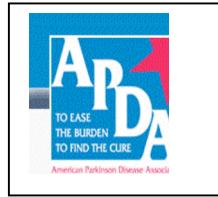


American Parkinson Disease Association, Inc
5368 Fredericksburg Rd, Suite 200
San Antonio, TX 78229-6108



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AAPSG Calendar, April 2005 - June 2005

All Support Group Meetings are for PD Patients, their Caregivers, Family and Supportive Friends.

Alamo Area Parkinson's Support Group

Second Monday every month, 1 PM
Sunset Ridge Church of Christ, 95 Brees Boulevard
11 Apr –
9 May –
13 Jun –

Young-Onset Parkinson's Support Group

Second Saturday every month, 10 AM
Thornton Elementary School, 6450 Pembroke
9 Apr – No meeting due to today's Walk-A-Thon,
Eisenhower Park 9:00AM
14 May – Dr Gary Penny – Taking anti-depression
drugs with PD meds
11 Jun –

DBS Support Group "Live Wires"

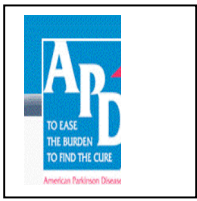
Fourth Saturday every month, 10 AM - Location varies; call Sandra Farris, 830-257-3811
sandyfar@omniglobal.net or Judy Hoopman 830-997-7705 ralanh@kctc.com for current location.

PD Support Group of Lower Rio Grande Valley

Meets Third Tuesday in Sept–Nov, & Jan-May.
2:30 PM, Golden Palms Retirement Center,
2101 Treasure Hills Blvd, Harlingen, TX.
For more information call Pauline and Bill Frink at
956-421-3360, or e-mail mrspgfrink@rgv.rr.com

PD Support Group Poteet, Texas

Meets Second Saturday every month,
11 AM – 1 PM. Poteet Grange Hall - Bring a
covered dish. For more info call
830-276-4824.



American Parkinson's Disease Association, Inc
 Alamo Area Parkinson Support Groups
 5368 Fredericksburg Rd, Suite 200, San Antonio, Texas 78229-6108
 Phone 210-344-8828, www.aapsg.org
 APDA Information & Referral Center, Dr Eric Pappert Medical Director
 Phone 210-567-6688

Quarterly Newsletter, April 2005

Editor: Dianne Johnson

Publishers: Carla & Doak Walker

Local News

Executive Board, 2002-2004

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Carolyn Deel	Kip Morrison

You may leave a message for any AAPSG Officer or Board Member at 210-344-8828.

PD Awareness Month

April has been designated PD Awareness Month. April 11th is PD Awareness Day
2005 APDA Parkinson's Walk-A-Thon
Each and every one of you can participate and help find a cure.

This years AAPSG Parkinson's Walk will be held on Saturday April 9th at Eisenhower Park (NW Military Dr, north of 1604) Pavilion #2, 9:00 – 11:00 AM. Come help us raise money for PD research. If you are unable to attend please send a donation to:

APDA, AAPSG
 C/o Rose Tristan,
 Access Quality Therapy Services,
 5368 Fredericksburg Rd, STE 200
 San Antonio, TX 78229

All money raised is sent directly to APDA for PD research. For more information contact: Rose Tristan at 877-362-0126 or 210-349-0096, or email to rtristan@accessqualitycare.com
 Sponsors list on next page.

Local "Ask the Dr" Column

Call your questions to 210-567-6688 or email them to diannejohnsonrn@aol.com and Dr. Pappert will answer them in future newsletters.

PLEASE NOTIFY US IF YOUR LOCAL ADDRESS OR E-MAIL ADDRESS CHANGES

Doak Walker shalom6@peoplepc.com , 210-674-3013, 7650 Hwy 90W #40, San Antonio, TX 78227-4059.

