The PARKINSON RESEARCH FOUNDATION, with headquarters in Sarasota, Florida, is committed to reaching out across America and the world in an effort to provide the finest help and support network available for the six million people with Parkinson’s disease and those who love them.

With the establishment of PARKINSON PLACE in September 2012, our 7500 square foot destination site now provides over 80 free programs each month for Florida residents and snowbirds living or visiting our beautiful city. PARKINSON PLACE open Monday – Friday with FREE membership for patients and caregivers had 6,196 visits from January to August of this year.

With the realization that only a small percent of the Parkinson population can visit us onsite, the PARKINSON RESEARCH FOUNDATION has made a renewed commitment to develop the most sophisticated websites to bring you the latest information, research updates, empowerment programs, Ask-The-Doctor Lunch and Learns and videos of classes that you can do at home by means of Video Podcasts and Blogs with physicians and other experts in the field.

ParkinsonResearchFoundation.org, our scientific site, dedicates to education, up-and-coming research, the latest Parkinson-related information, articles of interest and Ask-The-Doctor with Juan Sanchez-Ramos, MD, PhD, Fellowship Trained Movement Disorders Specialist and PRF Medical Director.

ParkinsonPlace.org is the place to go for help, support, motivation, in home classes, sociability and the opportunity to be part of what we do at Parkinson Place, all at your fingertips, in the convenience of your own home, on your computer screen, there when you need it!

There is no longer a need to feel lost, alone or isolated with Parkinson’s disease. By means of our websites, PRF is committed to reaching out to you in an effort to provide everything you need to assure peace of mind and a better life today.

Please visit ParkinsonResearchFoundation.org and ParkinsonPlace.org everyday as new information and viewing opportunities are being added daily just for you. Remember that you have Parkinsons, Parkinsons does not have you! It’s up to you to hold on to that belief and reach out for all the support and resources that the Parkinson Research Foundation makes available to you.

Please go to ParkinsonResearchFoundation.org to see what you can do to help in our ongoing efforts to make the world a better place for those living with Parkinson’s disease.
As Chairman, I take great pride in sharing the Parkinson Research Foundation’s new and unique vision for Sarasota. “SEE PASS” promotes destination trips to Parkinson Place and all of the arts, leisure and luxury that Sarasota, Florida has to offer.

Following its opening in September 2012, Parkinson Place, a first of its kind, 7500 square foot destination site dedicated to the physical, mental, emotional and social needs of those living with Parkinson’s, has grown leaps and bounds now offering over 80 free programs each month to include five different exercise classes (Gentle Yoga, Fun Fitness, Tai Chi, Dance for Parkinsons, Ageless Grace) as well as ongoing weekly education and empowerment programs to include “Ask-The-Doctor” and “Parkinson Power” Lunch and Learns.

Additional programs include Voice Aerobics, Parkinson Chorus, Art 101 plus daily opportunities for interaction, sociability and support. Patients, caregivers, family members and friends, whether Florida residents or snow birds, come daily to enjoy and benefit from evidence based programs all taught by certified instructors committed to quality of life for all.

Parkinson Place is home for University of South Florida’s Parkinson Clinic offering consultations, by appointment only, with Juan Sanchez-Ramos, MD, PhD, the areas only Fellowship Trained Movement Disorders Specialist. Patrick J. Madden, Board Certified Neurologist, is available on site to see Parkinson patients every Tuesday and Thursday.

Sarasota, Florida, one of the most beautiful cities in America, offers the best of everything. Located on the Gulf of Mexico’s Sun Coast, Sarasota is easily accessed by three convenient airports Sarasota/Bradenton, Tampa International and Fort Myers. Siesta Key Beach, rated #1 in the world, is noted for sugar like white sand, warm turquoise blue water and breathtaking sunsets.

Arts and culture surround you with the John & Mabel Ringling Museum, Sarasota Ballet, Historic Asolo Theater as well as many other opportunities for live performances. Metro Sarasota and St. Armand’s Circle on Lido Beach offer the best in outdoor strolling and dining with galleries, bistros, fine restaurants and endless shopping opportunities.

