

Worse after sct and tx. Numbness, burning, shooting pains and sensory loss. Also had extreme swelling. Pain meds help. I have learned to live with it. Massage helps and seems to desensitize feet and hands especially. I take plaquenel (a malaria med) for swelling and inflammation, which has mostly resolved that.

Frances V: My hubby had it bad. He took Lyrica. He would not let me touch his feet to rub them with anything. Pain meds helped some.

Patti S: Howard has it in his hands and feet. He takes tramadol and gabapentin. He wears a fentanyl patch and takes oxy for the breakthrough pain. Sounds like a lot, but keeps it down.

Julie W: I've had it forever it seems and it's HORRIBLE!!! Started out on Amitriptyline and Neurontin. When I maxed out on those, they changed me to Lyrica. The Lyrica worked GREAT, but made me a disoriented mess and I couldn't drive! But I had to go back to original meds, but they didn't work anymore! I was changed to Nortriptyline and Neurontin and have gotten about 80% relief! I had my first visual of how bad my feet have gotten yesterday. I bumped my foot on a chair. It didn't hurt at all. I went to the bathroom, came back out and when I reclined in my chair, I noticed that half my nail was gone on that toe! I didn't feel it at all...still don't!

Pamela C: My husband Sam has neuropathy in his feet... That's actually how we found out he had multiple myeloma. Thankfully, it's been three years and two back-to-back transplants later, but the neuropathy hasn't worsened. At night he puts Vics Vapor rub on his feet and slips some socks on. I breathe better and he sleeps better. Sounds weird, but it helps the stinging.

Donna D: Cymbalta 60 mg every other day. Walking and exercise.

Kathy C: I just have smoldering multiple myeloma – MRI's a few weeks ago show no myeloma and lab work O.K. But I have the peripheral neuralgia and lots of arthritis pain. My doctor put me on cymbalta about 6-8 weeks ago but I hate the dizzy groggy feeling (60 mg).

Sandy W: I got neuropathy in my feet and ankles from taking thalidomide. I take Lyrica for it. I was taking 600 MG a day but I cut back to 150 at night and just live with the discomfort during the day.

Lillie K: I take neurotin 300 mg 3 or 4 times a day. It helps some. I can sure tell when I haven't taken the neurontin. I have the burning pain yet numbness. It is worse in my feet & hands. My back hurts very badly.

Dorothy G: I take 400mg 4x a day of gabapentin every day, I also take topamax along with that, 200mg every day.

Chris G: I take gabapentin and duloxetine (Cymbalta) and that helps as long as I am not on my feet for too long on hard surfaces. I have not found any shoes that I can tolerate very well. The cushioning always seems to be in the wrong place...the heel, not the ball of the foot.

Joanne V: Yup and nothing works. I will not put anymore toxins in my body.

Julie v: I had neuropathy really bad for months after my auto SCT. It slowly subsided over the years, but never fully disappeared and continues on, as I continue on with Revlimid 10mg. Best advice I have... keep moving as best you can! WALK, walk, walk!! And HYDRATE all the time! Water, water, water and I also mix 100% cranberry/juice blends with water and sparkling water.

Lin C: I did, as I get further out from chemo, it seems to be dissipating. I feel blessed!



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Frederick D: For neuropathy make sure that you take ALL B VITAMINS. They are important for nerve function. STANDARD PROCESS is the gold standard for quality vitamins. Their vitamins are 100% all natural and contain B4 which is missing in most all commercial vitamins. Alpha or R-Lipoic Acid, N acetyl cysteine, I carnitine- excellent anti oxidants to prevent free radical damage. Also consider taking serrapeptase or nattokinase for proper blood circulation.

Diana L: gabapentin

Dave F: I take Gabapentin, which takes the edge off of it but I still have numb toes. I was prescribed EMLA cream and it works ok but it's a bit messy to apply.

Lizzy S: Peppermint essential oils mixed with fractionated coconut oil rubbed on my feet and calves every morning. I never go barefoot. In the summer, I live in flip flops and in the winter, it's Uggs all the way.

Mike H: I had neuropathy so horribly by the time I went home after ASCT I couldn't return to work. Tried gabapentin, lyrica & cymbalta. I finally went to a higher dose of cymbalta to keep it reigned in, but still need oxycodone to be able to have a sort of normalcy.

Angela W: I take metanx or L-methyl B6-B12. It seems to help some. I still use a pain patch that I hope will come off soon.

Bianca B: I'm using Bebapentin. It does help but I still feel it, especially at night.

Migdalia B: My husband takes oxyconden and oxycontin for the pain!

Aliece T: I take the OxyContin and Lyrica when pain is at its worse, which is usually in middle of night. My husband has to massage my hand and I run it under hot water.

Sarah L: I have neuropathy in my forefoot. Fortunately it's the numb kind, not the pain kind, but occasionally the nerves get irritated and it itches like crazy. The only thing that helps that is Bert's Bees hand salve. I think the eucalyptus oil in it is soothing to the nerves.

Kim S: Vitamin B6 has helped me. I was also told fish oil and amino acid helps.

Kevin G: I have it BAD as well. I went to a pain doctor and I'm doing a thing called NEUROSTIMALTION THERAPY. It basically tricks your brain from feeling the pain. Two small (50 cent piece size) probes in your back. One up by the shoulders and the other by other hips. Sends electric pulses that you can control the speed and strength to your hands and feet. No need for Fentanyl patches or OxyContin anymore. It does wonders for the pain

Mark B: I have it bad after my recent stem cell transplant. I have tried icy hot patches on my feet, tylenol, and nuerontin. I was also told to try riding an exercise bike to increase blood flow which help a little but that was before my transplant. I haven't found a solution.

Kevin G: Exercise helps me (walking and riding a bike), lots of WATER 12oz an hour that is what I try to do. I'm in the restroom a lot.

Lisa K: I do IVIG and I take 1800 Gabapentin. I also take 15 MG morphine sulfate as needed at bed time 50 Nortriptyline.

Maria P: My husband has it really bad to the point where it's too painful to walk. Gabapentin did not work. Lyrica was 150.00 on my insurance (couldn't afford it). Heating pad works temporarily. He takes morphine 25mg in the am and 25mg in the pm, also dilaudid 4mg as needed, b complex and lots of water. He's up trying to walk a little more than before. We were told not to be inpatient it will get better.

Donna F: Gabapentin works for me. It was so bad in my feet I couldn't even walk. If I try to cut back I can tell the

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- MAFB (14;20) Group
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- CCND1 (11;14) Group
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- Myeloma Patients with Chromosome 13 Deletion Group
- Myeloma Patients with Chromosome 17 Deletion Group
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difference right away!!

Michael C: I had neuropathy and they prescribed Gabapentin. Had it for about 3 months then it just went away.

Sonya L: Lyrica, Alpha lipoic acid, oxy...

Teddy T: I use Gabapentin too and I also wear socks to bed and that helps at night. If your feet are worse when lying down then what's happening is it's in your back that's triggering the neuropathy. Our vertebrae deplete with MM and it might be causing a pinched nerve that's hitting your feet. I notice if I move around and add more pillows, I can get comfy. If you get up and the pain goes away when you walk around, then it's in your back so tell the doctor and maybe they can get you some shots of steroid from a pain clinic. It works for me and I also noticed my Neuropathy isn't as bad.

Donna P: I have had C.I.D.P. (Chronic Inflammatory Demyelinating Polyneuropathy) for 15 years and I was having I.V.I.G every 3 mounts. I had a stem cell transplant because of my Multiple Myeloma and now my C.I.D.P. isn't as bad, my doctor has me on Neurontin 300mg twice a day. So far it is working.

Joni S: Using Gabapentin 1100mg 3x a day, for bilateral peripheral neuropathy. I take 150mg Elavil at night. Fentanyl 25mg patch change q48hrs. Oxycodone 5mg as needed for breakthrough pain. When I do my Neupogen injection I have increased pain in bilateral femurs & sacral pain (had pathological stress fracture across my sacrum).

Sara G: My mother has reversed her mild neuropathy with toe tapping. She does it twice daily as often as she can.

Liz S: Mine is much better thanks to accupuncture, neurotin, alpha lipoic acid.

Michelle L: They're starting me on lyrica

Peter W: I am using lyrica, morning and night to mask neuropathic pain in my feet. It works fairly well masking about 75% of the pain.

Cathy S: I've been using gabapentin, three times a day. Doesn't take it away completely but I'm satisfied.

Karen K: I got severe neuropathy from valcade five years ago. I take neurotic three times a day. It is helpful but I can't exercise like I want to. Bike riding is the best for me.

Janice R: Mine started with chemo, and got really bad at the sct. Both feet and legs, both hands and fingers. Gabanentin caused hallucinations. Nortriptyline helps a little. Can get insurance company to approve Lyrica. Went to a program with a chiropractor that was 3 months, not covered by insurance was 4k. Had vibration, laser and tens electrical. Had some exercising. It also helped a bit. Now have it in feet, and ankles, and fingers above the last joint. Hard to walk, picking up things is hard, but at least I don't have the constant pain. I feel lucky with no pain.

Rhonda T: They gave me lyrica but I haven't started yet. I have it bad in my feet. It caused me to have a bad fall on the sidewalk. I had to use a cane for a month.

Barb M: After my SCT my legs started to get better – now almost 6 months post – I have very little discomfort. You will get thru it – it sucks right now but try to take as many breaks as possible and don't put yourself in a situation that you can't sit down right away. Good Luck.

Susan D: My husband has peripheral neuropathy in both feet. He is 7 years post auto sct. 10mg maintenance revl. Walking walking walking helps. Recently having a little dizziness on standing but passes. Then out with the dog again.

Silvia O: Oxycodone, massage and walking helps a little but I think there's no cure for neuropathy.

Kathy A: Neurontin 300mg TID and cutting Velcade to 50% dosage has helped greatly. Just a little annoying numbness in toes now. Tart cherry juice at bedtime and I'm sleeping better than I have for years. Which helps my energy level, too.

Why Do People Beat the Average Multiple Myeloma Life Expectancy Prognosis? Or How To Improve Your Myeloma Survival Rate!

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With myeloma, sometimes it's just mind over matter

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A New Facebook Group for Myeloma Family and Caregivers

Joanne L: I take 300mg of Gabapentin 3 times a day for the neuropathy. I have it mostly in my hands and arms. It's a real pain. I have to stop every 10 minutes or so and let my arms hang until the numbness goes away. Some days are better than others, but when it's bad... it's bad!!! Stay Positive and stay strong!

Susan A: I got some neuropathy from Velcade, some numbness in my feet. After SCT it was worse. 2+ years later it has gotten much worse with sharp pains and all over aching. Tried Neurontin and Lyrica, which did nothing. Now on Cymbalta which may be helping a little. Doctor gave me a compounded cream.

multiple myeloma

myeloma

neuropathy

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ABOUT AUTHOR

LIZZY



Lizzy Smith was diagnosed with multiple myeloma in January 2012 at the age of 44. Within days, she made major life changes leaving her job, a painful marriage and moved from San Diego to Utah to seek treatment at Huntsman Cancer Institute in Salt Lake City. She says that going from a "normal" life of career, children, husband and home to single mom, cancer warrior, and dependent on her mother and father to care for her during treatment, was quite the journey. "It was a jarring wake-up call that my priorities needed a re-set. In that respect, I am grateful for cancer, as strange as that seems." Today, Lizzy is in remission and doing well. Her greatest passion is myeloma advocacy. "To the extent I'm able, I want to show others that despite life's biggest challenges, it is possible to survive and come out stronger than ever," she says.

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2 COMMENTS

GINA on OCTOBER 22, 2014 12:04 PM

My Mom has suffered from Neuropathy for quite a while, and, one of her biggest triggers is sugar. Always within 3 hours of consuming sugar, her feet start burning and aching. She cut out all sugar and takes Gabapentin and the Neuropathy is at a minimum. She is now in her first day of a new trial for aggressive Multiple Myeloma. Her Bone Marrow Biopsy showed 85%, and she has multiple lesions in her bones. We are hoping and praying this trial will work for her.

REPLY >

checklist of effects while off Thalidomide, March 24 '12--

Dizziness

3/25 definitely lightheaded

3/31 much more clearheaded; C says she saw the improvement by 3/26. I feel less fretful and seem able to think ahead without so much crowding my mind. Calmer, all in all. Still tend to forget things, particularly in sequence of chores, but maybe a little less, and it bothers me less. A big gain here is that I feel less clumsy.

4/8 I still have to be aware of balance issues, particularly in going to the bathroom at night. But I am surer on my feet much more quickly in the mornings, where it used to take an hour or so before my head and feet really woke up.