Our Web Site www.aapsg.org



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Parkinson's Walk-A-Thon Sponsors

Gold Sponsors (\$1000); SAS, Dr. Suzanne K. Gazda/Integra Clinical Research

Silver Sponsors (\$500); Schwarz Pharmaceutical

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In-Kind Donations; Ben E Keith, Crispy Cream Donuts, Girl Scouts of San Antonio, Lackland AFB, Liz Face Painting, Oak Hills Country Club, PF Chang

Parkinson Disease, Parkinson-Plus, Parkinson Syndrome, Parkinsonism, Atypical Parkinson Disease, and Parkinson-Like PD

Abe Lieberman MD

I was told I have PD. I've read or heard the term Parkinsonism or Parkinson Syndrome. Is there a difference? One doctor said I had PD. Another said I had Atypical Parkinson Disease. And a third said I had PD-Plus. Are they the same or different?

These are legitimate questions by people who are confused by terms doctors use to convey differences among seemingly similar disorders. The doctors, in seeking to convey the differences, often create confusion. The purpose of this article is to offer a reasonable explanation of the terms.

1. PD is a disorder of slow (over many years) progression characterized by the presence, in most (but not all) people, of 4 main symptoms: rigidity or stiffness, a resting tremor, bradykinesia or slowness of movement, difficulty walking which may be associated with difficulty with balance. Most, but not all, of the symptoms respond to Sinemet (levodopa) or an agonist (Mirapex, Permax, and Requip).

2. PD-Plus refers to a group of disorders which at one time during their evolution, may resemble PD. The PD-Plus disorders may have other symptoms not found in PD. That is why they're called PD-Plus. They respond poorly or not at all to Sinemet or the agonists. At one time in their progression the PD-Plus disorders may be mistaken for PD and vice versa. The cause of all of them is unknown.

The more common PD-Plus disorders are:

A. Progressive Supranuclear Palsy (PSP). For every 100 people with PD there are 5 with PSP. It is characterized by early and severe difficulty with balance and by an inability to move the eyes. Dudley Moore the actor had PSP.

B. Multiple System Atrophy (MSA). For every 100 people with PD there are 5 with MSA. There are 3 variants of MSA.

- **Shy Drager** variant which includes difficulties resulting from involvement of the **Autonomic Nervous System (ANS)** which regulates automatic body activities such as swallowing.
- **Striato-nigral Degeneration** which resembles PD but doesn't respond to Sinemet or the agonists.
- **Olivopontocerebellar Atrophy** which is characterized by early and severe difficulty with balance.

3. Corticobasilar Degeneration (CBD). Resembles PSP, but unlike PSP, which starts on both sides simultaneously, CBD may start first on one side. Rigidity is more of a problem than in PSP. Eye movements may or may not be affected. For every 100 people with PD there is 1 with CBD.

4. Parkinson Syndrome, or Parkinsonism, or Atypical PD is often used synonymously with PD-Plus. Or it may be used to describe a person who has PD symptoms but who doesn't actually have PD. Thus the Parkinson disorders which result from carbon monoxide or manganese or severe head injuries are called Parkinson Syndromes. The term Parkinson Syndrome or Parkinsonism, although confusing, continue to be used. I prefer to use the term PD-Like disorder.

5. PD-Like disorder. This is a term I use to include all conditions of the PD-Plus disorders, Parkinson syndromes or Parkinsonism, **which are NOT PD.** I include disorders such as **Essential Tremor** which is often confused by lay people for PD. I include **Wilson Disease**, a disorder of copper metabolism, which may in young people resemble PD. I include **dystonia** (an alteration in muscle tone) which may be part of PD or may occur separately from PD. I include **Restless Leg Syndrome** which may occur with PD but usually occurs separately from PD.

Technologies called single photon emission computed tomography or SPECT and positron emission tomography or PET can measure biochemical changes in the striatum, changes which mirror the loss of dopamine cells in the substantia nigra. Using different isotopes alone and in combination, SPECT and PET are increasingly able to tell in life if a person has PD or a PD-like disorder. Yet, the expertise needed to use the different isotopes for distinguishing between PD and the PD-like disorder are not widely available.

In PD, on post-mortem examination, the loss of dopamine cells in the substantia nigra is accompanied by a marker present in most of the dying cells. This marker is found in a part of the cell called the cytoplasm. Under the microscope it appears as a round body, almost filling the cell. This is called a **Lewy body**, after Friedrich Lewy the doctor who first described it. How the Lewy body is formed, whether it is a sign of death or recovery, and the composition of the Lewy body are questions which science is seeking to answer. Such answers will bring us a long way forward toward understanding PD.

