

THE VIRGINIAN

SERVING VIRGINIA & WEST VIRGINIA

VIRGINIA CHAPTER NEWSLETTER

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FROM THE PRESIDENT

Joe Powers

Truth Never Hurts

That's what Pete always said – Pete Kopeha. We first met at Catholic University after the war. Pete was a World War II vet – son of Ukrainian immigrants, who had remained in Germany during the occupation. He spoke Ukrainian and could hold his own in Russian too - thus helping the “DP's” – the displaced persons and refugees from Eastern Europe. After the war he'd worked in the steel mills of Pennsylvania, and then in 1951 decided to attend college. We were both in Dr. Behrend's 2nd year German class – and sat in the last row hoping he wouldn't call on us to translate. Pete was on CU's last football team. I worked 30 hours/week so we both often missed the homework. Afterwards, by coincidence we both had careers with the same Defense Agency, and worked together for the next 30 years. We were involved with very large information systems. Pete was really a genius; he could evaluate tons of information and see relationships and meaning that others couldn't. **Often his evaluations were not what management expected – or wanted to hear – that's when he'd remind everyone that “truth never hurts”.**

This preamble is by way of introducing a discussion on the need and adequacy of funding MG/autoimmune research.

Elsewhere we've reprinted statements by Dr. Pascuzzi, Chair of MGFA's Medical/Scientific Board, that promise development of a 5-10 year research plan. Although long overdue, it represents a very positive step that all Chapters and each member should wholeheartedly support by “digging

deeper” to help their Chapters fund the projected research. MGFA's Annual Report describes 4 specific research goals:

- Identification/understanding of the “triggers” that cause MG.
- Improvement of diagnostic techniques.
- Development of “new and better treatment regimes”.
- Improvement of clinician education.

By the end of the year, the MSAB has committed to completing the plan with specific milestones and priorities.

Concurrently, MGFA has inaugurated a Research Endowment Fund. Last year, Chapters gave \$106,000 for this purpose and the target for this year is \$125,000. MGFA's Annual Report (available at www.myasthenia.org) describes how funding is being used.

Each year a National Conference for Chapter members is provided, usually in conjunction with a “Scientific Session” for doctors and MG researchers.

Every 5 years an “International Scientific MG Conference” is held in cooperation with the New York Academy of Science. **The next meeting is now scheduled for May 14-16, 2007 in Chicago.** In addition, specific research support is directed to student fellowships and a post-doctoral fellowship. In 2005, there were three student fellowships of \$3000 each and one post-doctoral fellowship of \$50,000 on “gaining a better understanding of the triggers, influences and factors involved with the initiation of MG...and a clinical flair-up of the disease.”

Now comes the hard part that's intended to emphasize the need for substantially more funding that might be realized through a pro-active advocacy program. It would complement the Research Endowment Fund.

Let's try to look at the above evidence objectively and see what conclusions can be drawn from the

facts. MGFA provides a focal point for MG research through their sponsorship of scientific conferences that is essential and invaluable – and well done! That's one conclusion.

The student fellowships are essential as a means of attracting bright young medical students to consider MG/autoimmune diseases as a clinical area of specialty in their future practice of medicine. The post-doctoral fellowships are essential for making progress in preventive measures and improved therapies. It would obviously be desirable to extend both fellowship programs. A second conclusion.

In the cover article by Dr. Pascuzzi, he outlines the progress made over the last 40 years, and characterizes them as “stunning”. He's correct because without them, many of us would not be here today. Dr. Pascuzzi proceeds to pose several fundamental questions concerning “cause”, “triggers”, genetics, the role of the thymus, and/or a combination of these factors. To these very basic issues “we can realistically look at ways in which to prevent the development of MG or to minimize the severity of symptoms”. So obviously, we have quite a ways to go – a lot of research, very basic research, is still needed. Another conclusion.

The next question then has to be “do we have the resources needed to get there – to get the answers to the very fundamental issues? And by “resources” we mean the doctors and scientists with an interest in neuromuscular diseases as well as the academic resources, laboratories, instrumentation and dollars needed to make it all work. The answer is obviously no – the resources available today are inadequate. Therefore, the need for MGFA's Endowment Fund requires every one of us to dig deeper in making contributions. Another conclusion.

