Parkinson's disease NICE guidelines 2017

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Time lines

- Scoping exercise for NICE guidelines – August 2014
- Development of guidelines – October 2014-September 2016
- Guidelines out for consultation – October-November 2016
- Response to consultation
- Guidelines finalised – April 2017

Committee

- NICE staff – Statisticians, Health economists, Data analysts etc
- Chair of committee – Neurologist
- Clinicians – 2 Neurologists, 2 Geriatricians, 1 each of PDNS, Physiotherapist, Old Age Psychiatrist, Dietician, Pharmacologist.
- Advisory experts – Speech and Language therapy, Occupational therapy, Neurosurgery
- Patient, Carer

2006 Guidelines

- First NICE guidelines for PD
- All people with suspected PD should be referred to a specialist service
- All people with PD should have access to physiotherapy
- Etc, etc

2017 Guidelines

First-Line treatment

- **Offer** levodopa to people in the early stages of Parkinson's disease whose motor symptoms impact on their quality of life
- **Offer** a choice of dopamine agonists, levodopa or monoamine oxidase B (MAO-B) inhibitors to people in the early stages of Parkinson's disease whose motor symptoms do not impact on their quality of life

Adjuvant treatment of Motor symptoms

- **Offer** a choice of dopamine agonists, MAO-B inhibitors or catechol-O-methyl transferase (COMT) inhibitors as an adjunct to levodopa for people with Parkinson's disease who have developed dyskinesia or motor fluctuations despite optimal levodopa therapy
- If dyskinesia is not adequately managed by modifying existing therapy, **consider** amantadine

Impulse Control Disorders

- When starting dopamine agonist therapy, give people and their family members and carers (as appropriate) oral and written information about impulse control disorders
- Discuss potential impulse control disorders at review appointments, particularly when modifying therapy, and record that the discussion has taken place

Managing Impulse Control Disorders

- When managing impulse control disorders, modify dopaminergic therapy by first gradually reducing any dopamine agonist
- **Offer** specialist cognitive behavioural therapy targeted at impulse control disorders if modifying dopaminergic therapy is not effective

Sleep

- **Consider** modafinil to treat excessive daytime sleepiness in people with Parkinson's disease, only if a detailed sleep history has excluded reversible pharmacological and physical causes
- **Consider** clonazepam or melatonin to treat RBD if a medicines review has addressed possible pharmacological causes (Nb not licensed for this indication)

Orthostatic Hypotension

- Review existing medicines-anti hypertensives, dopaminergics, anticholinergics, and anti depressants
- **Consider** midodrine taking into account the contraindications and monitoring requirements (including monitoring for supine hypertension)
- If midodrine contraindicated, not tolerated or not effective, **consider** fludrocortisone (not licensed)

Psychotic Symptoms (hallucinations and delusions)

- **Consider** quetiapine to treat hallucinations and delusions (not licensed)
- **Offer** clozapine to treat hallucinations and delusions – registration with a patient monitoring service is needed (Nb ACP-103 not available at the time so not considered)

Parkinson's disease Dementia

- **Offer** a cholinesterase inhibitor for people with mild or moderate PD dementia (Nb rivastigmine only 1 licensed)
- **Consider** a cholinesterase inhibitor for people with severe PD dementia
- **Consider** memantine for people with PD dementia, if cholinesterase inhibitors are not tolerated or are contraindicated (not licensed)

Physiotherapy and Physical activity

- **Refer** to physiotherapy in early stages for assessment, education and advice, including information about physical activity
- **Offer** PD-specific physiotherapy for people experiencing balance or motor function problems

Occupational Therapy

- **Consider** referring early PD patients to OT with experience of PD for assessment, education and advice on motor and non-motor symptoms
- **Offer** PD-specific OT for people having difficulties with ADL

Speech and Language Therapy (SLT)

- **Consider** referring people with early PD to SLT with experience of PD for assessment, education and advice
- **Offer** SLT for people with PD experiencing problems with communication, swallowing or saliva
  - For swallowing problems interventions may include expiratory muscle strength training
  - For speech and communication **consider** attention to effort therapies

Drooling

- Try non-pharmacological management first
- **Consider** glycopyrronium bromide to manage drooling of saliva in people with PD (not licensed)
- If contraindicated, or not tolerated, **consider** referral for Botulinum toxin A (not licensed)
- Take care when using anticholinergic medicines other than glycopyrronium bromide, and ideally use topically (eg, Atropine) – Nb risk of cognitive adverse effects

Nutrition

- Discuss a protein redistribution diet for people with motor fluctuations but don't reduce total daily protein consumption
- Advise people with PD to take vitamin D supplements

DBS and Duo-dopa

- **Consider** DBS for people with advanced PD whose symptoms are not adequately controlled by best medical therapy
- Do not offer levodopa–carbidopa intestinal gel for people with PD (those already on this can continue it)

Palliative Care

- Offer people with PD and their family members and carers oral and written information about disease progression, possible adverse effects, advance care planning, including advanced decisions to refuse treatment (ADRT) and do not attempt resuscitation (DNACPR) orders and lasting power of attorney for finance and/or health and social care
- Consider referring people at any stage of PD to the Palliative Care Team to provide the opportunity to discuss palliative care and care at the end of life

Recommendations for Research

- Orthostatic hypotension treatment with midodrine compared with fludrocortisone and other agents
- What is the effectiveness of cholinesterase inhibitors compared to atypical anti-psychotics for treating psychotic symptoms
- What is the best first-line treatment for REM sleep behaviour disorder (RBD)?
- Can physiotherapy started early in the course of PD delay symptom onset or reduce symptom severity? (Nb exercise)

Thank you