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Articles in the Bransongoers Gazette cannot be reprinted without express consent of the author of that particular article and the Editor of Bransongoers Gazette.

Congratulations, Paul Bjorling!

The winner of our 'Name the Newsletter' contest is Paul Bjorling from Eureka, KS. Paul won a free registration to our Bransongoers Annual Internet Polio Reunion in May of 2007. Congratulations, Paul! Watch for our other contests in upcoming issues.

Carpal Tunnel Syndrome and Post-Polio Syndrome

by Allen C. Hill, GBPPA Member

A while ago, one of the fingers in my left ("good") hand suddenly lost a noticeable amount of function. My neurologist was following it, somewhat puzzled as to what it might be, but apparently not seriously alarmed.

When I recently went to the Spaulding Rehabilitation Hospital post-polio clinic for an evaluation, they recommended a nerve conduction and electro-myelogram study of my arms and hands to see what was going on.

The test showed that the finger-function problem was "just" post-polio. It also turned up something serious - severe median neuropathy (carpal tunnel syndrome) in that hand. I am functionally one-handed, and losing the use of my left hand would be catastrophic.

What was interesting, and scary, was that I did not have the normal symptoms of severe carpal tunnel: I had not lost significant feeling in my thumb and first two fingers, there was no new weakness apparent in the hand and I did not have any significant pain. I did have a very slight numbness in my fingertips, as though I had gotten some glue on them, and hadn't quite washed away all the residue.

My primary doctor quickly referred me to a hand surgeon, who did the usual physical exam, testing my grip, testing fingertip sensitivity and so on. When he was done, he asked me in a slightly puzzled voice, "Why do you think you need carpal tunnel surgery?" The physical exam had been within the normal range.

Once he looked at the nerve conduction results, he knew why I had been referred. I had the surgery a few weeks later, and it seems to have been a total success.

Meanwhile, back at Spaulding, when I mentioned that we had found carpal tunnel problems, they said that it was not unusual in their experience for someone with

post-polio to have them and not show the classic symptoms. Apparently, I was one of many.

The moral of this story is (again) that post-polio produces strange effects that even a good doctor who is not a PPS specialist can easily miss. We need expert evaluation and counsel from time to time, even if nothing seems askew and we're doing "just great, thank you." And while the nerve-conduction/EMG was not a lot of fun, it was not the torture I had been anticipating. I have had minor dental procedures that were far worse.

Reprinted from the GBPPA Newsletter 'Triumph'

The Knife Is Not So Rough If...

This is an excerpt from an article by Dr. Richard L. Bruno.

Dr. Bruno put this article on the Internet and asked that it be shared with polio survivors. If you have to go under the knife, we suggest that you give a copy of this article to each member of the surgical team and to the nurses on the hospital floor where you will be staying. Discuss the article with your doctor and ask that a copy be put in your medical chart.

PRE-OPERATIVE PREPARATION - This is the most important period, since this is the period when you must establish communication with the surgical team. After a second opinion, meet with the surgeon and the anesthesiologist to discuss in detail your complete polio and general medical histories and any problems that might arise before and during surgery, in the recovery room and on the nursing floor.

LUNGS - It is recommended that all polio survivors have pulmonary function studies as part of your preoperative testing. This will help the surgical team evaluate the proper type of anesthesia for you and will help eliminate any unpleasant surprises coming off a respirator at the end of surgery.

PHYSICAL ASSISTANCE - X-ray and examining tables are built at heights that are convenient for the professional, not the patient. Many polio survivors cannot step on a stool to get on a high table. Polio survivors must ask for help in transferring. Since most polio survivors are not good at asking for help, they need to find a phrase with which they are comfortable that will communicate their needs. If you run into someone that does not want to help or work with you, ask for someone else to help or ask to speak to their supervisor

GENERAL ANESTHETICS - Polio survivors are exquisitely sensitive to anesthetic. A little anesthetic goes a long way and lasts a long time due to the damage of the brain stem - called the reticular activating system. Polio survivors have been known to sleep for days after surgery. For polio survivors we use the RULES OF 2 for surgery.

ANESTHETIC RULE OF 2 - Polio survivors need the typical dose of anesthetic



'Who should I call first? 911 or Technical Support?'

divided by 2. This is merely to remind anesthesiologists that polio survivors need much less anesthetic than do other patients. Also, polio survivors can be sensitive to atropine-like drugs used during surgery.

