

Appendix 3

SYMPTOMS OF DRUG REDUCTION AND WITHDRAWAL

The first part of this appendix has two lists of symptoms: those caused by drug withdrawal and those set in motion during recovery. The latter are listed because many of them might easily be confused with drug withdrawal. The second part of this appendix explains why the symptoms of drug reduction/withdrawal and the symptoms of Parkinson's are so similar. Please keep in mind that the following symptoms may occur during reduction of dopamine-enhancing drugs whether or not a person has ever had Parkinson's disease. A person might have similar symptoms to those listed below even if he only used dopamine-enhancing drugs recreationally. Therefore, although many of the symptoms below are easily confused with Parkinson's disease, they are actually drug reduction symptoms. It may be impossible in any given moment for a PDer to be able to determine whether or not his drug reduction symptoms are due to his Parkinson's or his drug reduction; both can cause the exact same symptoms of dopamine deficiency. The only way to know if the symptoms are due to drug reduction or Parkinson's is to wait about ten weeks and see if they start to go away. The symptoms of drug reduction may not be completely gone in ten weeks, but they should be starting to modify somewhat. It may take months and even years before the symptoms of drug reduction are completely gone, and even then there may be residual, semipermanent brain damage.

How can one know if one's difficulties are stemming from drug reduction/withdrawal? If the following symptoms do begin to change, vacillate, or modify within a few months, it is likely that that they are drug reduction symptoms and not Parkinson's symptoms.

These lists are not complete by any means. Every person will create his own unique repertoire of symptoms. The following information is merely to give you some ideas of how and why these symptoms manifest so that you can logically interpret your own behaviors, which may be similar or may be superficially different.

Symptoms of drug withdrawal

Tremor

The tremor of drug withdrawal can be mild or ferocious. It can affect the hands, the face, or any body part. It can resemble the tremoring of Parkinson's or it can consist of the whole upper torso jerking back and forth. The back and forth motions are more common than side-to-side motions. The head may bob back and forth.

Whole body shaking

The whole body may shake violently, rattling the teeth and vibrating as if the body parts are going to go flying off, as if the body is a rat being shaken by an invisible cat. The whole body may also be consumed with small shakes, as if it's being vibrated.

Insomnia

This symptom is particularly onerous, as it contributes to all the others. How many times have I heard, “If only I could get a night’s sleep, none of the other symptoms would be as bad.” The insomnia is not simply a matter of lying in bed, unable to sleep. It is usually quite panicked and resistant to fatigue. It is as if the body has forgotten how to sleep and instead remains on full alert during the night. It is normal for people to pace the darkened house endlessly during the months of drug withdrawal. This is an extreme version of the restless pacing that occurs in Parkinson’s and is one of the most common symptoms of withdrawal.

Urination

There may be an increased sensitivity in the bladder, creating a sense of almost constant urgency. Drug reducers often complain about their frequency of urination. During the night, you may need to urinate every hour, if not more.

NOTE: If you are having this symptom, do visit your doctor and find out if you have a bladder infection or some other medically treatable situation. Not all bladder infections are painful. We have had two patients who assumed that their urgency was part of their drug withdrawal. Only when it continued after all their other withdrawal symptoms were gone did they realize that they had infections. There is no need to suffer needlessly, and a bladder infection gone wrong can rapidly damage a kidney.

Bizarre dreams, nightmares

It may be a side effect of sleep deprivation, and it may not. In any case, your dreams during this time, if you ever do fall asleep, may be terrifying. One patient had recurring dreams of his grandmother’s death; his grandmother had been the only person in his childhood who had ever shown him any tenderness.

