HealthCare
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TRUST

DR A LORD FRCP
CONSULTANT GERIATRICIAN

Elderly Medicine
Queen Alexandra Hospital
Cosham
Portsmouth PO6 3LY

Tel:
Extension:
Direct Line:
Fax:
Code A

AL/BN/DV/ Code A

22 June 1998

Dr J Grocock
Code A

Dear Dr Grocock

ARTHUR CUNNINGHAM, DOB Code A
HA: MERLIN PARK REST HOME, FORT ROAD, GOSPORT

Dr Stuart Morgan requested this domiciliary visit on 16 June following your initial referral on 11 June. I visited Mr Cunningham at Merlin Park Rest Home on 19 June.

Walking in I was most struck at the amount of weight Mr Cunningham seems to have lost since I last saw him in out-patients on 10 March. He moved to Merlin Park Rest Home at the end of April and understandably felt very low in his spirits and although this is still so, he agrees that he is settling in and also mentioned that he did not feel he would be there much longer and mentioned the possibility of a move to an RAF home. This was certainly mentioned last year and I am uncertain at this stage as to whether this is a realistic option for the future.

Mr Cunningham's main functional problem at present is that he finds the bed too soft and misses the monkey pole and rails that he had in his flat which made his transfers much easier. However, he is able to get out of bed with the assistance of one person and although his transfers are extremely unsteady, one carer can usually manage him. He has difficulty turning over in bed at night and feels that the mattress on the bed is too soft, although this has been changed recently. He is able to use a bottle successfully 3-4 times at night to pass water and denies any difficulty in micturition. He is on a soft diet, his bowels are regular and constipation has not been a particular problem. He is breathless occasionally as before, but denies any definite angina and oedema has not been a problem. He has had 2 falls since moving into the rest home and has not had episodes of loss of consciousness. Dysphagia is not a problem. The staff at the rest home have not noticed periods of shuffling or freezing. Hallucinations have not been a problem in the last few days although this was so quite a few weeks after he moved in.

At present his medication consists of Cocareldopa 250/25 at 6.00 am, 3.00 pm and 12 midnight, Cocareldopa 100/10 at 10.30 am and 7.00 pm, Amlodipine 5mg mane, Diazepam 0.5 - 5mg on average once a day and Codanthrusate 2 capsules prn nocte.

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Mr Cunningham was seen at 4.35 pm (an hour and a half after his previous dose of Levodopa) and was extremely dystonic, the dystonia affecting his entire body and right upper and lower limbs. He had a mild tremor in the left upper limb but had no rigidity in his limbs at all, was not particularly bradykinetic, there was no seborrhoea or sialorrhoea. Transfers were extremely hazardous and he was lurching even more than before and he had to be steadied by 2 people, although he used a stick. His voice was soft as before, but there was reasonable modulation. His pulse was 80 a minute and regular, blood pressure was 140/80 sitting, venous pressure was not raised, heart sounds were normal and his chest was clear. I could not feel any masses or tenderness in his abdomen. He was very weak around the hips with a left foot drop as before.

Overall I feel that Mr Cunningham is on too much Levodopa and this has been my opinion since October last year. Unfortunately Mr Cunningham has never agreed with this and our previous attempts at dosage reduction were unsuccessful. I feel that his unsteadiness at present is a result of too much Levodopa which has resulted in dystonia as well as likely severe postural hypotension (he was too unsteady to check a standing blood pressure today). I feel that the Diazepam leads to hypotonia which renders his unstable lumbosacral spine more so. I agree that Mr Cunningham is depressed at the move into Merlin Park Rest Home and felt that his short-term memory was worse than before as he was quite repetitive. In addition, functionally things are difficult for him as the flat was well adapted to his needs. He had quite a few implements that he could use. He still has his electric wheelchair but I gather than this is downstairs.

I have taken the liberty of reducing his Levodopa further and have also phased out the timings to regular 4 hourly dosing during the day so that this would provide us with a baseline from which to make further adjustments. His therapeutic regimen now consists of Cocareldopa 250/25 at 6.00 am and 10.00 pm, Cocareldopa 100/10 at 10.00 am, 2.00 pm and 6.00 pm, Amlodipine 5mg daily and Co-danthrusate as before. I have asked the rest home to offer 2.5mg of Diazepam if he requests it. I hope that the Diazepam could be reduced gradually in the future. Mr Cunningham has agreed to these changes to his medication.

As you mention that his records have been misplaced I am sending you a copy of my out-patient letter of 10 March which mentions the dose of Levodopa he was then taking, and also his reluctance to reduce the dose further. If you wish further copies of the correspondence please let me know and I would be happy to send them on to you.

We will need to ascertain as to whether Mr Cunningham is going to remain at Merlin Park over the next few months as it would be rather pointless fitting rails if he is to move in the near future. I agree that Mr Cunningham is depressed but feel that referral to Dr Banks for an assessment of his mental state could be deferred until the dose of Levodopa is reduced as much as possible as it is the excessive Levodopa that has caused his hallucinations.

Cont/d...

Mr Cunningham has agreed to day hospital attendances and I hope we are able to help him this time around.

Yours sincerely

Code A

Dr A Lord FRCP
Consultant Physician in Geriatrics

Enc.

cc Sister A Stewart, DDH, GWMH