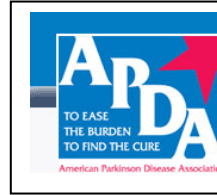


American Parkinson Disease Association, Inc
2929 Mossrock, Suite 200
San Antonio, TX 78230-5137



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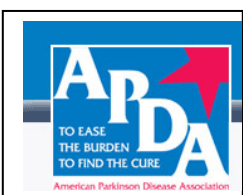
NOTE

Our Web Site is located at www.aapsg.org
Hosted by PCA Web Design & Hosting in Plano, Texas, Toll Free: 888-229-4747,
E-mail: info@pcawebdesign.com.

PLEASE NOTIFY US OF ADDRESS/E-MAIL CHANGES.

POC: Kim Johnson Vineyard kjv624@yahoo.com 1028 PR 1712, Mico, TX 78056.
We can't get information to you if we don't know where you are living.

See last page for support group information



American Parkinson's Disease Association, Inc
 Alamo Area Parkinson Support Groups
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 Phone 210-349-0096, www.aapsg.org
 APDA I & R Center Phone 210-567-6688

Quarterly Newsletter, July 2009

Editor: Dianne Johnson, R.N.

Local News

Executive Board, 2009

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Understanding drug-induced parkinsonism

When Dr. James Parkinson described the shaking palsy in 1817, he referred to syndrome characterized by the presence of resting tremor, stiffness (rigidity), and slowness (bradykinesia) in addition to loss of postural reflexes and freezing. We now use the term "parkinsonism" to describe these symptoms. It is idiopathic, or Parkinson disease (PD) in most situation. However, a drug-induced parkinsonism (DIP) is not that rare. Therefore, when a patient appears "parkinsonian", one must obtain a careful medical and medication history, as this is often reversible, especially if the offending drug is discontinued early.

Here is one case scenario: A 46-year-old man developed arm and hand tremors two weeks after initiating perphenazine for mood disorder. His psychiatrist promptly changed it to quetiapine four weeks, though his tremor persisted. As a result, he was referred to a neurologist. He had a history of hypertension, hypercholesterolemia, and chronic nausea. His medications include verapamil, lovastatin, and metoclopramide. When examined by his neurologist, he had tremors in both hands and arms. The tremor however was worse with posture (arms out-stretched) and mildly present at rest (hands resting on his lap). He didn't appear slow during examination and his posture/gait was normal.

What did we learn from this case? Well, first of all, "not all the shakes mean PD. This is very important since a handful of patients with DIP are unfortunately misdiagnosed with PD. Your neurologist will recognize "clues" during examination (a), identify "risk factors" when taking medical history (b), and question offending "drugs" (c) that may be a culprit to your symptoms. This is very crucial as DIP is reversible. Thus, early recognition usually leads to a better prognosis.

A	B	C (few examples)
Subacute bilateral onset and progression of symptoms time-locked with medication intake Early presence of postural tremor Concurrent oral-buccal dyskinesias	High dose/potencyneuroleptics Elderly Female (female:male ratio 2:1) Hereditary Parkinson disease Preclinical parkinsonism AIDS Coexistence of tardive dyskinesia	High risk Neuroleptics: old (& some newer ones) Antiemetics Intermediate risk Certain anticonvulsants, mood stabilizer like Lithium Lower risk† <u>Some</u> Antiarrhythmic, Antidepressants, Antifungals/Antibiotics, Chemotherapeutics, etc.

Tests you do not want to miss. Apart from identifying a potential offending drug or agent, your neurologist might order a series of test to look for other secondary causes of parkinsonism. This is all depending on the result of your physical examination. Depending on the age presentation, clinical manifestations to include

hepatic, neurologic, psychiatric, and ophthalmologic abnormalities, your neurologist may send you for more testing. Your thyroid function may also be checked as this can usually present with some type of tremor if the gland is overactive (hyperthyroid) or it can make the person slow if the gland is underactive (hypothyroid).

Management of DIP can be as easy as discontinuing the offending agent. Most symptoms rapidly improved as early as four weeks. Though in few cases, DIP may persist or remit slowly despite prompt discontinuation of the offending drug. Some patients may require medications *temporarily* to relieve symptoms. In some cases, offending drugs may not be that easy to discontinue especially if the patient require it to treat his or her mood disorder. Your neurologist can tell you the best drugs available if you have DIP.