Hallucinations

Wide-awake versions of the bizarre dreams and nightmares can appear and disappear. A common hallucination is a voice speaking to you, telling you that you are getting worse, that no one understands what you are going through, that you need the medication. This voice can create a thousand reasons why you need more medication and how to justify taking it. It will hound you. You may not be able to tell if this is a voice from outside your body or if it is your own inner voice talking to you. I have had patients who scream at the voice, “Shut up!” but to no avail. The voice may tell you that it is your only friend, that you are being used, that you cannot trust the people around you, that you should listen to the voice. A common point that the voice likes to make is this: “You are old, and you’re going to die anyway. Who cares if you die an addict? Better to die an addict and feel good than to live and be in pain for the rest of your life. What if you die tomorrow? You will have done all this suffering for no reason. You will die soon anyway, so take more pills.”

Nausea

This can range from distaste for food, to fear of food, to vomiting and dry heaves. Curiously, sometimes the powerful distaste for food will not prevent you being able to put away a large meal. Some patients manage to keep eating their regular meals during

the months when they are nauseated. If excessive weight loss is a problem, bear in mind that sometimes a beer or glass of wine, by elevating dopamine, can invoke the return of a healthier appetite.

Weight loss

Most people lose a lot of weight during drug withdrawal. This is due to the nausea, the pacing, the shaking, and the insomnia. It is a serious concern for many patients. The loss of muscle mass is particularly troublesome for a recovering PDer who is trying to re-grow muscle.

Pacing

This restless pacing can be accompanied by shaking, head wagging, clutching at the gut, and a tendency to walk in straight lines, turning corners only with difficulty.

Repeating words

A person might latch onto one phrase, or one word, and repeat it endlessly. It can be logical, or it can be a response to a hallucination, making no apparent sense. A common one is “Help me, help me, help me, help me, help me, help me, help me.”

Heightened sensitivity

Lights may seem blinding. Sounds may seem deafening. Smells may be nauseating. Tastes may be too powerful. Ambient temperatures may seem too hot or too cold. Clothing might feel too heavy. Internal sensations may also be heightened, so that the actions of the gastrointestinal tract are painful, and the cramping of muscles is excruciating. This heightened sensitivity can be severe. I have seen people curled up in a ball, eyes squinched shut, hands over their ears, repeating, “I can’t take it, I can’t take it.”

Sense of doom

There may be a certainty that death is hovering. One person felt Death sitting on her shoulder for weeks.

Paranoia

Not so severe as the sense of doom, the paranoia is extremely common. It can manifest as fear of being left alone, fear of the night, fear of the telephone, or a certainty that people are plotting. I had one patient, an English chap who had worked in the merchant marines, who, during the worst of every drug reduction, kept warning us that Tahitians were trying to beat him up. If he had a fall that left a bruise, he would show us the bruise as proof that the Tahitians had shown up while he was sleeping and beaten him.

Temperature regulation

The body may be unable to regulate temperature. If the person feels cold, he may be curled up in a tight ball, shivering, unable to relax or even move his limbs. If he is too hot, he may be sweating and flushed.

Muscle cramping

There may be powerful cramping, or there can be pain from a muscle being held in one position, immobile, for hours. Some people are in such pain from their immobility that they cry out to their caregiver every few minutes, requesting help to move to a better position. I had one caregiver who kept notes. Her husband needed to be moved more than twenty times in one hour. Each time, the pain from immobility was so bad that her previously stoic husband was whimpering.

Dystonia

Dystonia, muscle cramping, and tension anywhere in the body may be worse during drug withdrawal. It can be very painful.

Loss of balance

The slowness of response during drug withdrawal can make it impossible for a person to perform the necessary balance corrections. Falls can occur. Also, uncontrolled walking backwards or sideways is not unusual.

Dizziness

A common side effect of many of the dopamine-enhancing drugs is dizziness. It can also occur during withdrawal. This contributes to the loss of balance.

Violent behavior

The survival mechanisms of the limbic area can cause unexpected, uncharacteristic behavior. These behaviors can range from mere surliness to violence. In our experience, the spousal violence is most likely to occur during a drug withdrawal phase when the caregiving spouse refuses to tell the PDer where the drugs are hidden.

