

Parkinson's Patients Support Groups, Inc.

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Groups Are Key to Good Health

ScienceDaily (Sep. 10, 2009) — The quality of a person's social life could have an even greater impact than diet and exercise on their health and well-being. There is growing evidence that being a member of a social group can significantly reduce the risk of conditions like stroke, dementia and even the common cold.

New research by the Universities of Exeter and Queensland, Australia, shows that membership of social groups has a positive impact on health and well-being. The work highlights the importance of belonging to a range of social groups, of hanging onto social groups, and of building new social groups in dealing with life changes such as having a stroke and being diagnosed with dementia.

Writing in *Scientific American Mind*, the researchers from the Universities of Exeter, Queensland and Kansas review a number of previous studies, including many of their own, which identify a link between group membership and physical and mental health. Some more recent studies which support the same conclusion are presented by the Exeter-based researchers at the British Science Festival. Commenting on this work, Professor Alex Haslam of the University of Exeter, said: "We are social animals who live and have evolved to live in social groups. Membership of groups, from football teams to book clubs and voluntary societies, gives us a sense of social identity. This is an indispensable part of who we are and what we need to be in order to lead rich and fulfilling lives. For this reason groups are central to mental functioning, health and well-being."

These conclusions are based a number of recent studies which were reviewed in the article and presented at the Science Festival. These included:

- A 2008 study (published in *Neuropsychological Rehabilitation*) of stroke sufferers. This showed that being able to maintain valued group memberships played as important a role in positive recovery as an ability to overcome cognitive

difficulties (e.g., problems with memory and language). After their stroke, people's life satisfaction increased by 12% for every group membership that they were able to retain.

- A 2009 study (in press at *Ageing and Society*) of residents entering a new care home. This showed that those who participated as a group in decisions related to the decoration of communal areas used those areas 57% more over the next month and were far happier as a result. In contrast, the use of space by residents in a control group declined by 60%. Moreover, these differences were still apparent three months later.
- Another 2009 study (under review at *Psychology and Aging*) looked at the impact of group interventions on the health and well-being of 73 people residing in care. After a period of six weeks the researchers found that people who took part in a reminiscence group showed a 12% increase in their memory performance, while those who received individual reminiscence or a control intervention showed no change.
- Another 2009 study (in press at the *Journal of Clinical and Experimental Neuropsychology*) also studied nursing home residents and looked at the relationship between their sense of identity and well-being and the severity of their dementia. The study's key finding was that a strong sense of identity associated with perceived membership of social groups, was a much better predictor of residents' well-being than their level of dementia.

Summarizing this and other work in the article, Professor Jolanda Jetten from the University of Queensland commented: "New research shows just how important groups and social identity are to well-being. This is something that people often overlook in the rush to find medical solutions to problems associated with ageing, but

it is time that these factors were taken much more seriously."

Dr Catherine Haslam of the University of Exeter, another of the works' co-authors, agrees: "On the basis of what is now a very large body of research we would urge the medical community to recognise the key role that participation in group life can play in protecting our mental and physical health. It's much cheaper than medication, with far fewer side effects, and is also much more enjoyable."

Urgent Message from American Academy of Neurology: Contact Congress Now!

The Health Care Reform debate is well underway in Congress. With the House and Senate both considering legislation, now is the time to act to ensure the voice of Neurology is heard.

Although there are many issues being considered, including the elimination of the flawed Sustainable Growth Rate formula that cuts physician reimbursement under Medicare each year, one issue stands out specifically for Neurology: Primary Care Bonuses. Both the House and Senate are considering providing bonuses to physicians who provide "primary care services." How Congress will define who will be eligible for these bonuses is not yet clear, making it vital that Capitol Hill hears your voice!

Over 60% of services that neurologists provide are for Evaluation and Management (E&M) services, which places Neurology in a very small group that includes primary care, geriatrics, and pediatrics. Congress is considering a Primary Care Bonus to offset the inequities in our current procedure-biased reimbursement system. The Academy is committed to placing neurology in the small group adding value to the important service you provide to your patient's health and disease management. Today you can add your voice to remind Congress to add neurology to the list of specialties deserving of such a bonus.

Please send a message to your members of Congress describing the kind of care that neurologists provide so Washington will understand that any bonus provided for primary care services needs to include Neurology! With just three clicks, you can send an email letter of support to your member of Congress. Your voice is powerful and helps our patients and our profession. Thank you for all of your support!

