

Parkinson's Disease

The main symptoms of Parkinson's disease are usually stiffness, shaking (tremor), and slowness of movement. Other symptoms (listed below) may also develop. Symptoms typically become gradually worse over time. Treatment often provides good relief of symptoms for several years.

What is Parkinson's disease?

Parkinson's disease (PD) is a chronic (persistent) disorder of part of the brain. It is named after the doctor who first described it. It mainly affects the way the brain co-ordinates the movements of the muscles in various parts of the body.

Who gets Parkinson's disease?

PD mainly develops in people over the age of 50. It becomes more common with increasing age. About 5 in 1,000 people in their 60s, and about 40 in 1,000 people in their 80s have PD. It affects both men and women but is a little more common in men. Rarely, it develops in people under the age of 50.

PD is not usually inherited, and it can affect anyone. However, genetic (hereditary) factors may be important in the small number of people who develop PD before the age of 50.

What causes Parkinson's disease?

A small part of the brain called the substantia nigra is mainly affected. This area of the brain sends messages down nerves in the spinal cord to help control the muscles of the body. Messages are passed between brain cells, nerves and muscles by chemicals called neurotransmitters. Dopamine is the main neurotransmitter that is made by the brain cells in the substantia nigra.

If you have PD, a number of cells in the substantia nigra become damaged and die. The exact cause of this is not known. Over time, more and more cells become damaged and die. As cells are damaged, the amount of dopamine that is produced is reduced. A combination of the reduction of cells and a low level of dopamine in the cells in this part of the brain causes nerve messages to the muscles to become slowed and abnormal.

Parkinson's disease symptoms

The brain cells and nerves affected in PD normally help to produce smooth, co-ordinated movements of muscles. Therefore, three common Parkinson's symptoms that gradually develop are:

- **Slowness of movement** (bradykinesia). For example, it may become more of an effort to walk or to get up out of a chair. When this first develops you may mistake it as just 'getting on in years'. The diagnosis of PD may not become apparent unless other symptoms occur. In time, a typical walking pattern often develops. This is a 'shuffling' walk with some difficulty in starting, stopping, and turning easily.
- **Stiffness of muscles** (rigidity), and muscles may feel more tense. Also, your arms do not tend to swing as much when you walk.
- **Shaking** (tremor) is common, but does not always occur. It typically affects the fingers, thumbs, hands, and arms, but can affect other parts of the body. It is most noticeable when you are resting. It may become worse when you are anxious or emotional. It tends to become less when you use your hand to do something such as picking up an object.

The symptoms tend slowly to become worse. However, the speed in which symptoms become worse varies from person to person. It may take several years before they become bad enough to have much effect on your life. At first, one side of your body may be more affected than the other.

Some other symptoms may develop due to problems with the way affected brain cells and nerves control the muscles. These include:

- Fewer facial expressions such as smiling or frowning. Reduced blinking.
- Difficulty with fine movements such as tying shoe laces or buttoning shirts.
- Difficulty with writing (handwriting tends to become smaller).
- Difficulty with balance and posture and an increased tendency to fall.
- Speech may become slow and monotonous.
- Swallowing may become troublesome, and saliva may pool in the mouth.
- Tiredness, and aches and pains.

Various other symptoms develop in some cases, mainly as the condition becomes worse. These include:

- Constipation.
- Bladder symptoms and sometimes incontinence.
- Hallucinations (seeing, hearing or smelling things that are not real).
- Sweating.
- Sexual difficulties.
- Alterations in your sense of smell.
- Difficulties with sleeping.
- Weight loss.
- Pain.
- Depression.
- Anxiety.
- Problems with controlling impulses. For example, compulsive eating, shopping or gambling. (This could be linked to some types of medication - see 'Which drugs are used to treat Parkinson's disease?' section, below.)

Also, for reasons that are unclear, people with PD have an increased risk of developing melanoma skin cancer. So, if you have PD, you should ensure that you use sun cream, stay out of the sun in the hottest part of the day, wear a sunhat, and protect your skin from the sun where possible. See separate leaflets called '*Cancer of the Skin - Melanoma*' and '*Sun and Health*' for more details.