Lying

Uncharacteristic lying about everything in general, and about drug doses in particular, can occur during drug withdrawal. This one seems particularly devastating to the spouses. After being lied to about sneaking some medication, one wife sobbed, "I can handle anything. I don't mind being up all night, I don't mind helping him with everything, but I can't stand it that he is starting to lie to me." I had to assure her that this is pure routine during drug withdrawal and not to take it personally. It was not her husband's mind that was doing this – it was his limbic system.

Illogic

A person can become fixated on one thought or caught up in a world of illogic. This is particularly common in their illogic about their medications. A person in a condition of drug withdrawal might easily declare that, "I originally decreased my drugs because they were making me tic, but now, if I increase my drugs, they won't do that, because I've figured out a system of counting to ten backwards to trick them so that I won't tic anymore."

In our clinic in Santa Cruz, we used to listen in amazement to some of the brazen illogic that patients would present as their justifications for resuming their previous med

levels, or even, despite worsening side effects, increasing them beyond their previous levels.

“It’s never been so bad”

A subset of the illogic of this period is that the person going through it has absolutely no ability to assess his own situation. The withdrawal hell is hell, and every time it is the worst. The person in a state of brain trauma cannot say, “This time is less severe than last time,” or “I’m no longer hallucinating, I must be doing a bit better.”

Instead, every single day during which the limbic area is fairly dopamine deficient will be equally bad. Patients nearly always insist, during every single withdrawal, “This is the worst withdrawal I’ve had yet.” I may point out to them that in previous times, they were unable to sleep or walk, and this time they are merely hypersensitive to sound or sleeping poorly but still sleeping. They just stare at me with a look of incomprehension and repeat, “This is the worst it’s ever been. The reductions have never hit me so hard before.”

The days and months of drug reduction are a cloudy mist in the mind. It is pointless to expect a person to remember objectively how he felt during any given drug reduction. Just assume that every single one will be, without question, “The worst reduction yet.”

Emotions

A person might manifest any sort of emotion, from sobbing with self-pity to raging to hysteria. These behaviors may be frightening, as they may be uncharacteristic. For example, a previously stoic woman may blubber, and a previously sedate man may lash out violently, spittle hanging on his lips and a wild glare in his eye.

Inability to initiate movement, and freezing

A person may find himself stuck in a chair or on the toilet, unable to figure out how to stand up. The eyelids may seem stuck together, or the blink reflex may be greatly slowed. The fingers may not grip well. Movement in general may be slow and clumsy, or it may vacillate between rapid movement and freezing.

Foot sticking

A subset of the above, there may be a tendency to clumsy foot sticking, foot dragging and shuffling during drug withdrawal. Just picture the classic alcoholic who is having DTs. He may be tripping over himself and failing to lift his feet. There may also be an inability to make the feet, or any limb, behave as directed. Festinating gait, a variant of the foot sticking and difficulty in initiating movement, may manifest.

Inability to talk

Also a subset of the inability to initiate movement, the speech may be slow or mumbling.

Hunched posture

The shoulders may be pulled forward, the head thrust forward, and the torso bent forward from the waist. This can be so extreme that the head is literally between the

knees when standing. This is always terrifying to behold. We actually see it fairly often both in recovering PDers and in people who are reducing their drugs. This extreme caricature of hunched posture was described beautifully in Oliver Sacks' book, *Awakenings*, when they abruptly stopped giving L-dopa to one of the subjects in his experiment. Remember, this subject did NOT have Parkinson's disease or stooped posture previous to her brief fling with the drug. But after taking L-dopa for a short time, and then having the L-dopa withdrawn, she not only carried her back bent over so far that her head was on her knees, but she looked for all the world like someone suffering from a severe caricature of Parkinson's.

Drooling

Salivary problems can range from a bit of spray during rapid speech or a bit of spittle lurking in the corner of the mouth, all the way to long streamers of drool hanging from useless lips. Drooling can also be caused by most of the anti-PD medications as well. Just picture, for a moment, a person who is completely stoned on heroin or sloshing with alcohol. Picture the bleary eyes, the staggering steps, and yes, the drool hanging out of the mouth. This word picture is just a reminder that dopamine-enhancing drugs can cause drooling as well as inhibit it. In any case, during drug withdrawal, drooling can also occur.

