Connecticut Parkinson's Working Group Newsletter July 2002

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Connecticut Parkinson's Working Group 20 July 2002 Workshops
Parkinson's Disease and the Body-Mind Connection

The success of the April workshops has encouraged us to continue this program. On July 20 from 10 a.m. to 12 noon we will sponsor two workshops centered on the body-mind connection. This wide-ranging topic generated many suggestions for specific workshops. We have chosen two, and now you have the difficult task of selecting one. The format used in April has been adjusted; there is no charge to attend.

The workshop schedule is as follows:

9:30 - 10 a.m.	sign in
10 - 10:15 a.m.	introduction and overview
10:15 - 11:15 a.m.	workshops - choose one

The power of positive thinking and other coping strategies for depression in Parkinson's Disease

Presented by Danna Jennings, MD

This workshop will cover the difficulty in recognizing depression, the causes of depression, and strategies for the successful treatment of depression in PD.

To sleep, perchance to dream: Sleep and Fatigue in Parkinson's Disease.

Presented by Antonelle (Toni) DeMarcaida, MD

We will talk about why we sleep, and what sleep does for our general well being. I will discuss various sleep problems in PD. I will have a demonstration of sleep apnea studies and the CPAP machine that is used to overcome this problem. I will have videotapes on sleep disorders and maybe mattress demonstrations.

11:30 a.m. - 12 noon wrap up; both sessions will come together for concluding comments.

Our regularly scheduled meeting will be held from 1 - 3:30p.m.

CONNECTICUT PARKINSON WORKING GROUP MEETING **20 July 2002**

at the Connecticut Valley Hospital, Middletown from 1 PM onward **Saturday**

Refreshments (drinks & snacks) provided by Brian C.'s employer Crystal Rock.

Directions to Connecticut Valley Hospital, Haviland Hall, Middletown, CT

From Route 9 Southbound:

Exit 12 - Silver Street exit, then left onto Silver Street. Take first right onto Eastern Drive. Go left at main entrance onto Flood Dr. (greenhouse on right hand side). Follow Flood Dr. to first stop sign; at stop sign (in front of daycare center); take a right onto Harvey Drive. Entrance to parking area is right after daycare center on left. Haviland Hall is directly across from parking area and just before the A frame chapel.

From Route 9 Northbound:

Exit 12 - Bow Lane. Right at the exit onto Bow Lane, an immediate left onto Harvey Drive. Parking area is on your right in front of A frame chapel. Haviland Hall is directly across from parking area.

Car Pooling: If you need or can supply a ride PLEASE contact Jackie Dorwin.

If there are any questions you may email Jackie Dorwin at **jdorwin@aol.com**, telephone **203.453.2655**, or Stan Wertheimer at **stan.wertheimer@gmail.com**, telephone **860.572.9965**.

What my first CPWG Workshops meant to me! April 20 Steve Holahan

For me the word "workshop" carried a lot of negative connotations. When I was a banker, workshops at industry conferences where either at the beginning or end of the event and were thinly veiled excuses for spending a few extra days in some posh resort locale! While my experience with the "working group" was positive based on my one meeting last fall, somehow all those years of workshops, full of bankers in goofy colored slacks with their golf bags propped up nearby, had conditioned me to expect little. So I arrived 20 minutes late thinking that I would only be missing sales pitches from therapists who couldn't really know how PD affected me?

The real meeting, of course, began after lunch! This "we are heroes" meeting is where we try to do things for the rest of the world. I am not making light of this, but sometimes we must shed the hero role and accept that of a victim. To be a victim, at times even a helpless victim, is not an easy thing for most PWPs to accept. Without realizing it, I was about to encounter this clash first hand. And what makes you feel more like a victim than a good arm-twitching, back-spastic, face-and-leg-freezing OFF? And like the proverbial bad penny it turned up just as I started my first workshop. Seeing my discomfort one of the physical therapists said she would work one-on-one with me. What followed was one of the most enlightening 30 minutes of my life. First I learned that my bravado and macho approach to physical limitations was wasteful of my energy but also dangerous to my health. It is better to relax and loosen and then train the original muscles than it is to use brute strength to force the surrounding muscles to do the task. I also was shown how out of shape some of my antagonist muscle groups had become because of PD imbalances. But the right therapy and exercise could start to correct these problems, all I had to do is to listen to the therapists and let them help me! The benefits of this more passive approach. One, it saves "powder" for the harder fights ahead. Two, it is easier to accept that some battles will not be won! Learning to use a wheelchair rather than always struggling to walk and stay balanced with increasingly cramped and unresponsive leg muscles may seem like a defeat; in fact the switch to a wheelchair might actually be an energy saving liberating step that increases overall mobility.

