Parkinson’s disease, also called shaking palsy, has been known since the 19th century. The first attempts to treat the disease date back to the late nineteenth century, when atropine or belladonna root extracts were started [1].

Modern treatment with L-dopa and dopamine agonists have superior efficacy but do not have curative action. Patients diagnosed with Parkinson’s suffer because of a neurological or idiopathic degenerative condition that primarily affects the motor system. Thus, nervous cells are not destroyed by a virus, but by a process of degeneration, whose origin seem to have a neurotoxic and genetic component. Other causes associated with the etiopathology of Parkinson’s disease are stroke and drugs [2,3].

The social impact of this disease is extremely important for both the patient himself and the fact that it is the second pathological neurological condition as a frequency [4].

The number of centers dedicated to the treatment of Parkinson’s disease has increased in recent years. An association of Parkinson’s patients have also been created. These have greatly contributed to the development of a better knowledge of Parkinson’s disease and the problems faced by patients among the general public.

The onset of the disease is unknown, studies estimate the place of the beginning of degeneration process in gut to parasympathetic neurons level, 10-20 years before the most obvious clinical signs are motor movements, related to agitation, stiffness, slow motion, difficulty walking, thinking problems and behavioural disorders.

These are called parkinsonism, or a parkinsonian syndrome [5]. In the advanced stages of the disease dementia, depression and anxiety can occur. Other symptoms include sensory, sleep and emotional problems—nonmotor symptoms [6,7].

The positive diagnosis is based on the clinical examination and on the medical history of the patients. Patients who develop similar clinical manifestations of Parkinson’s disease following a stroke or, especially, drug use, fall into the diagnosis of Parkinson’s syndrome plus [8-10].

Among the radiological methods, MRI has become more accurate in diagnosing the disease over time, especially through the T2 and SWI sequences, and both can demonstrate the characteristic aspect of the substantia nigra [11]. This refers to the disappearance of swallow tail aspect at this level [12] but the technique is also used to exclude other diseases that may be secondary causes of parkinsonism, such as encephalitis, chronic ischemic lesions, tumors and hydrocephalus [13, 14].

PET-CT can measure the metabolic activity of dopamine carriers from basal ganglia, reducing their activity characterized by Parkinson’s disease.

Currently, the drugs used to treat this disease are levodopa (always combined with a dopa decarboxylase inhibitor and sometimes with a COMT inhibitor), dopamine agonists and MAO-B inhibitors [11].

The purpose of this study is to evaluate the efficacy of modern current drug therapy for Parkinson’s disease by correlating clinical and imaging data.

Experimental part

Material and methods

The study group included 99 de novo patients diagnosed with Parkinson’s disease, out of a total of 283, in the Department of Neurology at the Emergency Hospital “Prof. Dr. N. Oblu” hospitalized during 01.01.2015 - 31.12.2018. On this group of patients we conducted their demographic and clinical analysis, clinical examination and psychiatric in order to highlight clinical, motor and non-motoric manifestations and of these, which are the most useful therapeutic measures. We have assessed the evolution of Parkinson’s disease in these patients for a period of 3 years: 2015-2018.

This was possible by an follow up at a 6-month interval, occasionally being clinically reviewed. The MRI investigation was repeated over 12 months.

Keywords: Parkinson’s treatment, Parkinson’s disease MRI, follow up protocol, behavioural disorders
Results and discussions

Our clinic’s hospitalization registry shows 99 patients diagnosed with Parkinson’s disease in 2015-2018, out of a total of 283 who were hospitalized within that time (fig. 1).

Age related distribution results in the group of patients studied is: 3 persons with an age belonging to the category of under 40 years; 34 people belong to the 40-60 age category and 246 people belong to the over 60 category. The incidence is therefore wider in the over 60 age group followed by the 40-60 age group.

The patients studied showed motor clinical manifestations marked by tremor and muscle stiffness but also disautonomic (tables 1, 2).

The neuropsychiatric manifestations are present by: psycho-emotional lability, tendency to impulsiveness, depressive phenomenon in different grades of psychopathological intensity, psychotic disorders such as hallucinaton, confusion (table 3).

The drug treatment was administered according to the age of the patients. The age of 60 years is correlated with a late stage of illness in most cases (table 4).

In the radiological study we investigated the patients using MRI, after clinical diagnosis and then after one year. The images point indirect signs of basal ganglia disorders (fig. 4, 5, 6).

| Tremor | Muscular rigidity | Bradykinesia | Postural instability |
|--------|-------------------|--------------|---------------------|
| 269    | 258               | 256          | 199                 |
| 95%    | 91%               | 90%          | 52%                 |

Table 1
THE MAIN MOTOR MANIFESTATIONS

| Digestive disorders | Olfactory disorders | Cardiac disorders | Urinary disorders | Sleepiness disorders | Sensory disorders | Thermoregulation |
|---------------------|---------------------|-------------------|-------------------|---------------------|------------------|------------------|
| 70                  | 65                  | 60                | 5                 | 40                  | 50               | 7                |
| 24%                 | 23%                 | 21%               | 1%                | 14%                 | 17%              | 2%               |

Table 2
DISAUTONOMOUS DISORDERS IN NON-MOTOR SYMPTOMATOLOGY

| Depression | Psychotic symptomatology (hallucination, delirium) | Cognitive dysfunction | Dementia |
|------------|---------------------------------------------------|-----------------------|----------|
| 150        | 20                                                | 138                   | 56       |
| 56%        | 7%                                                | 48%                   | 19%      |