4/14 last week's entry holds true. Probably a little more sureness on my feet, yet.

4/23 The main impression is my greater calmness, ability to take things in stride instead of the agitation I always had to rein in when on Thalidomide.

4/30 Same report as last week, remarkable calm, friends commenting on how well I look and seem to be doing.

5/7 Same report as last week.

5/14 Same report as last week.

Walking

3/25 can't do a straight line on the floor

3/31 better at the straight line, although still not normal. Sense of balance is improved, although trips to bathroom at night still have to be done very carefully.

4/8 still better at the straight line. And walking the neighborhood this morning, I felt steadier than in a long time.

4/14 Main improvement is walking the neighborhood, which I now do without constantly watching my balance.

4/23 Again, in walking the neighborhood I'm much surer, don't feel the sailor-like gait of before.

4/30 Same report as last week.

5/7 Same report as last week.

5/14 Same report as last week.

Numbness

3/25 wooden sensation, especially in left foot. Hands cramps regulr and troublesome.

3/31 still much numbness in feet, although I think there's more sensation in ball of left foot etc. Hands seem definitely better, although still some stiffness. Leg cramps haven't bothered the past few nights in bed, but on 3/26 or 3/27 I had one of the worst ever,

making me scramble out of bed to stand on it and nearly tipping over when I did. So that's still be be watched warily.

4/8 right foot has gone from feeling wooden to asleep, that feeling of being able to shake it awake, although it doesn't get any less than that. More sensation in the ball of the foot when I probe with something pointed; the primary dead spot is in the underjoint of the big toe. The left foot is now the more numb one. Both feet still are awkward in bed, feeling something like constant chilblains and clumsy to maneuver. Leg cramps aren't as frequent, but I have to watch out for them in how I lay.

4/14 level of numbness is about the same as last week, with the right foot maybe slightly improved. Left foot still the numbest, especially in the ball and big toe joint. Early in the week I had one very tough night in bed when the feet felt big and clumsy and, as best I can describe the sensation, cooked. Have not had that trouble since, nor any bad episode of leg cramps.

4/23 Numbness remains about the same. Last night and a couple of others this week, the feet were bothersome in bed; the sensation is hard to describe, but something like a feeling of swelling.

4/30 This category shows less quantifiable improvement, as I had a couple of rough nights in bed. I'm taking two aspirin an hour or so before bedtime to see if that'll help. Testing the numbness, it may be a bit less week by week, but there's also considerable tingling; I'm still conscious of wooden feet, although not in hazard from them as much.

5/7 This remains the category of least progress. Feet were troublesome in bed last night and a couple of others; also some leg spasms, although no cramps as severe as some in the past. Still some hand cramps, too, although all in all the hands operate better than before.

5/14 Maybe some improvement in feeling in bottom of feet. No troublesome spells in bed.

conclusion

3/31 Have marked so much improvement I've talked with C about the next 6-7 weeks as possibly my "steadiest" stint I can ever have. Odds are that Dr. Chen will need to put me on some medication, when I see him in late May, to combat the creeping lambda light chain results. C and I are wondering if it'll be possible to go on and off medication, like now, since I/we seem able to recognize the effects.

4/8 Significant improvement mentally, psychologically, general sense of well-being. I feel sixty again! I think I act increasingly measured and sure in movements that made me feel clumsy before. It also seems that I'm thinking in progression, instead of hit-and-miss as before.

4/14 This was a testing week, busy to the point of hectic with booktour and other questions popping up, and I definitely seemed much calmer, deliberate, unrattled, in handling things. I have felt so sharp, mentally and energy-wise, that I has made me wonder what my past five and a half years would have been like without the myeloma gauntlet.

4/23 A hectic week again on booktour etc. and I was able to handle matters calmly, without doubts and worres hanging on and nagging. Less second-guessing of myself, maybe is the way to put it.

4/30 The feeling of having a new head, a new me (except for feet and hands), is still a psychological high.

5/7 Mood and calm are much the same as last week.

5/14 Much the same as last week. Relatively unbothered even by the urine and blood tests I'm starting, although I know they'll do a lot to determine my fate.

Dizziness

3/25 definitely lightheaded

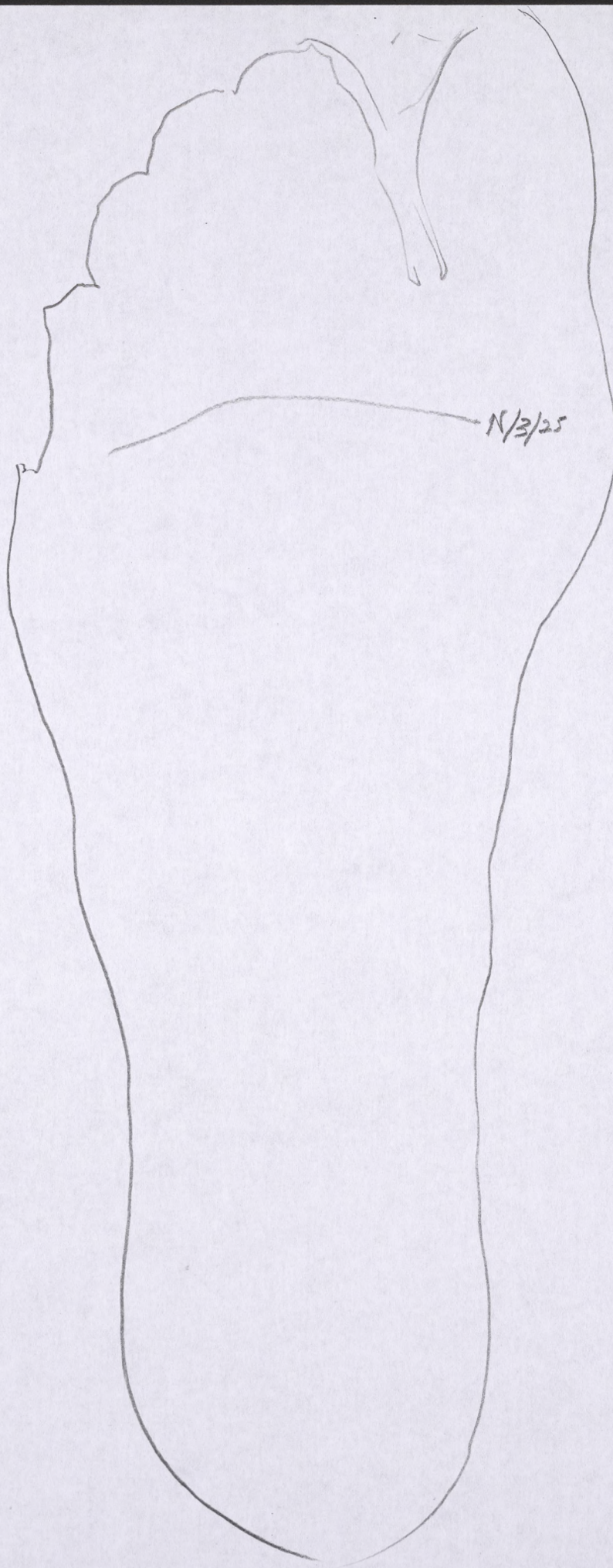
Walking

3/25 can't do a straight line

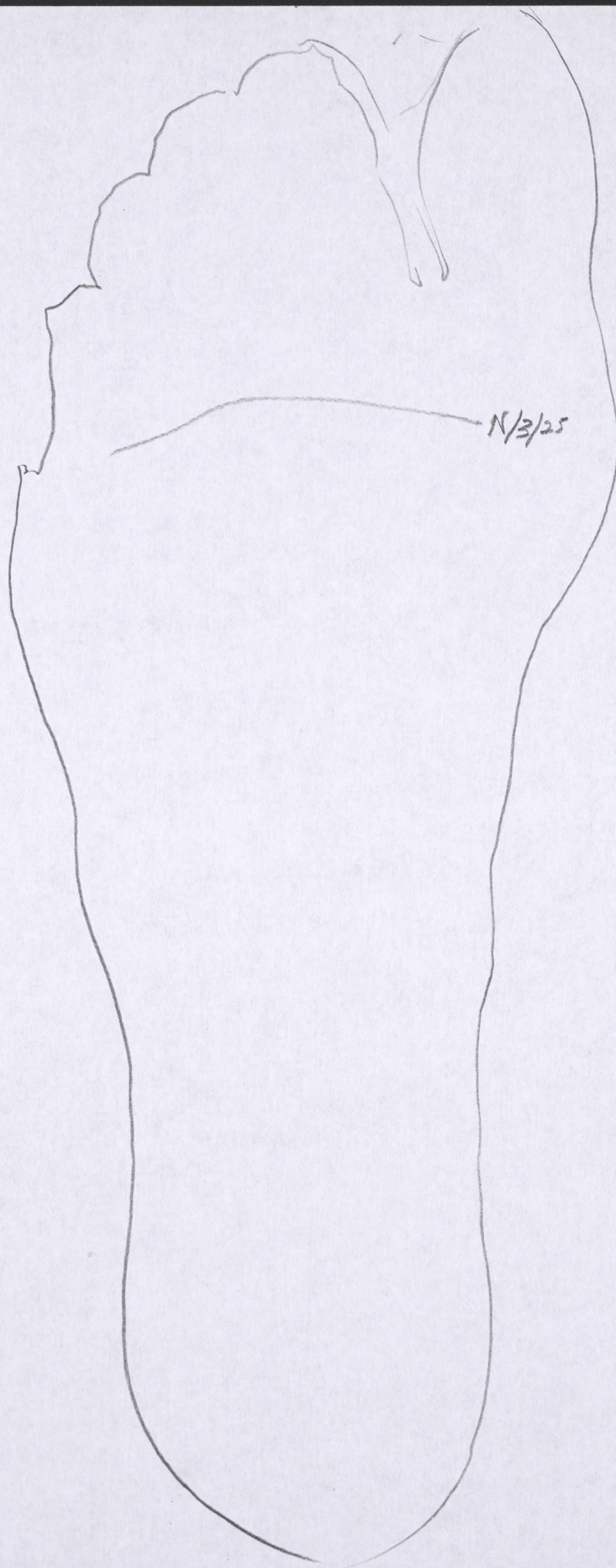
Numbness

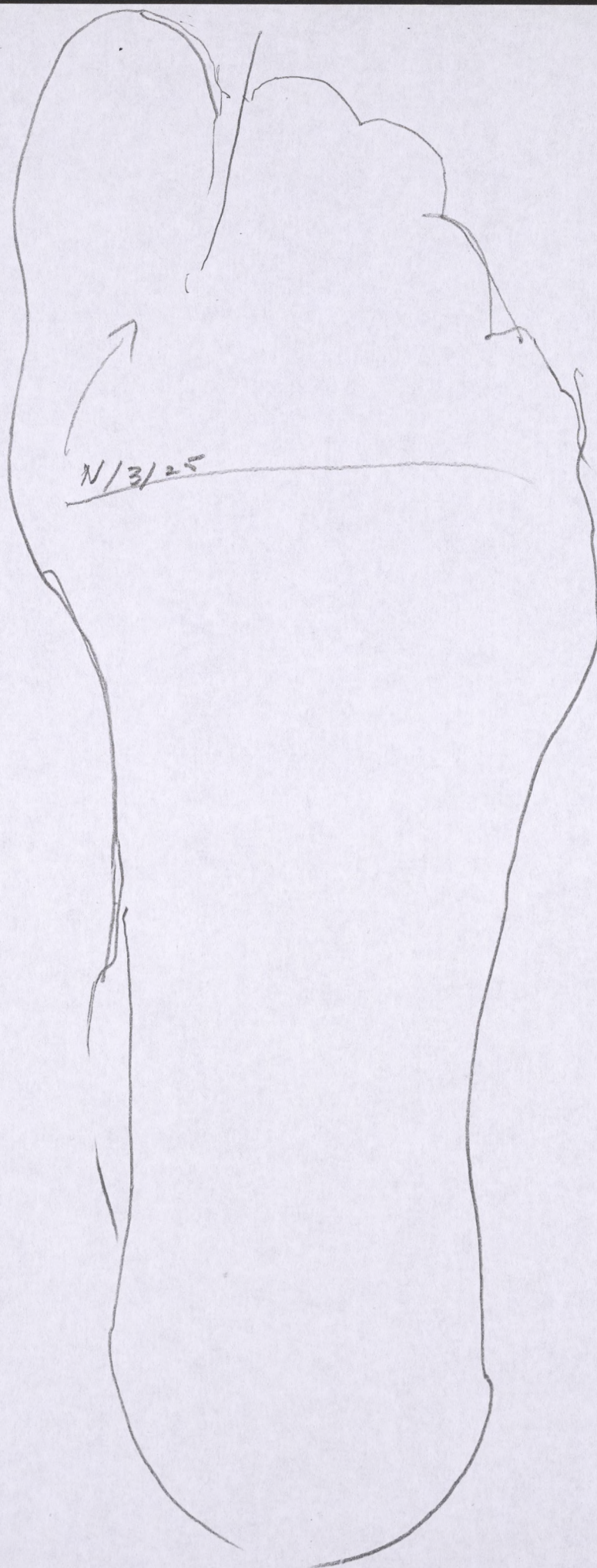
3/25 distinct sensation, especially in left foot

make
checklist



N/3/25





An old fashioned [herbal remedy](#), [Capsaicin](#), works so well it is now part of the standard of care for



neurologists treating this disorder. Capsaicin is the active substance in hot peppers, which depletes a pain transmitter called Substance P when applied to the skin repeatedly. It can cause a burning and stinging sensation when first applied, but this diminishes over time and eventually people using Capsaicin four times a day get relief from neuropathy pain. This cream is available by prescription.