POSITIONING - One overlooked problem is the positioning of the post-polio patient on the operating table. Muscle atrophy, scoliosis and spinal fusion may make certain positions problematic. It would be advisable for the patient to be awake during positioning on the table to prevent post-op complications.

POST-OPERATIVE CARE:

COLD - Polio survivors are extremely sensitive to cold because they have difficulty regulating their body temperature. No polio survivor should have same-day surgery for any reason except for the simplest procedure that requires a local anesthetic.

POST-ANESTHETIC RULE OF 2 - Polio survivors require 2 times as long to recover from the effects of any anesthetics.

BLOOD AND GUTS - Polio survivors with muscle atrophy will have a smaller blood volume that would be expected for their weight and height. Therefore bleeding during surgery may be more of a problem. Polio survivors cannot control the size of their blood vessels, since the nerves that make the smooth muscle around veins and capillaries contract were paralyzed by poliovirus. Therefore, polio survivors' blood vessels open under anesthetic and dump the heat of their warm blood into the cold recovery room. Polio survivors must be kept warm.

VOMITING - Another post-op problem related to brain stem damage is vomiting. Polio survivors are more apt to faint (having vasovagal syncope and even brief a systoles) when they attempt to vomit. It is important that post-op emetic control be discussed with the anesthesiologist and administered before going to the recovery room.

CHOKING - Polio survivors, who are aware of having swallowing problems, and sometimes in those without apparent swallowing difficulty, cannot clear secretions and may choke when they are lying on their backs. Polio survivors' secretions need to be monitored in the recovery room and they should be positioned on their side if possible so that secretions can drain.

PAIN - The single most troublesome problem after surgery is pain control. Under-medication is a serious problem for the post-polio patient since two research studies have shown that polio survivors are twice as sensitive to pain as those who didn't have polio.

RULE OF 2 FOR PAIN Polio survivors need 2 times the dose of pain medication for 2 times as long.

RECOVERY - Polio survivors need more bed rest than most patients, because of autonomic nervous system damage. Polio survivors are the best judges of when they can move, stand and walk safely.

RULE OF 2 FOR RECOVERY - Polio survivors should stay in bed 2 times longer than other patients.

RULE OF 2 FOR LENGTH OF STAY - Polio survivors need to stay in the hospital 2 times longer than other patients.

RULE OF 2 FOR WORK - Polio survivors need 2 times the number of days of rest at home before they return to work or household duties.

RULE OF 2 FOR FEELING BETTER - Polio survivors need 2 times longer to feel back to normal again.

CONCLUSION

All of the Rules of 2 are suggestions for polio survivors and the surgical team; they are not a substitute for specific information about the individual patient and communication among all members of the treatment team, including the patient.

Reprinted from HEALTHSMART USA Weekend, Mar ch 10-12, 2006

Diabetes: The Other “Silent Killer”

Dr. Tedd Mitchell

Undetected, it ravages bodies in an unfettered fashion. High blood pressure long has been referred to as the “silent killer,” because patients suffering from the illness often don’t realize they have a problem until their organs are seriously damaged. Like high blood pressure, diabetes is a disease that sneaks up on millions of Americans. It’s increasingly recognized as a major cause of death and disability, yet many who suffer from diabetes are unaware they even have it until they experience a debilitating side effect of the disease.

This disorder damages many tissues. Most complications involve the cardiovascular system (heart, disease and stroke, for example). Other problems caused by diabetes include blindness, kidney disease, nerve damage, impotence, amputations, the inability to fight infection and complications in pregnancy (including birth defects). The trouble is, because many aren’t aware they even have diabetes, the illness damages the body in an unfettered fashion before being discovered.

Type 2 diabetes is by far the most common form of the disease. Those at higher risk include elderly people, people with a family history of diabetes and overweight folks. Certain ethnic groups, such as Hispanics, blacks, Native Americans and those of Pacific Island heritage, also are at higher risk.

The good news: Diabetes responds nicely to behavior modification. Two of the most effective tools for combating the illness are weight control and exercise. In fact, our nation’s growing obesity problem is linked to the increase in diabetes over the past few decades. Numerous studies have shown a strong association between increasing fitness and decreasing one’s risk for diabetes.