To diagnose PD, and not a PD-like disorder, there must be at least a 60% loss of dopamine cells and many if not most of them must contain Lewy bodies. In the PD-like disorders there may be an equal or greater loss of dopamine cells; but the dying cells do NOT contain Lewy bodies. It is as though a different process is killing them. The usually greater loss of dopamine cells in the PD-like disorders explains, in part, why they are less responsive to Sinemet; why, if they do respond, the response is less dramatic. In PD, but not in the PD-like, the cells in the striatum are normal. Because the cells in the striatum are normal, the receptors for dopamine on these cells are normal. PD patients respond to dopamine agonists (drugs which act like dopamine on the receptors). In some of the PD-like disorders the cells in the striatum are injured or dead. And, in some of the PD-like disorders the cells in another brain region called the globus pallidus are injured or dead. The cells in the striatum extend their processes to the globus pallidus. Because in the PD-like disorders the cells in the striatum and the globus pallidus are injured or dead, the PD-like disorders respond poorly to agonists.

During an office examination, the changes in the striatum and the globus pallidus cannot be detected. However, the response to Sinemet or an agonist can be detected. Thus sometimes when the diagnosis of PD or PD-like is unclear, a patient will be placed on Sinemet or an agonist as a test. The test can last until both doctor and patient are certain there is (or is not) a response.

PD starts slowly and progresses slowly. This mirrors the slow loss of dopamine cells. The PD-like disorders start and progress more rapidly. From onset of symptoms (often not appreciated except in retrospect) to diagnosis can be 2-4 years in PD, 1-2 years in the PD-like disorders. From diagnosis to need of symptomatic treatment may be 1-2 years in PD, less in the PD-like disorders.

If dopamine agonists are started first, approximately 80% of patients respond. Among patients who do not respond are patients originally diagnosed with PD but later diagnosed with a PD-like disorder. 30% of patients treated with an agonist can be maintained on the agonist (without Sinemet) for up to 4 years. Such patients rarely develop dyskinesia. Seventy percent of patients treated with an agonist need Sinemet within 4 years. If Sinemet is started first, approximately 80% of patients respond and approximately half have dyskinesia. Among patients who respond minimally or not at all are patients originally diagnosed with PD but later diagnosed with a PD-like disorder. Such patients do not have dyskinesia. A moderate to marked response to an agonist or Sinemet usually means PD. The development of dyskinesia usually means PD. A minimal or no response to an agonist or Sinemet usually (but not always) means a PD-like disorder. A relatively rapid course, 1-2 years from onset of symptoms to diagnosis, usually means a PD-like disorder. Exceptions are people over 70 years in whom PD progresses more rapidly. This reflects the superimposition of PD with its loss of dopamine cells on an age related loss of dopamine cells. Older people have a smaller reserve and thus their PD can progress more rapidly.

PD is diagnosed on the basis of 4 main symptoms. Not all people have all 4 symptoms when they're diagnosed. And not all people develop all 4 symptoms during the course of their PD. The 4 main symptoms are contrasted in PD and the PD-like disorders.

1. Rigidity which the patient may feel a stiffness or a "soreness" in a shoulder or a hip. The rigidity usually starts asymmetrically, more on one side than the other, more in the arms and legs than the neck and trunk. . In the PD-like disorders, especially PSP, the rigidity usually starts on both sides simultaneously, is felt more in the neck and trunk and is rarely described as "soreness". In CBD the rigidity, like in PD, may start asymmetrically, more on one side than the other, more in the arms and legs.

