Advanced Learning in PALLIATIVE MEDICINE

Parkinson's Disease: Practical Pearls for the Palliative Care Provider

FAIRMONT WINNIPEG

MAY 30, 2026

PCAND

Palliative Care for Advanced Non-Malignant Diseases

Presenter Disclosure

- **Faculty / Presenter Name**: Dr. Daphna Grossman
- **Relationships with financial sponsors**:

Grants/Research Support:

MoHLTC –research grant

Scully Foundation – research support

Speakers Bureau/Honoraria:

Canadian Academy of Geriatric Psychiatry

Learning Objectives

- Share pearls for the management of Parkinson's related motor symptoms
- Share more pearls for the management of Parkinson's related non-motor symptoms
- Share even more pearls about managing issues at EoL
- Peak interest to learn more about Parkinson's Disease at upcoming Horizon's Neurology Series in Vancouver November 20th

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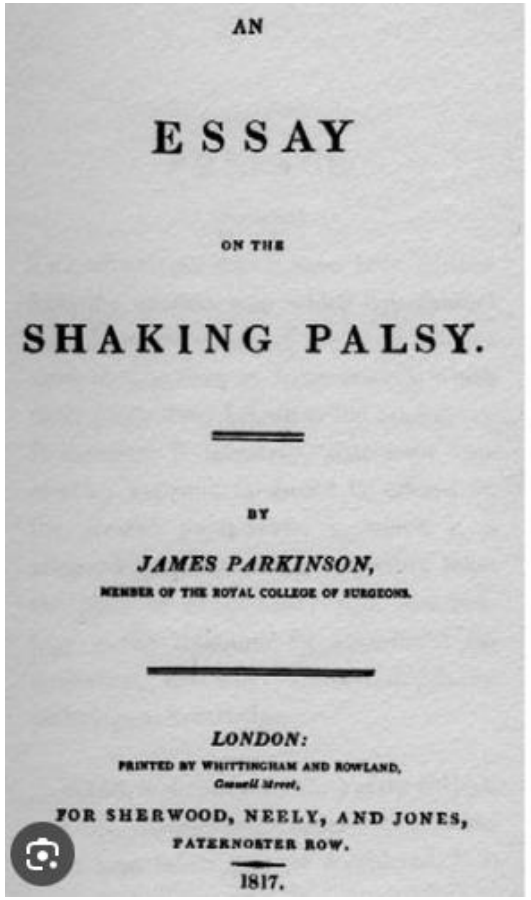
PARKINSON'S DISEASE

- Fastest growing neurological disease & most common movement disorder
- Number of Canadian seniors with PD will double to ≈ 150K by 2031
- 82% of cases are ≥ age 65


AN

ESSAY

ON THE

SHAKING PALSY.

BY

JAMES PARKINSON,

MEMBER OF THE ROYAL COLLEGE OF SURGEONS.

LONDON:

PRINTED BY WHITTINGHAM AND ROWLAND,
Cannell Street,

FOR SHERWOOD, NEELY, AND JONES,
PATERNOSTER ROW.

1817.


FIG. 316.

Mr. EM

- **75 YO Lives at home with wife at home**
- **Diagnosed with Parkinson's Disease 6 years ago**
- **Multiple co-morbidities**

Motor – the medication is not working as quickly as it did before and is not lasting as long

Affix patient label within this box

Edmonton Symptom Assessment System Revised (ESAS-r)

Please circle the number that best describes how you feel NOW:

No Pain	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Pain
No Tiredness *(Tiredness = lack of energy)*	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Tiredness
No Drowsiness *(Drowsiness = feeling sleepy)*	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Drowsiness
No Nausea	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Nausea
No Lack of Appetite	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Lack of Appetitie
No Shortness of Breath	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Shortness of Breath
No Depression *(Depression = feeling sad)*	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Depression
No Anxiety *(Anxiety = feeling nervous)*	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Anxiety
Best Wellbeing *(Wellbeing = how you feel overall)*	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Wellbeing
No _____ Other Problem *(For example constipation)*	0	1	2	3	4	5	6	7	8	9	10	Worst Possible _____

