Transcript Details

This is a transcript of a continuing medical education (CME) activity. Additional media formats for the activity and full activity details (including sponsor and supporter, disclosures, and instructions for claiming credit) are available by visiting: https://reachmd.com/programs/cme/routine-screening-for-psychotic-symptoms-in-individuals-with-parkinsons-disease-psychosis-leads-to-earlier-diagnosis/15418/

Time needed to complete: 1h 13m

ReachMD
www.reachmd.com
info@reachmd.com
(866) 423-7849

Routine Screening for Psychotic Symptoms in Individuals with Parkinson’s Disease Psychosis Leads to Earlier Diagnosis

Announcer:
Welcome to CME on ReachMD. This episode is part of our MinuteCME curriculum.

Prior to beginning the activity, please be sure to review the faculty and commercial support disclosure statements as well as the learning objectives.

Dr. Kremens:
Hello, my name is Dr. Daniel Kremens, and I'm an Associate Professor of Neurology, Vice Chair for Education, and Co-Director of the Parkinson's Disease and Movement Disorders Program at Sidney Kimmel Medical College at Thomas Jefferson University in Philadelphia, Pennsylvania. And my topic today is Routine Screening for Psychotic Symptoms in Individuals with Parkinson’s Disease Psychosis Leads to Earlier Diagnosis.

So Parkinson's disease psychosis is one of the most common conditions associated with Parkinson's disease. Parkinson's disease itself has been described as a pandemic, with both the United States and global prevalence projected to more than double in the next two to three decades. And it's estimated that greater than 50% of patients will experience Parkinson’s disease psychosis at some point during the course of their illness.

In 2007, the NINDS came up with provisional diagnostic criteria for Parkinson's disease psychosis, and it has a distinct clinical appearance. First, you have to have the presence of one or more of the following in a patient who already is diagnosed with Parkinson's disease, and these include hallucinations, delusions, illusions, and a sense of presence. The patient must have a primary diagnosis of Parkinson's disease, and the Parkinson's disease psychosis symptoms must occur after the onset of Parkinson's disease. They must be recurrent or continuous for at least a month. And they may occur with or without insight, dementia, or Parkinson's disease treatment. For many years, people thought that Parkinson's psychosis was a result of the treatment of Parkinson's disease. We now know that that's not true and that it can occur independent of treatment. And in fact, sometimes when we stop treatment, patients still remain psychotic. And of course, we want to rule out other medical or psychological causes for Parkinson's disease psychosis.

So what are the risk factors? Well, there are endogenous risk factors such as advanced age, cognitive impairment or dementia probably being the most common one, the duration and severity of Parkinson's disease, the presence of sleep disturbances, the presence of other psychiatric symptoms, such as anxiety or depression, and visual abnormalities or loss of visual acuity. And then we have exogenous factors. And these include medications for the treatment of Parkinson's disease, and then other medications such as anticholinergics or benzodiazepines, which may precipitate psychosis.

One of the challenges in Parkinson's disease psychosis is a lot of people feel that hallucinations are benign. Well, it's important to note there are no such thing as benign hallucinations. Once these hallucinations start, they almost inevitably worsen and lead to greater problems. Chris Goetz did a study looking at 48 Parkinson's patients with so-called benign hallucinations. These are patients who had a Unified Parkinson’s Disease Rating Scale Thought Disorder Score of 2, meaning that they had insight, who were receiving no treatment for hallucinations for at least 3 years, or until a thought disorder score of 3, meaning loss of insight, or 4, meaning delusions occurred; 81% of the patient's progressed to a thought disorder score of 3 or 4, 9 of the patients did retain a thought disorder score of 2, but 7 of

those 9 patients had their Parkinson's disease medications reduced to treat the hallucinations, thereby impacting their motor symptoms. And 3 of them required antipsychotics. Only 2 patients, or 4%, were stable over the course of the 3 years. Therefore, we know that once these symptoms start, they almost inevitably worsen in patients, and we need to think about treating them earlier.

