

Primary Care Neurology Society Meeting

Conference details: 6 November, 2008; Cardiff, UK. **Reviewed by:** CAH Fisher, The Marches Surgery, Leominster, UK. AJ Larner, WCNN, Liverpool, UK.

The recent meeting of the Primary Care Neurology Society (P-CNS; www.p-cns.org.uk), which seeks to develop links between primary and secondary care in order to optimise the care and management of patients with neurological disorders, covered a wide variety of subjects in lectures, debate, and 'breakout sessions'.

Pain is a big part of GP life. Professor Joanna Zakrzewska ("Pro-Zak") gave a comprehensive overview of facial pain and its management, reporting a prevalence of 12–15% and stressing the importance of differentiating dentoalveolar, neuropathic, oral and other pain, since this determines the appropriate referral pathway. She focused specifically on four conditions and the terms that patients often use to describe their pain: temporomandibular joint dysfunction is often 'dull and nagging', burning mouth syndrome (BMS) is 'burning and tingling', persistent idiopathic facial pain is often 'nagging' and trigeminal neuralgia (TN) is 'sharp and shooting' and sometimes likened to electric shocks. Patients often have other pain syndromes, such as irritable bowel syndrome, and 'hypervigilance' for physical symptoms is common. Patient reassurance and education, for example with leaflets, were common themes in the management of all these conditions, along with identification of comorbidity such as depression which may merit treatment in its own right. As for pharmacotherapy, though often used (e.g. tricyclics, SSRIs) there is little compelling evidence in terms of randomised controlled trials, the best available being for carbamazepine and oxcarbazepine in TN (guidelines are available, e.g. *European Journal of Neurology* 2008;15:1013-28) and clonazepam in BMS. Cognitive behaviour therapy is an option, although access is limited.

Also on the subject of pain, Mark Ritchie spoke on chronic non-malignant pain. A useful overview of 'yellow flags' included strategies for combating commonly held misbeliefs such as that all pain must resolve before resuming work or activities, and that pain is harmful, which leads to fear avoidance behaviour. The use of pain diaries was promoted, requiring patients to score their pain daily, and list one positive and one negative experience each day, thereby encouraging linkage between psychological state and pain experience. Diaries can also allow patients to avoid displaying pain behaviour ('catastrophising') at doctor consultations, by referring to pain levels over a period of time.



Venue: Welsh Institute of Sport, Cardiff.

Dementia and mild cognitive impairment (MCI) were addressed by Roy Jones. His advice regarding the general assessment of patients with memory complaints in primary care was: history taking, including from a reliable informant, especially focusing on medication use (anticholinergic drug effects are an important cause of non-degenerative MCI) and alcohol consumption; clinical examination; and then investigations. Treatment of a low vitamin B12 level in these patients was generally found to produce no change at all. As regards cognitive tests, MMSE was advocated if GPs were comfortable with this, although it has

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been thought too long for use in the primary care setting and interpretation is difficult. A recent paper suggested that other screening tests such as GPCog and MiniCog might be helpful in primary care (*International Psychogeriatrics* 2008;20:911-26).

A lively debate on the role of placebo as an active treatment for neurological conditions resulted in a change of mind in favour for a few delegates about the acceptability of this approach. Edzard Ernst argued that since the placebo effect is part of the non-specific effect of all medications, in addition to the desired pharmacological effect, the placebo effect is a bonus which negates the point of prescribing a placebo on its own. However, as Andrew Lawson made clear, the ethical debate is far

from simple, and no doubt will continue to run.