Patient Name _____

Date *(yyyy-Mon-dd)*

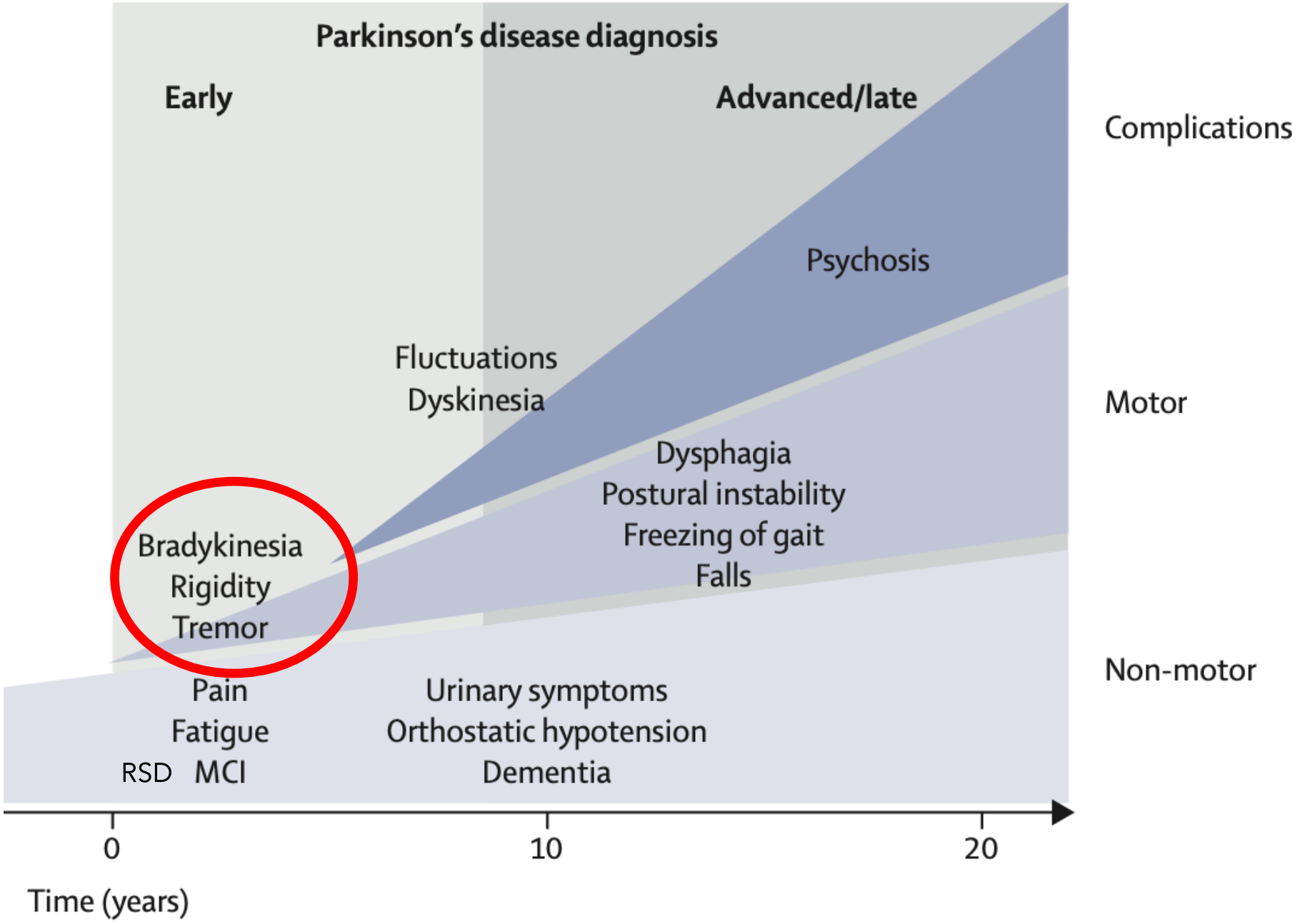
Time *(hh:mm)*

Completed by *(Check one)*
- ☐ Patient
- ☐ Family Caregiver
- ☐ Health Care Professional Caregiver
- ☐ Caregiver-assisted

Body Diagram on Reverse

07903(Rev2015-08) Side A

Constipation
Insomnia
Dizziness



Lang & Kalia, Parkinson's Disease: Lancet 2015; 386: 896–912

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Question 1

"The Parkinson's medication is not working as quickly as it did before and is not lasting as long."

