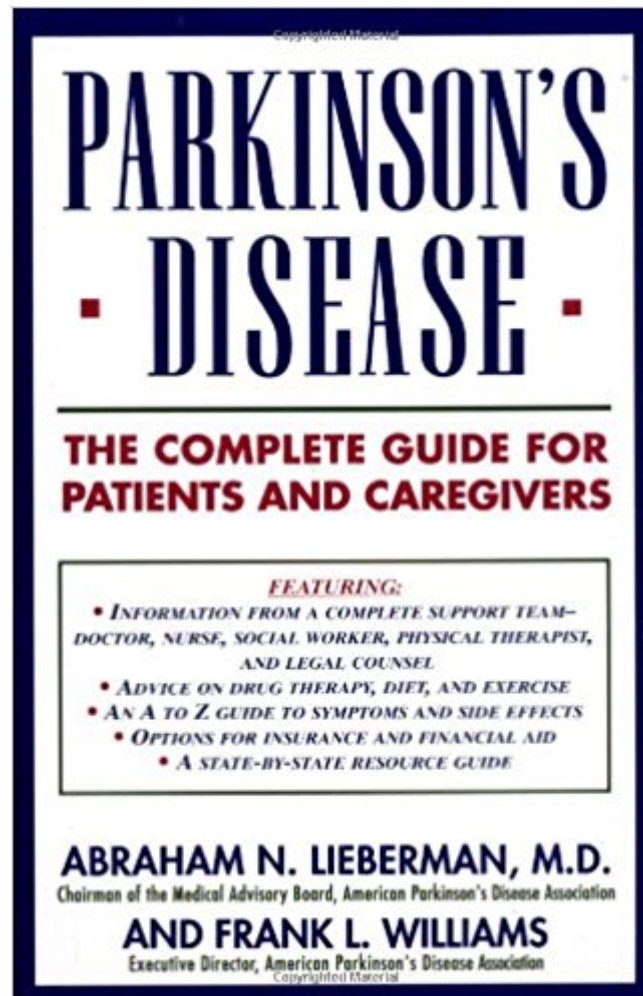




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Parkinson's Disease: The Complete Guide For Patients And Caregivers



Synopsis

Personal, accessible, informative. A guide for Parkinson patients and their caregivers that addresses the body and the spirit. Written by an expert team of health-care professionals-including a neurologist, a social worker, a nurse practitioner, a physical therapist, and an attorney/financial planner-this guide takes every aspect of living with chronic degenerative illness into consideration. You will find the answers to your most urgent questions: -How can I overcome the functional limitations of Parkinson's disease? -What are the pros and cons of various medications commonly used to treat Parkinson's? -Why is it important to stay fit and eat right despite the limits Parkinson's disease may put on my body? -What are some of the breakthroughs in alternative treatments? -What can I do to better cope with the psychological and emotional issues inherent in living with Parkinson's? -As a caregiver, how can I best juggle a program of care for a loved one and still find time for myself? -What insurance options and other forms of financial aid are available and how can one protect one's assets and life savings from long-term illness? Parkinson's Disease, which features an A to Z Guide to Symptoms and Side Effects and a state-by-state Resource Guide, will help you and your family succeed in your struggle to lead an easier and more fulfilling life.

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Customer Reviews

Abraham N. Lieberman, M.D., is a board-certified neurologist who is Chief of Movement Disorders at the Barrow Neurological Institute in Phoenix, Arizona, and Chairman of the Medical Advisory Board of the American Parkinson's Disease Association (APDA). He had been Professor of Neurology at New York University Medical Center. He has been the recipient of numerous research

grants and awards used to study various aspects of Parkinson's disease.