2. Tremor which the patient feels at rest with the arms relaxed and not moving. The **resting tremor** of PD usually starts asymmetrically. If a resting tremor is present, and marked, and is more on one side than the other, it is virtually specific for PD. A resting tremor is rarely present in the PD-like disorders. Twenty percent of PD patients, usually in addition to a resting tremor, have a tremor (called a **postural or sustention tremor**) when they extend their arms or when they move their arms (called an **action or kinetic tremor**). Some patients have both a postural and action tremor. In half of patients with PD and a sustention tremor, the tremor appears before the resting tremor and may be confused with a condition called Essential Tremor (ET). ET is perhaps 20 times more common than PD. In perhaps 10 % the tremor is sufficiently severe to require treatment. Rarely, ET becomes PD. Whether ET is a fore-runner of PD, or a co-incidence is, at present, unknown.

3. Bradykinesia or slowness of movement is part of PD, and often part of the PD-like disorders, especially PSP and MSA. In PD the slowness of movement usually responds to Sinemet or the agonists. In the PD-like disorders the slowness of movement does not respond to Sinemet or the agonists. This is because, in the PD-like disorders, the changes in the brain are more extensive and wide-spread.

4. Difficulty walking in PD results from a combination of slowness of movement of the legs and difficulty with balance. The slowness of movement, but not the difficulty with balance, responds to Sinemet and the agonists. When difficulty walking occurs in the PD-like disorders there is usually more and earlier difficulty with balance. If a disorder begins with difficulty with balance the disorder is more likely to be a PD-like disorder.

PD and the PD-Like disorders have other symptoms. The appearance in time of the particular symptom (early or late in the disorder) and the severity of the symptom in proportion to the 4 main symptoms may, sometimes, distinguish PD from the PD-Like disorders. Among the more common symptoms are:

1. Dementia. Thirty percent of people with PD develop dementia. This usually occurs after the diagnosis of PD. The dementia of PD is often, but not always, called: **Lewy Body Disease (LBD)** because Lewy Bodies are seen in cells in brain regions outside the substantia nigra. It is more common after age 70, and is usually not as frequent in PSP and MSA. Whether the absence of dementia is a feature of these disorders or whether people with these disorders do not live as long as people with PD (and so do not have time to develop dementia) is unknown. There's a debate as to whether the appearance of PD symptoms then dementia or the appearance of dementia then PD symptoms are the same or different disorders. In some people when dementia appears before PD is diagnosed it is called **Alzheimer Disease with Parkinsonism**.

Although at post-mortem examination differences between LBD and Alzheimer can be appreciated, in life the differences may not be. PD with dementia, Lewy Body Disease, and Alzheimer with Parkinsonism are sometimes called PD-Plus or PD-like disorders.

2. Difficulty with eye movements. Some people with PD have difficulty moving their eyes. This usually occurs later in PD. The difficulty in moving the eyes may not be apparent on an office examination but is apparent to the patient who has difficulty reading. In PSP the difficulty with eye movements appears early, and is apparent on an office examination. In some people with PSP the difficulty moving the eyes progresses to paralysis.

3. Difficulty swallowing. Develops usually late in both PD and PSP, but early in MSA.

4. Postural hypotension or a drop in blood pressure on standing. This appears later in PD, is usually not disabling, and is usually related to drugs: Sinemet and the agonists. Postural hypotension appears early in MSA, may be disabling, and is not related to drugs. It results from involvement of the ANS.

5. Difficulty in urinating can occur in late PD. It is annoying but often not disabling. MSA may progress

to an inability to empty the bladder.

From the above, PD and PD-Plus disorders may be thought of as people who look alike because they dress alike. Underneath they are different, each from PD, and each from the other.

Help for Family Caregivers

Being a caregiver for a person with Parkinson's disease is a very stressful experience. Since 1996 we have been conducting a research study on relaxation therapy for family caregivers. We work with the caregivers to teach them relaxation and coping strategies that can be used at home on a daily basis to reduce stress. We measure the relaxation response using biofeedback equipment and assess the immune response.

Interested Participants

Who: Family caregivers of individuals with PD.

What: Participants will be asked to come for a minimum of 8 weeks. Relaxation and coping skills will be taught that can be practiced at home. During our test periods the participant will also be assessed with a biofeedback machine for muscle tension, skin conductance, temperature, and pulse rate. Blood will be drawn to assess the immune response to the relaxation therapy.

Where: Testing and training in stress management techniques will be conducted at the Audie L. Murphy Hospital located at 7400 Merton Minter Blvd., San Antonio, TX, 78229.

