Maladie de Parkinson et soins palliatifs

- *Liens d'intérêts déclarés par l'intervenant :*
  - *Orkyn*
  - *Aguettant*
  - *LVL*
  - *NHC*

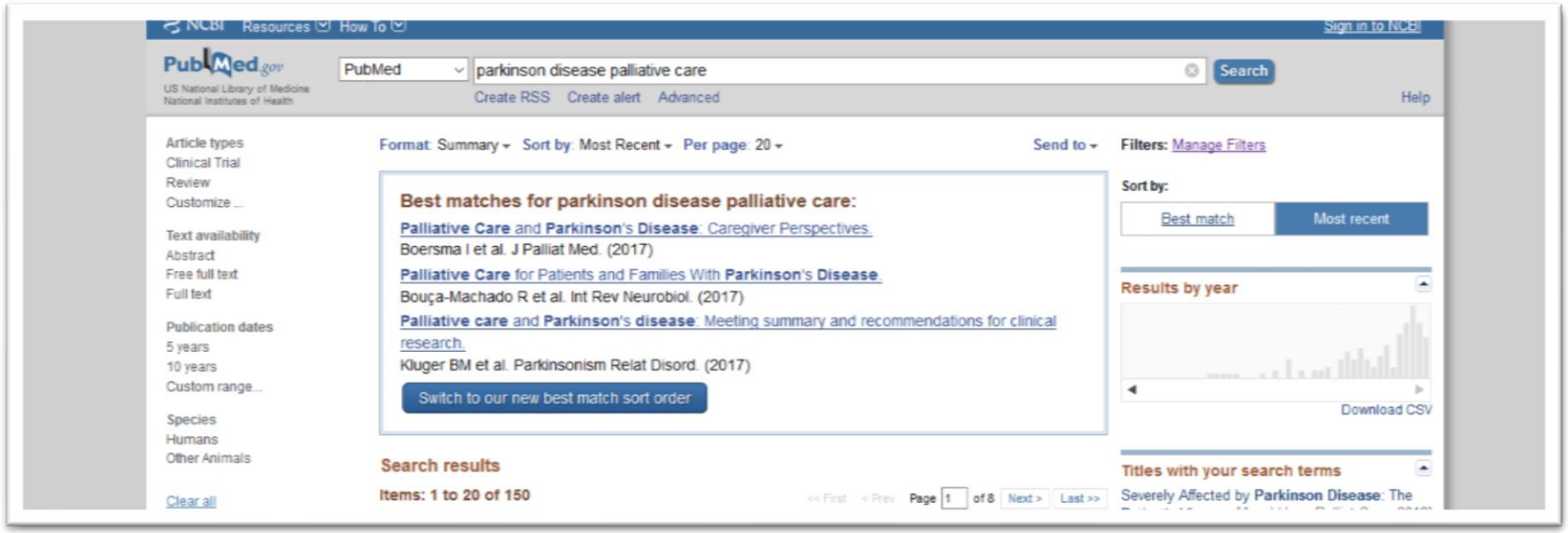
mention de la nature du ou des liens d'intérêts

E.P.U.

Neurologue

Palliatologue

Grande pauvreté de la littérature



Syndromes parkinsoniens

- Maladie de Parkinson
- Syndromes Parkinsoniens atypiques
  - Atrophie multi-systématisée (AMS)
  - Paralysie supra-nucléaire progressive
  - Dégénérescence cortico-basale
  - Maladie à Corps de Lewy diffus
- Pas de pratique formalisée

