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MDS Alert

Clinical Management: Use The MDS To Ease Parkinson's Disease-Related Problems

At second glance, these conditions may have something in common.

The MDS assessment can provide a "big picture" for residents with Parkinson's disease, helping you identify related clinical problems and negative outcomes to improve care and prevent F tags. So if you've checked Parkinson's disease in Section I, keep your eye out for these conditions:

Falls in Section J. Residents with Parkinson's disease can be a fall waiting to happen due to their abnormal gait, postural instability, stooped posture, "freezing" and rigidity. A number of fall-prevention interventions can help.

• An individualized exercise program focusing on "flexibility, strength and cardiovascular endurance," advises **Shehla Rooney, PT**, president, **Premier Therapy Solutions LLC** in Cookeville, TN.

Specifically, trunk strengthening exercises help the person's posture, balance and cardiopulmonary status, she adds.

• The right kind of ambulation assistance. Walking in front of the person, facing him and holding his hands can help control his forward momentum to prevent him from falling forward if he has a "rapid festinating gait," Rooney says. Using this method, caregivers can also provide rhythm to walking and encourage arm-swinging, Rooney notes.

• Adding lifts to the person's shoes in some cases. "If a person with Parkinson's disease falls backward all the time, sometimes providing heel lifts on his shoes can be helpful because the lifts pitch him forward a centimeter or two," helping him to hold onto a walker if he starts to lean backward, advises **Mónica M. Kurtis, MD**, at **Columbia University Medical Center** in New York City.

Hallucinations in Section J. Patients taking anti-Parkinson's medications, which boost dopamine, can develop hallucinations or delusions.

Tip: Watch for early signs of hallucinations, which usually start as illusions or misperceptions of actual stimuli in the environment, Kurtis suggests. At that point, the person usually realizes that she's having a false sensory experience. But "as the hallucinations become more full blown," patients lose that insight and could wander out on the street, for example, because they hallucinated that someone told them to go somewhere, she cautions.

Antipsychotics in Section O4. If a resident develops anti-Parkinson-medication-induced hallucinations or delusions, titrating the medication downward may help. But if it doesn't or the Parkinson's symptoms worsen significantly and the person thus requires an antipsychotic to treat the psychosis, the clinician should prescribe clozapine or quetiapine, which don't cause as many extrapyramidal effects as some of the other commonly used antipsychotics.

Clozaril (clozapine) does require blood test monitoring, so most nursing home physicians choose Seroquel (quetiapine), says consulting pharmacist **Kitty Anderson** in Salt Lake City.

Residents who develop psychosis as part of Parkinson's disease should also receive the aforementioned antipsychotics, if needed. But keep in mind that the facility may perhaps not need to treat mild psychotic symptoms, adds Anderson.

"Antipsychotics, including Seroquel, shouldn't be used unless they are improving the patient's quality of life," she emphasizes.

Tip: Don't assume that delirium symptoms, including hallucinations, are due to Parkinson's disease or anti-Parkinson

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medication. Look for acute illness, pain and other causes, including other medications.

Mood indicators in Section E. Depression is very common in Parkinson's disease and needs to be treated with SSRI antidepressants, for example, says Kurtis.

Pain in Section J. Sources estimate that half or more people with Parkinson's disease experience pain related to the disease.

Managing the person's anti-Parkinson's medications more effectively to prevent "peaks and valleys" in blood levels may help ease the pain. (For a list of questions to assess the resident's pain, see the article below.)

Resource: The Parkinson's Disease Foundation provides an overview of the causes of Parkinson's-related pain and treatment options: http://www.pdf.org/Publications/newsletters/winter04_05/Pain_in_Parkinsons_Disease.cfm.

Range-of-motion deficits. This may show up in Section G4 if it produces a functional deficit -- or it could be a focus for restorative nursing if it's not already being offered and coded in Section P3. Exercise focusing on improving joint range-of-motion helps fight the rigidity that can occur with Parkinson's disease, says Kurtis.

As for the benefits of exercise overall, "preliminary data in animal models suggest that exercise may be neuroprotective and prevent the degeneration of dopamine neurons in the substantia nigra," Kurtis says.

Decline in cognitive status. Almost 40 percent of residents with Parkinson's disease eventually develop dementia, according to Kurtis.

Patients with Parkinson's disease who are manifesting dementia can be treated with the same medications prescribed for Alzheimer's disease, according to Kurtis and Anderson.

Clinical gem: If a resident with Parkinson's has dementia, pramipexole and ropinirole can be a problem because they may cause confusion and memory loss, cautions Kurtis.

Heads up: Other conditions that may show up in a person with Parkinson's include incontinence, constipation and fecal impaction (Section H), unintended weight loss (Section K), and communication problems (Section C).

Resource: For an overview of nutritional problems seen in Parkinson's disease, go to http://www.nutritionucanlivewith.com/repletion.htm.

Editor's note: For a free copy of a Long-Term Care Survey article providing expert tips for managing anti-Parkinson's medications to help avoid motor fluctuations or "on and off" cycles, please e-mail your request to the editor at KarenL@Eliresearch.com.

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