Chapter One Understanding Parkinson's Disease Alan remembers quite clearly the day he first noticed that his left hand shook. It was a Monday, the day he was to make a sales presentation he'd spent a month preparing. Sitting quietly at his desk, this 54-year-old businessman felt his hand trembling, slightly but persistently. "I put it down to nerves, fatigue, whatever. I'd been feeling depressed and more tired than usual, but otherwise I was in great physical shape. I was only 54. I didn't give it a second thought -- until it kept happening." For Beth, a 68-year-old retired schoolteacher, the onset of her condition was much more gradual, occurring over the course of more than a year. "I tired easily and moved much more slowly. My gardening chores became more difficult and painful to perform. I thought it was just the price I had to pay for getting on in years," she recalls. "But my husband became alarmed when he saw me dragging my right leg, and he complained that I wasn't smiling as much and that I seemed to be staring off into space all the time. When I noticed that I was sort of shuffling when I walked, I became alarmed, too." Both Alan and Beth would later be diagnosed as having Parkinson's disease, a degenerative brain disease suffered by about one million Americans, most over the age of 50, and just slightly more men than women. They would learn that certain cells in a part of the brain known as the substantia nigra were dying -- cells essential to the process of normal human movement. As the cells of the substantia nigra continue to die off, proper movement and balance deteriorate. But neither of them received the diagnosis of Parkinson's on the first visit to a physician. "My doctor put me through a complete checkup: blood test, chest x-rays, urinalysis, the works," Alan recounts. "He also asked me endless questions about my work routine, what foods I ate, what kind of stress I was under. Because I was feeling so depressed, he referred me to a psychiatrist, whom I saw for about six or seven months. The psychiatrist prescribed antidepressants, but I still wasn't feeling any better. If anything, I felt worse. Then I went to another neurologist, who said, and I quote, 'Well, it doesn't look like Parkinson's disease anyway.' I guess he said this because I didn't have very pronounced symptoms. In fact, my tremor seemed to disappear whenever I went to the doctor! It took about another year and two other neurologists before the diagnosis of PD was confirmed." Beth's experience was a bit less complicated, but still involved a number of different tests. "Because of my age and because it seemed to be only my right side that felt odd," Beth recalls, "my doctor wanted to rule out the possibility that I'd had a mild stroke without knowing it. He told me up front that a stroke was highly unlikely, mainly because the symptoms seemed to come on gradually and get worse. But he wanted to make sure." Although Beth's physician suspected PD almost from the start,

he knew it was important to rule out the many other conditions -- some common and others quite rare -- that might account for Beth's symptoms (see Appendix II). Many people suffer from symptoms similar to those caused by Parkinson's disease, but do not actually have the disease itself. When a patient suffers from another disease that produces parkinsonian symptoms, he or she is said to have secondary Parkinson's disease. The causes of these diseases range from the rare, including the inherited, to those caused by certain drugs or toxins. Classic Parkinson's disease, in which the cells of the substantia nigra are being destroyed for an as-yet-unknown reason, is usually referred to as primary or "idiopathic" Parkinson's disease. No simple blood test or x-ray will confirm PD: The diagnosis is arrived at primarily through physician observation, the elimination of other diseases as the cause of the symptoms, and finally the patient's response to drugs known to reduce the effects of Parkinson's disease (discussed in Chapter Four). Although you may receive the diagnosis of PD directly from your primary-care physician -- many patients do -- both Alan and Beth eventually saw brain specialists as well. Neurologists are trained in the art of deciphering the intricate circuitry of the body's least-understood organ, the brain. A complete neurological exam is an intense, often time-consuming, but almost never painful, experience. It usually begins with the neurologist taking a thorough medical history. He or she will probably ask what other medical conditions you have and what drugs you may be taking, your history of childhood diseases, and if you have had any accidents that involved head or spinal injury. You also will be asked about your family's medical history, especially that of first-tier relatives such as parents, grandparents, siblings, and children, and second-tier relatives such as aunts, uncles, and cousins. This information may help the neurologist rule out some inherited conditions, such as Wilson's disease, that may resemble Parkinson's disease. Then the doctor performs the physical exam. When a motor (movement) disorder such as Parkinson's disease is suspected, the neurologist will pay special attention to your muscles: how they contract, their strength, and their tone (their resistance to passive movement). The doctor will most likely use the reflex hammer not only in the usual places, such as your knee and elbows, and ankles, but perhaps on your jaw and in other places as well. Every muscle has a reflex, even those that control chewing and swallowing. Eye movements are studied because the neurologist can tell many things about the function of your nervous system by studying how your eyes move from side to side and up and down. In Parkinson's disease and in some of the diseases that resemble it, there may be a limitation in eye movement -- a subtle limitation of which you may not be aware. Next, the neurologist often likes to see how you move about, how you open and close your hands, tap your feet, how you stand, walk down a hallway, sit back down in your chair. Many neurologists, especially when they suspect PD, will request a sample

