The treatment with Parkinson who cares?

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Parkinson's disease is the second most common neurodegenerative disorder in developed countries, after Alzheimer's disease, with an estimated prevalence of three patients per 1000 population. The diagnosis is not always easy because it is mostly based on the clinical features that are in part present in several other akinetic rigid syndromes. Moreover, there are no reliable biological markers for confirmation of the disease and nor for the differential diagnosis between the several disorders that can present with the same core syndrome. In fact, there are frequent errors in clinical diagnosis as shown in clinico-pathological series, even in up to 25% of patients regularly examined up to the time of their death by neurologists well-experienced with the disease (Hughes et al. 1992).
Several studies in Europe and other parts of the world have shown there is great discrepancy between the prevalence of Parkinson’s disease in different geographical areas depending on whether the information comes from clinical records or sales of dopaminomimetic drugs, and what is found during door-to-door surveys (De Pedro-Cuesta 1991). In general, it is estimated that akinetic–rigid syndromes are unrecognized in as many as 30–50% of cases, and that the rate of under diagnosis is greatest in rural areas where specialized care is more difficult to obtain. Also the diagnosis is made 2 or 3 years earlier by neurologists compared with general practitioners or other medical specialists.

The treatment of patients with Parkinson’s disease is not straightforward and it changes as the disease evolves over about 20 years on average. Choosing the optimal therapy is not only a question of patient wellbeing but also a matter of critical economic importance. The number of compounds on the market with different pharmaceutical preparations of L-DOPA, and combinations of inhibitors of the different L-DOPA metabolizing enzymes, and dopamine agonists increases every year and so do the costs of the new compounds that enter the market. Furthermore, the drugs that are considered as first line anti-parkinsonian agents are often used in combination with anti-depressants, hypnotics, tranquillizers, putative neuroprotective agents and other medications for the management of the most frequent symptoms of the disease and its complications. The cost of all this medication 10 years ago was as much as $4120 per year (Dodel et al. 1998), but probably is now substantially more. The total cost of care – including nursing, behavioural and physiotherapy, speech therapy, psychotherapy and hospital care – was estimated at $13 560 per year (Dodel et al. 1998). New therapies, including deep brain stimulation, intermittent or continuous apomorphine, and gastro-duodenal L-DOPA infusion, provide additional therapeutic tools but further increase the costs.

Making the correct diagnosis, as soon as possible, and choosing the most effective treatment at every point in the evolution of the disease, is very important for the patients and also for the health care system. To optimize both diagnosis and treatment it is critical that the patients are followed up by an integrated team of professionals with special expertise in this disease. The neurologist expert in Parkinson’s disease should fulfil certain criteria including formal training in Parkinson’s disease or neurodegenerative disorders, a clinical practice orientated towards these disorders, and research related to the disease. The nurses, physiotherapists and neuropsychologists should all be members of the team. Other professionals – general practitioners, geriatricians, internists, etc. – also have a role in the care of these patients but they should be supervised by the specialized team.

REFERENCES
The Treatment of Patients with Parkinson's Disease: Who Cares?

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