Symptoms of recovery from Parkinson's

In addition to the symptoms listed above, which can occur during drug withdrawal, the following symptoms may also be occurring. These symptoms are normal during recovery from Parkinson's, whether or not a person ever took the medication. When these symptoms are occurring in a person who is also going through drug withdrawal, they can add to the confusion of trying to figure out what is causing what.

Extreme emotionalism

While this may or may not occur during drug withdrawal, it is certainly the norm for people recovering from Parkinson's. Self-pity, extreme neediness, fear of being left alone, bleating, whining, and crying, are all common during this time. Many caregivers and spouses feel that they are being tested by their PDers. It is as if, after a lifetime of never trusting themselves or their care to another person, the recovering PDers are trying to see just how needy they can be before the caregiver announces his resignation. Many caregivers say that their charge acts infantile from time to time. It has been proposed that for many of these PDers, this is the first time in their life when they felt that it was safe to cry for help or be needy, and that they are acting out the infancy or childhood that they never had. During this time, there may be instances of name calling or cruel teasing – behaviors that the PDer had never indulged in, even as a child. This behavior often responds very quickly to an adult discussion as to what will and will not be accepted. However, sometimes the PDer is incapable of doing overnight maturation. This infantilism is much easier to tolerate if the childhood history of the PDer is well understood.

Pain

While oversensitivity to sight, sound, taste and touch are all normal during drug withdrawal, there is also significant pain associated with recovering from PD. Although most of the pain is in the extremities (the hands and feet), there can also be tremendous pain throughout the body, from the skin down into the bones, and in the gastrointestinal tract as well. The pains of recovering from Parkinson's can be fleeting or last for weeks. They can be acute or they can be a mild tingling under the skin. Please read more about this in the book, *Recovering from Parkinson's Disease, A Patient's Handbook*.¹

Deep Sleep

During recovery, most people will have two-hour periods during the day during which they fall, helplessly, into a state of utter immobility, regardless of their physical condition during the rest of the day. Most PDers have this experience between the hours of seven a.m. and nine a.m. All the dopamine in the world will not provide mobility during these hours; this is a time that deep healing occurs along the Stomach channel. This time frame is approximate; some people may sleep from 6:30 to 8, and others from 7:30 to 10. But it is still the same syndrome, regardless. If there are injuries in addition to those of the Stomach channel, other times of day may also be subject to these complete body shut downs. These periods of unrousable stillness may last for a few weeks, occurring at the same time every day, or they may extend over a period of more than a year and come and go somewhat.

If a person is having Offs from their drugs, and trying to decide if they are from overmedication or undermedication, these (approximately) two hour spans will just add one more layer of confusion to the fun.

Taking more drugs during this time is a waste of drugs and a nuisance to the brain – the body has shut down to make repairs, and it will remain shut down until the repair time has passed.

It is quite astonishing to behold when a person wakes up in the early morning, has a perfectly normal start to the day, and then falls motionless, as if anaesthetized, into a rigid heaviness, unable to speak or even blink. Two hours later, the spell is broken, and the person gets up as if nothing had happened, and continues on his day, moving at whatever is his normal tempo. The next day, it happens again. This extreme level of immobilization does not occur with everyone, but it can happen.

Weakness

A person who is recovering from Parkinson's may have muscles that are turning to pudding. The previously rigid, steely, and diseased muscles along the line from the chin to the foot will be dissolving, prior to the formation of new muscle. During this time, it may feel as though there is no muscle whatsoever along these lines. This is different from the inability to initiate movement that occurs in Parkinson's. This is pure weakness. The limbs may be limp. They may even flop helplessly. They may be so weak that it will be impossible to get up from the toilet or a chair, or to even roll over in bed. It *may* be distinguishable from the helplessness of Parkinson's, however. As an example of the

¹ J. Walton-Hadlock, *Recovering from Parkinson's Disease, A Patient's Handbook*, 2003. This book is available online for free at www.pdrecovery.org

difference, here's a description of a simple activity from the Parkinson's patient's viewpoint and from the viewpoint of someone who has recovered from Parkinson's.

