**KISS: Parkinson's Disease**

Based on **NICE 2019, NG127** & **NICE July 2017** and **BMJ 2017;358:j1951**

**Diagnosis:**
- Diagnosis depends on the presence of **bradykinesia** plus **one of rigidity, rest tremor or postural instability** ([click here for full diagnostic criteria](#)).
- Refer all suspected cases early and **untreated** for specialist diagnostic confirmation.
- All patients who drive must inform the DVLA ([click here for DVLA notification link](#)).

**Non-pharmacological management:**
- Exercise - **physical activity** has been shown to be very important in reducing motor and non-motor symptoms; consider referring to **physio** especially if balance or motor problems.
- Consider referral to **Occupational Therapy** if difficulty with activities of daily living & to **Speech & Language therapy** if problems with communication, swallowing or saliva.
- Patient information and support: lots of good information from **Parkinson’s UK**.

**Drug treatment of motor symptoms:**
- All drugs are for symptomatic benefit and none influence the long-term progression.
- Initiation and alteration of all drugs should be done under specialist supervision.
- **First-line drugs:**
  - **Levodopa** - better for motor symptoms with fewer adverse effects but higher long-term motor complications.
  - **Dopamine agonists** (non-ergot derived e.g. pramipexole, ropinirole) - less good for motor symptoms but fewer motor complications, but higher adverse effects.
  - **MAO-B inhibitors** - less good for motor symptoms but fewer motor complications, but higher adverse effects.
- **Adjuvant** therapy: consider adding dopamine agonist, MAO-B inhibitor or COMT inhibitor to levodopa if dyskinesia or motor fluctuations despite optimal levodopa therapy.
- **Impulse control disorders** (e.g. hypersexuality, gambling, binge eating) can occur with any dopaminergic therapy, but particularly dopamine agonists; warn patients and family about this potential complication as can be distressing.
  - If it occurs seek specialist advice, but we should not alter/stop medications without advice - medications usually need to be slowly reduced due to risk of dopamine withdrawal.

**Non-motor symptom treatment** (review potential causative/contributory drugs in all cases):
- Day time sleepiness, particularly associated with dopamine agonists; consider **modafinil**.
- Rapid eye movement sleep disorder - consider **clonazepam** or **melatonin**.
- Orthostatic hypotension: meds review important; consider **midodrine** or **fludrocortisone**.
- Depression ([CKS 2018](#)) - can be difficult to diagnose as features may be wrongly attributed to the PD; consider **CBT**; best evidence for **TCAs** but use may be limited by side effects (cognitive impairment and falls) so **SSRIs** may be more appropriate.
- Psychosis: don’t treat if well tolerated; consider **quetiapine** or clozapine (specialist only).
- Dementia: consider **cholinesterase inhibitor** or **memantine**.
- Drooling: refer to **speech & language therapy** or consider **glycopyrronium bromide**.

**Palliative care** - consider referring at any stage to consider end of life care.