But “if “past is prologue”, and knowing the level of investment required for research and the development of new therapies, we'd

also have to say that getting sufficient endowment funding will be more than challenging. Because of the amount of money needed to realistically develop scientific breakthroughs, it demonstrates the need for a strong, proactive advocacy program that would be a complimentary source of needed resources. And, by advocating for more Congressional funding of the NIH Autoimmune Research Program, we will help provide an additional source of funding for Dr. Pascuzzi and other scientists. Note that “a rising tide lifts all boats”. That’s the last conclusion.

Congress has had your tax dollars to do more medical research – yet patients have been denied the benefits of additional medical research because of Congressional spending on non-essentials. Since Patient Support Groups – including MGFA – are not well organized to lobby for their members, other special interest groups did organize and advocate for special appropriations through the “earmark” process – where a Representative simply requests special funding for a specific project. Here’s an example from 6,000 such non-essential “earmarks”:

- \$100,000 for a National Wine and Grape Initiative
- \$180,000 for a study of hydroponic tomato production
- \$1,500,000 for a William Faulkner museum
- \$1,000,000 for an the mystic aquarium
- \$200,000 for tourism development in Oil City, PA
- \$750,000 for a conference center in Pomona, CA
- \$300,000 for the Bronx Council for marketing local art
- \$6,300,000 for a wind demonstration project

And, on and on – “earmarks” that eventually totaled the equivalent of the entire NIH Budget of \$28 billion!

With life and death issues at stake, it would seem that the priorities would be self-evident. But if patient support organizations and individual patients are not willing to be their own advocate, then other special interests will use your tax dollars on projects like the ones above.

The advocacy plan submitted by the Virginia Chapter 15 months ago – and not yet implemented – is a basis for redirecting Congressional priorities and using your tax dollars to benefit you and Dr. Pascuzzi’s research programs. Our recommendation: implement the advocacy program as complimentary to the Endowment Fund. We need all the help we can get!

Fall Chapter Membership Meeting

We will be holding our Fall Chapter Membership Meeting on Saturday, November 11, 2006 at 1 p.m. in Richmond, Virginia. The meeting will be held at the MCV Alumni House on the VCU Health System or MCV campus. **The MCV Alumni House is located at 1016 East Clay Street. Parking is available in the patient/visitors deck at the VCU Health System and is free on the weekends.** There is also street parking around the VCU Health System campus.

The speaker will be Dr. Scott A. Vota, DO. Dr. Vota is an Assistant Professor of Neurology with the Department of Neurology at the Virginia Commonwealth University (VCU). Dr. Vota is the Associate Director of the Neurology Residency Program at VCU. Dr. Vota co-chairs the Monday afternoon Muscular Dystrophy Association Clinic. They see 200+ Myasthenia Gravis (MG) patients each month during this clinic.

Dr. Vota will be giving us a presentation on: the basics of MG; medications for MG and why physicians prescribe them to patients as well as current research.

Please join us for this presentation from Dr. Vota. Please RSVP to Phyllis Birkhead, Program Director, PBirkhead@earthlink.net, or 1-800-728-4405. If you need directions, please contact us.

Northern Virginia Support Group In Remembrance

We are sad to report the death of Wendell Steele, husband of Anita Steele, our group leader for the Northern Virginia group. Anita and Wendell were a team that provided critical support and leadership to the Chapter.

Their son contracted Myasthenia at an early age, and as a consequence they were determined to help find a cure and to help other patients as well. Anita has led the Northern Virginia group for the past seven years and shared both her home and care with patients needing help.

Earlier this month Wendell and Anita scheduled a wonderful picnic at their home on the shores of the Rappahannock River. It was a memorable event, now even more meaningful with Wendell’s passing. He was not able to be with us that day – he was already hospitalized at MCV as a candidate for a heart transplant, but both said the picnic should go on as scheduled. It was Wendell’s way to never give up and to always think of others. Wendell was a Viet Nam veteran, a talented artist, a loving husband, father, and grandfather – and he was a friend to all. He will be greatly missed. Our prayers and love we send to Anita and her family.