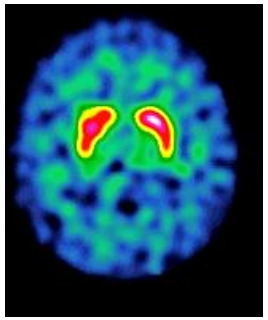
Epidémiologie

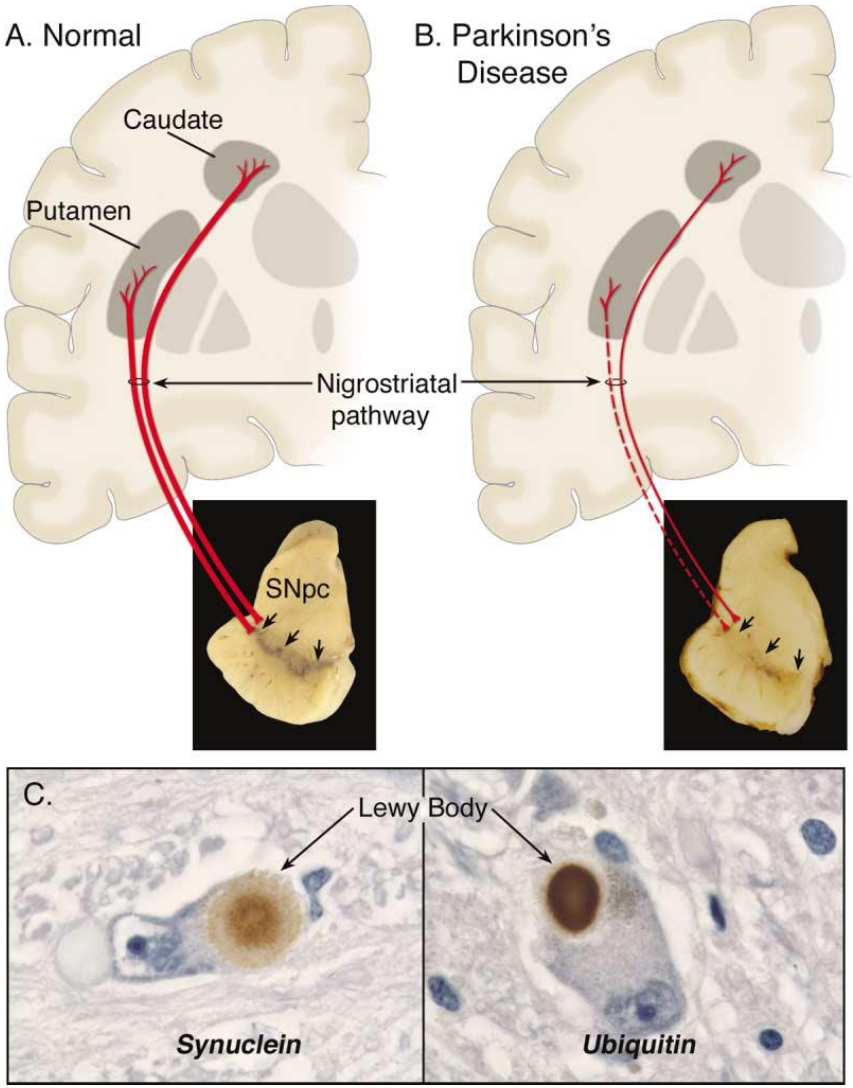
- Environ 150 000 personnes en France
- 2éme maladie neurodégénérative
- 2ème maladie génératrice de handicap lourd
- Age moyen de début ≈ 70 ans
- Durée d'évolution prévisible avec un traitement bien conduit 15 a 25 ans

