Balancing Sleep and Motor Symptoms: A Case Report of Managing Insomnia in Parkinson’s Disease

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Abstract

Objective: The management of insomnia presents as a challenge for many Parkinson’s disease patients and their care teams. Insomnia in patients with Parkinson’s disease may be attributed to the side effect profiles of several medications that are commonly used to treat Parkinson’s disease. Additionally, the progression of the disease is associated with disruption of circadian rhythms, nocturnal symptoms, blurred melatonin secretion, and late melatonin onset all of which can contribute to worsening sleep. This case aims to demonstrate how a patient’s medication profile, which included several Parkinson’s disease medications, could be optimized to control motor symptoms and reduce the occurrence of insomnia through the use of comprehensive medication review services.

Case report: A 71-year-old male with Parkinson’s disease was developing severe symptoms of tardive dyskinesia due to his chronic carbidopa/levodopa/entacapone therapy. In order to address the tardive dyskinesia, entacapone was discontinued and amantadine was initiated to offset the stiffness and bradykinesia that he was experiencing. The addition of amantadine resulted in nightmares and poor sleep quality, even though he was already taking mirtazapine to treat his depressive status and insomnia. The patient’s healthcare team collaborated with a clinical pharmacist to adjust the Parkinson’s disease regimen and optimize mirtazapine dosage, all of which resulted in notable improvements in his reported insomnia and quality of life.

Discussion and Conclusion: Optimizing motor control in patients with Parkinson’s disease, while mitigating insomnia side effects of medications, can be a very complex process. The main goal for patients who encounter this problem is to enhance their current Parkinson’s disease therapy by identifying medications that can contribute to insomnia and to optimize the regimen to address the patient’s symptoms and disease progression. Alternative treatments to manage insomnia in patients with Parkinson’s disease should also be considered, including the addition of melatonin and/or the use of bright light therapy.

Keywords: Insomnia • Bradykinesia • Parkinson’s disease • Tardive dyskinesia • Mirtazapine • Amantadine • Entacapone • Motor symptoms • Sleep • Melatonin • Bright light therapy • Comprehensive medication reviews

Abbreviations: PD: Parkinson’s Disease; L-Dopa: Levodopa; COMT: Catechol-O-Methyltransferase; SNF: Skilled Nursing Facility; TD: Tardive Dyskinesia; MDD: Major Depressive Disorder; BLT: Bright Light Therapy

Introduction

Parkinson’s Disease (PD) is commonly referred to as a disorder of the extrapyramidal system [1]. Its diagnosis requires the presence of bradykinesia and at least one of the following hallmark motor features: muscular rigidity, resting tremor, and/or postural instability [2]. Although the pathogenesis of PD is not explicitly known, evidence suggests that there is an association between the degeneration of dopaminergic neurons in the substantia nigra region of the brain and the severity of cardinal motor features [3,4]. Dopamine is a neurotransmitter that is critical for muscle coordination and movement; therefore, a reduction in dopamine results in motor impediment [4]. Levodopa (L-dopa) is a precursor to dopamine and functions as dopamine replacement in patients with motor disorders [5]. Carbidopa is a medication that prevents peripheral metabolism of L-dopa by directly inhibiting the dopa decarboxylase enzymes, therefore providing additional treatment efficacy when used in conjunction with levodopa [5]. The carbidopa/levodopa combination is considered the standard of PD therapy [5]. Unfortunately, long-term L-dopa therapy can result in a variety of motor complications, including dose “wearing off” and peak-dose dyskinesias [8]. With each year of L-dopa therapy, a patient’s risk of developing motor fluctuations or dyskinesias increases by 10% [7]. The catechol-O-methyltransferase (COMT) inhibitor, entacapone, can be a useful add-on therapy to help attenuate motor fluctuations in carbidopa/levodopa-treated patients [8]. On the other hand, entacapone can contribute to the early development of dyskinesias (25% occurrence rate) [9]. Amantadine is an agent that is used in PD to treat dyskinesias associated with peak-dose carbidopa/levodopa and is commonly added to a medication regimen for the treatment of moderate to severe stages of PD.

