



Showing love and sharing life

A young man and his sister look
back on the kidney transplant
that changed their lives.

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SOCIAL WORK

A day in the life of Tania Teolis, social worker

Social worker Tania Teolis is responsible for a 26-bed unit in the Department of Internal Medicine of the Royal Victoria Hospital of the McGill University Health Centre (RVH-MUHC). She sees patients aged 18 to 100 years of age with a variety of medical issues like pneumonia, cardiac problems, sepsis, alcohol or drug abuse, dementia and cancer. Her main role is to identify and respond to the emotional, psychosocial and environmental needs of patients and their families and friends following a diagnosis.

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MESSAGE FROM NORMAND RINFRET

Winners of this Year’s Q+ Challenge

It can be said that magic happens when clinical teams and patients come together to create and implement quality improvement projects. The Q+ Challenge, now in its fourth year, is living proof of that. Each year, the superb entries make the Selection Committee’s job of choosing a winner in and of itself a challenge.

I would like to begin by thanking everyone who submitted a project for evaluation. This is how new programs come to be, including the unique 2015 winning entry from a team in the Mental Health Mission. Dr. Kathryn J. Gill and Ronna Schwartz led this team and, as in the past, were supported by patients’ input and participation. Entitled the Recovery Transition Program (RTP), their initiative aims to enhance the patient experience, promote long-term recovery by reducing relapses and re-admissions, and improve quality of life. RTP will also train a cohort with lived experience of mental illness to become ‘certified peer mentors’, able to deliver recovery-oriented support, workshops and self-management tools.

RTP is a wonderful reflection of our commitment to encourage patient participation in everything we do. Dr. Nadia Szkrumelak, MUHC Psychiatrist-in-Chief’s recent note to the winners speaks volumes to the program’s quality:

“It is, as the reviewers noted, a noteworthy proposal because of the unique way it addresses the needs of the patients throughout the entire process, from design to implementation. I have every confidence that this project will achieve the desired results of easing patients’ transitions to community care when they are ready to be discharged from the MUHC, creating a culture in which patients feel included and empowered in their care, and working towards providing care at the highest level.”



Back row, left to right: Antonis Paraherakis, Robert Glesinger (patient), Michael Menezes (patient), Dr. Kathryn Gill and Josef Schmidt (patient). Bottom row, left to right: Patricia Lucas (patient), Ronna Schwartz, Cecilia Vanier (patient) and Melissa Myers.

I echo Dr. Szkrumelak’s sentiment and extend my sincere congratulations to the winning team, which will receive a grant of \$150,000 to bring the project to life. The funds will be earmarked for programs, equipment, human resources or expertise not covered by the hospital’s operating budget. I would also like to underscore that the Q+ Challenge was spearheaded four years ago by Valerie Shannon, a former director of nursing at the MUHC and Chair of the Montreal General Hospital Corporation, and was immediately embraced by Patricia Lefebvre, Director of Quality, Patient Safety and Performance, and her team. Many thanks to them and to the Selection Committee, which included four representatives of the Participatient Program.

Normand Rinfret,
President and Executive Director

HR CORNER

The flu is still around!

Read up on MUHC Occupational Health and Safety guidelines for influenza and other infectious diseases

Healthcare workers of the MUHC experiencing a **fever or any other influenza-like symptom must NOT come to work**. They are to call in “sick” to their department and contact the Occupational Health and Safety department at extension: 44FLU (44358). They may return to work after being symptom free for 24 hours.

Healthcare workers of the MUHC experiencing: **nausea, vomiting, diarrhea or a rash, must NOT come to work**. They are to call in “sick” to their department and contact the Occupational Health and Safety department at extension: 44FLU (44358) for an evaluation.

A healthcare worker present at work experiencing any of the above mentioned symptoms will be advised to leave the work premises by their immediate supervisor. The Occupational Health and Safety department must be made aware of such an event at extension 44FLU (44358).

