

Lionel Cosin Day Hospital 2007

September 19th 2007

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Outline

- Purpose of the Day Hospital
- What we don't do
- “Traditional Day hospital patient”
- Current additional services

- Recent changes in the management of Parkinson's Disease

- What would you like? What should we be doing better?

Day Hospital

- Multidisciplinary team
 - doctors, nurses, OTs, physios
 - falls specialist nurse
 - orthotist, monthly clinic

also: speech therapist, dietician
?psychologist

“Typical Day Hospital Patients”

Primarily medical

- Complex, frail / long problem / drug list
- Blood transfusions
- Heart failure

Multidisciplinary issues

- Falls
- Osteoarthritis, immobility etc
- Parkinsonism Idiopathic Parkinson’s Disease
- Post stroke – NSF
- Other degenerative neurological conditions

Day Hospital after an admission

- On going physio / OT etc
- “Frequent fliers”
- Not sorted e.g. from MAU
- Concerned about coping - Support family
- Severe heart failure
- FU of new diagnosis - e.g. PD

What the DH offers that is different from OP

- Multidisciplinary in-put
- More time
 - assessment
 - observation
- Continuity of care – consequences?
- OP - pathology drugs DH - function
- Often managing a patient rather than treating
- “Care management rather than crisis management”

What sort of things do we discover?

- Cognitive impairment – consequences
- Concordance with medication
 - n.b. diuretics
- Incontinence
- Care issues

Current services 1

- “Traditional Day Hospital patient”
 - Full geriatric assessment
- Rapid access clinic (Dr Sarah Smith)
- Falls service (Dr Adam Darowski)
 - Falls clinic (OP)
 - Falls specialist nurses
 - Balance and safety groups
 - Tilt table testing
 - Research