West Virginia Group Makes a Difference

Our fellow Chapter members in West Virginia have been busy as usual: with projects to inform new patients and healthcare professionals with “Information Packets” that were distributed to local hospitals and clinics. Initiated by West Virginia’s first Support Group leader, Becky Charlton, they’re paying dividends with new members joining the group.

Their August meeting celebrated life with a watermelon feast – and a discussion on strategies to make everyday activities easier, such as using a chair for support when standing. Other topics included the side effects of taking Prednisone. And, of course, they always have good things to nibble.

On Saturday, October 14th, the group will host a “soup and sandwich” luncheon at the Princeton Advent Christian Church in Princeton, WV at 1 pm. (Because of printing and mailing constraints notice of this meeting may be too late.) All our members are invited to attend. **If you would like to attend this or future meetings and need directions, please call Karen Farmer, our group leader**

for the WV group. She can be contacted at (304) 324-5852 or (304) 922-0393. You can also contact Phyllis Birkhead at (800) 728-4405 or by email at PMBirkhead@earthlink.net.

From the Program Director

Email Change:

PMBirkhead@earthlink.net

Welcome, Georgiann!!!

We are pleased to announce a new Board Member. Ms. Georgiann Davis has been an active member for the past year and has agreed to serve on our Board of Trustees and as Secretary of the Board.

Georgiann works with the Virginia Coordinated Care Program (VCC) at the VCU Health System (or MCV Hospitals) in Richmond, VA. She is the Member Education Coordinator and she provides information and assistance to patients in the Richmond and tri-cities areas. Georgiann educates the patients on the VCC program and assists the patients with any problems they may have.

She plans to represent our Chapter at an upcoming conference sponsored by the National Organization of Rare Diseases (NORD). The conference will focus on medical research issues affecting rare diseases, including MG.

NIH's "Road Map for Research" is to be reviewed as it applies to rare diseases, as well as action being taken by FDA to speed the process of developing and testing new medications and therapies. We will bring you a summary of the conference in an upcoming newsletter.

Georgiann has dealt with the symptoms of MG for almost 20 years and we hope to share her story in our next newsletter.

We are very excited about Georgiann's enthusiasm and interest in serving our Chapter. Her focus for the next several months will be to start support groups in Richmond and Hampton Roads. If you would be interested in helping her with either of these support groups, contact Georgiann at (804)357-1663 or auntgigers@comcast.net or Phyllis Birkhead at 1-800-728-4405 or PMBirkhead@earthlink.net

CHC Fall Campaign Reminder

Your Chapter needs your help! If not already, very soon the Community Health Charities will begin their fall campaigns in your workplace. The local United Way campaigns will also begin throughout the state.

All of the CHC of VA campaigns should have us clearly listed in their brochure. Our designation code is #6037.

For the CHC of the National Capital Area, our designation code is #6004, and again, we should be clearly listed in their brochures.

The United Way campaigns may work a little differently. In some of them, we will be listed in the "Local Agencies" under "Unaffiliated Organizations". In others, we may not be listed at all. **Please note that you may "write-in" your favorite charity if we are not listed.** Most United Way in Virginia honors these "write-in" designations. This alternative is not always fully disclosed by campaign assistants, but you will be permitted to exercise your choice if you are willing to insist. **You should write in Myasthenia Gravis Foundation, 6037, and add Virginia Chapter and our mailing address.** United Way extracts a fee for this service, but it is a way for you to support our Chapter via your workplace campaign.

Please feel free to call me at 1-800-728-4405 or email PMBirkhead@earthlink.net if you have any questions on how we may be listed in these campaigns.

And, of course, you can always contribute directly to our Chapter by sending your tax deductible contribution to: Dan Marsh, Treasurer, VA Chapter, MGFA, 5552 Oliver Lane, Broad Run, VA 20137-1934.

