Practice guidelines on Parkinson disease

Diagnosis and prognosis of new-onset Parkinson disease

This evidence-based Practice Parameter by Suchowersky et al. determined that clinical features such as early falls, lack of tremor, and poor response to levodopa are helpful in distinguishing other forms of parkinsonism from PD. Factors predictive of more rapid progression in PD include older age at onset and presence of comorbidities.

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Neuroprotection and alternative therapies in PD

Suchowersky et al. in this evidence-based review conclude that no therapy has as yet been proven to be neuroprotective in PD. No vitamins, food additives, or manual therapies have been shown to improve motor function. However, exercise may be helpful in improving motor function, and speech therapy may be helpful in improving speech volume.

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Treatment of PD with motor fluctuations and dyskinesia

The Pahwa et al. review of the medical and surgical treatment of patients with PD with motor fluctuations and dyskinesia concludes that entacapone and rasagiline are effective. Apomorphine, cabergoline, and selegiline are possibly effective. Amantadine is possibly effective in reducing dyskinesia. Deep brain stimulation of the subthalamic nucleus is possibly effective in reducing motor fluctuations and dyskinesia.

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Detecting and treating depression, psychosis and dementia in PD

The Miyasaki et al. evidence-based review concludes that three useful depression screening tools are available: the Beck, the Hamilton, and the Montgomery Asberg. The Mini-Mental State Examination and the CAMCog are useful dementia screens, but screening tests for PD psychosis are not available. Clozapine can be considered for treatment of psychosis; olanzapine should not be considered. Donepezil or rivastigmine should be considered for PD dementia.

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Editorial perspective

Roger L. Albin notes that in addition to being aids to clinical practice, these Practice Parameters are excellent, critical reviews of the literature relevant to the questions posed. However, the success of such Parameters as guides to practice rests on the nature of the underlying evidence. No amount of thoughtful analysis can overcome deficits in basic knowledge. Out of over 20 different recommendations, there is one Level A recommendation, about one third are Level B recommendations, and the remainder are Level C and Level U recommendations. But even if the Practice Parameter process does not lead to many definitive recommendations for clinical practice, these exercises point out crucial directions for clinical research. Thus these Practice Parameters may influence our clinical research agenda and have long term benefit.

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No difference between IFN β -1a and IFN β -1b in clinical effect on relapsing-remitting MS

Koch-Henriksen et al. found that the clinical effect of IFN β 1a 22 mcg QW subcutaneously and IFN β -1b 250 mcg every other day were virtually equal in a 24-month open-label randomized study of 301 patients with relapsing-remitting MS.

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Syncope in migraine

Thijs et al. studied the association between migraine and symptoms of autonomic nervous system dysfunction. In this population-based study subjects with migraine showed an increased prevalence of syncope and orthostatic intolerance.

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Why might PD patients volunteer for phase I gene transfer?

Kim et al. report that the answer depends mostly on patients' attitudes regarding risk, optimism about science, and an action orientation, rather than on their clinical, functional, or demographic characteristics.

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The editorial by Jerry Mendell and K. Reed Clark notes that there are multiple potential strategies for gene therapy that can be explored in PD, including both neurorestoration and neuroprotection. Moreover, PD is a prototypic chronic, neurodegenerative disease. Other diseases will be susceptible to similar strategies. Kim et al. consider the clinical side of the issues that patients consider when volunteering for an experimental phase I gene transfer study. Patients with PD were evenly split between willing (n = 46) and unwilling (n = 46) to participate. The willing group was inherently more decisive, believing "it was better to do something rather than just waiting for my PD to get worse." The unwilling group was deterred by risk, which could not be justified by personal or societal benefits. Their findings are reassuring for the consenting process since differences were not related to comprehension, therapeutic misconceptions, or difference in expectations between willing and unwilling participants. Instead, the differences reflected the values and preferences of the individuals.

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Post-irradiation reversible migraine-like episodes

(A) MRI T1 with gadolinium 6 days after episode onset: enhancement of cerebral gyri on the left. (B) Angiogram 3 months after the episode showing narrow P2 segment of the left PCA (white arrows show L vs R). The occipital branches of left PCA were narrowed with a reduced arteriographic blush vs the right.

Partap et al. report on three new patients and review eight previous cases who had reversible episodes of severe headache with focal neurologic deficit developing years after irradiation for cranial neoplasms.

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Lethal African trypanosomiasis: MRI and neuropathology

Braakman et al. report a case of lethal human African trypanosomiasis. MRI findings and autopsy results differentiate between human African trypanosomiasis-induced encephalitis and arsenic encephalopathy caused by melarsoprol.

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Melarsoprol toxicity vs inflammatory encephalopathy in trypanosomiasis

Kumar et al. report a steroid responsive inflammatory CNS illness that occurred after treatment of human African trypanosomiasis with the trivalent arsenical melarsoprol. They differentiate this from melarsoprol-related encephalopathy.

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The editorial by Peter Kennedy about these two articles notes that there are 300 to 500,000 cases of human African trypanosomiasis (HAT) annually with at least 60,000 deaths. Reviewing the cause and clinical picture of HAT, Kennedy notes that untreated, the patient will typically deteriorate and die after the development of seizures, incontinence, increasing cerebral edema, and coma. With increasing global tourism physicians in the West must be vigilant for the possibility of HAT in individuals who develop CNS symptoms after returning from Africa; hospital pharmacies must have access to appropriate drugs for both early and late stage disease.

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