How is Parkinson's disease diagnosed?

There is no test that can prove that you have PD. The diagnosis is based on your having the typical symptoms (described above). In the early stage of the disease, when symptoms are mild, it may be difficult for a doctor to say if you definitely have PD. As the symptoms gradually become worse, the diagnosis often becomes more clear.

PD is sometimes confused with other conditions. Some conditions can give 'Parkinsonism' features - that is, symptoms similar to PD, but caused by other conditions. For example, some drugs used to treat other conditions can cause side-effects which resemble symptoms of PD. Some rare brain disorders can also cause similar symptoms.

Therefore, it is normal practice in the UK to be referred to a specialist if PD is suspected. The specialist will be used to diagnosing PD and ruling out other causes of the symptoms. They will usually be either a neurologist or a doctor specialised in elderly care. If there is still doubt about the diagnosis, sometimes a special scan of the brain is carried out. This helps to differentiate PD from some other conditions that can cause Parkinsonism features.

Does Parkinson's disease cause dementia?

The cells in the brain affected in PD are not in the 'thinking' parts of the brain and dementia is not a typical early feature of PD. However, if you have PD you have an increased risk of developing dementia. About half of people with PD develop dementia at some stage. If dementia occurs, it tends to develop in older people with PD (aged over 70). Early dementia in younger people with PD virtually never develops. It is thought that PD alone does not cause dementia, but other age-related factors in addition to PD may increase the risk of dementia developing.

What are the treatments for Parkinson's disease?

There is no cure for PD, and no treatment prevents the disease from progressing. However, treatments can usually ease symptoms.

- At first, you may not need any treatment when the symptoms are mild. A specialist may simply see you every now and then to monitor how the disease is progressing.
- A drug that eases symptoms is usually started when symptoms become troublesome.
- Therapies such as physiotherapy, occupational therapy and speech therapy may also be useful as the disease progresses.
- Surgery may be an option for severe cases.

Which drugs are used to treat Parkinson's disease?

It is not clear at present which drug is best to use first in early PD or which drug combinations are best in later-stage PD. Recent guidelines, released by the Scottish Intercollegiate Guidelines Network (SIGN), recommend starting with a dopamine agonist, levodopa with a dopa-decarboxylase inhibitor or a monoamine oxidase inhibitor. Other drugs are also sometimes used, usually in addition to one of these three main types of drug.

Levodopa

This drug has been used for many years. Nearly all people with PD notice a good improvement in symptoms after starting levodopa. The body converts levodopa to dopamine. Therefore, the low level of dopamine in the affected part of the brain increases with levodopa. A low dose is usually started at first. Over time, the dose often needs to be increased to control the symptoms.

Levodopa is always combined with another drug (either benserazide or carbidopa). These prevent levodopa from being converted into dopamine in the bloodstream. This reduces side-effects and increases the amount that gets to the brain where it is converted to dopamine. The combination of levodopa and benserazide is called co-beneldopa, and the combination of levodopa and carbidopa is called co-careldopa. (The common brand names for these are Sinemet® and Madopar®.)

Side-effects sometimes occur when you first start levodopa. However, most people have no problems with low doses. Read the leaflet in the drug packet for a full list of possible side-effects. Nausea (feeling sick) is the most common. This is less likely to occur if you take a small dose at first, and then gradually build it up. If nausea is a problem, then it can usually be eased by an anti-sickness drug called domperidone. Compulsive behaviour may occasionally be a side effect of levodopa.

Levodopa tends to work less well over time. Therefore, the dose usually needs to be increased every now and then. Unfortunately, over time as the dose increases (typically after several years), most people taking levodopa develop problems. These include 'on-off' effects. This is where you can switch quite suddenly between being 'on' and able to move, and being 'off' and immobile. Muscle problems also commonly develop which can cause uncontrollable jerky movements and other effects (dyskinesias). These problems related to long-term use of levodopa can become quite disabling, tiring and painful.