Whereas Sarasota is the place to be for those living with Parkinsons, the Parkinson Research Foundation commits to helping Parkinson patients and caregivers in the effort to visit us to experience the full scope of amenities that we have to offer to include casual & fine dining, arts & leisure, endless entertainment, and most of all the extraordinary opportunity to come and participate in Parkinson Place with all of its free programs, activities & special events all focused on giving you a better life today. Membership is FREE and easy. To learn more about Parkinson Place, please visit us online at ParkinsonPlace.org or call 941-893-4188.

We look forward to your visit!
Kind Regards,

Lawrence Hoffheimer, Chairman

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**Insights into Levodopa-Induced Dyskinesia**

by: Juan Sanchez-Ramos, MD, PhD

The appearance of dance-like (choreic) or twisting (dystonic) involuntary movements can be very troublesome for both patient and physician. Typically these involuntary movements (dyskinesia) appear after 3 to 5 years in patients treated with levodopa/carbidopa (LD). LD-induced dyskinesias (LID) can involve any or all limbs, face or trunk and can be severe enough to interfere with everyday activities. In fact the dyskinesias can, in some patients, be more incapacitating than the primary signs and symptoms of the illness.

Despite knowing a lot about the clinical phenomenon, it is still not clear how these involuntary movements develop and how best to prevent them from appearing. Here are some of the fundamental concepts that suggest disease severity is the most important factor for development of LID:

1. Severe nigro-striatal terminal degeneration results in the inability to buffer fluctuating striatal dopamine levels. Therefore the fluctuating clinical response (such as wearing off) to LD comes to depend on the circulating dopamine levels and fluctuating responses to LD.

*continued on page 3*
Blood levels of LD and the timing of LD administration.

2. In healthy people without PD who have an intact nigrostriatal dopamine system, LD is thought to be converted (decarboxylated) into dopamine primarily in nigrostriatal terminals. The precise site and extent to which LD is decarboxylated in the advanced Parkinsonian brain remains uncertain, as most striatal dopamine terminals have degenerated.

3. It is assumed that LD administration enhances dopamine synthesis and release in the surviving nigrostriatal neurons, but it is also possible that LD can be decarboxylated and released as dopamine by non-dopamine cells (ie serotonin terminals, striatal capillaries, noradrenergic neurons and monoaminergic striatal interneurons).

4. LD remains effective even in very advanced PD patients, where it is assumed that virtually all terminals in the dorsal striatum have undergone degeneration. Thus, it has been suggested that abnormal regulation of dopamine release from serotonin terminals and other sites may be disruptive to striatal function and contribute to the development of dyskinesia.

However, recent research findings suggest that LD dose, and not disease severity, is the key risk factor for the development of dyskinesia in PD patients (See article below). Moreover, LDID can occur in patients with tyrosine hydroxylase (TH) deficiency who presumably have preserved dopamine terminals and striatal innervation. TH deficiency is an autosomal recessive disorder leading to a defect in the production of dopamine, epinephrine, and norepinephrine. This disorder is improved with LD treatment. LDID can develop in these patients just as they can in some patients with dopa-responsive dystonia in which nigrostriatal projections also are spared.

So how can we put this picture together? In the cases of TH deficiency, dyskinesia appears to be primarily related to postsynaptic mechanisms, such as dopamine receptor supersensitivity with abnormalities in intracellular signaling cascades in striatal neurons. Presynaptic dopaminergic mechanisms and changes related to loss of co-transmitters appear to be of lesser importance in TH deficiency. Is LD-induced dyskinesia in PD caused by a similar mechanism? The role of nigrostriatal lesion (which correlates with disease severity) as the critical origin of LDID in PD patients appears to be well documented. So we can surmise that LDID may develop in different ways, not only by disturbed presynaptic dopamine release and synaptic kinetics but also by abnormal receptor stimulation.

Recommendations to Mitigate Development of Levodopa-Induced Dyskinesia

A recent study investigating the risk factors for development of LDID was recently completed (See Reference below). Factors that were predictive of dyskinesia, were, in rank order: young age at onset, higher LD-dose, low body weight, North American geographic region, levodopa/carbidopa/entacapone (Stalevo) treatment group, female gender, and more severe Unified Parkinson’s Disease Rating Scale (UPDRS) Part II. There were similar predictors for development of “wearing-off” but included baseline UPDRS Part III and excluded weight and treatment allocation. Most importantly, the risk of developing dyskinesia or wearing-off was closely linked to LD-dose.