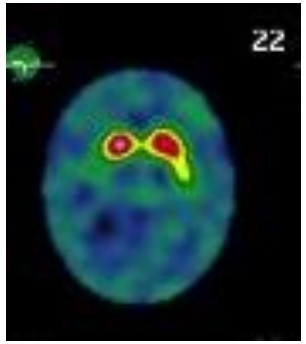
SFAP

FISP
Fédération francophone
Internationale de Soins Palliatifs

Maladie de Parkinson: mort des neurones dopaminergiques

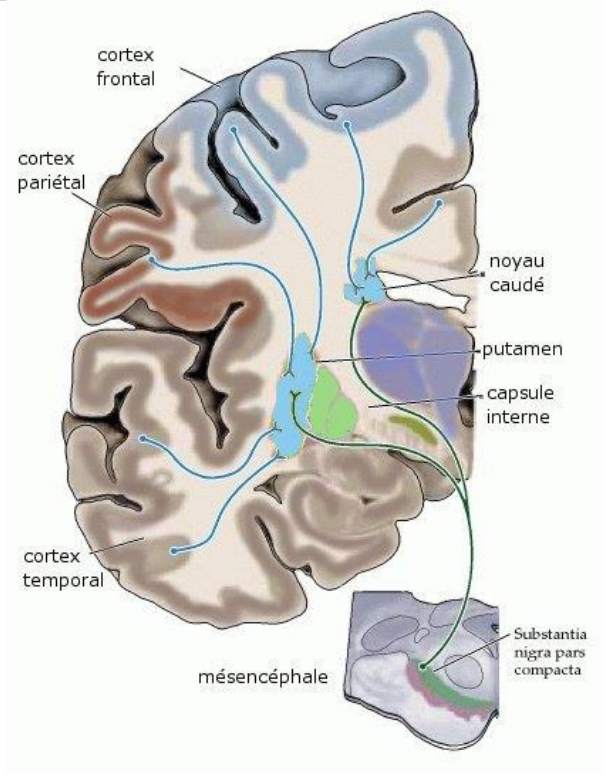


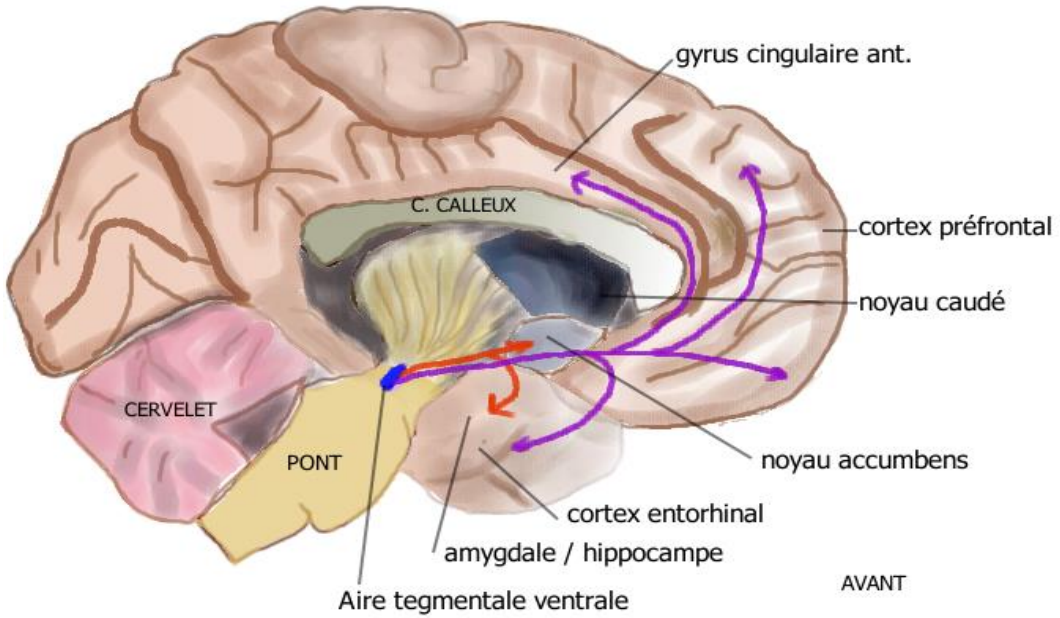




Dauer and Przedbosrki Neuron 2003

Voies dopaminergiques