Dopamine agonists

Dopamine agonists are drugs that act on the same receptors in the brain as dopamine. So, in effect, they act like a substitute for dopamine. Unlike levodopa, they do not need to be converted in the body to become active. There are several types. Ropinirole, pramipexole, or rotigotine are used most commonly. Bromocriptine, cabergoline or pergolide are alternatives but are used less often because of the risk of possible (rare) side-effects, including thickening of the heart valves and thickening and scarring of the lung tissue. Close monitoring is needed whilst taking bromocriptine, cabergoline or pergolide. Each of the dopamine agonists has different brand names.

Possible side-effects when one is first started are similar to levodopa (nausea, etc). However, the side-effects tend to ease off over several days or weeks. Again, if nausea is a problem, then it can usually be eased by the anti-sickness drug called domperidone. Also, drowsiness can occur with these drugs. Drowsiness may be severe and may affect your ability to drive. Compulsive behaviour can be a side-effect and is more common with this group of drugs than with levodopa. Other side-effects are less common but read the leaflet in the drug packet for a full list of possible side-effects.

Sometimes a dopamine agonist is used in combination with levodopa in the later stages of PD. Apomorphine is another dopamine agonist that is used in combination with levodopa. It needs to be given by an injection under the skin. It is used in people who have PD in its later stages who have severe 'off' episodes where they become immobile. It can help to reverse these 'off' episodes but its effect only lasts for about an hour. Frequent injections are therefore needed. Because of this, sometimes the drug is given as a continuous infusion, using tubing with a needle or cannula at the end that is inserted under the skin so that the drug can flow into your body.

Monoamine oxidase-B inhibitors

These drugs are another alternative to levodopa for early PD. They include selegiline and rasagiline. These drugs work by blocking (inhibiting) the effect of a chemical in the brain called monoamine oxidase-B (MAO-B). This chemical is involved in the breakdown of levodopa and dopamine. If the action of MAO-B is inhibited then the effect of any dopamine lasts longer. Most people will require levodopa eventually. However, if you take an MAO-B inhibitor at first, it may delay the need for levodopa for months or years.

Sometimes these drugs are used in combination with levodopa in the later stages of PD.

Other drugs used for Parkinson's disease

- Catechol-O-methyltransferase (COMT) inhibitors are relatively new drugs. They include tolcapone and entacapone. These help to stop the breakdown of levodopa by the body, so more of each dose of levodopa can get into the brain to work. A COMT inhibitor is sometimes advised in addition to levodopa when symptoms are not well controlled by levodopa alone.
- Other drugs are sometimes used to help relieve symptoms. They have various effects which try to correct the chemical imbalance in the brain. They include betablockers, amantadine, and anticholinergic drugs. One of these may be tried when symptoms are mild. However, you are likely to need levodopa or a dopamine agonist at some point.

There is a big trial underway at the moment to try to determine the most effective drug treatment, with the fewest side-effects, for early and late PD. Information about the trial can be found using the website detailed at the end of this leaflet.

Various things may influence which drug is advised. For example, your age, severity of symptoms, how well your symptoms respond to treatment, if side-effects develop, other drugs that you may take, etc. Your specialist will advise on the best drug to take for you. Whatever drug or drugs you are prescribed, read the leaflet in the drug packet for a full list of possible side-effects. Mention to your doctor if you develop a troublesome side-effect. A modification of the dose, dose schedule, or the type of medication, may be possible to help keep side-effects to a minimum.

The dose of the drug that you start with usually needs to be increased over time. In time, combinations of drugs may be required for best control of symptoms. The treatment schemes and doses can vary greatly from person to person. As the disease progresses, the symptoms may not be so well controlled by drugs.

Other treatments for Parkinson's disease

A specialist nurse

A specialist PD nurse is available in many PD clinics to provide support, information and counselling. A specialist nurse can also monitor response to treatment, and can give advice on how to adjust medication if necessary.

Therapies

For example:

- A physiotherapist can advise on posture, walking and exercises.
- An occupational therapist can advise on such things as home adaptations which may ease many tasks.
- If difficulties with speech, swallowing or saliva occur, a speech and language therapist can help.
- The advice of a dietician and other therapists may be needed for some people.
- A psychologist may be able to help if you have problems with depression.