This study is one of the longest and largest prospective double-blind trials evaluating the initiation of L-dopa therapy in PD patients and has important clinical implications. In order to mitigate development of LDID, the authors recommend that clinicians:

1) Initiate L-dopa treatment in PD patients with low doses
2) Increase the dose in small increments, using the lowest dose of L-dopa that provides satisfactory clinical control, particularly in younger patients and women.
3) Caution against increasing the LD-dose by large increments, and suggest avoiding doses greater than 400 mg/day when not clinically necessary.
4) In order to reduce the risk of motor complications, polypharmacy using concurrent drugs, such as dopamine agonists (such as pramipexole, ropinirole, rotigotine) and monoamine oxidase B inhibitors, may be preferable to continuously increasing the LD-dose.
5) It may also be important to consider the mg/kg dose when prescribing L-dopa, particularly in females, to account for the effect of weight on the risk of inducing motor complications.
6) Although it is recommended that low doses of L-dopa be used when possible, physicians should not be discouraged from employing the dose that is required to provide patients with satisfactory clinical control and avoid disability. It is the indiscriminate use of unnecessarily high doses that should be avoided.

The authors final comment: “It is astonishing that, 50 years after the introduction of L-dopa, there is so little information to guide physicians on how to best employ this drug.”


Source material:

Parkinson’s disease is usually thought of as a movement disorder, but there are many other symptoms that are not related to movement. Depression, loss of sense of smell, anxiety, constipation, and changes in voice...these symptoms often come to mind with Parkinson’s. Skin is the largest organ of the body, and yes, Parkinson’s affects skin, too. It is frequently under-diagnosed or untreated, time with the Parkinson’s neurologist is limited and focus is often on the more troublesome movement problems. Skin problems can be more than just annoying, and they need to be considered and treated, too.

One of the most troublesome skin issues seen early in the development of Parkinson’s is seborrhea. Greasy skin and limp, oily hair with dandruff has been associated with Parkinson’s for many decades now. Areas around the nose and forehead are most affected. The exact mechanism which causes seborrhea to develop is not yet understood, but undoubtedly relates to the loss of dopamine on the functions of glands located in the skin.

Chronic problems with seborrhea can lead to dermatitis. Skin and hair need to be washed frequently and anti-dandruff shampoos may be helpful. But if dermatitis develops in spite of cleanliness, topical steroids may need to be tried. Seborrheic dermatitis can also develop around the eyes, causing small patches that form little flakes of skin that can get into the eyelashes and the eyes. Washing carefully with dandruff shampoos and letting it run gently over tightly closed eyes can often help. Interestingly, when dopamine replacement is implemented, seborrhea often improves. It seems to be more active when the disease itself is active.

Tai Chi, How Does it Help Individuals with Parkinson’s Disease?

By Kathi Sims, RN
Medical Exercise Specialist, Certified Parkinson Fitness Instructor, Certified Tai Chi Instructor, Certified Aqua Fitness Instructor

Exercise in general is important for a healthy lifestyle and is the key to disease management. For Parkinson’s disease exercise routines are often recommended to help balance, strength, flexibility and the coordinated movements necessary for everyday living. An NIH-funded study, reported in the February 9, 2012 issue of the New England Journal of Medicine, evaluated three different forms of exercise. Resistance training, stretching and Tai Chi and found that Tai Chi led to the greatest overall improvements in balance and stability for patients with mild to moderate Parkinson’s disease. Other benefits of participation in a Tai Chi program include:

- Increased flexibility and muscle strengthening
- A greater fitness level generally
- Improved body posture
- Improvement in balance which results in less risk of falling
- Integration of mind, body and spirit
- An increase in the work of the heart and lungs thereby improving the blood and oxygen supply circulating in the body

Tai Chi is gentle, focusing on fluid circular movements that are relaxed and slow in tempo. Breathing is deep and slow aiding concentration, relaxing the body and allowing the life force, or Chi, to flow unimpeded throughout the body. It is sometimes referred to as “mindful meditation.”

These benefits can be achieved by all individuals with Parkinson’s disease despite their level of functioning. Tai Chi can be performed standing unassisted, standing with a chair nearby for support or seated.