Vaccination is the most effective way to prevent influenza and all healthcare workers, whether they give direct patient care or not, should get vaccinated every year. **The flu vaccine is available and is free for all MUHC personnel. Call extension 44FLU (44358) to book an appointment.**

FACE TO FACE WITH...



Helina Asumadu, patient attendant (PAB) in the Internal Medicine Department of the Royal Victoria Hospital, MUHC.

I tell jokes, dance and sing for patients; I want to bring a smile to their faces. I never forget that the patient is somebody’s mommy, somebody’s daddy, somebody’s son, somebody’s daughter.

Why did you decide to become a PAB?
It’s all because of my grandmother. Back home in Kumasi, Ghana, where I come from, older people stay with the family, so we all lived together. She was old and very, very funny. I took care of her, and we became close. That made me want take care of old people and people who are sick. She died at 121 years of age, when I was already living in Canada.

How long have you been here?
More than 25 years. At 17, I left Ghana for Germany. I was in high school there when I met my future husband, Maxwell, who’s also Ghanaian. He lived in Montreal and was visiting a friend in Germany.

So love made you move to Canada. Did you start working as a PAB right away?
No. At first, I worked in a seniors’ home, but I thought ‘I can do better; I want to be a patient assistant.’ So I went back to school to earn a Canadian high school diploma and then I got a job as a PAB at the Royal Victoria Hospital. I’m proud to work at the MUHC.

Tell me about your typical day on C-9.
You’ll laugh. My shift starts at 7:30 a.m., but at times I’m here at 6 a.m. I come in early to find a parking space, then I come to the floor, relax and drink my coffee. Most days, I check on all my 12 patients even before my shift starts. I tell them ‘I’ll come back later to take care of you.’ On a typical day, I’ll wash them, change their bed, give them breakfast. Some patients like to talk. I tell them: Let me finish my job, and I will come back and talk.

What do you talk about?
Their personal lives, their children, movies, music, whatever they want to talk about.

You seem to really like your job.
Of course, I do! For me, taking care of sick people is more than giving them medication. A shower and a clean bed, for example, can make patients feel better. Cleanliness is important to me, so I always make sure patients’ rooms are spotless. I also tell jokes, dance and sing for them; I want to bring a smile to their faces. I never forget the patient is somebody’s mommy, somebody’s daddy, somebody’s son, somebody’s daughter.

What’s the secret to being a good PAB?
If you put yourself in your patients’ shoes all the time, you will enjoy taking care of them.

CONFESSIONS...

Three things you can’t live without: God, my children – Albert is training to become a doctor; Felicity works at the airport, and Kevin is in college – and my job.

Favourite hobby: Watching movies and cooking. I cook almost every day; I don’t like leftovers.

Favourite fitness activity: I exercise every day as soon as I get home from work! I have a small gym in the garage and I watch movies and dance videos while I work out. Once in a while, I take a long relaxing bath in my Jacuzzi afterwards.

Favourite place in Montreal: My home

Favourite travel destination: I visit Ghana and Germany almost every year because I have family in those places, but this year, we’re going to Cuba. I want to see how people live there.

Favourite quality in a person: I don’t give up easily, so I like people who are perseverant.

Favourite place at the MUHC: My unit on C09. It’s like my home.

Everybody has a story. We’d like to hear yours. Please, contact us at public.affairs@muhc.mcgill.ca

The therapeutic power of music

Music stimulates many areas of the brain and engages the body, mind and spirit. Who has never let themselves be carried away by a sweet melody, a playful rhythm or touching lyrics? We do appreciate music since immemorial times, but today, we also know how to use its benefits in a care relationship within a structured environment. This is what our six music therapists do at the McGill University Health Centre (MUHC).

MUHC music therapists are a group of professionals who work with similar tools and goals, with patients living different experiences and struggles. They help their patients decrease isolation, anxiety and pain perception, express themselves and relax, improve their mood and morale, stimulate their memory and attention and develop coping strategies. They also support families and loved ones. In pediatrics, interventions also aim to promote children’s development through the use of musical instruments adapted to their level of functioning and particular individual needs.