[Contact Congress Now!](#)

Utilizing Fava Beans for Parkinson's Disease Treatment: A Learning Experience from a PD Patient

By Chi-Wei Lin, Ph.D.

It is well known that certain plants such as velvet bean (*Mucuna pruriens*) and fava bean (*Vicia faba*) are natural sources of L-dopa, the main drug for treating Parkinson's disease (PD). However, there is very little data available to indicate that L-dopa from these natural sources is actually effective in PD management. In this communication, I describe my learning experience in the use of the fava bean and the strategy developed to achieve its effective use for my own PD.

I have a background in science and medicine (Ph.D. biochemistry; a cancer researcher for 28 years). I was diagnosed with PD eight years ago (2001), when I was 65. I started L-dopa therapy in January of 2006, and since May of 2006, I have been taking fava beans continuously as a supplement for L-dopa.

Maximizing the Brain Uptake of L-dopa

Ordinarily, L-dopa in blood circulation is quickly broken down before it can enter the brain where it is converted to the neurotransmitter dopamine. Two enzymes are responsible for breaking down L-dopa in the blood: dopa-decarboxylase (DDC) and catechol-O-methyl-transferase (COMT). More than 90% of L-dopa is broken down before it can pass through the blood-brain barrier and enter the brain.

Fortunately, there are medicinal chemical inhibitors available which block the activity of these two enzymes. Carbidopa (Lodosyn) is an effective competitive inhibitor. With carbidopa, the amount of L-dopa taken up by the brain can be increased to about 30%, and with both carbidopa and entacapone, up to 60%. The drug Sinemet is L-dopa with carbidopa. and Stalevo is L-dopa with both carbidopa and entacapone.

Research has established that a ratio of about 4 to 1 between L-dopa and carbidopa produces the optimal effect to inhibit DDC. This ratio is maintained for all different dose levels of Stalevo and Sinemet. On the other hand, the action of entacapone on COMT is non-competitive, so a sufficient level of entacapone in the blood needs to be maintained, independent of the dose level of L-dopa, to inhibit the COMT effectively.

The use of these inhibitors has greatly increased the efficiency of chemical L-dopa in PD management. Assuming that DDC and COMT act similarly on the L-dopa from fava beans, one should be able to utilize the

same inhibitors to enhance brain uptake and achieve an effective use of L-dopa from natural fava beans.

One problem in using fava beans for PD is that it usually requires one to take too many beans to produce an effect. Fava beans contain a maximum of about 5% to 6% of L-dopa on a dry weight basis.

Since, without inhibitors, most of the L-dopa is broken down so that less than 10% is taken up by the brain, one can estimate that to achieve an effectiveness equivalent to one Stalevo 100 (L-dopa/carbidopa/entacapone: 100mg/25mg/200mg), one must consume about 120g or about a quarter pound of fava beans. Most early- to mid-stage PD patients take Stalevo three or four times a day. To achieve an equivalent result, one would need to eat about a pound of fava beans a day. Most people find this level of bean consumption intolerable. However, if carbidopa and entacapone are taken with fava beans in proper dosages, it is possible to enhance brain uptake of fava bean L-dopa and reduce the amount of beans needed to 1/5 or 1/6 pound per day. This allows for the use of natural fava bean for PD treatment.

Use of Capsulated Dry Bean Powder for Consistency and Convenience

Other problems with the use fava beans for PD are inconvenience and inaccuracy. Eating fresh fava beans several times a day for a long period of time (years) is inconvenient, and it is difficult to control the L-dopa dosage. A constant supply of fresh beans may not be always available. Each batch of beans may contain different levels of L-dopa.

To overcome these problems, I converted fresh fava beans into dry bean powder, analyzed L-dopa content in the powder, and packaged the correct amount of the powder in capsules to contain a known amount of L-dopa.

The procedure I have been using to make the capsules involves obtaining a large batch of fresh fava beans, enough for more than a year's supply, from a local organic farmer in the spring. The beans are dried in a food drier and then ground into powder with a coffee grinder. Each capsule contains 25mg of L-dopa, based on the result of L-dopa analysis.

With these capsules, I can take fava beans anytime, day or night, at home or away. I also know how much natural L-dopa I have taken and am able to maintain an accurate and constant L-dopa dose from this natural source.