ARE YOU AT RISK?

About as funny as a rubber crutch in a polio ward. Jack Nicklaus said "Polio was only slightly worse than peddling insurance"

The best way to find out is to be evaluated by your doctor, who can perform the appropriate blood tests and interpret them for you.

You also can pick up a glucose monitoring kit at the drugstore and check your blood yourself. Be sure to fast for a minimum of eight hours before you perform the test to ensure that any food eaten recently will not alter the results. Follow the kit's directions, and use the guidelines below to see how you stack up against the general glucose guidelines from the National Institutes of Health.

GENERAL GLUCOSE GUIDELINES

Normal blood sugar = Less than 100 mg/dl

Pre-diabetic – 100 to 125 mg/dl

Diabetic = 126 mg/dl or more

Contributing Editor, Tedd Mitchell, M.D., is medical director of the Wellness Program at the renowned Cooper Clinic in Dallas.

Doctor's Advise...

(I don't know what doctor wrote this, but I like him!)

Health Question and Answer Session

Q: I've heard that cardiovascular exercise can prolong life; is this true?

A: Your heart is only good for so many beats, and that's it... Don't waste them on exercise. Everything wears out eventually. Speeding up your heart will not make you live longer; that's like saying you can extend the life of your car by driving it faster. Want to live longer? Take a nap.

Q: Should I cut down on meat and eat more fruits and vegetables?

A: You must grasp logistical efficiencies. What does a cow eat? Hay and corn. And what are these? Vegetables. So a steak is nothing more than an efficient mechanism of delivering vegetables to your system. Need grain? Eat chicken. Beef is also a good source of field grass (green leafy vegetable). And a pork chop can give you 100% of your recommended daily allowance of vegetable products.

Q: Should I reduce my alcohol intake?

A: No, not at all. Wine is made from fruit. Brandy is distilled wine, that means they take the water out of the fruity bit so you get even more of the goodness that way. Beer is also made out of grain. Bottoms up!

Q: How can I calculate my body/fat ratio?

A: Well, if you have a body and you have fat, your ratio is one to one. If you have two bodies, your ratio is two to one, etc.

Q: What are some of the advantages of participating in a regular exercise program?

A: Can't think of a single one, sorry. My philosophy is: No Pain... Good!

Q: Aren't fried foods bad for you?

A: YOU'RE NOT LISTENING!!! Foods are fried these days in vegetable oil. In fact, they're permeated in it. How could getting more vegetables be bad for you?

Q: Will sit-ups help prevent me from getting a little soft around the middle?

A: Definitely not! When you exercise a muscle, it gets bigger. You should only be doing sit-ups if you want a bigger stomach.

Q: Is chocolate bad for me?

A: Are you crazy? HELLO. Cocoa beans! Another vegetable!!! It's the best feel-good food around!

Q: Is swimming good for your figure?

A: If swimming is good for your figure, explain whales to me.

Q: Is getting in-shape important for my lifestyle?

A: Hey! 'Round' is a shape!

Well, I hope this has cleared up any misconceptions you may have had about food and diets.

And remember:

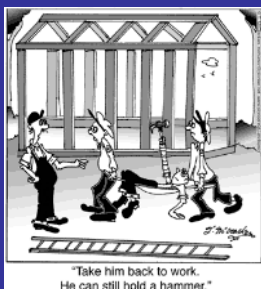
"Life should NOT be a journey to the grave with the intention of arriving safely in an attractive and well preserved body, but rather to skid in sideways – Chardonnay in one hand – chocolate in the other – body thoroughly used up, totally worn out and screaming “Whoa – what a ride.”

HHS Provides Funding to States for Alternatives to Nursing Home Care in Medicaid

States will get additional help from the federal government to support elderly and disabled Medicaid recipients who wish to live in the community rather than institutions, US Health & Human Services (HHS) Secretary Mike Leavitt announced Wednesday, July 26, 2006.

Through competitive grants, the Centers for Medicare & Medicaid Services (CMS) will give states a total of \$1.75 billion over five years to help shift Medicaid from its historical emphasis on institutional long-term care services to a system that offers more choices for seniors and persons with disabilities from all age groups, including home and community-based services. This Money Follows the Person "rebalancing" initiative was included in the Deficit Reduction Act of 2005 (DRA) currently being implemented by CMS. This endeavor is also a part of President Bush's New Freedom Initiative.