I'm not sure that the victim/hero metaphor is the best, or whether active /passive is better, but what that wonderful workshop show me in total clarity was that PD is a destroyer of balance directly in our physical life and indirectly in our mental emotional and spiritual being. To be effective and then successful in our war with PD our tactics and strategies must be carefully crafted blends of active and passive therapies so as to return a new and sustainable balance to our physical and metaphysical lives, as we grow old with PD.

My final lesson is simple; I will be on time to the next PD workshops!!

Proposed Mission Statement

The mission statement group, ably led by Anne R., has come up with the following:

The mission of the Connecticut Parkinson's Working Group is to provide education and support to those affected by Parkinson's Disease and to collaborate with the medical community to enhance treatment and research in Parkinson's Disease.

We hope to come to consensus at the 20 July meeting.

Support Parkinson's Research Walk

On 13 October 2002 IND is sponsoring a walk to support research. The location is the Fairfield Pavilion on Fairfield Beach Road in Fairfield. Check-in time is 9 A.M.; walk start time is 10 A.M. The route is 2 miles through the local neighborhood. For more information call 203.401.4300 or access www.indd.org .

Update on the name of our group Stan Wertheimer

The original rationale for naming the group was that it should have the words ***Connecticut, Parkinson's*** and an indication that we comprise people who are actively working for improved treatment for and finding a cure to PD, as well as a support group. It should also be short. Hence ***Connecticut Parkinson's Working Group***. At our last meeting there were some comments that the placement and use of the word ***Working*** was misleading; it gave the impression that one had to be gainfully employed to join.

On the other hand, as has been pointed out by people who have been engaged in the group's work, the original way (CPWG) is how we have come to be known and a change would be confusing at this time. There have been suggestions that we find a snappy acronym.

We must settle this issue so we can proceed with finalizing a mission statement, applying for tax exempt status and incorporating. Editorially, I feel that unless there is serious objection to the current name we should stick with it. The issue will be raised at the 20 July meeting.

A protein that exists normally in most of the cells in the brain has been identified as a possible factor in the development of Parkinson's disease.

The discovery could point the way to treatments.

In lab experiments, when the brain protein alpha-synuclein combines with dopamine in nerve cells it can trigger the production of toxic reactive oxygen molecules that kill the nerves, according to a research team led by Dr Bruce Yankner of Harvard Medical School.

If this process operates in patients the same way it does in the laboratory, it could set scientists on the path to potential treatments, Dr Yankner said. But it also adds to the debate over whether the current use of dopamine in the treatment of Parkinson's could make things worse in the long run, he added. The findings appear in the journal **Nature Medicine**.

Additions to our library.

The following books purchased with $100 contribution from an anonymous donor:

* Eat Well, Stay Well with Parkinson's Disease
  A nutrition handbook for people with Parkinson's, Kathrynne Holden, MS, RD
* Food-Medication Interactions, 12th edition
  Zaneta M. Pronsky, MS, RD, FADA
* Herb-Drug Handbook, 2nd edition
  Susan M. Herr, RD, CDN
* Meemaw Has Parkinson's Disease
  Sally G. Rascoe, Houston Area Parkinson Society

Purchased with CPWG funds:

* Living With Parkinson's Disease, Kathleen E. Biziere and Mathias C. Kurth

Brian will buy these books soon with CPWG funds:

* Lucky Man by Michael J. Fox
* Shaking Up Parkinson's by Abraham Lieberman
* Saving Millie by Morton Kondrake
* A Life Shaken: My encounter with Parkinson's Disease by Joel Havemann

FROM: The Associated Press State & Local Wire March 18, 2002, Monday

University of Kentucky Announces Innovative Experimental Treatment for PD by Steve Bailey, Associated Press Writer

Researchers at the University of Kentucky are set to begin an innovative clinical trial of a device they believe can reverse the degenerative effects of PD. The device is an implantable pump that delivers a naturally occurring protein that stimulates the growth of dopamine neurons in the brain, by catheter directly into the part of the brain that is damaged in PD. "Current treatments of PD focus only on improving the symptoms of the illness but do nothing to actually restore function to the parts of the brain ravaged by the disease," Greg Gerhardt, director of the school's Morris K. Udall PD Research Center of Excellence, said during a news conference to announce the trial.