Breakout sessions examined stroke and TIA, MS relapse, anxiety and depression, and movement disorders. Since 40% of strokes are recurrent events, Hamsaraj Shetty pointed out that opportunities for intervention are being missed. In a comprehensive talk, he covered the evidence base for thrombolysis, which, though compelling, is currently available in only two centres in Wales, and not on a full-time basis. A sea change in GP attitudes to stroke may be one necessity if thrombolytic therapy is to become a reality, with patients being directed immediately to hospital, rather than seeing the GP first. John Potakar covered the classification of anxiety disorders and their differentiation from normal anxiety, and the potential role of alcohol, an anxiolytic, in sustaining anxiety through a dependence syndrome. Delegates were challenged by a case scenario which encompassed the pharmacodynamics and pharmacokinetics of SSRIs, the discontinuation syndrome, and the serotonin syndrome. Dwarak Sastry and his specialist Parkinson's disease nurse gave a comprehensive overview of diagnosis and treatment of PD, particularly stressing non-organic symptoms. Anxiety is present in 20-40% of patients, and often fluctuates with the motor state. Treatment should therefore be targeted at improving motor fluctuations, and at treating depression.

Alistair Church rounded off the day with an exposition on the causes and treatment of dizziness, a topic often perceived as complex but from which a few simple lessons may be distilled. His clinical algorithm, eminently applicable in primary care, required initial differentiation of vertigo from other causes of dizziness, then of first episode from recurrent vertigo. The former may be vestibular neuronitis or an acute brainstem event: a lack of neurological signs, a build up of symptoms, patient ability to stand, and a positive head thrust test favour vestibular neuronitis. For recurrent vertigo, the key question relates to whether the symptoms are positional or not. Non-positional recurrent vertigo may be migrainous vertigo, a condition far commoner than Meniere's disease. Recurrent positional vertigo suggests the diagnosis of benign positional paroxysmal vertigo which may be diagnosed with the Dix-Hallpike test and treated with the Epley manoeuvre, both of which may, with a little training, be performed in the primary care setting. ♦

Progress: Advancing Parkinson's Research

The Parkinson's Disease Society research conference

Conference details: 3-4 November, 2008; York, UK. **Reviewed by:** Neil Archibald, Parkinson's Disease Society Research Fellow, Clinical Ageing Research Unit, Newcastle University, UK.

Neurology, with all its sub-speciality interests, is well served by the dazzling array of conferences that pepper almost every month of the year. In the era of the 'mega-conference', with thousands of delegates, satellite symposia and parallel sessions, one could be forgiven for overlooking the arrival of a new kid on the block. That would be a shame however as the recent Parkinson's Disease Society (PDS) conference in York brings something a little different to the table. With a focus on showcasing the work of young researchers, many supported or funded by the PDS, alongside that of keynote speakers from around the world, there was a relaxed and almost 'family' feel to the two-day meeting.

After a welcome from the Director of Research and Development of the PDS, the conference kicked off in earnest with Bastiaan Bloem's entertaining and fascinating tour of gait and balance disturbances in Parkinson's disease (PD) and related disorders. With a focus on clinical assessment of gait disorders, why and how people with PD fall, the neural correlates of gait and the development and delivery of cost-effective community physiotherapy in PD, the tone was set for a meeting marrying both basic science and clinical approaches to movement disorders in the hope of translating research into new pharmacological and non-pharmacological treatment options for PD.

The second keynote speaker, Jeffrey Kordower, outlined the state-of-the-art in stem cell and gene therapy research, both in non-human primate models of PD and, most importantly, the early trial results in humans. After the disappointment of the 'false dawn' of foetal transplants for PD treatment, the speaker introduced a necessary note of caution in the interpretation of results from non-blinded non-placebo controlled surgical trials in the field. Despite the media interest, it seems stem cell therapy is a long way from the bedside or neurosurgical theatre but the pace of progress in gene therapy research is brisker. Safe and tolerable it may be in the small number of selected patients so far to receive the treatment but we must wait patiently for the larger-scale trial results before loosening the grip on the reins of our enthusiasm for another surgical breakthrough in the treatment of PD.



York Minster.

