WPA
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In this Issue...

Letter from the President 2
Letter from the Former President 3
Thinking and Moving 4
Trinity Village Parkinson Forum and "Possibilities" Parkinson Programs 5
Is Deep Brain Stimulation Surgery Right for You? 6
Wearing Off 7
Are You A Safe Driver? 9
My First DBS Surgery 10
Why I Love Parkinson's 11
Love and Death 12
Save the Date 13
Parkinson, Posture and Physical Therapy 14
Treat Your Family to a Holiday Party 15
Donations and Memorials . . 16
New Support Groups 17
NEW Tear-Out Support Group Locations 18

"Psychogenic" Parkinson Disease

by Paul A. Nausieda, MD

I was recently asked whether I had ever seen a case of "psychogenic" Parkinson disease. The concept is pretty simple: an individual develops the symptoms of Parkinson disease as a result of psychological stressors and has nothing wrong with their central nervous system and no concept that the problem is not organic. In the psychiatric literature this phenomenon is often referred to as a conversion reaction or a somatoform disorder and had previously been called "hysteria". The latter word has become so broadly applied that it has gone out of favor (perhaps also due to the fact that the word is derived from the Greek word for uterus and struck many as sexist). At any rate, these reactions traditionally arise in younger people, are usually abrupt in onset and time-related to an identifiable stressful event. With psychotherapy the symptoms resolve and identify the non-organic nature of the condition. There is usually an implied "secondary gain" i.e., the symptoms allow some adaptation to the situation that creates them. I recall a patient a number of years ago who suddenly could not walk. Her family had decided that she needed to take horseback riding lessons but she was terrified of horses and the prospect of falling off one. When the family insisted that lessons were to be taken, in spite of her protestations, she suddenly could not walk let alone ride a horse. When the parents abandoned the desire for an equestrian daughter the paralysis cleared. The symptom in this case was pretty typical – what is called a "negative symptom;" something one is unable to do. Other typical examples include deafness, blindness, loss of sensation, or inability to speak. The question is whether someone could get symptoms of Parkinson disease via a similar mechanism.

A very prominent psychoanalyst showed me a case many years ago that he felt reflected Parkinson disease as a conversion reaction. I have to admit that the woman certainly looked like she had Parkinson disease, but he insisted that the symptoms would go away when she recognized her internal psychological conflicts. (I never saw her without symptoms, but he was so eminent that I was not about to question the diagnosis). In the last thirty years there have been a few patients in whom I transiently entertained that diagnosis, only to abandon it as the disease progressed. Reports of psychogenic Parkinson disease generally lack long term follow-up or autopsy confirmation but the concept has recently been popularized and may create problems in some instances.

The cardinal problem is that Parkinson disease remains diagnosed by examination alone in a living individual. A diagnosis requires two of the cardinal features of the disease to be present on examination: slowness, stiffness, rest

continued on page 8

Letter from the President

Keith Brewer, WPA Board President

I am honored to take this opportunity to introduce myself to you as the newly elected President of the Wisconsin Parkinson Association. I have had the privilege to serve on your Board of Directors since 1999 under the leadership of Dick Schumann, who has just stepped down from his duties as President. Dick has made a tremendous impact in the growth and success of our organization by serving as President for the last 12 years. On behalf of the entire organization, I would like to extend our gratitude for his service, leadership, and the passion he has brought to the fight to find a cure for Parkinson disease.

I do have big shoes to fill, but I look forward to the challenge, as finding a cure for Parkinson disease is a passion of mine. As the youngest of 12 children, I watched my mother, LaVerne Brewer, wage her quiet war against the ravages of Parkinson disease for over 20 years. I have seen first hand the effects of the disease on the individual and the family. My sisters and I were her primary caregivers for over 6 years until she found peace in April of 2004. Her courage inspires me to work towards finding a cure to help those afflicted with Parkinson's.

My family and I decided in 1998 to find a way to raise money to help fund the activities of the Wisconsin Parkinson Association and the Parkinson Research Institute. We began a golf outing that occurs annually the weekend before Mother's Day to raise awareness and support for these two nonprofit organizations. I am proud to say our efforts have resulted in raising over $150,000 since its inception.

On a personal note, my wife Kate and I are the proud parents of a new baby boy, James Dean Brewer, who was born May 2, 2006 – just 4 days before our golf outing this year!

Thank you for this opportunity to serve as your President. I am pleased to announce the election of three new board officers, Frank Lorenz, Vice-president, Win Reinemann, Treasurer and Barbara Whicker, Secretary. Each brings years of business and board experience as well as first hand knowledge of PD. As an executive team we look forward to working hard to achieve the goals of providing support and resources to those with Parkinson disease and to finding a cure. I welcome your comments, suggestions and ideas regarding how we can best serve our membership. I can be emailed directly at kbrew12@wi.rr.com or you can call the Wisconsin Parkinson Association and they will get you in touch with me.

Letter from the Past President

Richard R. Schumann, WPA Board President

For the past number of years I have been your President and I have tried to do the best job that I could. There have been a great number of people that I have worked with that have made the WPA a success. When you start thanking people you always forget some key people but I think that a bigger mistake is not thanking anyone.

Over the years we have gone to and from different hospitals but there has always been one constant, Dr. Nausieda. You will never find a more dedicated individual. We have not always agreed but we do respect one another and the group of doctors and professional people he has assembled are second to none. (We are very fortunate).

The last few years have been very exciting for the WPA: the research facilities, the new board members, the funds raised, our new coordinator Vicki Conte, the golf outings and the Galas.

My special thanks to the people who have worked so hard with the Board to raise funds to find a cure: The George Prescott family, the Keith Brewer family, Bill Ihlenfeld, Frank Lorenz, all our board members and all of our donors.

This year's Gala was spectacular and special thanks go to Dacy Reimer, Nicole Christiansen and the rest of the Gala Committee. My special thanks go to some of the people that donated auction items: William Wilson of William Wilson Jewelry, Bob Lang of Erin Hills Golf Club, Norm & Martha Eckstaedt of the Red Circle Inn, Chuck Wood of Lac Labelle Golf Club. Of course, I thank all who contributed and all who purchased items.

When I became your President I really did not know what to expect. Well, two people really kept me going in the right direction: Gloria Bock and Jackie Hoeft. Thanks to both of you again and again.

Keith Brewer is our new President. I can't say enough good things about him. He's responsible for annual golf outings the last nine years. Keith and his family raised over $25,000 this year alone. With Keith at the helm, we will have a great Board; but we could use a few more dedicated individuals.

Finally, we come to the person who has taught me more about Parkinson's and life then anyone else. I'm sure that was not her goal. My wife Deanna has had Parkinson disease for twenty seven years. Yes, she's the one that you saw dancing up a storm at the Gala this year. She has the four keys to making Parkinson's tolerable:

1. A Good Attitude
2. Exercise
3. Family Support
4. A Great Doctor

Thank you all so much for your support of the WPA and your support in finding a cure.

Thinking and Moving

by Gary Leo, DO

When speaking about Parkinson disease (PD), we often focus on difficulties with movement. The motor system is affected by tremor, rigidity, slowness of movement and balance problems. These motor limitations give the most obvious features of PD. We often overlook more subtle problems with memory and concentration that can also be a part of PD. Also, importantly, these thinking limitations may have a direct effect upon motor abilities and movement. In this article I will discuss memory limitations in PD and how they may interfere with movement.

First I need to define the meaning of "thinking problems." This term consists of a number of different abilities. These abilities consist of memory, executive function, language and math skills, and perception (the five senses). In PD the thinking problems are usually confined to memory and executive function. Memory can be divided into two types. Long-term memory involves information that has occurred some time ago and we have had time to rehearse the information. Short-term memory involves information we have learned within the last few hours or days. We tend to think that a person who can remember events that occurred long ago has a good memory. However this is only one aspect of memory. People who have difficulty in concentrating (paying attention) will have impairment of short-term memory. People with PD may have difficulty with both types of memory. This probably occurs because persons with PD think the way they move – slowly. Sometimes it may be hard to focus upon an activity in order to record the event. Some people may also have difficulty recalling a past event because they lose track of what they are trying to remember.

Executive function is the understanding of the relationship between different objects or activities. We call this executive function because it helps us to execute different abilities to accomplish a task. Executive function is involved in learning by trial and error. It also allows us to use already learned information to adapt to a new situation. For example when you drive an unfamiliar car you do not need to read the owners manual to learn how to use the windshield wipers. Because executive function is important in relating one situation to another, it is important in judgment and safety issues.

Fortunately these difficulties with memory and executive function have minimal or no effect on most people under the age of 75. People who are older with PD may have more difficulty with thinking. About a third of all people over 75 experience memory problems.

It is important to know that this difficulty with thinking can also cause impaired movement. As I had said previously, people with PD tend to think the way they move – slowly. For those with thinking problems, they will move the way they think. If the thinking is confused, the movement will be poor and people may have difficulty with walking and falls. This occurs because of problems with executive function. A person is unable to use trial and error to help with learning. A person may have a problem learning to use the new computer or even difficulty learning to use a cane or walker. Planning is also compromised and people tend to be impulsive. Therefore a person can go through training with a therapist to learn to walk with a walker but have difficulty following through with the instructions at home. In addition to the movement problems, people with impaired cognition may have impaired sleep with frequent awakenings and vivid dreams. The sleep loss contributes to impaired memory and can cause a person to become irritable and anxious. Once a person becomes anxious, thinking becomes even more difficult, further adding to the problem.