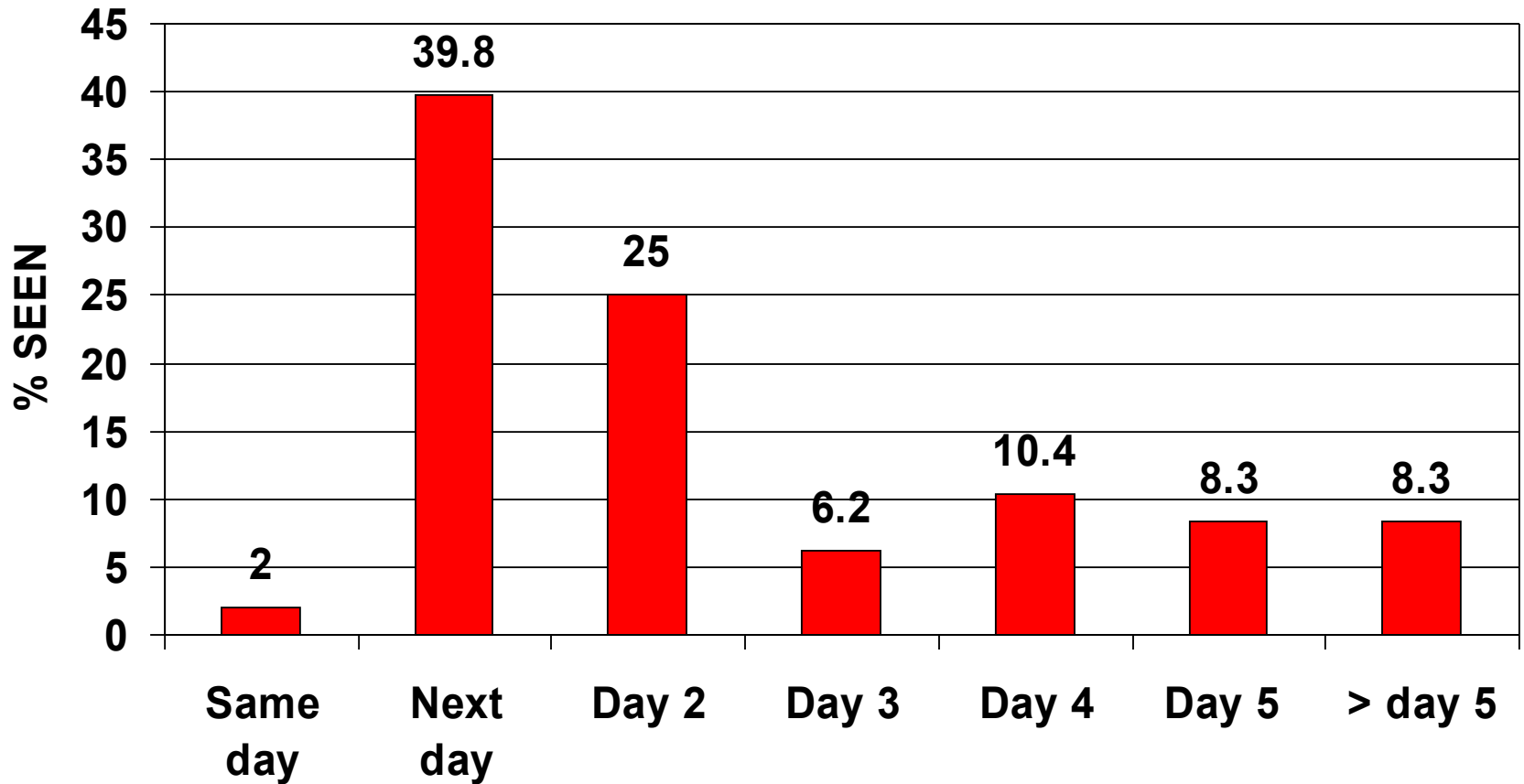
Current services 2

- Memory clinic / Dementia programme
(Dr Neil Stewart Prof Gordon Wilcock)
- TIA clinic (Dr Sebastian Fairweather)
- Movement disorder clinic (Dr Sudhir Singh
Dr Hilary Hart)
 - Multidisciplinary care of patients with PD and similar conditions

Rapid Access Clinic

- Current service launched May 2007 by GP fax:
 - 52 referrals in first 10 weeks
 - 87.5% from GPs
 - 51% would have otherwise gone to the acute take
 - Estimated that an acute admission was avoided in 41%
 - 8.3% admitted from RAC

Timing of appointments



RAC diagnoses

	Audit 1 Dec 2000 – June 2001	Audit 2 Oct 2002 – March 2003	Audit 3 Aug 2003 – Jan 2004	Audit 4 May 2007 – July 2007
Cancer	11%	22%	12%	3%
CCF	10%	12%	18%	25%
Anaemia	7%	7%	7%	13%
TIA	5%	14%	12%	20%
Poor mobility/falls	9%	8%	7%	15%
Other	58%	37%	44%	24%

Typical patients

- Severe heart failure
 - needing i/v diuretics
 - can be seen daily
 - monitored acutely and referred on to normal DH care
- Severe anaemia
 - transfuse up to 2 units / day
 - initiate investigation of cause
- Multiple pathologies with acute deterioration
- TIAs

Accessing the service

- Fax referral to 01865 228790
 - Appointment arranged by telephone with patient
- Telephone 01865 228777
- Feedback:
 - Urgent information telephoned or faxed same day
 - Letters dispatched within a week

TIA clinic

- Initiate appropriate investigation
 - Bloods
 - Carotid doppler
 - ECG / 24 hour ECG
 - CT /MRI
 - ECHO
- Initiate appropriate Rx
 - Aspirin normally GP
 - Statin
 - Rx of BP
 - ACE

TIA clinic ABCD score

Risk factor	Category	Score
A Age	Age \geq 60	1
	Age < 60	0
B Blood pressure at assessment	SBP >140 or DBP \geq 90	1
	Other	0
C Clinical features	Unilateral weakness	2
	Speech disturbance (only)	1
	Other	0
D Duration	\geq 60 minutes	2
	10 – 59 minutes	1
	> 10 minutes	0
TOTAL		6

Risk of stroke at 7 days by ABCD score

ABCD score	N(%)	Events	% Risk
≤ 3	184 (49)	0	0
4	90 (24)	1 (5)	1.1
5	66 (18)	8 (40)	12.1
6	35 (9)	11 (55)	31.4
Total	375 (100)	20 (100)	5.3

“OXMAC” Relocation to Day Hospital

- Consultant staff:
 - Neil Stewart
 - Gordon Wilcock
- Supported by:
 - Medical staff in training
 - Memory clinic nurse(s) including OBMHT
 - OPTIMA early next year

Dementia Programme

Co-locate the following on level 4:

- The clinic in the LCDH (September 07)
- Academic Dementia Grouping in refurbished accommodation on level 4 (Feb 08):
 - OPTIMA
 - and a new Translational Clinical Trials initiative (BRC development)
 - Thames Valley DeNDRon Regional Centre
 - CDCIG (Cochrane Dementia and Cognitive Improvement Group)
- Brings together Smith, McShane, Jacoby, Stewart and Wilcock and an integrated programme

