Sodium Oxybate for Excessive Daytime Sleepiness in Parkinson Disease

An Open-Label Polysomnographic Study

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Background: Many patients with Parkinson disease (PD) have excessive daytime sleepiness and numerous nocturnal sleep abnormalities.

Objective: To determine the safety and efficacy of the controlled drug sodium oxybate in a multicenter, open-label, polysomnographic study in subjects with PD and sleep disorders.

Design, Setting, and Patients: Inclusion required an Epworth Sleepiness Scale (ESS) score greater than 10 and any subjective nocturnal sleep concern, usually insomnia. An acclimation and screening polysomnogram was performed to exclude subjects with sleep-disordered breathing. The following evening, subjects underwent another polysomnogram, followed by an evaluation with the Unified Parkinson Disease Rating Scale (UPDRS) while practically defined off (“off”) PD medications, ESS (primary efficacy point), Pittsburgh Sleep Quality Inventory, and Fatigue Severity Scale. Subjects then started sodium oxybate therapy, which was titrated from 3 to 9 g per night in split doses (at bedtime and 4 hours later) across 6 weeks, and returned for subjective sleep assessments. They then returned at 12 weeks after initiating therapy for a third polysomnogram, an off-medication UPDRS evaluation, and subjective sleep assessments. Data are expressed as mean (SD).

Results: We enrolled 38 subjects. At screening, 8 had sleep apnea (n=7) or depression (n=1). Twenty-seven of 30 subjects completed the study. Three dropped out owing to dizziness (n=3) and concurrent depression (n=1). The mean dose of sodium oxybate was 7.8 (1.7) g per night. The ESS score improved from 15.6 (4.2) to 9.0 (5.0) (P<.001); the Pittsburgh Sleep Quality Inventory score, from 10.9 (4.0) to 6.6 (3.9) (P<.001); and the Fatigue Severity Scale score, from 42.9 (13.2) to 36.3 (14.3) (P<.001). Mean slow-wave sleep time increased from 41.3 (33.2) to 78.0 (61.2) minutes (P=.005). Changes in off-medication UPDRS scores were not significant, from 28.4 (10.3) to 26.2 (9.6).

Conclusion: Nocturnally administered sodium oxybate improved excessive daytime sleepiness and fatigue in PD.

Trial Registration: clinicaltrials.gov Identifier: NCT00641186

Arch Neurol. 2008;65(10):1337-1340
Subjects were recruited from the Baylor College of Medicine Parkinson Disease Center and Movement Disorder Clinic and Raleigh Neurology Associates. The protocol was approved by the Baylor College of Medicine Institutional Review Board and the Western Institutional Review Board. All subjects signed informed consent.

Within 7 days, the subjects underwent the entry PSG. They were subsequently excluded if they had more than mild sleep apnea (apnea/hypopnea index >15) and oxygen desaturation levels consistently below 90%. Obstructive apneas were scored as 10 seconds of more than 90% airflow reduction with continued respiratory effort. Obstructive hypopneas were scored as 10-second epochs of more than 30% airflow reduction associated with either a 3% oxygen desaturation or an electroencephalographic arousal.

Within 7 days, the subjects underwent the screening/acclimation PSG. They returned to the clinic the following morning without taking their usual PD medications (off-medication state) and underwent assessment with the Unified Parkinson Disease Rating Scale (UPDRS). After taking their PD medications, they completed the Fatigue Severity Scale (FSS), Pittsburgh Sleep Quality Inventory (PSQI), the 36-Item Short Form Health Survey quality-of-life assessment, and the ESS (primary efficacy point). The subjects then started sodium oxybate therapy, 4.5 g per night, to be taken in 2 equally divided doses: 2.25 g (4.5 mL) at bedtime, and 2.25 g (4.5 mL) 2.5 to 4.0 hours later. They woke naturally or set an alarm for their second dose. A follow-up telephone call 1 week later reviewed medication adherence and any possible adverse effects. The subjects were examined after 2 weeks of therapy with reevaluations of the ESS score, vital signs, and adverse events. The dose was increased to 6 g per night, to be taken in 2 equally divided doses. After another follow-up telephone call and according to the clinical judgment of site investigators, the dose was increased weekly by 1.5-g increments to a maximum nightly dose of 9.0 g. In the event that adverse effects developed with the higher doses, the dose could be reduced to a tolerated level for the remainder of the trial. The final clinic visit (study day 36) included a final PSG, followed by an off-medication UPDRS evaluation, then a repeated battery of tests after PD medication therapy was restored. The subjects returned all unused drug.

The primary efficacy point was change in the ESS score (daytime sleepiness). Other measures of daytime symptoms (the FSS score) and nocturnal symptoms (the polysomnogram and PSQI) were secondary measures. Statistics included descriptive calculations and paired, 2-tailed t tests. Significance was set at \( P < .05 \). Study design, data management, database design, statistical analysis, and manuscript drafting were all performed by the primary investigator (W.G.O.), who maintains ownership of the data. The primary investigator received an Investigational New Drug exemption from the US Food and Drug Administration for the study. Unless otherwise specified, data are expressed as mean (SD).