The cause for the thinking decline may be due to the Parkinson disease itself; but it also may be due to medication, medical illness or another neurological problem. This difficulty with thinking should be investigated by your physician. Evaluation may involve the use of blood tests and possibly a brain scan. A simple problem such as a urinary tract infection may result not only in confusion but also a decline in movement. Treating these medical problems will result in overall improvement in the PD. Once other medical and neurological causes have been eliminated, attention is directed to improving the thinking. This can be accomplished by reducing the PD medications. It is important to remember that the medications used to treat PD are very potent. The medications may either have no effect upon thinking or may make thinking worse. Whenever a person has confusion I always try to reduce the PD meds. This may result in some slowing of movement, however it is important to remember that movement is impaired when a

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person is confused. A person's walking and balance will only improve when the thinking is clear. Improving the sleep at night and reducing anxiety is also very important. An anxious person loses self-confidence, which further limits mobility. You cannot function well during the day if your sleep is poor.

When faced with a situation in which there has been an abrupt increase in confusion, the first thing to do is to improve sleep and reduce anxiety. Next we focus upon improving memory. There are medications available such as Aricept, Razadyne, Exelon and Namenda which may improve thinking in PD. These medications can be very helpful in improving both memory as well as other types of thinking. Finally when anxiety and memory are improved the walking and balance will improve.

Fortunately thinking problems occur in a minority of people with PD. However when the thinking is involved it will also cause problems with movement and balance. If faced with this difficulty, improvement in thinking is necessary before the mobility can improve.

Trinity Village Parkinson Forum and "Possibilities" Parkinson Programs

On August 30, 2006, 78 people attended a forum at Trinity Village in Milwaukee in which each speaker emphasized the need to add exercise to the regime of treating Parkinson disease. Dr. Katherine Widnell spoke about creating new pathways in the brain through treadmill exercise. Thea Vorass, Music Therapist talked about singing as a way to strengthen the voice. Pat Culotti demonstrated Tai Chi and described the ways this ancient Chinese art can realign the body's energies and improve circulation, balance, coordination, stamina and endurance. Dr. Trevor Hyde gave an engaging talk about memory – how it works and how it can be improved. Dr. Cristina Ospina took general questions and Dr. Paul Nausieda gave a brief greeting and his stamp of approval on this collaboration.

Trinity Village is located at 7300 W. Dean Road, between Good Hope and Brown Deer just east of 76th Street. They will begin offering classes in 8-week sessions on October 16. A water exercise class will meet on Mondays at 1:00 pm. Water exercise is among the safest and most effective for people with PD. A singing class will be offered on Wednesdays at 11:00 am followed by lunch and Tai Chi at 1:00 pm The voice class is not only for people who have sung in the past. It is for anyone who has ever sung the Star Spangled Banner or warbled in the shower. This class is for fun and voice improvement. Lunch is available for a nominal price in two areas of Trinity Village or you may bring your own lunch and enjoy it in one of the pleasant dining areas available. Visit with classmates before exercising your body and mind with the slow, deliberate and gentle movements of Tai Chi.

Embrace the "possibilities" of improving your voice, your strength and mobility and your attitude by spending some time this fall at Trinity Village. $50.00 covers one or all three classes for the 8-week sessions. People with Parkinson's with or without their care partners are encouraged to attend. To register, please call 414-371-7367.

A monthly support group at Trinity Village will begin on October 1 at 2:30 pm and continue on the first Monday of each month (except January).

Is Deep Brain Stimulation Surgery Right for You?

by Katherine Widnell, MD, PhD

While the use of medications (levodopa or dopamine agonists) remains the mainstay of treatment for Parkinson disease, long-term levodopa treatment is complicated by dyskinesia and motor fluctuations in which patients cycle between "on" periods and "off" periods. Deep Brain Stimulation (DBS) of the subthalamic nucleus or thalamus is an approved treatment for patients with a functionally disabling disease despite best medical therapy.

During DBS surgery, electrodes are implanted either in the subthalamic nucleus or a region of the thalamus. One week after placement of the electrodes, leads from the implanted electrodes are connected to a device known as an implantable pulse generator, which is placed under the skin in the area of the collarbone. This generator then delivers continuous high frequency electrical stimulation to the sub-thalamus via the implanted electrodes. This form of stimulation helps the sub-thalamus "rebalance" the control messages in the movement control centers of the brain, serving to suppress the motor symptoms of Parkinson disease. Patients may turn the pulse generator off and on by passing a hand-held magnet over the device. The batteries that power the pulse generator need to be surgically replaced every 3 to 5 years.

I have found that many patients come to the clinic with misperceptions about this surgery, and so I would like to dispel a few myths. First of all, with the exception of improvements in tremor, the surgery DOES NOT work any better than the best response to medication. If walking or balance does not improve with medication, the surgery will not add ANY additional benefit. The surgery DOES NOT slow the progression of the disease. The surgery only allows us to decrease the dose of medication, which prevents the side effects of dyskinesias seen with high-dose levodopa. Patients will still need to take medications after the surgery; however, we can usually decrease the dose by about 50%. The best candidates for DBS surgery are patients who have intractable tremor (not responsive to medication), side effects from medication (such as dyskinesias) or significant end-of-dose wearing off (but a clear and good response to medication) who wish to decrease the number of times medications are taken each day. If there is cognitive impairment (memory or thinking problems), these can be worsened by the surgery.

There is 1-3% incidence of serious complications such as stroke, hemorrhage, or infection. A surgeon who tells you that he or she has never had a patient experience a complication is either lying or does not do enough of these surgeries. As in real estate, location really matters so I strongly recommend having the surgery performed by a neurosurgeon with specialty training and who performs 1-3 DBS surgeries a week. It is a technically challenging surgery, and if the electrodes are off by 1-2mm, it can be almost impossible to program the stimulator after the surgery.

I always counsel patients that while the surgery is extremely effective in the correct patient, it is always safer to use medications and that patients should not be referred for surgery unless they have had a thorough trial of PD medications. Most centers (ours included) recommend a formal evaluation for "candidacy" for the surgery. This includes:

1. Ensuring that appropriate medication trials have been implemented.
2. Videotaping the examination in the "off" (off medications for at least 12 hours) and "on" state to prove that there is a response to medication and to demonstrate to the patient the best effect that he or she can expect from surgery. I often show these videotapes after the surgery to remind patients of what they looked like before the surgery and to reinforce the best "on" response that we can expect with DBS programming.
3. Neuropsychiatric testing to ensure that there is not cognitive impairment or significant (and untreated) anxiety or depression. In addition, it is important to ensure that there are adequate coping skills (and caregiver support) in case there is a complication during or after the surgery.

Finally, the surgery is not a quick fix. I tell patients that it usually takes about six months after the surgery to find the right balance between DBS stimulation and medications. As all patients know, medication adjustments can be frustrating and this is often not an easy period. While the surgery can lead to dramatic improvements in quality of life, it is very important to have realistic expectations about what it can and cannot do.

Wearing Off

by Maria Cristina Ospina, MD

One of the important factors for getting a smooth response from your Parkinson disease (PD) medications is recognizing the signs and symptoms of PD that might slowly creep up on you between doses. The term "wearing off" is commonly used to express the phenomenon of the return of PD signs and symptoms between doses. Wearing off phenomenon is usually due to a gradual decline in dopamine levels in the brain. A dose of Sinemet that used to work for 3 or 4 hours now works only for 2.5 or 3.5 hours. At about 30 minutes before your next dose you may go through several vaguely defined signs and symptoms. Perhaps you did not know what they were, why they were happening or what to do with them. You can get wearing off if you are taking Sinemet, Mirapex, or Requip.

If you continue not to recognize these signs and symptoms of wearing off and not adjust your PD medications, you will allow your dopamine levels to go down so low that you will start shaking, shuffling, freezing and experience the full blown signs and symptoms of PD. Some patients refer to this as "crashing." When this has occurred, even if you do take another dose of Sinemet after you have crashed, the next dose may or may not be as effective as the previous dose. So what you need to do is pay attention to what your inner self is telling your body and keep yourself in the driver's seat. You want to manage the disease not have the disease manage you. From our experience by listening very closely to patients like you, we have come to understand that there are several subtle things that you will manifest as the early signs of "wearing off." I am listing some of them below and if you experience something else that deserves addition to the list, please let me know.