The protein being used in the study is called Glia cell line-derived neurotrophic factor (GDNF). "GDNF is a very important compound," Gerhardt said. "In animal models, we've shown that the direct infusion of GDNF into the section of the brain affected by PD can actually restore function to brain cells that are damaged or dying."

The study is a Phase I clinical research trial, meaning that researchers primarily will be investigating the safety of the device on participants. "The patients will be studied for about 9 months after the pump and catheter are implanted," said principal investigator Dr. John Slevin, a professor in the University of Kentucky's College of Medicine's Department of Neurology. "Once we prove that it is safe, we will expand the study to look more closely at its efficacy, how it actually works."

GDNF is found naturally in the human brain but tends to decrease as a person ages. It is believed that the destruction of dopamine neurons, which are aided in growth by the protein, causes the symptoms of PD. Laboratory studies have shown that GDNF both protects and promotes regeneration of injured dopamine neurons and may directly influence the degenerative disease process. "Basically, what we're trying to do is improve, or even restore, normal circuitry in the brain that has been cut off by Parkinson's," said Don Gash, a professor in the college's Department of Anatomy and Neurobiology. "We've seen very profound improvements in motor function of animals who had shown symptoms of late-stage Parkinson's. We have actually seen that injured neurons that have shrunk grow back to normal size range when treated with GDNF."

The battery-powered pump, about the size of a small yo-yo and refillable, is implanted into the abdomen of the patient with a tiny tube connecting it with a small catheter in the brain. The pump's programmable computer precisely regulates the flow of a four-week supply of GDNF directly into the brain via the catheter. The pump currently is approved for delivery of drugs directly to the fluid around the spinal cord in patients with some conditions.

> Comment from Dr. Abe Lieberman Several years ago Amgen, a biotech company, infused GDNF through a catheter into the ventricles (the fluid reservoirs in the brain). The infusion did NOT reverse the symptoms of PD and the side effects including severe weight loss halted the study. In the University of Kentucky study the infusion is directly into the substantia nigra, the site of destruction in PD. It is hoped, but not known, that this direct delivery may succeed where the delivery into the ventricles did not help.

Why Dopamine Neurons Die

Occasionally, a research report that sounds impossibly technical contains really important information. Such is a new report that appears in the November 9, 2001 issue of the prestigious journal Science, entitled "Kinetic stabilization of the alpha-synuclein protofibril by a dopamine-alpha-synuclein adduct." This paper, which comes from the research group of Peter Lansbury at Brigham and Women's Hospital in Boston, provides an exciting new understanding of why it is that dopamine neurons die in Parkinson disease. For decades, scientists have known that dopamine neurons die in PD, but no one understood why these neurons in particular were affected.

A new clue comes from the Lansbury group's investigation of the molecule called alpha-synuclein. All of us have alpha-synuclein, and alpha-synuclein is one of the proteins that is found within the Lewy body, the abnormal clump of proteins found in the brains of PD patients. In certain rare forms of inherited PD, there is a

mutation in the alpha-synuclein molecule. Most people with PD, however, do not have a mutation in their alpha-synuclein.

Alpha-synuclein molecules have the tendency to aggregate, or stick together. Normal versions of alpha-synuclein stick together such that they form long chains, called fibrils. However, before the point that fibrils are formed, individual molecules clump together in little groups, called protofibrils. The protofibrils eventually stick together to form the longer strand-like fibrils. The Lansbury group has previously shown that the protofibrils are bad actors: these smaller clumps can damage cell membranes, which may lead to death of the cell.

In most situations, the dangerous protofibrils are not an issue, since they rapidly convert to the harmless fibril form on their own. However, the Lansbury group has found that certain substances can prevent the conversion of protofibrils to fibrils. Remember that preventing this conversion would result in more of the dangerous protofibrils. Interestingly, these researchers have found that dopamine and many related substances can inhibit the conversion of protofibrils to fibrils.

So, how does this add up? One way to piece this together is to understand that, while many cells in the brain contain alpha-synuclein, only a few cell groups in the brain contain dopamine. One such group of cells is the substantia nigra, the area of the brain that is destroyed in PD. In these cells, it is possible that the dopamine is allowing more of the dangerous protofibril form of alpha-synuclein to exist, thus ensuring that those cells will die. This scenario is purely speculative at this point. However, the report by Conway and colleagues may point the way to cracking the long mystery of why dopamine cells die in PD.

Reference:

Conway KA, Rochet J-C, Bieganski RM, and Lansbury PT Jr. Kinetic stabilization of the alpha-synuclein protofibril by a dopamine-alpha-synuclein adduct. Science 2001;294:1346-1349.

