

THE AMERICAN PARKINSON DISEASE ASSOCIATION, INC.

Parkinson Plaza • 135 Parkinson Avenue • Staten Island, NY 10305-1425
(718) 981-8001 • 1(800) 223-2732 • Fax: (718) 981-4399
Website: www.apdaparkinson.org

EDUCATIONAL SUPPLEMENT #5

Hospitalization of A Parkinson Patient

Joseph H. Friedman, M.D.,

Clinical Professor Dept. Clinical Neuroscience,
Brown University Medical School, Providence, R.I.

Director, APDA Information and Referral Center
Kent Hospital, Warwick, R.I.

Director, Neurohealth PD & Movement Disorder Center, Warwick, R.I.

Hospitalization is an occasional necessity for patients with Parkinson's disease (PD). Rarely, however, is PD itself the cause of it. Other conditions may develop, such as a hip fracture or pneumonia, the most common complications of PD, as well as all the other medical problems that afflict PD patients in equal proportion to the general population.

The problems that PD patients run into are so similar, regardless of the hospital or the medical condition, that it is important for the patient and the caregiver to be aware in advance of what is likely to happen and to

make proper provisions ahead of time.

First, it is unlikely that PD medications[®] will be given as prescribed by the physician who originally ordered them, unless the nursing staff and attending physician (if he or she is not a neurologist) are explicitly given schedules in advance. If a person takes Sinemet[®] (carbidopa/levodopa) or dopamine agonists, three times a day before meals, the hospital staff frequently transcribes this order into "TID" (an abbreviation for the Latin translation of three times daily), which could result in 8AM – 4PM – Midnight schedule. A home

schedule of 7 AM – 11 AM – 3PM – 7PM may be translated into a “QID” (four times daily) or “q6h” (every six hours) schedule of 7AM – 1PM – 7PM - 1AM. When the daily schedule gets more complex, with a dopamine agonist at mealtimes, a whole and half tablet

of Sinemet scheduled at different times, or when patients take Sinemet on an “as needed” or “demand” schedule, (PRN is the hospital term), all hell breaks loose. Most physicians and nurses are used to dealing with antihypertensives, diuretics, antibiotics and other drugs where a firm schedule either doesn’t matter, or where the aim is to provide a fairly continuous drug level over a 24-hour period. It is not usual hospital policy to allow the patients to take medications when they deem necessary. This requires a physician’s official approval.

Be sure that the drug schedule, with time and dose, is understood and copied into the hospital orders (unless whatever changes are made can be explained). Be sure that the Sinemet (carbidopa/levodopa) strength is correct. It comes as 10/100, 25/ 100, 25/250 for the standard form, while the long acting form (Sinemet CR®) comes in two strengths, 25/100 and 50/200. The generic formulations of carbidopa/levodopa and Sinemet have the same colors at the equivalent strengths.

Don’t take or give medications on your own. Let the staff know what is supposed to be given and when, including “as needed” doses.

Some medication changes can be accepted. Sometimes drugs need to be reduced. Often, simplification of scheduling must be made because the nursing staff cannot deliver drugs exactly on time. Give the staff some leeway.

In some cases, patients may be taking medicines not stocked in the hospital pharmacy. This will always be the case when the patient is enrolled in an

experimental drug protocol. It is therefore necessary to bring these medicines in their original bottles and the instructions to the hospital to insure that doses are not missed.

PD patients who fluctuate (“on” and “off” periods) are usually poorly understood in the hospital. They frequently incur the wrath of the staff members who think the patient is trying to be “babied” when they turn “off,” asking for help in dressing or eating when they had been sauntering down the corridor unassisted only a few minutes earlier. Occasionally dyskinesias, the writhing movements caused by levodopa overmedication or over sensitivity are thought to be attention-getting tricks rather than involuntary and unwanted movements.

The best provision to solve this problem is an “in-service” teaching session for the nursing staff. Unfortunately, unless there is a knowledgeable nurse or doctor available to do this, it is not done. When this situation does arise, the attending physician should be informed and asked to educate the staff. Oftentimes, giving literature on PD to the staff may be very helpful.

You have to keep in mind that the hospital staff wants the patient to be well cared for. When they “blame” the patient, it is usually from ignorance. Always assume that the staff wants what’s best for the patient and that can be taught. Teach them. Explain the situation in a supportive manner, and do not be hostile or take a negative attitude. “I really appreciate your efforts; but I think you may have never taken care of a PD patient with my husband’s type of problems before. He is really different than most of the PD patients. Let me explain his situation and give you some literature to read.” Do not accuse the staff of being incompetent and uncaring. Ask them to call the patient’s neurologist.