Two oral antioxidants are worth mentioning here, and both have scientific evidence in their favor. One of the theories about neuropathy is that it is caused by increased oxidative stress on the nerves, and that antioxidants could therefore repair and prevent that. The antioxidants for which we have the most data are Alpha Lipoic Acid (600 mg per day); and Acetyl L-Carnitine (1000 mg three times daily). These are available in many health food stores.

And finally, consider [magnets for pain relief](#). In a multicenter study of patients with diabetic peripheral neuropathy, the use of magnetic shoe inserts ([Magsteps, from Nikken Inc.](#) were the brand used) was associated with significant improvement in symptoms over a period of months (see the 2003 article by Weintraub et al. in the journal Archives of Physical Medicine & Rehabilitation). Only be careful if you have diabetic neuropathy not to wear any hard shoe insert like this without a good sock to avoid blisters and possible ulcers from friction.

To your health and wellness,

Robert Pendergrast, MD

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Neuropathy treatment, holistic medicine solutions.

In my years of medical practice, neuropathy treatment has been near the top of the list of futile efforts by conventional medicine. Prescription drugs have been tried over and over which were initially designed to treat something else, with the hope they could provide some relief. Some have worked pretty well most of the time, some have worked not so well part of the time, and some have been complete failures. And often these drugs come with significant side effects. It's against that backdrop that complementary and alternative medicine (CAM) strategies for neuropathy treatment grew in popular use. Some of these have also been failures, but some have been promising, and I have personally observed some remarkable successes where conventional medicine failed.



What is neuropathy? This term generally means some combination of loss of sensation (numbness), weakness, and pain (tingling or burning) in the nerves. The most common one is diabetic neuropathy, usually involving the nerves in both feet symmetrically. Remember that if you have these symptoms, get a thorough diagnosis by a doctor, as other things can cause the same symptoms, and there are many different types of neuropathy.

A brief remark here about the place of CAM and the need for more research in this area. An area like neuropathy treatment where conventional medicine is often unsatisfactory and where patients are already

using CAM is the ideal setting for clinical research to get answers on whether these approaches work. But even before research results are available, I do not mind recommending such approaches as long as I am persuaded that they are not harmful and that conventional approaches have failed.

So what are some promising holistic medicine approaches to neuropathy treatment?

First, remember that for diabetic neuropathy, the most important holistic medicine strategy is prevention by good control of blood sugar. Adherence to a healthy diet, weight control, and regular physical activity are key. You'd rather not get this in the first place.

mayoclinic.com

Peripheral neuropathy: Alternative medicine

By Mayo Clinic staff

Some people with peripheral neuropathy try complementary and alternative treatments for relief of their symptoms. Although these techniques haven't been as rigorously studied as most medications, the following therapies have shown some promise in the treatment of peripheral neuropathy:

- **Acupuncture.** Acupuncture involves the insertion of thin needles into various points on your body. Acupuncture may reduce symptoms in about three-quarters of people with peripheral neuropathy. However, you may need multiple acupuncture sessions before you notice improvement. Acupuncture is generally considered safe when performed by a certified practitioner using sterile needles.
- **Alpha-lipoic acid.** Used as a treatment for peripheral neuropathy in Europe for years, this antioxidant may help reduce the symptoms of peripheral neuropathy. Discuss the use of alpha-lipoic acid with your doctor before using it, because alpha-lipoic acid may affect your blood sugar levels. Other side effects may include stomach upset and skin rash.
- **Biofeedback.** During a biofeedback session, the therapist applies electrical sensors to different parts of your body to monitor your body's physiological response to your peripheral neuropathy symptoms. The biofeedback device then teaches you how your body responds using cues, such as a beeping sound or flashing lights. This feedback can help you associate your body's response with certain physical functions. Once you begin to recognize your body's responses, you can learn ways to lessen the reaction through certain techniques, such as relaxation or guided imagery.

Prevention Lifestyle and home remedies

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Holistic Health

by RICHARD MALIK

Peripheral neuropathy (PN) is a very common condition that manifests as numbness, tingling or pain. It commonly occurs in the hands or feet, but can also occur in other parts of the body. It may sound confusing, but PN can also cause decreased sensation, increased sensation, or changes in sensation in these areas. For example, non-painful stimuli such as a light touch can be experienced as intensely uncomfortable or even painful. These diverse and seemingly contradictory symptoms occur when the nerves beyond the brain and spinal column are irritated or functioning abnormally.

One of the challenges of addressing peripheral neuropathy is that there are many possible causes. Perhaps the most common is diabetes, but others include trauma, Lyme disease, herpes virus infections (shingles or chickenpox virus), poor circulation, carpal tunnel syndrome, auto-immune disease, endocrine disease, and other diseases that alter the body's ability to maintain electrolytes or waste products of cellular metabolism at healthy levels. Sometimes, no cause is found for the poor nerve function, while other times it is chalked up to an inherited condition called familial peripheral neuropathy. Also, PN may be a side effect from a medication, medical procedure or from an exposure to a pollution or toxin.

So, the first step in treating peripheral neuropathy is to try to identify the cause. This is usually done through taking a thorough medical history, blood tests, and sometimes testing nerve and muscle function with an electromyograph.

Obviously, a discussion natural approaches for all the causes of peripheral neuropathy is too lengthy for this article. However, I would like to discuss some of the more important approaches.

Nutrient Deficiencies and PN

Identifying nutrient deficiencies is fundamental to the initial assessment of many medical conditions, including PN. We know that deficiencies of thiamin (vitamin B-1) and vitamin B-12 can cause PN symptoms. These nutrients are commonly deficient in people that consume a lot of alcohol on a regular basis. Testing for vitamin B-12 can be done through blood tests that measure blood levels (serum vitamin B-12) or actual metabolic activity of vitamin B-12 dependent enzymes (methylmalonic acid and homocysteine).

If you are at risk for these nutrient deficiencies, there are some steps you can take. Taking a high-dose multivitamin can help prevent these deficiencies and can provide rapid benefit. For those that want to use food as their medicine, B-12 is found in meat, shellfish, poultry, eggs, and milk while thiamine is found in legumes, whole grains, nuts, spinach, and pork.

Diabetic PN

In cases of diabetic PN, medical studies and my clinical experience show that alpha-lipoic-acid (ALA) and vitamin B-12 can be very effective for improving nerve function. ALA is a naturally occurring anti-oxidant that is both fat and water soluble. 100-1800mg daily works well in diabetic patients, but care should be monitored because ALA can lower blood sugar levels. This can be dangerous in a diabetic patient. Vitamin B-12 is a non-toxic essential nutrient that can be taken orally or injected into the muscle. Studies on PN and vitamin B-12 have used intramuscular injection, but there is good reason to believe that high oral doses are just as effective.

Chemotherapy Induced PN

Patients undergoing chemotherapy experience PN from the toxicity of the chemotherapy agents.

✎ Glutamine has been shown in several medical studies to dramatically reduce the incidence and severity of chemotherapy induced PN. Better yet, glutamine is very safe and improves the health of the gastrointestinal mucous membranes and immune function in chemotherapy patients. Effective doses are very high; as high as 15 grams twice daily!

Circulation and PN

Another important cause of peripheral neuropathy is poor blood flow to the affected nerves. Vitamin E, ginger, coenzyme Q-10, gotu kola, and other therapies can be effective in these circumstances. Vitamin E improves circulation in a condition called intermittent claudication; it can be effective at 400-800 IU per day.

Coenzyme Q-10 does not help to improve circulation as vitamin E, ginger, and gotu kola do. But it does help the nerves make the most of the circulation it gets by optimizing oxygen usage and acting as an anti-oxidant. Coenzyme Q-10 is effective at 100-300mg per day.

There are some precautions with these therapies you should be aware of. First, it's a good idea to keep vitamin E supplementation below 800IU per day (remember to include all supplements in that calculation) as some studies show side effects above that amount. Ginger and Gotu kola should not be used with blood thinners like Coumadin and Warfarin.

Effective Therapy for PN

Natural medicines can be very effective for serious medical conditions. It is so important to first have an accurate diagnosis and then to work with someone that understands these medicines and the body's physiology to be able to guide you in a plan that is likely to be effective and sure to be safe.

Richard Malik is a licensed naturopathic physician with a practice in Lakeville, CT. You can find more of his articles at www.maliknd.com

Original URL:

<http://blog.timesunion.com/holistichealth/peripheral-neuropathy-a-naturopaths-perspective/264/>

Waitress serving kisses will require direct order

Ask Amy

Amy Dickinson
Syndicated columnist

DEAR AMY: My husband and I frequent a local restaurant every week. We have been going to this place for at least four years now and sometimes two or three times a week.

There is one waitress who insists on taking care of us. She is good at what she does, but every time she greets us she kisses us on our lips.

It is very uncomfortable, and we do not like it.

I have mentioned to her a few times that I have a cold and so "no kisses for me," but then the next time we go in she does it again!

We would hate to stop going to this

place, but what else could we do?

—Diner in a Dilemma

DEAR DINER: The only thing left to do is to tell this person, "I apologize because I should have told you a long time ago, but I really don't like to be kissed when we come in. It makes me uncomfortable. I hope you understand."

DEAR AMY: I am interested in amplifying your response to 22-year-old "Confused," who wondered whether it's socially acceptable to go slow sexually in a new relationship.

I'm an older guy who, when I was single, never had sex early on in relationships with women. My personality is such that I could not be comfortable physically with a partner without an emotional connection first.

When I met the wonderful woman whom I've been with for 18 years, we spent several months becoming friends before getting physical, which was

right for us.

For me, this has nothing to do with morals, values, respectability or what works for other people, but everything to do with my own emotional makeup. I doubt that I'm unique.

In my hippie youth I couldn't understand why I wasn't having sex when many of my peers were!

Only years later did I come to understand that I had simply been unwilling to have physical intimacy without emotional intimacy.

—Happy I Waited

DEAR HAPPY: Thank you for sharing a man's point of view.

I've heard from many readers responding to "Confused." Several report regretting they had had sex too soon in a relationship.

So far, no one has told me they were happy they'd had sex early.

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Send questions via e-mail to askamy@tribune.com or by mail to Ask Amy, Chicago Tribune, TT500, 435 N. Michigan Ave., Chicago, IL 60611.

PEOPLE'S PHARMACY

Gluten-free coconut cookies stop chronic diarrhea

BY JOE AND TERESA
GRAEDON
Syndicated columnists

Q: After months of daily diarrhea, my teenage son just underwent biopsies and was diagnosed with Crohn's disease. Gluten can sometimes be irritating for people with Crohn's, so we are trying to avoid it in his diet. That means we can't use store-bought coconut macaroons, though we read in your column that they could help calm diarrhea.

I have modified the recipe on the package of coconut to make him macaroons. He's been eating them for the past couple of weeks, and the constant diarrhea has subsided. Best of all, he is starting to gain back some of the 22 pounds that he lost during the past few months before he was diagnosed.

Here's my recipe: Mix 6 tablespoons sweet rice flour, 1/4 teaspoon salt, 1 teaspoon almond extract, 4 egg whites, one 14-ounce package of shredded coconut and 1/3 cup chocolate chips. Drop onto a cookie sheet and bake at 325 degrees until the tops turn light brown, about 15 or 20 minutes.

A: Thanks for sharing your remedy. It sounds delicious. Many people with the inflammatory digestive-tract disease known as Crohn's suffer from chronic diarrhea. In fact, we first learned about coconut macaroon cookies for this problem from Donald Agar, a Crohn's patient. He discovered the benefits for himself and notified us so we could alert others. He found that two macaroon cookies daily controlled his diarrhea.