There are over 100 forms of Tai Chi. The program being offered at Parkinson Place is the Sun (pronounced “soon”) form of Tai Chi created in the early 20th century by Sun Lu-Tang. Dr. Paul Lam, a physician living in Australia, along with a group of medical specialists condensed this form to a program which they felt to be the easiest and most effective for individuals with medical conditions.

This Sun Tai Chi program consists of 6 basic movements and 6 advanced movements. While these movements may seem awkward in the beginning, they will become easier and flow more smoothly as involvement in the program progresses.

Movements are taught in small progressions and these are repeated until individuals are comfortable with them. This will result in a feeling of success as initial feelings of frustration disappear. Feelings of calm will also be experienced and will enhance the flow of Chi throughout the body.

Studies have shown that Tai Chi is effective in strengthening muscles by 15-20%. Another study showed that the Sun form of Tai Chi improved physical function and balance by 30%. The results of the Parkinson research on the benefits of Tai Chi are dramatic and impressive.

Skin Problems and Care in Parkinson’s

Parkinson’s disease is usually thought of as a movement disorder, but there are many other symptoms that are not related to movement. Depression, loss of sense of smell, anxiety, constipation, and changes in voice...these symptoms often come to mind with Parkinson’s. Skin is the largest organ of the body, and yes, Parkinson’s affects skin, too. It is frequently under-diagnosed or untreated, time with the Parkinson’s neurologist is limited and focus is often on the more troublesome movement problems. Skin problems can be more than just annoying, and they need to be considered and treated, too.

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Skin Problems and Care in Parkinson’s continued from page 4

Sialorrhea or excessive saliva is a common Parkinson’s symptom. Sometimes it has been thought that due to the difficulty with swallowing, people with Parkinson’s often have excessive saliva accumulate in the mouth from not swallowing often enough. There have been several studies that have found excessive amounts of saliva do appear to be produced in some subjects, so swallowing is not the only issue.

Skin around the lips and mouth can become irritated from excessive saliva, especially if drooling occurs. The friction of constant wiping can make it even worse. If not taken care of, the skin can begin to break down and cause even more discomfort. Lip balms and creams to protect the skin can help. Medications such as anticholinergics may be used to help dry up the secretions and botulinum toxin injections in salivary glands have helped some patients.

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Drenching sweats, or hyperhidrosis, are another majorly discomfiting and embarrassing problem for people with Parkinson’s. Night sweats which soak all the bed clothes are especially difficult to endure. The excessive sweating involves mainly the head, including the face, and the trunk while the palms of the hands remain amazingly dry. Hyperhidrosis usually occurs if the dose of dopamine is either too high or too low. If the sweating occurs during off-periods, increasing the dopamine dose can help. Beta blockers, such as propranolol, are sometimes useful.

Problems with sensations of tingling or pain in the skin are also a common Parkinson’s complaint and are also probably due to the loss of dopamine. Skin lesions, cancerous and non-cancerous appear to occur a bit more frequently in the Parkinson’s population than in the general population. Some studies have found a slight correlation and other studies find the rates about the same. It is difficult to tell if Parkinson’s and skin lesions are connected, because as people age, both become more prevalent. Possibly, because people with Parkinson’s often have other sensations in their skin, lesions may not be noticed as quickly. And additionally, since the skin of people with Parkinson’s is very sensitive, it may have a stronger reaction to exposure to sun.

A further concern is the implication of levodopa treatment in developing malignant melanoma. Current guidelines for physicians often state that if a patient has undiagnosed or suspicious skin lesions, dopamine should not be used. The reason being that both dopamine and melanin share biochemical pathways in their synthesis. But studies have shown that there is not necessarily a correlation, that the occurrences of melanoma in Parkinson’s patients may simply be coincidental.

Skin patches for treatment of Parkinson’s offer a more continuous and even delivery of medication without taking so many pills. While for the most part, it was well liked by people with Parkinson’s, it did have drawbacks of skin irritation. Although it was recommended that the site of application be changed every day, sometimes the skin reactions lasted too long on sensitive and fragile skin and caused too much discomfort. The FDA withdrew their approval, and the patch was re-formulated and has again received FDA approval. If the patch is used, careful attention must be paid to the skin in the areas of application.