More about MG and the Cancer Connection

Recently a few alarm bells have sounded drawing attention to autoimmunity and the "cancer connection". Although it's been known for some time that a relatively small percentage of MG patients will be diagnosed with a malignant thymoma, some thymomas may be defined as

"indeterminate" – neither malignant nor benign, thus raising the question of whether follow up CT or MRI exams should be made.

As noted in our Spring 06 edition, the National Cancer Institute has observed a notable incidence of subsequent follow up malignancies in patients with thymomas, particularly non-Hodgkins (NH) lymphoma, as well as digestive system cancers and soft tissue sarcomas.

A second study reported in the Journal of the National Cancer Institute (4 January 06) re-emphasized the connection between autoimmunity, chronic inflammatory disorders and again NH lymphoma.

A third study, at Mt. Sinai Medical Center in New York showed non-Hodgkins patients were 2.6 times more likely to have had an autoimmune illness. An increased risk of lymphoma, noted by the same study, was inferred from use of potential immuno-suppressant therapy.

Some pharmaceutical warnings now also note the possible cancer connection. Imuran – or the generic version, Azathioprine, was singled out in 06 by Walters Kluwer Health, Inc. with the following warning:

"Long-term use of this medicine (at 50 mg) increases the risk of developing neoplasias (cancerous or non-cancerous growths). Azathioprine can also cause blood disorders (e.g. Leucopenia)."

The warning continues at length, advising patients to notify their doctor if unusual growths develop, if there is easy bruising or bleeding, or signs of infection such as a persistent sore throat or fever. Extensive cautions are also noted if you are taking cardiovascular drugs.

A second immuno-suppressant drug, CellCept – or the generic version, Mycophenolate Mofetil – was also noted with warnings of "serious, possibly fatal infections"... "and may increase the risk of developing lymph node tumors (lymphoma)." Patients are instructed to notify their doctor immediately if they develop any symptoms of infection, including weight loss, night sweats, enlarged lymph nodes or skin growths.

Although CellCept was only recently approved by FDA specifically for MG treatment, extensive follow up clinical trials for these drugs in treating MG have not been done.

As if to corroborate these warnings, we recently heard from Barry Levine, President of the Upstate New York Chapter, that he was recently diagnosed with non-Hodgkins lymphoma – after taking Imuran (275 mg) for six years and is now being treated with chemotherapy. His predecessor also developed NH lymphoma after taking Imuran over a 20 year period. **Obviously individual patient differences must be taken into account, as well as dosage levels and treatment duration.**

One of the drugs Barry is being given, he reports, is the monoclonal drug, “Rituxan” – a drug that only seeks out and destroys B cells that contain CD20. That drug has apparently put his MG into remission. Barry rightfully points out that MG patients taking Imuran should be familiar with NH lymphoma symptoms. So, here they are:

Lymphoma Symptoms

Often, the first sign of lymphoma is a painless swelling in the neck, under an arm, or in the groin.

- Lymph nodes or tissues elsewhere in the body may also swell. The spleen, for example, often becomes enlarged in lymphoma.
- The enlarged lymph node sometimes causes other symptoms by pressing against a vein or lymphatic vessel (swelling of an arm or leg), a nerve (pain, numbness, or tingling), or the stomach (early feeling of fullness).
- Enlargement of the spleen may cause abdominal pain or discomfort.
- Many people have no other symptoms.

Symptoms of lymphoma may include the following:

- Fevers
- Chills
- Unexplained weight loss
- Night sweats
- Lack of energy

- Itching

These symptoms are nonspecific. This means that they could be caused by any number of conditions unrelated to MG or cancer. For instance, they could be signs of the flu or other viral infection, but in those cases, they would not last very long. In lymphoma, the symptoms persist over time and cannot be explained by an infection or another disease.

I spoke with Barry recently, and he’s in good spirits saying “I’m not ready to check out just yet, and plan to be active in our Fall MG program”. Barry – you’re a great role model and we wish you well – and our prayers are with you from all of us!

Targeting the B cell in Autoimmune Diseases

--By Robert A. Eisenberg, M.D., Professor of Medicine; Chief, Division of Rheumatology, University of Pennsylvania. Dr. Eisenberg is a member of AARDA's Scientific Advisory Board.