Rolling over in bed

A person with advancing Parkinson's may roll over in bed in this characteristic manner: the knees are brought up to the chest. The shoulders are pushed forward. Then, with a rocking motion generated in the hips or shoulders, or by using an arm to pull the whole body over, the body shifts position with no twisting movement occurring at the waist. The spine is fairly inflexible throughout the rotation.

A person who is turning to a jelly because of being in the middle of recovery from PD will be unable to do any of the above motions simply because he doesn't even have the strength to pull his knees up to his chest. When he does turn over, if he can, he may find that the top half of his body has flopped over, and the lower half is still laying in the former position, heavy, inert, unable to move. He may need to be rolled over by a spouse or caregiver. If so, the spouse or caregiver may find him much harder to move than in his PD days; his limp passivity will be much harder to shove around than his previously rigid frame.

A person who doesn't take medications will have an advantage in assessing whether or not the movements, as described above, are more rigid or more limp. A person who was taking medication will not actually know how he used to move, because his motions and his mind will have been masked by the medications. He will not be able to make an astute comparison.

Some of each

Of course, none of this happens overnight. There is a gradual transition from the immobility and tension of Parkinson's to the immobility and mushy muscles of recovery. It is extremely frustrating, during the long months of increasing weakness, trying to decide what is going on.

A nice landmark is facial expression. The facial muscles recover their strength more quickly than the large muscles of the legs and torso. If a person who previously wore the mask has now recovered facial expression, it is a good guess that his increasing immobility is due, at least in part, to his muscles dissolving prior to reconstruction.

This is all well and good for the person who never used any medications. They must simply wait it out. The person who is trying to reduce medication during this time will be in a more difficult position. He and his loved ones will be plagued with doubts as to whether or not the immobility is an indication of overfast drug reduction. These doubts will be augmented by the fact that the drug reductions will reduce the will power center in his brain to a crumb of cheese, and his inner voice will be making the case to him that nothing matters anymore anyway, so why not take more drugs. This is a difficult time.

DRUG WITHDRAWAL UNCERTAINTIES

During drug withdrawal, our patients were baffled as to which symptoms were being caused by the drug reduction and which ones were remaining from their Parkinson's. The distinction between drug reduction symptoms and Parkinson's disease symptoms is a grey zone, without distinct lines of black or white. *All the symptoms, regardless of cause, are related to changing dopamine levels.*

The symptoms of drug withdrawal listed above can occur in nearly any addict, not just a person easing off his anti-PD meds. And yet, when a PDer's body starts showing some of these symptoms, they will have an uncanny resemblance to his old Parkinson's symptoms, filling the PDer with uncertainty as to his recovery.

Many symptoms of drug withdrawal are interchangeable with the symptoms of Parkinson's. They may manifest only slightly differently in the PDer than in the drug user, and that is the result of habit, and nothing inherent in the drugs. But these differences, however slight, may be worrisome to the recovering PDer.

When a drug user develops a tremor during drug withdrawal, he may tremor in any body part. When the PDer manifests tremor during withdrawal, his body will naturally find it easiest to use those body parts that already have a pattern of tremor established. In other words, if the PDer used to have a left foot tremor, then during drug withdrawal he might be likely to manifest a left foot tremor. Thus, the PDer may conclude, incorrectly, that his tremor has returned. The addict who never had PD doesn't make any such assumption. He just concludes that the tremoring is a part of his "cranking"¹ and doesn't give Parkinson's disease a thought.

As another example, a person experiencing drug withdrawal may tend to hunch over in a fetal, defensive posture. This curling up may involve bringing the knees up or pulling the shoulders forwards. When the PDer, who used to be hunched forward, starts to assume a protective posture during his trouncing from drug withdrawal, it is most likely that his body will select his old tried and true fetal form. He will pull his shoulders forward in his remembered position from his PD days.

