Welcome to the Winter 2020 edition of Parkinson’s Post!

Our Nebraska Medicine/UNMC Parkinson Disease Patient, Family, and Caregiver Symposium on October 14, 2019 was an awesome event! There were more than 800 attendees and 25 Vendors/Sponsors to join us. The education sessions were provided by our renowned Movement Disorder Faculty and Therapy Department, and focused on Parkinson Disease Motor and Non-Motor Symptoms, New and Emerging Therapies/Advanced Management, and Optimizing the Quality of Life with Parkinson’s Disease. We also included multiple Question and Answer sessions that allowed attendees opportunities to ask our PD Experts a constellation of questions. The symposium concluded with our Keynote Speaker, Brian Grant, whom delivered an inspirational testament of his journey with Parkinson’s disease.

Please follow the following link to obtain access to all symposium powerpoint presentations and video playlist on YouTube: [http://www.unmc.edu/neurologicalsciences/patient-care/programs/movement-disorders.html](http://www.unmc.edu/neurologicalsciences/patient-care/programs/movement-disorders.html)
It’s a new year! Time to live BIG! One way to live BIG is to take control of your health and participate in a daily exercise program. While there are many types of exercise programs you can participate in, there are some that have been developed specifically to target the symptoms associated with Parkinson’s disease. One such program is LSVT BIG. Lee Silverman Voice Training (LSVT) started when the Silverman family expressed their desire to hear and understand the speech of their loved one, Mrs. Lee Silverman. She began working with a speech language pathologist on an intensive amplitude-based exercise program for the speech motor system. As her voice volume and projection improved, it was discovered that the same intensive amplitude-based exercise concepts could be implemented for the limb motor system. This was the launching point for LSVT BIG.

The goal of LSVT BIG is for an individual to use bigger movements automatically in everyday living. LSVT BIG is performed with a physical or occupational therapist that has been trained and certified in the LSVT BIG program. Intensity is fundamental to motor learning and neuroplasticity. To achieve this, the recommended protocol is treatment 4 days a week for 4 weeks and daily home exercise practice. During the treatment sessions, you learn a series of standardized exercises that are performed with high intensity. High intensity = 100% effort + repetitions + resistance + accuracy + large amplitude. Intensive practice is important for maximal plasticity (Kleim & Jones, 2008). Arousing the sensorimotor system is necessary to override bradykinesia (slowness of movement) and hypokinesia (decreased movement). You will learn to self-monitor your movement and identify with the amount of effort needed to consistently produce bigger, more normal amplitude movements. Often what is perceived as being too big, is actually more normal movement. Through internal cues, repetition, and high effort, you can recalibrate the sensorimotor system and achieve improved functional movement for daily tasks and mobility.

Another component of LSVT BIG is BIG walking. Walking is practiced at each session with focus on big arm swing, big steps, and big posture. This helps to improve gait efficiency, gait speed, and safety for community ambulation. A goal of LSVT BIG walking is to reduce the frequency of freezing. If a freeze does occur, remember the 4 S’s to resume movement: Stop BIG, Stand BIG, Shift BIG, and Step BIG. These strategies can help you resume walking and reduce fall risk.

Throughout the LSVT BIG program, you will be challenged to think BIG. Thinking BIG is necessary to perform at 100% effort, practice large amplitude movements, and maintain high intensity during the exercise session. You can move better, feel better, and take control of your health by participating in an exercise program like LSVT BIG. The time is now to live BIG! Talk with your physician about treatment orders to participate in LSVT BIG with a certified physical or occupational therapist.

Think BIG, move BIG, and live BIG!!
Mediterranean Diet

Jenna Paseka, MS, RD, LMNT
Nutrition Therapist | Neurological Sciences Department | Nebraska Medicine

The Mediterranean diet is an eating approach that can help increase your intake of nutritious foods and maintain a healthy weight.

It is recognized as one of the healthy eating plans recommended by the Dietary Guidelines for Americans. The Mediterranean diet may provide benefits in heart and brain health, cancer prevention, and diabetes prevention and control.

These are some of the main concepts:

• Foods to enjoy every day: whole grains, fruits, vegetables, beans, herbs, spices, nuts, seeds and healthy fats such as olive oil and avocados. Meals are built around plant-based foods.
• Twice weekly servings of fish and seafood.
• Moderate portions of dairy foods, eggs and occasional poultry.
• Infrequent servings of red meats and sweets.
• Avoid foods and beverages with added sugars, sodium, saturated fats and trans fats.
• Red wine in moderation. Check with your physician before drinking alcohol.

