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/expert-recommended-best-practices-treatment-strategies-for-parkinsons-disease-psychosis/15424/

Time needed to complete: 1h 13m

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

Expert Recommended Best Practices: Treatment Strategies for Parkinson's Disease Psychosis

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, and the Co-Director of the Parkinson's Disease and Movement Disorders Center at Sidney Kimmel Medical College in Philadelphia, Pennsylvania. And today's topic is Expert Recommended Best Practices: Treatment Strategies for Parkinson’s Disease Psychosis. I'm joined today by two experts. First, Dr. Rajesh Pahwa. Hi, Dr. Pahwa, would you like to introduce yourself?

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

Dr. Kremens:
And we're also joined today by Dr. Stuart Isaacson. Stu?

Dr. Isaacson:
Thanks, Dan. 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:
So today we're going to be addressing the important topic of treatment strategies for Parkinson's disease psychosis. But one of the challenges is, before you can even get the treatment, you have to have access for the diagnosis to Parkinson's disease psychosis. Parkinson's disease is the second most common neurodegenerative disease in the world, with approximately a million people in the United States being – who have the disease, but most recently, there was a reassessment of the number of initial new diagnoses. It had been thought to be about 60,000 a year, and now it was estimated to be 90,000 a year. And there are about 600 fellowship trained movement disorder specialists in the United States. The average patient with Parkinson's disease in the United States doesn't even see a neurologist, let alone a movement disorder specialist, for the first 5 years of their disease. So you can imagine the barriers to access in treatment with this condition. So for my co-participants, what's your experience with access?

Dr. Pahwa:
Yeah, I think that that's a big challenge. And I think it is an issue that our patients have to wait for a long time to get into see us, whether it's for follow-up or to see us as new patients. And the best we can do is train more fellows to go out there, that they can actually help treat patients with Parkinson's.

Dr. Kremens:
Yeah, it really is a challenge. And you know, in certain cities or areas, metropolitan areas, there may be a little more access. In certain

rural areas, there may be no access. There are some states without a single movement disorder specialist. And when you're talking about something like Parkinson's disease psychosis, it's such a devastating condition, that access to treatment is critical.

So saying that let's switch and take a look at treatment given that - how impactful this condition is. So, Stu, what's your approach to treating Parkinson's disease psychosis?

Dr. Isaacson:
Well, it's an important question, Dan, because, you know, we have to ask about these symptoms in order to make the diagnosis. So very early on, we have to ask if patients are having illusions, or hallucinations, or a false sense of presence of passage, or delusions and see how frequently they occur. Once a month? Once a week? Once a day? Several times a day. How severe are they? And what insight is present or lost about these?

And then we have to decide if it's impacting our treatment of the motor symptoms. Because very often, even when we decide not to treat Parkinson's psychosis, it impacts the treatment of the motor symptom because we begin not to increase medication that we otherwise would have. We've been decreasing dopaminergic medications and, as a consequence, for our patients in terms of their activities of daily living, their quality of life, work, exercise, and sometimes increasing the risk of falls. So we have to think about treating this sooner rather than later so it doesn't prevent a terrible problem when it increases suddenly, and we get that emergency phone call. And we have to ask about it earlier, not just movement disorder neurologists, but all neurologists and internists, geriatricians, nurse practitioners, and PAs; anyone taken care of people with Parkinson's should be asking about these symptoms, like they asked about sleep, and memory, constipation. Do you ever see things that aren't there? And so on.

Dr. Pahwa:
And I think one other thing we need to remember is always reassess the patient's medication before we start looking at treatment. Have they started any new medications? Have they started a narcotic pain medicine, for example? We also need to assess, have they developed any infections recently? So I always order a urinalysis on them. Have they had any recent flu-like symptoms or anything? So I think we need to make sure there are not any other medical issues going on. They have not started any new medications that may have precipitated it. And then we basically assess how much it is affecting both the patient and the caregiver, and at times, we have to start using medications to actually help with their psychosis.

Dr. Kremens:
So once we've made that decision that we have to treat the patient with, we've ruled out infections, we've looked for other causes potentially for Parkinson's disease psychosis, what's your approach to the medications in Parkinson's psychosis? Stu, perhaps you'd like to give us your approach?

Dr. Isaacson:
Well, sometimes we use non-pharmacological measures, redirection and reassurance, psychosocial counseling that can be done. But we're often faced with having to begin to medication, an antipsychotic. There's only very few antipsychotics that can be reasonably used in people with Parkinson's disease. Indeed, the Movement Disorders Society, the American Geriatric Society, Beers Criteria, cautions against all antipsychotics because they block dopamine and worsen motor Parkinsonism, except for three, clozapine which requires blood monitoring, quetiapine which is used off label and dose can be limited by somnolence and orthostatic hypotension, and pimavanserin which is the only FDA approved medication for Parkinson's disease psychosis to treat hallucinations and delusions.

So I think we have to begin to think about the use of an antipsychotic. We use pimavanserin first line because of the FDA regulatory approval, and because of the specific blocking only of serotonin 2A receptor, so we don't see somnolence or orthostatic hypotension as an adverse event, at least in trials.

Dr. Kremens:
And, Raj, what's your approach when you're thinking about medications for Parkinson's disease psychosis?

Dr. Pahwa:
Yeah, I agree with Stu. I think we usually start with pimavanserin because it is a specific 5 – 2A receptor antagonist, or I should say, inverse agonist, because it doesn't have any dopamine blocking issues going on. So I don't have to worry about worsening of Parkinson's. I don't have to worry about orthostatic hypotension. I don't have to worry about somnolence.

If my patient needs or cannot tolerate or does not respond to pimavanserin, I will look at either using quetiapine or clozapine. The issue with clozapine is the majority of my patients will not like to have their blood count done. So they really avoid taking clozapine. Quetiapine is a reasonable option, but I usually use that as my second-line medication.

Dr. Kremens:

So and I agree, I think that the best evidence in Parkinson's psychosis is for pimavanserin. It has a double-blind, placebo-controlled study that demonstrated improvement on the SAPS-PD. Quetiapine has been studied a number of times in a small double-blind randomized placebo-controlled studies and the majority of those studies, it's failed to demonstrate any benefit. Clozapine has been demonstrated to be safe and efficacious, but it does require blood monitoring. And you can imagine how difficult that would have been during COVID with a number of our patients.

I think what's key to point out is that none of us are recommending use with any of the typical or other atypical antipsychotics, because they have been demonstrated to be dangerous in Parkinson's patients. So we shouldn't be using those.

So we - thanks for your attention. And thanks for your recommendations from the experts regarding the treatment of Parkinson's disease psychosis. I think we've learned today that access remains a major barrier in the treatment of Parkinson's disease psychosis. But once you can get access, there are a number of treatment options. I think in our panel we favor pimavanserin, the only FDA approved treatment for Parkinson's disease psychosis, with clozapine and quetiapine being potential other options in some patients.

Thanks very much for your participation.

Dr. Isaacson:
Thank you.

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.