Q: I read that turmeric could help relieve muscle pain, so I

began taking three capsules each day for my fibromyalgia. The pain has eased somewhat, but the greatest benefit was that the neuropathy in my feet has almost entirely disappeared.

After two weeks, I urged my sister, 10 years younger than me and with a much more severe neuropathy problem, to try it. She began taking turmeric and is now almost completely pain-free.

A: Neuropathy can manifest as numbness, tingling or pain in hands or feet. This kind of nerve disorder is notoriously hard to treat.

Turmeric has long been used in the traditional medical systems of Asia. Malaysian scientists confirmed last year that an extract of this bright-yellow spice could quell nerve-related pain in rodents. The anti-inflammatory activity of turmeric also may provide benefit.

Q: Thanks for writing about ginger tea for colds. I've been fighting a bad cold for several days. When I read about this, I used a potato peeler to cut thin slices of ginger. I put them in a cup of water and stuck it in the microwave. After two minutes, I added a little sugar. My congestion felt better even before I finished the drink.

A: We are big fans of ginger tea for congestion. Your approach sounds simple and tasty. Ginger does not have the side effects found with many over-the-counter cold-symptom relievers.

In their column, Joe and Teresa Graedon answer letters from readers. Write to them c/o King Features Syndicate, 300 W. 57th St., 15th floor, New York, NY 10019, or via their website: www.peoplespharmacy.org

HOROSCOPES

TODAY: March 13, 2011

Rating the day: 10 is easiest, 0 is most challenging.

ARIES (MARCH 21-APRIL 19): Today is a 6. The day proves to be more challenging than usual. If you can, just stay home and take care of your nest and loved ones. Write some family history together.

TAURUS (APRIL 20-MAY 20): Today is an 8. Get in communication with a father figure. If you can, take him for a walk in the park, the beach or the mountains. He has something important to say.

GEMINI (MAY 21-JUNE 21): Today is a 6. The day has promise. Just handle with care. Others, and yourself, could be more temperamental than usual. Be sure not to overextend yourself. Rest and let go.

CANCER (JUNE 22-JULY 22): Today is a 7. It could be one of those days in which you feel like you want to accomplish many goals, but distractions keep you unfocused. Don't stress about it.

LEO (JULY 23-AUG. 22): Today is a 6. Stay in bed a bit longer. Make sure you're taking care of yourself. Don't over-think it.

VIRGO (AUG. 23-SEPT. 22): Today is a 6. If you question your purpose in life, don't take it too seriously. Deep inside, you know the path you need to take at this fork in the road.

LIBRA (SEPT. 23-OCT. 22): Today is a 9. If your career is a rollercoaster, you climb up to new highs. It might seem pretty boring for a moment. But there's a thrilling rush just ahead.

SCORPIO (OCT. 23-NOV. 21): Today is a 6. Listen to Helen Keller: "Life is either a daring adventure or nothing. Security does not exist in nature; avoiding danger is no safer in the long run than exposure."

SAGITTARIUS (NOV. 22-DEC. 21): Today is a 5. Don't gamble with your money. Mistakes are bound to happen. Learn from them. Pay attention to your judgments. Don't be harsh on yourself or others.

CAPRICORN (DEC. 22-JAN. 19): Today is a 6. It is a great day to relax at home, or escape into nature or a good story. It may take something to avoid insensitivity or argument. Take it easy.

AQUARIUS (JAN. 20-FEB. 18): Today is a 7. It's a day to get things done. Power through and reduce the length of your list. Be prepared for distractions. Go with the flow.

PISCES (FEB. 19-MARCH 20): Today is a 6. There are too many dangers inside your head. Better go outside and play ball with the kids. Fresh air will do you good and clear your ideas.

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RANT & RAVE

RAVE To the couple who ordered a delicious blackberry cobbler for us as they left Chinook's restaurant. They didn't know us or that we were celebrating our 24th wedding anniversary, most likely our last since my husband has terminal cancer.

RANT To the local grocery store that didn't have the decency to apologize for wrongly searching my bag and interrogating me for no reason in front of shoppers. I went into the store in search of a specific kind of bread and when I didn't find what I wanted and was leaving the store, I was asked to show what was in my purse and questioned why I wasn't making a purchase.

RAVE To all the hale and hearty bikers I pass while driving to work each morning. They come in all shapes and sizes and ride all different kinds of bicycles, in every kind of weather. Know that there is one motorist who sees you and says, "Yay! Good for you!" and hopes that one day he'll have the guts to get out there and join you. (My gut could sure use it.)

RANT AND RAVE To whoever stole my purse from my grocery cart with my credit cards, keys to my home and car, photo book of my grandchildren, cellphone, \$400 in cash and

many more hard if not impossible to replace items. I'm in my 70s; the cash was my grocery allowance for the month. Rave to all the wonderful people at QFC who looked everywhere for my purse and to the nice woman who drove me home.

RAVE To the genius who figured out how to rescue my x-country skis that accidentally slid into a half-frozen lake. We couldn't figure out how to get them off the thin ice; I thought I'd seen the last of them and left on foot. My girlfriend returned the next weekend and, lo and behold, the skis were in a snowbank by a trail sign and she brought them back to me. How did you do that?

RANT To the lowlife who hit the car behind me that then hit me during rush hour on I-5. Fleeing the scene of an accident is not only illegal but just rude.

The Seattle Times publishes reader rants and raves on a space-available basis. We reserve the right to edit for length or content. Send yours to rantandrave@seattletimes.com



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< Club

FROM H1

Club founder Dr. Kyo Koike, for example, was elected director of the Association of Camera Clubs of America in 1928, and shortly afterward became an associate member of the Royal Photographic Society of Great Britain — “one of the greatest honors for a photographer of that time,” author Martin points out. In 1922, future club member McBride had equally striking success when three of her floral studies won a place at the Royal Photographic Society of Great Britain’s 67th annual salon.

Her close associates Wayne Albee and Frank Asakichi Kunishige won similar international recognition, while club member Soichi Sunami, in 1930, became the archival photographer for New York’s Museum of Modern Art. (Take one look at his stunning shots of Martha Graham, Agnes de Mille and other early modern-dance pioneers, and you can see why.)

After seeing these images and learning some of these facts, one naturally wonders why the camera club came so close to being forgotten.

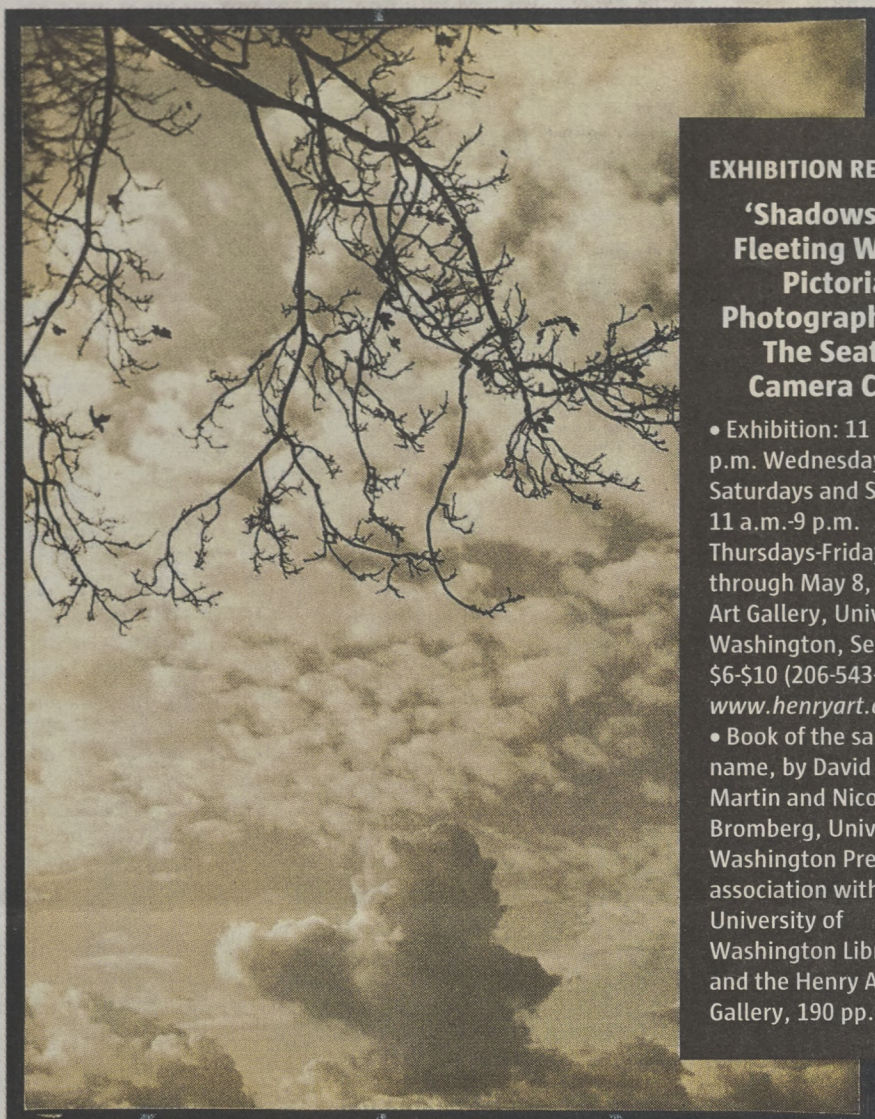
Changing fashion in photography is one reason. But the biggest factors that led to the club’s dissolution and most of its members’ cessation of photographic activity were the economic hit of the Great Depression and, even more devastating, President Roosevelt’s Executive Order 9066 following the attack on Pearl Harbor.

Roosevelt’s order removed all West Coast Japanese-American citizens to internment camps for the duration of World War II, a years-long disruption to their lives that often led to them losing everything they had: homes, businesses, family belongings. In the case of some SCC members, that meant photographs, equipment and all records of their achievements. Even worse, it was declared illegal for them to own or operate a camera. By 1942, the shared passion for photography across divides of race and gender that marked the SCC must have seemed like a pipe dream.

The club that Dr. Koike established in 1924 was preceded by some lively photographic activity in Seattle (Imogen Cunningham and Edward Curtis come to mind). But no formal camera society emerged. As Dr. Koike, who emigrated from Japan to Seattle in 1916, later wrote, “We waited patiently for a long time, thinking that some Americans might organize a society for the friends of photography.”

When that didn’t happen, he and 38 other camera enthusiasts, all of Japanese ancestry, got things started, holding their meetings at the Gyokkoken Café on the fringes of what was then Japantown (now the International District). Most regarded themselves as “Pictorialists,” meaning their goal “was to establish photography as a fine-art medium and to exhibit their photographs with the same commitment and professionalism afforded to painting.”

The painting style that most strongly shaped their work was Impressionism, al-



PHOTOS COURTESY OF HENRY ART GALLERY

“Autumn Clouds,” by Iwao Matsushita, who was instrumental in preserving the work of the Seattle Camera Club.



Choreographer Martha Graham in “Lamentation,” circa 1930, by Soichi Sunami.

though Symbolism had a strong influence too. Soft focus characterized much of the work. Kunishige’s “7:15 a.m.,” for instance, achieves a fogged effect not just through tricks of the camera lens, but by printing the image on “Textura Tissue,” a paper Kunishige manufactured and sold nationally out of his Seattle studio. Its crepe-like texture adds a fragility to his floral studies, his nudes and his cityscapes.

Dr. Koike’s work tends to be crisper in its rendering of mountain vistas, maritime scenes and more. Sometimes his titles add a metaphysical twist to the image at hand, as in “Called a Home” (c. 1925), where the title lends emotional heft to a rustic, cabinlike houseboat, and “Own Image” (c. 1930), in which the water reflection of a sailboat overpowers what we see of the boat itself.

McBride, curiously, is more under a Japanese influ-

ence than many of her Japanese-American colleagues. Her floral studies are a delicate delight — whereas Kunishige’s, by contrast, rival Robert Mapplethorpe’s in their languid sensuality. McBride has other strengths, too. Her portrait of Roi Partridge (Imogen Cunningham’s husband) is a handsomely moody work.

Other key SCC figures include Iwao Matsushita, whose rugged mountain landscapes have a sublime power, and Yukio Morinaga, whose street scenes, especially of Pioneer Square and Seattle’s waterfront, are a loving homage to the city.