of your handwriting. In addition, the doctor will take special note of what we think of as body language: Do you cross your legs often or casually brush hair from your face? How often do you blink? Do you smile, frown, or otherwise show emotion when you are speaking or listening? Even the way you get dressed after the exam is data for the doctor's calculations. Your memory, your ability to do simple mathematical equations, and the sophistication of your abstract reasoning may also be measured at this time. One test for mental function requires you to spell a five-letter word such as "world" forward and backward. This test requires not only rote learning but the ability to juggle things in your mind, remember them, and rearrange them. Don't be surprised if the exam involves a bit of philosophy as well. To measure your powers of abstract thinking, the neurologist may ask you to interpret a proverb or cliché: What does "A rolling stone gathers no moss" mean to you? for instance. Of course, no right or wrong answer exists to such a question, but how you describe your reaction to it may tell the doctor a great deal about the way your brain is functioning. More than likely, and again to rule out other conditions that may account for your symptoms, other medical tests may be required. One of the most useful is magnetic resonance imaging, or MRI, which has replaced the computerized axial tomogram, otherwise known as the CAT or, preferably, the CT scan. First introduced in 1984, the MRI scan has become an invaluable medical tool. Hundreds of times more detailed than the ordinary x-ray, MRI scanning can be used to see inside any of the body's organs, including the brain. The MRI scan is a simple, completely painless procedure, although a few rare patients experience claustrophobia after being placed within the scanner. You'll lie flat on a special table as a powerful magnetic field is created around you. Special radio-frequency waves are pulsed through the field. A detector will pick up changes in the field as the radio waves pass through your brain, then feed the data about tissue density into a computer for analysis. A picture of the result is displayed on a computer screen. The test takes about 20 to 30 minutes and will detect any tumors, cysts, abscesses, or other problems that may be causing your motor dysfunction. Invaluable information on previous, unsuspected strokes may also be obtained. To rule out brain damage from injury or other neurological disorders not detected on the MRI, the neurologist may request that you have an EEG, an electroencephalogram. If you're scheduled for an EEG, expect to perhaps feel a bit sticky (often glue is used on your scalp) but otherwise completely comfortable. Electrodes are attached to your scalp to record your brain's faint electrical activity. In order to measure how your brain reacts to changes, you may be subjected to flashing lights or noise during the exam. Other tests may also be administered before your doctor or neurologist determines that you are, indeed, suffering from Parkinson's disease. Although these tests may seem tedious and may be costly, remember that there are other diseases that can be

confused with PD. Since PD is a lifelong condition, it is important to rule out these other diseases, which may require special treatment. One test, called the positron emission tomography, or PET, scan, has provided valuable insights into Parkinson's disease. An extremely sophisticated test, the PET scan can actually detect the presence and location of brain chemicals, something once possible only through the removal of the brain for biochemical analysis. In fact, it may be possible for a PET scan to detect a loss of dopamine -- the brain chemical missing or in short supply in the brain of a Parkinson's disease patient -- before symptoms of Parkinson's disease are apparent. Unfortunately, PET scan equipment is very expensive, costing millions of dollars, and the test is currently available at just a few research centers throughout the world. Eventually, both Alan and Beth were told by their neurologists that they were indeed suffering from Parkinson's disease. Although their initial symptoms were completely different, each had enough of the cardinal signs of PD that their doctors felt confident that PD was the underlying cause. Alan's shaking hand, depression and exhaustion, and the stiffness in Beth's right side, the dragging of her foot, and her lack of facial expressions were all caused by the same disease.