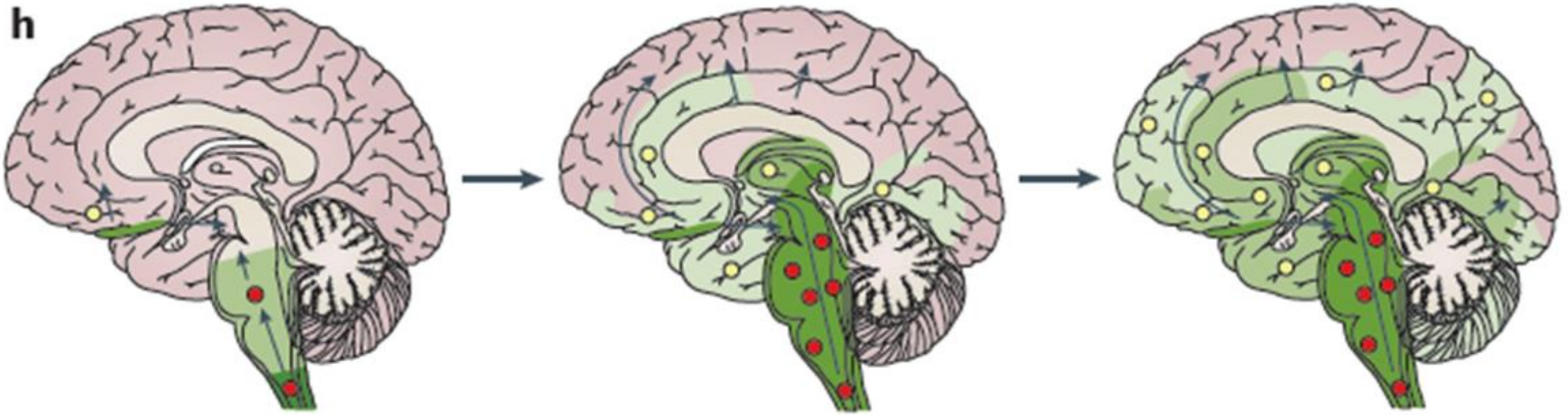
<u>Voie nigro-striatale</u>

- 80% des neurones dopa,
- Contrôle des fonctions motrices

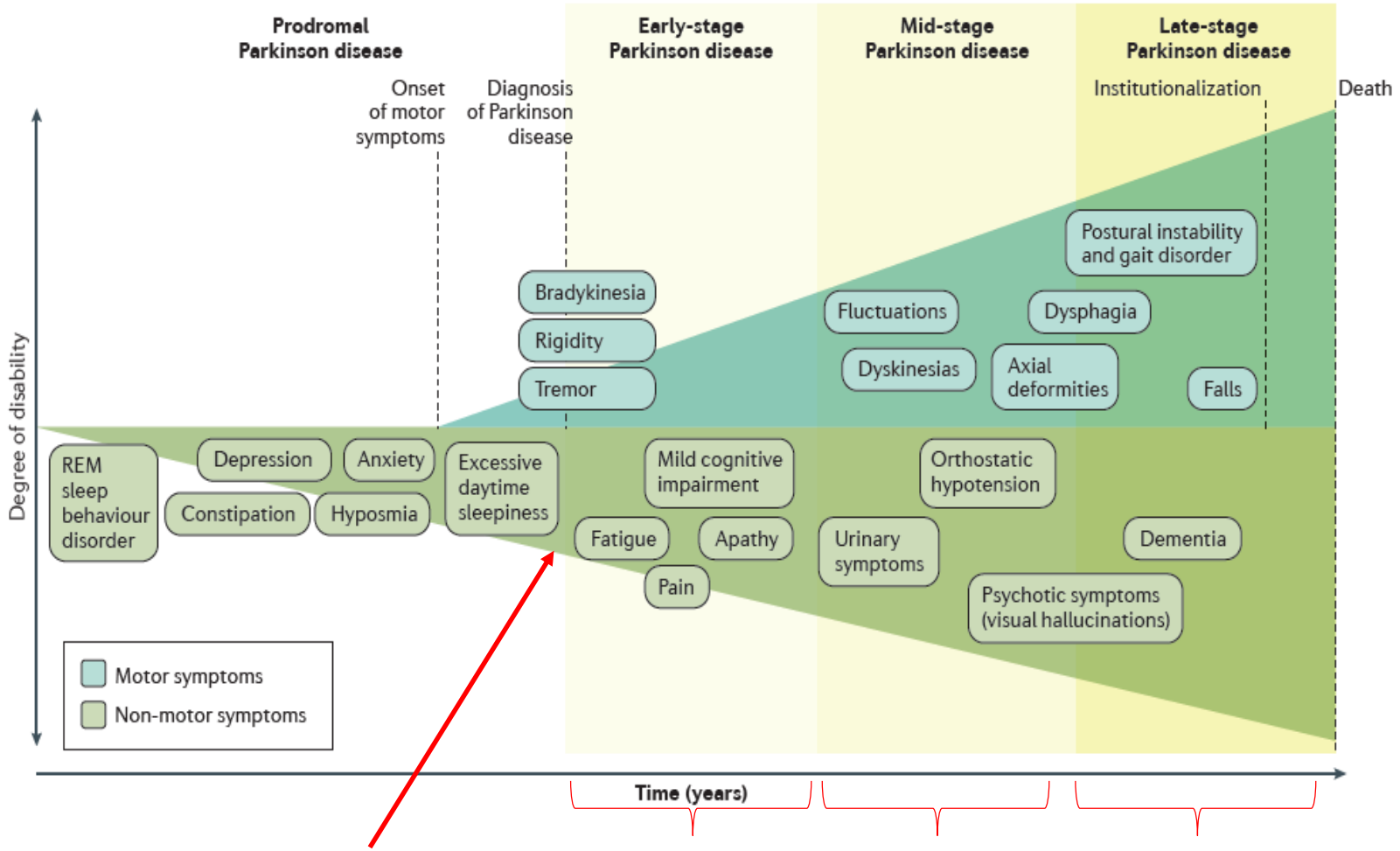
<u>Voie mésolimbique, voie mésocorticale</u>

- Système de récompense
- Fonctions éxécutives

La maladie de Parkinson: au delà de la dopamine....