Does Mr. EM's Levocarb dose need to be adjusted?

- Yes
- No
- I have no idea

Levodopa – More Dopamine!!!

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Medication Name	Empty Stomach	Absorption decreased by Iron	Can Be Crushed	Long-Acting Formulation	BP Affect	GI Side Effects	Neuro-Pschiatric (confusion/ psychosis
Levodopa-Carbidopa (Sinemet)	✓	✓	✓	✓	↓	↑ Improved with carbs	↑
Levodopa-Benserozide (Prolopa)	✓	✓	✗	✗	↓	↓	↑

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Question: Do I need to increase my Parkinson's Meds?

He may not need to increase the Levocarb dose!

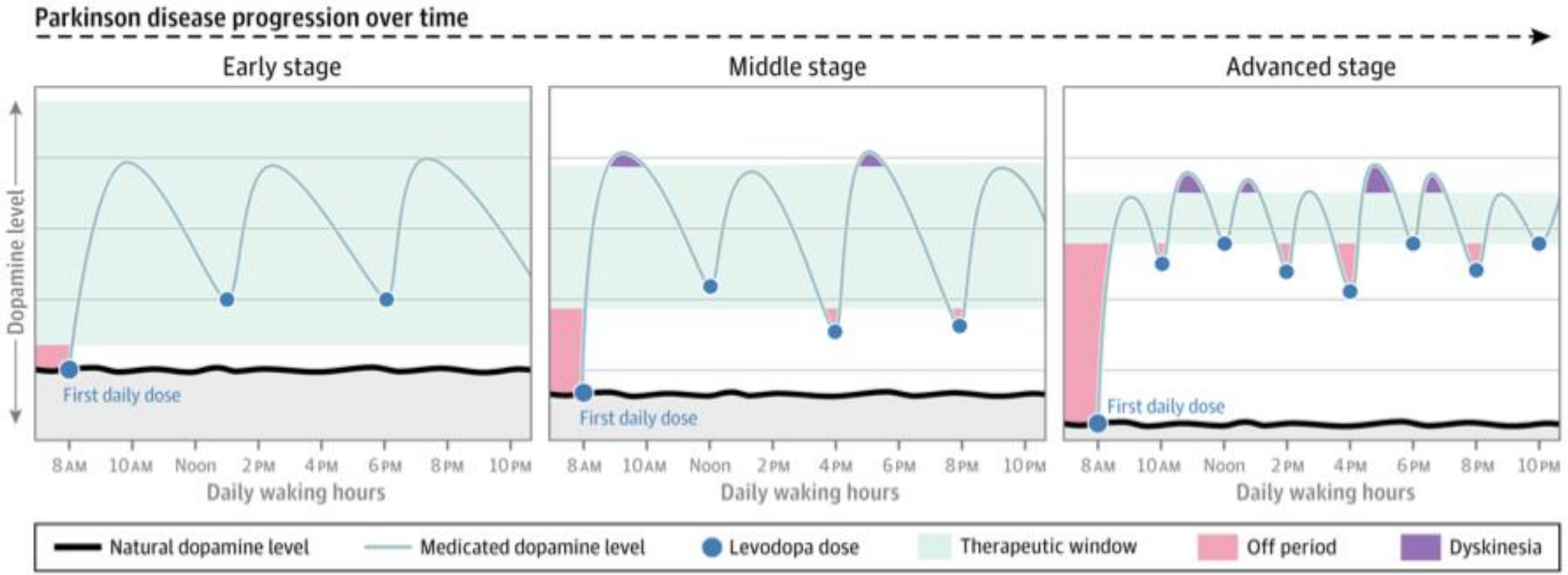
You review timing of his medications and notice he is taking it too close to meals – tell him to eat at least ½

e delayed gastric
of Levodopa

, and you add

erate at same time as the Levocarb- you adjust the dose of the iron medication to take with lunch

Armstrong et al. JAMA. 2020 Feb 11;323(6):548-560



Motor Symptoms- progression over time – After Levodopa's Honeymoon phase

Wearing off, dyskinesia, freezing, on/off fluctuations

Adjunctive treatments – Make Dopamine last longer!!!