And this has a tremendous impact on both the patients, caregivers, and society. Psychosis was responsible for 24% of all hospital admissions as well as increased mortality in patients with Parkinson's disease. It's predictor of long care term – long-term care placement, and its treatment is associated with over double the cost compared to a Parkinson's patient without psychosis. And caregivers of patients with Parkinson's psychosis are deeply impacted, reporting higher levels of depression, and over 40% reported that their own health suffered as a caregiver of someone with Parkinson's disease psychosis.

These symptoms are often underreported. There was a study of 242 patients looking at non-declared non-motor symptoms. And the patients were asked whether their symptoms were declared during the appointment with a physician and whether they were declared in a symptom survey that they were given. And when they reviewed the surveys, they found that symptoms that had been disclosed in the survey weren't disclosed to the physician for 41% of the patients who had experienced hallucinations, and for 65% of the patients who had experienced delusions.

Why would patients not report their symptoms? Well, first patients are often embarrassed or fearful. 'Doctor will think I'm crazy if I tell them I see things.' It also may not be clear to the patients that don't non-motor symptoms are - that they're experiencing are related to their Parkinson's disease. Sometimes people think there's a problem with their glasses if they're seeing spots on the wall. And a lot of times office visits are very focused on motor symptom management, and as a result, non-motor symptoms aren't addressed.

So screening is critical for early diagnosis. Existing screening tools and rating scales for Parkinson's psychosis were developed primarily for clinical studies. And they're too lengthy for routine clinical use, and don't clearly define psychotic symptoms enough for physicians to make informed decisions. So the lack of this simple, straightforward, standardized screening and diagnostic approach limits the identification of patients who are suffering from Parkinson's disease psychosis, and it lowers the likelihood of early and effective treatment.

But Dr. Pahwa and colleagues have recently proposed a simple two-part screening tool to help facilitate the diagnosis and treatment of patients with Parkinson's disease psychosis. So the first part of the screening tool consists of two broad questions which are administered in the waiting room prior to the visit in either paper or digital form. And these questions can be answered by either the patient or the caregiver. And these two questions are: Does the patient see, hear, or otherwise sense things others do not? And then some examples are given, for example, seeing people or animals that are not there, hearing music, or misidentifying objects. And then the second question: Does the patient believe thing others do not believe to be true? And again, examples are given. For example, that their spouse is cheating, others are trying to harm them or deceiving them or conspiring against them. If the patient or caregiver answers yes to either of these questions, the clinician assessment should then be completed in order to make decisions regarding treatment.

What about the clinician assessment? Again, to simplify the clinician assessment, specific examples of hallucinations and delusions that would need to be treated aren't included. It's a simple single question for the clinician to ask and that is: Does the patient have hallucinations or delusions that affect or disrupt any of his or her behaviors or activities, or cause distress, including to the caregiver? By using this simple question, this allows the clinician to evaluate and discuss with the patient and caregiver, how often hallucinations and delusions occur and how disruptive they are in order to make a decision regarding treatment. The wording effect or disrupt implies a negative impact on patient activity or behavior in any way.

So in conclusion, untreated symptoms of psychosis in Parkinson's disease are associated with progressive Parkinson's disease psychosis symptoms, poorer outcomes, impaired quality of life, and significant distress to the caregiver and patient. Patients often do not discuss Parkinson's disease psychosis symptoms, and physicians do a poor job asking about them. A recently proposed two-part screening tool may allow for earlier identification and intervention in the management of Parkinson's disease psychosis.

So thanks for joining me today on this important program on Parkinson's disease psychosis.

Announcer:
You have been listening to CME on ReachMD. This activity is jointly provided by Global Learning Collaborative (GLC) and TotalCME, Inc. and is part of our MinuteCME curriculum.

To receive your free CME credit, or to download this activity, go to ReachMD.com/CME. Thank you for listening.