"With this program, people who need long-term care and prefer to live in their own homes and communities can do so," Secretary Leavitt said. "States will also get more for their money by giving the elderly and people with disabilities more



'Take him back to work. He can still hold a hammer.'

control over how and where they get the Medicaid-funded long-term care services they need."

"We've worked with advocates and states for years to end the institutional bias in Medicaid, and now we've got the best opportunity ever to do it," said Mark B. McClellan, M.D., Ph.D., CMS Administrator. "We need to move as quickly as possible to make that shift across Medicaid. With new Federal funding, there is no longer any excuse for the status quo."

States interested in applying for a "Money Follows the Person" grant can propose new programs to CMS that are aimed at sustaining people in their homes or communities who would have otherwise received care in a nursing home or other institution. The qualified expenditures may be eligible for an enhanced match rate from the federal government equal to an increase of 50 percent of the usual state Medicaid percentage contribution in addition to the usual match rate. In effect, the federal government will pay for 75 to 90 percent of the costs of transitioning individuals out of nursing homes and into community settings, and the associated long-term care benefit costs. Grant funds may also be used to help control how they receive these services.

The higher matching rate will be applied to certain services provided to an individual for a one-year period after the individual moves out of an institution and into the community. Funds can be used not only for alternatives to institutional care services, such as home health care; they can also be used for home modification costs, respite services to augment informal or unpaid caregivers, personal care and assistive devices. In their applications, states are encouraged to coordinate with local and state housing authorities to provide coordinated assistance for community-based housing needs. CMS and the Department of Housing and Urban Development (HUD) have made steps to establish a new interagency liaison to support this coordination.

"We know that accessible, affordable, integrated housing is critical to a person's ability to make the transition into the community", HUD Secretary Alphonso Jackson said. "My agency will strongly urge the Public Housing Agencies and Housing Finance Agencies in the states to work collaboratively with Medicaid programs to help create opportunities for those moving out of institutions into the community."

Each state awarded a grant must continue to provide community services after the year of enhanced match as long as the person needs community services and is Medicaid eligible. The deadline for the first year's applications is Nov. 1, 2006. Demonstration grants will be competitively awarded to states from Jan. 1, 2007 through Sept. 30, 2011. Funds will be available for a five-year period; however, states must participate in the demonstration for a minimum of two consecutive years.

The Medicaid program traditionally pays for care for persons who are elderly and those with disabilities living in institutions who needed help with activities of daily living, because institutional care was the norm when the Medicaid law

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was enacted forty years ago. To provide home and community -based services, states must get a "waiver" of normal program rules designed to pay for care in institutions. Waivers and demonstration programs offer the promise of significantly lower costs per beneficiary and reductions in overall Medicaid spending as a result of giving individuals control over how to get their services, rather than requiring them to use institutional care in order to get Medicaid long -term care benefits. But rebalancing Medicaid coverage may have some short -term costs, which the new federal program enables states to overcome.

In addition to the Money Follows the Person initiative, the DRA made many changes in Medicaid that will allow states to add home and community-based services to their permanent array of benefits without having to go through the waiver process. For example, under another DRA provision, states now have the option to provide home and community-based services without needing a waiver.

"Even though personal control leads to better results and lower costs for people with a disability, it's still true today that most elderly or disabled enrollees do not have a choice about how they get their long-term care services under Medicaid," said Dr. McClellan. "By working with states, advocates, and Medicaid enrollees to take advantage of these unprecedented opportunities, that's going to change."

A copy of the "2006 Money Follows the Person Rebalancing Initiative Demonstration Program," including the application forms, can be obtained at <http://www.grants.gov/>. For more details about the New Freedom Initiative, visit the CMS Web site at: <http://www.cms.hhs.gov/newfreedom/>.

INFLAMMATION and PPS

By Marcia Falconer, PhD

Post-Polio Syndrome (PPS) has been a recognized condition for more than 25 years, with reports of similar symptoms going back to the 1800's. However, we still do not have a grasp of the underlying cause, or causes, of PPS!