However, amantadine is associated with various anticholinergic side effects, such as orthostatic hypotension (≥ 29%), dizziness (≥ 29%) and insomnia (5-10%) [10]. The inability to initiate or maintain sleep is a frequent symptom in patients with PD [11]. Insomnia is likely to occur as the disease progresses; the increase in nocturnal symptoms of rigidity, motor fluctuations, and pain often disrupt sleep [12]. Additionally, use of medications such as selegiline, amantadine and other drugs with anticholinergic properties can

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Contribute to insomnia in patients with PD [13]. The disruption of circadian rhythms has also been observed in patients with PD [13]. Accompanying this is a blunting of melatonin secretion which correlates with symptoms of excessive daytime sleepiness [14]. According to Bolitho et al., patients with PD that were treated with dopaminergic medications were found to have a phase-advanced melatonin onset (i.e., an earlier shift in circadian rhythm) relative to sleep onset, reinforcing the postulation that dopamine therapy may play a role in circadian disruption [8,13]. The purpose of this case report is to highlight these concepts and identify how to optimize the medication profile of a patient with PD to control motor symptoms and reduce the occurrence of insomnia through the use of comprehensive medication review services.

Case Report

The following information for this patient case report was collected through discussions with the patient’s healthcare team and use of electronic health records. Seeking assistance in treating the patient’s uncontrolled symptoms, the provider consulted a clinical pharmacist about medication management for PD. A 71-year-old male with a past medical history of benign prostatic hyperplasia, hyperlipidemia, PD, type-2 diabetes, hypertension, atrial fibrillation, generalized anxiety disorder, Major Depressive Disorder (MDD), and dementia was admitted to a Skilled Nursing Facility (SNF). SNF admission occurred after a fall at his nursing home and for the management of severe Tardive Dyskinesia (TD) due to chronic treatment with carbidopa/levodopa/entacapone. As a first step, the patient’s entacapone therapy was discontinued to counter the severity of his TD symptoms. Unfortunately, the removal of entacapone worsened his immobility. Amantadine 100 mg was then initiated once daily in the morning to address the stiffness and bradykinesia that he was experiencing. The patient was also taking ropinirole 2 mg for PD and mirtazapine 15 mg for mood, sleep management, and weight gain. A full list of the patient’s medications was reviewed upon SNF admission can be found in Table 1 and a detailed timeline following the patient’s case can be observed in Figure 1. After the addition of amantadine, the patient continued to experience TD symptoms; however, they were not as burdensome as they were before entacapone was discontinued. He began having severe nightmares the day after his first amantadine dose and routinely slept for only 2 hours every night for the next two weeks. At this point in time, the provider consulted the clinical pharmacist who recommended decreasing the dose of mirtazapine from 15 mg to 7.5 mg to address the patient’s issues with sleep in addition to his MDD.

Almost one week later, the patient experienced a second fall. He sustained Table 1. Comprehensive list of medications: This table provides an overview of the patient’s medication list and medication changes made.

<table>
<thead>
<tr>
<th>Medications</th>
<th>Medication Changes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cholecalciferol 1000-unit tablet once daily</td>
<td>Unchanged</td>
</tr>
<tr>
<td>Ketoconazole 20 mg/mL medicated shampoo as directed</td>
<td>Unchanged</td>
</tr>
<tr>
<td>Ropinirole 2 mg tablet once daily</td>
<td>Unchanged</td>
</tr>
<tr>
<td>Ketoconazole 20 mg/mL topical cream as needed</td>
<td>Unchanged</td>
</tr>
<tr>
<td>Polyethylene glycol 3350 17000 mg powder as needed</td>
<td>Unchanged</td>
</tr>
<tr>
<td>Amantadine 50 mg/mL oral solution 100 mg once daily in the morning</td>
<td>Originally at 100 mg, then decreased to 50 mg, then increased to 75 mg</td>
</tr>
<tr>
<td>Amlodipine 10 mg tablet once daily</td>
<td>New therapy initiation</td>
</tr>
<tr>
<td>Carbidopa/Levodopa 50-200 mg ER tablet once daily</td>
<td>Unchanged</td>
</tr>
<tr>
<td>Entacapone 200 mg tablet once daily</td>
<td>Discontinued</td>
</tr>
<tr>
<td>Mirtazapine 15 mg tablet once daily at bedtime</td>
<td>Originally at 15 mg, decreased dose to 7.5 mg</td>
</tr>
</tbody>
</table>

