

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" pe-

riods) are usually poorly understood in the hospital. They frequently incur the wrath of the staff 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 oversensitivity 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, this 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 want what's best for the patient and that they 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 CAT scans, 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 sometimes 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 antipsychotic drugs are very useful in most patients, they are to be

avoided, if possible, in PD patients because most make Parkinson symptoms worse. I recommend sedative drugs instead, such as diazepam (Valium) and its chemical cousins. 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 Clozapine. This is the only antipsychotic demonstrated not to worsen PD. A new drug, Olanzapine, may also be useful, but it has not yet been adequately tested.

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

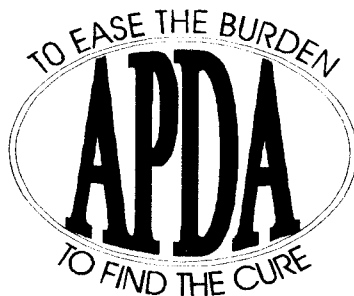
While hospitalized, the patient should be mobilized as much as possible. Physical therapy should be ordered as soon as possible to prevent decompensation, which may be permanent in a frail, elderly person. Once acute hospital care is no longer required, some patients should be considered for inpatient 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 infection less likely to develop.

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. If needed, metoclopramide can be replaced by cisapride (Propulsid), and 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 seligiline (Eldepryl), it is recommended that the narcotic pain medication mep- eridine (Demerol) not be used because of a possible interaction.

**Advanced Directives: Durable Power of At- torney for Health Care & Living Wills:** It is important to decide in advance of a life threat- ening emergency what to do about it. This may avoid severe family problems later on. Many patients have strong feelings about be- ing put on mechanical breathing devices or having a variety of invasive procedures per- formed. This issue should be discussed be- fore 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 ex- perience, 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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