All patients—whether they have knowledge of music or not—can benefit from music therapy and the various types of musical intervention. Depending on their needs, music therapists can have patients listen to carefully selected music, interpret a song for them or get them to improvise and compose music using the music instruments they put at their disposal.



Deborah Salmon works at the Palliative Care Unit of the Royal Victoria Hospital

Deborah Salmon “In Palliative care, I try to discover what is meaningful to each patient, and use music to help them connect to their most authentic selves, to loved ones, or to their spirituality, and to promote a general sense of *bien-être*. Patients may choose to listen to or sing songs that help them express difficult emotions around love and loss, or they may request music that takes them back to happier times, or that express hope and faith. Some patients work on ‘legacy’ projects, recording messages, or composing songs to leave for loved ones. I feel enormously privileged to work with people who are living this profound phase of life.”

Dany Bouchard “In psychiatry, music therapy sessions are provided individually or in group settings to help reduce anxiety and feelings of isolation, maintain cognitive skills (attention, concentration, refocus on here and now), increase the capacity of feeling pleasure, and improve social skills and self-esteem. Through improvisation, interpretation of meaningful songs and musical composition, patients learn new ways to express difficult emotions and explore their creativity. I focus on doing what’s best for patients. In some cases, this can include listening to soothing music, playing percussion to ventilate difficult affects, or even writing lyrics and finding music that allows them to better manage their emotions. Sometimes we record songs that patients make up with me. What I like the most about my work is the creativity that it produces, as well as the relational and human aspect that grows and deepens with patients through the universal language of music.”



Kelly-Ann Van der Meer works with adult cancer patients at the Cedars Cancer Centre

Kelly-Ann Van der Meer “In cancer care, music therapy helps improve how the patients cope and adjust to their medical treatments. Musical interventions help reduce perception of pain and side-effects of chemo, reduce demoralization, better cope with emotional and social changes, adapt to changes in physical appearance and explore existential questions. I evaluate the patient’s primary need and then propose one or two musical interventions, such as improvisation, listening to me play music, or a combination of the two. Some patients are intimidated by the instruments, but I know the tricks to bring them to touch them. Being creative helps patients express emotions that they cannot put into words, reconnect with themselves and distance themselves from difficult events.”



Christelle Jacquet and Pascal Comeau help young patients at the Montreal Children’s Hospital

Christelle Jacquet “We use music therapy to maintain or improve the quality of life of babies, children, adolescents and their families and promote adaptation to the illness and hospitalization. Music creates a more normal environment, stimulates all the senses and helps people cope with life challenges. In addition, musical activities facilitate interaction and communication and help in the overall development of children who are hospitalized for weeks. I feel privileged to contribute to comfort and growth of children hospitalized at the beginning of their lives, but also to support new parents in learning their role. It is a heart-warming gift to witness a smile!”

Pascal Comeau “At the hospital, the children play with instruments, sing or write songs, choose music to listen to, and move and play to the sound of music. One way or another, they all enjoy it. For example, a baby can be soothed listening to sweet songs in his father’s arms, and a teenager can write lyrics and play instruments to express his feelings and to feel in control despite a sudden and serious illness. The aspect of my job that I like most is that I make a positive difference for these patients and their families with a medium that easily reaches children and that I love: music!”



Dany Bouchard dedicates himself to inpatients and outpatients facing mental health issues at the Montreal General Hospital

Joanie Ayotte “My patients are residents of the Camille-Lefebvre Pavillon, where they receive long-term care. I offer individual music therapy sessions to patients with respiratory problems. Music acts as a stimulator to facilitate communication, while singing and conversation help improve lung capacity. I also facilitate group sessions where residents have the opportunity to move and socialize. By using songs that have special meaning for patients, we can bring out memories and thus help maintain cognitive abilities of older people. I find it fantastic to see the elderly awakening through music, reciting the words of a familiar song or singing despite aphasia that prevents them from communicating verbally. It’s a real gift to work with these patients.”

