

Management of motor symptoms in people with Parkinson's with motor complications – opicapone place in therapy

Management of Parkinson's in SEL is based on the guidance and principles published in the NICE Guideline NG71; Parkinson's disease in Adults; Published July 2017.¹

Before starting treatment for people with Parkinson's disease the specialist will consider and discuss:

- The person's individual clinical circumstances, for example, their symptoms, comorbidities and risks from polypharmacy
- The person's individual lifestyle circumstance, preferences, needs and goals
- The potential benefits and harms of the different drug classes – see NICE guideline for further information¹

Levodopa remains the most effective drug for the management of Parkinson's disease (PD). Adjuvant treatments may also be needed for people who are not adequately controlled on levodopa alone, with the aim of reducing motor complications and improving quality of life.

If a person with Parkinson's disease has developed dyskinesia and/or motor fluctuations (which can occur within 9 months of starting treatment), including medicines 'wearing off', seek advice from a healthcare professional with specialist expertise in Parkinson's disease before modifying therapy.¹

The specialist will offer a choice of:

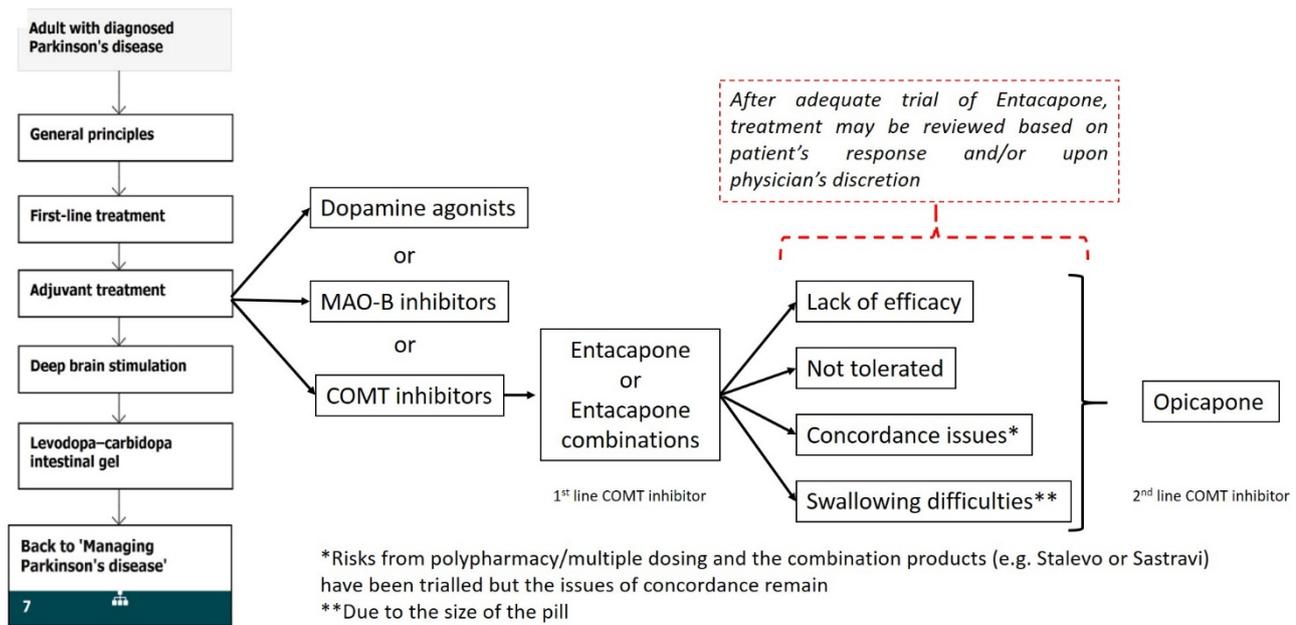
- Dopamine agonists (ropinirole and pramipexole orally, and rotigotine where severe swallowing difficulties or oral absorption is impaired ('delayed time to on')) with careful counselling on the risks of and monitoring for effects of Impulse Control Disorders
- Monoamine Oxidase-B (MAO-B) inhibitors (rasagiline or selegiline) .Modern data would suggest that using early MAO B may be useful and currently rasagiline is the only MAO B which has some evidence of benefit on the basis of a delayed start design study in PD.
- Catechol-O-Methyltransferase (COMT) inhibitors (entacapone and opicapone (see below for further information on opicapone place in pathway))

The NICE information for the [Public guideline](#) provides some useful information which the specialist will go through with the patient based on their individual information needs.