Figure 1. Patient case timeline: This figure visualizes the order of the events detailing this patient case, including key events that led to medication changes and the patient’s status report following the medication changes.
no injuries from the fall but his SNF stay was extended. The dose of amantadine was reduced to 50 mg once daily for better management of dyskinesias and to reduce the risk of orthostasis. Following the fall incident, the patient had a resting blood pressure of 159/94 mmHg. His healthcare provider initiated amlodipine 10 mg once daily to address his elevated blood pressure. Staff members who followed up three days after the fall incident and medication adjustments reported that the patient’s sleep quality significantly improved and that he was experiencing less dyskinesia. Five days following the status improvement (four weeks after addition of amantadine), the patient began exhibiting severe bradykinesia and required additional help for movement. Subsequently, the clinical pharmacist determined that the 50 mg dose of amantadine lacked the therapeutic efficacy to treat the patient’s bradykinesia and suggested to increase the dose to 75 mg while being mindful of potential insomnia side effects. Following the dose increase, the patient regained his motor functionality, but his insomnia symptoms returned, although to a lesser degree than before. The patient’s healthcare team, in collaboration with a clinical pharmacist, adjusted the patient’s PD medications in consideration of side effect profiles and of the patient’s newly initiated antihypertensive therapy, which all may have contributed to better management of insomnia. The patient and provider have determined that additional non-pharmacological therapies may be clinically warranted, and plans are being made to trial those options. The healthcare team decided to continue to evaluate medications and weigh risks versus benefits as the patient progresses.

Discussion

The main goal for this patient was to optimize his current PD regimen and improve his quality of life by addressing his ongoing motor symptoms and reducing medication side effects. In this particular patient case, entacapone was causing TD, while amantadine and mirtazapine were contributing to insomnia. Amantadine at high doses (300 mg if monotherapy or 200 mg if on other antiparkinson drug(s)) is stimulating due to its ability to enhance dopamine release [15]. As mentioned before, amantadine is used to manage tremor, rigidity, bradykinesia, and, most commonly, L-dopa-induced dyskinesia. Although its mechanism of action is not entirely clear, the drug is known to enhance dopamine release from pre-synaptic terminals and inhibit NMDA receptors [12]. Common side effects of amantadine include syncope (< 29%), psychosis (< 25%), dizziness (< 29%), orthostatic hypotension (< 29%), insomnia (5-10%), abnormal dreams (1-5%) and dry mouth (1-16%) [10]. Elderly patients are particularly prone to developing confusion with amantadine use, but dividing amantadine into two daily doses of the IR formulation can help reduce CNS effects [10]. In this case, amantadine was added to treat the patient’s L-dopa-induced dyskinesia; however, at the same time, it contributed to the worsening of his sleep quality. Orthostatic hypotension related to amantadine therapy could have contributed to the patient’s second fall at the SNF. Based on these clinical observations, an initial dose reduction from 100 mg to 50 mg was proposed.

This lower dose of amantadine might have lessened the patient’s risk of insomnia and orthostatic hypotension; however, 50 mg is considered to be sub-therapeutic for the treatment of motor symptoms [10]. Decreasing the dose of amantadine resulted in a return of the patient’s bradykinesia. To optimize the therapeutic efficacy of amantadine while trying to balance the risk of side effects, the clinical pharmacist recommended a modest dose increase from 50 mg to 75 mg. Although current literature only supports the use of amantadine 100 mg to treat peak-dose levodopa, amantadine 75 mg proved to be a minimum effective dose for this patient through trial and error, with a clinically guided approach. Amantadine is primarily excreted unchanged (80-90%) in the urine and avoids metabolism through the liver [15]. Phase III studies found that healthy older males (≥ 60 years) have a significantly increased average half-life elimination of 29 hours compared to 18 hours in patients with normal renal function [18]. This patient may experience diminished clearance of amantadine because of his low body weight and his age, so dose modifications should be prioritized. This careful titration strategy could be utilized in older patients to obtain clinical benefits while mitigating risks due to increased sensitivity to medication effects. In this particular patient case, the patient’s bradykinesia improved with the dose increase from 50 mg to 75 mg.