1. Your spouse is talking to you and you have no idea what he/she is saying. (This is quite common if you have been married for longer than 25 years, but it may also be one of the earliest signs of wearing off. e.g. "I have told him about this four times in the last 30 minutes doc, I think he did not pay attention to anything I said!")
2. You just cannot seem to pay attention anymore.
3. The TV program that you have been watching, your favorite, is not funny anymore.
4. You experience sudden onset of depression and a tendency to feel like crying.
5. You have to push the armrest more than twice to get up, even though you were able to get out of a chair without much difficulty a few minutes earlier.
6. There is a sense of tightness of the neck and head that has come on without your awareness.
7. For some unexplained reason you have difficulties in finding appropriate words.
8. You experience blurred vision. You are reading something, you suddenly feel like some of the words are starting to move, they may even move out of the paper or book.
9. You have a sudden onset of stuttering.
10. You become restless because something inside you tells you to keep moving. You get in and out of the chair, even though you have great difficulty, then walk up and down the corridor, you go back to your chair and sit for a while, and within a few seconds you feel like you have to get up and move. (This phenomenon is called "Akathesia" in Greek or motor restlessness)
11. And of course the symptoms that we are all familiar with Tremor, Rigidity, Bradykinesia (slowness of movement) and trouble with balance.

Discuss these "wearing off" signs and symptoms with your neurologist. Together you can arrive at the best medication adjustment solution.

“Psychogenic” Parkinson Disease

by Paul A. Nausieda, MD

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tremor, and balance and posture abnormalities consistent with Parkinsonism. Many physicians are troubled when encountering early cases of Parkinsonism because the line between normal aging and early symptoms of Parkinson’s may be difficult. This, in my experience, is often a problem when the patient suggests the diagnosis before the physician does. The problem is amplified when there is a financial or legal issue involved such as a worker’s compensation or a disability claim. The other problem is that patients generally recognize that something is wrong before a general examination will pick up the findings. I have seen a fair number of patients who were told they were imagining their symptoms by more than one physician when the real problem was early Parkinson disease. This, of course, becomes apparent over time, but is often a source of frustration and confusion for the patient confronted with a diagnosis of “psychogenic” complaints.

This is not to say that psychological factors are not important in Parkinson disease. Apart from the obvious observations that anxiety makes tremors worse and depression makes patients even slower, complex psychological forces often dictate the course of the disease to a remarkable degree. This takes us back to the concept of “secondary gain” that we mentioned initially. The problem is best demonstrated with a few examples.

A number of years ago we had a woman in the clinic who appeared to have well controlled Parkinson disease for a few years and then became impossible to control with unpredictable episodes of freezing and intermittent confusion. We admitted her multiple times only to find that she would immediately be alert and mentally intact and do well in therapy with low doses of medication. We would send her home in a few days, but within 3 or 4 weeks the problems would return. At face value it looked like a problem with drug side effects. When one looked at the family situation it became more complex. The patient had married for the second time and had an adult daughter she was very close to from the first marriage. The new husband had a “dream”: live in Door County for the summer and Southern Florida for the winter. The daughter (who didn’t care for him) lived in Milwaukee. The periods when the patient would deteriorate always seemed to occur within a few weeks of going to the home in Florida or Door County. After discharge she usually stayed with the daughter for a number of weeks and seemed fine in this setting. When confronted with this issue, she adamantly denied that she had any problems with living out of the area and denied any hostility toward her new husband. This went on for nearly three years as the husband became more and more frustrated and started to have a few extra cocktails every day to handle the stress of emergency trips to Milwaukee from the two places he always dreamed about living. While his wife was in the hospital he collapsed as a result of a major stroke and ended up on the same unit, unable to speak and paralyzed on the right side. His wife put him in a local nursing home, moved in with her daughter, and was never admitted for Parkinson disease for the remainder of her life. Clearly, Parkinson disease was used as a vehicle for winning a debate in this marriage. Was this patient consciously getting worse to control her husband? I don’t think so. She was mild mannered and he was quite brash and dominant. I don’t think he was the sort of personality you could successfully argue with and she didn’t even try. While there are psychological forces at work, the patient was not imagining that she had Parkinson disease. The point is that treating her as a Parkinson patient was not going to get her better while the domestic situation remained unchanged.

There are less dramatic examples that are equally educational. I recently saw a man whose medications had been changed a dozen times in 2 years. He had been on every anti-Parkinson medication at least once, multiple antidepressants and two medications used to treat dementia. He had been on very high doses of levodopa, and later was on very low doses, which seemed rather odd. In talking with him and his wife she was quick to point out that the medicines were expensive and “none of them help him”. She described him as “helpless” and “totally confused”. On examination he was quiet, but totally oriented and did fine on mental status testing. He had minimal findings on examination, got up from the chair and walked without difficulty. He had mild Parkinson disease. Clearly the multiple medication changes were made in response to the wife’s complaints. I asked her why she was angry (this was pretty obvious and required no mind reading). She seemed taken aback by this but then told me that she “had no life” and was chained to the house as a result of the disease. I offered the observation that she shouldn’t feel guilty because her husband was ill. She insisted she was not guilty, and I asked her why she stayed with him given the

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situation. At this, she stated, "I cannot leave him". I don't claim to have figured this situation out yet, but it sure looks like another disease focused domestic battle. Being sick is a very effective way to make people do what you want them to (though the price is high for the patient). I'm sure that no one does this consciously, but it is effective and clearly has secondary gain associated with the role. Again, the point is that treating the Parkinson disease is not going to solve this situation and this patient had already been a testimonial to the futility of the effort. Aggressive attempts at treatment of the Parkinson disease in patients like this often leads to major side effects and other complications and it is important to understand the dynamics involved to avoid this.

I don't think anyone develops Parkinson disease as a psychological symptom. I do think that psychological situations have to be recognized when you treat any chronic disease and especially this one. If you wonder why we ask questions about your lives and how your family interacts it is not idle curiosity or an attempt to be conversational. Stress and conflict can alter the course of Parkinson disease greatly and identification of these issues is as important as the choice of a medication for your symptoms.

Are You A Safe Driver?

by Erica Vitek, MOT, OTP

Motor vehicle accidents are the leading cause of injury related deaths among 65-74 year olds and are the second leading cause (after falls) among 75-84 year olds *(Physician Guide for Assessing & Counseling Older Drivers, 2003).*

Driving a car is not a simple task. It involves a complex interaction between many body systems, including memory, concentration, attention, muscular reaction time, flexibility (ie., checking your blind-spot), and vision (ie., ability to identify contrasting objects, acuity or need for corrective lenses, and depth perception). Ninety percent of the information required for driving is acquired visually. Medical changes that occur as a consequence of aging, chronic illness, or progressive disease may influence driving skills and roadway safety.

The occupational therapy department at Aurora Sinai Medical Center in Milwaukee, Wisconsin is offering a clinical assessment that will help identify if there are functional problems that may affect driving safety. We have acquired all of the most commonly used and researched equipment from around the nation to provide the most accurate testing. Areas tested include physical, mental and visual abilities.

After the clinical assessment is completed, a behind the wheel evaluation is performed on a separate date by a

Certified Driving Rehabilitation Specialist (CDRS). With information from the clinical assessment combined with the behind-the-wheel performance, the CDRS will make a decision determining your ability to drive. Your physician also will be involved and notified of the results.

If you would like to schedule a driving evaluation or obtain additional information, please contact Aurora Sinai Medical Center at 414-219-5241. Please direct your questions to an occupational therapist.

My First DBS Surgery

by Paul Mamerow, PA-C

It's been eight years since I assisted in an Operating Room. Today I am only observing. Still I have to admit to being a little nervous. I've read all about Deep Brain Stimulation surgery, and I've viewed videos and slides depicting the procedure. Now I'm going to see it "up close and personal." I want to be able to answer the questions my patients ask me about it.

Chris Sheridan, RN and Program Coordinator for Froedtert Hospital's DBS program, will be my guide. After changing into our OR scrubs, we go to the pre-Op room where I meet "Frances" (not her real name) who is here for placement of a DBS electrode on the left side of her brain to treat her essential tremor. Although placement of DBS electrodes for essential tremor is slightly different than for Parkinson disease, the rest of the procedure is virtually identical. Frances already has a stimulator lead on her right side and is an "old hand" at the procedure. To my surprise, she seems relaxed and jocular.

In a little while, Dr. Brian Koppel, the surgeon heading the team, arrives to place the head frame. The frame, Chris notes, is a matter of concern for many patients. It provides a stable platform for attaching the small, motorized apparatus that advances the DBS electrode into the brain. More importantly, because the frame does not move in relation to the patient's head throughout the surgery, it provides an accurate "frame of reference" for reaching the critical structures deep within the brain.

Although securing the head frame might sound painful, it apparently isn't. And Frances, who had been through all this before, shows no qualms as Dr. Koppel prepares to attach it. The frame is secured by means of four small pins that are screwed into place, two on the sides of the forehead and two on the back of the head. The pins actually pass through the skin and make snug contact with the bony skull beneath. But Frances feels no pain – only slight pressure – because these areas have been numbed and will remain numb throughout the surgery. The pins will leave no mark after surgery.

Next, we wheel Frances to the radiology suite for a CT (X-ray computed tomography) of her head with the frame in place. This CT will be matched with an MRI (magnetic resonance imaging) film taken earlier in the week. The CT procedure takes all of fifteen minutes and Frances goes back to the pre-Op room where the anesthesiologist will place an IV and an arterial line in preparation for surgery. Here Frances waits – about an hour or so – for her surgery to begin. Meanwhile upstairs in the OR, Dr. Koppel and the surgical team are busy "plotting" the best pathway for placing the DBS electrode.