Histoire naturelle de la maladie



70 ans

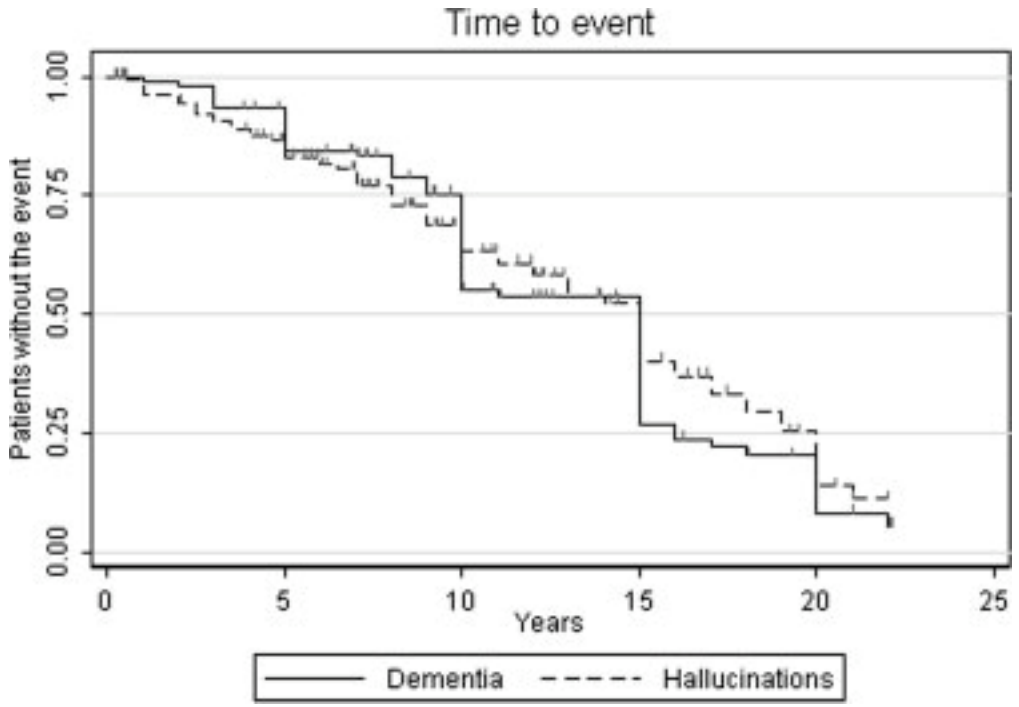
Lune de miel

Maladie installée

Déclin

G. Caplain

Evolution à long terme: cognition



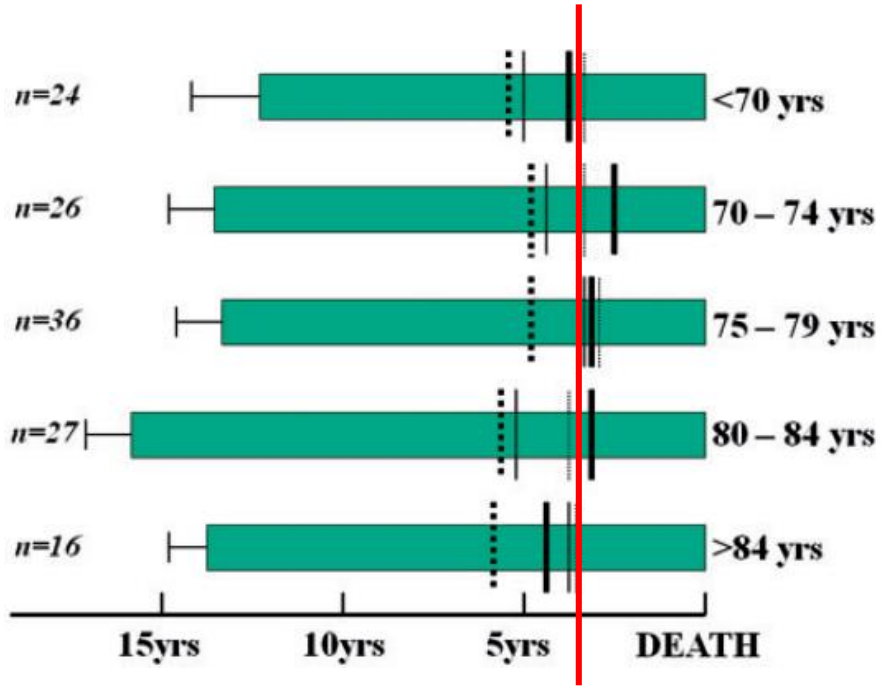
- Age moyen à l'entrée: 63 ans
- Après 20 ans:
  - 74 % des patients sont décédés
  - Parmi les survivants
    - 83% sont déments
    - 81% tombent