One photographer who fits the “Pictorialist” category less neatly is Haffer, the most restlessly experimental of the group. In “His First Growth,” she goes for a pencil-sketch-like effect in her rendering of the wispy hairs on a baby’s head. She also uses photocollage and lens distortions

EXHIBITION REVIEW

‘Shadows of a Fleeting World: Pictorial Photography and The Seattle Camera Club’

• Exhibition: 11 a.m.-4 p.m. Wednesdays, Saturdays and Sundays, 11 a.m.-9 p.m. Thursdays-Fridays, through May 8, Henry Art Gallery, University of Washington, Seattle; \$6-\$10 (206-543-2280 or www.henryart.org).
• Book of the same name, by David F. Martin and Nicolette Bromberg, University of Washington Press in association with University of Washington Libraries and the Henry Art Gallery, 190 pp., \$45.



HARRY A. KIRWIN

What became of Seattle Camera Club members and their work?

The disappearance of work by photographers who were sent to internment camps was considerable. In San Francisco and Los Angeles, the destruction of this legacy was close to complete. In Seattle, much was also lost — but a significant body of work survived for several reasons. Here’s the scoop on the fate of seven key photographers in the show:

Dr. Kyo Koike: Dr. Koike (standing second from left in the photo above), thanks to his medical practice, had the funds to continue his photography even after SCC folded. His internment at Minidoka in Idaho undermined his health, and he died in 1947, shortly after his return to Seattle. He left all his work and his meticulous records of the club’s activities and publications to fellow photographer Iwao Matsushita.

Frank Asakichi Kunishige: Kunishige and his wife, Gin, were also interned in Minidoka and remained in Idaho for a while after their release. There Kunishige, one of the few SCC members who had made his living as a photographer, held several exhibitions. He returned to Seattle in 1950, in poor health, and died in 1960. His widow later married member Iwao Matsushita.

Iwao Matsushita: Matsushita was held in Montana, where for more than two years he was separated from his emotionally fragile wife, Hanaye (held at Minidoka). Upon their release, they returned to Seattle, where Matsushita, a former teacher of Japanese at the University of Washington, was offered a job in the UW’s Far Eastern Library. Hanaye died in 1965 and Matsushita married Gin Kunishige in 1967. It was through Matsushita’s connection with Robert Monroe, head of UW Libraries, Special Collections, that much of the Seattle Camera Club’s legacy survives. Along with photos and archival material, Monroe acquired Matsushita’s 8-mm films, which include lively scenes of 1930s Seattle, now on view in the lobby of the Henry.

Yukio Morinaga: Fewer than three dozen of Morinaga’s photographs survive, out of hundreds. Fellow SCC member Virna Haffer, who ran her own studio in Tacoma, bought him a house and gave him work following his internment at Minidoka. But he was defiant of the government that had incarcerated him, refusing to pay taxes. In a final desperate gesture, he starved himself to death at age 80 in 1968.

Virna Haffer: Haffer continued in her experimental vein, exhibiting her work internationally while working as a commercial photographer in Tacoma. In the 1960s, her interest shifted to photograms (a way of making “photographic prints ... without the use of a camera or negative”). She died in 1974.

Soichi Sunami: Even though Sunami was living on the East Coast during the internment-camp era, he destroyed much of his early work, including all his nudes, “for fear of repercussion from the government,” author David F. Martin reports. He died in 1971. Along with his work for MoMA, he left a number of dance studies, housed at the New York Public Library and Jerome Robbins Dance Division.

Ella E. McBride: The fate of McBride’s work is the biggest surprise here. As author Nicolette Bromberg explains, “The Modernist sharp-focus documentary style of photography dominated the art world in the decades after the 1920s, and over time Pictorial photography came to be regarded [as] outmoded and uninspired.” McBride’s work, firmly in the Pictorialist school, lost favor. She continued to operate a studio in Seattle into her 90s and was profiled on her 100th birthday in The Seattle Times in 1962. After her death at 103, an archive of her negatives was put up for donation to any institution willing to house them. The Museum of History & Industry picked out “a random selection,” Martin tells us. The rest were destroyed — and with them, much Seattle history.

Michael Upchurch, Seattle Times arts writer

Michael Upchurch:
mupchurch@seattletimes.com

< SXSW

FROM H1

ing up vans to make the 40-hour drive, due southeast.

They’re making the trip to party with big-name acts (Cee-Lo will be there; Kanye West is rumored) and network with lesser-known artists and industry insiders.

The city will crawl with music journalists, as well. I’ll be down there to be exposed to new music, seek out a few names I’ve been admiring from afar, and catch up with Seattle musicians. Check the Matson on Music blog at seattletimes.com/matsononmusic for in-the-field coverage.

Among the Seattle acts I’ll be trailing: Hip-hop act Shabazz Palaces, jangle-rock band Tea Cozies, folk band The Head and the Heart, and UW dance-music duo Beat Connection.



ALAN BERNER / THE SEATTLE TIMES

Producer Ryan Lewis, left, and rapper Macklemore are on their first headlining national tour, which will include a stop in Austin, Texas, at South by Southwest.

Shabazz Palaces

This should be the year when the rest of America finally catches on to Shabazz Palaces, Seattle’s mystical, left-field hip-hop group, signed a few months back to

Sub Pop. Here’s what Shabazz auteur Palaceer Lazaro (Grammy winner Ishmael Butler) said about last year’s SXSW:

“I didn’t realize what it was going to be like until I got

WEB EXTRA

Find a list of over three dozen Seattle acts heading to SXSW — including Blue Scholars, Ivan & Alyosha and The Moondoggles — and follow the action as it happens at seattletimes.com/matsononmusic.com

down there. Any venue that could possibly facilitate any live anything was doing it. So it was just like a musical Disneyland, for me. [...] It was eye opening, the amount of stuff that was going on musically. And I only touched the music part of it. I didn’t go to the panels, or the seminars. It’s an amazingly huge event.”

Tea Cozies

Led by dueling singer/guitarists Brady Harvey and Jesi Reed, Tea Cozies makes energetic pop rock. The band supplied theme music for Seattle director Lynn Shelton’s “\$5 Cover” series for MTV, but is still largely unknown. Harvey hopes to correct that at SXSW:

“I think our No. 1 reason [for playing SXSW] is exposure. It seems like a really good way to get your music out to a lot of different kinds of people, and a lot of those people are writers, and labels, and other rad bands. And fans.”

The Head and the Heart

Chris Zsche plays bass in The Head and the Heart, breakout stars of the Ballard folk scene. He answered my phone call in Austin, where his band was opening for the Walkmen, and pointed out a reason SXSW might appeal

to Northerners:

“It’s like a summer day in Seattle. It’s like paradise down here. The idea of a summer house in Austin, or something ... I understand why rich people do that.”

Beat Connection

UW student duo Beat Connection makes dance music touched by synth-pop and hip-hop, with beachy sound effects mixed in (moving water, screeching seagulls). This is what they said when I asked what they would do at SXSW:

“Play as many shows as possible (we hear Mika Miko holds the record with 12), see James Blake and Miami Horror, keep a calm and level head through the circus that is SXSW, and learn how to be more active and helpful participants in a thriving all-ages music scene here in Seattle.”

Andrew Matson:
matson.andrew@gmail.com

Dr. Chen phone visit, 19 March '12

My main concern is mobility, particularly the numbness in my feet and secondarily the stiffness and sometimes cramps in my hands. The woodenness of my feet is uncomfortable enough that I can't take long driving trips; I can drive locally pretty well, but I'm leery of even a trip to Portland or Vancouver. And I feel clumsier than I used to in working in the garden and so on--I'm very careful and I have not fallen, but it's at the back of my mind pretty much all the time. So, I'm wondering if there's anything I can try for a better sense of feeling in my feet.

I've looked at neuropathy websites, which are heavily diabetes oriented, and wondered if there are any alternative treatments you think would be worth a try. There were three or four specific ones:

--Capsaicin cream, which I guess is a prescription item.

--Alpha Lipoic Acid (which the Mayo Clinic suggests but warns it may affect blood sugar or cause stomach upset and skin rash.)

--Turmeric, which seems to show up in patients' comments rather than doctors' recommendations.

--Lastly, acupuncture.

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To the office of:

Chen, Eric Y

Subject:

neuropathy

Message:

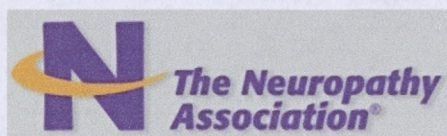
Dr. Chen, hi.

Neuropathy is bothering me enough -- besides the numbness and some loss of balance , there seems to be an emotional side effect; I get upset more easily than I used to -- that I wonder if I might carefully test out holistic palliatives. What do you think?

Neuropathy websites, heavily diabetes oriented, list various options; I wonder specifically about trying Capsaicin creme and/or turmeric or ginger. All advice is welcome!

Maximum 5000 characters.

For immediate medical help, call your physician's office or the [Consulting Nurse Service](#).

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American Academy of Neurology Publishes Guideline on Best Treatments for Painful Diabetic Neuropathy

By Natacha T. Pires, M.B.B.S., Director, Medical & Public Affairs

The American Academy of Neurology (AAN) has issued a new guideline on the most effective treatments for diabetic neuropathy. These guidelines were developed to provide clinicians with a scientifically sound and clinically relevant evidence-based guideline for the treatment of people with painful diabetic neuropathy (PDN) or diabetic nerve pain.

Diabetic neuropathy is the leading cause of neuropathy in the U.S. It is also one of the most common complications of diabetes, resulting from damage to peripheral nerves due to prolonged exposure to high amounts of glucose in the bloodstream. DPN manifests as intense and sometimes debilitating chronic nerve pain often described as aching, tingling, burning and numbness. It has major implications on quality of life, ability to function, morbidity, and costs from a public health perspective. According to lead guideline author Vera Bril, M.D., F.R.C.P., with the University of Toronto and a member of the American Academy of Neurology, "It is estimated that diabetic nerve pain affects 16% of the more than 25 million people living with diabetes in the U.S. and is often unreported and more often untreated, with an estimated two out of five cases not receiving care."

With so many treatment options available for painful diabetic neuropathy, a rational approach to treating a person with PDN requires an understanding of the evidence for each treatment. The guidelines were developed by physician members from the American Academy of Neurology (AAN), the American Association of Neuromuscular and Electrodiagnostic Medicine (AANEM), and the American Academy of Physical Medicine and Rehabilitation (AAPM&R). The physicians reviewed and analyzed all literature from 1960 to August 2008, aiming to address the basic question: "What is the efficacy of a given treatment (pharmacologic: anticonvulsants, antidepressants, opioids, others; and non-pharmacologic: electrical stimulation, magnetic field treatment, low-intensity laser treatment, Reiki massage, others) to reduce pain and improve physical function and quality of life (QOL) in patients with PDN?" The guideline is published in the April 11, 2011, on-line issue of *Neurology*®, the medical journal of the American Academy of Neurology.

According to the guideline, strong evidence shows the seizure drug pregabalin is effective in treating painful diabetic neuropathy and can improve quality of life; however, doctors should determine if it is appropriate for their patients on a case-by-case basis. In addition, the guideline found that several other treatments are probably effective and should be considered, including the seizure drugs gabapentin and valproate, antidepressants such as venlafaxine, duloxetine and amitriptyline and painkillers such as opioids and capsaicin. Transcutaneous electric nerve stimulation (TENS), a widely used pain therapy involving a portable device, was also found to be probably effective for treating painful diabetic neuropathy.

Dr. Bril confirms, "We were pleased to see that so many of these pain treatments had high-quality studies that support their use. Still, it is important that more research be done to show how well these treatments can be tolerated over time since diabetic nerve pain is a chronic condition that affects a person's quality of life and ability to function." The recommendations of this guideline will serve as the foundation for a new set of tools the AAN is creating for doctors to measure the quality of care they provide people with nerve pain.

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Visit <http://www.aan.com/press/index.cfm?fuseaction=release.view&release=935> to read more about the AAN's Guideline on painful diabetic neuropathy.

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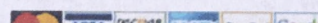
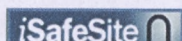
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EVAN
S. Times 1/22/12 ✓
**PEOPLE'S
PHARMACY**

BPA levels in canned foods, register receipts

BY JOE AND TERESA GRAEDON
Syndicated columnists

Q: I was alarmed to read that eating canned soup can raise body levels of BPA. If this is true for canned soups, wouldn't it follow that other canned foods would pose the same problem?

A: Bisphenol A (BPA) is a component in clear hard plastics and the linings of cans. Many canned foods contain BPA that leaches into the food from the lining.

Research published in the Journal of the American Medical Association showed that people who ate canned soup for a week dramatically increased the amount of BPA in their urine (Nov. 23/30, 2011). Because BPA can act like estrogen in the body, this is worrisome.

Another reader commented: "It's not just soup but any canned food that may be exposed to BPA. Some companies do not line their cans with BPA. Look online to find the brands that are BPA-free."