Thirty-eight subjects with PD were enrolled to achieve 30 successful screenings. We excluded 8 subjects at screening secondary to sleep apnea criteria (n = 7) and depression (n = 1). Three subjects dropped out after randomization for dizziness (n = 3) and concurrent depression (n = 1); 2 of these dropped out before any follow-up data were collected and were therefore excluded from the efficacy analysis. The 6-week subjective sleep data in the third subject were included as the last observation carried forward.

The mean age of the 30 subjects (of whom 24 were men) was 61.5 (8.7) years, and the duration of PD was 8.6 (5.5) years (range, 1-25 years). The Hoehn and Yahr stages were 2.0 (n = 14), 2.5 (n = 11), and 3.0 (n = 5). Twenty-seven subjects were white, 2 were Hispanic, and 1 was Asian. The mean entry Mini-Mental State Examination score was 29.1 (1.3) (range, 25-30). All subjects were treated with a dopamine agonist without levodopa (n = 8), levodopa without a dopamine agonist (n = 3), or levodopa and a dopamine agonist (n = 19). Six of the subjects taking levodopa and a dopamine agonist also took a monoamine oxidase type B inhibitor; 10 subjects took a catechol-O-methyltransferase inhibitor; and 11 subjects took amantadine hydrochloride.

The mean final dose of sodium oxybate was 7.8 (1.7) g per night. The final nightly doses were 3.0 g (n = 2), 4.5 g (n = 1), 6.0 g (n = 6), 7.5 g (n = 4), and 9.0 g (n = 17). The ESS, PSQI, and FSS scores improved significantly. Changes in the 36-Item Short Form Health Survey score were not significant (Table 1).

Slow-wave sleep time increased in 27 subjects, \( P = .005 \) (Table 2), whereas rapid eye movement sleep time was modestly reduced. Total apneas mildly in-
creased, but the mean and maximum oxygen desaturation values did not change. No other PSG features changed significantly. Increased SWS time (in minutes) did not correlate with reduced ESS scores ($r=0.10; P=.09$).

Mean off-medication morning UPDRS motor scores were stable in 27 subjects, changing from 28.4 (10.3) to 26.2 (9.6) (NS). No subject subjectively reported that there was any meaningful change in his or her motor symptoms.

Adverse events probably or definitely related to the drug included dizziness (n = 3), nocturia/enuresis (n = 3), nausea (n = 1), daytime sleepiness (n = 1), reduced alertness (n = 1), and rebound morning tremor (n = 1). One subject reported increased morning tremor. Additional adverse events that were considered not related to the study drug included constipation (n = 1), delusions (n = 1), and, in a single subject, bradycardia, anxiety, depression, and edema. Twenty-two of 30 subjects (73%) reported no adverse events.

At the study’s conclusion, 18 of 27 subjects (67%) completed application forms for the central distribution pharmacy to continue sodium oxybate therapy.

**COMMENT**

Overall, nocturnally administered sodium oxybate was well tolerated, increased SWS, and improved subjective nighttime and daytime sleep problems and daytime fatigue in subjects with PD. Improvements in ESS were similar to or better than those found when the drug is used as therapy for narcolepsy. The PD motor features were unchanged.

The mechanism by which sodium oxybate improves EDS is not known. It is known to increase SWS; however, our study did not show a significant correlation between improved SWS and ESS scores. The SWS change in our study compared only 2 nights and is variable. In addition, our study was not powered in any way to specifically address this question, so we cannot entirely exclude the possibility of SWS variations. Sodium oxybate has also been postulated to improve EDS by decreasing sleep fragmentation in narcolepsy trials; however, we found improved EDS without reduced awakenings in this PD study. Furthermore, deep brain stimulation of the subthalamic nucleus improves sleep fragmentation associated with nocturnal motor abnormalities in subjects with PD but has not improved EDS in a small number of studied subjects.

As an alternative explanation, nocturnal sodium oxybate use may result in the rebound vigilant state observed during the day after nighttime administration. The short half-life of sodium oxybate allows for complete washout by the morning, when increased release of stored dopamine and norepinephrine may occur and contribute to the observed enhanced wakefulness. Dopamine release is actually inhibited while the drug is active, which may account for the nonsignificant increase in periodic limb movements. We did not believe that the slight increase in apnea was clinically meaningful, but this needs to be monitored. There was no evidence of abuse.