Analysis of L-dopa Content in Fava Bean Powder

The L-dopa content in each batch of dried bean powder was analyzed using a HPLC (High Pressure Liquid

Chromatography) technique, and using purchased chemical L-dopa as the standard. (I will not go into the technical details of this analysis.) My dried bean powder from different batches usually had an L-dopa content of around 5% on a dried weight basis (10g of fresh beans yielded about 1g of dried bean). Therefore, each 500mg capsule contained about 25mg of L-dopa.

My Experience in Using Fava Beans

I was diagnosed about eight years ago (2001) with early Parkinson's disease.

My main symptoms were rigidity, lack of balance, and an overall feeling of anxiety. I did not, and still do not, have a tremor. For several years my treatment was selegiline (Elderpryl), Amantadine, and Mirapex.

Most of this time I had varying degrees of sleep difficulty. My neurologist encouraged me to try alternative remedies for my symptoms. I added Coenzyme Q-10 (300mg/day), N-acetyl-L-cysteine (a precursor of glutathione), vitamin E, ginkgo biloba, and several commercial fava preparations for various lengths of time. I also had acupuncture for about a year. However, there was no indication that any of these things benefited me.

In early 2006 I added Stalevo to my medications, at 150mg/day (3x50mg) initially. At about the same time, I decided to make a more concerted effort to explore the usefulness of fava beans for PD by making capsules from a large batch of beans.

Between January and February of 2007, when Mirapex was gradually eliminated as it caused intolerable drowsiness, fava bean L-dopa dosage was increased from 75mg to 150mg/day (from 3 to 6 capsules). My dosages of L-dopa from both Stalevo and fava beans have since increased to levels wherein most of my symptoms have disappeared.

I now take 600mg/day of L-dopa from Stalevo and 375mg/day of L-dopa from fava beans. To maintain a constant level of medications in my blood all the time, I divide my medications into six portions and take them every four hours, day and night.

Over the past two years, I have been almost asymptomatic and able to lead an active and normal life, including playing tennis, driving, gardening, and carrying out the duties of mayor of my small town. I have not experienced any significant sleeping disorder, "on-off" phenomenon, or dyskinesia.

As a potential indication for progression of my PD, my total L-dopa dosage has increased from 700mg (500mg

from Stalevo and 200mg from fava beans) to 925mg (600mg from Stalevo and 326mg from fava beans) per day over the past 20 months.

There have been no serious side effects after more than two years of using fava beans continuously. Taking 15 fava bean capsules a day, I occasionally experienced uncomfortable bloating, especially when the bean was taken on an empty stomach. Since I reduced my late evening and night fava bean capsules, the problem has markedly subsided.

Until recently, after taking fava beans for almost two years, I did not have any real indication that I had actually received clear benefits from it. However, two events that occurred recently finally gave me indications that I was indeed benefitting from the fava bean capsules. The first was about a year ago. I felt the need to increase my L-dopa dosage while I was on 600mg of L-dopa from Stalevo and 250mg of L-dopa from fava beans. Instead of increasing the Stalevo dosage, I increased fava bean L-dopa to 375mg (from 10 to 15 capsules) per day. This was enough for me to regain my overall physical condition and mental attitude. I've been on this dosage for the past eight months.

The second event was in early December 2008. I decided to see whether completely eliminating fava beans would have an effect. This would provide a more definitive indication of their effectiveness. I reduced my fava bean intake gradually from 15 to 0 capsules over six days, while staying on the Stalevo at 600mg. I felt no effects for three days without fava beans. I was able to carry out my normal activities, including playing tennis. However, on the fourth day without fava beans, I felt normal in the morning, but at about 2 p.m. there was a rapid return of many of my PD symptoms. The first was the feeling of anxiety, followed by stiffness in my legs and lower back, and rapid loss of strength and mobility. I felt tired, but was not able to fall sleep. I developed shortness of breath, had sore shoulders and tired arms. All these symptoms developed in under two hours. At 4 p.m. I felt uncomfortable enough to end the trial. I took one Stalevo 100 tablet at that time and another Stalevo 50 half an hour later. By 5, most of the symptoms disappeared, although I was still tired and slow. I slept poorly that night and was tired the next day. Normal feelings returned several days later, after I resumed my fava bean supplement regimen.

A fundamental premise of herbal medicine is that in the same plant material, there may be other components, in addition to the active components, which may act synergistically or complementally to enhance the therapeutic effectiveness and/or reduce side effects of the active components. This synergistic action or counteraction

against side effects likely will not occur with chemically synthesized compounds or may be lost when extraction procedures are used to isolate or concentrate the active components from the natural sources.

