

AMERICAN PARKINSON DISEASE ASSOCIATION

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EDUCATIONAL SUPPLEMENT 5

Hospitalization of A Parkinson's Patient

By Joseph H. Friedman, M.D.

Hospitalization is an occasional necessity for patients with Parkinson's disease (PD). Rarely, however, 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 have 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 8 a.m. - 4 p.m. - Midnight schedule. A home schedule of 7 a.m. - 11 a.m. - 3 p.m. - 7 p.m. may be translated into a "QID" (four times daily) or "q6h" (every six hours) schedule of 7 a.m. - 1 p.m. - 7 p.m. - 1 a.m.

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,) it becomes more challenging to the hospital staff. 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 patient to take medications when necessary. This requires a physician's 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 a hospital's pharmacy. This will always be the case when the patient is enrolled in an experimental drug protocol. It is therefore necessary to take 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. Frequently, staff members do not understand why a patient who has turned "off" is requesting help with dressing or eating walking 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 doesn't occur. 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 helpful.

Bear 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 this 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 never have 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 is that you direct 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 push 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. 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 to both the patient and to the family. Families may consider hiring a private nurse or sitter to stay with the patient during this time to promote safety.

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. If however, an injected drug must be used, then I recommend lorazepam (Ativan®) or diazepam (Valium®). While it is true that these 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 (Seroquel®). The second-line drug is clozapine (Clozaril®). They are the only antipsychotics demonstrated not to worsen PD. Olanzapine (Zyprexa®), risperidone (Risperdal®) and aripiprazole (Abilify®) 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 physical therapy" 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 it.

Certain medications should be avoided by PD patients. Metoclopramide (Reglan®), which is used for gut motility problems, and prochlorperazine (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 time. For patients taking selegiline (Eldepryl®), it is recommended that the narcotic pain medication meperidine

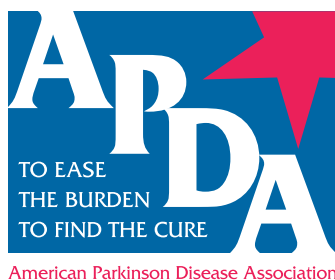
(Demerol®) not be used because of a possible interaction.

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It is important to decide in advance of a life threatening emergency what to do about it. This may preclude 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 prior to the emergency, and the staff should be properly directed on the level of intervention the patient and family want.

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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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