Parkinson Society Southwestern Ontario

Parkinson's in Women

SIGNS AND SYMPTOMS THAT CAN LOOK DIFFERENT

In Canada, nearly 1% of adults aged 65 and older live with Parkinson's Disease (PD)[3]. Although men are diagnosed almost twice as often as women[3], thousands of women across the country are living with PD, and growing evidence shows that biological and social factors shape their experience of the disease in unique ways. Understanding these differences can help you manage your health and get the best care possible.

Motor Symptoms

Motor symptoms emerge later in women, with an average age of onset two years later compared with men[7]. Tremor (involuntary shaking, usually in the hands or arms) is the most common first presenting symptom in women. Compared with men, women have reduced rigidity, worse postural instability, and report greater functional disability[2].

Motor fluctuations are more common among women with PD and are associated with poor quality of life. Additionally, women with PD have twice the risk of hip fracture compared with women without PD [7]. Women have less risk of developing camptocormia (abnormal severe forward flexion of the trunk while standing or walking) comparing with men.

Non-Motor Symptoms

Women report higher levels of fatigue (extreme tiredness) and physical pain related to the disease. Symptoms such as restless legs, gastrointestinal dysfunction, constipation, excessive sweating, trouble swallowing food or liquids (dysphagia), loss of taste or smell, and weight changes are also more common in women [1, 2, 6].

Women with Parkinson's tend to have better-preserved cognitive abilities. They usually perform better on tasks involving attention, working memory, quick thinking, problem-solving, and verbal fluency. However, women may have more difficulty with visuospatial functions, such as judging space, shapes, or distances around them [7, 2, 6].

Women often experience stronger anxiety and deeper episodes of depression [7, 2, 6].

Gender Gap

Women with PD experience a greater delay in receiving an accurate diagnosis and a referral to a movement-disorder specialist compared with men[1]. Women may also be underdiagnosed until their symptoms become more severe[4].

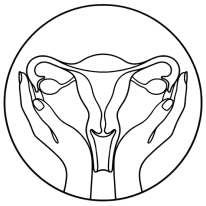
Women have a higher likelihood of being approved for Deep Brain Stimulation (DBS) therapy. However, they are less frequently referred for DBS evaluation, undergo DBS less often, and access surgical treatment later than men[6, 4].

A study evaluating patients referred for DBS assessment in Germany and the UK found evidence of a gender gap affecting women with PD[5]. The reasons appear to be non-clinical. Possible explanations include referral biases in specialty care, patient preferences, such as greater fear of surgery among women, and unmeasured factors like socioeconomic status[5].

Pharmacological Therapy

In the absence of a disease-modifying therapy, PD treatment currently focuses on controlling motor symptoms through levodopa supplementation[2]. Women with PD tend to have a better response to levodopa and may be more likely to receive less doses than men[6]. However, women develop more involuntary, uncontrolled movements as a side effect of this medicine (dyskinesias). This difference may be explained by the higher proportion of levodopa that enters the bloodstream (bioavailability) in women compared with men [7, 1, 2, 6].

Additionally, women have greater risk of "wearing off," meaning that the medication becomes less effective before the next dose[1].



The Role of Hormones

Evidence suggests that estrogens playing a neuroprotective role in women against the disease. A strong link has been shown between early menopause and earlier onset of PD[7]. However, the evidence on the impact of hormone-replacement therapy on the risk of developing PD, as well as on PD symptoms in women, remains inconsistent[1]. Additionally, estrogens cannot be recommended as a treatment for PD because they may increase the risk of certain types of cancer in both sexes and can cause feminizing effects in males[7].

Deep Brain Stimulation (DBS)

DBS is an effective treatment for advanced PD, improving quality of life as well as motor and non-motor symptoms[5]. It is indicated for patients with advanced PD who experience motor fluctuations and dyskinesia that can no longer be adequately managed with medication[6].

With DBS, Women show greater improvement in emotional well-being, the ability to perform activities of daily living and social life[2]. Additionally, quality-of-life measures improve more in women than in men[2], and only women experience improvement in attention and memory[5].

Beneficial effects are observed in both genders in the domains of sleep/fatigue, urinary symptoms, and miscellaneous symptoms. Improvements also occur in tremor, dyskinesia, motor fluctuations, mobility, activities of daily living, cognition, bodily discomfort, and stigma[5].

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Challenges in Getting Care

For both, men and women with PD, having a caregiver can help prevent hospitalizations and delay nursing home admissions[4]. However, because women tend to live longer than men, disabled women are more likely than disabled men to lack a spousal caregiver[7]. Women also have higher use of advanced nursing care services (such as skilled nursing facilities, home health, and hospice) and lower use of direct physician care[4].

Women often take on the role of primary caregivers for their children and partners, as well as household responsibilities, which adds to their burden and can make them feel unsupported in their journey with PD[1]. In addition, women in general receive less support during chronic illness, especially in older age, because they are more likely to live alone[4].

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