Take home message: Prompt recognition of DIP is the key. The next step is discontinuation of the offending agent if possible. Most cases remit within 4 months after stopping the causative drugs. Rarely, DIP can be persistent, unremitting, and disabling. In such cases, certain drugs may provide temporary symptomatic relief.



Ask your neurologist

Email your questions to kjv824@yahoo.com

Q: My wife who has a history of PD for 17 years recently developed a new symptom. She has this concerning urge to yell. Is it from PD? What should we do about it?

A: This type of behavior falls under non-motor symptoms and are very common in PD patients especially in more advanced state. Few other examples are visual hallucination, vivid dreaming, dream re-enactment behavior, moodiness, and many others. To determine the cause of the symptoms, and also to help decide which medication to use, your physician will have to ask the patient with some few questions. The first question usually said is "Did you start a new medication?" Medications are notorious for causing behavioral and cognitive changes in many patients. The second question usually asked is "is it related to his current PD medicine?" Few minutes after taking medicine (peak time) or when medication is wearing off, cognitive, behavioral, and even motor symptoms of PD do fluctuate.

If the cause can't be identified, then the most appropriate and rational explanation would be that the disease itself is advancing. Studies show that in advance PD, behavioral change is uncommon. Patients can develop various types of obsession or compulsion to do certain behavior. Many patients develop various types of moods, cognitive, and psychiatric impairments. While we have medications available to treat or mask these symptoms, the initial step should be educating and reassuring the patient and the caregiver. Studies show that patients who are conscious of these symptoms are much more likely to better adapt with the change as compare to those patients who can't otherwise recognize that they have new symptom after all.

If the symptoms are bothersome or disabling enough, your neurologist can discuss some medications available.



Depression and Memory

One of the cardinal signs of depression is memory impairment. Recognizing the connection can be the first step toward treatment.

© 2001 Memory Loss & the Brain

At its worst, depression leaves few corners of the human mind unscathed. Many people suffering from this chronic illness lose their appetites, their ability to sleep normally, their sex drive, and the very ability to enjoy the simplest pleasures. Among the more conspicuous of the casualties is memory. Scientists are probing the connection between depression and memory—some in hopes of improving treatments, others to improve understanding of the deep connections between mind, mood, and memory. Using brain imaging techniques, we are even beginning to see some of those connections.

Hobbling the executive brain

Memory is but one of a suite of higher or "executive" brain functions hobbled by depression. In addition to becoming forgetful, a person suffering from major depression may have trouble initiating tasks, making decisions, planning future actions, or organizing thoughts. This is thought to trace to imbalances in the chemicals, called neurotransmitters, that enable individual brain cells to "talk" to each other and store new memories.

One of the ways that depression affects memory is by skewing the types of memories people tend to recall while in the grip of melancholy. We all tend to remember happy events when we are happy and sad events when we are sad, explains Norman Rosenthal, MD, a professor of clinical psychiatry at Georgetown University Medical School. A depressed person tends to recall mostly the negative, unhappy experiences. This can appear to family and friends as a loss of memory. It also reinforces the person's drab and negative view of life, fueling the depression.

Coordination of memory

It is also well known that depression impairs the ability to create long-term memories. It really comes down to a lack of attention and concentration, explains Constantine Lyketsos, MD, director of neuropsychiatry at the Johns Hopkins School of Medicine. For example, a depressed man agrees to meet a spouse or friend at a certain address. An hour later, he realizes he has "forgotten" the address. But perhaps due to a lack of attention and concentration—a hallmark of the depressed mental state—he never really formed an enduring memory of the address in the first place.

This type of event reflects a loss of coordination between working, short-term, and long-term memory. Imagine these forms of memory as a series of bins, explains Lyketsos. The working memory bin keeps track of events as they happen, but only for a short time. At a picnic, working memory registers your

conscious experiences as you find a seat, eat, and watch the volleyball game.

But only a few of these experiences will become permanently stored in your brain. A few exciting or important events, such as a fantastic play in the volleyball game, might get passed from working memory into short-term memory—the bin where we store memories for minutes or hours. The rest of the events will fade, displaced from working memory by more recent events. Over time, some items in the short-term memory are moved into the final bin, long-term memory, where they may endure for a lifetime.