The tools they use for planning the surgery are a technological marvel. To understand how they work, it is worth reviewing the difference between a CT and an MRI. A CT scan uses X-rays to show dense materials such as metal (the head frame) or bone (the skull). An MRI scan, on the other hand, is good at depicting soft tissues (deep brain structures). The tool Dr. Koppel uses actually "merges" the CT and MRI images in three dimensions. Remember, the MRI shows the structures within the brain that Dr. Koppel wants to reach. The CT shows the metal frame that will serve as Dr. Koppel's external reference to locate these structures. The merged image allows Dr. Koppel not only to visualize what direction the electrode must take to reach its target, but also exactly where the electrode-advancing apparatus should be mounted on the head frame.

Once the electrode path has been plotted, Frances is wheeled into the OR and transferred onto the OR table. The upper portion of the bed is elevated about thirty degrees and the head frame is anchored to the bed. The OR staff talk to Frances to make sure she is comfortable, placing a pillow or two under her knees. Frances will remain awake for the bulk of the surgery, and no general anesthetic is needed since the brain itself has no feeling.

When everything is ready, Dr. Koppel numbs the scalp and makes an incision about three inches long. He next uses a drill to bore a hole about the size of a nickel through the skull. This portion of the operation takes about twenty minutes. The electrode advancing motor is mounted, and the team is now ready to begin "brain mapping."

This is the longest, and perhaps most tedious, part of the surgery requiring several hours or more. While the merged images help Dr. Koppel target the electrode, it only gets him to the near vicinity of the final mark. Dr. Koppel uses a "recording probe," essentially a thin wire, to locate a specific

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sensory nucleus in the brain. Its location can be verified by its characteristic electrical pattern. Once the probe finds this location, it can be withdrawn and moved either forward, backward or sideways to find the motor nucleus where tremor resides.

The procedure, of course, is far more involved and time-consuming than my description, but it enables the team to adjust for variations in brain structure that occur from person to person. Once the motor nucleus is located, the DBS electrode is inserted and a weak current is run through it. Frances' tremor subsides, verifying that we're "on target." It's time to close.

Dr. Koppel next inserts a "cap" to close the hole in the skull. A fluoroscopic X-ray machine is brought into the OR to verify the electrode has not moved during this final step. Then a wire is attached to the electrode and passed under the skin of the scalp. The surgical resident sutures and cleans the incision, and Frances is ready to have the head frame removed. She sighs as she's finally able to rest her head back onto the bed. It's been a long day.

In fact, six-and-a-half hours have passed since I first met Frances in pre-Op. She's been a trooper. Chris Sheridan leads me back to the locker room so I can change out of my scrubs. "I tell our patients that the day of surgery will be a long and tiring one," Chris says. "But it's just one day. More importantly, it's one day that can have a profound effect on the rest of their lives." After seeing the surgery and its results, I agree.

Why I Love Parkinson's

by Jon Kalb

1. I love Parkinson's because when I was diagnosed I finally understood what was wrong with me. I do not have polio, coronary disease, or cancer.
2. I love Parkinson's because I am convinced that a love of nature, combined with regular exercise, is part of the cure. I thrive on warm sunshine, cold spring waters, and the changing of the seasons.
3. I love Parkinson's because I know I will still be around to enjoy my grandchildren, even though I am increasingly disabled.
4. I love Parkinson's because the disease has taught me that I do not need alcohol, cigarettes, caffeine, or illicit drugs to get high on life.
5. I love Parkinson's because it has increased my awareness of diet and nutrition to combat the toxins that feed bad habits.
6. I love Parkinson's because I frequently experience stomach pain, which I am convinced is neurological in origin. My doctors are not convinced, but they don't know everything.
7. I love Parkinson's because when I take my medications I often feel light–headed, confused and irritable, not because I have Alzheimer's, Huntington's, or a brain tumor.
8. I love Parkinson's because my weight loss is due to loss of appetite, caused by nausea, dry mouth, and difficulty in swallowing, not because I am a victim of famine, starvation, or poverty.
9. I love Parkinson's because those closest to me understand my problems with speech, balance, and rigidity. They also recognize that my loss of facial expressions on the one hand and increased emotions on the other are part of the symptoms.
10. I love Parkinson's because during my sleep my medications induce vivid dreams and delusions of night people visiting me in my semi-consciousness. I welcome these images over wakefulness.
11. I love Parkinson's because I read more and appreciate the arts more, and value companionship more.
12. I love Parkinson's because I can still do my work, despite memory loss and fatigue, and because I have learned to be more understanding of others with disabilities.
13. I love Parkinson's because my condition is due to a chemical deficiency in my brain. I am not a victim of a flood, earthquake, pestilence or terrorism.
14. I love Parkinson's because of the life I still have and the opportunities I have. I look forward to a future filled with new and exciting adventures.

Mr. Kalb, a geologist, lives in Austin, Texas, and was diagnosed with Parkinson's in 1996. He and his wife have two daughters.

Love and Death

by Vicki Conte

The message I've been carrying to support groups this past year has been one of the mind/body/spirit experience. There are things we can do to improve our physical health. There are even more practices that impact our minds and spirits. We often talk about ways to "feed the soul." Yes, many of us can develop habits that will enrich our lives. Some of us are closer to facing the end of life and want to look at ways to prepare for that inevitability. I have been asked several times this month to address the subject of death. When I need inspiration, I turn to my bulletin board.

I have a picture of a craggy, old Jesuit priest on this bulletin board. I cut it out of a magazine years ago because he looked both wise and happy and because I was moved by the quotation above the picture. Fr. Pierre Cyrac, SJ had this to say: "All God cares about is that we love – nothing else." The purpose of the precious items on my bulletin board is to feed my soul. I have photos of my children, my brothers, my parents, my niece and nephew full of finger paint, and some dear friends. I have a postcard of the ceiling of the Sistine Chapel. I have five bookmarks adorned with five beautiful flowers – Daffodil, Tulip, Sweet Pea, Hyacinth and Ranunculus – each a different color, each an individual, delicate shape. I have a picture of the rare roseate spoonbill, a bird I once saw raise up out of "the river of grass" that is the Everglades in Florida. The sun highlighted his pink wings. I was speechless.

And I have a photograph of my mother some 18 years ago, carrying a large bag of bread, walking beside my tottering daughter who appears smaller than the bag of bread. They are walking away from me toward a group of geese on the ground, toward a lagoon and a luscious weeping willow tree. They both have short blonde hair. They both tilt slightly to the right as they raise the heels of their left feet. They are relaxed and happy. I remember that. They are feeding their souls as they feed the geese. And here, 18 years later, they are feeding my soul as I study this picture and feel the love between them.

Love is tangible. Love does not die. Love returns to itself to be used again and again. I used to whisper in my son's ear when he was very young, "I am pouring this love into you so that you will return it to the world." And he does. I could have, should have perhaps, taught him to study harder, improve his grades, etc. I chose to encourage him to share love. He is struggling semester by semester through college; but he is a natural at communing with nature, respecting the homeless, bringing a smile to the faces of his many friends, delighting in animals of all shapes and sizes, adoring his grandpa and his girlfriend and sending real, palpable love through the telephone wires to his mother every week.

Does the diagnosis of Parkinson disease affect our ability to give and receive love?

My answer would be, "only if we let it." When we withdraw from our loved ones, from our friends, from nature and from the other aspects of life that feed our soul we are depriving ourselves of sharing love. The voice may grow soft and slow. The facial muscles may struggle to convey emotion. We really have to work to communicate love. When care partners return home from work or errands, you may feel joy at their return; you may feel your love for them. But have you figured out how to convey that? And when these same care partners return home, they may feel great comfort in your presence and a great sense of security in all the years they have returned home to you. But do they express that or just head into the kitchen to start the next meal?

I'm not speaking of romantic love here. Referring to one of the ultimate romantic fictions, *Gone with the Wind,* one of my teachers said, "and good riddance!" Our society has glorified a kind of superficial, romantic notion of love. I am speaking of the love that transcends all the drama associated with romance. When chronic illness is part of the equation, it is necessary to get at the heart of love and learn to express it and share it in all the ways possible. Those of you that have come to know me have quickly learned that I am a toucher. I would rather hug you than shake your hand and don't be surprised if I throw in a kiss especially if you are in a wheelchair and your forehead is in kissing range. I also love to hold the hands of the person with whom I'm speaking or pat the knee of someone I'm sitting beside. I would rather follow my instinct to share love in this way and run the risk of being thought to be patronizing or inappropriate. Everyone senses that I am sharing love. There are now many of you that hug me first. Thank you!

Our culture has also misled us regarding death. We are taught to associate love with life. We are taught, usually quite subtly, to fear death. We certainly are not taught to talk about death. Our medical profession is charged with saving lives and often in the case of people with PD, a good neurologist can snatch patients from the brink of death and restore them to their pre-crisis state… at least for a time. People with terminal cancer can

continued from previous page

be kept alive much longer now with new drugs and other treatments. Is that a good thing? We can only answer that for ourselves. But we should answer. And we can't answer questions that we have ignored. We can't discuss death if we pretend it's optional.