The Parkinson's Disease Syndrome

As stated earlier, no specific blood test or x-ray will establish Parkinson's disease as a definitive diagnosis. All of Alan's and Beth's tests came back negative: no viruses, tumors, or strokes were causing their symptoms. Apart from ruling out other diseases, what determined the positive diagnosis of PD for Alan and Beth were their own apt descriptions of their symptoms combined with the observations made by their doctors. Because of this diagnostic process, misdiagnoses can, and often do, occur. Most general practitioners see just two or three new PD patients in an entire year, and even neurologists can be confused by PD's subtle symptoms. Like Alan, you may even find yourself on a psychiatrist's couch for a time before a proper diagnosis is made. This may be frustrating to both patient and doctor. In the past, it was unimportant as to the length of time it took to diagnose Parkinson's disease because no therapy was available that would affect its progression or severity. Today, although there remains no cure for this progressive brain disease, the advent of a new drug, called selegiline (Eldepryl or deprenyl), may indeed change the course of the disease (see Chapter Four). Now, waiting years, or even months, to begin therapy for Parkinson's disease is no more acceptable than delaying the diagnosis and treatment of a tumor. One reason this book is being written is to help physicians and patients alike learn as much as possible about PD so that its signs and symptoms are recognized early and treatment started soon. The damage Parkinson's disease does to the brain causes myriad problems related to movement and behavior, some obvious and others more subtle. PD can, in time, result in some patients becoming completely akinetic (totally immobile). In others, few overt manifestations of the

disease are present for many years. Most people who suffer from PD come to their physicians with moderate complaints which may progress, slowly or quickly depending on the individual, over a number of years. It is important to state again -- and it will be repeated several times throughout this book -- that Parkinson's disease affects each patient differently, as do the drugs used to treat it. That said, there are hallmark signs of Parkinson's disease. One or more of these signs are always present in a PD patient.

Cardinal Signs of Parkinson's Disease

Resting Tremor:

Tremor, such as the one Alan experienced, occurs in about half to three-quarters of all parkinsonians. It appears most often in the hands and feet, and occasionally may also involve the head, neck, face, lips, tongue, or jaw. The shaking is regular and rhythmic, with a frequency of about 4 to 6 beats per second. In the beginning, the tremor may be worse on one side of the body than the other and the tremor may vary at different times of the day. Physical or emotional stress may also cause tremor to become worse. "Sometimes I don't even realize my hand is shaking until someone else points it out," says Joe, a patient who has had Parkinson's disease for about 10 years, in describing the uncontrollable tremor that mainly affects his left leg and hand. "A few years ago, I could make it stop if I really concentrated. Now, it's gotten so that I have tremor most of the time, especially in between doses of medication. Sometimes I call myself the 'Shake, rattle, and roll man!'"

Rigidity:

Beth's very first symptom was a feeling of stiffness in her right side. "I thought I'd overworked the muscles in my leg, somehow, or slept in the wrong position. But it never went away." What Beth is experiencing is commonly referred to as rigidity. When your muscles are rigid, they are constantly tensed in a state of sustained contraction -- much more tense than the average muscle -- even when they should be relaxed. This tension usually is perceived by the patient as stiffness or achiness, and it is the physician who labels it rigidity. The doctor does this by performing a simple test: After first asking a patient to relax his or her muscles, the doctor then flexes the patient's arm or leg. The resistance to the movement felt by the doctor is known as rigidity. If the arm moves smoothly but with stiffness, the condition is termed lead-pipe rigidity, because it resembles the way it would feel to bend a lead pipe. If the arm catches along the path of the flexion, the way a ratchet would in a machine, the doctor might term it cogwheeling rigidity. This cogwheeling effect is thought to be caused by a tremor, deep within the muscles and not always visibly apparent, superimposed over the increased tone of the muscle. Rigidity in Parkinson's disease involves all voluntary muscles, therefore affecting many different activities and body functions. Restricted movement of the arms and legs, evident when the patient is walking with the arms held at the sides and not swinging, is the most obvious result of rigidity, but proper breathing, eating and swallowing, and speech also may be hampered. Beth's poverty of facial expression, first noticed by her husband, is a sign of rigidity. In fact, many