Many autoimmune diseases are associated with characteristic autoantibodies, which may serve as diagnostic markers or even cause some of the tissue injury. Since antibodies are made by lymphocytes of the B lineage, it has thus been assumed that B cells play an important role in these conditions, even though the failure to control autoimmune reactions has often been imputed to the other main lymphocyte subset, the T cell. It has become increasingly clear; however, that the B cell itself has a number of immunoregulatory functions that go beyond its task of producing antibodies.

In addition, mouse experiments, particularly with spontaneous models of systemic lupus erythematosus, have indicated that the genetic background that causes the loss of self tolerance is expressed in the B cell itself: that is, the B cell is programmed to produce autoantibodies by its own genes. Of course, the full expression of this program does usually require the interaction with other cells in the immune system.

The leap from identifying the essential role of the B cell in autoimmune diseases to targeting it with

specific therapy became possible in 1997, when a B-cell-depleting monoclonal antibody was FDA approved for the treatment of B-cell lymphomas. Rituximab is a chimeric (mouse/human hybrid) monoclonal antibody that binds to the CD20 antigen found on all B cells (and only on B cells) from early in their development until their final terminal differentiation into high-level antibody producing plasma cells. Patients treated with rituximab experience an almost complete loss of B cells from their peripheral blood, which persists for 6 months or longer.

Investigators from a variety of medical specialties initiated small trials to determine whether rituximab was safe and possibly efficacious in many autoimmune diseases. As of summer 2006, rituximab has been proven to work only in rheumatoid arthritis and is FDA approved for that disease. However, substantial uncontrolled anecdotal data strongly suggests that it may be useful in other diseases, including SLE, autoimmune hemolytic anemia, immune thrombocytopenia purpura, several autoimmune neurologic diseases, Wegener’s granulomatosis, dermatomyositis/polymyositis, membranous glomerulonephritis, and others. In many patients with these diseases treated with rituximab, the clinical improvement that is seen is not necessarily accompanied by a fall in the titers of the autoantibodies in the serum. Thus, the removal of B cells probably blocks functions other than just autoantibody production.

More recently, additional B-cell targeting agents are being tested, with promising results. Epratuzamab is a monoclonal antibody that recognizes CD22, a B-cell specific surface antigen with a distribution similar to that of CD20. Epratuzamab does not deplete B cells from the blood nearly so completely as does rituximab, but its binding to the CD22 molecule probably sends a negative signal that may be important for its potential therapeutic effect. So far, only uncontrolled data are available, but randomized controlled trials are ongoing. Belimumab is a monoclonal antibody that binds and thereby inactivates BlyS, a soluble

protein that normally interacts with B cells to help them survive and proliferate. It is known that removing BLYS-mediated stimulation in animal models prevents autoimmunity. Ongoing trials in humans indicate some therapeutic effect in rheumatoid arthritis and possibly in SLE.

All of these drugs--rituximab, epratuzamab, and belimumab--are monoclonal antibodies, with a high degree of specificity for their B-cell targets. They are part of the larger class of biologicals, which are drugs made from complex physiological molecules. Other examples of this class are soluble receptors. For example, genetically engineered soluble receptors for BLYS can block B-cell stimulation by binding up BLYS and thereby preventing it from interacting with BLYS receptors on the B cells. Several such agents are being developed.

The major side effects of all biologicals usually result from their specific actions, although occasionally a patient can make his/her own antibodies to the drug and have some kind of allergic reaction. It will be important to continue to watch for additional adverse events, such as serious infections.

Overall, the biologicals and, in particular, those that target B cells are offering new options for the treatment of autoimmune diseases. Perhaps in the future it even will be possible to combine such agents, either concomitantly or sequentially, to provide a more effective regimen. Since each patient responds somewhat differently to each drug, it will become increasingly important to be able to individualize treatment. This will require an improved understanding of the drugs= physiological actions and the roles of B cells in disease.