After two bouts of cancer treated with surgeries, chemotherapy, and other medications, I have thought about death. I know I'd want to plan for death by seeing a few places I've wanted to see, spending time with a variety of people that I love, studying the seasons one last time, finding a dog that would lay across my legs, watching all my favorite movies again and finally crawling into my very comfortable bed in a pair of cotton striped pajamas and inviting my kids, one at a time, to sleep overnight and hold my hand.

Before a girl menstruates, her mother talks to her and gives her a book to read. Before a couple gives birth, they attend childbirth classes. Death is also a natural event in life. Thinking about it, talking about it, and preparing for it makes sense.

I was with my mother when she died. She was in hospice. I spent the night with her. I stroked her hair and held her hand and at one point, after telling her it was OK to go, I told her that I would miss her very much. A tear emerged from her closed left eye and ran across her nose. I told her that I loved her; that we all did. I told her we knew she loved us. I named my dad, my brothers, their wives, all the grandchildren, her sister and nieces and their families. I told her that all that love would continue between us. I told her that we would take care of each other with the love that existed between us. My mother opened her eyes – for the first time in several days – and looked at me to say good-bye. She breathed her last and was gone. I was instantly struck by the fact that this experience was part of the same fabric as birth. There is that first breath and then the last. It is the same.

The final lines of Thornton Wilder's Pulitzer Prize winning novel, *The Bridge of San Luis Rey,* ends thus: "…we ourselves shall be loved for a while and forgotten. But the love will have been enough; all those impulses of love return to the love that made them. Even memory is not necessary for love. There is a land of the living and a land of the dead and the bridge is love, the only survival, the only meaning."

I encourage you to share love and to talk about death. These are not directions for the faint of heart. These are directions for you, the already tested Parkinson community.

Save the Date!

The Parkinsons Action Network (PAN) will present a one-day regional forum in Milwaukee, Wisconsin on November 11, 2006. Patients, families and friends who are interested in learning more about how to advocate effectively are invited to attend. Representatives from Wisconsin, Minnesota, Illinois, Indiana and Michigan will attend sessions and share information. Contact the Wisconsin Parkinson Association at 1-800-972-5455 for more details. We hope to see you at the forum.

Betty Sancier
State Coordinator
Parkinson Action Network
bettysan@uwm.edu

Parkinson, Posture and Physical Therapy

Ann Brophy, PT and Cindy Marti, PT of Spinal Dynamics of Wisconsin

Sometimes "what's new" in any given area of study involves revisiting what we already know and considering it in a new light. Emerging technologies, advances in medicine, and current trends in research all influence our views of Parkinson disease and our treatment approaches. Physical therapists at Wauwatosa-based Spinal Dynamics of Wisconsin are embarking on a new opportunity to create a specialized program for evaluating and treating postural dysfunction in people with Parkinson disease.

As the name implies, the primary focus of Spinal Dynamics is providing physical therapy treatment for people with a variety of spinal disorders. While treatment approaches to spine care vary depending on the diagnosis, one universally addressed issue is posture. It is, in fact, an emphasis on posture that caught the attention of one of the Midwest's foremost experts in Parkinson disease, Dr. Paul Nausieda.

In his work as medical director of the Regional Parkinson Center, Dr. Nausieda noticed a trend in certain classifications of his patients toward worsening posture. In some cases, a fairly rapid development of scoliosis occurred. (Scoliosis is a lateral curvature of the spine as viewed from behind). In other cases, a rounded upper back posture (kyphosis) developed. Despite therapy and exercise programs, Dr. Nausieda observed that most patients did not improve in posture. He was looking for someone to "think outside the box" – to develop a specific, measurable postural improvement program for patients who desperately want to sit and stand more upright.

Postural dysfunction in Parkinson patients is one of the well-known hallmarks of the disease. We now ask the questions: "Are there more effective ways to make meaningful postural changes for these patients?" and "How will we quantify our outcomes to know if we are successful?" We decided to accept the challenge – to learn and contribute to new physical therapy thoughts that will lead us to better measurable results.

We feel our intervention must be directed toward making functional improvements, not just improved cosmetic appearances. In these early months of our work, we have identified some common patterns of muscle imbalance (tightness and weakness) that are part of postural dysfunctions. We have also recognized several key functional problems that can occur with progressive spinal collapse:

- Reduced lung capacity
- Neck and back pain
- Compromised agility and mobility with transfers
- Reduced ambulation safety and endurance
- Psychological stress related to negative body image, lack of postural control

Reduced lung capacity and organ compromise are probably the most serious consequences of a progressive collapse of the spine. We know that the cause of death in the Parkinson population is often from pneumonia. Reduced tidal volume makes for an inefficient cough, thereby limiting the patient's ability to clear mucus from lungs. We have begun measuring breathing capacity changes related to changes in posture as a hopeful step in minimizing this risk for patients.

In any population of patients with spinal mal-alignment, joints and muscles are stressed, which contributes to neck and back pain. A vicious cycle ensues as ongoing pain leads to further worsened posture. We can use accepted pain measurement tools to evaluate the effects of posture-focused physical therapy intervention on pain in Parkinson disease.

Ambulation (a patient's ability to walk) and transfers (like moving from sit to stand) can be compromised due to alterations in upright alignment. These are critical parameters for independent living. We believe there is great potential for posture improvements to functionally improve ambulation and transfers in Parkinson patients.

The psychological effects of living with Parkinson disease are challenging. Can we make patients feel better emotionally by giving them tools to better control their posture and positively affect their physical appearance? To date, our patients have told us yes. Effectively measuring this – and sharing our knowledge – will perhaps be our most rewarding outcome of all.

Some of the physical therapy interventions used include:

- Digital posture photos for patient teaching and observation of change
- Soft posture support braces
- Sitting supports
- Taping for posture facilitation
- Spinal stabilization exercises
- Aggressive stretching and spinal/tissue mobilization
- Spirometer measured breathing

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The “mother of learning” is repetition. All patients are given multiple strategies to understand the value of repetition and motivate them for home compliance.

Posture dysfunction isn’t new. Parkinson disease isn’t new. Physical therapy isn’t new. But we can create new ideas from existing knowledge if we apply ourselves creatively – if we think outside of the box. We will continue to evaluate what works and what doesn’t and adjust programs accordingly. Parkinson patients and their physicians may want to consider whether a referral to specialized therapists for posture intervention should be part of the treatment plan.

Treat Your Family to a Holiday Party

Photo opportunity and gifts from Santa • Holiday sing-a-long • Raffle Prizes and much more!

Saturday, December 9, 2006

10:00 am – 1:00 pm
Lunch will be served promptly at 11:30 am

Clarion Hotel & Conference Center
5311 S. Howell Avenue, Milwaukee, Wisconsin
Ballroom B/C

$12.00 per person / $6.00 per child (13 and under)

Please make your check payable to the WPA and mail to:

Wisconsin Parkinson Association
Attn: Jackie Hoeft
945 N. 12th Street, Suite 4602
Milwaukee, WI 53233

414-219-7060 • phone

RSVP by November 27, 2006

Menu choices:

A. Sliced Baked Ham topped with pineapple sauce and served with mashed potatoes and gravy and chef-select hot vegetable

B. Roast Pork Loin layered on stuffing served with mashed potatoes and gravy, chef-select hot vegetable

C. Baked Cod Four Seasons topped with green and red pepper, mushrooms, onions and served with wild rice and chef-select hot vegetable

Dessert will be a cheesecake with strawberry topping.

All entrees are served with a garden salad with raspberry vinaigrette dressing, rolls and butter, coffee, tea and milk.

Please fill out the form below and return with check to the WPA.

Name ______________________________ Lunch Choice ____________________

Name ______________________________ Lunch Choice ____________________

Name ______________________________ Lunch Choice ____________________

Name ______________________________ Lunch Choice ____________________

# of Adults _____ **# of Children** ______ **Amount Enclosed $**____________

Donations and Memorials

We are grateful for every donation we receive. Due to space limitations, we are only able to list the names of those individuals who donated $25 or more to the Wisconsin Parkinson Association.

In Memory of Dr. James Bass
All Saints/Racine YMCA Parkinson Fitness Class
Mrs. Elizabeth Bass
Mr. & Mrs. Robert Crossett
Capital Investment Services of America, Inc.