patients have a masklike stare, produced by the immobilization of facial muscles and reduction in eye-blinking frequency. Margaret, a 65-year-old patient diagnosed with PD five years ago, describes rigidity this way: "Rigidity makes me feel as if I haven't had a good stretch in about a hundred years and won't be able to take one for another hundred! I'm tight as a drum, and every movement is difficult." **Bradykinesia:** From the Latin brady (slow) and kinesia (movement), this term describes the often frustratingly long time it takes person with PD to walk, to sit down, or to perform other ordinary movements. In addition to his tremor, Joe suffers from increasing bradykinesia. He describes it this way: "I'm one of the few men I know who loves to relax in a hot bath -- I always have. I used to be able to start the bath water, go pour myself a glass of wine, grab a book, get undressed, and get back in time to shut off the tap and jump right in. Now, if I did that, I'd have a flood for sure! Now I get everything ready before I turn on the water. If I'm having a good day, I just have time to get undressed before the tub is full." For some patients, this slowness affects not only movement but speech and even thought as well. The fact that a PD sufferer may not make certain semi-automatic gestures, such as crossing the legs or scratching the forehead, is also an aspect of bradykinesia. **Postural Instability:** Standing up straight, picking up your feet and gently swinging your arms while you walk, being able to right yourself if bumped, are all movements that most of us perform without much conscious thought. You also know instinctively where in space your body is -- you don't have to "remember" to uncross your legs before you stand, for instance, your body automatically responds. Some parkinsonians, however, lose these so-called postural reflexes and fall easily. Generally speaking, some aspect of one or more of these four cardinal signs of PD will be present in a patient. Sometimes a patient will display few parkinsonian symptoms at first, but instead will experience one or more secondary manifestations of the disease. Most often, these secondary signs develop in patients who first experience one of the cardinal signs. Again, not every patient will experience these symptoms, nor may they be experienced exactly as described here. **Secondary Signs of Parkinson's Disease** **Gait Disturbances:** Many patients with PD develop a stooped, slightly bent posture and tend to propel themselves forward while walking, a syndrome known as festination. Festination consists of an acceleration and abbreviation of movement and, in some patients, of thought as well. Some patients complain of actually feeling "in a hurry" against their will. Some patients may shuffle as they walk, as Beth does, or may have trouble turning around quickly. Together with the loss of postural reflexes, such gait disturbances often lead to dangerous falls, one of the most disabling results of Parkinson's disease. Some doctors believe that gait disturbances result from a combination of rigidity, bradykinesia, and postural instability, while others feel it is a separate symptom. **Dexterity and Coordination Difficulties:** A failing tennis serve, increasing golf

scores, worsening handwriting, all are among the many signs that Parkinson's disease may be affecting your manual dexterity. These changes may result from a combination of rigidity and bradykinesia or may be a separate phenomenon. When your doctor watches you dress or undress during your examination, it is so that he or she can observe how you manipulate the buttons on your shirt or tie your shoelaces, tasks that require fine motor coordination. Many times, patients first complain of increasingly illegible handwriting: typically, the problem consists of a script that gets smaller and harder to read the longer one writes, called micrographia. That's why your physician may ask you for a handwriting sample during your examination.