Mediterranean Diet Example (from Academy of Nutrition and Dietetics):

**Breakfast:** 2 slices whole grain bread with 1 tsp olive oil and 1 ounce feta cheese, 1 orange and 1 cup unsweetened coffee or water

**Lunch:** 1 cup lentil soup, ½ cup tabbouleh (parsley and bulgur salad), ½ whole grain pita bread, ½ cup hummus, ½ cup cucumber slices, ½ cup olives and 1 cup unsweetened tea or water

**Dinner:** 3 ounces grilled fish; 1 cup whole grain pasta with ¼ cup marinara sauce; ¼ cup fresh basil and ½ cup sautéed eggplant; 1 cup spinach or romaine salad with 1 Tbsp olive oil and 1 ounce almonds; ½ cup grapes and 1 cup unsweetened tea or water

**Snack:** 1 cup Greek yogurt and ½ cup figs

Heading into 2020, take some of these concepts and incorporate them into your daily meals and snacks. Do not be afraid to try something new!

For recipes and more ideas, check out [https://oldwayspt.org/recipes](https://oldwayspt.org/recipes) and click “Mediterranean diet” on the left hand side.
Behavioral Management of Hallucinations in Parkinson’s Disease
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Hallucinations and illusions are common in people with Parkinson’s disease (PD), affecting 25-70% of patients with PD over the course of the disease (Parkinson’s Foundation, 2018).

### DEFINITIONS

<table>
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<tr>
<th>Illusions</th>
<th>Misperception of something that is actually there. An example would be mistaking a pile of clothes on the floor for your dog.</th>
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<tr>
<td>Hallucinations</td>
<td>Unusual sensory experiences in which one sees, hears, smells, tastes, or feels something that is not actually present.</td>
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In people who have PD, visual hallucinations/illusions are more common than those affecting the other senses. People with hallucinations commonly report:

- Seeing well-formed people, animals, or objects, which are typically non-threatening, familiar, and appear only briefly.
- Having a “passage hallucination,” or a brief sensation that there is a person or animal moving by in the periphery of their visual field.

A few factors are thought to contribute to the development of PD-related hallucinations/illusions:

- Effects of medications used to treat PD.
- PD-related changes in the structure and activity of visual pathways in the brain.

When hallucinations first appear, individuals with Parkinson’s disease usually have insight. That is, they understand that this unusual sensory experience is a symptom of PD and not reality. As the disease progresses, people sometimes lose insight. This may lead to changes in behavior, which put the person and their caregivers at greater risk.

Fortunately, there are several behavioral strategies that can be helpful in managing hallucinations in PD. The strategies that will be effective to manage hallucinations and illusions in PD depend on each person and the characteristics of the illusions/hallucinations.

**Changes to the Environment:**

- Keep dark areas well-lit, such as hallways and staircases, and turn on extra lights at night to help reduce visual hallucinations/illusions.
- Remove or secure any dangerous/hazardous items (e.g., weapons, cleaning products) to prevent accidents or injuries.
- Hallucinations can reduce a person’s ability to pay attention to their environment. Remove or move any items that could present a tripping hazard.

**When Experiencing Hallucinations:**

- Keep a detailed record of hallucinations to help identify if there are any triggers. This may improve predictability of hallucinations, make them less distressing, and facilitate productive conversations with medical providers.
- Engage in reality-testing such as attempting to touch what you are seeing. If the hallucinations are people, you could have them interact with the environment. If they do not, that is a good sign the person is a hallucination.
- Sleep deprivation can increase the occurrence of hallucinations/illusions.
- People often feel embarrassed by mental health symptoms, but hallucinations/illusions are common in PD. Not disclosing them can lead to social withdrawal and prevent conversations about treatment options. Talk about your hallucinations with loved ones and your medical providers.

**For Caregivers:**

- If the person has preserved insight, gently pointing out that they are experiencing a hallucination may be sufficient.
- If insight is poor, arguing with someone will only increase their agitation. Instead, go along with what they are saying or attempt to distract the person.
- If someone becomes agitated or aggressive, just remember the “5 S’s.”
  - Stay calm
  - Support - Attempt to reassure the person they are safe, and engage in active listening
  - Slow – Try not to make any sudden movements
  - Space – Do not crowd the person
  - Safety – If you feel your loved one is a danger to themselves and/or others, call 911.
- Tell medical providers and trusted loved ones about the hallucinations.