Joanie Ayotte works with geriatric patients of the Camille-Lefebvre Pavilion at Lachine Hospital



TELL US ABOUT YOUR SUCCESS STORIES! THEY DESERVE TO BE RECOGNIZED. The Public Affairs and Strategic Planning department wants to highlight your accomplishments via its platforms, including web and printed publications (MUHC today, enBref, muhc.ca and social networks). If you, your team or your colleagues, across the MUHC, have provided exceptional care, completed a major project or simply demonstrated altruism, contact us! public.affairs@muhc.mcgill.ca



Katherine and her brother Daniel.

Showing love and sharing life

On National Organ and Tissue Donor Awareness Week – April 18 to April 25 – a young man and his sister look back on the operation that changed their lives.

It’s nothing short of a miracle,” says 29-year-old Daniel Paradis as he reflects on the live donor kidney transplant at the McGill University Health Centre (MUHC) that spared him dialysis and greatly improved his quality of life. In April 2014, Daniel was told by his doctor that he would need a kidney transplant soon. After 10 years living with IgA nephropathy, a rare degenerative kidney disease also known as Berger’s disease, Dan’s health was declining: he wasn’t responding well to medication and his kidney function was below 20 per cent and diminishing day by day. For Daniel, dialysis was around the corner.

“I always thought a transplant was something in the future, but I never

expected it to happen at that point in my life,” says Dan, who’s a video editor and host for a YouTube channel. “After I told my friends and family, we started figuring out who could be my donor.”

The process of evaluating a compatible live donor takes three to six months. Candidates must undergo a battery of tests and see several specialists. At first, Dan’s mother was selected as the most suitable donor, but at the last minute a kidney ultrasound revealed otherwise. The next candidate on the list was Dan’s younger sister, Katherine. After all the tests were done, she was a 100 per cent match.

“It’s hard to explain, but from the beginning I had this feeling it was going to be me,” says Katherine, who’s 25 years old. “Dan’s my hero, and I’m super close to him. In my heart and in my mind, I knew I wanted to help him.”

Katherine plays the saxophone and is studying jazz at Concordia University. Even though live donation is performed by laparoscopic surgery, it’s still painful. “Of course, I was worried the surgery might affect my capacity to play my instrument, but I was more scared of not being able to give Dan my kidney than of going into the operating room.”

After a successful transplant, recovery

The transplant was performed on August 25 at the Royal Victoria Hospital of the MUHC. The kidney started working right away, and blood tests showed an immediate improvement in Daniel’s kidney function. At the hospital he was under the care of a “fantastic and dedicated” nurse, Alejandro Ramirez.

“Alejandro would come in and make me walk, even when I didn’t feel like walking. He was stern but compassionate and wouldn’t let me get away with being just miserable.”

In spite of a few difficult moments, Daniel was soon discharged and within a month started to feel much better than before the operation.

“Before my transplant I had to urinate every 45 minutes, even during the night, so for years my sleep was severely affected,” Daniel says. “After the operation, my quality of life improved immediately; I would wake up feeling rested and had much more energy.”

Unexpectedly, the operation was much more challenging for Katherine. Recovery is usually easier for the donor, but she had major internal bleeding and needed two blood transfusions.

“I was in severe pain, but the nurses at the hospital were amazing to me. If I had

“What’s love if it’s not meant to be shown? What is life if it’s not meant be shared?” asks Katherine, who donated a kidney to her brother Daniel.

all the money in the world, I would buy each of them a new car and I would buy Debbie a house.”

Debbie is Living Donor Coordinator

Debbie Harmidy, who sees donors from the beginning of the process to the day of the surgery and sometimes afterwards. For Katherine, Debbie was “a life saver”.

“There’s Mom, the tooth fairy and then there’s Debbie,” says Katherine. “She cared about Dan and me; I could see it in her eyes and I could feel it. I’m going to remember her for the rest of my life.”