Cohorte de 149 patients suivis pendant 20 ans

Hely et al. Mov Disord 2008

Le stade terminal de la MPI

Vis hallucinations
Démence
Chutes fréquentes
Institutionnalisation



5 groupes selon l'âge du décès

Brain Bank de Londres, 129 MP confirmées

Kempster et al, Brain 2010

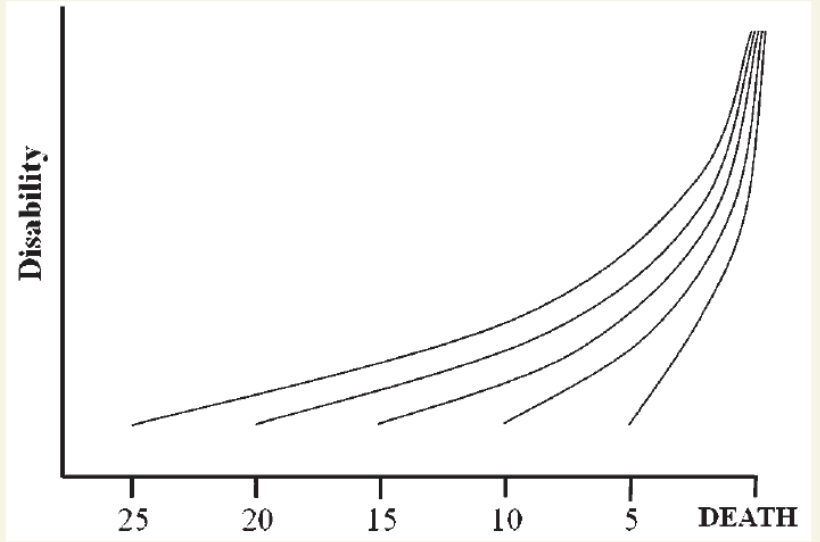


Figure 4 Schematic representation of exponential clinical progression over different disease durations, with clinical disability plotted against disease course in years.

G. Caplain

Traitement

- 3 classes pharmacologiques:
  - Les agonistes dopaminergiques
    - Sélégiline, Rasagiline
  - Les IMAO-B
    - Ropinirole, pramipexole, piribédil, apomorphine, lisuride, bromocriptine
  - La lévodopa
    - Eventuellement en association avec ICOMT.

SFAP

FISP
Fédération francophone
Internationale de Soins Palliatifs

Maladie de Parkinson: mortalité

- Cohorte de 230 patients Norvégiens
  - Suivi de 1993 à 2005
- Survie médiane début des symptômes moteurs: 15.8 ans (2.2 – 36 ans)
- Facteurs prédictifs d'une mortalité précoce
  - Début tardif
  - Sévérité des symptômes moteurs
  - Démence et troubles psychiatriques

Forsaa EB, Neurology 2010

Causes de décès différentes de la population générale

Co-morbidité	Parkinson	Non Parkinson
Démence	26. 2 % (1)	11.7 % (9)
Pneumopathie	22.3 % (2)	14.1 % (4)
Stroke	14.2 % (3)	13.4 % (5)
Cancer	11.1 % (5)	29.6 % (1)
Cardiopathie ischémique	13.4 % (4)	20.7 % (2)

On meurt aussi de la maladie de Parkinson !