In Memory of Anne Brigham
Mr. & Mrs. Eugene Goodearle
Ervin R. Dahlmann
Ms. Eleanore Dahlmann
Mr. & Mrs. Michael Gasperic
Reggie & Joy Henkel
Mr. & Mrs. Alan Schulthess
Mr. & Mrs. Peter Sekula

In Memory of Joyce Depies
Joseph Depies

In Memory of Lilo Freeman
Elmer Winter

In Memory of Dr. Robert Fruchtman
Ms. Phyllis Rosenfield & Family

In Memory of Eldred Heidschmidt
Jan Heidschmidt

In Memory of Thomas Himmelspach
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Mr. & Mrs. Mark Voelz

In Memory of John M. Hinkle
Mr. & Mrs. Jack Hansen
Leland Holm, Jr.
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In Memory of Elaine Krueger
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In Memory of Heinz Metz
Mr. & Mrs. Phil Nolte
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In Memory of John H. Nielsen
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In Memory of Dorothy Sample
Denise Romenesko

In Memory of Lucille Schneider
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In Memory of Kenneth Schnese
Gail Bowers-McKay

In Memory of Clarence Schuefer
Joan Wypych & Family

In Memory of Edmund Sikorski
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Mr. & Mrs. Daniel Duda
Joan Dwyer
Sophie Nowak & Rev. Henry Meus
Sandy & Fred Sisson
Tom, Chris & Tommy Wolf

In Memory of George Styduhar
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S&J Rayl Corporation
The Schindler Family
Mrs. Barbara Styduhar
Marjorie Sutton
Mr. & Mrs. Terry Wright

In Memory of Carol Wertz
Mr. & Mrs. Eugene Goodearle

Donation in honor of Rammer/ McMullen wedding
Ms. Sarah Rammer

Donation in honor of Ann Burns and Marvin Weber wedding
Mr. & Mrs. Robert Christensen

Donations and Memorials (continued)

ASSOCIATE ($250-$999)

HSBC Philanthropic Programs
Oostburg Area United Fund, Inc.
Cheryl Prescott

SUSTAINING FRIEND ($100-$249)

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Floyd Shields
Robert Snyder
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Rita Westover

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Barbara Winiecki
Nancy & Sam Woodburn
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Mr. & Mrs. Roy Zoerb

Welcome New Support Groups

A new support group is starting at **Trinity Village,** 7300 W. Dean Road (between Good Hope and Brown Deer just east of 76th). This group will meet on the first Monday of each month at 2:30 pm beginning October 1. Parking is available on 72nd Street and the 72nd Street entrance can be used. Vicki Conte will facilitate this group initially and will be looking for eager co-facilitators. Contact Vicki directly at 414-219-7840. While we will begin as a combined group – people with PD and care partners together, we will frequently separate into two groups to give an opportunity for people with PD and care partners to share their respective concerns.

A group of residents of **Franciscan Gardens** in South Milwaukee has been meeting for several months with good results. They are ready to open the group to the public. They will meet on the third Tuesday of the month at 2:00 pm at 1000 Williams Ave, South Milwaukee. Contact Rob Robison at 414-570-5370. Rob works at Franciscan Gardens and is a person with PD. Thank you, Rob for your dedication in starting this group.

For almost one year a group of **men with PD** has been meeting once or twice per month. Three months ago, a group of **women with PD** began. These are not drop-in groups and the number of members is limited. The participants have found this format especially meaningful. If you are interested in learning more, please call Vicki Conte at 414-219-7840. There may be a need to organize other men-only, women-only and care partner-only groups.

REMINDER!

The WPA has discontinued the mailing of reminder flyers to individual support groups. We have been working hard to find the best format for notifying you about group meetings and speakers. Won't you please take the time to review the support groups in your area and mark your calendar if there is a meeting you want to attend. If you regularly attend meetings and have missed receiving the reminder flyers, just mark you calendars now in advance, or tear out the perforated pages and post them on your refrigerator. Meetings take place at the same day, time and place each month. Facilitators and speakers are looking for you! If you've never attended a support group, or if you haven't attended one for quite some time, put your toe in the water. The temperature has changed!

The WPA is focusing on a positive psychology model of empowerment. Our large events and our support group meetings most often involve information about issues related to the body, mind and spirit. When we look at the whole person, it is possible to decide that we are "healthy" despite the Parkinson diagnosis.

Illinois

Dixon, IL
KSB Hospital, Private Dining Room, 403 East 1st Street, 2nd Thursday at 1:00 pm
Contact: Anne Hilliard at 815-285-5575

Joliet, IL
SOS Children's Center, Bruce & Briggs Road, 1st Wednesday at 1:00 pm
Contact: Jackie Mansholt at 815-740-1100

Libertyville, IL
Lake County Parkinson Support Group, Condell Medical Center
Condell Drive and Milwaukee Avenue (Rt. # 21) 4th Wednesday 7:00 – 9:00 pm
Contact: Phillip & Diane Fragassi at 847-246-0128

Northfield, IL
North Shore Senior Center, 161 Northfield, Every Wednesday at 1:00 pm (except August)
Contact: Michele Corrado at 847-784-6038

Rochelle, IL
Rochelle Community Hospital, 900 North Second Street, Hospital Auxiliary Room
4th Monday at 6:30 pm
Contact: Pat Docter at 815-562-9613 or Pat Uldahl at 815-562-2181 ext. 2580

Rockford, IL
Wesley Willows, 4141 North Rockton Avenue, 2nd Wednesday at 10:00 am
Contact: Faye Ford at 815-885-4897

Rockford, IL
Young Parkinsons, Gloria Dei Lutheran Church, 4700 Augustana Drive
3rd Tuesday at 7:00 pm
Contact: Sharon Habing at 815-398-1720

Rock Island, IL
Trinity Medical Center, 2701 – 17th Street, 2nd Thursday at 3:00 pm
Contact: Jane Hoffman at 309-779-2624

Special Events

DIXON, IL
November 9, 1:00 pm
Gail Beck, Registered Dietician will talk about nutritional issues in Parkinson disease

December 14, 1:00 pm
Holiday Party – Bring finger foods to share with the group

January 11, 1:00 pm
Snow Storms – Bring your favorite or least favorite snow story

ROCHELLE, IL
November 27, 6:30pm
Faith, Hope and Spiritual Healing presented by Judy Williams, Chaplain at Rochelle Hospital

No Meetings Until March 2007

ROCKFORD, IL
November 8, 10:00 am
Retired Pastor Troy Hedricks will discuss Everyday Living with Spiritually

December 13, 11:30 am – 1:30 pm
Holiday Luncheon - $4 per person, contact Faye for more information. Payment due by December 6

January 10, 10:00 am
We will view a video on laughter being the best medicine from the 2006 Parkinson Disease Symposium
Lunch Outings: November 14 & January 9, location TBA. Contact Faye for more information.

ROCKFORD, IL – *Young Parkinsons*
November 28, 6:30 pm (changed date)
Annual Chinese dinner night at the Great Wall, 4228 E. State Street, Rockford

No December Meeting

January 16, 6:30 pm
We will start the New Year with a dinner meeting at a restaurant to be announced. Contact Sharon for more information.

NOVEMBER

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JANUARY

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Special Events

BURLINGTON, IA

November 16, 2:00 pm
Caregiver needs and hospital routine

December 21, 2:00 pm
Holiday Party, Blackhawk Room
No January & February Meetings

DAVENPORT, IA

November 18, 2:00 pm
Guest speaker Craig Bode, Physical Therapist from Rock Valley Physical Therapy

December 16, 2:00 pm
Holiday Party. If able, bring a treat to share.

January 20, 2:00 pm
To be announced

DUBUQUE, IA

November 18, 10:00 am (changed date)
Updates on Medicare Part D

No December Meeting

January 27, 10:00 am
Learn to Use Less Salt! Pat Fisher, RD, LD. Hy-Vee Registered Dietitian

NEWTON, IA

No November and December Meetings

January 15, 1:30 pm
To be announced

Indiana

Bloomington, IN
Monroe County YMCA, 2125 South Highland, 1st and 4th Thursday at 11:15 pm
Contact: Margie at 812-332-5555

South Bend, IN
Michiana Parkinson Awareness Group, The Leighton Center, 534 North Michigan Street
1st Wednesday at 1:30 pm
Contact: James Banner at 574-291-4217

Iowa

Burlington, IA
Great River Medical Center, 1225 Gear Avenue, 3rd Thursday at 2:00 pm
Contact: Sherry Engberg at 319-752-3359

Clinton, IA
Mercy Medical Center, South Campus Board Room, 638 South Bluff Boulevard
2nd Saturday at 10:00 am
Contact: Don and Rita Schneider at 563-243-5585

Davenport, IA
Center for Active Seniors, 1035 West Kimberly Road, 3rd Saturday 2:00 – 4:00 pm
Contact: Dot Christiansen at 563-332-5071

Decorah, IA
Winneshiek Medical Center, 901 Montgomery Street, 4th Wednesday at 1:30 pm
Contact: Linda Nolting at 563-568-5040

Dubuque, IA
Stonehill Adult Daycare Center, 3485 Windsor Avenue, 4th Saturday at 10:00 am
Contact: Jane Osterhaus at 563-582-7313

Newton, IA
Newton Public Library, 3rd Monday at 1:30 pm
Contact: John McConeghey at 641-791-4639 or Florence Crow at 641-791-4581

Washington, IA
United Presbyterian Home, 1203 E. Washington Street, 2nd Tuesday at 3:30 pm
Contact: Amy Kleese at 319-653-5473

Waukon, IA
Veteran's Memorial Hospital, 404 1st Street Southeast, 3rd Thursday at 1:00 pm
Contact: Linda Nolting at 563-568-5040

Michigan

Calumet, MI
Keweenaw Home Nursing, 311 Sixth Street, 2nd Monday at 1:00 pm
Contact: Diane Tidberg or Colin Munn at 906-337-5700

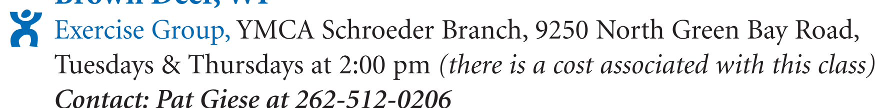
Wisconsin

Appleton, WI
Thompson Community Center, Ogilvie Hall, 820 West College, Suite 1
4th Thursday at 2:00 pm
Contact: Mary Peters at 920-733-7649 or 920-751-0443