Benefits: Besides the relaxation and coping skills that will be learned, monetary compensation will be given for participation in the study.

Investigator: Sharon Lewis, RN, PhD, FAAN, University of Texas Health Science Center, South Texas Veterans Health Care System.

If you are interested in participating or would like more information, call Denise Miner-Williams at 210-383-6725 or Sharon Lewis at 210-949-3696

Memory Problems That Should Trigger an Evaluation

There are some very basic warning signs that anyone concerned about dementia or memory loss should look for. Ask yourself the following questions and report the results to your doctor.

- Do you frequently misplace objects?
- Do you have difficulty performing complex tasks that require a series of actions (such as cooking)?
- Are you increasingly unable to respond effectively to problems at home or work?
- Do you have difficulty with orientation or relationships?
- Do you have trouble driving that you did not have before?
- Do you find that you are often unable to find the right words to express your thoughts?
- Do you have difficulty conversing or following conversation?
- Has your behavior changed? For example, do you feel more irritable and/or aggressive?
- Have you become disassociated or indifferent to what is happening around you?

Early diagnosis is always important when coping with dementia. If dementia is caught early, there are more treatment options that your health-care provider can review with you. It also may be that some of your memory loss is just a normal part of aging; your doctor will be able to differentiate between normal, age-related memory loss and severe dementia. Ask your friends, family, or your physician to let you know if you exhibit any of the symptoms listed above. Inform your physician if you are easily distracted, have trouble concentrating, have a problem choosing words, or if it takes more time for you to understand or think of what you want to say.

HAPS Newsletter

Clinical Trials Web Site

Try this new site, www.pdtrials.org to check out current clinical trials.

FREE Screening

Access Quality Therapy Services provides free screening for speech and balance at their offices on 5368 Fredericksburg Rd, San Antonio and 10790 Toepperwein Rd, Converse. Call 210-349-0096 for an appointment. The Parkinson Outreach Center/Parkinson's Outreach Program is located at 5368 Fredericksburg (near Kens-5 TV), San Antonio, TX 78229. Free pamphlets and videos are available. Sandra Ganske, RNC, AQTS, Director of Community Education, 210-349-0096.

Memory Exercises

1. Pay Attention. Stop--look--listen. It takes no more than a second to say, "I am putting the keys in my jacket pocket."

2. Rehearse & Repeat. Rehearse (repeat to yourself) the idea you want to tell your spouse. You may forget if you used shampoo, but you'll remember your new idea.

3. Chunk. Chunking will aid short term or working memory. A 10-digit number 3013661755 can be remembered easier as 301 366 1755.

4. Get Organized. List your medication needs by the time and place to be taken. Medications taken before, with, or after meals are usually stored in the kitchen. You must also plan for times you do not eat at home. Organize other medications, for example, eye drops, lotions and ointments as well.

5. Use Cues. There are two strategies.

--**Visual elaboration** is simply creating a mental snapshot to help enhance a memory. The visual image should be associated with a very familiar object.

--**Verbal elaboration.** Some of the verbal elaborations you have used include acronyms such as IRS and PTA; word associations such as "spring forward, fall back" to reset your clock. You want a simple way to remember your PIN number and your telephone credit card. Change the numbers into letters that correspond to their location on a telephone or ATM keypad, for example, ABCD = 2223. You can use any four letter name or word such as John = 5646 and blue = 2583.

HAPS Newsletter

"Will you please help my daddy?"

Nina Brown

Hopefully the words softly spoken by 3 year old Suzanna, who attended the 11th Annual Parkinson Action Network (PAN) Forum, did not fall on deaf ears. As head of HAPS Advocacy Committee, founding members of Texans for the Advancement of Medical Research and state coordinators for PAN, my husband Joe and I went to Washington to give a voice to other Texans. This year Suzanna, along with 16 other Texans, crowded into our senators offices and then split up to visit our representatives. Please notice that I said "**our.**" The representatives who really care reminded us that they work for us and let us know how important it is that they hear our needs in order to represent us. So we told them.