Katherine couldn’t practice the saxophone for a while and was exhausted for the first few months after surgery. Now that she’s doing better, she says that in spite of the complications, the whole experience gave her a new perspective on life.

“I used to worry about my future as a musician. But when something becomes a matter of life and death, all little doubts fizzle away. This experience made me be more of the person I want to be and it brought me back to the fundamentals of just how lucky we are to be alive and to live in a country where we have access to free quality medical care.”

The sibling’s relationship was also transformed. “The transplant definitely made us closer,” says Katherine.

From Dan’s perspective he is incredibly thankful for the sacrifice his sister made for him. “I realize how insanely lucky I am to have a suitable donor who’s so close to me. Many people languish for a very long time on lists and on dialysis without finding a donor,” he says. “Katie was very brave.”



Debbie Harmidy

The sweetest gift

I have been totally impressed by our donors’ generosity, dedication and willingness to go above and beyond,” says MUHC Living Donor Coordinator Debbie Harmidy, who followed Katherine Paradis throughout the donation process. “Katie, like many of our donors, had many demands placed on her so I applaud her positive spirit and determination to make this happen. Our donors are very special individuals. When you think about it, it’s probably the biggest gift you can give anybody.”



Alejandro Ramirez

A little tough love for patients post-surgery

“Sometimes your favourite teacher isn’t the one who’s smiling at you, but the one who makes you work and learn,” says Nurse Alejandro Ramirez, who works at the Transplantation Unit of the Royal Victoria Hospital and cared for transplant recipient Daniel Paradis. “After surgery, I tell patients we are going to work together at recovery, and the more I explain what I’m doing and why, the more relaxed and confident they become. As nurses, our work is inspiring because we contribute to a profound and positive change in the lives of our patients and their family.”



- Eivy Joy :** 😊 feeling positive at Royal Victoria Hospital - Glen Site. Loving the doctors, nurses and staff at MUHC - McGill University Health Centre. Proud of the Filipinos who work at MUHC. #mymuhc #glensite #filipinonurses #nurses
- @Toomomgigthy:** I’m learning nursing in McGill for 2 weeks, from Japan. Visiting MUHC was great experience! Thank you for warm welcoming!



- @beatricepirate -** Weird photo from today but just want to give a shout out to @dusm_muhc and their staff at the asthma day hospital for taking such good care of me. I didn’t know what a full blown attack could do and I’m pretty sure they saved me today.



Stay informed and join the conversation!

Did you know that the MUHC has a Social Media Policy that is available on the Intranet?

Continued from page 1 — **A day in the life of Tania Teolis, social worker**

7:45 a.m. It's the start of a work day for Tania. She checks her phone and email messages, as well as the list of new admissions. Among her clients today are a 44-year-old woman suffering from alcohol withdrawal, a homeless man



9:00 a.m. Tania attends the multidisciplinary rounds, where a resident and/or attending physician, a physiotherapist, an occupational therapist, a dietitian, a liaison nurse, an assistant nurse manager and a social worker review work done on the previous day and discuss new cases. *I never start my day with an agenda. It all depends on who comes in overnight or what is discussed in rounds with my colleagues. Nothing is textbook, and that's the beauty of it.*

with pneumonia and a young mother who had a stroke a few months ago and now has anemia. Tania must assess the potential impact of their health issue on their family life, relationships, employment, financial situation and more and help them cope with their new reality.

Tania and 100-year-old Mr. Schwartz



Visit muhc.ca and discover—all in pictures—the rest of Tania's day!

10:00 a.m.