Medication Class	Medication	Neuro-psychiatric side effects	Cardio-vascular side effects	GI side effects	GU side effects	Motor side effects
Dopamine Agonist	Pramipexole Ropinirole Rotigotine Transdermal	**Confusion** **Hallucinations** Psychosis (more than Levodopa Impulse control OCD	**Orthostatic hypotention** Dizziness Edema	**Nausea**		Less dyskinesia than Levodopa
MAO-B Inhibitors	Selegiline Rasagiline Safinamide	Confusion **Hallucinations** Psychosis **Seratonin Syndrome**	Dizziness	**Constipation**		Dyskinesia
COMT Inhibitors (Catechol-O-methyltransferase) Treats wearing off of Levodopa	Entacapone			Nausea **Diarrhea** Brown/orange stained teeth	Brown/orange stained urine	Dyskinesia
Anticholinergics Reduces dyskinesia	Amantadine	**Hallucination** Confusion Insomnia		**Constipation**	**Urinary retention**	

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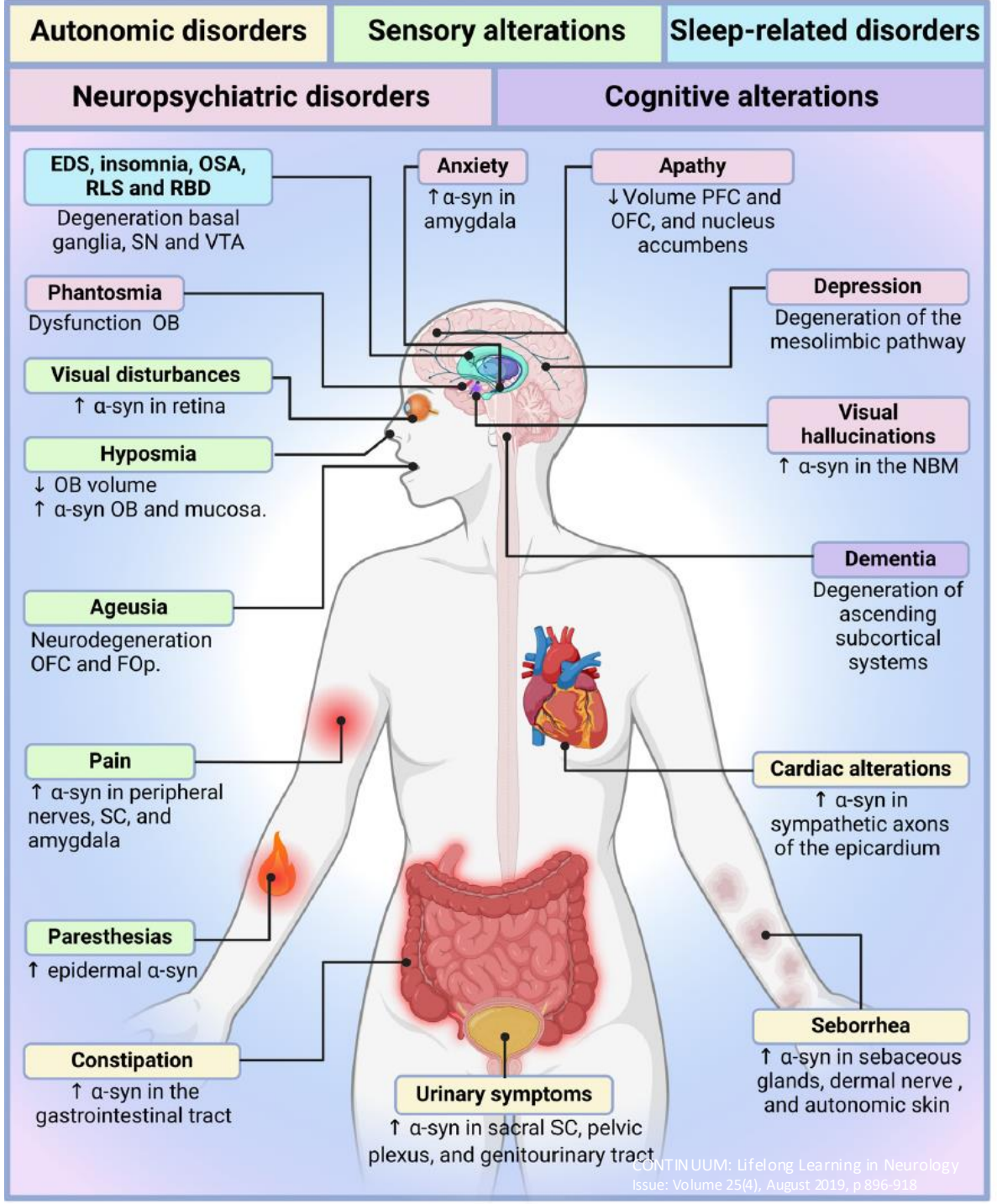
Non-Motor Symptoms in PD