Current DoH guidance for Primary Care and other settings

- All patients with (suspected) dementia should be referred to a specialist service
- People with MCI should be referred for comprehensive assessment, and monitoring
- High index of suspicion of cognitive impairment in high risk groups e.g. stroke and PD

The main functions of the clinic include, (and we would encourage referrals in relation to these):

Assessment of questionable and early dementia (MMSE >15-18). Needs a third party history

Diagnostic sub typing

Deciding therapeutic strategy for patients, and providing advice to them and their carers

Monitoring questionable dementia

Monitoring treatment responses

Collaborating with OBMHT colleagues

Teaching

Research

(Moving towards a one stop clinic approach)

Movement Disorders

- Out patient clinic twice a month
- Day Hospital
 - Multidisciplinary input

Recent changes in the management of Parkinson's disease

- NICE Guidelines June 2006
- Non motor symptoms
- Medication issues

NICE Guidelines

Key priorities for implementation

- People with suspected PD should be referred ***quickly*** and ***untreated*** to a specialist with expertise in the differential diagnosis of this condition
 - Suspected mild should be seen within 6 weeks
 - Later disease with complex problems within 2 weeks
- The diagnosis of PD should be reviewed regularly and reconsidered if atypical features develop
 - Should be seen regularly at 6 – 12 months

NICE Guidelines 2

Key priorities for implementation

- Regular access to specialist nursing care
 - Clinical monitoring and medication adjustment
 - A continuing contact for support, including home visits, when appropriate
 - A reliable source of information about clinical and social matters of concern to people with PD and their carers

which may be provided by a Parkinson's disease nurse specialist

NICE Guidelines 3

Key priorities for implementation

- Access to physiotherapy
- Access to occupational therapy
- Access to speech and language therapy
- Palliative care

- Day Hospital and Clinic - we can provide a service for patients with PD which meets many of the guidelines recommended by NICE
- ***But*** - most of our (and your) patients ***don't*** have access to a PD nurse specialist
- We are working with neurologists and psychogeriatricians

Non-motor symptoms of PD 1

- Neuropsychiatric symptoms
 - Depression / anxiety /apathy
 - Hallucinations, illusions, delusions
 - Dementia
- Sleep disorders
 - Restless legs
 - REM sleep disorder
 - Vivid dreaming
 - Excessive daytime sleepiness

Non-motor symptoms of PD 2

- Autonomic symptoms
 - Bladder: urgency, incontinence nocturia
 - Sweating
 - Orthostatic hypotension
 - Falls related to OH
 - Sexual dysfunction
 - Dry eyes

Non-motor symptoms of PD 3

- G I symptoms – overlap with autonomic
 - Dribbling of saliva
 - Dysphagia, choking , reflux, vomiting
 - Constipation, unsatisfactory voiding
- Sensory
 - Loss of smell, taste
 - Pain
 - Paraesthesiae

Non-motor symptoms of PD 4

- Also
 - Fatigue
 - Diplopia
 - Blurred vision
 - Seborrhoea
 - Weight loss



Non-motor symptoms Questionnaire

Name: Date: Age:

Centre ID: Male Female

NON-MOVEMENT PROBLEMS IN PARKINSON'S

The movement symptoms of Parkinson's are well known. However, other problems can sometimes occur as part of the condition or its treatment. It is important that the doctor knows about these, particularly if they are troublesome for you.

A range of problems is listed below. Please tick the box 'Yes' if you have experienced it during the past month. The doctor or nurse may ask you some questions to help decide. If you have not experienced the problem in the past month tick the 'No' box. You should answer 'No' even if you have had the problem in the past but not in the past month.

Have you experienced any of the following in the last month?