Freezing: Patients with Parkinson's disease can experience sudden, involuntary arrest of voluntary movement, a "freezing in one's tracks," so to speak. Although freezing is usually considered a feature of bradykinesia (slowness of movement), it may be a separate phenomenon that can occur independent of other PD symptoms. Characterized by an inability to initiate movement or carry out repetitious acts such as finger tapping or even speaking, freezing is most disabling when it affects walking. Patients feel as if their feet are virtually stuck to the floor, suddenly and often unpredictably. Many patients are particularly prone to freezing when they approach a door or when they turn.

Speech and Swallowing Dysfunction: Patients may complain of slurred, whispered speech, even in the early stages of Parkinson's disease. Others may find that their speech is becoming monotonous or lacking in emotional expression. These symptoms are due to the involvement of the muscles that are used in creating speech, from the diaphragm and throat to the lips and tongue. As some of the muscles that control speech are also involved in swallowing, some patients may complain of swallowing difficulty and may occasionally choke on some foods or pills. Swallowing difficulty is rarely a problem early in the disease.

Visual Symptoms: Patients usually do not complain of visual difficulties because PD does not affect the optic nerves, the nerves that receive visual impressions. Because PD can affect the muscles that move the eyes, however, some patients complain of having difficulty reading. In addition, some drugs that are used to treat PD, particularly the class of drugs called anticholinergic agents, may constrict the pupils, causing blurry vision. A decrease in the number of times per minute patients blink their eyes may lead to other vision-related problems. The normal "windshield wiper effect" of blinking -- the wiping away of debris such as dust, smoke, or other irritants -- is lost. Conjunctivitis (inflammation of the mucous membrane that covers the front of the eye and lines the inside of the eyelids) may result.

Depression: Serious psychological diseases often occur in Parkinson's disease and chief among them is depression. Although some symptoms of depression are related to the dramatically altered self-image the patient has when faced with the realities of a chronic illness, the occurrence of depression is higher in PD patients than in equally disabled

patients with other diseases. This leads physicians to consider that PD also causes changes in the brain's chemistry that result in depression. Depression may occur early or late in PD and may range from mild to severe (requiring hospitalization).

Dementia: The term dementia refers to the progressive loss of memory and other intellectual functions, along with associated changes in behavior and personality. Dementia is the most extreme of the mental changes that occur in PD and is much more common in older (ages 70 and over) than in younger patients -- as many as 30 percent of patients in the older age group develop dementia. Alzheimer's disease, which affects about 15 percent of the population over 65, is considered a form of dementia. In some PD patients, the occurrence of dementia may represent the coincidental development of Alzheimer's disease. In most PD patients, however, the dementia is caused by disease progression. The occurrence of dementia makes treatment of PD more difficult because some of the drugs that improve the motor symptoms of PD (tremor, rigidity, bradykinesia) usually aggravate dementia. Commonly, patients with PD will display other symptoms such as personality changes, loss of initiative, and fearfulness. However, these changes, although disturbing, do not mean the patient necessarily will develop dementia later in the course of the disease. The fact that younger patients appear to respond better to medication and exhibit fewer mental changes than their older counterparts has led some scientists to feel that there may be two separate diseases: In younger patients, PD tends to be primarily a motor disease, while in many older patients, PD is both a motor disease and a disease causing disturbances of cognition and emotion.

Pain and Sensory Discomfort: Although pain is rarely a symptom of PD itself, it may be a side effect of medication. Muscle cramps, stiffness, and spasms are the most common complaints. Dystonias, or prolonged spasms, are sometimes painful and usually occur in the muscles of the shoulder, neck, trunk, and calves. Numbness, tingling, and a burning sensation can occur during any stage of the disease, even before motor function is impaired or the disease is diagnosed.

Sexual Difficulty: Every aspect of sexual activity -- from initial arousal to orgasm -- involves the nervous system, the part of your body that PD most affects. Many PD patients, therefore, experience sexual dysfunction at some point during the course of the disease. While some difficulties may be related to the effects of PD on the nervous system, others result from the mood swings, anxiety, and frustration experienced by some people suffering from a chronic illness. Some difficulties may be caused by the drugs used to treat PD.