We do not know how many polio survivors will develop PPS; estimates range from 20% to over 80%. We do not know why some polio survivors develop PPS and others do not. There is no diagnostic test and PPS remains a diagnosis arrived at after exclusion of other somewhat similar conditions. We do not understand why there is a lag time between recovery from the acute illness and development of symptoms severe enough to compromise the quality of life.

It seems there is very little that we do understand about PPS. However, if we can discover the underlying cause(s) of PPS; if we can find out what is happening at the cellular and even sub-cellular level, there is promise of being able to answer all of these perplexing issues. There is also promise of being able to treat and possibly even prevent the onset of many perhaps most, PPS symptoms.

Little research has been done on PPS, probably because polio survivors are a dying breed. After worldwide eradication of polio, the 'lifespan' of PPS will be equal to that of the youngest living polio survivor. Or will it? Poliomyelitis continues to cause paralysis although now the virus causing the illness is not the poliovirus but the West Nile Virus, or enterovirus 71, or one of several Coxsackie viruses.

The nerve damage caused by these viruses is virtually identical to that caused by the polio virus and therefore it is likely that PPS, perhaps by then called Post-Viral Syndrome, will continue to bring new limitations to survivors in any years after they thought they had recovered. So it remains important to examine the underlying cause of new muscle weakness, central fatigue, pain, memory and word finding problems and other symptoms that accompany PPS.

Fortunately, current research in other areas holds great promise for explaining what is happening to so many polio survivors. The cause of virtually all PPS symptoms can be explained by one word: inflammation! Front line research in the fields of neurology, immunology, physiology and virology is coming together and the many pieces of the puzzle are being laid upon the table.

A good analogy is to think about a jigsaw puzzle. When you dump a 1000 piece puzzle out of the box, some pieces land right side up, others upside down. There is little hope of assembling the puzzle until you turn all the pieces right side up. The next step is to put all the straight edged pieces in a pile and then assemble the outer edge of the puzzle to give you a general outline. After this it is helpful to group pieces with similar patterns or colours together.

This is approximately where we are today in our understanding of how inflammation is related to almost all chronic diseases; PPS, MS, ALS, CFS, Parkinson's, irritable bowel syndrome, arteriosclerosis and many, many others. This also gives you some idea of how far we have to go until we have a complete picture! Let's look at the puzzle pieces that seem to belong to PPS.

Inflammation has two major causes; injury (including viral and bacterial infection, cuts, strains, operations, etc.) and psychological stress (including major events such as death of a relative, divorce, and job loss, but also including milder, repetitive stress that is encountered every day).

In a person with PPS, when the body suffers an injury, such as physically overdoing by climbing too many stairs, walking on uneven ground, etc. the first reaction is for the cells in the affected area to release a chemical messenger. This messenger, called a proinflammatory cytokine, tells specialized cells, whose job it is to protect you from invading organisms, to come to the site of the injury. At the same time the proinflammatory cytokines activate resident cells and cells that have migrated to the injury and all of them produce more proinflammatory cytokines setting up a cascade of events that will involve the entire body.

Two pro-inflammatory cytokines, interleukin-1 and Tumour Necrosis Factor Alpha, are especially important in triggering an acute immune response, the body's first line of defense. The acute immune response involves developing a



'Why, yes, we are an equal opportunity wrecking company.'

fever, fatigue, loss of appetite, sleepiness and other symptoms. It goes away within a few days. However, if the injury is repeated often – say if a person with PPS persists in exercising a stressed out muscle – then a chronic immune response will set in. The response to chronic stress involves the entire body including the brain and produces central fatigue, new muscle weakness, problems with short term memory and word finding, irritable bowel syndrome and other symptoms.

Recognize them? Indeed. These are the post-polio syndrome symptoms we are so familiar with. In an effort to keep this article shorter than a textbook on immunology, I have omitted the complex chain of events that takes place in the body between the original stress and the onset of PPS symptoms. There are many, many research papers that amply document what happens in the body after activation of the immune system by proinflammatory cytokines and that eventually results in symptoms identical to those of PPS.

Let's take a brief look at how proinflammatory cytokines may be the underlying cause of new muscle weakness. We begin with acute polio and the death of a large number of nerves whose job was to innervate muscles by telling the muscles to contract or relax and thereby allowing you to move a leg or an arm. If 60% of the nerves leading to a leg or arm died, the limb was paralyzed. When fewer nerves died the result was varying degrees of muscle weakness.