In the case of L-dopa for PD, velvet bean and fava bean are only two known natural products found to have significant concentration of L-dopa, as the results of extensive searches involving hundreds of plant species. Each of these has a maximal L-dopa content of about 5% in their natural states. At this concentration, effective use of these beans for PD treatment is limited, since great amounts of bean consumption are needed to reach therapeutic effectiveness.

But by enhancing the brain uptake of L-dopa in these natural products with the use of enzyme inhibitors, dosages of bean uptake can be reduced to tolerable levels. This approach opens a number of possibilities for using the natural source of L-dopa in a number of PD treatment strategies.

Potentially, with enzyme inhibitors, fava beans may be used as the sole source of L-dopa in early stages of PD when L-dopa dosage requirements are low. This application may delay the use of chemical L-dopa, until the amount of bean required exceeds the amount tolerable.

Alternatively, as in my case, fava beans are useful in combination with Stalevo to reduce Stalevo dosage. With this combination, I may benefit from a pure synthetic chemical for its effectiveness and from an untreated natural plant material for a potential synergistic and/or counter side effect, and possibly, long-lasting action.

Further, it is well known that natural medicines metabolize differently from their chemically synthesized counterparts. Drugs from natural sources tend to act more slowly and last longer. In cases of advanced PD, the fast action of chemical L-dopa has widely been speculated to be the cause of dyskinesia in L-dopa therapy. Therefore, one should consider the possibility of replacing a portion of the chemical L-dopa with slow-acting and long-lasting fava bean L-dopa as a strategy for eliminating or reducing dyskinesia in the treatment of advanced PD.

Although my experience has indicated to me that fava beans have been useful in the management of my symptoms, because PD is a complex disease with significant variations among individual people, each patient must consult his or her neurologist before embarking on the use of fava beans.

Log on to www.ppsg.org

Hospice: Care for the Whole Family

By Georgia Rock,
Vice President of Hospice

When a person receives a diagnosis of a life-threatening illness, it creates a huge ripple of change throughout that person's life and that of their families and friends. Patients and families facing a serious illness continually have to make decisions about care and options. As a disease progresses, such as with Parkinson's, it can be daunting to make these choices.

Choosing hospice care can be one of the more difficult decisions a family has to make on behalf of a loved one. Hospice is often equated with giving up on a family member who has a life-limiting illness. Hospice is not about giving up, but taking control. When the end of a person's days may be in sight, hospice does all it can to ensure that life continues with as little disruption as possible. Choosing hospice is the time for a patient and his or her family to ask themselves how do we want to say goodbye? What lasting memories do we wish to create?

It is never easy to say goodbye to a sick and dying family member or friend. Hospice can transform this incapacitating time of pain, fear and loss into a time of love, growth, and care.

The Hospice philosophy focuses on comfort care rather than a curative approach. The service provided by a hospice agency begins with measures to provide pain and symptom management. But, more importantly, when hospice manages uncomfortable symptoms, it can restore a degree of normalcy in a dying person's life—the patient can become a person again, and perhaps get a chance to paint the final touches on the canvas of his or her own life.

More than 1.4 million people were served by the nation's hospice programs last year. In a recent study of 4493 patients, published in the March 2007 issue of the *Journal of Pain and Symptom Management*, it was found that those admitted to hospice lived an average of 29 days longer than those who did not have hospice care. When every day becomes precious, another month is a treasured gift.

Originally serving mainly cancer patients, hospice has progressively been serving more non-cancer patients. The most common non-cancer diagnoses are conditions such as dementia, end-stage Alzheimer's, and Parkinson's diseases, followed by cardiovascular disease.

These changes in hospice patient trends have created challenges for physicians, patients, and families facing

end-of-life issues. These issues can include difficulty in estimating the remaining length of life, timing appropriate discussions about hospice, and long-term care concerns. Often these concerns can delay admission to hospice, but invariably, family members often wish they had admitted their loved one into hospice earlier due to the support and care received.

It is common for family members to express to us that they wish they had known about hospice care earlier as their loved ones disease progressed. Hospice supports the whole family and often brings support and relief to all involved with the care of a seriously ill patient.

What to expect when a loved one is admitted into hospice?