This ex-PDer is likely to demonstrate his old, hunched, PD posture during withdrawal. This is quite similar to the classic withdrawal/fetal position posture. However, this patient's MD, seeing the hunching, may disregard the possibility of drug withdrawal, and wrongly assert that his Parkinson's is still very much in place.

This reverting to the established PD pattern during times of dopamine deficiency and stress can make it very difficult to determine whether or not the person still has Parkinson's or if he is merely in the agonies of drug withdrawal. Here is an example of the tendency for the body to revert to familiar habits in times of stress:

A bee sting remembrance

Lynne had completely recovered from Parkinson's disease nearly two years earlier and no longer had any symptoms whatsoever. Her doctor had told her that she had been misdiagnosed – which is as close as one can get to being told that one has recovered. But one terrifying night she thought that it had all returned.

She was highly allergic to bee sting. She had had an anaphylactic shock reaction more than twenty years earlier, so she was always wary in case of bee sting and knew how to respond if one occurred.

On the night in question, she had just rubbed a new brand of salve onto a cut on her hand. She'd cut her finger that morning in the garden. As the cut suddenly started itching and then throbbing violently, and a flash of heat started traveling up her arm, she read the label on the salve – it was made with beeswax.

¹ Cranking is a slang term for drug withdrawal symptoms.

She immediately took the appropriate steps: a dose of Benedryl (an antihistamine), together with a dose of epinephrine, a lung and heart stimulant. Together, these two drugs act to keep the airways open and sedate the histamine response which can, in highly allergic people, be fatal. All went as expected: her heart rate increased, and she felt alternately groggy and hyper alert for the next two hours, which is the correct response to the medicines, and her body stopped reacting to the bee sting.

But the most fascinating part of the response was this: during these two hours, when her body was being stressed by the allergen and the drugs, and no doubt, the fear inherent in having an anaphylactic reaction, she assumed every single one of her old Parkinson's symptoms. Her right hand started a pill-rolling tremor, her right arm up to her elbow was shaking, and she carried her arms bent at the elbow, pulled up tightly to her body. Her shoulders rolled forward, her ears practically resting on her shoulders. The tension in the front muscles of her neck pulled her chin down towards her chest. Her steps became a shuffle, and her legs moved with great rigidity as she paced back and forth in the hallway in her house. She felt her facial expression disappearing. Her mouth hung slightly open, with spittle suspended in the corner of her mouth. Her voice was weak and shaky.

She didn't even realize how she looked until she shuffled past a mirror. She stared with horror. Her Parkinson's disease was back in full force! Her husband helped put her to bed, and she fell into a deep, Benedryl-induced sleep.

In the morning, as she lay in bed before rising, she felt fine, but she was frightened of what she might see in the mirror. Had the Parkinson's returned?

The body that looked back at her in the mirror was perfectly normal, not one sign of Parkinson's. She tried her handwriting; it was nice and big. She sang in the shower and her voice was perfectly normal. That was three years ago. She has not had any similar episodes since that night.

Her body adapted certain behaviors during her years with Parkinson's. She now suspects that any time she is severely stressed, she might temporarily manifest some of her old PD physiology of excess adrenal stress, with its concomitant scattering and decreasing of dopamine. During these times, her body might use the same postures or behaviors that she adapted to manifest her old PD lack of dopamine. It makes sense that, in future instances of dopamine deficiency, she may revert to these patterns, or you might call them symptoms, for as long as the emergency or the dopamine deficiency exists.

This means that, if she develops hypothermia, she might shuffle. If she finds herself in a traumatic emergency, she may have a right hand tremor in the weeks afterwards, as the body comes to terms with the shock.