In addition, novel ways of following the effects of the drugs on the disease and on B cells in general will require the development of so-called biomarkers, or laboratory tests which reflect the activity of disease, especially how it is modified by the B-cell targeted drug. Because such biomarkers could provide safe and convenient ways to monitor therapy, they would permit regimens to be modified as needed for optimal results in each patient. We can have

reasonable hope that the not-too-distant future will bring attractive new therapeutic options in autoimmune diseases, comparable to great successes of the anti-TNF drugs in rheumatoid arthritis and other diseases.

Source: Autoimmune Diseases Assoc., In Focus Newsletter, Vol. 14, No. 3, Sept. 2006.

Internet Sites of Interest

The “**Partnership for Prescription Assistance**” may be able to help you obtain free or lower cost drugs from your state if you qualify financially. Call 888-477-2669 or visit www.pparx.org. Those 65 and older with annual incomes less than \$14,700 (single) or \$19,800 (couple) may qualify for additional drug coverage under Medicare at even lower costs.

The International Federation of Pharmaceutical Manufacturers and Associations provides a portal on behalf of its member companies and associations, designed as a single entry, allowing the user to search for comprehensive information on ongoing clinical trials or results of completed trials. Searches can be for a disease or a product name. The advanced search allows terms to be combined or excluded and provides for limitations by country.

www.ifpma.org/clinicaltrials.html.

The University of Iowa’s Hardin Library for Health Sciences provides information about Myasthenia at:

www.lib.uiowa.edu/hardin/md/myasthenia.html and includes pictures of myasthenics at www.lib.uiowa.edu/hardin/md/myasthenia.html#pics.

The **Rural Nurse Organization** provides access to the Clinical Digital Libraries Project which provides information on Myasthenia Gravis through an extensive network of links to information. The Clinical Digital Libraries Project was established in the fall of 1997 as a research, teaching and service effort that seeks to develop and test a model for health sciences libraries to adopt in order to provide professional digital library services to their offsite (including rural) clinical users.

<http://ruralnurseorganization-dl.slis.ua.edu/clinical/neurology/neuromusculardisorders/myastheniagravis.htm>

E-medicine provides an article discussing Myasthenia Gravis written as a part of medical training in ophthalmology for the general practitioner. The authors include information on the pathology of MG, its frequency, the physical symptoms, causes, diagnosis, care and treatment.

www.emedicine.com/oph/topic263.htm.

MG Medication Assistance Programs

Contact information for patient assistance programs for some MG related medications:

CellCept – Have your prescribing physician call Roche Pharmaceuticals at 1-800-772-5790 for an application.

Cyclosporine (Sandimmune & Neoral) – For more information, call the Novartis Assistance Program at 1-800-277-2254.

Mytelase – For more information call Sanofi-Synthelabo at 1-800-446-6267.

Mestinon – Valeant Pharmaceuticals Indigent Patient Assistance Program (IPAP), call Melissa Noble at 1-800-548-5100 extension 3349 for more information on their program or an application.

Congressional Give-away to the Pharmaceutical Industry

The pharmaceutical industry publication, “RPM Report” recently reported expected increases in revenue of \$2 billion additional dollars as a result of transferring 6.4 million Medicaid patients to Medicare for drug coverage. Under Medicaid, the drug companies were required to charge the government their lowest price – but under the new law, drug companies can charge whatever they want. And of course, the drug companies haven’t wasted any time in doing just that.

According to a University of Minnesota study by Stephen W. Shondelmeyer, the government is now paying 20%-30% more for most prescriptions under the new Medicare rules. For the 12 months through March of this year, drug prices have increased over 6% - twice the rate of inflation! By

allowing the pharmaceutical companies to charge the maximum, with volume discounts specifically outlawed, Congress has awarded the drug companies with an extra \$2 billion. And, of course, the American taxpayer will foot the bill. But that's all right, isn't it?

MED NOTES

Review Suggests Heart Checks in MG

People with myasthenia gravis (MG), a disease in which the immune system attacks the part of each muscle fiber that receives nerve signals, aren't usually told they're at risk for heart disease. But researchers at the Cooper Hospital/University Medical Center of the Robert Wood Johnson Medical School in Camden, NJ, say they recommend that physicians set a "low threshold for pursuing cardiac investigations in patients with MG with unexplained fatigue or exercise intolerance, especially if disproportionate to other signs of MG."