In later stages of Parkinson’s, people may be much more sedentary than in the earlier stages. Off-time, stiffness and immobility as well as difficulty turning in bed can be challenging. Sitting or lying down for long periods together with the friction of bedclothes can cause pressure sores to develop and lead to the breakdown of sensitive skin. Add to this, the moisture of either night sweats or urinary incontinence, and the bacteria, and skin damage is inevitable. In as little as two days, ulcers can develop. Because immobility and rigidity are usually at the root of these problems, keeping the person with Parkinson’s mobile is the best treatment: making sure that dopamine and other medication is timely and properly regulated. While it sounds simple, it is very difficult and complex and not easy to effect. Caregivers, from caring physicians, nurses, spouses and family members all have to be carefully trained.

Fungal infections in incontinent patients are also a high risk. Fungal infections look like red patches that are moist and itchy. They can spread across the skin very rapidly. Treatment consists of an antifungal cream, such as mycostatin. Special care must be taken with folds in the skin, to keep them clean and dry.

Parkinson’s affects the skin in many ways. Sensory perceptions of hot and cold, pain and touch are diminished from nerve loss in the skin. MicroRNAs (MiRNA) are non-coding RNA that helps regulate cell cycles; differentiation and growth are also involved in skin. In Parkinson’s, these regulators have been found in an altered state. Just exactly how the dopamine system affects them and how they affect wound healing is yet to be discovered. Together with the other non-motor, autonomic system changes, the skin presents an area for more research and better understanding of how Parkinson’s impacts the whole person.

Pan, T; Li, X; Jankovic, J.; The Association between Parkinson’s disease and Melanoma. Int. J. Cancer; 2011;128(10):2251-2260.
Twenty three physician-scientists recently compiled a series of vignettes illustrating the extent that hallucinations, delusions (a persistent false belief held in the face of strong contradictory evidence) and compulsive behaviors have in the lives of people with Parkinson's disease. Though the subject has been studied, the authors assert there are few detailed descriptions of the various psychiatric problems that patients contend with. The purpose of their collaboration was to inform the physician who may lack experience with PD patients, to ensure a greater appreciation for the impact the complications of the illness have on daily lives.

Hallucinations & Delusions

A woman with PD saw small carbidopa/levodopa-blue men, average estimated height 10 inches, arrived during the evening news, hammered away (not too noisy because their hammers were equally small) at the baseboard fixing it up, every night for years. She liked the company. They always left at 11:15 p.m. She didn't tell her doctor about them until they began to hang around longer, and she felt odd about going to bed when they were still there.

One of my patients had amantadine-related auditory hallucinations that sounded like church music. She thought her time had come. When she understood that these were probably due to the medication, she began to enjoy them and did not want a change in medication.

The husband of my 70-year-old patient from the Southern Tier of New York who mentioned almost as an aside that he was down at their mailbox one afternoon when “Kaploonee, kaploonee, doc ... I go runnin’ up to the trailer, and there’s Ma with the shotgun out the kitchen window, takin’ pot-shots at the side of the barn. I say, ‘Ma, ubacha shootin’ at? she says, ‘Them rascals sneakin’ into the barn again’.” Of course, there was nobody there, but she had recurring hallucinations of barn-intruders. The amazing thing was that her husband strongly advocated that she be left on the pramipexole—it had had a dramatically favorable impact on her motor function!

A 75-year-old man with moderate dementia saw people in his house daily. They were strangers. He was not fearful of them but made sure he kept his wallet in his trousers when they were about. He also was annoyed with them for not helping him get dressed.

I had a patient many years ago before the atypical neuroleptics who regularly saw two squirrels in his house. He would attempt to sit on them and crush them when they were on his chair, but they always seemed to get away. He would see them in the refrigerator on opening the door but could never understand how they managed to get in. He carefully and repeatedly inspected all sides of the refrigerator trying to find the access route that the squirrels used. He taped up all the base boards, electrical outlets, and door and window cracks trying to prevent them from being able to get in and out of his apartment—he insisted that they must have been able to use such small openings because there was no other explanation for their ability to come and go as they pleased. He refused to believe that these could be hallucinations (despite the fact the he had seemingly sat on them multiple times without finding them crushed in his chair on getting up) and did not want his medications changed for fear of worsening the control he had of his Parkinson symptoms (which was relatively good without other adverse events).