SFAP

FISP
Fédération francophone Internationale de Soins Palliatifs

Lethbridge et al. Prog Pall Care 2014
Pennington et al. Park Relat Disord 2010

Causes de mortalité

Parkinsonism and Related Disorders 16 (2010) 434–437

Contents lists available at ScienceDirect

Parkinsonism and Related Disorders

journal homepage: www.elsevier.com/locate/parkreldis

The cause of death in idiopathic Parkinson's disease☆

Susan Pennington [a], Kalyani Snell [b], Mark Lee [c], Richard Walker [d,*]

[a] ST3 Palliative Medicine Marie Curie hospice, Marie Curie Drive, Newcastle upon Tyne, NE4 6SS, UK
[b] SpR Palliative Medicine, Marie Curie hospice, Marie Curie Drive, Newcastle upon Tyne, NE4 6SS, UK
[c] Consultant in Palliative Medicine, St Benedict's Hospice, Monkwearmouth Hospital, Newcastle Road, Sunderland, SR5 1NB, UK
[d] Consultant Physician and Honorary Professor, Department of Medicine, North Tyneside General Hospital, Rake Lane, North Shields, Tyne and Wear, NE28 9NH, UK

A B S T R A C T

Objectives: To identify the cause of death in patients with idiopathic Parkinson's disease (IPD)
Background: Current literature provides little data relating to cause of death in IPD and much is based on the recording of IPD on death certificates.
Methods: All patients under the care of a Parkinson's disease (PD) service who had died between 1999 and 2006 inclusive were identified and further classified into those with IPD according to the UK PD Society Brain Bank Criteria. Details were extracted from the service database and medical notes and further information obtained from the Office for National Statistics (ONS). Corrections were made for data classified using the International Classification of Diseases (ICD) 9 classification (prior to 2001) in order to compare accurately with data classified using ICD 10. Trends in cause of death were identified. Comparative data was obtained from the ONS for a control population.
Results: Of 219 patients on the database who had died, 143 were identified as having IPD. They were more likely to be classified as dying from pneumonia, and less likely as malignancy or ischaemic heart disease, than the control population. Pneumonia was a terminal event in 45%. IPD was recorded on the death certificate in only 63% of patients.
Conclusion: As expected, pneumonia is very often the terminal event. As previously demonstrated, malignancy is uncommon. Death certificate documentation is inadequate in one third of certificates; this has implications for research.

Troubles de la déglutition

- Fréquence « brute »: 12 %

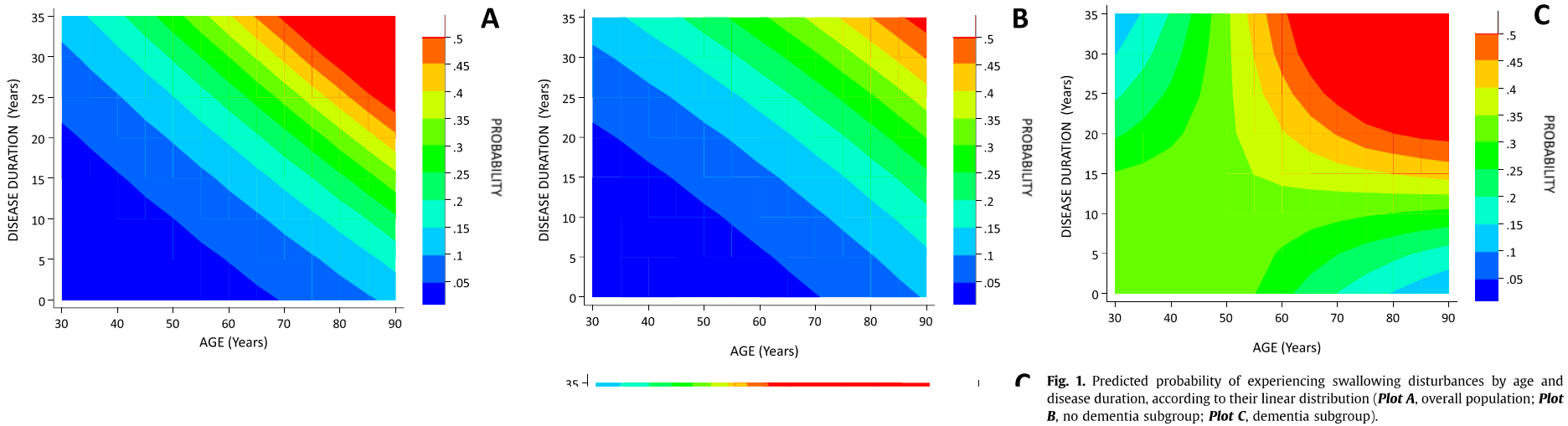


Fig. 1. Predicted probability of experiencing swallowing disturbances by age and disease duration, according to their linear distribution (***Plot A***, overall population; ***Plot B***, no dementia subgroup; ***Plot C***, dementia subgroup).