A depressed person, Lyketsos explains, may be too inattentive and unfocused to file passing events in short-term memory. In this case, it isn't so much that the depressed person has forgotten, but that the memory was never stored in the first place.

Where it happens

Brain imaging technology allows us to "see" the connections between depression and memory. Many studies, for example, have shown that brain-cell activity in the frontal lobes—located in the front of the brain, behind the forehead—is often reduced in depressed people. Part of the explanation for this may involve a brain chemical called serotonin. Among other things, serotonin regulates blood flow, providing cells with the fuel they need to operate. Blood flow in the brain can be monitored indirectly with a medical imaging technology called positron emission tomography (PET).

Depressed people generally have decreased levels of serotonin, which may explain the reduced brain-cell activity. Additionally, serotonin is involved in regulating arousal—the ability feel interested in or stimulated by normally pleasurable activities. The new "second-generation" antidepressant drugs, selective serotonin reuptake inhibitors (SSRIs) and monoamine oxidase (MAO) inhibitors, boost arousal by increasing the amount of available serotonin in the brain.

Restoring memory

Depression is a highly treatable condition. There are many approaches, including medication and psychotherapy, which can reduce depressive symptoms. Unfortunately, many "older-generation" antidepressant medications alleviated the mood disorder but made memory problems worse. It is hoped that today's generation of medications (SSRIs and MAO inhibitors) will be better able to treat depression with fewer side effects.

There is some scientific evidence that treating depression can indeed help reduce memory complaints. One recent study, conducted by Finnish researchers, involved 174 adults with major depression. At the start of the study, the depressed patients performed poorly on several neuropsychological tests of memory, including the ability to repeat short stories or lists from memory. For the next six months, the patients were given treatment for their depression, including medication and/or therapy. At the end of this period, patients whose depression had been reduced also reported fewer memory problems. Their performance on the memory tests also improved.



Parkinson Disease May Affect Your Spouse As Well

Getting over it

The first step to conquering depression is to recognize the symptoms of a serious psychological condition. The second step is to seek help. Every patient is different, but in most cases some combination of treatment methods can help dispel the mists of sadness and also reduce symptoms such as forgetfulness-making it easier to remember why life is worth living after all.

Do You Have Depression?

Major depression is a serious psychiatric condition, characterized by persistent feelings of sadness, guilt or worthlessness, often accompanied by:

- Difficulty concentrating, remembering, or making decisions.
- A loss of interest in people and/or activities that once brought you pleasure.
- A change in eating or sleeping habits.
- Feeling tired all the time.
- Restlessness or irritability.
- Thoughts of death, suicide, or harming yourself.

If you have some or all of these symptoms, talk to your doctor or a mental health care provider. Depression can be treated.

The [National Alliance for the Mentally Ill \(NAMI\)](http://www.nami.org) can point you to local affiliates that can guide you to treatment resources in your area. Write to: 2107 Wilson Boulevard, Suite 300, Arlington, VA, 22201-3042. Tel: 800-950-NAMI. Or browse the web: <http://www.nami.org>

The [National Institute of Mental Health](http://www.nimh.nih.gov) will send you free information about depression and its treatment. Contact the Information Resources and Inquiries Branch, 800-421-4211. On the web, browse <http://www.nimh.nih.gov>.

If you are living with a chronic disease, you know that it can affect everyone around you--including your family and friends, and especially your caregiver. Usually the caregiver is a spouse but may also be a good friend or other family member. The caregiver can be under a lot of pressure or feel rushed to "get everything done" and may even experience anxiety or depression.

When you think of Parkinson (PD) disease, the classic motor symptoms come to mind: stiffness, difficulty with balance, shakiness of the hands, and slow movements. There are, however, symptoms of PD that are not related to motor function. These others symptoms may include depression, dizziness, constipation, problems with sexual function, and a change in the way you think or process information. These are called non-motor symptoms.

A recent study looked at the ways in which early- to middle-stage PD can have an effect on the spouse caregiver (husband or wife). The researchers wanted to find out if there was a link between the two different types of PD symptoms (motor and non-motor) and the mental health of the caregiver. Researchers examined the motor and non-motor symptoms of people with early- to middle-stage PD and then looked at levels of depression and different types of strain experienced by caregivers.