Compulsive Behaviors

We have a patient who first became somewhat obsessed with getting a good bargain. He would watch Home Shopping Network, attend garage sales, and constantly snip coupons, sometimes purchasing things he did not need just because he thought it was a good deal. This was a definite change from his past behavior but neither we nor his family became concerned until he began the strange and potentially dangerous habit of jumping into trash dumpsters, seeking hidden “treasures” that other people had thrown away. He came home smelling of garbage frequently and would always get “busted” by his wife because of the foul odors emanating from his person. Despite the family problems that this peculiar habit caused, he was driven to continue “dumpster diving,” being convinced that the next dumpster that he dove into would hold some hidden wonder.

A patient told me that he had always liked to fish but had not realized how excessive it had become until he was reduced his dopamine agonist, at which point he no longer had to fish every day regardless of the weather. He stopped climbing on rocks, where he had fallen multiple times, in order to fish. Another life-long avid fisherman reported that on a dopamine agonist his fishing got out of control. He would sometimes spend 24-hrs straight ice fishing. This resolved on stopping the medication.

A 42-year-old man with a 4-year history of PD had been on a monoamine-oxidase inibitor and dopamine agonists only. He came to the office with his wife with compulsive behaviors that were beyond the expected. He had two obsessive thoughts with associated compulsions. The first was an uncontrollable thought to cut wood. Once he had chopped all the firewood, he moved to dead trees then live trees then large bushes. He had pretty much completely cleared out his front and back yard of thicker diameter plants by the time he came to the office. His second compulsion was similar in severity but involved washing cars in his driveway. If there was a car in the driveway, he could not think of anything else, but washing it, sometimes twice. All of his obsessive thoughts and associated behaviors were gone when the dopamine agonist was tapered and discontinued.

Approximately 7 months earlier, after taking pramipexole 0.5 mg t.i.d. for several months, a middle-aged woman developed a compulsive eating behavior. She had to eat at least a dozen Braeburn apples daily. She bought 20-30 apples every 2 days, and gained 20 pounds in 3 months. She denied any increase in hunger; only her eating quantity/volume increased. The apples could only be Braeburn apples. She ate little else because “nothing appealed to me. All I could think of was ‘I’ve got to get a Braeburn’.”

Taken from real PD patients, the vignettes illustrate the diversity of experiences people endure. Though the numbers vary, it is generally accepted that 30% of drug-treated patients with PD experience hallucinations, of these visual types are most common, though auditory hallucinations occur as well. Delusions typically follow the hallucination and have a paranoid nature. Obsessive disorders in patients have only been recognized as recently as 2002, though a punding (an activity characterized by compulsive fascination with and performance of repetitive, mechanical tasks) was described earlier in 1994. Neurologists and patients may be familiar with gambling, hypersexuality, and compulsive eating or shopping, though the compulsive component to the behaviors has a wide spectrum. It’s likely other behavioral alterations brought on by the disease, or certain medications, will be recognized in time, with persistent effort. Not until dopamine agonists had been in
Royal Caribbean Luxury Cruise Line’s “Independence of the Seas” sails Sunday, March 9, 2014 from Ft. Lauderdale (Port Everglades) on a grand tour of the Western Caribbean with stops at Grand Cayman, Jamaica and the beautiful private island of Labadee.

Please join us for the perfect opportunity to get away and enjoy the luxury of fun, relaxation, sociability, fine food, island shopping, tropical drinks, the finest entertainment and breathtaking sunsets.

While at sea benefit from Physician Lectures, “Ask-The-Doctors” Interactive Q&A Panel Discussions, Engaging & Empowering Motivational Talks, Fun Fitness Interactive Group Exercise, Sit or Stand Tai Chi and Sensational Parties and Social Events!

Special Guests for the entire cruise include our distinguished faculty Juan Sanchez-Ramos, MD, PhD, Thomas N. Chase, SB, MD and Kathleen Clarence-Smith, MD, PhD, all renowned experts in their field. Don’t miss the opportunity to hear them speak as well as 1-1 time during dining & social time.

Distinguished Speakers & Talk Titles

“Parkinson’s Disease – What, Where & How?”

Juan Sanchez-Ramos, MD, PhD – Dr. Sanchez-Ramos is a Professor of Neurology at University of South Florida where he holds the Helen Ellis Endowed Chair for Parkinson’s disease research. He directs the USF Parkinson Clinic at Parkinson Place in Sarasota, FL and serves as Medical Director for the Parkinson Research Foundation.