We told them how soldiers are routinely exposed to a wide range of chemicals, low level radiation and other external stressors and toxins. The number of veterans in our small Texas group was surprising and disturbing! Susan, who was discharged from the military with PD over 20 years ago, is so affected she is unable to hold her head upright. Ron had to give up his job as a college professor because he can no longer write or speak to give lectures. They, along with veterans, James and Terry, presented our request for \$40 million to continue the DOD's Neurotoxin Exposure Treatment Research Program. NETRP's research has not only given valuable information on how to protect military personnel and minimize future exposures to toxic substances or harmful situations, but has produced beneficial results for those who suffer from neuro-degenerative diseases such as PD, Alzheimer's and ALS.

We told them about the VA's PD Research, Education and Clinical Centers (PADRECC), a program that conducts research in biomedicine, provides rehabilitation and health services and runs clinical trials each year for at least 40,000 PD veterans. One of the six in the country is in Houston.

Ken, also a veteran, was able to work his way up the corporate ladder until he was diagnosed at 35 and was forced to give up his highly paid, successful position to go on disability. His wife, Patty who is working toward her doctorate in psychology, told us how her mother, a WW II nurse, has spent the last

15 years frozen inside her own body, unable to care for herself, unable to spend time with her grandchildren and great grandchildren. Ken sees his future in the eyes of Patty's mother. Along with the rest of us, Ken and Patty asked for sponsorship of the Castle-DeGette Stem Cell Research bill in the House and the companion bill in the Senate which states that no federal funds shall be used to derive stem cells or destroy embryos and that research on stem cell lines derived after August 9, 2001 shall be eligible for federal funding which will meet ethical guidelines established by NIH. Stem cell research has potential to save lives and improve the health of hundreds of thousands suffering from now-incurable diseases including PD, diabetes, Alzheimer's, cancer, heart disease, spinal cord injury, traumatic brain injury, ALS, blindness, multiple sclerosis, sickle cell anemia, strokes, muscular dystrophy, and others. Kees, the recipient of two brain surgeries, came with his wife, Faye and their daughter, Suzanna. Faye is a surgeon, who related that she could take out an appendix or gall bladder and "fix" the problem but she couldn't "fix" her husband. Faye wants Kees to be able to walk Suzanna down the aisle. They asked for support for a 6% increase for the National Institutes of Health budget and greater funding for Parkinson's, explaining that the budget President Bush sent to Congress had an increase of only .05 percent...an increase that won't allow research already begun to continue, because it doesn't keep up with biomedical inflation. We asked that our Senators and Representatives join a working group or caucus that will keep them informed about issues involving PD. We asked for their help.

Everyone attending the Forum was there at great physical, emotional, financial and personal sacrifice. Vickie, whose caregiver was unable to come, didn't let that stop her from coming alone, walker and all. Louis and Betsy somehow managed to make the long walks from building to building. I loaned Terry my scooter because he could barely walk. I took a fall (not because I didn't have the scooter) and fractured some ribs. Cayce was there so others won't suffer like her mother, as was Dianne, who watches the toll PD takes. Susan, Ron, James, Terry and Ken have lost their jobs and are forced to live on disability. They would much rather be productive and give to society rather than take. Jimmy, now 50 prays he will be able to continue working until he is 55. Years ago, Harvard estimated that the costs of PD to our country from Medicare disability and lost wages, was \$25 billion a year. I can't think of a more compelling, more economical or more compassionate way to spend our tax dollars today to protect tomorrow. Can you? When there is a natural disaster our government immediately finds ways to offer relief. Why isn't it considered a disaster that approximately 2800 men, women and children are *dying* every day accompanied by the prolonged pain and suffering of disease? A similar number of people died dramatically on 9/11. While not as dramatic as the horror of a terrorist attack to our country, the anguish to families watching their loved ones die after having been attacked by diseases that potentially can be cured is just as great. 9/11 was truly a tragic disaster that neither you nor I could prevent, but we're living daily with a disaster that can be prevented, as well as the devastating economic impact from chronic diseases that could be cured or controlled! We must get more research!

