Southern Health NHS
NHS Foundation Trust

Medical Secretariat
Lymington New Forest Hospital
Wellworthy Road
LYMINGTON Hampshire
SO41 8QD

Fax: 01590 663068
www.southernhealth.nhs.uk

1 October 2012

Parkinson's Disease Clinic: 21 September 2012

Dr L Mayo
Waterfront And Solent Surgery
Jones Lane
Hythe
Southampton
SO45 6AW

Dear Lesley

MR JOHN DEXTER

Diagnosis:
1. Benign essential tremor, possible left-sided Parkinson's

Plan:
1. For DAT scan
2. GP to try beta-blocker, suggest Propranolol 10 mg tds initially, increasing up to 160 mg daily (which can be given as a long-acting drug). If unable to tolerate, could use a smaller dose of a beta-blocker before highly stressful events. Could also try Primidone 6.25 (quarter of a 25 mg tablet) daily, if able to tolerate drowsiness

Thanks for asking me to see this charming 72 year old, right-handed, retired management consultant, who describes a history of shaking which began many, many years ago, when he was performing in an operetta and, likewise, he describes, over 10 years ago, being unable to take notes at a meeting because of a right-handed shake. Gradually, this has deteriorated and he has also been aware that he is unable to use a fork with his left hand, because of shake. When they ran a bed and breakfast, he was unable to clear the breakfast plates or serve a fried egg!. In addition to this, over the last year, he has noticed that he has developed a left-handed tremor at rest and also has some jaw tremor. On direct questioning, he has a reduced sense of smell, but this may be due to nasal polyps. He also has a little bit of bilateral drooling. On direct questioning, otherwise, there were really very few other symptoms. He had some prostatism which has been treated with an alphablocker. His mobility is fine, he has no difficulty getting in and out of bed or turning over and, in fact, he demonstrated by lying on the floor how easy it was for him to manage. He has noticed difficulty with dexterity of his hands, but this is largely because of shaking, rather than bradykinesia. His writing has deteriorated, largely because of jerking and shaking, rather than because of micrographia. He continues to drive.

On examination he looked well. He was very agile. Pulse 60, regular. Blood pressure 145/90 sitting; 143/76 standing. There were no other abnormalities in the cardiorespiratory system. The abdomen was not examined. He had bilateral knee effusions, but otherwise his joints were fine. On examination of his nervous system, he had an obvious resting

tremor in the left hand, but no other really obvious features of parkinsonism. His gait was completely normal. The tremor in his left hand was actually a little coarse, but could be parkinsonian. A glabellar tap was negative. The rest of his cranial nerves were normal, including external ocular movements and saccades. In his upper limbs, power and tone were normal, although there was a mild increase in his tone bilaterally with recruitment. It certainly was not worse on the left. Reflexes were normal and he had an obvious intention tremor bilaterally, but a resting tremor on the left. In his lower limbs, power, tone and reflexes were normal, plantars were downgoing and sensation was normal. He had a 4-step 180° turn and a negative Romberg's. Examining him for bradykinesia, using finger and thumb opposition, it was completely normal on the right hand side. On the left hand side it was largely normal, although notably slower than on the right. His gait was, as I mentioned, normal.

In summary, I think, therefore, he has a longstanding benign essential tremor which, in itself, is troublesome, but said to benign to distinguish it from Parkinson's. It will deteriorate and I think it is perfectly reasonable for him to take a beta-blocker. Obviously we need to watch the effects on his blood pressure, given he is already on an alpha-blocker, and I have outlined the doses above. Primidone may be useful, as it may block the feedback cycle, which may contribute to tremor, but, in my experience, people are usually unable to tolerate the drowsiness. ***However***, I am concerned that he certainly does have a resting tremor in the left hand, which is not typical of essential tremor and, in addition to that, has some bilateral increase in tone. I do wonder whether there is not an element of parkinsonism here and after discussion we agreed that he would go to Southampton and have a DAT scan to look at his in more detail, as it would help us manage things in future without doing blind drug trials. I will review him again in four months to see how things have gone.

With best wishes.

Yours sincerely

Dictated by and checked electronically, but sent unsigned

Dr Gill Turner
Community Consultant Geriatrician