or a different type of medication may be warranted for some patients, he added.

Choice of agent is unclear in part because randomized, controlled trials of antipsychotics in Parkinson's disease frequently exclude demented cases, he said. Also, there is a lack of randomized, controlled trials to support use of quetiapine.

"The jury is out on memantine, but for the moment … studies are favoring use of the drug," Dr. Burn said.

Dr. Burn and his colleagues are planning a study in which they will randomize 500 patients with Parkinson's disease and dementia to either donepezil or placebo. Secondary measures will include caregiver distress, strain, and health economics. "We hope to reconcile some unanswered questions." ■

Disclosures: *Dr. Burn disclosed that he was recently a member of the advisory board for Eisai Inc.*

REM Sleep Disorder Might Predict Parkinson's Disease

MIAMI BEACH — A patient with REM sleep behavior disorder has about a 50/50 chance for developing Parkinson's disease within 12 years, according to a recently published report.

REM sleep behavior disorder (RBD) "is a striking parasomnia very common in Parkinson's disease," Dr. Ronald Postuma said. Also, because RBD often precedes the onset of symptoms of Parkinson's disease, patients with this sleep disorder should be closely followed and counseled about their increased risk, he said at the World Federation of Neurology World Congress on Parkinson's Disease and Related Disorders.

RBD is characterized by speech and body movement during the rapid eye movement phase of sleep. "Normally, we are paralyzed when we dream. You lose this in RBD," he said. Other phases of sleep appear normal. Apnea, sleep walking, and sleep talking are part of the differential diagnosis, said Dr. Postuma, who is a member of the neurology faculty at McGill University, Montreal, and is a neurologist at Montreal General Hospital.

Dr. Postuma and his colleagues conducted follow-up with 93 patients who were diagnosed with RBD at the Hôpital du Sacré-Coeur in Montreal. During follow-up, 26 of these patients developed a neurodegenerative disease—14 developed Parkinson's disease; 7, Lewy body dementia; 4, dementia; and 1, multiple system atrophy (Neurology 2009; 72:1296-300).

Based on these findings, the estimated 5-year risk of neurodegenerative disease was 18%, the estimated 10-year risk was 41%, and the estimated 12-year risk was 52%. A diagnosis of RBD, therefore, carries important counseling implications.

The consensus is that about 35% of patients with Parkinson's disease have RBD, Dr. Postuma said. Prevalence estimates are higher from polysomnography studies, with reports that 40%-60% of Parkinson's disease patients have signs.

"An important clinical question is: Do you need polysomnography to diagnose RBD?" he said. Proponents point out that mimics of RBD can have consequences and some are treatable, such as apnea. Opponents say that patient history is often reliable for diagnosis and polysomnography is expensive. Dr. Postuma's approach is a compromise of sorts: With the relatively rare RBD, "the stakes are high" and he always recommends polysomnography.

Medication may be worthwhile, he added, particularly if a patient has a history of being violent during episodes of RBD. ■

Disclosures: *Dr. Postuma reported having no relevant financial ties.*

Green Tea Polyphenols Do Not Modify Course of Parkinson's

MIAMI BEACH — Green tea polyphenols taken daily provide minor symptomatic improvement for people with Parkinson's disease, particularly those with more severe disease at baseline, according to findings in a 12-month study. However, the green tea did not provide any disease-modifying effect, Dr. Piu Chan said.

The study lends some confirmation to observations in China of a dose-dependent protective effect of tea drinking against Parkinson's disease, Dr. Chan said at the World Federation of Neurology World Congress on Parkinson's Disease and Related Disorders.

To determine the safety, tolerability, and efficacy of green tea polyphenols for slowing progression of Parkinson's disease, Dr. Chan and his colleagues conducted a randomized, double-blind, placebo-controlled, and delayed-start study. They enrolled 410 untreated people with Parkinson's disease at 32 sites. Participants were randomized to 0.4 g (102 people), 0.8 g (103), or 1.2 g (104) of green tea polyphenols daily, or placebo (101). At 6 months, the placebo group switched to 1.2 g of green tea polyphenols daily as well.

For comparison, Dr. Chan said two cups of green tea typically contain about 300 mg polyphenols. Patients were assessed at baseline and at 3, 6, 9, and 12 months. They also kept a tea consumption diary. Change in Unified Parkinson Disease Rating Scale (UPDRS) score was the main outcome. Although a significant improvement in UPDRS scores was observed at 6 months for patients in each dosage group, they were no longer significantly different at 12 months compared with placebo.

Although green tea extract was safe and well tolerated, there was "no obvious disease-modifying effect seen," said Dr. Chan, director, Beijing Institute of Geriatrics and Department of Neurology, Xuanwu Hospital of Capital University of Medical Sciences, Beijing.

"You pretty much don't see a significant difference around 12 months," Dr. Chan said. There was a 2.5- to 3.5-point increase in UPDRS scores in all groups compared with baseline.

The UPDRS improvement was most marked in the patients with more severe disease at baseline, Dr. Chan said.

Adverse events were similar between groups, with the exception of a slight increase in insomnia in patients treated with green tea polyphenols.

Despite the less than encouraging disease modification results, the study is ongoing. "We are following up with about 2,000 patients now," he said. ■

Disclosures: *Dr. Chan reported having no conflicts of interest.*