Great Progress in Participation! New Positions

At the April 20, 2002 meeting the following members took on the respective positions:

John L. - grant writing
Anne R. - mission statement
Michael A. - mission statement
Jack R. - mission statement, approach Michael J. Fox as a speaker
Jim R. - treasurer
Steve H. - assistant treasurer
Pat Sullivan - secretary
Pat G. - membership
Tom Sullivan - workshops
Jackie Dorwin - facilitator, conduct info sessions, meet with doctors, have care partner gatherings, maintain telephone network, send out newsletter
Stan Wertheimer - facilitator, conduct info sessions, meet with doctors, edit and compose newsletter

Other volunteers:

Judy I. - membership
Jim B. - crafts coordinator

If anyone has been missed please don't take offense; it was an error on my part. Please contact Stan W with the correction.

People needed for Clinical Trials at IND

Contact: Susan Mendick, MPH 203.401.4337 or FAX 203.789.8037

Study: A phase 1 study with anti-depressant CP-607, 366. We are looking at the safety of the drug and the activity in the serotonin. To be eligible: 18-55 years, no history of significant health problems, no drug

allergies, no positive urine drug screen, limited alcohol use, non-smoker, post menopausal or surgically sterile, no medications. If you participate: 12 visits, two of which are 14-hour days, the rest begin at 7:30 AM for 2 hours. Pay: $2000

Contact: JoAnn Palange 203.401.4300
Study: Voice Study, Healthy Control. Participants will take (double-blind) a dose of ritalin one visit, ativan one visit, a placebo one visit; in all cases wait 2 hours then do a voice test and cognitive maze. Total time 3-3.5 hours. To be eligible: 18-35 years, RIGHT-HANDED, limited cigarettes. If you participate: Study starts after 5 August 2002, 3-4 weeks, 4 visits. Pay $400

Request for Help From Dr. Abe Lieberman

From his online answering service:

My husband has been on either mevecor or lipitor for the past 13 years. dx. PD 1 1/2 years ago. Statins, drugs that lower cholesterol, are among the most commonly used drugs in America. The commonly used "statins" are: Pravastatin, brand name Pravachol, Lovastatin, brand name Mevacor, Simastatin, brand name Zocor, Atorvastatin, brand name Lipitor. The "statins" lower low density cholesterol (LDL-the bad cholesterol) and have a major role in reducing heart attacks and stroke. Recently at the University of Miami, we saw a patient, whose PD was diagnosed shortly after he was started on a "statin."

As "statins" are commonly used drugs, and as many people are on "statins", our thinking was starting a "statin" and diagnosing PD was a coincidence. We received a similar report from a colleague in Germany who had reported the possible association 7 years ago in a letter to the journal the "Annals of Neurology." Recently we received an email from a reader questioning the relationship of "statins" to PD. We and another colleague are examining our patient records to see if there could be such a relationship and are looking into the possibility in our laboratory. At this time we are NOT saying "statins" cause or worsen PD. We're like Homeland Defense asking you to be vigilant. We would like to ask:

Was your PD diagnosed a year or more AFTER you started a "statin"?
Did your PD get WORSE a year or more AFTER you started a "statin"?
Was your PD diagnosed a year or more BEFORE you started a "statin"?
Was your PD BETTER or UNCHANGED AFTER you started a "statin"?

We would like to hear from of you. Abe Lieberman askthedoctor@www.parkinson.org.

Sleep Disturbances In Parkinson's Disease

Cynthia L. Comella, MD, ABSM, Associate Professor, Department of Neurological Sciences, Rush Medical College

Sleep disturbances are common in Parkinson's disease, affecting as many as 70% of patients during the course of the disease. Sleep disturbances have a significant effect on function and quality of life for both the patients and their caregivers. The consequences of poor sleep and excessive sleepiness during the daytime on the activities of daily living have recently been recognized by clinicians.

The sleep disturbances associated with Parkinson's disease arise for several reasons. A frequent early complaint is difficulty staying asleep during the night. Parkinson disease patients with this problem often have no difficulty falling asleep, but then will wake up in the early morning hours feeling stiff and slow, sometimes with recurrent Parkinson tremor.