In many people, original paralysis or severe weakness eventually resolved; voluntary movement was restored and you could once again use your arm or leg. The body developed a neat trick to allow this to happen. The surviving nerves were able to send out 'neuronal sprouts' to attach to and innervate muscles that had been orphaned when the nerve originally attached to them died off. Thus the surviving nerves were able to activate not only the muscle that they always innervated, but also surrounding muscles creating something called a "motor unit".

This repair was essentially stable for many years. However 30 or more years after recovery from polio, many people begin experiencing new muscle weakness. Often the weakness is in the 'good' arm or leg. This may be due to the fact that the 'good' arm or leg was used more. Clearly something happened to the neuronal sprouts; either they no longer could maintain full time attachment to the motor unit or else they may have died off completely. This caused the appearance of new muscle weakness. Once again, I've simplified this a bit – although the general picture is correct. But this is a description of what is happening, not an explanation of why it is happening.

Enter proinflammatory cytokines. Remember them? Researchers have well established that proinflammatory cytokines cause cells to release neurotoxic proteins. These neurotoxic proteins can damage or even kill neurons by a number of mechanisms including changing the outer membrane of the nerve cell resulting in cell death or increasing reactive oxygen inside the nerve cell, which also leads to cell death. It is probable that the neuronal sprouts, that have served so well for so long, are more fragile and may be the first target of

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**May your enemies
get cramps in
their legs when
they dance on
your grave.**

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proinflammatory cytokines in the central nervous system.

A very important fact is that nerve death only occurs in an activated immune system. The next question is "Do people with PPS have an activated immune system?" The answer is YES! There have been a number of research papers indicating that polio survivors with PPS symptoms have an activated immune system while polio survivors who do not report PPS symptoms do not have an activated immune system [1].

A very recent research paper [2] looked at cytokines in people with PPS, polio survivors without PPS, people with multiple sclerosis (MS), a well-known inflammatory neurological disease, and people who had no neurological problems. They found that people with PPS and MS have proinflammatory cytokines in their central nervous system while polio survivors who do not have PPS and people without neurological problems do NOT have proinflammatory cytokines in their central nervous system.

What might cause the presence of these proinflammatory cytokines in people with PPS? One hypothesis is the presence of very low levels of polio virus RNA hiding in nerve cells. This poliovirus RNA is not capable of infecting you or other people, but is capable of triggering the production of proinflammatory cytokines and with that, an underlying state of chronic immune system activation.

Other researchers have demonstrated a clear connection between the presence of proinflammatory cytokines and central fatigue [3]. Psychological stress – the kind that doesn't involve overdoing physically – is perceived in the brain and the brain produces proinflammatory cytokines. This can cause profound fatigue, inability to concentrate and other symptoms [4].

Remember that 1000 piece jigsaw puzzle we have spread out on the table? We are now able to put together some of the same coloured pieces to make small pictures that are part of the larger picture. In the same way, we are piecing together what happens when a person with PPS experiences physical or psychological stress. We start to see small pictures and we can just begin to discern the larger picture coming together.

We are coming to the place where it may be possible to treat PPS symptoms using anti-inflammatory medications. A very exciting trial, using intravenous immunoglobulin treatment, is currently underway in Sweden. Preliminary trials of this treatment in people with PPS have yielded dramatic improvements in fatigue and muscle strength! [5,6]

Other treatments to reduce PPS symptoms may be based upon traditional anti-inflammatory medicines such as aspirin, ibuprofen, indomethacin and others.

All treatments would have to be done under the supervision of your doctor, but in the meantime, there are some things you can do that are known to minimize inflammation in the body – and with that you might have a reduction of PPS symptoms.

- Meditation. You might try meditation. Yes it works...if you do it consistently.
- Exercise. Appropriate exercise, under the guidance of a knowledgeable physiotherapist, will definitely lower inflammatory cytokine levels.
- Pacing. Pace yourself and don't overdo. This is easier said than done but if you understand that seriously overusing muscles will start the proinflammatory cascade of events and with that bring on or intensify PPS symptoms, perhaps you will be able to justify resting before you go too far.
- Weight loss. Adipose tissue – commonly known as fat – is also a producer of inflammatory cytokines. If you needed a good reason to lose weight, here it is.