There is another overlooked source of BPA. A different reader warns: "BPA also coats the paper that many store receipts are printed on. It comes off on hands. Consumers should decline receipts, or handle them with care and wash their hands afterward. Children should never be allowed to handle these receipts." Research has confirmed that register receipts often contain BPA that can be absorbed through the skin (Environmental Health Perspectives online, Jan. 1, 2012).

Q: I am an international flight attendant. I was pleased to read in your column that coffee might be used for asthma in an emergency.

I think we have some kind of asthma medication in our enhanced medical kit, but just in case, I now know we can use coffee as a backup plan.

A: There is some controversy about how effective caffeine is to open airways. A methodical review of the medical literature concluded that it can "improve lung function for up to four hours" (Cochrane Summaries, Oct. 5, 2011). When nothing else is available, a couple of cups of strong coffee might help.

Q: My father has atrial fibrillation and is treated with a pacemaker and digoxin.

His heart doctor ordered amitriptyline because of a burning sensation in his feet. He had fainting spells within two weeks of starting on the amitriptyline. With his heart condition, what is a good alternative for treating his neuropathy?

A: Amitriptyline is an old-fashioned antidepressant that is sometimes prescribed for nerve pain (peripheral neuropathy).

This drug is rarely appropriate for senior citizens. For one thing, it can trigger irregular heart rhythms, which might have contributed to the fainting spells. This drug also can cause dry mouth, dizziness, drowsiness, constipation and confusion, among other side effects.

Your father might ask his doctor about benfotiamine, a synthetic form of vitamin B-1. Studies suggest it helps ease neuropathy for some people (Pharmacological Research, June 2010).

In their column, Joe and Teresa Graedon answer letters from readers. Write to them c/o King Features Syndicate, 300 W. 57th St., 15th floor, New York, NY 10019, or via their website: www.peoplespharmacy.org

The Seattle Times



Henri Arnold and Mike Argirion

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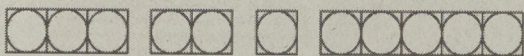
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Complete the grid so that every row, column and 3x3 box contains every digit from 1 to 9 inclusively.

4					6			8
7		6	2	3				
		2			1		3	
	4				7		5	3
			3		2			
3	7		8				1	
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DIFFICULTY RATING: ★ ★ ★ ★


Last Sunday's answer

5	4	9	7	3	2	6	8	1
1	7	3	9	6	8	5	4	2
2	6	8	1	5	4	9	7	3
8	9	7	4	1	5	3	2	6
6	3	5	2	7	9	8	1	4
4	2	1	3	8	6	7	9	5
3	1	4	6	9	7	2	5	8
7	8	6	5	2	1	4	3	9
9	5	2	8	4	3	1	6	7

Jumble Answers:

giblet unruly sprawl spotty harder
ers didn't want Sylvester Stallone to star in
," so he — Put up a fight

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PERSONAL HEALTH | Jane E. Brody

The Many Ills of Peripheral Nerve Damage

If you have ever slept on an arm and awakened with a "dead" hand, or sat too long with your legs crossed and had your foot fall asleep, you have some inkling of what many people with peripheral neuropathy experience day in and day out, often with no relief in sight.

And numbness and tingling are hardly the worst symptoms of this highly variable condition, which involves damage to one or more of the myriad nerves outside the brain and spinal cord. Effects may include disabling pain, stinging, swelling, burning, itching, muscle weakness, twitching, loss of sensation, hypersensitivity to touch, lack of coordination, difficulty breathing, digestive disorders, dizziness, impotence, incontinence, and even paralysis and death.

I realize now that I had a mild, reversible bout of peripheral neuropathy several decades ago when a misplaced shot of morphine damaged a sensory nerve in my thigh. It took three years for the nerve to recover, and for much of that time I could not tolerate anything brushing against my leg.

One of my sons, too, was afflicted when a nerve behind his knee was injured during a basketball game. He had no feeling or mobility in his foot for nine months, but after several years the nerve healed and he regained full use of his foot.

And a good friend was nearly paralyzed, also temporarily, following a flu shot, by a far more serious form of peripheral neuropathy — an autoimmune affliction called Guillain-Barré syndrome, in which one's own antibodies attack the myelin sheath that protects nerves throughout the body.

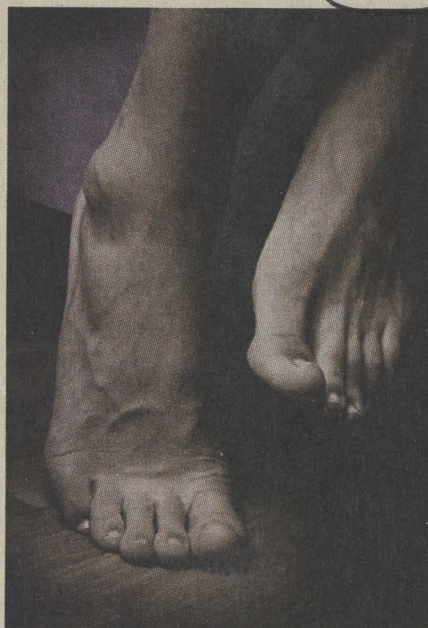
There are hundreds of forms of peripheral neuropathy. A medical guide describing them, compiled by a team of neurologists at the behest of the Neuropathy Association, fills a booklet the size of a two-year wall calendar.

The association, which sponsors research and provides education and support for patients and families dealing with peripheral neuropathy, estimates that the disorder afflicts more than 20 million Americans at any given time. If the cause can be corrected, peripheral nerves can regenerate slowly and patients can recover, although not always completely.

But many people never recover. They must learn to live with the disorder, with the help of treatments and devices that can ease their discomfort and disability. With such a wide array of symptoms and causes, getting a correct diagnosis is often a challenge. Worse, frustrated patients are sometimes told, "It's all in your head."

Causes Behind an Ailment

There are three types of peripheral nerves: sensory nerves, which transmit sensations like pain, touch, heat and cold; motor nerves, which control the action of muscles throughout the body; and autonomic nerves,



which regulate functions that are not under conscious control, like blood pressure, digestion and heart rate. Symptoms of neuropathy depend on what nerves are involved.

Someone with damaged sensory nerves might not feel heat, for example, and could be scalded by an overly hot bath. Neuropathy of the motor nerves can result in weakness, lack of coordination or paralysis; neuropathy of the autonomic nerves can lead to high blood pressure, irregular heart rate, diarrhea or constipation, impotence and incontinence.

The list of possible causes of neuropathy is far too long for this column. They include inherited conditions like Charcot-Marie-Tooth disease; infections or inflammatory disorders like hepatitis, Lyme disease, AIDS, rheumatoid arthritis and lupus; organ diseases like diabetes, hypothyroidism and kidney disease; exposure to toxic substances like industrial solvents, heavy metals, sniffed glue and some cancer drugs; trauma to or pressure on a nerve from an injury, cast, crutches, abnormal body position, repetitive motion (as in carpal tunnel syndrome), tumor or abnormal bone growth; alcoholism; and deficiency of vitamin B12.

The most common cause, accounting for nearly a third of neuropathy cases, is diabetes, especially among those whose blood sugar levels are poorly controlled. Half of all people with diabetes eventually begin to lose sensation and develop pain and sometimes weakness in their feet and hands. In people with diabetes, even minor injuries to the feet, if not quickly and properly treated, can result in gangrene and amputations.

In nearly a third of cases, no cause is ever found, leaving patients with no other recourse than treatment of their symptoms.

Suspected cases are best referred to a neurologist, who should begin by taking a complete personal and family medical history and performing a physical and neurological examination, checking on reflexes, muscle strength and tone, sensations, balance and coordination.

A complete workup is likely to include blood tests, urinalysis, a nerve conduction study and electronic measurements of muscle activity. Imaging studies, like a CT scan or an M.R.I., may reveal a tumor, vertebral damage or abnormal bone growth. In some cases, a nerve or muscle biopsy may be done.

Relief and Restoration

If the underlying cause cannot be corrected, the goals of treatment are relief of symptoms and restoration of lost functions. Pain control is paramount. Effective relief may come from over-the-counter remedies or a lidocaine patch but sometimes requires prescribed opiates.

Many with neuropathic pain have benefited from drugs licensed for other uses, including antiseizure medications like gabapentin, topiramate (Topamax) and pregabalin (Lyrica) and antidepressants like the tricyclic amitriptyline and the selective serotonin and norepinephrine reuptake inhibitor duloxetine (Cymbalta). Vitamin B12 deficiency can be treated with supplements and fortified cereals or by judicious consumption of meats, poultry, fish, eggs and dairy products.

And since alcohol and tobacco are particularly risky for people with neuropathy, or a health problem that predisposes them to it, they have every reason to quit smoking and to drink only in moderation.

Many patients are helped by physical therapy, occupational therapy and devices like braces, splints and wheelchairs. Railings on stairways and in the bathroom, elimination of tripping hazards like scatter rugs, and improved lighting (including night-lights) can reduce the risk of falls. For those insensitive to heat, a thermometer should be used to test water in a tub, shower or sink. Orthopedic shoes are invaluable to patients with lost sensitivity in their feet or impaired balance.

A variety of mechanical aids can make it easier to live with peripheral neuropathy, among them kitchen tools made by Oxo. Those with digestive problems might try eating small frequent meals and sleeping with their heads elevated.

Other helpful sources include the book "Peripheral Neuropathy: When the Numbness, Weakness and Pain Won't Stop" (Demos Health, 2006), by Dr. Norman Latov, professor of neurology and neuroscience at Weill Cornell Medical College; and the Neuropathy Association, 60 East 42nd Street, Suite 942, New York, N.Y. 10165-0930 (800-247-6968, or online at www.neuropathy.org). The association maintains a list of support groups and of centers that specialize in diagnosing and treating neuropathy.

POSTINGS | RECENT ENTRIES FROM OUR BLOGS

blender for biology has created such a mashup of invasive and exotic plants and animals, not to mention microbes, that the core mission of an entire discipline, restoration ecology, is in danger of vanishing.

Barbara Midgette replies: I'm at Cape Hatteras, where just offshore there are now breeding lionfish, deadly escapees from the exotic fish aquarium trade. A couple of years ago there were only a few, but now they appear to be established.

Gary Kirkland: Humans are part of nature. Much evidence

supports this premise. . . . Spreading species from one ecosystem to another is part of evolution and encourages adaptive traits.

Well

From Tara Parker-Pope's blog, nytimes.com/well.

Colleges with a reputation for heavy drinking and a party culture have been largely ineffective at curtailing student drinking over the past decade, new research shows.

University of Minnesota researchers tracked the drinking

habits of students at 18 colleges with a reputation for heavy drinking. In 1993, 28 percent of students said they frequently binged on alcohol. A similar survey in 2005 found that 32 percent were frequent binge drinkers, according to a report last month in The Journal of Studies on Alcohol and Drugs.

The study didn't measure what the various colleges were doing to address heavy drinking, but other studies have shown that they often take the wrong approach, with programs that simply warn students about the risks

of alcohol. Research suggests that it is more effective to get students to compare their drinking habits with those of their peers, showing them that regular excessive drinking isn't the norm.

Solution to puzzle on Page 2.



J&R

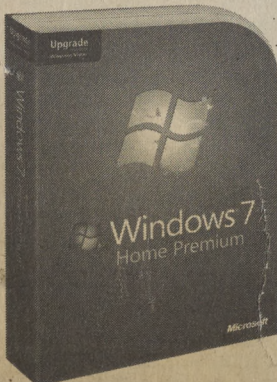
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PERSONAL HEALTH | Jane E. Brody

Shedding Light on a Tremor Disorder

"Essential" usually means vital, necessary, indispensable. But in medicine, the word can assume a different cast, meaning inherent or intrinsic, not symptomatic of anything else, lacking a known cause.

Since the mid-19th century, "essential tremor" has been the diagnosis for a disorder of uncontrollable shaking — usually of the hands but sometimes of the head and other body parts, or the voice — that is not due to some other condition. And without knowing what causes it, doctors have been slow to come up with treatments to subdue it.

As a result, millions of individuals suffer to varying degrees with embarrassment and humiliation, social isolation and difficulties holding down a job or performing the tasks of daily life. When you cannot drink a glass of water or eat soup without spilling it because your hand shakes violently, you are unlikely to join others for a dinner out. When you have to depend on someone else to button your shirt or zip your jacket, you may not go out at all.

Wherever those with essential tremor go, people are likely to stare at them and assume they have a drug or alcohol problem, said Catherine Rice, executive director of the International Essential Tremor Foundation in Lenexa, Kan. (Call it at 888-387-3667 or visit its Web site: www.essentialtremor.org.)