A patient becomes hospice appropriate when it is apparent that a cure is no longer a possibility, and the patient has been given a life expectancy of six months or less. The qualifying criteria from Medicare changes for different diseases and for multiple diseases. Hospice can improve the quality of care and provide comfort and dignity. If an individual survives longer than six months that does not mean that discharge from hospice will occur. The patient's need for hospice will be reevaluated at this time.

Some of the criteria for Parkinson's disease include immobility, impaired function, incontinence, and other parameters, e.g., recurrent infections, low albumin, etc. A patient with Parkinson's disease whose disease has progressed to the point that they are rendered "immobile, mostly unresponsive, incontinent, and physically wasted" would most likely qualify for hospice.

Upon admission to hospice, the patient and family are connected with a hospice team. This team focuses on meeting the medical, emotional, and spiritual needs of the patient and family. The patient's condition, cultural background, and personal preferences play a major role in the tone and direction of care.

Along with family members, the hospice team led by a nurse, includes a social worker, personal care aide, spiritual care counselor, physician and volunteer. A plan of care is developed based on input from all team members, including the patient. The patient's regular doctor, or primary care physician, is still in charge of the patient care and works in partnership with the hospice doctor on decisions about medications and pain management. The hospice team makes regularly scheduled home visits, and is on call and available 24/7 for consultation. Although the team is not a replacement for family members or caregivers, they will arrive at a patient's home in times of

need or when a caregiver needs additional support or education.

Who pays for hospice?

If your family member's health insurance is Medicare, a senior HMO or Medi-Cal, they are entitled to hospice care benefits. Anyone with Medicare Part A is entitled to the Medicare Hospice Benefit, which covers many of the medical costs associated with hospice care. This includes visits from all Hospice team members, medication, equipment and supplies related to the terminal diagnosis.

Hospice care supports the entire family

Hospice is designed to support the entire family physically, emotionally and spiritually. The hospice team provides compassionate care and reassures the patient and family members that they are not alone during a difficult time. The family also has the comfort of knowing they have access to skilled and caring professionals that can help them understand what to expect, and provide them with ideas on how to cope. The support continues throughout the process and continues with bereavement services as the family grieves their loss.

Most importantly, hospice can be a time where a loved one is stabilized and their pain is optimally managed. Family and friends have more time to share memories and reminisce, to forgive and be forgiven, to say thank you, reassure one another, and say "I Love You" and "Goodbye."

Pathways Home Health, Hospice & Private Duty is a non-profit community based organization with one mission: to provide, high quality patient and family-centered home health and hospice care, promoting comfort, independence and dignity. Pathways cares for patients in their place of residence whether it be their home, hospital, nursing home or assisted living facility. Founded in 1977, Pathways now serves over 5000 families annually in five Bay Area counties. Pathways is accredited by The Joint Commission and is a member of the Visiting Nurses Association of America, California Hospice & Palliative Care Association, and the National Hospice & Palliative Care Organization.

Side bar story

More than 1.4 million people were served by the nation's hospice programs last year. Yet for every person that received hospice care, it is estimated that another individual would have benefited from the services of hospice but didn't get this compassionate care at the end of their life.

There are eight key messages about hospice care that everyone, healthcare professionals and the public alike, should understand.

1. In California, hospice is not a place but a special kind of care focusing on relief of pain, symptom control, and spiritual and emotional support. Care goes out to the patient and family caregivers.
2. Hospice is not about "giving up" but instead focuses on quality of life, making the wishes of the patient and family caregivers a priority.
3. The majority of hospice care takes place in the home, where the person can be surrounded by family and familiar settings. Yet inpatient services are available if symptoms cannot be properly attended to at home.
4. Hospice costs are covered by Medicare, Medicaid in most states, and by most insurance programs and HMOs.
5. The expenses of all medicines related to the life-limiting illness are covered under the Medicare Hospice Benefit.
6. Hospice provides support and caregiving training to family caregivers in the home.
7. Bereavement support is available to families for a year after the death of their loved one.
8. The most common statement made by families who chose hospice for their loved one is, "we wish we had known about hospice sooner."

For more information visit Pathways at <http://www.pathwayshealth.org> or info@pathwayshealth.org or call 1-888-755-7855.

PD Dance: Poetry in Motion

Date: Tuesdays

Time: 10:30 am- 12 noon

Location: The Parkinson's Institute

These ongoing classes in movement to music are designed for persons with Parkinson's disease. Emphasis is not on disability but on current ability, enjoyment of music, recreation, exercise, and socializing.

