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The Building Blocks: Early Recognition, Assessment, and Treatment Intervention for Parkinson's Disease Psychosis

Announcer:
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Dr. Kremens:
Hello, my name is Dr. Daniel Kremens, and I'm an Associate Professor of Neurology and the Co-Director of the Parkinson's Disease and Movement Disorder Program at Sidney Kimmel Medical College in Philadelphia, Pennsylvania. And today we're going to be talking about The Building Blocks: Early Recognition, Assessment, and Treatment of Parkinson's Disease Psychosis. And with me today, I have two participants, Dr. Rajesh Pahwa. Dr. Pahwa, would you like to introduce yourself?

Dr. Pahwa:
Yes, I'm Rajesh Pahwa. I'm Professor of Neurology, and Division Chair for Parkinson's Disease and Movement Disorders at the University of Kansas Medical Center, Kansas City, Kansas.

Dr. Kremens:
And Dr. Isaacson.

Dr. Isaacson:
Hi, I'm Stuart Isaacson. I'm the Director of the Parkinson's Disease and Movement Disorders Center of Boca Raton, in Boca Raton, Florida.

Dr. Kremens:
Parkinson's disease is the second most common neurodegenerative disease in the world, affecting about a million people in the United States. And it's thought that up to 50% of people will develop Parkinson's disease psychosis at some point during the course of their illness. Despite the fact that Parkinson's disease psychosis is so common, it's unrecognized and often patients won't discuss it at visits. So we know that early recognition and assessment is critical for treatment of Parkinson's disease, psychosis.

So Raj, how do you make that early diagnosis of Parkinson's disease psychosis?

Dr. Pahwa:
So I think it's very important to get an understanding of PD psychosis from the patient, and especially the caregiver, right from the time they have the diagnosis of Parkinson's, because PD psychosis can begin at any time during the disease course. So what I personally recommend is, while the patient is waiting in the nursing - I'm sorry, in the waiting room, or in the room for the physician to come in, that they fill a simple question, saying that: Are they seeing things that are not there? Or do they feel there are things out there that other people might be thinking? Or do they believe certain things that may not be true? And I ask both the patient and the caregiver to look over these questions and to complete them. If both of them say no, I don't even go into that question. But if one of them says yes, then I go a little deeper when I see the patient trying to get a better feel of what exactly is going on. Are they seeing patients? Do they believe

certain things are going on? Because that gives me a better idea how bad they may be. Because if someone says, 'Oh, I saw an animal one month ago for a few seconds and never seen it again,' that doesn't concern me, as opposed to someone saying they're seeing a dog every day all the time, and the dog is bothering them. So that definitely is something I do an evaluation to find out how severe or bothersome it may be.

Dr. Kremens:
Well, I think that the fact that you use the simple question, pre the examination, might be a really key way for us to make the diagnosis early. Because, you know, patients often don't volunteer the information unless you specifically ask them. And why would that be if it's so common? Well, some people believe that it's related to the fact that patients may be frightened or embarrassed that if they confess that they're having these sorts of things, you know, they may not be believed, or they might be thought that they're crazy. Another issue is some patients don't associate it with their Parkinson's disease. They don't realize. I had one patient who was seeing things on the wall and kept going to the optometrist to get his glasses adjusted. So there are many reasons why patients don't, you know, volunteer this. And if we don't ask these specific questions, we may not find out.

The other thing is, so much of the visit is often spent on motor symptoms of Parkinson's disease, the tremor, the gait problems. And as a result, sometimes, particularly given the press that we have now and seeing patients in the time limitations, we simply just don't ask about these other non-motor symptoms.

Stu, what approach do you have to make an early recognition?