Population totale

Non dément

Dément

Cereda et al. Park relat disord 2014

Gastrostomie

Parkinsonism and Related Disorders 43 (2017) 110–113

Contents lists available at ScienceDirect

Parkinsonism and Related Disorders

journal homepage: www.elsevier.com/locate/parkreldis

Short communication

Outcome of gastrostomy in parkinsonism: A retrospective study

Clémence Marois [a, 1], Maria Del Mar Amador [a, 1], Christine Payan [b], Lucette Lacomblez [a, b, c, d, e, f], Anne-Marie Bonnet [a], Bertrand Degos [a], Jean-Christophe Corvol [a, c, d, e, f], Marie Vidailhet [a, c, d, e, f], Nadine Le Forestier [a, g], Valérie Mesnage [h], David Grabli [a, d, e, f, *, 2]

A B S T R A C T

Objective: To investigate the indications and the outcomes of gastrostomy tube insertion in patients with parkinsonian syndromes.

Methods: Consecutive patients with Parkinson's disease or atypical parkinsonism, seen in two French tertiary referral movement disorders centers, that received gastrostomy tube insertion (GTI) for feeding between 2008 and 2014 were included in this retrospective study. Data regarding clinical status, indications and outcomes were retrieved from medical files. The main outcome measure was survival duration following gastrostomy insertion according to Kaplan-Meier estimate. Cox analysis was also performed to identify factors associated with survival. Finally, we described short term and long term adverse effects occurring during the follow-up period.

Results: We identified 33 patients with Parkinsonism that received GTI during the study period. One patient was excluded from the analysis because of missing data. Among 32 patients, 7 (22%) had Parkinson's disease and 25 (78%) had atypical parkinsonism. The median survival following the procedure was 186 days (CI 95% [62–309]). In Cox model analysis, total dependency was the only factor negatively associated with survival (HR 0.1; 95% CI [0.02–0.4], p = 0.001). Pneumonia was the most frequent adverse event.

Conclusion: In this sample of patients with parkinsonian syndromes, survival after GTI was short particularly in totally dependent subjects. Aspiration pneumonia was not prevented by GTI. A larger prospective study is warranted to assess the potential benefits of gastrostomy, in order to identify the most appropriate indications and timing for the procedure.

SFAP

FISP
Fédération francophone Internationale de Soins Palliatifs

Le « OFF »

- Réapparition des signes de Parkinsonisme
  - « Blocage » moteur
  - Tremblements
  - Dystonies/crampes
  - Anxiété/dépression
  - Fatigue
  - Douleurs, souvent diffuses
- Liées au sousdosage

SFAP

FISP
Fédération francophone
Internationale de Soins Palliatifs

Prévenir le « OFF »

- Tout l'enjeu du traitement… Quelque soit le stade évolutif
  - Le traitement anti parkinsonien peut être considéré comme
    - « Antalgique »
    - « Myorelaxant »
    - « Anxiolytique »
    - Préventif de la grabatisation
- Si la voie per os n'est plus possible, s'interroger sur l'utilisation de l'apomorphine à la seringue électrique

SFAP

FISP
Fédération francophone
Internationale de Soins Palliatifs

Apomorphine

- Agoniste dopaminergique injectable
- Emétisant, et doit donc être utilisé sous couverture d'un antiémétisant instauré 48h avant
- Très efficace
- Petites doses
- Peut donner des troubles cognitifs

SFAP

FISP
Fédération francophone
Internationale de Soins Palliatifs

Autres traitements

- Les benzodiazépines
  - plutôt myorelaxantes:
    - Tétrazépam, Clonazépam
  - Plutôt anxyolitiques
    - Alprazolam, prazépam
- Les anti épileptiques
  - Gabapentine, prégabaline…..

SFAP

FISP
Fédération francophone Internationale de Soins Palliatifs

En pratique

- Le traitement anti parkinsonien ne doit pas être arrêté, tant que faire se peut
- Les troubles de la déglutition sont une complication évolutive fréquente
- Il existe des alternatives au traitement per os

SFAP

FISP
Fédération francophone
Internationale de Soins Palliatifs

Merci de votre attention

G. Caplain