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Opicapone prescribing information and adverse event reporting is available on page 4.



Standard of care: Real-world needs and real-world stories in Parkinson's disease

BIAL's symposium at the 11th Annual Congress of the European Academy of Neurology (EAN), Monday 23 June 2025, Helsinki, Finland



The real-world need for OFF symptom management

Professor Fabrizio Stocchi, University and Institute for Research and Medical Care, IRCCS San Raffaele Rome, Italy

Early recognition of OFF in PD remains challenging.¹

Patient questioning should be personalised from the early stages of Parkinson's disease, ideally incorporating appropriate diagnostic scales such as the WOQ, as symptoms may emerge as early as within the first year following diagnosis.^{1,2}

“OFF is a change in the clinical state of a patient with PD where motor and/or NMS appear or worsen and result in functional disability”³

Challenges of OFFs



Each patient is different
Every day can be different

When treating motor fluctuations, **combining different types of adjunct therapies** rather than using only one at a time provides a rational approach:⁴ polytherapy may allow for **lower individual doses**, which can minimise the risk of side effects.⁵ Polytherapy can begin with the combination of levodopa with benserazide or carbidopa (to inhibit DDC)⁶ and, thus, there is a natural extension to add and combine COMT

inhibitors to further optimise peripheral levodopa. Other adjunct therapies may also be considered, such as MAO-B inhibitors and DAs using the same approach.⁴

However, polytherapy for PD symptom control is not always used to its full potential.

Recent evidence suggests that appropriate levodopa dosing combined with adjunctive medications can stabilise patients with advanced PD and improve their quality of life over a 2-year period,⁷ suggesting that this **proactive approach may be key to achieving better symptom control** in patients with early motor fluctuations in the long term.



THE REAL-WORLD STORIES

Improving daytime symptoms

Professor Regina Katzenschlager, Klinik Donaustadt, Vienna, Austria

Professor Katzenschlager addressed the topic of daytime symptoms in patients with PD, **highlighting the efficacy of the COMT inhibitor opicapone**. Opicapone functions as a **peripheral inhibitor of COMT**,⁸ and is distinguished by its high binding affinity and slow dissociation.^{9,10} These properties contribute to a long duration of action which results in a **sustained increase in levodopa exposure**.^{11–13} Consequently, opicapone is dosed once daily.¹⁴

In **extensive Phase III clinical trials**, opicapone **demonstrated efficacy** with a **favourable safety**

and tolerability profile.^{15,16} The number of patients who discontinued because of TEAEs was low and similar between placebo and opicapone; the most common TEAE observed with opicapone was dyskinesia, affecting 16–24% of those in trials.^{15,16}

Importantly, Professor Katzenschlager shared her clinical experience: if dopaminergic side effects such as dyskinesia arise when opicapone is introduced, it is better to manage baseline **levodopa therapy rather than discontinue opicapone**.

Further evidence for the use of opicapone in early motor fluctuations comes from the **REONPARK study**.¹⁷



Prospective 2-year real-world observational study in Spain
Target recruitment:
260 patients in 26 sites



Initiated on a COMT inhibitor
(physician's choice)



Patients with PD and wearing-off
for <2 years on a COMT inhibitor



Impact of COMT inhibitor initiation on:

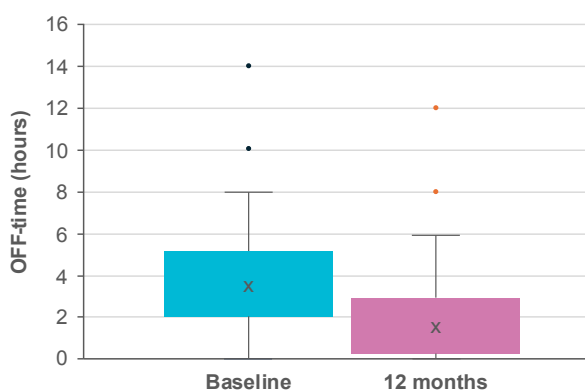
- Levodopa dosing
- Functional status
- Disease burden
- NMS
- QOL

A 12-month interim analysis of 89 patients reported:¹⁸

- **98.9% receiving opicapone**
- **Mean levodopa daily dose: 464 ± 192 mg**
- **Significant OFF-time reduction** (Figure, below left)
- **Reduced functional impact of OFFs** (Figure, below right)

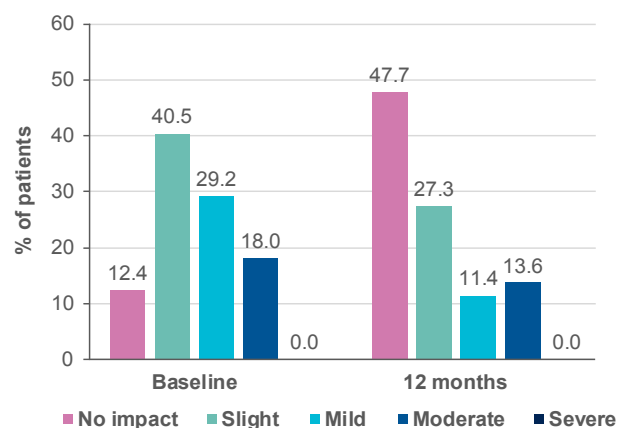
Reduction in mean OFF-time at 12 months¹⁸

3.8 ± 2.6h → 1.9 ± 2.2h (p<0.001)



Reduction in functional impact of OFFs at 12 months¹⁸

No impact: 12.4% → 47.7%



This real-world study supports the use of opicapone in patients with emerging motor fluctuations,^{17,18} adding to the evidence of opicapone's efficacy in managing both motor and non-motor symptoms^{19,20} and highlighting the importance of early clinical detection and intervention for motor fluctuations

