EDITORIAL

The importance of psychological symptoms in Parkinson’s disease

This issue of *Age and Ageing* includes the last of three papers describing community-based studies in North Wales on Parkinson’s disease, and some of its problems—diagnosis, prevalence and importance of depression and impact on quality of life [1–3]. These reports are of importance to geriatricians, who are inevitably involved in the management of Parkinson’s disease, most sufferers from it being elderly. This importance is increased by their community-based sampling frames, which reflect the overall situation better than hospital-based ones, and by the fact that all three papers are well-referenced.

The first paper [1] deals with the problem of accuracy of diagnosis, and concludes that only 51% of 402 patients from a community disease register met accepted criteria for Parkinson’s disease. There is confusion with essential tremor, with the gait apraxia of vascular pseudo-parkinsonism (‘lower-body parkinsonism’) and with the mild parkinsonian manifestations common in Alzheimer’s disease. These are reminders of the adage that ‘not all that shakes is Parkinson’s’, and of the need for confirmation of the diagnosis by specialists.

The second paper [2] derives from a sample which overlaps with that of the first, but which differs in time frame and in methodology (patients with severe dementia being excluded), so that numbers are somewhat different. It uses the validated self-rating Geriatric Depression Scale-15 (GDS-15) [4] to discover the prevalence of important depressive symptomatology in 132 patients with Parkinson’s disease (84; 61%—about twice the usual figure for hospital patients, although methodological differences make rigorous comparison impossible) and 79 caring spouses (28; 31%). Severity of disease (as measured by the Webster score [5]), its duration, and cognitive impairment (as measured by the CAMCOG score [6]) were significantly related to the GDS-15 score in patients, although the possibility of a ‘chicken and egg’ problem is recognized.

The GDS-15 score of the carers was best predicted by the patient’s GDS-15 score, severity and duration of disease and cognitive impairment being of greater importance than not significantly associated. Most importantly, less than 7% of those with high GDS-15 scores, either patients or carers, were being treated with antidepressants; this gives a clear message about the need for detection of depressive symptoms in patients with Parkinson’s disease and also their carers.

The third paper [3] deals with the difficult problems of quality of life and its assessment. These difficulties derive in part from the vagueness of the concept (except in relation to individuals) and the doubtful value of adding apples and oranges in attempting to balance scores given to physical, emotional and social items. Given the numerous potential causes of individual disabilities in elderly people, a single score may be justifiable. However, in a condition as common in old age as Parkinson’s disease (which has several important virtually disease-specific symptoms, such as difficulty in turning in bed and embarrassment at eating in public because of the effect of tremor on table manners) a good case can be made for a disease-specific measure of quality of life, no matter how much ‘contamination’ there may be from other causes of symptoms. The Parkinson’s Disease Quality of Life questionnaire, developed in the Netherlands [7], is one of only two such measures [8], and was used in this study.

Age, disease severity (as measured by the GDS-15 scale [4]), and cognitive impairment (as measured by CAMCOG [6]) were all associated with decreasing quality of life. Again, the importance in Parkinson’s disease of psychological as well as physical symptoms is brought out, and this highlights the necessity of enquiring into them if the disease is to be managed optimally.

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References


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