**APPENDIX 3. Pharmacotherapy for Common Non-Motor Symptoms of Parkinson Disease**[17,40,45,85-91]

| Symptom | Medication | Considerations for Use |
|---|---|---|
| GI dysmotility: constipation and gastroparesis | • First-line: PEG 3350 (8.5–17 g daily BID)<br>• Second-line: stimulants like sennosides or bisacodyl<br>• Domperidone (10 mg BID) | • Trial medication if behaviour modifications are no longer managing symptoms.<br>• Most patients with Parkinson disease will need multiple agents to manage constipation as disease progresses.<br>• A combination of PEG to soften stool and a stimulant to increase motility (as patients often have reduced GI motility) is typically used.<br>• Domperidone 10 mg BID can be added for upper GI symptoms due to gastroparesis. |
| Urinary urge incontinence | • Mirabegron (25–50 mg daily at bedtime)<br>• Fesoterodine (4–8 mg daily at bedtime)<br>• Solifenacin (5–10 mg daily) | • Consider behavioural modifications first, such as avoiding coffee, reducing fluid consumption before bed, and reducing culprit medications like diuretics.<br>• Once constipation is addressed and urinary retention is ruled out, pharmacologic management may be tried.<br>• The options listed here are least likely to lead to central side effects, such as confusion. Monitor for peripheral anticholinergic side effects, such as dry mouth and constipation with fesoterodine and solifenacin. |
| Insomnia | • Melatonin (0.3–5 mg at bedtime)<br>• Trazodone (12.5–25 mg daily at bedtime) | • Good sleep hygiene should be recommended first, along with optimization of nighttime dopaminergic treatment to reduce physical discomfort (e.g., restless legs from wearing off). |
| REM sleep behaviour disorder (RBD) | • Melatonin (3–15 mg at bedtime), preferably timed release<br>• Clonazepam (0.25–2 mg at bedtime) | • Melatonin can be prescribed before clonazepam as it is safer and better tolerated than clonazepam. Dual action or extended release melatonin better manages RBD events that occur later in the sleep period.<br>• If RBD is not managed with melatonin, start with a low dose of clonazepam and titrate slowly. |
| Depression | • SNRIs<br>• SSRIs<br>• TCAs | • Cognitive behavioural therapy can help manage symptoms in addition to antidepressant medication.<br>• SSRIs and SNRIs are effective at managing depression in patients with Parkinson disease (e.g., citalopram, paroxetine, venlafaxine). TCAs may be more effective but have more side effects and are less preferred.<br>• MAO-B inhibitors and dopamine agonists prescribed to manage motor symptoms may confer antidepressant benefits. |
| Dementia | • Donepezil (5–10mg daily)<br>• Rivastigmine (3–6 mg BID)<br>• Memantine (5–10 mg BID) | • Donepezil or rivastigmine should be tried if there are no contraindications, but note that anorexia, bradycardia, or worsened orthostatic hypotension could be side effects.<br>• Memantine can be substituted for or added to donepezil if not tolerated or insufficiently effective. |

**Note:** Appendix 3 continues on next page

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