Dr. Isaacson:
Well, I think it's important to recognize that Parkinson's psychosis can begin quite early in the disease. It may not be with delusions; it may be mild hallucinations, it could also be illusions where there's a stimulus that's misperceived; a tree that looks like a person, for instance, or a sense of presence or passage where you feel someone's in the room or someone's moving behind you. But you never know if patients are experiencing these things unless you ask. And it's why we really advocate for asking about it, in the same way that we ask about a tremor, or constipation, or lightheadedness. Or how do you sleep at night? Or how's your memory? Do you ever see things that aren't there? Just by asking you about it in a non-stigmatizing way, can really be helpful, I think, to elicit for patients who are experiencing these symptoms, whether they're having them currently and how frequent they are and how severe they are, and to really assess the insight they have into whether these things are real or not real.

Dr. Kremens:
So, you know, when we conduct clinical studies, we often use validated measurement scales, and one of these things is called the SAPS-PD, or the Scale for the Assessment of Positive Symptoms, and this is what's been used in some of the psychosis studies. But you know, this really isn't actually practical when we're seeing patients. So what ways do you have to assess a patient for their psychosis when you're seeing them in a regular clinic visit as opposed to a study visit?

Dr. Pahwa:
Right. So me personally, I really talk to the patient and try to get an understanding. Like I said, if someone says, 'Oh, I see something once in a while,' or 'I believe there's a bunch of clothes rising and I think there are kids sitting on there,' it's not a big issue, the patient pretty much has an insight. Similarly, if the hallucinations are present, does the patient feel that these are real or not? And if the patient says, 'Yeah, I see some dogs. But I know you have taught me over the time that medications can cause it, my disease can cause it, I know it's not real. I look away and look back and it's gone.' Again, it's not an issue. So for me, that's still mild.

And then we come to the part where the hallucinations can become bothersome for the patient, that the dog is there all the time, and it's beginning to annoy them. You know, even if their insight is still there, that the patient knows it's not real, to me, that's something I would like to consider treating it.

Then you have patients where they have lots of insight, and this dog is there, they really are scared of it. They have people in the house, they're trying to feed the people, they're believing the spouse is stealing from them, having an affair, which to me would be really a significant issue which may require more of an urgent treatment from that part. So for me, it's like, no, it's not present. Maybe it's mild. Maybe it's mild, but not bothersome, getting to a moderate part, and then severe, which would require immediate attention from my part.

Dr. Kremens:
So one thing I think is important that I always keep in mind is that, you know, there really is no such thing as a benign hallucination. We know now Chris Goetz did a wonderful study several years back, where they looked at 48 patients who had hallucinations, but still had insight. And they followed them for 3 years. And at the end of the 3 years, only 2 patients had not progressed to the point where they had lost insight or had developed delusions. And I think what this study demonstrates is that once these hallucinations start in the vast majority of people, they're going to continue, and they get worse. So my threshold to treat may actually be a little earlier because I like to

get on top of that before the patient is getting the delusions or thinking that someone's breaking into a house and now they're calling 911.

Stu, what are your thoughts?

Dr. Isaacson:
Well, I think I agree with you, because very often once when patients begin to experience even infrequent or even mild symptoms, it begins to translate into our treatment paradigm for treating motor symptoms becomes constricted, and we become more hesitant I think to increase or adjust medication. So even mild infrequent emergence of psychosis symptoms of illusions, or presence, hallucinations, impact how we treat our patients motor-wise. And once a patient with Parkinson's develops psychosis, we no longer treat their motor symptoms, as well I think we need to begin to not increase the medicine, and actually sometimes to begin to decrease the medicine. And this impacts their motor symptoms, increasing their risk of falls, impairing their quality of life and such. So it's very important to assess early and then to try to a treat it early as well.

Dr. Kremens:
So I think we've learned today that Parkinson's disease psychosis is a very common problem in Parkinson's disease, but it can be addressed and it can be addressed through early assessment, early recognition, and then allowing us to treat the patient because we're going to end up in a therapeutic bind, as you point out, Dr. Isaacson. We're left with treating the psychosis, we're treating the movement, and we start balancing those, and that can lead to that therapeutic bind where we end up undertreating both of them.

So I want to thank my co-participants today for your insights on building blocks, early recognition, assessment, and treatment of Parkinson's disease, psychosis. Thank you.

Dr. Isaacson:
Thank you.

Announcer:
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