- Is it the disease?
- Is it the meds?
- Is it an underlying illness?
- Is it all of the above?



CONTINUUM: Lifelong Learning in Neurology
Issue: Volume 25(4), August 2019, p 896-918

Pain

- Numbness
- Paresthesia
- Muscle Cramps

Non-Pharmacological

Exercise

PT/OT

Complimentary Therapy

Pharmacological

Acetaminophen

Gabapentinoids

- Usually low dose Gabapentin 100mg hs or Pregabalin 25mg hs and titrate. (Can help with insomnia and anxiety)

Magnesium – muscle cramps?

D/C Statins - ? Contributing to muscle pain

Botox injections- pain due to muscle spasms

Opioid analgesics

Constipation/ Diarrhea – Disease and/or the Meds

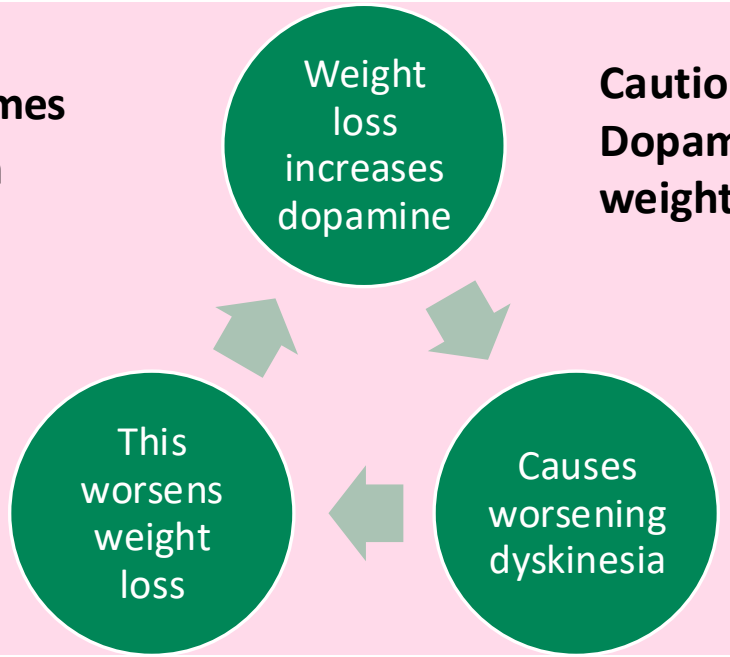
Constipation	Consider side effects of Parkinson medications – Entacapone, Amantadine
Use	Use stimulants for constipation
Diarrhea	Consider side effects of Cholinesterase Inhibitors PRN Loperamide
Consider	Consider abdominal flat plate to r/o overflow diarrhea

Nausea/Vomiting

- Urinary rete
- Constipatio
- Infection
- Electrolyte
- Poor gastric mot
- Medication
- Parkinson's Medication!!!!