Now, thanks to the devoted efforts of a few researchers here and abroad, all this may change. Recent studies have begun to unravel the mysteries of essential tremor, and "essential" may someday be dropped from its name.

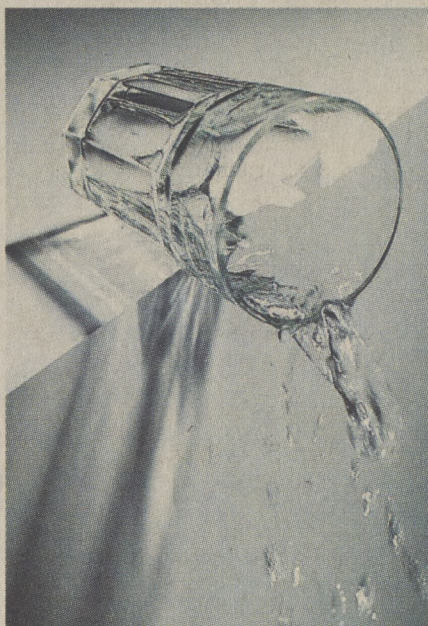
"Until very recently," Dr. Elan D. Louis, a pioneering neurologist and epidemiologist at the College of Physicians and Surgeons at Columbia University, told me, "essential tremor was thought to have no known pathology, no changes in the brain, which led to a medical dead end." But in the last five years, Dr. Louis said, discoveries in three areas — the brain, clinical findings and genetics and environment — "have changed our understanding of this disease."

And as our understanding evolves, he predicts that rational therapies will follow.

Common Over Age 65

Essential tremor is a neurological disorder that causes uncontrollable shaking of one or more body parts during voluntary movement. The symptoms disappear at rest. In that way it differs from Parkinson's disease, in which shaking at rest is a common symptom that disappears during movement. But those with essential tremor are four to five times as likely to develop Parkinson's as people without tremor, and both conditions involve related changes in the brain.

Though essential tremor most often affects older people — as many as 1 in 5 over 65 have it — it can occur at any age, even in young children. It is typically progressive,



RYAN McVAY/GETTY IMAGES

getting worse as people age.

Stephen Remillard of Steamboat Springs, Colo., said he learned he had essential tremor while in kindergarten, when it affected just his hands. But the condition worsened as he got older, and by high school, Mr. Remillard said, "all my extremities as well as my voice were affected." When he had to speak in class, he said, "it came off as if I was nervous, though I've always been a very confident person."

The academic challenges related to tremor prompted him to drop out of college. But the biggest blow to Mr. Remillard's self-esteem came when he tried to join the military and was rejected by the Army, Marines, Air Force and Coast Guard. Rather than feel sorry for himself, he returned to college, graduating last May, and started playing sports. Now 25, he works for a ski corporation and runs marathons to raise money for causes like the Lance Armstrong Foundation.

For Richard Crandell, a 66-year-old guitarist from Eugene, Ore., the problem began around age 60, forcing him to abandon his instrument. But he, too, was not to be defeated: he took up the mbira, an African thumb piano that he plays with two thumbs and an index finger.

Still, Mr. Crandell said, he has problems shaving, brushing his teeth, using a computer and slicing and dicing in the kitchen. And at the bank, he has to ask the teller to fill in his forms "because my handwriting is all over the place."

Ms. Rice said essential tremor ran in her family. "My great-aunts used to shake uncontrollably, starting in their early 40s and becoming quite severe by the time they were 60," she said. "They found it very difficult to

cook, though their job was to feed the farmhands. They couldn't pick up a heavy pan without spilling the contents. They had to give up crocheting and other things they truly loved."

New Findings

Dr. Louis and colleagues have established a centralized brain repository that has revealed underlying abnormalities in essential tremor patients. The scientists collect detailed clinical and physiological data on each person, and after death their brains are shipped to Columbia, where they are analyzed and compared with the brains of normal individuals.

Of the 50 brains studied so far, Dr. Louis said, "all are degenerative and have very clear pathological changes, although there are several types, suggesting this is probably a family of diseases." In one subtype, Lewy bodies, which also occur in Parkinson's disease, are found in the brain but in a different area from Parkinson's. (Mr. Crandell's father died of Parkinson's, and there have been suggestions that the disorders may be linked.)

In about 80 percent of the brains, there are degenerative changes in the cerebellum, including a loss of cells that produce a major inhibitory neurotransmitter called GABA. Other abnormal findings include a messy arrangement of neurofilaments, which may interfere with nerve cell transmission.

Clinically, essential tremor is now considered a neuropsychiatric disease that can include unsteadiness, abnormal eye movements, problems with coordination and cognitive changes that sometimes progress to dementia.

Even certain personality types tend to be overrepresented among patients with essential tremor, Dr. Louis said. Many "are very detail-oriented and tightly wound and have higher harm-avoidance scores," he said.

Two environmental toxins have been found to be elevated in tremor patients: lead and a dietary chemical called harmane that occurs naturally in plants and animals. When meat is cooked for long periods or at high temperatures, as in barbecuing, levels of harmane rise sharply. Dr. Louis called these "tantalizing leads."

Despite the problems caused by their disorder, most patients with essential tremor never seek treatment. Two drugs, propranolol (Inderal) and primidone (Mysoline), developed to treat other conditions, have proved helpful for many but not all patients. A costly surgical treatment, deep brain stimulation, has helped to reduce tremors in about 80 percent of patients who have tried it.

Caffeine, certain prescription drugs and undue stress can make symptoms worse and are best avoided. Though alcohol can temporarily relieve tremors, regular heavy drinking is a recognized cause of the disorder.

POSTINGS | RECENT ENTRIES FROM OUR BLOGS

Dot Earth

From Andrew C. Revkin's blog, nytimes.com/dotearth.

In the first comprehensive international report on Antarctica's climate, there was strong agreement that the West Antarctic Ice Sheet will substantially contribute to the continuing rise in sea levels in a warming world, while increased snowfall in the interior could offset the contribution somewhat. The study also noted a 10 percent rise in the area of sea ice around the continent since 1980, which the authors said appeared to be related to changes in

winds ascribed to the depletion of the ozone layer there.

The sleepy Atlantic hurricane season ended last week, with the development of a Pacific El Niño condition predictably shifting winds into a pattern that stifles Atlantic storms. I asked Tom Knutson of the Geophysical Fluid Dynamics Laboratory in Princeton, N.J., about the conditions in relation to the discussion about how warming could affect tropical storms. He said a "convincing greenhouse-gas-driven change has not emerged in the data so far, in my view, and may well be 'in the noise' due to both large

natural variability (compared to the expected size of the greenhouse-gas-driven signal) and data quality issues."

That doesn't mean a signal is unlikely to emerge, particularly in tracking of storms in the strongest categories.

The New Old Age

Paula Span posted at nytimes.com/newoldage.

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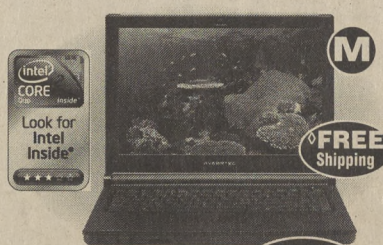
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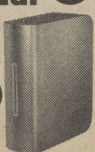
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appropriate steps to manage them in order for patients to realize the full benefits of this agent.

In order to prevent potential birth defects and ensure the safe use of thalidomide, the System for Thalidomide Education and Prescribing Information (STEPS®) has been implemented in conjunction with the Food and Drug Administration (FDA) and several advocacy groups. *Zeldis 1999* The critical period of thalidomide-induced teratogenicity is thought to occur between 34 and 50 days after the last menstrual cycle. *Lenz 1962* Accordingly, thalidomide should never be used by pregnant women or those considering pregnancy. Women of childbearing potential may be treated with thalidomide providing they abstain from sexual intercourse or use 2 methods of birth control, 1 of which should be an effective barrier method. The STEPS® program includes pregnancy testing and contraception for female patients and contraceptive counseling for both male and female patients. It requires that all patients provide informed consent before qualifying for thalidomide therapy and complete telephone surveys every 28 days during treatment. Physicians, physician assistants, and advanced registered nurse practitioners must also register with the STEPS® program, indicating that they will comply with these requirements, before they can prescribe thalidomide. The registration process involves a telephone survey and a written registration form that can be faxed to the manufacturer (Celgene Corporation). *Zeldis 1999* Thalidomide is available in 50-mg white, hard-gelatin capsules imprinted with the word "Celgene." Thalidomide is supplied in boxes of 6 prescription packs of 14 capsules each for a total of 84 capsules per box. Thalidomide PI Prescriptions are written for a 28-day supply without any refills.

Management of Adverse effects

In general, adverse effects are usually mild to moderate in severity and related to the thalidomide start, and cumulative dose.

Sedation

Thalidomide frequently causes drowsiness and somnolence, particularly at doses of 200 mg or higher. Patients with poor performance status of 3 or 4 tend to be more susceptible to this adverse effect according to the use of thalidomide at the Cleveland Clinic(<http://www.clevelandclinic.org/myeloma>) with multiple myeloma patients. Signs and symptoms associated with sedation include dizziness, weakness, fatigue, unsteadiness, confusion, blurred vision, and memory loss. Sedation can be minimized by gradually increasing the thalidomide dose by 50 mg per week in those with performance status of 2 or worse and by 50 to 100 mg per week in those with performance status of 0 or 1. The sedative effects usually decline over time, and most patients become tolerant after continued treatment for several weeks. The sedative effects should be allowed to diminish before escalating the dose to the next level.

Thalidomide administration is not recommended during the daytime because of its sedative properties. Instead, it should be given in the evening 1 or 2 hours before retiring. This dosing strategy is generally effective in minimizing drowsiness and lethargy in the morning. However, if the patient is increasingly lethargic in the early morning hours, thalidomide should be taken earlier in the evening. If this change fails, dosing adjustments may be necessary, such as a dose reduction followed by a more gradual dose escalation every 2 weeks. Patients should be warned about the risks of driving or operating heavy machinery while receiving thalidomide. To help reduce dizziness, patients should increase fluid intake to 8 to 10 glasses per day, and they should be advised to change positions slowly. *Hussein 2000* For example, patients should sit upright for several minutes before standing from a recumbent position. *Hussein 2000* Finally, it is important to ensure that patients avoid other medications that can worsen the sedative effects of thalidomide, including alcohol, sedatives, tranquilizers, and antidepressants.

Constipation

With the appropriate use of bowel regimens at the initiation of thalidomide therapy in myeloma patients at the Cleveland Clinic, the occurrence of constipation occurs is virtually not present. This complication can be incapacitating without the appropriate care, because many patients are also receiving narcotics. Together, thalidomide and narcotics decrease bowel motility. Prevention is the key to constipation management. Patients should be advised to increase their intake of fluid and dietary fiber. Stool softeners/laxatives, such as Senokot-S, psyllium, milk of magnesium, or docusate sodium, may also be started at the beginning of thalidomide therapy in order to achieve regular bowel movements. Exercise may reduce constipation and should be encouraged as tolerated. More aggressive therapy, including use of suppositories and enemas, may be considered providing the patient is adequately hydrated. In severe cases, intermittent dosing or a dose reduction may be necessary until the constipation has resolved.

Rash

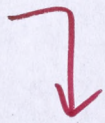
Two different types of rashes may occur in patients during thalidomide therapy. The more common rash, which usually occurs within the first 2-6 weeks of treatment, is typically non-pruritic, erythematous, and macular, generally starting on the trunk and then spreading to the back and proximal extremities. *Hasslet 1997* In the absence of systemic signs and symptoms, this rash should be managed symptomatically by using soothing creams, and if necessary antihistamines, or topical corticosteroids. A significant proportion of multiple myeloma patients treated at the Cleveland Clinic develops a mild asymptomatic rash that does not require any specific therapy other than monitoring. This form of rash often resolves with continued therapy.

The presence of pruritic rash, fever, eosinophilia, or reduced blood pressure may indicate a potentially serious reaction to thalidomide. Thalidomide PI Such patients should be monitored carefully, and thalidomide should be discontinued until a full clinical evaluation has been completed. Those patients should not be re-challenged with thalidomide, as the risk of severe allergic reaction in the form of Stevens Johnson is highly. Thalidomide should not be resumed if the rash is exfoliative, purpuric, or bullous, or if Stevens-Johnson syndrome or toxic epidermal necrolysis (TEN) is suspected. Stevens-Johnson syndrome generally presents with sore throat, malaise, fever, and erosions of mucous membranes followed several days later by the development of small blisters on purpuric lesions and subsequently by the detachment of the outer epidermal layer. *Stern 2001* Up to 10% of the body surface area may detach. TEN is the most serious skin reaction; it usually develops acutely with lesions similar to those seen in Stevens-Johnson syndrome, resulting in epidermal detachment of more than 30% of the body surface. *Stern 2001*

Peripheral Neuropathy

Peripheral neuropathy is a common and potentially severe adverse effect of thalidomide therapy occurring in as many as 80% of the patients. Thalidomide PI The incidence of neuropathy appears to be related to the dose and the duration of therapy. *Zomas 2000*. This toxicity presents initially as numbness, tingling, pain, or burning of the toes and feet and subsequently of the fingers and hands. It may be described as a sensation of "pins and needles." These symptoms usually improve after the thalidomide is discontinued; however in occasional cases the symptoms and signs are not reversible. The relationship between the cumulative thalidomide dose and neuropathy is unclear.