**Table 1. Sleep and Fatigue Results**

<table>
<thead>
<tr>
<th>Instrument</th>
<th>Before Sodium Oxybate Therapy</th>
<th>After Sodium Oxybate Therapy</th>
<th>$P$ Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>ESS</td>
<td>15.6 (4.2)</td>
<td>9.0 (5.0)</td>
<td>$&lt;.001$</td>
</tr>
<tr>
<td>PSQI</td>
<td>10.9 (4.0)</td>
<td>6.6 (3.9)</td>
<td>$&lt;.001$</td>
</tr>
<tr>
<td>FSS</td>
<td>42.9 (13.2)</td>
<td>36.3 (14.3)</td>
<td>$&lt;.001$</td>
</tr>
<tr>
<td>SF-36</td>
<td>95.7 (7.1)</td>
<td>92.3 (5.1)</td>
<td>.71</td>
</tr>
</tbody>
</table>

**Table 2. PSG Results in 27 Subjects With Parkinson Disease**

<table>
<thead>
<tr>
<th>Mean (SD) Findings</th>
<th>Before Sodium Oxybate Therapy</th>
<th>After Sodium Oxybate Therapy</th>
<th>$P$ Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total sleep time, min</td>
<td>363 (65)</td>
<td>353 (74)</td>
<td>.11</td>
</tr>
<tr>
<td>Stage 1, min</td>
<td>40 (45)</td>
<td>34 (44)</td>
<td>.23</td>
</tr>
<tr>
<td>Stage 2, min</td>
<td>215 (88)</td>
<td>197 (78)</td>
<td>.27</td>
</tr>
<tr>
<td>Stages 3-4, min</td>
<td>41 (33)</td>
<td>78 (61)</td>
<td>.005</td>
</tr>
<tr>
<td>REM sleep, min</td>
<td>57 (39)</td>
<td>37 (24)</td>
<td>.002</td>
</tr>
<tr>
<td>Sleep efficiency, %</td>
<td>75 (14)</td>
<td>74 (15)</td>
<td>.29</td>
</tr>
<tr>
<td>Total No. of PLMs</td>
<td>14 (14)</td>
<td>22 (30)</td>
<td>.13</td>
</tr>
<tr>
<td>Total apnea/hypopnea index</td>
<td>7 (6)</td>
<td>13 (12)</td>
<td>.004</td>
</tr>
<tr>
<td>Mean oxygen saturation level, %</td>
<td>93.9 (2.5)</td>
<td>94.1 (2.3)</td>
<td>.68</td>
</tr>
<tr>
<td>Minimum oxygen saturation</td>
<td>88.3 (3.5)</td>
<td>87.0 (3.6)</td>
<td>.44</td>
</tr>
<tr>
<td>level, %</td>
<td>57 (42)</td>
<td>59 (77)</td>
<td>.69</td>
</tr>
</tbody>
</table>

This study has all of the shortcomings of any open-label trial. We intentionally designed broad inclusion criteria and did not exclude subjects with restless leg symptons or rapid eye movement sleep behavior disorder, neither of which appears to affect EDS in PD. Given the robust efficacy and good tolerability of the study drug and the lack of effective treatment for EDS in patients with PD, we believe that controlled trials using objective measures of daytime sleepiness are justified.

**Accepted for Publication:** April 13, 2008.

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**Author Contributions:** Study concept and design: Ondo. Acquisition of data: Ondo, Perkins, Swick, Hull, Jimenez, Garris, and Pardi. Analysis and interpretation of data: Ondo. Drafting of the manuscript: Ondo. Critical revision of the manuscript for important intellectual content: Ondo, Perkins, Swick, Hull, Jimenez, Garris, and Pardi. Statistical analysis: Ondo. Administrative, technical, and material support: Ondo, Perkins, Swick, Hull, Jimenez, Garris, and Pardi. Obtained funding: Ondo. Study supervision: Ondo.
Financial Disclosure: Dr Ondo has received research grant support from Jazz Pharmaceuticals, Inc; is a member of the speaker's bureau for Allergan, Boehringer Ingelheim, GlaxoSmithKline, TEVA, UCB Pharma, and Valeant; and has received research funding from Allergan, Boehringer Ingelheim, Forest, Schwartz Pharmaceuticals, and Valeant. Dr Perkins is a member of the speaker's bureau for Boehringer Ingelheim, Cephalon, GlaxoSmithKline, and Jazz Pharmaceuticals, Inc; and has received research support and has served on the professional advisory board for Jazz Pharmaceuticals, Inc. Dr Swick is a member of the speaker's bureau for Boehringer Ingelheim, Cephalon, GlaxoSmithKline, Jazz Pharmaceuticals; has received research support from Cephalon, GlaxoSmithKline, Jazz Pharmaceuticals, Inc, Merck, Pfizer, Sanofi-Aventis, Somazom, and Takeda; and has served on the professional advisory board for Jazz Pharmaceuticals, Inc. Mr Pardi is an employee of Jazz Pharmaceuticals, Inc, and provided assistance in the analysis of the data and the review of the manuscript.

Funding/Support: This study was supported by an unrestricted research grant and supply of the study drug from Jazz Pharmaceuticals, Inc.

REFERENCES