Tania's first client is Mr. Schwartz, a feisty, independent 100-year-old man with significant cognitive impairments. The team believes his safety will be compromised if he returns home, so he will have to be relocated to a nursing home. Tania has talked to Mr. Schwartz's nephew, who has a mandate to become his legal representative. She will complete a psychosocial report, liaise with a CLSC to initiate placement and homologate/activate the mandate. Mr. Schwartz has recently been made aware. *Seventy-five per cent of my day is dedicated to direct patient care, and that includes speaking with family members, friends and neighbours who're involved in their care. Most patients don't live in isolation.*

9:30 a.m. While she listens to colleagues, Tania decides which cases she must attend to first. Most of her clients are elderly people; some patients have severe cognitive impairments, dementia or loss of autonomy and will no longer be able to return home; others have just received a diagnosis of severe illness. *Each patient comes to the hospital with their own story. It's important to support them and to try to be culturally sensitive to their beliefs and values.*

The redevelopment of the Lachine Hospital: a unique, exciting and creative experience

The Lachine Hospital Redevelopment Project was officially launched in March when 40 people came together for a full day to brainstorm the \$71.5 million project announced by the Ministère de la santé et des services sociaux (MSSS) in September 2015.

"We rarely have an opportunity to brainstorm like this," says Dr. Ewa Sidorowicz, associate director general of Medical Affairs and director of Professional Services. "This is the first in a series of workshops to design a care and work environment focussed on patients and staff."

The day consisted of a series of creative exercises aimed at identifying the core values and beliefs of the Lachine Hospital to ensure that the architecture authentically reflected this.

No fewer than 2,862 ideas were put forward and have been summarized. They will provide the guiding principles submitted for discussion to various stakeholders. These principles will be integrated into the functional plan that will guide the architects at the design stage.

CANCER AND MENTAL HEALTH

Dealing with the distress caused by cancer

The MUHC is participating in a research project that aims to support cancer patients' psychological wellbeing

Six years ago, Julie Szasz was diagnosed with stage IIB breast cancer, which is considered a treatable cancer. "I was young, and they said 'she'll be fine', so I thought, 'I'll be fine,'" she recalls. "But psychologically, things were not easy. I overlooked getting any psychosocial help because I didn't believe — and nobody insisted — that this would be necessary for me."

Although it's well-known that distress seriously impacts cancer patients' outcomes, including adherence to treatment and quality of life, psychosocial care has lagged behind other treatment advances. But a new three-year joint project between the Rossy Cancer Network (RCN) and Cancer Care Ontario (CCO), called Improving Patient Experience and Health Outcomes Collaborative, or iPEHOC, aims to change this reality. Julie, who was re-diagnosed with metastatic breast cancer three years ago, is one of four patient advisors for the project.

"The literature reports that 35 to 45 per cent of cancer patients experience sufficient emotional distress to warrant professional intervention," explains Dr. Marc Hamel, project co-lead and clinical director of Psychosocial Oncology at the McGill University Health Centre (MUHC). A lot of the distress can be managed by front-line staff, but about 15 per cent

of patients need referral to a mental healthcare professional."

"The idea behind this initiative is that once we understand the patient's experience through the screening and outcome measures, we will be able to target the symptom and identify the right intervention in a timely manner," explains Dr. Zeev Rosberger, iPEHOC's principal investigator and the director of the Louise Granofsky-Psychosocial Oncology Program at the Jewish General Hospital (JGH).

Patients will be offered a distress screening questionnaire, already in use in Ontario, at set intervals in their treatment journey using a tablet computer. The software will assess their responses and generate a summary that outlines needs and interventions on an ongoing basis. The summary will in turn be provided to both the health team and the patient.

At the MUHC, the screening will be tested at the Lung Clinic of the Cedars Cancer Centre. The same pilot will take place at St. Mary's Hospital Centre and in select cancer clinics at the JGH. The study, financed by the Canadian Partnership against Cancer and the RCN, will also be implemented among Inuit, First Nations and Métis communities treated within the McGill RUIS (Réseau universitaire intégré de santé).

iPEHOC is the first project of its kind in Quebec. "We want to standardize screening across Montreal, across the province, and across the country, so that every patient — whether they are seen in



Dr. Marc Hamel

Montreal or elsewhere — can expect the same kind of assessment and screening," says Dr. Hamel.

Julie stresses that this project is not just for research or just about statistics. "It's about helping patients right now," she says. "From the get-go, patients have to feel that if something doesn't feel right, then someone is addressing that."