Table 3
NEUROPSYCHIC DYSFUNCTION IN NON-MOTOR SYMPTOMATOLOGY

| IMAO (Rasagilino) | I-CCMT (entacapone) | Dopaminergic agonist (Ropinirol, Pramipexol) | L-dopa and benserazide |
|-------------------|---------------------|---------------------------------------------|------------------------|
| 40-60 ans         | 3%                  | 27%                                         | 58%                    | 59%                    |
| > 60 ans          | 7%                  | 37%                                         | 81%                    | 95%                    |

Table 4
MEDICATION OF MOTOR SYMPTOMS IN PARKINSON’S DISEASE
Muscle rigidity is evident in the majority of cases, with a frequency of 91%. This muscular tension disorder determines the attitude characterized parkinsonian patients (fugue attitude) with a slight flexion in all joints. Daily activities (performing body hygiene, lifting a chair) are performed with difficulty, demanding according to gravity, personal care. When rigidity is accentuated, lumbar, posterior cervical pain may appear.

Muscular hypertonia is objectified through: cogwheel sign, Noica sign, exaggerated posture reflex, palmo-mental reflex, sharp oral reflex, exaggerated nasopalpebral reflex, plantar skin reflex, decreased abdominal skin reflex or abolit.

Bradykinesia is present in the majority of cases, a proportion of 90%, it is shown as slow, in different grade, daily activities. The difficulty of walking appears in the initiation of walking or absence of automatic movements, by small hesitant steps, difficulty or blockage of return. Bradykinesia is visible by micrograph (small writing, illegible), hypomimic (decreased movements imitate), rarely blinked eyes and hypophony (voice decreased).

Postural instability is less common, but it appeared in an important stage in the evolution of the disease, because postural instability is difficult to treat and a source of disability in an advanced stage of the disease.

The most common non-motor manifestation encountered are digestive disorders with a percentage of 24%, followed by cardiac manifestations, represented by orthostatic hypotension 25%.

The digestive manifestations are present by:
- Deglutition disorders - dysphagia for solids and liquids, occurring as a result of inability to push the pharyngeal food balls and that the inability to contract the upper esophagus, appears late in the course of the disease, with intermittent, more rarely permanent appearance.
- Sialorrhea, appears due to the inability to swallow saliva, which accumulates in the oral cavity, it is correlated directly proportional to the severity of the dysphagia.
- Slowing intestinal transit (constipation).
- Inability to push the pharyngeal food balls and the inability to contract the upper esophagus, appears late in the course of the disease, with intermittent appearance more rarely permanent.

The most common non-motor manifestations are followed by a percentage of 24%, followed by cardiac manifestations, represented by orthostatic hypotension 25%[20, 21].

Urinary disorders are of 1% frequency, and are present by:
- Frequency of urination
- Urinary retention disorders;
- Difficulty of complete and incomplete urination;
- Disturbances of thermoregulation are present by hyperhidrosis;

Sleep disorders are manifested by the difficulty of sleeping and the inability to mention sleep, with frequent nocturnal awakenings. Most often occurs reversal of the sleep-wake rhythm (nocturnal insomnia and exaggerated daytime sleepiness).

Cognitive conditions have a high share of 48%. Cognitive conditions can also occur in patients recently diagnosed with Parkinson’s disease. In MP are frequent affections of executive functions, such as planning and decision-making ability, working memory, language, Visuo-spatial ability (especially the perception and interpretation of visual information), reaction time, and ‘Warning. Since Parkinson’s disease is a progressive disease, cognitive conditions worsen in a short time.
Depression is the most common form of psychic manifestation in Parkinson’s disease, with a frequency of 56% in the group studied, characterized by a state of sadness, loss of hope for a long period of time, losing the interest for activities made for pleasure [22].

The dementia is present by the disorders of recovery, confusion inas of recognition and computation, disorientation in an advanced stage with a frequency of 13%. Throughout the study, psychotic symptomatology is present by a frequency of 16%.

Novel compounds such as L 4 (IC50 = 0.11 .mu.M), L8 (IC50 = 0.18 .mu.M), L16 (IC50 = 0.27 um) and L17 (IC50 = 0.48 .mu.m) had selectivity and MAO inhibitory activity B similar to Selegilina. These or others could improve the treatment of Parkinson’s disease [23].

Parkinson’s disease still affects cerebral circulation and especially the ventricular system. A new model called Modified Gray Wolf Optimization (MGWO) was proposed based on the traditional Wolf Wolf Optimizer (GWO), which acts as a search strategy for selecting features. It uses different types of data sets related to voice, handwriting (spiral and meander) and speech. The presentation algorithm contributes to prediction of Parkinson’s disease with an estimated accuracy of 94.83%, a detection rate of 98.28% [24].

Data from our study shows that MRI equipment used with even less than 3T power may indicate some brain damage with a direct or indirect diagnosis of Parkinson’s disease. Once those aspects have been detected and recorded, remote tracking and assessment of a patient’s prognosis is much easier and more accurate.

The current optimal treatment consists in the continuous administration of L-Dopa derivatives via the portable Duodopa (PDP) pump without feedback. Closed loop control for PDP thus provides a fully automated drug therapy [25, 26].

Conclusions
The results of our study show at least a temporary improvement in the quality of life of the patients in the study group following the initiation of progressive release levodopa treatment correlated with the administration of dopamine inhibitors. MRI technology is indispensable in achieving a differential diagnosis but, monitoring the response of dopaminergic centers to medicative treatment.

We believe that the use of advanced radiological techniques such as 3T IRM or PET-SCAN can significantly enhance the results of Parkinson’s disease.

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