Surgery

Surgical techniques are being developed which may help some people who have had PD for several years. Surgery does not cure PD, but may help to ease symptoms when drugs are not working well. For example, chronic deep brain stimulation is a technique that involves putting a pulse generator (like a heart pacemaker) in the chest wall. Fine cables are tunnelled under the skin to electrodes placed in the brain. The electrodes stimulate the parts of the brain that are affected by PD and can help to ease symptoms. The long-term safety of this surgery is not certain and a trial is currently underway to look at this.

Complementary therapies

Complementary therapies do not affect symptoms or the course of the disease. However, some therapies are good at easing stress and anxiety, which may help in your general wellbeing. Beware of any treatment that claims to 'cure' PD.

Some other general points

Stay as active as possible. Exercise regularly as much as you are able. This may not be possible when the condition is more advanced, but it is something to consider when symptoms are not too bad. You may walk more slowly than before, but a daily walk is good exercise and may help to loosen up stiff muscles. Well-meaning relatives or friends may tell you to rest and take things easy. However, as much as possible and for as long as possible, resist the temptation for others to do things for you just because it may be quicker.

Constipation is common in people with PD. Help to reduce the chance of this by having lots to drink, and eat plenty of vegetables, fruit, and foods high in fibre. Exercise can also improve constipation. Sometimes laxatives may be needed to treat constipation.

Some drugs taken for other conditions can interfere with dopamine and make PD worse. These may be prescribed for such things as mental illness, sickness, vertigo and dizziness. Check with your doctor if you are unsure about any drugs that you take.

Medication. Make sure you know exactly when to take your medication. Dose schedules and timings are important. A pharmacist will be able to advise and help if you have difficulty in getting tablets out of blister packs, have difficulty in remembering when to take your drugs, or have any other queries about medication. Report any suspected side-effects to your doctor. For example, hallucinations (seeing or hearing things), confusion and mental changes are possible side-effects of some drugs used to treat PD.

Driving. If you are a driver you should tell the DVLA and your insurance company if you develop PD. Your insurance may be invalid if you do not. Depending on the severity of symptoms and the drugs that you are taking, you may still be allowed to drive following a medical assessment.

Depression is common in people with PD. Depression can cause symptoms which may seem as if PD is getting worse (such as lack of energy and becoming slower). If you seem to become worse quite quickly, over a few weeks or so, depression may be the cause. Tell your doctor if you suspect this. Depression can often be treated.

Some practical tips may help. For example: it is easier to get up from a high chair than from a low couch; consider using Velcro® fasteners instead of buttons; carrying a walking stick when out may increase your confidence if unsteadiness is a problem. Parkinson's UK (details below) has plenty of further advice on coping and living with PD.

How do symptoms progress and what is the outlook (prognosis)?

The symptoms of PD tend to become gradually worse over time. However, the speed of progression varies greatly from person to person. When symptoms first begin, you may not need treatment when symptoms are relatively mild.

Most people with PD can expect to have some time of relatively mild symptoms, and then when the symptoms become worse, several years of good or reasonable control of the symptoms with medication. But everyone is different, and it is difficult to predict for an individual how quickly the disease will progress. Some people may only be slightly disabled 20 years after PD first begins, whereas others may be very disabled after 10 years.

Research into PD is active. For example, one main aim of research is to find drugs that prevent the damage to the affected cells, rather than just treating the symptoms, which is the main value of treatment at present. Further research on these chemicals continues. Research is also underway using stem cell therapy to help treat PD.

Further help and information

Parkinson's UK

215 Vauxhall Bridge Road, London, SW1V 1EJ

Helpline: 0808 800 0303 Web: www.parkinsons.org.uk

Provides help and information on all aspects of PD. There are many local branches too.

PD Med

Information about a large ongoing trial to find which drug is best to use first in early PD or which drug combinations are best in later stage PD.

Web: www.pdmed.bham.ac.uk

Further reading & references

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