Death and sickness

Symptoms of dopamine deficiency are not rare, nor are they the exclusive domain of Parkinson's disease. It is normal for a person with hypothermia to tremor, pull the arms in tightly, and to walk with a shuffling stride. It is normal for a person who has been through a shock to feel shaky and want to curl up tightly. However, for a person who has once had PD, these symptoms may always evoke the fear that Parkinson's has magically, instantaneously, re-erupted. Fortunately, this is not the case.

I have since seen the same phenomenon with patients in response to the death of a spouse, and in response to severe illness, as was the case with Taylor Paul. In the case of

the spousal death, the patient had never taken medications for PD. He had recovered to the point that he was no longer manifesting any Parkinson's symptoms when his wife was diagnosed with kidney cancer. She quickly switched from caregiver to care *needer*. She died five months after her diagnosis. During her time of illness, he didn't manifest his old Parkinson's symptoms. But immediately after she died, his old symptoms reappeared. He was trembling and hunched over, and his micrographia reappeared. He was extremely weak. Happily, his voice never went back to a whisper, and he continued to have facial expression and initiation of movement. However, to the casual observer, it looked rather like the Parkinson's had somewhat returned. It was nearly a year before all his PDish symptoms faded away again.

In the case of Taylor Paul, with the severe fever and infectious disease, it was nearly two months before he was even starting to feel like his recovered self again. Again, Taylor Paul's doctor assumed that all weakness must be due to Parkinson's and only Parkinson's, even though Taylor Paul's infectious disease was so severe it nearly killed him.

In other words, as a response to stress, the body might choose to revert back to its known defensive, PDish posture until the stress is gone. All bodies can create dopamine deficient symptoms during times of stress, but it would be the height of madness to insist that they all have temporary Parkinson's disease. But all recovering PDer's may have a tendency to re-robe themselves in their own, particular PD symptoms when they are stressed. This short term resumption of old, remembered symptoms invariably raises the question, for themselves and loved ones, as to whether or not the Parkinson's has abruptly returned, in full battle dress. In our experience, this has not been the case.

It will be a matter of removing or getting over the stress, the illness, the shock, or the cold. When the stressor is gone, the PDish symptoms will cease as quickly as they came.

So keeping all this in mind, the symptoms listed here can occur in anyone, not just a PDer or a recovering PDer who makes a decrease in his dopamine enhancing drugs. All of these symptoms have been mentioned already in the course of the book. This is only a list of the most commonly seen symptoms of drug withdrawal. There is an infinitude of potential variations on this list. Each person walks this path alone, however, and during the course of drug withdrawal, one may invent nearly any behavior that serves as balm to the tormented limbic area.

Summary

In summary, most of the symptoms of drug withdrawal look similar to patterns seen in Parkinson's disease. This is because the symptoms of drug withdrawal are symptoms of dopamine deficiency. Those aspects of Parkinson's disease that are caused by dopamine deficiency will therefore resemble the symptoms of drug withdrawal.

However, in Parkinson's disease, these symptoms develop slowly, over years. During drug withdrawal, these symptoms can develop over a matter of days. They can also resolve abruptly, or vary over the course of days, or even months. The two sets of symptoms are so similar that an MD *cannot* recognize whether or not symptoms are coming from drug withdrawal or from Parkinson's disease. However, if you have been following your patient's case closely, you may be able to tell the difference.

Appendix 3

A health practitioner or caregiver will be well served by making a keen study of the personality and exact movement patterns of the PDer in their care. Then, when this same person starts manifesting personality changes and irrational behavior, together with some new physical symptoms that are subtly different from his symptoms of Parkinson's, you may be able to guess that there is something afoot that may be recovery and not PD or drug related.

Then again, even this is not proof of anything. Every person with Parkinson's has slightly different symptoms. Every person going through drug withdrawal will work through it in a slightly different manner. Everyone recovering from PD will do it in his own, unique way. Guessing which symptom is being caused by what process at any given point in time is nearly impossible for the person in the throes of drug withdrawal, or for an outsider, such as the family doctor. The spouse or care-giving friend, who knows the PDer's history and can compare every symptom with patterns in his past, has the best chance of anyone at guessing what is going on.