In a comprehensive review of some 60 studies of MG and heart abnormalities conducted since the early 20th century, the authors found that various types of abnormalities are probably more common in this disease than they are in the general population.

Maya Guglin and colleagues say that inflammatory heart disease (myocarditis), rhythm disturbances, blocks of conduction signals through the heart, contraction abnormalities, and cardiac disease secondary to respiratory dysfunction have all been noted in people with MG over the years. They caution that many of the studies were conducted without taking into account the patients' ages and other factors besides their MG that may have contributed to their heart problems. And the diagnostic criteria for MG have changed, meaning some patients may have been included in MG studies in past decades that wouldn't have MG by today's criteria.

Nevertheless, the article, published in the June 2003 issue of the *Journal of Clinical Neuromuscular Disease*, sounds a cautionary note and suggests a need for further investigations to determine the scope and possible causes of heart disease in MG patients.

Source: AMPS: Quest Jan-Feb. 2004. Reprinted from Pacific Northwest Chapter, MGFA. Fall/Winter 2005.

Losing by Snoozing

MG patients who need plenty of rest should be pleased to know that getting about 7 hours or more of sleep every night may help them maintain their weight, if not lose weight.

A Case Western Reserve University study what included 16,000 middle-aged women found that those who slept 5 hours or less each night were more likely to gain significant weight. Sleeping less apparently affects the resting metabolic rate – the number of calories burned during sleep.

The results of the study were presented by Dr. Sanjay Patel, M.D. at the May meeting of the American Thoracic Society International. Dr. Patel said other research suggested similar findings for men. So make sure you get plenty of those zzzzzzz's!

Dementia, Alzheimers – and Exercise!

All of us want to live to a ripe old age – preferably a healthy one – and wouldn't you know it, exercise is going to be one of the essential ingredients needed to get there! However, the National Institutes of Health reports on a potential obstacle to those "golden years."

Alzheimers, primarily affecting the "older generation", now includes 4.5 million Americans, 5% of whom are 65 to 74, and 50% of those over 85! A half million Americans report some form of cognitive impairment between 55 and 64.

Now, researchers are finding that exercise may help delay the onset of symptoms. Dr. Eric B. Larson, M.D. of the University of Washington, and author of the study is quoted as saying, "Physical and mental performance may go hand-in-hand, and anything you can do to improve one is likely to improve the other."

The study covered nearly 2300 participants over a 6 year period, and found that **those who scored high on physical activity tests were 3 times less likely to develop dementia** than those who scored low. Those who

scored poorly on the tests were more likely to develop dementia.

Some form of daily exercise, no matter how little, will also improve the MG patient's overall health as well as building a possible defense against Alzheimers. Check with your doctor first and ask for a referral to a physical therapist who can work out a graduated program for you and get you started under supervision. The therapist will also keep you and your doctor informed about your progress. Now you've got a team! So get moving!!

Source: Archives of Internal Medicine (22 May 06)

NUTRI-NUGGET

Dietary Evaluation

Here's a chance to check by way of the internet on your "diet" – that is to evaluate your food intake in comparison with USDA's Dietary Guidelines and Food Pyramid. An interactive website, www.mypyramidtracker.gov, enables you to enter all the foods you eat in one day – as well as your weight, age and other personal data, and the program will score the overall quality of your diet. It will tell you not only how many calories you consumed but how many you should be consuming to either maintain or lose weight – as well as the total fat, cholesterol, vitamins and minerals consumed. To get a better picture, you can enter more than one day's food intake and by actually measuring the food intake get a more accurate picture. The program will also provide an analysis of your daily physical activity level and estimate how many calories you're burning. So check it out!

Final Thoughts

It is in the loving –
not in being loved –
The heart is blessed;
It is in the giving –
Not in seeking gifts –
We find our quest. – Anon

***You can teach more with
your life than with your lips***