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JPF/smd

21 August 2015
(Clinic 19 August 2015)

Dear Dr Ramsey

Re: Mr John Dexter DOB 1/9/40
Seapie Corner Alma Place Yarmouth PO41 0QQ

It was a pleasure to meet Mr Dexter in the clinic today as well as his two nice friends who accompanied him. The short answer to the diagnostic issues in this man's case is that I think he does have signs of early idiopathic Parkinson's disease but also features of benign essential tremor which have been evident for a number of years. It is not terribly uncommon for the two conditions to co-exist or for Parkinson's disease to emerge from features that were not at first characteristic of the condition. In terms of disability, it is probably the action and postural tremor that is more of a problem to him but what is visible and in that sense more the more continuously evident to him, is the parkinsonian rest tremor. It is possible that with some drug manipulation that we might be able to improve the latter although of course appropriate treatments have been tried previously. I will come to all of that at the end of this letter.

He is a 74 year old right handed man. He dates tremor back five or six years and that seems to be borne out by the Primary Care summary which you kindly enclosed with your letter which I looked at after he left which indicates that he had consulted his GP with tremor in March 2009 where a diagnosis of benign essential tremor was made. A comment was also included to the effect that he had such a tremor for many years, presumably to a lesser degree. He told me that various treatments were tried but not effective and this included primidone and a β-blocker.

In due course he was referred to see my friend and colleague, Gill Turner at Lymington, close to where he then lived in the New Forest. She sent him for a DaTScan, an investigation that I generally am not in favour of and frown upon, although in Mr Dexter's case he is an example of the type of patient where the investigation is most likely to be of benefit. It sounds as if it was, in that it showed some reduced striatal uptake that was asymmetrical worse on the right hand side which of course would fit with his predominantly left sided parkinsonian features. Dr Turner prescribed rasagiline and Mr Dexter's recollection now is that this had no effects positive or negative and that is not particularly unusual. He subsequently was put onto levodopa in the form of Madopar and when he took this drug he said that it did not really help him and he felt "slight weird" so after a while he stopped it; in fact he stopped the rasagiline as well I believe. This withdrawal of medication also had no effect on his symptoms as far as I understand it. He subsequently has resumed the treatment and is now taking Madopar 12.5/50 one capsule three times a day. He does not think it is really helping although it is not making him feel peculiar any more either.

Re: Mr John Dexter DOB 1/9/40

He does not report any particular problems with slowness of movement or loss of function in his upper limbs. His walking and balance are reasonably good and apart from the tremor he feels fit in himself. He has noted a slight reduction in sense of smell over recent years but he still can smell things. He is an ex-smoker having given up in 1972 and he drinks about 20-30 units of alcohol per week.

In his past history he has had a number of deep vein thromboses and then a pulmonary embolus. He is now on lifelong warfarin. He was diagnosed with a prostate tumour around the turn of the year following a biopsy. He is now on medication called combodart.

He is a retired management consultant having worked in a number of industries all over the world. He moved to the Island after he lost his wife a year or so ago having previously lived in Hythe.

On examination, he had pretty good gait and balance. There was continuous rest tremor which was more marked on the left than the right and some loss of arm swing on the left when walking. Examination on the couch revealed action and postural tremor which emerged as the rest tremor gave way due to voluntary activity. This tremor was much more symmetrical. There was marginal bradykinesia of rapid fine finger movements on the left and there was some cogwheeling and slight stiffness of the left wrist compared with the right. There was no weakness, there were no reflex changes and plantar responses were flexor. There was no significant impairment of his postural reflexes.

I think that in view of the physical findings today and the history I obtained, that it is likely that he has tremor predominant idiopathic Parkinson's disease that has emerged in the context of background benign essential tremor. The management of the tremor is difficult. One therapeutic extreme that one could consider is stereotactic neurosurgery although I think the degree of tremor and the way it is affecting him would not merit that course of action at the moment. Pharmacological trials so far have not been helpful and I explained to him that it can be very difficult to treat tremor of all sorts and the treatment that generally works for essential tremor has not helped him (primidone and β-blockers) and that for Parkinson's disease, tremor is the least responsive of the three main features (tremor, bradykinesia and rigidity). I think, however, it would be worth trying him on more levodopa. What I would suggest is that next time he sees you for a repeat prescription you convert him directly from the Madopar he is now taking over to Sinemet taking the 12.5/50 tablets which are exactly the same strength. Once on this he should then convert to taking the drugs morning, lunchtime and in the early evening rather than at bed time for the last dose and that each dose should be increased to 1.5 tablets but in turn, starting with the morning dose. After two or three days go to 1.5 morning and lunchtime and then two or three days later, 1.5 tablets morning, lunch time and tea time. A further cycle of such escalation should take place a week later until he is on 2 tablets three times a day and further escalations of this type all the way up to 2 tablets three times a day which should be achieved over the next month or so. He is going to take note of whether this has any significant effects on him positive or negative and will contact my secretary here to let her know. I think it would be unnecessary for him to travel all the way from Yarmouth to tell me the results of his experiment and I can write to you and him with some advice.

In the fullness of time if that does not work, we may need to consider other options and he understands that one cannot guarantee that anything will work for tremor in a helpful way.

Yours sincerely

Dictated but sent unsigned to expedite

Dr Jonathan P Frankel
Consultant Neurologist

cc Mr J Dexter