THE REAL-WORLD STORIES



Night-time challenges – better nights, better days

Professor K Ray Chaudhuri, King's College London, London, UK
and King's College Hospital, Dubai, UAE

Motor fluctuations and non-motor fluctuations both emerge as PD progresses. **Non-motor fluctuations, such as sleep disturbances, excessive daytime sleepiness, and vivid dreams** often occur alongside motor symptoms.²¹ Professor Chaudhuri outlined a

number of studies that have demonstrated that adding opicapone to existing levodopa therapy improves sleep quality in patients with motor fluctuations.^{22,23}

The OASIS trial further supports this:²⁴



Phase IV, 6-week, exploratory, open-label, single-arm, multicentre study



Opicapone 50 mg once daily as an add-on to levodopa/DDCI therapy



Patients with PD experiencing wearing-off and associated sleep disorders
N=16



Change from baseline in PDSS-2 score

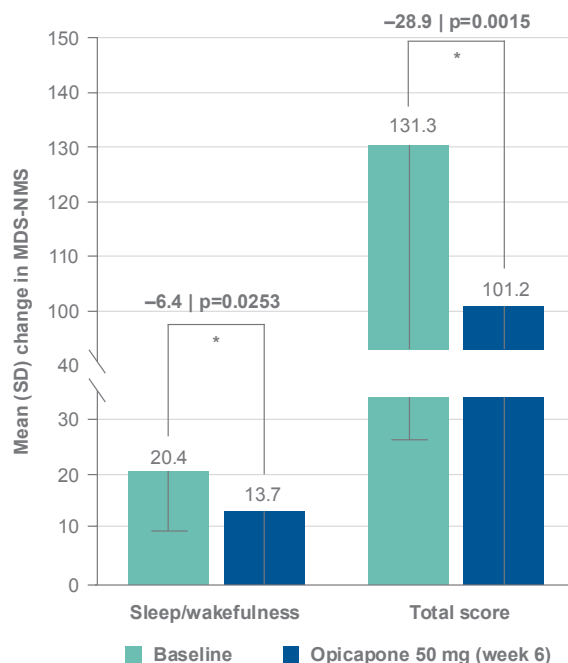
The trial showed:

- **Reduction in PDSS-2 total score of –7.9 points** (95% CI; –13.6, –2.2; $p=0.0099$)²⁴ (where MCID = –3.44 points²⁵)
- **Improvement in PDSS-2 domain of disturbed sleep of –4.7 points** (95% CI; –7.2, –2.3; $p=0.0009$)²⁴
- **Improvement in MDS-NMS total score** (see figure, opposite)

Opicapone also provided improvements of >30% on the PDSS-2 items:²⁶

- **Poor sleep quality previous week (–42%)**
- **Sleep latency (–50%)**
- **Sleep fragmentation (–39%)**
- **Poor restorative sleep (–41%)**
- **Difficulty moving or turning in bed (–35%)**
- **Tremor upon waking (–39%)**

Reduction in MDS-NMS score²⁴



Opicapone is a simple strategy, prolonging levodopa effect throughout the night, and can help many of these dopamine-responsive night-time symptoms of PD²⁴

Panel discussion

1

How can you exclude that, in the BIPARK trials, the improvement in OFF-time was offset by an increase in dyskinesia?

Prof Katzenschlager replied that patients with PD with marked dyskinesia (dyskinesia disability score >3 on 33 [disability] of the UPDRS) were not included in the BIPARK trials,^{15,16} but it is possible that patients with mild dyskinesia were included. She noted that these studies showed an increase in ON occurring without troublesome dyskinesia.^{15,16}

2

How do you decide to use opicapone instead of, for example, increasing levodopa, especially in patients with polypharmacy?

Prof Stocchi highlighted that it is a matter of how many doses the patient is already taking when deciding whether to use opicapone in patients with polypharmacy. The ADOPTION clinical programme showed that opicapone was more effective at reducing OFF-time compared with another 100 mg levodopa dose in patients with early signs of motor wearing-off.¹⁹ He added that clinicians need to base their decisions on the available data and their own experience.

3

Patients have a number of problems during the night, such as RBD, dyskinesia, PLM, etc. How can you say that the improvement is due to opicapone and not, for example, from a placebo effect or other indirect improvement?

Prof Chaudhuri recommended using screening tools to identify clinical symptoms.¹ If problems appear to be RBD or sleep apnoea, then opicapone treatment may not be the next step. However, if opicapone is prescribed and the symptoms improve, it is probably linked to the prolonging of levodopa^{11,12} (particularly influencing early morning OFF symptoms). This would support that the improvements are not due to the placebo effect or other indirect improvements.

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Abbreviations

CI, confidence interval; COMT, catechol-O-methyltransferase; DA, dopamine agonist; DDC, dopa-decarboxylase; MAO-B, monoamine oxidase-B; MCID, minimal clinically important difference; MDS-NMS, Movement Disorder Society Non-motor Rating Scale; NMS, non-motor symptoms; NMSS, Non-Motor Symptom Scale; PD, Parkinson's disease; PDSS-2, Parkinson's Disease Sleep Scale-2; PLM, periodic limb movement; QOL, quality of life; RBD, REM sleep behaviour disorder; REM, rapid eye movement; SD, standard deviation; SE, standard error; TEAE, treatment-emergent adverse event; UPDRS, Unified Parkinson's Disease Rating Scale; WOQ, Wearing-Off Questionnaire.

Prescribing Information

Please click [here](#) for opicapone UK PI and adverse event reporting statement