Before attempting to manage symptoms behaviorally, any sudden or drastic change to mental status (i.e., sudden confusion that is significantly different from baseline for that person) should be disclosed to a health care provider to rule out reversible causes of psychosis, such as, delirium or recent medication changes. Annual exams to evaluate hearing and vision are also important as normal, age-related declines in vision and hearing can contribute to experiencing hallucinations and illusions.

You can also discuss with your neurologist whether there are additional medical interventions for hallucinations.

You can also discuss with your neurologist whether there are additional medical interventions for hallucinations.
Modified Barium Swallow Study: What is it and when would it be recommended?

Hannah Jackman, MS, CCC-SLP
Speech Therapist | Nebraska Medicine

What is a modified barium swallow study? A modified barium swallow study (MBS) is completed under fluoroscopy, or X-ray. The machine is operated by a radiologist. The radiologist and speech-language pathologist both interpret the results and often times can provide results immediately following MBS. Liquids and foods contain barium to allow for viewing under the fluoroscopy machine. The patient is asked to swallow the food and liquid, while medical staff look for problems during the oral (mouth) and pharyngeal (throat) phases of swallowing.

When would a modified barium swallow study be recommended? Typically, a clinical swallow examination is completed initially prior to a modified barium swallow study to assess for dysphagia, or swallowing difficulties. After a clinical swallow examination, your doctor or speech language pathologist may recommend a modified barium swallow study for a more in-depth evaluation of your swallow function.

What is dysphagia? Dysphagia is the medical term for 'swallowing difficulty'. It can occur at any stage of Parkinson’s disease (PD) and can affect many parts of the swallowing mechanism. Symptoms of dysphagia include: difficulty chewing, moving the food from the front of your mouth to the back of your mouth, painful swallowing, coughing/choking while eating, feeling like food is stuck after you have swallowed, recurrent pneumonias, weight loss, and dehydration.

How do I seek help? If you think you are experiencing swallowing difficulties, the first step is to speak with your primary care physician or your neurologist. They will listen to your concerns and refer to a speech-language pathologist to complete a clinical swallow evaluation or modified barium swallow study if they think it is necessary.
The Lewy Body Dementias

Daniel L. Murman, MD, MS, FAAN
Director | Behavioral and Geriatric Neurology Program
Professor | Department of Neurological Sciences | University of Nebraska Medical Center

Where does the name Lewy body come from and what are “cortical” Lewy bodies? The Lewy body disorders are named after Dr. Friedrich Lewy, who discovered abnormal nerve cell inclusions in the autopsied brains of patients who died from Parkinson’s disease (PD). These inclusions were found in the motor control parts of the brain (i.e. basal ganglia nuclei, especially the substantia nigra). Dr. Lewy described these inclusions starting in the 1920’s and subsequently these abnormal inclusions were called “Lewy bodies.” In the 1960s, “cortical” Lewy bodies were discovered in patients with PD motor symptoms and features of dementia and psychiatric symptoms. These cortical Lewy bodies were composed of the same aggregated protein (i.e. alpha synuclein) seen in basal ganglia Lewy bodies, but they had a different appearance and distribution. Cortical Lewy bodies are found in the emotion parts of the brain (i.e. limbic system) and the thinking parts of the brain (i.e. cerebral cortex). Cortical Lewy bodies are associated with the changes in thinking and psychiatric symptoms seen in patients with one of the Lewy Body Dementias (i.e. PD with Dementia abbreviated PDD and Dementia with Lewy Bodies abbreviated DLB). Thus, Lewy bodies found in the brain at autopsy have helped us define and understand PD and the Lewy Body Dementias.

What does the term dementia mean and what is the difference between PDD and DLB? Dementia is defined as a decline in memory and thinking that is severe enough to limit a person’s ability to do every activities independently, such as driving, handle finances, shopping, cooking and taking medications. Dementia can be caused by many conditions, including cortical Lewy bodies, and can be classified as mild, moderate and severe. The main distinction between PDD or DLB is the timing of the dementia symptoms in relation to the timing of motor features of parkinsonism (i.e. stiffness/rigidity, slowness/bradykinesia, and tremor). In patients with PDD, motor symptoms appear first and typically for many years and then later a patient develops dementia symptoms. In patients with DLB, the dementia symptoms and the motor symptoms of parkinsonism develop together or the dementia symptoms precede the motor symptoms.