Baraboo, WI
First Congregational United Church of Christ, 131 6th Avenue, 3rd Monday at 2:00 pm
Contact: Sylvia Kriegl at 608-355-3289 or Geri Schoenoff at 608-356-3473

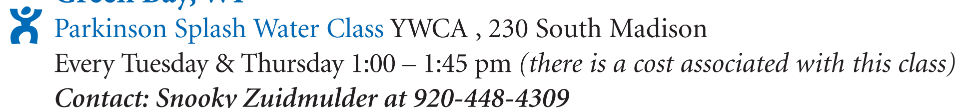
Beaver Dam, WI
Beaver Dam Community Hospital, Hillside Manor, 1st Floor Dining Room
803 South University Avenue, Last Thursday at 2:30 pm
Contact: Jean Hill at 920-887-6394

Brookfield, WI
Brookfield Regency, 777 North Brookfield Road, 1st Thursday at 2:30 pm
Contact: Winfield Reinemann at 262-786-6415

Brown Deer, WI

Exercise Group, YMCA Schroeder Branch, 9250 North Green Bay Road,
Tuesdays & Thursdays at 2:00 pm *(there is a cost associated with this class)*
Contact: Pat Giese at 262-512-0206

Campbellsport, WI
St. Joseph's Convent, 526 Mill Street, 1st Wednesday at 2:00 pm
Contact: Merriann Rose at 920-533-8351

Fond du Lac, WI
Aurora Health Center, 210 Wisconsin American Drive, American Room
4th Thursday at 10:00am
Contact: Vicki Conte at 414-219-7840

Green Bay, WI

Parkinson Splash Water Class YWCA , 230 South Madison
Every Tuesday & Thursday 1:00 – 1:45 pm *(there is a cost associated with this class)*
Contact: Snooky Zuidmulder at 920-448-4309

YWCA, 230 South Madison, 3rd Monday at 1:00 pm
Contact: Snooky Zuidmulder at 920-448-4309

Janesville, WI
First Baptist Church, 3414 Woodhall Drive, 1st Wednesday at 2:00 pm
Contact: Rosemary Herman at 608-752-5206

Kenosha, WI
Brookside Southport Room, 3506 Washington Road, 2nd Tuesday at 2:00 pm
Contact: Julie Topolovec at 262-657-7276

Kenosha Young Onset, Aurora Medical Center, 10400 – 75th Street, Hospital Room J
2nd Wednesday at 7:00 pm
Contact: Cindy Grueter at 262-552-0067

La Crosse, WI
Gunderson Lutheran Hospital, 1836 South Avenue, 4th Tuesday at 2:00 pm
Contact: Julie Holzwarth at 608-782-7300

Lancaster, WI
Grant County Parkinson Support Group, Youth & Agriculture Building (Fair Grounds), South Room, 4th Tuesday at 1:30 pm
Contact: Tracy Schildgen or Mary Rasmussen at 608-723-6416

Special Events

BROOKFIELD, WI
November 2, 2:30 pm
Ann Brophy, PT with Spinal Dynamics of Wisconsin – Discussion and demonstration of posture issues in Parkinson disease

December 7, 2:30 pm
TREVOR HYDE, PhD, Neuropyschologist from the Regional Parkinson Center, will discuss neuropyschology, neuorpysch testing and Parkinson disease

January 4, 2:30 pm
VICKI CONTE, Program Coordinator from the WPA, will show the Marilyn Bonjean, PhD Symposium video and lead a discuss about couplehood and chronic illness

FOND DU LAC, WI
No November and December Meetings

January 25, 10:00 am
VICKI CONTE, Program Coordinator from the Wisconsin Parkinson Association will speak on Parkinson disease and the mind, body and spirit

JANESVILLE, WI
November 1, 2:00 pm
Guest speaker Joann Woodman from Senior Connection and Mercy Respite Care

December 6, 12:00 pm (changed time)
Christmas Dinner

January 3, 2:00 pm
Guest speaker Pam Bidne from Huntington Place

KENOSHA, WI *– Brookside*
November 14, 2:00 pm
Aging & Disability Resource Center – Lauren Zielsdorf, Community Outreach Specialist

December 12, 2:00 pm
The Balance Center – Kelly Demelle, MPT, Physical Therapist

January 9, 2:00 pm
Foster Grandparent Program – Teresa Jacobs, Supervisor

Special Events

LA CROSSE, WI
November 28, 2:00 pm
Dr. Yannick Grenier, Movement Disorders Specialist

December 12, 11:30 am (changed date & time)
Christmas Lunch, call Julie for more information

No January Meeting

LANCASTER, WI
November 28, 1:30 pm
Holiday Party, call for more information

No December and January Meetings

MANITOWOC, WI
November 27, 1:30 pm
VICKI CONTE, Program Coordinator from the Wisconsin Parkinson Association, will present on "Living one day at a time, enjoying one moment at a time, and accepting hardships as a pathway to peace"

No December Meeting

January 22, 1:30 pm (note date change)
TREVOR HYDE, PhD, Neuropyschologist from the Regional Parkinson Center, will discuss cognitive and psychological issues in Parkinson disease

MARINETTE, WI
November 16, 10:00 am
VICKI CONTE, Program Coordinator from the Wisconsin Parkinson Association, will speak on Parkinson disease and the mind, body and spirit

MILWAUKEE, WI – *Franciscan Gardens*
November 21, 2:00 pm
Cathy Dorangrichia with Medtronic will discuss Activa Therapy (Deep Brain Stimulation) for Parkinson disease

December 19, 2:00 pm
Holiday Party, call for more information

January 16, 2:00 pm
VICKI CONTE, Program Coordinator from the Wisconsin Parkinson Association, will speak on Parkinson disease and the mind, body and spirit

Wisconsin

Manitowoc, WI
Manitowoc Senior Center, 3330 Custer Street, 4th Monday at 1:30 pm
Contact: Rita Hartman at 920-682-4711 or Vickie Rathsack at 920-726-4626

Marinette, WI
First Trinity Lutheran Parish Hall, 920 Wells Street, 3rd Thursday at 10:00 am
Contact: Virgil & Lorraine Thomson at 920-897-2461

Marshfield, WI
Marshfield Clinic, 1000 North Oak Avenue. Group time and day varies.
Call for dates.
Contact: Mahala Earnhart at 715-389-3670

Milwaukee, WI
Franciscan Gardens – NEW GROUP
1000 Williams Avenue, Gardens Community Room, 3rd Tuesday at 2:00 pm
Contact: Rob Robison at 414-570-5370

Trinity Village – NEW GROUP
7300 W. Dean Road, 1st Monday at 1:00 pm
Contact: Vicki Conte at 414-219-7840

St. John's on the Lake
1840 N. Prospect Avenue, First Floor Tower West, 3rd Thursday at 2:30 pm
Contact: Ed or Suzanne Weber at 414-273-5433

Milwaukee Weekly Exercise Group Washington Park Senior Center,
4420 West Vliet Street, Every Friday 9:30 – 11:00 am
Contact: Gail Meilinger at 414-462-2746

St. Clare Terrace – Dining Room (caregiver only group)
3553 South 41st Street, 3rd Wednesday at 2:00 pm
Contact: Audrey Behling at 414-543-7579 or Kate Olszewski at 262-672-0041

Muskego, WI
Tudor Oaks Retirement Community, Commons Conference Room
S77 W12929 McShane Drive, 1st Tuesday at 2:00 pm
Contact: Chaplain Steve Jones at 414-529-0100

Oconomowoc, WI
Oconomowoc Memorial Hospital, 791 Summit Avenue
3rd Friday at 1:15 pm (Caregivers Only), 3rd Friday at 2:00 pm (Support Group)
Contact: Peg Theder at 920-261-9805

Oshkosh, WI
Oshkosh Seniors Center, 200 North Campbell Road, 3rd Tuesday at 2:00 pm
Contact: Paula Stephens at 920-232-5305

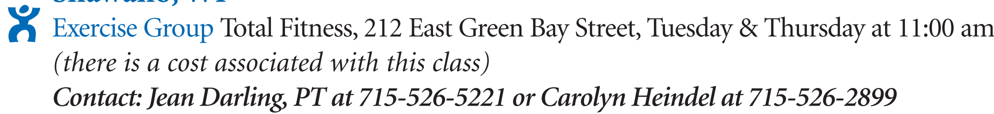
Racine, WI
Exercise Group Racine YWCA, 725 Lake Avenue, Every Monday & Wednesday
2:00 – 3:00 pm *(there is a cost associated with this class)*
Contact: Debbie Bednarek, MPT at 262-687-5323

Ridgewood Health Center, 3205 Wood Road, 3rd Tuesday at 2:00 pm
Contact: Barbara Whicker at 262-639-6299

St. Francis, WI
St. Ann's Center Adult Daycare Unit, 2801 East Morgan, 3rd Friday at 2:00 pm
Contact: Hattie Goodman at 414-744-5654

