

## INFORMATION FOR PROSPECTIVE PATIENTS Pallidotomy Programme For Parkinson's Disease

The following contains information which will be of value to patients considering coming to Cape Town for stereotactic treatment of Parkinson's Disease.

Since surgical treatment will not benefit certain patients with Parkinson's disease, and in order to prevent, as far as possible, unnecessary journeys to Cape Town for pre-operative assessments, we have devised a questionnaire for you to complete and require that you send a video of the patient suffering from Parkinson's Disease. This will give us a preliminary idea of the patient's condition. If at all possible, a medical report from your referring family doctor and neurologist should be submitted as well.

The completed **questionnaire**, **video** and **medical reports** should be sent to Dr R L Melvill.

Once we have received and studied this information we will contact you to let you know whether or not we can expect you to benefit from surgical treatment.

Should it be decided that it would be worthwhile coming to Cape Town, the program would include evaluation by a neurologist as well as functional assessment by the surgical team, Drs Melvill & Baxter. One normally expects that patients would spend about a week in Cape Town. During this time it is preferable that the patient is accompanied by a helper. Courtesy accommodation close to the hospital may be available for the patient's family members if necessary.

If there are any points which require clarification please do not hesitate to make contact with us.

### ADVICE ON SUBMISSION OF VIDEO (VCR) TAPE OF PATIENT

In order to assist in the selection of patients who live far from Cape Town and to avoid unnecessary expense of travelling just for an evaluation it is prudent to include a video of the patient's condition. Because the symptoms in Parkinson's Disease fluctuate, it is important to see the patient when symptoms are at their worst (i.e. when the patient is "off") and when the medication is most effective in controlling the symptoms (i.e. when the patient is "on").

When the patient is "off":

*Note: Do not confuse an "off" period with the "freezing" which occurs when the patient is seemingly completely immobile.*

1. The patient should be sitting in an upright chair with hands at rest in his/her lap.
2. The patient should then speak a few sentences, starting with "My name is....."
3. If there is a tremor, show a close-up view.



4. Then the patient with the worst arm out-stretched, must make a fist and then open and close the fist a number of times as quickly as possible.



5. This should be repeated with the least affected hand.

6. With the worst arm again out-stretched, the patient should tap his finger and thumb together a number of times as quickly as possible.



7. This should be repeated with the least affected hand.

8. The patient should fold his/her arms and rise from the chair.

Note: If the patient is unable to get up in this way, he/she should get up from the chair as normal, with assistance if necessary.

9. The patient should then walk three or four metres towards the video camera, with his arms unfolded and held in whatever position he is accustomed to using when walking.

*Note: If the patient is unable to walk without assistance, whatever help is usually given may be shown on the video.*

10. All of the above steps should be repeated when the patient is in the "on" phase.

## CLINICAL HISTORY

### PERSONAL DETAILS

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Sex: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: (H) \_\_\_\_\_ (W) \_\_\_\_\_ Fax: \_\_\_\_\_

Contact person in Cape Town - Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

GP: (Name) \_\_\_\_\_ Specialist: (Name) \_\_\_\_\_

(Address) \_\_\_\_\_ (Address) \_\_\_\_\_

Original referral: family doctor (GP)  \_\_\_\_\_  
(specify) specialist  \_\_\_\_\_  
friend / family  \_\_\_\_\_  
other  \_\_\_\_\_

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### CLINICAL DETAILS:

#### **Other illnesses:**

Please list any other **current** or **past** illnesses, including any operations that you have had:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If you have (or have had) any of the following, tick the relevant box:

Heart disease  High blood pressure  Pace maker   
Bleeding disorder  Stroke  Diabetes   
Brain surgery  (Please specify) \_\_\_\_\_

Have you had a CT scan or MRI scan of your brain before? \_\_\_\_\_

Please specify (date & findings) \_\_\_\_\_

Do you regularly take Aspirin or Aspirin-related drugs? \_\_\_\_\_ If yes, specify \_\_\_\_\_

Please list the medications (and doses) you are currently taking

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are you allergic to any medications? \_\_\_\_\_ If yes, specify \_\_\_\_\_

Are you RIGHT / LEFT handed? \_\_\_\_\_

### PARKINSON'S DISEASE - history

When did your Parkinson's disease start? \_\_\_\_\_ In which part of the body? \_\_\_\_\_

Which side of your body is **now most** affected? \_\_\_\_\_ ... / 2

Are you confined to bed \_\_\_\_\_, wheelchair \_\_\_\_\_, or housebound \_\_\_\_\_, or needing occasional help only \_\_\_\_\_?  
 Do you require assistance at night? \_\_\_\_\_ Do you require permanent assistance? \_\_\_\_\_  
 If yes, specify (family members / employed assistance) \_\_\_\_\_

Do you have any of the following?

(Please circle your response and elaborate if Y)

- Problems with walking Y / N \_\_\_\_\_
- Freezing Y / N \_\_\_\_\_
- Difficulty turning in bed Y / N \_\_\_\_\_
- Difficulty in standing up Y / N \_\_\_\_\_
- Balance problems Y / N \_\_\_\_\_
- Severe falling tendency Y / N \_\_\_\_\_
- Problems with swallowing Y / N \_\_\_\_\_
- Problems with your speech Y / N \_\_\_\_\_
- Memory problems Y / N \_\_\_\_\_
- Depression Y / N \_\_\_\_\_
- Muscular pain / cramps Where? \_\_\_\_\_
- Dyskinesias (involuntary withing movements) Where? \_\_\_\_\_

Please describe for each limb separately, the present severity of shaking, stiffness, slowness of movement and involuntary movements:

	none = 0	mild = 1	moderate = 2	severe = 3
	Shaking (Tremor)	Stiffness (Rigidity)	Slowness of movements (Bradykinesia)	Involuntary movements (Dyskinesia)
Head	_____	_____	_____	_____
Right arm	_____	_____	_____	_____
Right leg	_____	_____	_____	_____
Left arm	_____	_____	_____	_____
Left leg	_____	_____	_____	_____

What are your greatest problems in daily activities? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Other comments \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Did you answer this questionnaire without aid? \_\_\_\_\_ DATE \_\_\_\_\_ SIGNATURE \_\_\_\_\_