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Hallucinations— Psychosis Related To Parkinson's Disease

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Early in the course of PD, treatment usually goes well. However, after five to ten years, things start to change as treatment requires higher doses of medications and side effects become more problematic. One of the most problematic side effects in this phase of illness involves what doctors call psychosis. Unfortunately the word can have very negative connotations to lay people. To physicians, psychosis is an indicator that something is going wrong in the brain (including medication side effects). Psychosis usually is diagnosed when the patient has hallucinations or delusions.

A hallucination is a sensory perception that does not correspond to reality, such as seeing people at the dinner table when no one is there. Hallucinations can involve senses other than vision, like hearing someone conversing with you when no one is actually there. The hallucinations that are most common in PD include seeing people who are not there, like the dinner table guest mentioned above, seeing small animals that are not present, or hearing someone's voice who is not in fact present.

A delusion is a firm belief in something that is not true despite substantial evidence to the contrary. Sometimes these are explanations for hallucinations (e.g., you see someone at the dinner table and you tell your spouse that it must be bridge night because that's when you invite people). Other delusions can involve themes of persecution, jealousy, or theft. Hallucinations are more common than delusions in PD, so I will focus on them.

The good news is that most people who have PD don't have hallucinations—at the moment. In fact, before we had good treatments for PD, hallucinations were rather rare. The bad news is that many people with PD will have hallucinations at some point in their illness. Although the hallucinations may not bother the patient at this time, they tend to indicate that this is someone with a high risk of having other complications, so we usually try hard to reduce the hallucinations.

There is another good news/bad news story for treatment of hallucinations. The good news is that we can almost always get rid of the hallucinations. The bad news is that available treatments are far from perfect. Here is what we do to treat psychosis. First, we make sure there is no other, more urgent problem. People can develop hallucinations, usually along with confusion, from other serious illnesses like pneumonia or heart disease. Talking to and examining the patient usually clears that up, but in some cases blood work, a urine sample, or other tests may be needed. The second step in treatment is to reduce medications that affect the brain. Sometimes a medication may not be necessary and can be eliminated. Other times, we try to switch the patient to levodopa rather than dopamine agonists, because on average, levodopa has a lower risk of hallucinations for the same amount of benefit on movement.

These steps are important, but often do not abolish the hallucinations. In that case, an antipsychotic medication is important. There are three classes of medications here. (1) Older antipsychotics work, but are a bad idea in PD because they worsen the movement problems too much. (2) Clozapine clearly works, doesn't worsen PD movement symptoms, and is the right choice for many patients. However, it requires frequent blood draws (every week at first, eventually once or twice a month). This is because one or two people in 100 will have a potentially serious side effect, which the blood draws are meant to detect before it is too serious. (3) There are several other proposed treatments that seem like they should help but have not been proven to help. The best-known example is quetiapine, which is often prescribed for hallucinations, but in at least three studies in PD it did not work better than a placebo (sugar pill).

There are current studies being conducted to determine whether a new drug called pimavanserin is better than a placebo in fighting the hallucinations. Pimavanserin does not worsen PD like many antipsychotics do, and it does not have the same risks as clozapine does, but we don't yet know if it works. There is excitement in the field about pimavanserin because it is a different kind of antipsychotic, working on serotonin rather than dopamine.

For full information on this new drug or other treatments for hallucinations in PD, please contact Mary Creech, RN, MSW at **314-362-7651** or **maryc@npg.wustl.edu**. ■

New Satellite Resource Center Hours

Hours at the satellite center through the holidays and winter months will be by appointment only.

Please contact the Center at 314-362-3299 to make an appointment.