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/parkinsons-disease-psychosis-a-case-of-delusions-diagnosis-and-therapeutic-management/15421/

Time needed to complete: 1h 13m

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

Parkinson’s Disease Psychosis: A Case of Delusions, Diagnosis and Therapeutic Management

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 and Vice Chair for Education, and Co-Director of the Parkinson's Disease and Movement Disorder Program at Sidney Kimmel Medical College at Thomas Jefferson University in Philadelphia, Pennsylvania. And today I'll be presenting: Parkinson’s Disease Psychosis: A Case of Delusions, Diagnosis and Therapeutic Management.

So let's take a look at a case. So Sam Jones is a 78-year-old gentleman who was diagnosed with Parkinson's disease about 7 years ago. He's been doing pretty well, other than his Parkinson's disease. He has some mild anxiety and constipation, which are typical non-motor symptoms that we can see in Parkinson's disease. He's a retired executive and has been married to his wife, Lisa, for 46 years. They have two adult children, Beth and Anne, who live nearby. Mr. Jones presents for an urgent visit prior to his scheduled 6-month follow-up, and he's accompanied by his wife, but in addition, his daughter Beth has joined, and that's unusual, he normally just comes with his wife.

When asked what prompted this urgent visit, Mr. Jones appears mildly agitated, and he says he doesn't know why he's there because he feels fine. His daughter, Beth, says that for the past several months, he's accused his wife of infidelity with an elderly neighbor. Initially, they thought that he was joking, but his accusations became more frequent and demeaning. His wife is tearful and adamantly denies any impropriety. Beth confirms that there is nothing happening. In fact, the neighbor is quite ill and rarely interacts with anyone. The accusations came to a head over the weekend before the visit, when Mr. Jones actually accused his daughter, Beth, of stealing his money and helping her mother cover the affair.

This is his current medication regimen; he's taking carbidopa levodopa, 25/100 1 tablet 4 times daily, rasagiline 1 milligram daily, and sertraline, 25 milligrams daily. On an examination, he's afebrile, and his vital signs are unremarkable. He scores a 26 out of 30 on his Montreal Cognitive Assessment, missing 2 points for recall, 1 point for cube drawing, and 1 point for date. He has some mild bradykinesia bilaterally, which is worse when his left. He has some mild rigidity at his left wrist. His posture is slightly stooped. His stride length is mildly reduced with decreased left arm swing, a fairly typical examination for someone with Parkinson's disease.

Let's talk about how we diagnose Parkinson's disease psychosis. So Parkinson's disease psychosis has a distinct clinical profile that was described in 2007 by the NINDS Provisional Diagnostic Criteria. You have to have the presence of one of the following in a patient with Parkinson's disease: hallucinations, delusions, illusions, or a sense of presence. The patient must have a primary diagnosis of Parkinson's disease. And these symptoms must occur after the onset of the patient's 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. Other medical and psychological causes such as a urinary tract infection have to be ruled out.

So what do we mean by a hallucination? A hallucination is the perception of an object or event and the absence of external stimulus. It's

usually visual in Parkinson's psychosis, but it may be auditory, tactile, gustatory, or olfactory, which is really interesting considering that most Parkinson's patients have a markedly decreased sense of smell. The visual hallucinations are commonly of people or animals, they're generally brief, they often occur in dim lighting or at the end of the day, and insight is usually maintained initially, and then lost as disease progresses.

What are illusions? Illusions are misinterpretation or a disturbance in perception of an external stimulus. So this might be a case where a person looks out the window and sees a mailbox, but misperceives it for a burglar or someone standing outside.

False sense of presence. This is that vivid sensation that someone is present nearby when no one is actually there.

And then delusions. Delusions are the firmly sustained false beliefs maintained despite no evidence or evidence to the contrary. And in Parkinson's disease psychosis, there are really specific types of delusions. The most common ones are often focused on spousal infidelity or abandonment. You can have persecutory ones where the person believes that someone's stealing their money or poisoning their medications. And then more rarely, you can have reference hallucinations, which would be when someone believes, for example, that the commentator on television is speaking directly to them. We don't see bizarre hallucinations in Parkinson's disease psychosis, such as a Space Invaders are taking over my life. This is much more common in schizophrenia than in Parkinson's disease psychosis.

We asked Mr. Jones some simple screening questions about what his daughter and his wife are saying. Mr. Jones, in fact, confirms that he is very distraught because he's convinced that his wife is indeed having an affair, and that she and his daughter are stealing his retirement savings as well. You explain to Mr. Jones and his family that it's common for Parkinson's disease patients to have delusions as part of his disease. And you're going to make sure that nothing else, such as an infection, particularly a urinary tract infection, or medication, particularly something such as an anticholinergic or benzodiazepine that another physician may have added, are causing his delusional thinking. And you reassure Mr. Jones and his family that delusions are common, they're treatable, and you can discuss some options for treatment.

And what would those options include? Well, once we've ruled out some other cause for why that patient could have developed Parkinson's disease psychosis, the options include adding an antipsychotic. And there is one antipsychotic that is FDA indicated for Parkinson's disease psychosis, and that's pimavanserin, which has been demonstrated in the double-blind, placebo-controlled, randomized study to be efficacious and safe for the treatment of Parkinson's disease psychosis. And the Movement Disorder Society has given it its highest recommendation in an evidence-based review for the treatment of Parkinson's disease psychosis.

Other potential treatments would include clozapine, which has also been demonstrated to be efficacious in the treatment of Parkinson's disease psychosis, but does require relatively frequent blood draws to monitor for agranulocytosis. It does have the Movement Disorder Society's endorsement that it's efficacious, but it does note that it's an off-label use of the drug and that safety monitoring is required.

Olanzapine is also commonly used in the treatment of Parkinson's disease psychosis. But the Movement Disorder Society's evidence-based review notes that it has not proven itself in double-blind, placebo-controlled studies, and that it may only be possibly efficacious. It's also not FDA approved.

In my clinical practice, I tend to use pimavanserin as my first choice for Parkinson’s disease psychosis, given that it's FDA approved, and that it has been demonstrated to be safe and efficacious. But in patients where it's either not efficacious, or there are other barriers to obtain it, I would likely use quetiapine, and then probably clozapine after that, given the safety monitoring requirements.

So thanks for joining me today on Parkinson's disease, a case of delusions, diagnosis, and therapeutic management.

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.