What were the results of the study?

The researchers found that, although motor symptoms in the people with PD were linked with a few types of strain and depression in the caregiver, non-motor symptoms were even more strongly linked. This does not necessarily mean that symptoms of people with PD cause depression in caregivers but simply that there is a link between the two.

Why is this study important?

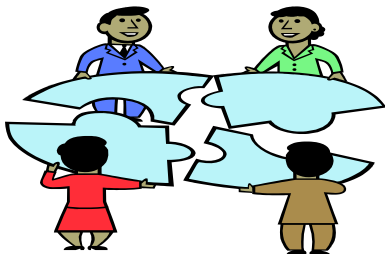
This study is important because, even though motor symptoms are more noticeable in the early and middle stages of PD, it seems to be the non-motor symptoms--the mood changes and the difficulty with thinking--of the person with PD that have an even greater effect on the caregiver at this time.

What can you do?

Be sure when you talk to your doctor about your PD, you share with him or her anything that has been bothering you. PD may affect more than how you are able to function physically; it may also affect your emotional and mental health--and perhaps those of your caregiver. Doctors need to treat the person who has PD, not just the disease. If your doctor doesn't ask you how you are feeling, start this discussion yourself. It is okay to ask for help, and together you can find resources in your community.

If you are a caregiver who finds it difficult to function because you feel depressed or overwhelmed, please ask for help. Caring for a loved one may be a challenging undertaking, but you don't have to do it alone. Be sure to take care of yourself first. Ask for help or check out local resources and support groups that will help you feel connected. You may also wish to take part in our PD discussion forum at WE MOVE. Here you can find help and support not only from people who have PD, but also from the people who care for them. Click on the discussion tab at the top of the home page. Scroll down to the Parkinson disease forum and log in to find others who, like you, are facing the challenges and joys of living with a person with PD.

Martinez-Martin P, Arroyo S, Rojo-Abuin JM, Rodriguez-Blazquez C, Frades B, de Pedro Cuesta J. Longitudinal Parkinson's Disease Patient Study (Estudio longitudinal de pacientes con enfermedad de Parkinson-ELEP) Group. Burden, perceived health status, and mood among caregivers of Parkinson's disease patients. Mov Disord. 2008 Aug 16. [Epub ahead of print].



Sudoku

		4				8		
	5		8		7		9	
7			1		2			6
8	6			3			7	9
		2				6		
9	4			1			8	5
3			9		1			4
	7		5		3		1	
		8				5		

Craft Corner

CD Campfire

By: Amanda Formaro



Recycle an old CD and make this fabulous miniature campfire! This makes a perfect gift for campers who love roasting marshmallows in the great outdoors.

What you'll need:

- Old CD
- Rocks – about the size of a quarter
- Sticks
- A handful of soil, dirt or sand
- White craft glue
- Small scraps of red, orange & yellow tissue paper
- Toothpick

How to make it:

1. Cover CD with glue and use a paintbrush or your finger to spread the glue out for an even coat.
2. Cover glue area with dirt or sand and tap off excess.
3. Use your finger to push back a little of the dirt from the edges, all the way around the CD, to make room for the rocks.
4. Squeeze out a generous amount of white glue onto the cleared edge of the CD. Press a rock into the glue.

5. Repeat until entire rim of the CD is covered in rocks.
6. If necessary, break sticks into approximately 4 inch pieces. Using white craft glue, build a "fire" with the sticks by laying them down in a teepee formation, gluing as you go.
7. Let everything dry for 2 hours (will not be completely dry, but won't slide around).
8. Tear tissue paper into small pieces, approximately 1" or 2" squares. Place tip of toothpick into the center (don't poke through) of a piece of red tissue paper. Wrap the tissue paper around the toothpick.
9. Dab some glue on the tip and dip it into the sticks, removing the toothpick once inserted. Repeat around the top of the sticks with several red pieces and then add a few orange toward the middle, and lastly one or two yellow pieces at the top of the stick mound.
10. Let project dry completely overnight.