	Yes	No		Yes	No
1 Dribbling of saliva during the daytime.	<input type="checkbox"/>	<input type="checkbox"/>	16 Feeling sad, 'low' or 'blue'.	<input type="checkbox"/>	<input type="checkbox"/>
2 Loss or change in your ability to taste or smell.	<input type="checkbox"/>	<input type="checkbox"/>	17 Feeling anxious, frightened or panicky.	<input type="checkbox"/>	<input type="checkbox"/>
3 Difficulty swallowing food or drink or problems with choking.	<input type="checkbox"/>	<input type="checkbox"/>	18 Feeling less interested in sex or more interested in sex.	<input type="checkbox"/>	<input type="checkbox"/>
4 Vomiting or feelings of sickness (nausea).	<input type="checkbox"/>	<input type="checkbox"/>	19 Finding it difficult to have sex when you try.	<input type="checkbox"/>	<input type="checkbox"/>
5 Constipation (less than three bowel movements a week) or having to strain to pass a stool.	<input type="checkbox"/>	<input type="checkbox"/>	20 Feeling light-headed, dizzy or weak standing from sitting or lying.	<input type="checkbox"/>	<input type="checkbox"/>
6 Bowel (faecal) incontinence.	<input type="checkbox"/>	<input type="checkbox"/>	21 Falling.	<input type="checkbox"/>	<input type="checkbox"/>
7 Feeling that your bowel emptying is incomplete after having been to the toilet.	<input type="checkbox"/>	<input type="checkbox"/>	22 Finding it difficult to stay awake during activities such as working, driving or eating.	<input type="checkbox"/>	<input type="checkbox"/>
8 A sense of urgency to pass urine makes you rush to the toilet.	<input type="checkbox"/>	<input type="checkbox"/>	23 Difficulty getting to sleep at night or staying asleep at night.	<input type="checkbox"/>	<input type="checkbox"/>
9 Getting up regularly at night to pass urine.	<input type="checkbox"/>	<input type="checkbox"/>	24 Intense, vivid or frightening dreams.	<input type="checkbox"/>	<input type="checkbox"/>
10 Unexplained pains (not due to known conditions such as arthritis).	<input type="checkbox"/>	<input type="checkbox"/>	25 Talking or moving about in your sleep, as if you are 'acting out' a dream.	<input type="checkbox"/>	<input type="checkbox"/>
11 Unexplained change in weight (not due to change in diet).	<input type="checkbox"/>	<input type="checkbox"/>	26 Unpleasant sensations in your legs at night or while resting, and a feeling that you need to move.	<input type="checkbox"/>	<input type="checkbox"/>
12 Problems remembering things that have happened recently or forgetting to do things.	<input type="checkbox"/>	<input type="checkbox"/>	27 Swelling of the legs.	<input type="checkbox"/>	<input type="checkbox"/>
13 Loss of interest in what is happening around you or in doing things.	<input type="checkbox"/>	<input type="checkbox"/>	28 Excessive sweating.	<input type="checkbox"/>	<input type="checkbox"/>
14 Seeing or hearing things that you know or are told are not there.	<input type="checkbox"/>	<input type="checkbox"/>	29 Double vision.	<input type="checkbox"/>	<input type="checkbox"/>
15 Difficulty concentrating or staying focussed.	<input type="checkbox"/>	<input type="checkbox"/>	30 Believing things are happening to you that other people say are not.	<input type="checkbox"/>	<input type="checkbox"/>

All the information you supply through this form will be treated with confidence and will only be used for the purpose for which it has been collected. Information supplied will be used for monitoring purposes. Your personal data will be processed and held in accordance with the Data Protection Act 1998. Developed and validated by the International PD Non Motor Group. For information contact: susanne.tluk@uhl.nhs.uk or allison.forbes@uhl.nhs.uk.

Medication 1

- L dopa preparations
 - Sinemet Madopar Duodopa
- Dopamine agonists
 - Ergot derivatives: Pergolide Cabergoline
 - Synthetic or non ergot Ropinirole Pramipexole
Rotigotine (patch)
 - Apomorphine
- COMT inhibitors Entacapone Tolacapone

Medication 2

- Maoi B inhibitors Selegeline Rasagaline
- Anti cholinergics Trihexyphenidyl
(benzhexol)
- Amantadine

Medication issues

- What not to use
 - Anticholinergics
 - Sinemet CR Madopar MR preparations in the daytime
 - Ergot agonists
 - Agonists where there are already psychiatric symptoms or cognitive impairment

Medication issues 2

- When to start - not too late
- What we use initially
 - L dopa, a dopamine agonist or an MAO-B inhibitor
- What to use next
 - In addition to L dopa – an agonist, a COMT inhibitor or an Maoi B inhibitor
 - In addition to an agonist – L dopa

Other medication

- Calcium and Vitamin D bisphosphonates
strontium ranelate
- For non motor symptoms
 - E.g. Laxatives, antidepressants
 - Choline esterase inhibitors

In Conclusion

- Lionel Cosin Day Hospital continues to offer multidisciplinary services for the frail elderly to reduce admissions
 - Generic, full geriatric assessment
 - Specialist clinics
- In the future
 - More clinical research
- Referrals
 - Day hospital and RAC: Fax 01865 228790
 - for other clinics within the DH: Fax 01865 234815 (Geratology Department Fax)