Peripheral neuropathy is usually reversible upon discontinuation of thalidomide, but the symptoms may resolve slowly in some patients or not at all in others. *Wulff 1985, Tseng 1996* Younger patients tend to recover more quickly and completely than those over 60 years of age. Patients who were treated previously



with chemotherapy, particularly with drugs that may cause neuropathy on their own, such as vincristine, are at increased risk of neuropathy during thalidomide therapy. Approximately 40% of myeloma patients have vitamin B12 and folate deficiency. *Beckmann 1995* By monitoring and correcting these deficiencies, it is often possible to minimize or eliminate neuropathic symptoms. (*Beckmann 1995*) Neuropathy may be increased in patients with peripheral nerve problems, such as amyloid nerve damage or diabetes mellitus.

Patients should be monitored monthly for signs of peripheral neuropathy during the first 3 months of therapy and periodically thereafter. Thalidomide PI Reducing the dose or temporarily discontinuing treatment will alleviate neuropathic symptoms in the majority of cases within 2 to 3 weeks. Treatment may be restarted only if symptoms have resolved. Avoiding cramped positions and pressure points may also be helpful. Another option is to give patients a trial of low-dose gabapentin (Neurontin®) starting at 300 mg t.i.d. and potentially escalating it to a total daily dose of 3600 mg.

Musculoskeletal Effects

Based on the Cleveland Clinic experience of patients with multiple myeloma taking thalidomide, achiness and muscle weakness is one of the most frustrating adverse effects of thalidomide, usually occurring after patients have received therapy for several weeks. These symptoms can be minimized or eliminated by increasing fluid intake and performing a regular exercise routine. In patients with increased cramping in their extremities, the administration of glucosamine sulfate 500 mg t.i.d. may help to relieve pain.

Neutropenia

A reduction in white blood cell counts may occur in some patients receiving thalidomide. According to product labeling, thalidomide therapy should not be initiated in patients who have an absolute neutrophil count (ANC) <750/mm³, and it should be interrupted if clinically appropriate in patients with persistent reductions in ANC below this level. Thalidomide PI accordingly, laboratory testing should be conducted on a regular basis. In the experience of the Cleveland Clinic myeloma group, the occurrence of neutropenia has not resulted in an increased incidence of infection, and consequently the thalidomide dose has not had to be changed or interrupted. In clinical studies conducted there, the dose of thalidomide is not adjusted based on the hematologic status.

Deep Vein Thrombosis

Deep vein thrombosis may occur rarely with single-agent thalidomide. In the study of 169 patients with multiple myeloma, the incidence of deep vein thrombosis was 1%. *Barlogie 2001* However, the risk of deep vein thrombosis is much higher if patients are treated with thalidomide in combination with chemotherapy. In a randomized controlled trial of patients with newly diagnosed multiple myeloma, deep vein thrombosis occurred in 28% of patients receiving thalidomide in combination with a multidrug chemotherapy regimen but in only 4% of those receiving chemotherapy alone. *Zangari 2001* By introducing anticoagulation therapy with low-molecular weight heparin followed by warfarin (to achieve an international normalized ratio of 2.5 to 3), it is possible to continue thalidomide therapy in a majority of patients. During thalidomide treatment, nurses should evaluate whether signs and symptoms of deep vein thrombosis are present, including swelling or inflammation in the lower extremities, leg cramping or pain, abnormal breath sounds, or chest pain. Available unpublished data from this institution shows that non of 100 relapsed refractory patients treated with Thalidomide in combination with different chemotherapy regimen have developed deep venous thrombosis, moreover non of the newly diagnosed patients that have received thalidomide with non Adriamycin containing chemotherapy.

Miscellaneous Adverse effects

Patients may also experience several nonspecific adverse effects, including mood changes, confusion, "buzzing in the ears," dry mouth, headache, dry skin, itching, brittle nails, thyroid problems, changes in heart rate, hypotension, and peripheral edema. When an adverse effect becomes problematic, then thalidomide should be withheld and the adverse effect investigated further. Some of these effects can be prevented or minimized by simple precautions. For example, patients with multiple myeloma should be kept well hydrated in order to prevent any hypotensive effects. Concomitant use of antihypertensive agents may contribute to or exacerbate these hypotensive symptoms, and accordingly, a reduction in the dose of the concomitant medication may be appropriate. Peripheral edema, which is generally mild and short lived, should be treated by intermittently elevating the extremities, resting supine for several hours each day, and using elastic stockings before rising from bed in the morning. In more severe cases, diuretics may be helpful or the dose of thalidomide may be reduced or withheld.

Thalidomide Dose

The dose, schedule, and duration of thalidomide treatment have varied considerably in clinical trials of patients with multiple myeloma. At the Cleveland Clinic, thalidomide is started at a dose of 50 mg, which is given in the evening about 1 to 2 hours before retiring. The dose is escalated in 50-mg increments each week until a maximum of 400 mg daily has been achieved. When patients experience an increased amount of adverse effects, thalidomide is lowered to the previous dose and then increased more slowly. In the experience of the Cleveland Clinic, this dosing strategy is associated with fewer adverse effects than regimens in which the starting dose is higher or dose escalations are made in larger increments. Usually when thalidomide is prescribed, Senakot-S is also prescribed to help maintain a good bowel regimen. Patients are encouraged to increase fluid intake and to eat a well-balanced meal.

Conclusion

On the basis of clinical trials as well as experience at many medical centers, thalidomide can benefit patients with relapsed and refractory multiple myeloma. A low starting dose and slow escalation of thalidomide results in a better tolerance to the therapy, and allow patients to receive a fair trial of the drug. As additional clinical trials are conducted, the role of thalidomide alone and in combination with other drugs will become more clearly defined. Patients receiving thalidomide may experience a variety of different adverse effects, and if managed inappropriately, these can limit the delivery of optimal dosages of the drug. Compared to the adverse effects of standard therapies, however, the toxicities associated with thalidomide are mild and very manageable. Accordingly, nurses must be proactive in recognizing adverse effects and taking appropriate steps to manage them.

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Increases complete response rate and event-free survival when combined with stem cell transplant and high-dose melphalan but does increase overall survival.

Relapses when thalidomide and high-dose melphalan and stem cell transplant are utilized appear to be more drug resistant than relapses in a controlled group not treated with thalidomide.

When utilized with high-dose melphalan and stem cell transplant the relapsed patients have a higher failure rate and shorter survival after salvage treatment.

30% durable responses even in patients with refractory or relapsed myeloma.

Targets myeloma cells in the bone marrow milieu.

Powerful teratogen with nearly 10,000 infants affected worldwide.

Fetal malformations occur when the drug is ingested by a pregnant woman between days 35 and 49 after the last menstrual period.

A single pill can cause teratogenic effects.

Approximately 40% of affected children die within the first year.

Malformations include absence of ears, arms, deafness, facial deformities, phocomelia, and gastrointestinal malformations.

Inhibits angiogenesis.

Teratogenicity results from inhibition of angiogenesis and neovascularization.

Peripheral neuropathy is the major dose limiting factor.

Neuropathy seen at doses varying from 25-16000 mg/day.

Neuropathy predominantly sensory, axonal, length dependent and nonreversible pattern that may affect the dorsal root ganglia.

Thalidomide neuropathy causes a small and large fiber sensory peripheral neuropathy with symmetrical loss of all modalities, in the lower extremities were affected most.

Typical neurologic complaints from thalidomide include tingling or painful paresthesias and numbness in the feet and sometimes the hands.

Motor neuropathy recurs very infrequently with this agent and if present is usually mild.

Autonomic manifestations are common and include constipation, anorexia nausea hypotension, and bradycardia.

Peripheral neuropathy symptoms are usually reversible with dose reduction or stoppage of treatment, occasionally some side effects may be permanent.

Incidence of thalidomide induced peripheral neuropathy ranges from 37-83%, with most patients experiencing mild to moderate grade 1-2 toxicity.

Peripheral neuropathy typically is associated with symmetric paresthesias, with loss of tactile and pain response along with numbness and muscle cramps.

Rates of peripheral neuropathy after thalidomide treatment varies from 15-70%, with the risk related to cumulative dose and duration of therapy.

Factors influencing risk of neurotoxicity include prior neuropathy, advancing age, exposure to previous neurotoxic chemotherapy, vitamin B12 and/or folate deficiencies. *Neither*

The risk and severity of thalidomide peripheral neuropathy increases with Coumadin dose and treatment duration, particularly if greater than 6 months.

Neurotoxicity may occur even with short term exposure.

Reduction or withdrawal of drug treatment can lead to symptom resolution in up to 16 weeks, although in some cases the neuropathy is irreversible.

Suppresses tumor necrosis-alpha factor production from monocytes and macrophages by accelerating TNF-alpha mRNA degradation and inhibiting activation of the transcription factor NF-kB.

Inhibits other cytokines including TGF- β and IL-1 β .

Decreases the helper to suppressor T cell ratio in the peripheral blood of healthy men.

Has activity in Behcet syndrome.

In a randomized study of 722 patients given placebo or Thalidomide with gemcitabine or carboplatin chemotherapy in advanced non-small cell lung cancer: Resulted in no improvement in overall survival, and increased risk of thrombotic events, and an unexpected impaired survival in patients with non-squamous histology (Siow Ming Lee).

Wide dosing range with daily doses of 50-800 mg.

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VITAMIN B-12

For some test types, you can compare your new results to earlier results. If you have this option, you'll see a "graph or chart results" button below the test results.

The standard range column has general high and low values. Ask your doctor what your target value should be, based on your own health factors.

You may [submit a form](#) to stop (or resume) receiving a paper version of lab results.

Component Results

Component	Your Value	Standard Range	Units	Flag
VITAMIN B-12	712	210 - 910	PG/ML	

General Information

Collected: 11/29/2011 10:46 AM

Resulted: 11/30/2011 1:51 PM

Ordered By: E Lynn Chapman, MD

Result Status: Final result

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VITAMIN D (25 HYDROXY) (GHC)

For some test types, you can compare your new results to earlier results. If you have this option, you'll see a "graph or chart results" button below the test results.

The standard range column has general high and low values. Ask your doctor what your target value should be, based on your own health factors.

You may [submit a form](#) to stop (or resume) receiving a paper version of lab results.

Component Results

Component	Your Value	Standard Range	Units	Flag
VITAMIN D (25 HYDROXY)	35	30 - 80	ng/mL	
REFERENCE INTERVAL: Vitamin D, 25-Hydroxy This assay accurately quantifies the sum of vitamin D3, 25-hydroxy and vitamin D2, 25-hydroxy. 0-17 years: Deficiency: less than 20 ng/mL Optimum level: greater than or equal to 20 ng/mL* *(Wagner CL et al. Pediatrics 2008; 122: 1142-52.) 18 years and older: Deficiency: Less than 20 ng/mL Insufficiency: 20-29 ng/mL Optimum Level: 30-80 ng/mL Possible Toxicity: Greater than 150 ng/mL Performed by ARUP Laboratories, 500 Chipeta Way, SLC, UT 84108 800-522-2787 www.aruplab.com, Sherrie L. Perkins, MD, Lab. Director				

General Information

Collected: 11/29/2011 10:46 AM

Resulted: 11/30/2011 8:07 AM

Ordered By: E Lynn Chapman, MD

Result Status: Final result

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FOLATE

For some test types, you can compare your new results to earlier results. If you have this option, you'll see a "graph or chart results" button below the test results.

The standard range column has general high and low values. Ask your doctor what your target value should be, based on your own health factors.

You may [submit a form](#) to stop (or resume) receiving a paper version of lab results.

Component Results

Component	Your Value	Standard Range	Units	Flag
FOLATE	18.8	3.1 - 17.5	ng/mL	H

General Information

Collected: 11/29/2011 10:46 AM

Resulted: 11/30/2011 1:51 PM

Ordered By: E Lynn Chapman, MD

Result Status: Final result

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