April, Parkinson’s Awareness month: Progress in the diagnosis



Dr. Ron Postuma, at the MUHC Movement Disorder Clinic.

Six years ago, at age 50, Eileen Cortina was diagnosed with Parkinson’s Disease. Her first thoughts after leaving her family doctor’s office were: “It is impossible. I am too young to get Parkinson’s Disease. I have a very healthy lifestyle, I exercise a lot and there is no history of Parkinson’s in my family. It has to be something else!”

At the time, Cortina was a very active woman working as a Sales Director in Montreal. But, one year before being diagnosed, she started noticing a few changes. “I started to feel very tired and my movements were much slower. I didn’t have the dexterity I had before and it was becoming harder to write,” she says.

Parkinson’s Disease (PD) is the second most common neurodegenerative disorder in the world after Alzheimer’s. An estimated 100,000 Canadians suffer from it. It is a neurological condition related to the death of specific brain cells, including cells that control movement, mood, sleep and cognition. The symptoms, which include tremors, slowness of movement, stiffness or rigidity, sleep disorders, loss of the sense of smell, depression, and cognitive dysfunction, can appear in people as young as their thirties, but more commonly appear after 60.

Although some drugs and clinical treatments can help control or minimize symptoms there is currently no cure. Since other diseases have similar features but require different treatments, making the right diagnosis is important for properly treating Parkinson’s. With medication, most people with this disease can live productive lives for many years after diagnosis.

“Since my diagnosis, I have tried different medications,” says Eileen. “You always have to balance the outcomes and the side effects. But I am pretty functional these days. I feel good and getting involved in awareness or fundraising initiatives gives purpose to being diagnosed with this disease. In this way I can help others with PD.”

Improving and accelerating Parkinson’s diagnosis

According to Dr. Ron Postuma, neurologist at the Montreal General Hospital of the McGill University Health Centre (MGH-MUHC), the rate of misdiagnosis for PD can be as high as 25 per cent. “Full diagnostic certainty is impossible during life because it closely resembles other neurological disorders,” explains Dr. Postuma, who has been working for 15 years on Parkinson’s. “On top of creating distress in patients, mistaken diagnosis also creates a challenge for researchers as the data collected in clinical studies can become compromised in their pool of subjects.”

Currently, diagnosis of Parkinson’s can only be established through an analysis of medical history and a neurological examination by a clinician with expertise in movement disorders – no objective test for the disease exists. However, a recent research led by an international group of experts, under the umbrella of the International Parkinson and Movement Disorder Society (MDS), may pave the way for improving diagnosis and advancing treatment of Parkinson’s.

“In light of the latest scientific insights and technological advances, we were able to establish a new list of criteria based on expert clinical diagnosis,” says Dr. Postuma, clinical-scientist from the Research Institute of the MUHC and from the Montreal Neurological Institute, who was co-chair of the MDS task force with Dr. Daniela Berg from Tübingen, Germany. “Our aim was to create a benchmark that will systematize the diagnostic process, make it reproducible across centres and enable a wider range of non PD-specialized clinicians to provide patients with an accurate diagnosis.”

For example, the sense of smell is commonly lost in PD patients but uncommonly lost in alternate diseases. Now, it is included in the diagnostic criteria as another way to help physicians make the diagnosis. The new criteria has ways to balance information by including negative features called ‘red flags’ that argue against a diagnosis of PD and positive features that argue for a PD diagnosis. Red flags rule out probable PD diagnosis only when they cannot be counterbalanced by supportive criteria.

The research team pushed their analysis further. They are also proposing a new stage classification of the disorder with the aim of focusing attention on the early stages of PD. The goal is to identify the features that signal the presence of the disease early on, even before patients may notice motor symptoms.

“Our hope is that, as research advances, our understanding of the mechanisms at play in the disorder will enable us to develop therapies and treatments that can be administered early in this process, eventually slowing or stopping the progression of PD altogether,” concludes Dr. Postuma.

Join us on line!



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