The last of the keynote speakers, Olivier Rascol, provided an insightful tour-de-force of pharmacological 'symptomatic' treatments for PD. Alas, we seem as far as ever from neuroprotection, so long the 'holy grail' for patients and clinicians alike. The pharmacological armoury is swelling however, with long-acting dopamine agonists and partial agonists, transdermal patches and drugs with non-dopaminergic mechanisms of action. Which of the dizzying array of cholinesterase inhibitors, adenosine A2 antagonists, serotonergic agonists and antagonists and noradrenergic antagonists will find a niche in clinical practice will depend on high-quality trials, but both surgical and pharmacological treatment options are evolving steadily and, importantly, offer something to both patients, carers, researchers and doctors alike – hope.

On to the flurry of short platform sessions now where I must declare an immediate conflict of interest. Setting aside my own (literally) fifteen minutes of 'fame', I was struck by the broad canvas of the meeting and the enthusiasm communicated by all those presenting their research – many for the first time. We learned of the influence of the tau genotype on dementia susceptibility in Parkinson's disease and how our current pathological staging systems leave many questions on the role of α -synuclein unanswered. The fascinating finding, in a large autopsy sample, of widespread α -synuclein pathology in many patients without clinical

signs of dementia or extrapyramidal symptoms heightens the ongoing debate as to the precise role Lewy bodies and Lewy neurites play in the development of PD and DLB.

We were introduced to the rat model of levodopa-induced dyskinesia with thoughts on the aetiological factors involved and the potential use of topiramate in its management – at least in rats! We also learned that dyskinetic rats find that unfamiliar surroundings worsen their dyskinesias whilst their favourite coloured sawdust in a familiar cage reduced the abnormal movements. Sawdust on the movement disorder clinic floor – a move unlikely to curry favour with infection control gurus in the NHS but a fascinating thought nonetheless.

The preliminary results of the PD-SURG trial were also presented, demonstrating a benefit in quality of life and motor function compared to best medical management for those undergoing deep brain stimulation (DBS). This confirms the bedside experience of most involved in referring patients for DBS, although the problem of identifying the candidates most likely to benefit remains a difficult issue. Early results from the PROMS-PD study, examining mood disturbances in PD, were also covered. We are only now beginning to appreciate the impact of depression and anxiety on people with PD and this important study should help us discern the clinical phenotypes of mood disorders in PD and throw light on the best treatment options for those affected.

As ever, one of the highlights of the meeting was the poster sessions, with an opportunity to chat with researchers on a more informal footing. I was struck not only by the high quality of the research but also by the breadth of projects on show. It would appear that almost no animal species is safe from our attempts to model the genetic, cellular and environmental factors that might contribute to the development of PD. In addition to the standard mice and rat models I was particularly interested to see the growth in research using the very accessible central nervous systems of *Drosophila*, zebrafish and nematodes. In the pharmacology collection, the focus seemed to be on the search for novel neuroprotective agents to prevent the striatonigral loss instigated by neuronal insults such as

MPTP. In the absence of methods to promote parkinsonism in animals mimicking the chronic decline of human PD the use of such agents remains a necessity.

I was heartened to see a clinico-pathological study from London suggesting that our clinical acumen does yield accurate diagnoses of PD and related disorders, at least in those patients attending specialist movement disorder services. Non-motor symptoms such as dementia, visual hallucinations and anxiety as well as orthostatic hypotension also seem highly characteristic of pathologically proven PD cases. I was also interested to read work from Northumbria NHS Trust on the

prevalence and nature of urinary symptoms in PD – a seemingly ubiquitous problem in PD and worthy of a much higher profile than it usually receives.