Wisconsin

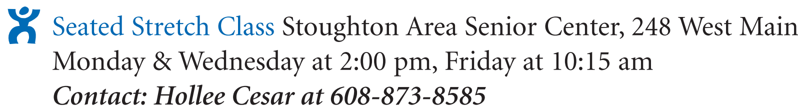
Shawano, WI
Shawano United Methodist Church, 1000 Engel Drive, 2nd Tuesday at 1:00 pm
Contact: Lorraine or John Lindfors at 715-799-4451

Shawano, WI

Exercise Group Total Fitness, 212 East Green Bay Street, Tuesday & Thursday at 11:00 am
(there is a cost associated with this class)
Contact: Jean Darling, PT at 715-526-5221 or Carolyn Heindel at 715-526-2899

Sheboygan, WI
Sheboygan Memorial Medical Center, 2629 N. 7th Street, Conference Room C
3rd Tuesday at 2:00 pm
Contact: Neal Buteyn at 920-564-2502

Stevens Point, WI
Lincoln Senior Center, 1519 Water Street, 4th Tuesday at 1:00 pm
Contact: Dana Cyra at 715-346-1401

Stoughton, WI
Stoughton Area Senior Center, 248 West Main, 4th Wednesday at 1:00 pm
Contact: Hollee Cesar at 608-873-8585


Seated Stretch Class Stoughton Area Senior Center, 248 West Main
Monday & Wednesday at 2:00 pm, Friday at 10:15 am
Contact: Hollee Cesar at 608-873-8585

Sturgeon Bay, WI
United Methodist Church, 836 Michigan Street, 1st Thursday at 1:00 pm
Contact: Carol Moellenberndt at 920-743-3476

Sun Prairie, WI
Colonial Club Senior Center, 301 Blankenheim Lane, Therapy Room
4th Monday at 1:00 pm
Contact: Melody Riedel at 608-837-4611

Walworth, WI
Inspirational Ministries – Pederson Center, Hwy. 67 and F, 3rd Wednesday at 2:00 pm
Contact: Audrey Yakes at 262-723-1288 or Leslie Weerts at 262-723-4272

Wausau, WI
Aging and Disability Resource Center, Conference Room B, 1000 Lakeview Drive
3rd Tuesday at 1:00 pm
Contact: Angie Zender at 715-359-5992 or Donna Boodle at 715-675-2040

West Allis, WI
Village At Manor Park Senior Center, 8621 W. Beloit Road
(enter under Red Canopy), 1st Friday at 2:30 pm
Contact: Vicki Conte at 414-219-7840

West Allis Memorial Hospital
Meeting Room C, 8901 West Lincoln Avenue, 4th Tuesday at 7:00 pm
Contact: Dale or Ellen Jante at 262-878-2362 or Dave or Carolyn Warhanek at 414-425-3280

West Bend, WI
Cedar Ridge Retirement Campus, 113 Cedar Ridge Drive, 3rd Monday at 1:00 pm
Contact: Kathy Stultz at 262-338-2821

Whitewater, WI
Fairhaven, 435 West Starin Boulevard, Lower Level Conference Room
2nd Monday at 1:00 pm
Contact: Marilyn Bauer at 920-563-3610 or Paul Zimmerman at 262-472-9781

Special Events

MILWAUKEE, WI – *St. John's on the Lake*
November 16, 2:30 pm
Marilyn Bonjean video – Relationship Health & Chronic Illness

No December Meeting

January 18, 2:30
Diane Kane video – Laugh For No Reason

MILWAUKEE, WI – *Trinity Village*
November 6, 1:00 pm
VICKI CONTE, Program Coordinator from the WPA, will discuss health of the body/mind/spirit emphasizing the mind

December 4, 1:00 pm
VICKI CONTE, Program Coordinator from the WPA, will discuss health of the body/mind/spirit emphasizing the spirit

No January Meeting

MILWAUKEE, WI – *Washington Park Exercise Group*
November 17, 10:45 am – Craft Room
To be announced

December 15, 10:45 am – Main Hall
A Christmas sing-a-long with Sister Ancele, a long time faculty member of the Mount Mary College music department

January 19, 10:45 am – Craft Room
To be announced

MUSKEGO, WI – *Tudor Oaks*
November 7, 2:00 pm
VICKI CONTE, Program Coordinator from the Wisconsin Parkinson Association will discuss guided imagery

December 5, 2:00 pm
TREVOR HYDE, PhD, Neuropyschologist from the Regional Parkinson Center, will discuss neuropyschology, neuorpysch testing and Parkinson disease

January 2, 2:00 pm
MARIA CRISTINA OSPINA, MD from the Regional Parkinson Center, will give an informal presentation with a question and answer period

Special Events

OSHKOSH, WI

November 21, 2:00 pm
Video of a speech by William Barnewitz, who has Parkinson disease and is the Principal French horn for the Milwaukee Symphony Orchestra. Discussion to follow.

No December Meeting

January 16, 2:00 pm
We will view a video about relationships and chronic illness from the 2006 Parkinson Disease Symposium followed by discussion.

RACINE, WI – *Ridgewood*

November 21, 2:00 pm
VICKI CONTE, Program Coordinator from the Wisconsin Parkinson Association, will present on "Living one day at a time, enjoying one moment at a time, and accepting hardships as a pathway to peace"

December 19
Holiday Event – Location, time and entertainment to be determined. Call for more information

January 16, 2:00 pm
Andrew Knight, MT-BC, WMTR, certified in neurological music therapy will discuss how to improve Parkinson symptoms through music

SHAWANO, WI – *United Methodist Church*

November 14, 1:00 pm
Presentation on the art of caregiving

December 12, 1:00 pm
Devotional Speaker

January 9, 1:00 pm
VICKI CONTE, Program Coordinator from the Wisconsin Parkinson Association, will speak on Parkinson disease and the mind/body/spirit

SHEBOYGAN, WI

November 21, 2:00 pm
TREVOR HYDE, PhD, Neuropyschologist from the Regional Parkinson Center, will discuss cognitive and psychological issues in Parkinson disease

December 19, 11:30 am (changed time)
Holiday Party – Fountain Park Family Restaurant, 922 N. 8th Street, Sheboygan

January 16, 2:00 pm
Reiki demonstration by Hands On Healing Energy

STEVENS POINT, WI

November 28, 1:00 pm
Donna Christensen and Cynthia Forster, Certified Lee Silverman Voice Therapists will discuss speech and swallowing problems in Parkinson disease and how LSVT can help. Register in advance by calling 715-346-1401

No December Meeting

January 23, 1:00 pm
VICKI CONTE, Program Coordinator from the Wisconsin Parkinson Association will give an overview on Parkinson disease

STOUGHTON, WI

No November and December Meetings

January 24, 1:00 pm
VICKI CONTE, Program Coordinator from the Wisconsin Parkinson Association, will speak on Parkinson disease and the mind/body/spirit

STURGEON BAY, WI

November 2, 1 pm
"Time to Talk" Bring your questions for each other

November 15, 11:30 am – 2:30 pm
Annual Caregiver Luncheon and speaker – call for more information

December 7, 11:30 am – 2:30 pm
Holiday Luncheon

January 4, 1:00 pm
Video from the 2006 Parkinson Disease Symposium followed by discussion

WEST ALLIS, WI – *Village at Manor Park*

November 3, 2:30 pm
Dr. GARY LEO from the Regional Parkinson Center, will discuss Medications and Parkinson Disease: Why what works for me won't work for you"

December 1, 2:30 pm
Andrew Knight, MT-BC, WMTR, certified in neurological music therapy will discuss how to improve Parkinson symptoms through music

January 5, 2:30 pm
TREVOR HYDE, PhD, Neuropyschologist from the Regional Parkinson Center, will discuss cognitive and psychological issues in Parkinson disease

WEST ALLIS, WI – *WA Memorial Hospital*

November 28, 7:00 pm
Cindy Dodian with Therapy Dog "Fearless"

No December Meeting

January 23, 7:00 pm
Frank Lorenz, WPA Board Member will discuss the WPA – Past, Present and Future

WEST BEND, WI

November 20, 1:00 pm
VICKI CONTE, Program Coordinator from the Wisconsin Parkinson Association, will speak on Parkinson disease and the mind/body/spirit

December 18, 1:00 pm
Holiday Party

January 15, 1:00 pm
MARIA CRISTINA OSPINA, MD from the Regional Parkinson Center, will give an informal presentation with a question and answer period

WHITEWATER, WI

November 13, 1:00 pm
Massage Therapist, Scott Feist

December 11, 1:00 pm
Holiday Luncheon at Cold Spring Inn (between Fort Atkinson & Whitewater on Hwy N). We will order off the menu, dutch treat.

January 8, 1:00 pm
Group Sharing

CREDITS

"The Network" is a publication for persons with Parkinson disease, their families and friends and any interested individuals and groups in the Midwest. It is published by the Regional Parkinson Center in cooperation with the Wisconsin Parkinson Association, the National Parkinson Foundation and Aurora Sinai Medical Center.

Information provided concerning medical diagnosis, treatment and research is not intended to answer individual problems, but to report and explain current information about Parkinson disease. Feel free to contact our program coordinator for general advice. You should always ask your physician about specific treatment issues.

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the network
Fall 2006

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