Help yourself, your loved ones, your friends and help Suzanna's daddy! Texas is a big state. We need your help. Whatever your position...make your voice heard. Become an advocate!

Write letters and send e-mails to your legislators

Make calls to your legislators

Submit letters to newspaper editors

Talk with and e-mail associates and leaders of community organizations

If you want some guidance or have any questions, please call us at 713-218-8888 or e-mail brown@ninajoe.com. Check out the following websites: www.hapsonline.org; www.parkinsonaction.org and www.txamr.org. The PAN forum will be on the PAN website for the next year. Check it out.

HAPS Letter

Fatigue

In 1993, 233 patients with PD were included in an 8 year study of fatigue. During the study, patient fatigue increased from 35.7% in 1993 to 42.9% in 1997 and 55.7% in 2001. Fatigue was related to disease progression, depression, and excessive daytime sleepiness (EDS). However, the prevalence of

fatigue in patients without depression and EDS remained high and increased from 32.1% to 38.9%. The authors confirmed the high prevalence of mental fatigue in patients with PD. In more than half of the patients, mental fatigue was persistent and seemed to be an independent symptom that develops parallel to PD progression.

Ives G, Wentzel-Larsen T, Larsen JP, NPF, AskTheDr

Enjoy a Cruise

Cruising is an easy and a great way to travel, but you must plan ahead. Tell the booking agent if traveling with a handicapped person and tell them what accommodations you need. Do not, however, ask for a handicapped stateroom unless you use a wheelchair because handicapped staterooms are quite limited. Do ask for a stateroom that is close to the mid-ship elevators, as it will require less walking. If you need help on the gang plank; ask for it. Parkinsonion People

NOTE: You can catch a cruise in Galveston TX.

Driving - What's the Bottom Line?

Having PD does not necessarily result in giving up driving. However, whether you are a person with PD or a loved one, it is important to be responsible and remember the dangers that PD presents to driving. Ignoring the effects will only create a more dangerous environment for you and other drivers. The best way to be a responsible driver is by paying attention to your driving skills and reporting any changes to your doctor. If you have concerns, don't avoid voicing them out of fear of losing your license. Doctors and family members are often happy to help you exhaust rehabilitation options before asking you to give up driving. If it does come to the point where family and/or doctors ask you to give up your keys, realize that it is in your best interest to stop driving and explore other transportation options.

PDF News & Review.

Access Quality Therapy Services is providing **FREE driving screening for seniors** using the Roadwise Review computer program. This computer program, developed by AAA to help seniors stay safe drivers, assess your driving ability by testing: leg strength, general mobility, head/neck flexibility, high contrast visual acuity (Normal Daylight Conditions), low contrast visual acuity (Rain or Fog), visualizing missing information, visual information processing speed, visual search, and working memory. For more

information or to schedule an appointment call 349-0096.

PDF Unveils New Line of Publications

The following new publications are now available from the PDF. *Web Resources for People with Parkinson's*; *Parkinson's Advocacy: The Keys to Empowerment*; and *Parkinson's Disease Q & A: A Guide for Patients*.

To obtain copies and to view other resources that PDF offers, visit www.pdf.org and fill out the publication request form, or call PDF at 1-800-457-6676. All print materials are FREE.

APDA - IBM STUDY UPDATE

A past edition of the Young Parkinson's (Summer 2004) newsletter reported on a study involving PD volunteers and IBM researchers on the effects of PD on computer usage. Study participants are providing recordings of their typing for analysis by the researchers. This feedback has already helped to improve the IBM program, which is being designed to reduce or eliminate many of the problems which plague computer users who have PD. When the current group has completed the testing, a second group will test the improved version of the program. Early results from the typing samples are providing helpful information regarding what keyboard setting changes may be needed to make typing easier. If you have a suggestion for a change that would make your keyboard easier to use, or if you would like more info about the study, contact Shari Trewin by e-mail Trewin@us.ibm.com or phone (914) 784-7616.

PD & PREGNANCY

Pregnancy in PD is not common, but it can and does happen. Little information is available in the medical literature on this subject and as a result, health care professionals can offer little counsel to women with PD who are contemplating becoming pregnant or who are already pregnant.