Blood Pressure Changes: Occasionally, the part of the brain that controls the activity of the sympathetic nerves, which regulate the heart and blood vessels, may be affected in PD. If the involvement of the sympathetic nervous system (which is part of the autonomic nervous system) is sufficiently severe, low blood pressure may result. Postural hypotension -- a drop in blood pressure upon standing -- may occur and be

experienced as dizziness or lightheadedness. Occasionally, some of the anti-Parkinson drugs may aggravate the postural hypotension and the patient may faint upon standing.

Dermatological Changes: Dermatitis, a type of eczema, is a common side effect of PD. It is characterized by scaly, oily skin, especially around the eyebrows, forehead, eyelids, or nose. It is caused by excess oil being secreted by the sebaceous glands, secondary to the involvement of the autonomic nervous system.

Gastrointestinal and Urinary Dysfunction: Bowel and bladder complaints are common among PD patients. Slowness of movement may affect the muscles that control the bowels, thereby slowing the transit of feces. Constipation, therefore, may be a common and recurrent problem for many patients. This condition is exacerbated if the PD sufferer has difficulty chewing and swallowing and therefore neglects eating enough roughage or drinking enough water. Some anti-Parkinson disease medications -- particularly the anticholinergics (see Chapter Four) -- may also aggravate constipation. Less frequently, there may be some sluggishness of the bladder musculature so that urination may also be slowed. There may also be difficulty in properly emptying out the bladder, and the patient may thus have to void again immediately after urinating.

Who Gets Parkinson's Disease? At the beginning of this chapter, you met two people, a man in his mid-50s and a woman in her late 60s, who had PD. Are Alan and Beth "typical" parkinsonians? In many ways they are. Scientists and physicians estimate that approximately 20 new cases per 100,000 people are diagnosed each year. By far, the majority of PD patients are, like Alan and Beth, over the age of 50 when they are first diagnosed. In fact, many of PD symptoms resemble, and can be mistaken for, the side effects of the normal aging process. Muscular rigidity, gait hesitation, postural imbalance, and some mental disturbances frequently occur in the sixth or seventh decades of a healthy person's life. Indeed, because the symptoms of PD often come on gradually, normal aging may seem at first to be a logical explanation for the difficulties.

As discussed, establishing the exact onset of symptoms in PD may be difficult, because vague complaints such as slow movement, mild aches and pains, easy fatigability, and depression may appear years before a patient feels ill enough to see a doctor and be diagnosed. It is rare for either Parkinson's disease patients or their doctors to be able to pinpoint exactly when PD started. Beth cannot recall, for example, when weeding her garden first caused her hands to ache, or when her leg began to drag. Moreover, by the time she felt these symptoms, the disease process had been ongoing for quite some time.

A majority of parkinsonians experience tremor as their first symptom, and most parkinsonians -- more than 75 percent -- experience tremor to a greater or lesser extent at some point during the course of their disease. Feelings of general muscle weakness and mood swings are also common among PD patients. Alan's depression and exhaustion are also common first symptoms.

On the other hand,

Alan and Beth are not "typical" parkinsonians because Parkinson's disease affects every individual differently. No doctor can reliably predict how fast or far PD will progress, what symptoms will be experienced, or how a patient will respond to treatment. In effect, there is no such thing as a "typical" Parkinson's disease patient at all. Although the majority of patients are over the age of 50, PD also is diagnosed in patients in their teens, 20s, 30s, and 40s. Unfortunately, reliable statistics on exactly who in the United States has PD are limited, mainly because such data are dependent on an accurate diagnosis. It is not clear if there is more PD among young people or if the apparent increase among young people results from improved diagnoses or heightened awareness about PD among today's population. It appears that the disease affects men slightly more than women. Why this sexual bias exists is not clear, although it is possible that either male hormones aggravate or female hormones protect against the process that causes PD. Some statistics indicate that African-Americans have a lower incidence of PD than Caucasians. It may be that African-Americans are somehow physically protected from the disease or, alternatively, that their limited access to quality health care and neurology specialists has distorted the true picture of Parkinson's disease in the United States.