Dance and movement instructor, Damara Ganley, has had PD/Dance training.

Admission free - Caregivers welcome

Students at wheelchair level must bring a care partner

Call **408.734.2800** to register now!

This newsletter is assembled by The Morgan Center.

Thank you!

Gait and Balance Classes at the PI

The Gait and Balance Classes at the Parkinson's Institute are great and fun. Come check them out!

The **Beginning Classes** run on **Thursdays** and the **Intensive Classes** run on **Wednesdays**. Both classes run from **10:30 to 12 noon**. A donation of **\$10.00 per session** is suggested. The classes are held at The Parkinson's Institute, at 675 Almanor Avenue, Sunnyvale, CA 94085. Please call **408.734.2800** if you have any questions.

PPSG Board Meetings

You are welcome to drop by our board meetings and share ideas with us! We meet on the **3rd Monday** of the month between **1:00 and 3:00 PM** at the Parkinson's Institute, at 675 Almanor Avenue, Sunnyvale, CA 94085. To confirm meeting dates and time, please call us at **408.542.5610**. If you are planning to attend, please call Charmaine Eng at 408.723.8116 (dial *82 before the number).

In Memory

Donations were recently received in memory of the following individuals: Thereso S. Limpin, Paul Smith, Gus Sotir, and Howard Wan.

In Honor

A Donation was recently received in honor of the following individual: Charmaine Eng.

Thank you so much for your donations! Please use return address labels, to help us acknowledge your donation properly. Your generous contributions go to support newsletters, education and community awareness of Parkinson's disease. Please mail your donations to: PPSG, P O Box 60188, Sunnyvale, CA 94088

October 8: A Free Seminar for Newly Diagnosed Patients and their Care-partners, at the PI

During the past two years, have you or your loved one received a diagnosis of Parkinson's disease? Have you become a patient of the Parkinson's Institute or Clinical Center?

If so, please join us for an informational session at the PI. Participants will receive education and support from our specially trained staff.

The seminar will be held on **October 8, 2009, from 1:30 to 3:30 pm**.

To reserve your seat, please call **Gloria** at **408.734.2800**.

Upcoming Conferences from APDA

The American Parkinson Disease Association (APDA) National Young Onset Center and the National Parkinson Foundation (NPF) Young Onset Parkinson Network are co-sponsoring a series of conferences for those living with young onset Parkinson's disease and their caregivers. The first conference will be held **October 23-24, 2009 in Dallas, Texas**. The second event is slated for **the spring of 2010 in Sacramento, CA**.

Each conference will kick off with a Friday evening welcome reception and be followed by a full day of presentations featuring national experts on a wide range of topics particularly relevant to younger people with PD. While the overall structure of the events will remain the same, new information will be presented in each of the four locations.

In order to make the Dallas program accessible to as many people as possible, some segments will be Web cast live and will be available for download following the event through the APDA and NPF Web sites. Visit the APDA National Young Onset Center Web site (www.youngparkinsons.org) or the NPF Web site (www.parkinson.org) to register for the Dallas conference, arrange to participate in the live Web cast, or to learn more about Sacramento program details as they become available.

Visit our PPSG website: www.ppsg.org for the following:

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To find out information on Parkinson's support groups and exercise classes, please log on to www.ppsg.org.

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Pay Less for Medications:

Partnership for Prescription Assistance:

A coalition of pharmaceutical companies, health-care providers, and patient advocacy groups that helps patients get free or discounted medications. Ninety-eight companies provide 2,500 drugs, from Advair to Zolofl. Since its launch four years ago, the PPA has helped supply \$14 billion worth of prescription drugs to 5.7 million people. Typically, a family of four earning about \$40,000 is eligible. To find out if you qualify, go to **PPARX.org. (888) 477-2669**

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This free prescription drug card program is produced to help all Americans cut their prescription drug costs. Simply go to www.yourrxcard.com and download your FREE Prescription Drug Card and receive savings of up to 75% at more than 57,000 national, regional, and local pharmacies. Benefits of the Card: no deductibles, no waiting periods, no pre-existing exclusions, everyone qualifies, instant activation, and membership is free. **(866) 561-1926.**

www.FresnoParkinsons.org

Truth for Living

The more generous we are,
The more joyous we become.

The more enthusiastic we are,
The more productive we become.

The more serving we are,
The more prosperous we become.

-William Arthur Ward-



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