- **Avoid anti-dopaminergic agents !!!!**

Pearl: Sometimes we need to watch the weight



Caution: Dopamine treatment is weight based.

bute to constipation

y not be as effective for N/V

- Helpful with early satiety

Take with carbs
Specialist may change type of Levodopa

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Orthostatic Hypotension (OH)

- Definition: standing drop in SBP >20 mm Hg, DBP >10 mmHg within 3 min.
- Due to disease and exacerbated by medication such as Levodopa
- **Should be part of the routine examination of a PD patient**
- BP meds should be reduced and given at bedtime to reduce impact on daytime BP.

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Orthostatic Hypotension: Non-Pharmacologic Treatment

- Avoid alcohol
- Increase fluid and salt intake in AM.
- Pump legs (point and flex ankles) before slowly getting up
- Wear abdominal binders before getting up in the morning to maintain splanchnic circulation
- Wear compression stockings if have peripheral edema

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Orthostatic Hypotension – Pharmacologic Tx

1: Midodrine

- 2.5mg (titrate up to max of 10mg/dose)
- Up to 3x per day (eg: 0800, 1200, 1600)
- Last dose at least 4 hours before bedtime
- Caution:
  - Can cause supine hypertension.
  - Wait 4 hours before lying down.
  - Keep head of bed elevated

2. Fludrocortisone (Florinef)

- Adjuvant to Midodrine.
- .05mg-.1mg/day
- Watch for edema

Depression and Anxiety

Have a **low threshold** for diagnosis of depression & anxiety (often under-diagnosed, misinterpreted as normal for PD)

Consider:

- trigger for anxiety/panic attacks : wearing off of PD medication - dystonia, choking of food, restless legs)

Treatment:

- SSRI – Sertraline, Escitalopram – Sertraline has less effect on QTc
- SNRI –Can exacerbate N/V and decrease appetite
- Mirtazapine – 3.75-15mg hs

Pearl:

May worsen Restless leg syndrome and REM sleep disorder – Take in AM

Interaction with MAO-B

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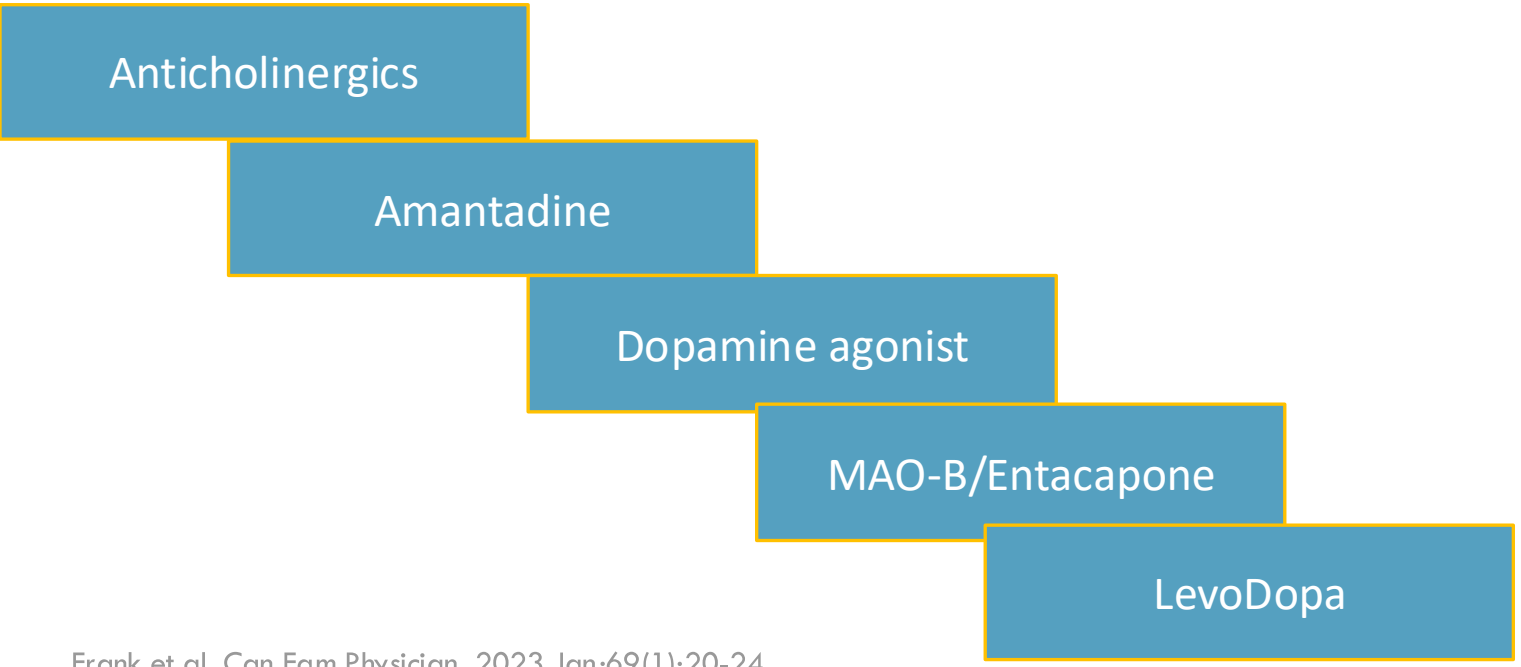
PD Psychosis