Hugh, a 24-year-old marketing executive from a large southern city, received his diagnosis two years ago -- the same week he earned his college diploma. "My first reaction was one of relief, to tell you the truth. I was convinced I had a brain tumor!" he recalls with a laugh. "It all started when I was in my junior or senior year in high school. My lower legs started feeling weak and trembly. And they kept getting worse. Then my handwriting started getting smaller. People kept asking me to repeat things and to speak more slowly." Hugh paused to recall his two-year odyssey. "I went to about six doctors before I got my diagnosis. I even had a spinal tap, which was one of the most painful and humiliating experiences I've ever had. All the while neurologists kept telling me, 'You can't have Parkinson's disease, you're too young.' But it turns out I do, and as daunting and humbling as it is, it's good to know. Now I can deal with it for what it is." Once they were diagnosed, Hugh, Alan, and Beth were told the proverbial "bad news and good news." The bad news is that, as yet, no cure for Parkinson's disease has been found. The good news is that there are effective drugs that will help them remain healthy, active people for many years and that there are drugs that may slow down the progression of the disease (see Chapter Four).

"When I first heard the diagnosis, my heart sank. My best friend's father had Parkinson's disease back in the 1950s and he became almost completely paralyzed. I was so afraid that that would happen to me," Beth declared. "But then my doctor told me about a Parkinson's patient he'd been treating for more than 15 years. At the age of 65, she still drove her car, tended her garden, and played bridge with her friends every Wednesday afternoon." Indeed, the drugs used to treat the symptoms of Parkinson's disease can

increase mobility, help stop tremors, and restore some flexibility and agility. Currently, anti-Parkinson drugs allow most patients to maintain relatively healthy and normal lives for about 5 to 20 years after diagnosis, depending on how fast the disease progresses in the particular individual. For patients in their 20s, 30s, and 40s, or for even younger patients like Emily, the future is less certain. However, the introduction of drugs like selegiline (also known as Eldepryl or deprenyl) may slow the progression of the disease by as much as 50 percent -- a ray of hope for younger Parkinson patients. Discovering what causes this disease and learning exactly how the brain is affected by it will go a long way both in developing therapies for patients of all ages and stages of the disease and in finding a cure. In the next two chapters, we'll see how far scientific research has come during the past two centuries in giving us a road map of the brain and the way it misfunctions in Parkinson's disease. Copyright © 1993 by The Philip Lief Group, Inc.

I have been diagnosed with Parkinson's for nigh on to 12 years now, but really only gained bits and pieces of knowledge as needed or thought important to my survival. Parkinson's Disease is a book recommended by an acquaintance, and I am very glad to have purchased it. The book is packed with tidbits of information. Many of the things in the book had been mentioned to me by Doctors, Nurses and other medical staff, but let's face it, with time pressing on both me and my treatment deliverers, I wasn't always able to assimilate what I was being told. I can study this book at my leisure, and indeed, have grasped new ideas much more easily through reading than I have been able to under the pressure of a 10 minute appointment every 3 months. Now I am able to formulate questions for my treatment team, instead of blindly trying to keep the disease at bay. So far, I have been fortunate not to see my carriage or health deteriorate overly much, but I know that can change at any time. For straight guidance on medications, diet and myriad other factors that can affect the Parkinson's Person, this book is well worth the price paid.

good information for those with Parkinson's.

As someone recently diagnosed and looking for answers to questions, this book answered them all. Excellent, quick read for someone with questions.

awesome

got this as my husband was recently diagnosed with Parkinson's the book helped to answer many

questions we had about the disease easy read great to keep around as a reference

Good.

A must read for all those concerned.

This product I cannot rate, as I ordered it for a friend who has a friend with Parkinson's Disease and she wanted to read this book.

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