The patient will often get up to urinate but will then be unable to fall back asleep. They will feel uncomfortable in bed and perhaps have difficulty rolling over. This type of sleep disturbance typically originates in the "wearing off" of Parkinson medications during the night with the recurrence of PD symptoms. The doctor may be able to readjust the medications to alleviate this type of sleep disturbance. Other types of

aids include the use of silk sheets and pajamas that enhance movement in bed. If there is frequent urination, it may also be advisable to have a consultation with the urologist to check for a primary urinary problem.

A second common type of sleep disturbance seen in Parkinson's disease is the occurrence of excessive daytime sleepiness with frequent dozing or napping during the day. A patient may find it almost impossible to stay awake and alert while doing sedentary activities such as reading or watching television. If more severe, there may even be the occurrence of dozing while doing active tasks such as driving or while eating. The daytime sleepiness and frequent naps may lead to an inability to sleep at night, further complicating the problem for both patient and caregiver. Sometimes the sleepiness during the day can be the result of a nighttime sleep problem, such as sleep apnea. Sleep apnea refers to an interruption in breathing during the night, preventing a restful sleep, and causing a reduction in oxygen in the blood. This should be evaluated by a sleep expert and may necessitate an evaluation in the sleep laboratory.

Sleepiness during the day sometimes is associated with the medications used to treat Parkinson's Disease. A particular class of medications, called the dopamine agonists, that includes drugs such as pramipexole (Mirapex), Pergolide (Permax) and Ropinerole (Requip) has been reported to cause significant sleepiness during the day. It seems that in some patients, high doses of these medications or a particular type of medication may give rise to these troublesome side effects. Unfortunately, it is not only the direct dopamine agonists that can cause sleepiness. Sometimes patients will report that after taking carbidopa/levodopa (Sinemet), they will have on overwhelming desire to sleep. This can occur as often as after every dose, or may be present only after the morning dose. The treatment of drug induced sleepiness must be individualized to the particular patient. In some patients, dose reduction can be helpful; other patients require switching from one drug to another. If the sleepiness does not respond to change in medication, there are stimulants, such as modafinil (Provigil) that have been successfully used.

A third type of sleep disturbance that has only recently been recognized as a part of Parkinson's disease itself. This disorder is called REM sleep disorder (RBD). REM sleep is dream sleep that occurs in cycles during the night. Normally, when someone is in dream (REM) sleep, his or her body muscles are unable to move. Although they may be actively dreaming, they appear to be sleeping quietly. In Parkinson's disease, there is sometimes the loss of this muscle relaxation during dream sleep, and the patient is actually able to "act out" their dreams. If the dreams are violent or aggressive, this may lead to rather violent behaviors on the part of the patient, such as kicking, hitting or choking. The patient is unaware that this event is occurring because they are actually asleep. The caregiver may be awoken by a hit or punch. The caregiver may even find it necessary to sleep in another room to avoid injury. In addition to potentially injuring a bedpartner, the patient is also at risk of injuring himself or herself through falling out of bed. RBD affects about 25% of PD patients. It is often mistaken for drug induced hallucinations, but is really a part of the disease itself. RBD tends to wax and wane in severity, sometimes even disappearing for long stretches of time. There are effective treatments for RBD if it is recognized. These treatments may spare both the caregiver and the patient the potentially harmful violent behaviors during the night.

A fourth type of sleep disorder is related to the occurrences of hallucinations. Hallucinations are usually the side effect of the medications used to treat Parkinson's disease. Hallucinations occur during wakefulness and are usually visual. The hallucinations may be of people, animals or other objects. Sometimes, hallucinations can be very frightening, with visions of people breaking into the home, or bizarre animals lurking under the couch. Patients with hallucinations have been found to have a reduction in the dream sleep (REM sleep) during the night. It may be that the reduction of nighttime dream sleep leads to the emergence of dreams during wakefulness (Hallucinations). Other associated sleep disturbances includes nighttime wakefulness and sleeping through out the day (day -night reversal). The treatment of hallucinations related to Parkinson disease treatment has is usually successful through the use of the "atypical" antipsychotic mediations, clozapine and quetiapine, that don,t worsen PD symptoms.

There are other reasons for sleep disturbances in Parkinson's disease, including associated depression, dementia, use of non-PD medications, sleep apnea, and others. The most important part in the assessment of sleep disturbances in Parkinson's disease is the recognition of the sleep problem and reporting it to the doctor. Many of the sleep disturbances can be further evaluated and treated. The peaceful nights and wakeful days may provide dramatic relief, not only to the PD patients but also to their caregivers.

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DISCLAIMER: Articles in this newsletter are for information only. Any questions of treatment should be discussed with your physician.

WRITE! your representatives in congress.

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