- Visual hallucinations or delusions
- ? Test and treat possible contributing causes – depends on GoC
- Consider **decreasing/deprescribing the medication for motor symptoms:**



You may need to add :
Quetiapine
Clozapine

Frank et al. Can Fam Physician. 2023 Jan;69(1):20-24.

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PD EoL

Question 2

Do you prescribe PR Levodopa at EoL when a person is no longer swallowing?

- Yes
- No
- I have not looked after a patient with PD at EoL

Loss of Oral Route at EOL

Should we prescribe PR Levodopa when a person no longer swallowing?

- "the limited scientific studies conducted in this area have failed to establish any discernible benefit." (Guthrie)
- It may be helpful if temporary reason for decreased oral intake and NG tube not appropriate or available. (Guthrie/Ebersbach)
- There is concern of sudden withdrawal and prefer down-titration with PR Levodoparather than acutely stopping Levodopa (Ebersbach)

Guthrie et al. Ochsner Journal 25:114–115, 2025
Ebersbach G et al. Management of delirium in Parkinson's disease. Journal of Neural Transmission (2019) 126:905–912

Pearl:

-Can manage symptoms with SC opioids and benzodiazepines.

-Can consider Rotigotine patch when unable to swallow

Calculator for Conversion from Levodopa to patch:

https://pdmedcalc.co.uk/calculator

Agitation and EoL

Neuroleptics

Oral Meds

- Quetiapine– first choice if oral route available

SC Meds

- Haloperidol (D1 receptor antagonist)- contraindicated

- Olanzapine
  - D2 receptor antagonist
  - Less anticholinergic than phenothiazine

- Phenothiazine (Methotrimeprazine)
  - D1 receptor antagonist (like haloperidol)
  - Anticholinergic – can relax muscles but also worsen delrium
  - When sedation is goal of treatment

Ebersbach G et al. Management of delirium in Parkinson's disease. Journal of Neural Transmission (2019) 126:905–912
Ibragimov K et al. Cochrate Database Syst Rev Jul 3(2024(7)

Pearl:

Consider adding **Benzodiazepines** to allow for lower dose of neuroleptic when sedation desired.

Learn more about Parkinson's and Palliative Care at the Horizon's Update November 20/26 in Vancouver

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JOIN OUR COMMUNITY OF PRACTICE

PCAND

Palliative Care for Advanced Non- Malignant Diseases

Palliative Care for Advanced Non-malignant Diseases (PCAND) is a **national community of practice** of palliative care providers for people with non-malignant diseases.

Supported by the **Canadian Society of Palliative Care Physicians**.

Holds **Royal College-accredited** quarterly virtual meetings.

Objectives:

- Provide **education** about non-malignant palliative care,
- Support **research** to build evidence for non-malignant palliative care, and
- **Advocate** to stakeholders for better access to quality non-malignant palliative care.

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