The APDA Young-Onset Information & Referral Center (1-800-223-9776) is working in collaboration with a movement disorders specialist and a PD nurse specialist in the United Kingdom who have designed a questionnaire to acquire anecdotal histories from women who have experienced one or more pregnancies after being diagnosed with PD. As a result, it is hoped that a fact sheet can be developed to enable women with PD who wish to become pregnant to make more informed choices. For more info or to request a questionnaire contact Mike Scott, PD Nurse Specialist, Medicine Level One, Conquest Hospital, St. Leonard's On Sea, East Sussex, UK TN37 7RD, telephone 0044 1424 755255 x 6432, e-mail: michael.scott@esht.nhs.uk

Memorials

In Memory of George W. Bennett, Jr
Berta Dodd-Marbut

In Memory of Betty Ann Blanchard
Carolyn Bellamy

In Memory of Berniece Embrey
River City Federal Credit Union

In Memory of Adrian Guardia
Concha Segovia, Dee & Judy Griffin, Faculty & Staff of Woodlawn Elementary School, Robert & Caroline Rodriguez, Linda D Voelzel John Sherman, Mary B. Garcia, Ronnie, Herman & Thelma Segovia, Texas Partnership for Accomplished Teaching

In Memory of Joe Guerra
Jonathon & Sondra Wiedenfeld

In Memory of Linda Hall
Kenneth & Martha Lynn Kumpf, Randall & Marsie Erwin, Theresa Kim, Evelyn Wirth, Darrel & Sandra Wilbanks, Ron & Joan Duval, Evelyn Wirth, Nancy Rheams, Ms EC Shaefer Frisbie, Nelda L Garza, Rob & Melinda Rodriguez

In Memory of Marvin E. Harbour
Janice Labar, Joyce Hagler

In Memory of Hanry Harms, Jr
Ernest & Melba Wolff
Gerald & Patricia Pieniazek

In Memory of Patsy Hines
William & Janet Haby, Joyce M. Wimer, E. L. Smith Plbgf Htg & A/C, Inc

In Memory of Casey Humphreys
Tuesday Bridge Club

In Memory of Joseph A. Jachimczyk
Melissa Mieras

In Memory of Ann H Tyler
Kathleen Ebert Viesca,
Friends and Family at City Public Service

In Memory of Lillian Jacobson
Richard Mohan, Mr & Mrs James Young,
Mary Joy Norton, Percylee & Charles Bowen,
Gloria Padilla, Mrs W. M. Records
Glenda Morgan, Mary Jo Klingeman,
Charles & Pat McFarland, E. Blanton,
Don & Maxine Sabol

In Memory of Irma Johnson
Kathryn & Thomas Hensey, Jan Barnes

In Memory of Elvira LaMon
Erna Rose Kirk, Betty McCue,
Office Resource Center,
Martha Boughton, Rose M. Richardson

In Memory of Eris Mangrem
NW Ms Regional Medical Center Nursery Staff,
Suzanne & Mike Tooley, Clyde & Frieda Smart,
Harold & Marcia Smart, Wayne Smart,
Sue Smart, Faye Crooks, Al & Billie Hisey,
Mike & Connie DeWald

In Memory of Walter A. Richter
George Crocker, Mary Rose Benham

In Memory of Leonard Seelig
Kelly Wenzel, Lucille Biegler, Pam Morrow
Dale & Jeanie Farnsworth,
Monday, Tuesday & Thursday Bridge Clubs,
Enrichment Team-Longs Creek Elementary
School, Leonard & Beverly Biemer; Hiriam &
Nancy Goya, Helen Wright, Pam Morrow, Dale &
Jeanie Farnsworth, Tom & Eileen Callahan,
Sonny & Linda Cross, Bart Callahan,
Myrtle Denham, Bunny Getzen, Howard &
Madeline Hyman, Virginia Bowden

In Memory of Ada Shoulders
Rebecca L. Collins

In Memory of Marguerite Sparks
Louise Mayfield

In Memory of Gail Hall Swearingen
Carolyn Bellamy

In Memory of Colonel Carl Taylor
M.E. Leeper, BG USA Ret