Those able to stay for the conference conclusion were fortunate to witness the prize giving ceremony for the two best posters. The honours went jointly to two groups of researchers; one from the University of Manchester and one including contributions from Northumbria, Newcastle, Glasgow and Belgium. The former received the award for their work on changes in the expression of G-protein signalling in the striatum of a unilateral model of PD and levodopa-induced dyski-

nesia and the latter for their studies on optimal cognitive and auditory cueing strategies for gait problems in PD. The prize originates from the generosity of the family of Dennis Pooley, who struggled with Parkinson's and Lewy body dementia until his untimely death. I can think of no better memorial to his life nor a more inspiring reminder of why it is that we had all been gathered under the same roof for the previous two days. My only worry for next year's conference is that the organisers might need to find a bigger venue, as a quick straw poll suggested most attendees had found the meeting as enjoyable as I and would hope to return. See you there in 2009? ♦

19th Meeting of the European Neurological Society

Conference details: 20-24 June, 2009; Milan, Italy. **Report by:** Prof G Said, ENS Executive Committee.

PREVIEW

Teaching programme:

- 22 practical workshops
- Practical sessions in clinical neurophysiology
- 23 Teaching courses covering all important topics in Neurology

Early registration deadline:

22 April, 2009

Abstract submission deadline:

11 February, 2009



programme for neurologists in training many young neurologists can be invited to attend high quality teaching and scientific sessions.

The teaching programme will continue on Sunday morning and afternoon with courses covering the different neurological subspecialties ranging from neuromuscular disorders to movement disorders and current treatments in neurology. An important workshop will be devoted to the management of multiple sclerosis (MS) patients which includes administration of disease-modifying treatment, symptomatic relief and neurorehabilitation. Many MS patients suffer from frequently severe and disabling symptoms, that affect their quality of life. Management of these symptoms is an important part of MS therapy. These symptoms include loss of mobility, spasticity, tremor, abnormal eye movements, pain, paroxysmal symptoms, bladder and bowel dysfunction, sexual disturbances, fatigue and depression.

Other practical approaches of current problems in neurology will be taken care of in workshops devoted to neuropathic pains and to new developments in treatment of headache.

Practical breakfast sessions on clinical neurophysiology have been included this year with hands-on sessions on EMG, nerve conduction studies and transcranial Doppler.

The scientific programme will start on

Monday morning with the first poster session, with scientific papers selected from abstracts submitted for presentation. Two different approaches to problems posed by management of stroke will be considered, the one in a teaching course, the other during the Presidential Symposium.

During the integrated teaching courses on diagnosis and treatment of dementia, management of stroke and disorders of the peripheral nervous system, selected scientific papers related to the topics will be presented.

Symposia on the molecular era of muscle disorders; pathophysiology of epilepsy, advances in diagnosis and treatment of Parkinson's disease and critical issues in multiple sclerosis will also take place during the meeting. Last but not least, oral and poster presentations with walking tours and interviews with presenters of scientific papers on various topics selected from the abstracts submitted will illustrate the vitality of neurology in Europe. ♦

Visit the ENS 2009 website

www.akm.ch/ens2009

- Continuously updated scientific programme
- Online registration as well a hotel & tour registration
- Option to compose your personal congress programme
- Details about the industrial exhibition and symposia arranged with the industry
- Information about Milan

Preparation for the 2009 ENS meeting, which will be held in Milan, June 20-24, is nearly complete. Only the programme of free scientific communications is still to be settled. The meeting will start on Saturday, June 20 with workshops on neurosonology, treatment with Botulinum toxin, early diagnosis of motor neuron disease, mild cognitive impairment and hyperkinetic movement disorders. The second part of the morning programme includes workshops on demyelinating disorders in children, neurological complications of HIV infection, disorders of gait and rehabilitation. Half-day teaching courses will start on Saturday afternoon with courses on neurology in internal medicine; differential diagnosis of multiple sclerosis; neuroimaging; intensive care in neurology; and management of the dizzy patient.

Courses and workshops at the 2008 meeting in Nice were very rewarding, with rooms completely filled with neurologists in training. Young neurologists are encouraged to apply for ENS support to attend the meeting, especially the teaching programme. Thanks to our