CHEF'S CORNER

Sample high-carbohydrate menu:

1 ½ cups split pea or lentil soup

1 oz whole-grain crackers

1 TB peanut butter

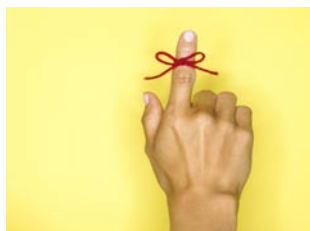
8 oz cranberry juice

½ cup grapes

Ratio 5:1

(694 calories, 122 g carb, 24 g pro, 16 g fiber, 66 mg calcium)

Kathrynne Holden, MS, RD
 Parkinson Nutrition Specialist
<http://www.nutritionucanlivewith.com>



TIP OF THE QUARTER

Memory Tip #4

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Think about the following questions:

1. Do you ever forget where you left your car keys?
2. Do you ever forget where you parked the car?
3. Do you ever forget where the grocery store is?

If you are like most healthy people, you answered "yes" to questions 1 and 2 but not 3. As we age, most of us occasionally forget where we've left the car keys or the car itself. This is annoying, but it is not usually a sign of serious memory impairment. By contrast, a person with normal memory almost never forgets the location of familiar landmarks like a grocery store.

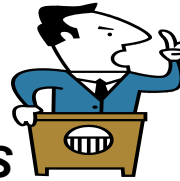
Why? The answer to the riddle is quite simple: the grocery store generally stays where it is, while the car keys may get tossed in a different place every day. As a result, the memory of where you put your keys today competes with older, conflicting memories of where you put them yesterday, and the day before that, and every day before that.

The best way to solve this problem is to avoid it. If you have trouble remembering where you put your keys, find a place near your front door where you can hang or store them -- and then always put them there. It may take you a few days to get into the habit, but once you do, you will be freed of having to remember their location. Like the grocery store, they will always be in the same place.

Similarly, if you have trouble remembering where you parked the car, make an effort to always park it in the same area of the parking lot. After a few times, you will have learned the location, and you will never again have to do the march of memory loss around parking lot, hunting for your car.



Speech and DBS



By Donald A. Robin, Ph.D.
UTHSCSA

One treatment for Parkinson's Disease (PD) is the placement of a Deep Brain Stimulator (DBS) in the subthalamic nucleus (STN) of the brain.

This treatment is typically used when patients are having unwanted side effects from their medications and as the disease severity increases to the point where medications are less effective. Estimates are that there over 45,000 people with PD have been implanted with a DBS unit throughout the world. In the San Antonio community between 50-100 people with PD receive DBS implants per year. Given the frequency with which the DBS surgery is being performed, it is important to understand what may improve and what may not improve with DBS stimulation.

It is clear that DBS stimulation in PD can alleviate many of the unwanted side effects of drug treatment. Indeed, many of the extra movements are improved by implantation. Importantly, most people with PD report an improvement (sometimes dramatic) in the quality of life with DBS stimulation. Improvements are reported in general body movements including walking, eating, and other activities of daily living. Thus, there is a reasonable expectation that many activities can be done more successfully with DBS stimulation. However, not all activities get better with DBS implantation.

Speech is the primary means by which humans communicate. Speech production is a motor skill that involves the coordination of muscles from the respiratory (breathing), phonatory (vocal cords), resonance (a muscle called the velum that channels air through the mouth or nose), and articulation (lips, tongue, jaw) systems. It is known that speech production is impaired in many people with PD. This type of impairment is called dysarthria (hypokinetic dysarthria) and results in low volume or loudness and distorted production of sounds. This then impairs the ability to be understood. It is estimated that as many as 90% of PD patients have a speech disorder or will eventually develop one. The issue then becomes what happens to speech with DBS stimulation.

Unfortunately, speech generally does not improve with DBS stimulation.

In fact, it is likely that speech gets substantially worse with DBS stimulation. Data show that as many as 60% of patients with implants have poorer speech with the stimulation than without. About 20% so no change in speech and 20% have some small improvement in speech. We do not know what the reason is for the differences between speech and other motor activities, but they are real and patients with PD should understand the risk of a speech disorder or speech getting worse with DBS stimulation.

