MedicinesUpdateExtra

NHS Greater Glasgow and Clyde

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PARKINSON'S DISEASE – PATIENT SCENARIOS

Scenario one

- Patient with Parkinson's disease (PD) presents with symptoms of confusion and is diagnosed with community acquired pneumonia.
- The patient is unable to swallow and is not able to tolerate an NG tube.
- PD medications on admission include:

Co-careldopa 25/100 at 7am, 11am, 3pm, 7pm and 11pm
Ropinirole m/r 8mg each morning

Issues to consider?

- Risk of missed doses
- Total daily dose of levodopa is 500mg
- Patient is already on a dopamine agonist

What would be the initial management plan for this patient?

- Confirm NG tube not appropriate
- If NG tube not appropriate then consider rotigotine patch – discuss with PD specialist regarding appropriateness of a rotigotine patch.
- If specialist advice is unavailable, consider rotigotine patch. Any contraindications? Refer to the NHSGGC PD nil by mouth guidance for information on what strength of patch may be suitable to prescribe until specialist advice is available
- In this case the patient is on a dopamine agonist and levodopa therapy. Initial rotigotine patch dose would be determined using the current dose of dopamine agonist only. Ropinirole 8mg once a day is roughly equivalent to 8mg/24hr rotigotine patch (see NHSGGC PD nil by mouth guidance - conversion table 2)
- As the patient is also normally on 500mg daily dose levodopa – monitor patient to see if further increase in rotigotine patch is required. The maximum daily dose of rotigotine patch is 16mg/24hrs
- Monitor for side-effects or lack of benefit and adjust accordingly
- Regular review of possible NG tube and transfer back to patient's usual medication is required.
- Refer to the main bulletin for information on issues to consider prior to prescribing rotigotine.

Scenario two

- Patient with PD admitted with aspiration pneumonia.
- Patient has swallowing difficulties but can manage soluble/liquid preparations.
- PD medications on admission include:

Co-beneldopa 50/200 capsules at 7am, 12pm and 7pm

Issues to consider?

- Risk of missed doses
- Total daily dose of levodopa is 600mg
- Patient is not already on a dopamine agonist – has the patient ever been given a dopamine agonist – any side-effects etc?
- Are there soluble or liquid formulations of co-beneldopa available?
- Intercurrent infection/risk of hallucinations/psychosis

What would be the initial management plan for this patient?

- Refer to the BNF to check for alternative formulations of co-beneldopa.
- Change co-beneldopa capsules to co-beneldopa dispersible tables. (e.g. dispersible co-beneldopa 25/100 – Two tablets three times a day).
- The patient should be monitored for any change in effect due to altered bioavailability. It may be appropriate to prescribe a small "when required" dose to cover any unexpected "on-off" effects. This should only be done by a PD specialist as there may be a detrimental effect of increasing total daily dose.

A few days later, the patient is unable to swallow and was unable to tolerate an NG tube. How should the patient be managed?

- Consider any contraindications to rotigotine
- Has the patient been given a dopamine agonist at any time previously (side-effects)? Seek urgent advice from PD specialist regarding alternative options.
- If specialist advice is unavailable (e.g. out of hours), consider rotigotine 4mg/24hr patch. See NHSGGC PD nil by mouth guidance for further information.
- Refer to the main bulletin for information on issues to consider prior to prescribing rotigotine.

Scenario three

- Patient with PD admitted over the weekend with a UTI.
- Medications on admission include:

Pramipexole M/R 3mg (2.1 mg base) at 7am

- Patient did not bring in her own medicines and only the standard release preparation of pramipexole is available within the hospital.

What should be done to ensure patient does not miss a dose or have a dose delay?

- The patient should be switched to the same daily dose of pramipexole given as the standard release preparation three times a day. I.e. in this case, the patient should receive pramipexole 1 mg (700 micrograms base) three times a day.

Scenario four

- Patient with PD admitted for surgery
- Medications on admission include:

Co-careldopa 25/100 at 7am, 12pm and 7pm

- Prior to surgery patient received 7am dose of co-careldopa
- Post surgery patient is experiencing active vomiting and is unable to take medications orally

Issues to consider?

- Advance planning
- Anti-emetics in PD
- Risk of missed doses
- Total daily levodopa dose is 300mg

What would be the initial management plan for this patient?

- Give appropriate anti-emetic (Avoid metoclopramide and prochlorperazine). Refer to therapeutics handbook "Parkinson's Disease in Acute Care" for further information on anti-emetics used in PD.
- Refer to PD specialists. In the case of elective surgery patients should be referred to PD specialists in advance of surgery to decide whether the patient's PD medications need to be altered for the period around their surgery and to consider any other issues in their management.
- If PD specialist is unavailable consider rotigotine 4mg/24hr patch. See NHSGGC PD nil by mouth guidance for further information.
- Refer to the main bulletin for information on issues to consider prior to prescribing rotigotine
- Regular review of patient and transfer back to patient's usual medication is required.

References:

1. SmythJ. The NEWT Guidelines for administration of medication to patients with enteral feeding tubes or swallowing difficulties. 2nd edition. North East Wales NHS Trust: 2010
2. White R, Bradnam V (2007) Handbook of Drug Administration via Enteral Feeding Tubes, Cambridge: Pharmaceutical Press