Another suggestion that I have is that you bring this article to their attention. Confusion is also a major problem for hospitalized patients and particularly older ones. The combined stress of another medical problem superimposed on PD, the changed environment with strangers invading one's privacy every few minutes, the continuous noise and lights, the feeling of an added degree of helplessness and dependence and the frequent introduction of new drugs often pushes the patient "over the edge" into a delirious state with disorientation, fragmented and distorted memory, misperceptions of what is going on, and even hallucinations.

This is so common, unfortunately, that it is to be expected. I try to tell my patients and their families before an elective procedure, such as a knee replacement or some other operation, that this problem may occur and not to worry. After surgery the confusion is probably due mainly to the effects of anesthesia combined with pain medication and the stress of the surgery itself.

This condition is not caused by a stroke and a CAT scan, MRI, EEG and various other tests are only rarely indicated. The problem is transient and will disappear once the underlying problem is controlled, physical recovery takes place, and the new medications are stopped. The best solution for this situation is to comfort the patient and to control the behavior when it threatens his/her well-being. Physical restraints are sometime required, but are very disturbing both to the patient and to the family.

Oftentimes physicians use antipsychotic medications such as haloperidol to control abnormal behavior. While Haldol® may be very useful in most patients, it is to be avoided, if possible, in PD patients because it makes Parkinson's symptoms worse.

Quetiapine and clozapine may be used, however, if an injected drug must be used then I recommend lorazepam (Ativan®) or diazepam (Valium®). While it is true that these drugs may worsen the confusion, they generally calm the patient to an extent that behavior problems are less common and less severe. Generally the delirium resolves itself over a few days and the sedative may then be stopped.

If an antipsychotic drug is required, the medication of choice is quetiapine. The second line drug is clozapine. They are the only anti-psychotics demonstrated not to worsen PD. Olanzapine, resperidone and aripiprazole all may worsen Parkinson's.

Usually the patient is amnesic for most of the delirious period and only remembers bits and pieces, as with a bad dream.

While hospitalized, the patient should be mobilized as much as possible. Physical therapy should be ordered as soon as possible to prevent decompensation, which may be permanent in a frail, elderly person. Once acute hospital care is no longer required, some patients should be considered for inpatient rehabilitation at a rehabilitation center. Since PD patients are subject to pneumonia, particular attention should be paid to the lungs, especially if the patient is deemed "at risk" for pneumonia by virtue of poor swallowing, weak coughing, immobility, etc. In these situations it is often wise to order a respiratory therapy consultation for "chest PT" before a problem develops. These therapists will clap on the chest for several minutes each day to help mobilize the sputum and make it easier to cough up. This opens the airways, making breathing easier and an infection less likely to develop.

Certain medications should be avoided by PD patients. Metoclopramide (Reglan®), which is used for gut motility problems, and

prochlor-perazine (Compazine®), which is used for nausea, should be used as little as possible, if at all. Prochlorperazine can be replaced by ondansetron (Zofran®). Zofran is quite expensive, but should only be required for a short period of time. For patients taking selegiline (Eldepryl®), it is recommended that the narcotic pain medication meperidine (Demerol®) not be used because of a possible interaction.

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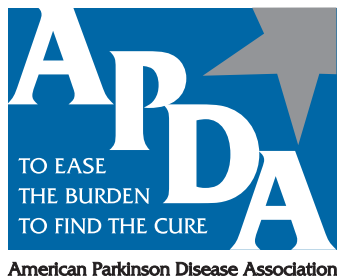
It is important to decide in advance of a life threatening emergency what to do about

it. This may avoid severe family problems later on. Many patients have strong feelings about being put on mechanical breathing devices or having a variety of invasive procedures performed. This issue should be discussed before the emergency and the staff should be properly directed on the level of intervention the patient and family want.

If there are any other problems you have experienced, please let me know by writing to me, at, Memorial Hospital of Rhode Island, 111 Brewster Street, Pawtucket, RI 02860, so that I can include them in future updates of this article.

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The information contained in this supplement is solely for the information of the reader. It should not be used for treatment purposes, but rather for discussion with the patient's own physician.



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