Finally there are a few things you can try. Drinking green tea encourages weight loss and it has neuroprotective qualities. There are also reports that undenatured whey protein may be beneficial. These things are probably not as effective as direct medication to lower proinflammatory cytokine levels, but as we incorporate them into everyday life, they will bring positive benefits.

And let's keep working on that jigsaw puzzle!

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- Information about Dr. Marcia Falconer:

Now retired, Dr. Falconer led a laboratory doing research in virology and molecular biology at The Centre for Food and Animal Research, Agriculture Canada Ottawa, Ontario, from 1993 to 2000.

Educational background:

- Post-doctoral fellow in molecular biology at Massachusetts Institute of Technology (Center for Cancer Research), Cambridge, Mass. USA. 1990 - 1992.
- Ph.D. in neuronal cell biology from University of Ottawa, Ottawa, Ontario,



'Hi. I'm Dr. Snyder. I'm your surgeon, and this is my seeing-eye companion, Sammy.'

Canada. 1990

- M.Sc. in cell biology from Carleton University, Ottawa, Ontario, Canada. 1985
- B.Sc. biology, Simmons College, Boston, Massachusetts. 1964

Selected published articles :

- Co-author with Professor Edward Bollenbach, "Late Functional Deterioration in Non Paralytic Polio", Am J Phys Med & Rehab, Jan/Feb 2000.
- "Non Paralytic Polio and PPS", A Lincolnshire Post Polio Network Newsletter Publication, January 1999.
- Other articles awaiting publication.

Polio Background:

Marcia was quarantined with polio at age 7 (1949). She had leg and arm weakness followed by complete recovery. Led an active life: swimming, ice-skating and cross country skiing. PPS symptoms first noticed in 1985, with fatigue and leg weakness becoming severe by 1996. PPS diagnosed in 1998.

FECPPSG Editor's Note: - This article is in the newsletter exactly as sent to us by Dr. Falconer – the only change being that we justified the margins. Many thanks Dr. Falconer.

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<mailto:falconer.pps@sympatico.ca>

CONTESTS:

Each month, we will feature a new contest. The prize for the August contest was a free registration for the 2007 Branson Reunion and has been awarded to Paul Bjorling, winner of the contest for coming up with the winning name for our newsletter. The newsletter premieres this month and is posted on this website (as you can see), sent by email or, for those who do not have internet, the US Postal Service. There were three (3) judges: Tom Post, Charlie Greulich and Don Hansche.

In the September contest, which began September 1, we're looking for the most humorous photo. Something like Charlie in his powerchair at a McDonald's Drive-Thru window (He really did! We'll have it on the website for show soon). You can check it out here: <http://www.postpoliobransongoers.com/contest.html>. Again, the judges are Tom Post, Charlie Greulich and Don Hansche.

Rules for entering the September contest :

- You do not have to be a member of the PPBG Support Group to enter;
- There can only be one winner;

- Entries must be received no later than midnight, September 26, 2006;
- There is no limit to the number of submissions you may enter, so long as you enter only one per submission;
- If any submission contains more than one photo, all of the photos in that submission will be disqualified;
- Submissions will be posted to the website as they are submitted;
- Judges may not enter the contest;
- Winner will be announced on the website on September 30, 2006 and in the October Issue of this newsletter.
- To enter, go to <http://www.postpoliobransongers.com/contest.html>.

"Race for a Cure" - Live Webcast Lecture on Polio

A web cast presentation about polio will given by Dr. David Oshinsky, author of the 2006 Pulitzer Prize winning book "Polio: An American Story", at the University of Texas at Austin. In his presentation entitled "Race for a Cure" he will tell the enthralling account of America's battle with polio, the terror it caused, and the intense effort to find a cure. We would like to invite all members and visitors of Post-Polio BransonGoers to view an educational and FREE web broadcast of the lecture, live, at 7 pm (central time) on September 7, 2006.

After that date, there will also be an archived video of the talk online. The link to the Lecture Series website, where the details of the lecture and the web cast will be found, is: <http://www.esi.utexas.edu/outreach/lectures.html>.

From the above mentioned website, signed copies of Professor Oshinsky's Pulitzer Prize winning book can be purchased for a 20% discount.

Thank you!
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