While there is a treatment that works for PD speech disorders called the Lee Silverman Voice Treatment (LSVT). This treatment has a high degree of efficacy underlying it and must be provided by a certified LSVT speech-language pathologist. However, LSVT has not been used extensively with DBS so we really do not know if it works or not to improve speech in people with DBS stimulation. It is in my opinion worth a try. It is also the case that changing the settings on the DBS unit can improve speech so that one may need a setting for general motor activities and another for speech. There is some indication that decreasing the stimulation on the left and increasing on the right can mitigate against speech problems and still help with general motor symptoms.



In Memory of Bob Sallee

*By: Wilma Schwarting
Thomas & Margaret Ballard
Anna Christen
Mr. & Mrs. Richard Townsend
Lina M. Steward*

In Honor of Mr. & Mrs. Ricks Wilson

From: The Ruskin C. Norman, Estate for Parkinson's Research

PREVIOUS AAPSG EVENTS:

***Parkinson's 5K Walk/Run
Saturday, May 30, 2009
McAllister Park***

Our 1st Annual 5k Run

And the winner is.....

***Emcee Joe Reinagel
from KENS5***



**Comal County BBQ
Saturday, April 25, 2009
Landa Park**



Dianne Johnson, RN and Tommy Dubuque



Dianne, Brieley Vineyard, and Marion

**17th Annual Symposium
Saturday June 6, 2009
Omni Hotel**



Dr. Robin (speaker) and Dianne Johnson, RN



Current News:

We are now on Facebook. Join our group to get current news, upcoming events, support group information, etc.

Check out our new blog page at: <http://voices.mysanantonio.com/aapsq/> on mysa.com



AAPSG SUPPORT GROUPS

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

Alamo Area PD Support Group San Antonio

Second Monday every month except Oct, 1 PM. Sunset Ridge Church of Christ, 95 Brees Blvd.

Young-Onset PD Support Group San Antonio

Second Saturday every month, 10 AM. Newforest Estates, a Senior Lifestyle Community, Auditorium, 5034 New Forest Dr.

DBS Support Group “Live Wires”

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

Caregivers Only Support Group, San Antonio

Second Tuesday every month, 10 AM. Bob Ross Senior Ctr, 2219 Babcock Rd. POC: Dianne Johnson, 210-567-6688, 651-9835, diannejohnsonr@aol.com .

Austin Young Onset Parkinson’s Support Group

AJ Hernandez/ Facilitator 512-671-0605, ajhernandez@alumni.utexas.net

Austin (Parsons House) PD Support Group

Third Friday every month, 10 AM. 1130 Camino La Costa, Austin, POC: Deborah Bryson or Jaime Eyer 512-454-0524/ 512-238-6000. Accolade Home Care

Bastrop Argent Court Assisted Living Support Group

Fourth Thursday every month, 2 PM. 508 Old Austin Hwy, Bastrop. POC: Shasta Martini 512-321-9500 #252, Jenny Bankston 512-252-1512

Burnet PD Support Group

Second Wednesday every month, 2 PM. 309 Industrial Blvd = St/ Bldg Behind Hospital Business Offices/Rehab = Enter: Patient /Finance. POC: Lynn Wisdom 512-715-3363 or Susie 512-345-1380

Cedar Park (Ranch Retirement Living) PD Educational Support

First Friday every month, 1 PM. 1301 Whitestone Blvd, Call 996-0700 for info, POC: Ms Deborah Bryson, 864-4075

Comal County Support Group

Fourth Saturday every month, 10 AM. 801 W San Antonio St, New Braunfels (McKenna Event Ctr Children’s Museum). POC: Tommy Dubuque tommydubuque@yahoo.com or call 830-227-5303

Fredericksburg PD Support Group

First Monday every month, 10 AM. Fredericksburg United Methodist Church in a room off the Fellowship Hall, 1800 North Llano Hwy. Coffee, juice and snacks are served. POC Judy Hoopman 830-997-7705 or ralanh@beecreek.net

Georgetown PD Support Group

Last Thursday every month, 2PM. Scott & White Meeting Rm, 4945 Williams Dr, Georgetown,
POC: Beverly Edwards 512-863-8443 edwards107@verizon.net

Lower Rio Grande Valley PD Support Group

Call for information on meetings. POC: Cheri Horkmann, phone 956-554-6028

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