“The Untold Story of PD – What Researchers Know but Haven’t Told Their Patients”

Thomas N. Chase, SB, MD – Dr. Chase has 40 years of experience in the discovery & development of new drugs for Central Nervous System disease, first at the National Institute of Health (NIH) and then as founding CEO of Hamilton Pharmaceuticals.

“Moving Better Medications from Bench to Market – Why Does It Take Too Long & Cost So Much”

Kathleen Clarence-Smith, MD, PhD – Dr. Clarence-Smith is an internationally recognized neurologist whose career has been dedicated to developing new pharmaceuticals and moving them forward from early stages onto the market.

For your fun & entertainment, the theme for the social side of the cruise is THE ROARING 20’S showcasing the Charleston and fashions and music of the era plus a “Speak Easy” Dance Party just for you. Get out your flapper dress and spats for a once in a lifetime fun opportunity!

Hallucinations, Delusions and Compulsions continued from page 6

use for twenty years, did physicians and researchers recognize they had deleterious effects on some patient’s behaviors.

Generally, hallucinations are treated with quetiapine or clozapine if patients are unable to reduce their dosage of levodopa/carbidopa. Some patients may benefit from cholinesterase inhibitors. The treatment of impulse control disorders is trickier. Though reducing or replacing the dopamine agonist is a reliable treatment approach, patients may also respond well to antipsychotics or serotonin reuptake inhibitors (antidepressants). Many impulse control disorders emerge in patients who do not take dopamine agonists, the problem is one of many for the patient with PD.

Citation:

Urban Dictionary: Punding
PARKINSON’S DISEASE, MUSIC AND MYSTERY

Music is one area that although it can be quantified into individual parts, is, as Aristotle commented “The whole is greater than the sum of its parts”. It is a process. Music’s effects on the human psyche and the variability of those effects defy explanation. Parkinson’s disease is also a process that has tended to defy explanation. Reducing disease to cellular function can explain the cellular function or “mis-function” and the interactions between the cellular relationships. It can show the how and what of the disease process, but it cannot tell us the why. Parkinson’s is a dynamic system, with many effects changing from moment to moment. Sometimes it is the “whole”; sometimes it is just a “part”.

Adding music therapy to treatment for Parkinson’s is bringing two dynamic systems (really many more) together to change the course of yet another. Exactly how music calms the Parkinson’s beast has yet to be determined. Yet more important is the fact that it is all a process, not an end point - the complexity of both dynamic systems interacting to bring the human state or the disease state to the edge of that creative process, to the edge of energy and potential and to stimulate new dynamic processes.

In complex systems, such as music and disease, there will always be missing information, unanswered questions. Part of the process knows there are limits; there are things perhaps we cannot quantify or “know”.

Life is still, and hopefully will always be a mystery. It is releasing and letting go, accepting those limits, and allowing “magic” to happen. Music is magic…. and mystery; and what a sweet mystery it is!

Where There’s a Will …

... there is increased hope for victory over Parkinson’s disease!

Many individuals have asked the Parkinson Research Foundation for advice on ways to include the Foundation as a beneficiary in their wills. It goes without saying that such bequests are of great value to the Foundation and play a key role in its ongoing efforts to improve the quality of life for those affected by Parkinson’s and their families.

The following language has been reviewed and is deemed a legally acceptable form for including such a bequest in a will:

“I give and bequeath to the Parkinson Research Foundation, 5969 Cattleridge Blvd., Ste. 100, Sarasota, FL 34232 for discretionary use in carrying out its aims and purposes, (the sum of $____) OR (a sum equal to ____% of the value of my gross estate at the time of my death under this will or any codicil hereto).”

Our Federal ID number is 20-0205035.

Some additional bequest options would include the bequest of a specific object of value or of the remainder of an estate after provisions for debts, general and specific bequests, and administrative expenses, including taxes.

Also, there are Charitable Remainder Trusts, which make annual payments to a beneficiary for a specific period of time (including a lifetime), after which the trust remainder is transferred to another designated organization, and Charitable Lead Trusts, which work in the exact reverse order.

The most important aspect considering or making any changes to a will is that the well-being of your own family occupies the top most position in your planning. And, for their and your protection, you should always consult an attorney about any changes you plan to make to your will.