The rationale for decreasing the mirtazapine dose from 15 mg to 7.5 mg was to promote sleep. Mirtazapine is an antidepressant that acts as a stimulant at high doses and as a histamine receptor antagonist at low doses [17]. It enhances noradrenergic and serotonergic activity by antagonizing adrenergic auto receptors and serotonin receptors [4]. Mirtazapine has preferentially high affinity for histamine-1 receptors at low doses, which results in a histaminic and serotonergic blockade that contributes to sedation [9]. Higher doses are expected to provide a more noradrenergic effect and, thus, a higher degree of activation, leading to benefits in maintaining wakefulness [17, 18]. The patient in this case benefited from the decreased dose of mirtazapine at bedtime because of its sleep-promoting sedative properties.

Another factor possibly contributing to the patient’s sleeping problems was his uncontrolled hypertension. The patient’s blood pressure reading of 159/94 mmHg indicated that he was hypertensive and not at goal per the American College of Cardiology and American Heart Association Guidelines [19]. The patient’s medication list (Table 1) did not include antihypertensive medications prior to entering the SNF. Hypertension can cause complications that contribute to difficulty in sleeping; chronic insomnia can also contribute to higher risk of hypertension [20]. The patient was started on amlodipine 10 mg for better blood pressure control and sleep quality management. It is important to note that elderly and frail patients are more sensitive to blood pressure changes, especially when taking antihypertensive therapy, and they should be counseled to get up slowly to avoid syncope due to orthostatic hypotension.

Although improvements have been made to better manage this patient’s insomnia, additional low-risk therapies for sleep maintenance should be discussed. Melatonin is a hypothalamic agent that can exert positive benefits for sleep for patients with PD who are experiencing insomnia, as its mechanism of action is to regulate the sleep-wake cycle [21]. Circadian rhythm disruptions in patients with PD can be addressed with melatonin’s chronobiotic properties. Doses exceeding 5 mg rarely show greater benefit, but when used as a chronobiotic (i.e., an agent that can cause phase adjustment of circadian rhythms), melatonin doses can be significantly lower (0.5 mg or less) to avoid sedation especially if given during the day time [13].

Another low-risk alternative for sleep aid is a nonpharmacological treatment known as Bright Light Therapy (BLT). BLT works by stimulating cells in the retina that connect to the hypothalamus, which helps control circadian rhythms [22]. Morning use of BLT has been found to be effective in treating sleep problems associated with circadian outcomes and insomnia symptoms. A caveat is that effects of BLT are only maintained with ongoing therapy [13].

Due to the complexity of this patient’s comorbidities, the medication changes required close monitoring for patient response and side effects. Such monitoring would not have been possible without the collaboration of the entire healthcare team. A general approach to balancing medication side effects with therapeutic efficacy is to adjust one medication at a time and assess patient
progress. The overall pharmacotherapy recommendations specific to this patient care are summarized in Table 2.

**Conclusion**

In conclusion, controlling motor symptoms in PD while mitigating side effects of insomnia is a medication balancing act. Due to the variability of side effects of PD medications, doses should be fine-tuned to the patient’s symptoms, and only one medication should be adjusted at a time. For the patient discussed in this case, although his insomnia symptoms weren’t entirely alleviated, there was an observed improvement in the severity of his insomnia after adjustments were made. These dose changes should be continued throughout the course of his therapy as necessary to address the most pertinent side effect concern at the time, as it may not be possible to completely avoid all medication adverse events. Alternative therapies, including BLT and melatonin, are also being considered as add-on therapies for the treatment of insomnia in this patient with PD.

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**References**