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Adapted from <https://www.nice.org.uk/guidance/ng71>

Figure 1: suggested treatment pathway.

Opicapone will be used in PD patients on levodopa/ DOPA decarboxylase inhibitors (DDCI) combinations experiencing end-of-dose motor fluctuations,³ in whom entacapone or entacapone combinations are either:

- not effective
- not tolerated due to side effects
- inappropriate due to swallowing difficulties or multiple daily dosing.

Patients stable on treatment with entacapone should not be considered for switching to opicapone.

NICE has published an evidence summary on opicapone (March 2017, Parkinson's disease with end-of-dose motor fluctuations: opicapone)². This evidence also comments on the likely place in therapy for opicapone. The review states that entacapone is the most prescribed COMT inhibitor as adjunctive therapy to levodopa and may be taken up to 10 times daily with each levodopa dose to manage end-of-dose motor fluctuations in PD. The use of tolcapone, instead, is limited because of the increased risk of hepatotoxicity and can only be prescribed and supervised by physicians experienced in the management of advanced PD².

As opicapone is taken once a day, which enables a simplified regimen compared with entacapone (although combination product of entacapone are available), specialists who reviewed opicapone highlighted that a combination product of entacapone may be difficult for some people who are on different levodopa doses at different times of the day.

Some people taking complicated dosing regimens may find it easier to add in a single tablet like opicapone and keep their familiar levodopa doses over the day. In addition, using a once daily opicapone enables flexible dosing of levodopa without altering opicapone dose, unlike when using entacapone. Therefore, these specialists suggested that opicapone may be an option to consider when entacapone is not tolerated or is inadequate at controlling symptoms².

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Note crushing entacapone multiple times a day is not practical in a Parkinson's patient with reduced manual dexterity and may cause issues for patients wishing to go out during a day. As per the flow chart, the specialist team will ensure an adequate trial of entacapone before considering opicapone. The result of a trial of entacapone is likely to be very clear very quickly and is likely to be affected by for example swallowing difficulties, intolerance e.g. diarrhoea or unacceptable urine discolouration, none of which are likely to improve with prolonged trial.

The Summary of Product Characteristics (SPC) for opicapone states that it is often necessary to adjust the daily dose of levodopa within the first days to first weeks after starting treatment with opicapone to reduce levodopa-related dopaminergic adverse reactions (e.g. dyskinesia, hallucinations, nausea, vomiting and orthostatic hypotension)³. Patients on opicapone should be referred back to the specialist when motor control worsens, or if patient is showing signs of side effects/difficulties coping with their current medication regimen. The specialist will review the whole treatment regimen at this time and consider individual patient tolerability and response to therapy.

Opicapone will be initiated by the neurology specialist with initial supply being made by the hospital after which the GP will be requested to continue prescribing.

Clinicians are advised to consult the current Summary of Product Characteristics (SPC) for up to date information on opicapone.

References/Useful Resources:

1. NICE Guideline NG71; Parkinson's disease in adults; Published July 2017: <https://www.nice.org.uk/guidance/ng71>
2. NICE Evidence Summary ES9; Parkinson's disease with end-of-dose motor fluctuations: Opicapone; Published March 2017: <https://www.nice.org.uk/advice/es9/chapter/Key-points>
3. Summary Of Product Characteristics; Ogentys 50mg Hard Capsules: <http://www.medicines.org.uk/emc/medicine/32365>

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