What are the symptoms and features of the Lewy Body Dementias? The clinical features of PDD and DLB are very similar. Both condition cause some combination of motor features of parkinsonism, including bradykinesia, rigidity, tremor, and eventually poor postural balance. The dementia symptoms can include problems with executive cognitive function (e.g. planning, multitasking, decision making), memory (e.g. retrieving information you have learned), visual spatial abilities (e.g. decoding complex aspects of what you see), and language (e.g. coming up with names). Fluctuations in thinking are very common in patients with PDD and DLB. Frequently patients have increased problems with thinking and confusion in the evening. This is where the term “sun downing” comes from. Patients with Lewy Body Dementia commonly have visual hallucinations, delusions, and are more likely to have dream enactment behaviors called REM Sleep Behavior Disorder (RBD). Patients with Lewy Body Dementia are at increased risk of acute confusion called delirium in the setting of hospitalizations, surgery, and medical illness.

What treatments are available for Lewy Body Dementia symptoms? The dementia symptoms of PDD and DLB can be improved with a group of oral medications called cholinesterase inhibitors. The brand and generic drugs names of this drug class include Exelon/rivastigmine, Aricept/donepezil and Razadyne/galantamine. These medications increase a brain chemical called acetylcholine and can help improve memory, attention, and everyday function and can decrease the severity of psychiatric symptoms such as hallucinations and delusions in some patients. Side effects can occur and include nausea, diarrhea and a runny nose. For patients with problematic visual hallucinations and delusions, we first try to adjust the PD medications that increase dopamine and are used to improve motor symptoms. The next option is to consider adding Nuplazid (pimavanserin), which is a medication that is FDA-approved for treating hallucinations in patients with PD. Problematic symptoms of dream enactment during sleep (RBD) can be treated with the over the counter medication melatonin or the prescription medication clonazepam/Klonopin.

The Lewy Body Disease Support Group meets, on the second Monday of every Month from 10 – 11:30 a.m. at the Milton R. Abrahams Library (5111 N 90th St, Omaha, NE) – please contact Charity Brumraugh (402.206.3963) for additional information.
Deep Brain Stimulation Therapy

Danish Bhatti, MD
Assistant Professor | Co-Director Comprehensive Parkinson Disease Clinic
Director | International Neurology Program
Associate Director | Movement Disorders Fellowship Program
Department of Neurological Sciences | University of Nebraska Medical Center

What is Deep Brain Stimulation therapy?
Deep Brain Stimulation (DBS) surgery or therapy is a treatment where a pacemaker type device is inserted into a patient’s brain with Parkinson’s disease (PD) to improve their motor symptoms or physical symptoms. DBS surgery consists of placing a wire with the tip in the deep part of the brain; the wire exits the skull through a hole and runs under the skin down into the chest where a pacemaker type battery is placed and connected with the wire in the brain which has contacts where electricity is delivered into the brain. The goal of DBS therapy is to improve tremors, movements or stiffness, etc.

What are the uses of DBS therapy?
DBS has been FDA approved for Essential Tremors since 1995 and for PD since 2005. In the United States, there are more than 150,000 patients with DBS and it is covered by insurances for treatment of tremor, symptoms of PD, and dystonia. DBS was recently approved for treatment of epilepsy and is being considered for treatment of depression.

What are the steps of DBS therapy?
The patients who are appropriate for the DBS surgery are usually selected by a Neurologist, then referred to a Neurosurgeon for surgically placement the system. The patients follow closely with their Neurologist for programming and adjustment of the stimulation. There are thousands of settings and combinations possible with the DBS system which is very different than a pacemaker which has just a few settings. DBS programming/settings depends on the patient, location of the wire, type of symptoms, medications and individual goals of therapy.

Who should get DBS Therapy?
DBS does not stop or slow the progression of symptoms or cure PD, however, it does manage PD motor symptoms similarly to Carbidopa/Levodopa (Sinemet). When taking oral medications for treatment/management of PD symptoms, patients sometimes experience increased fluctuations of motor symptoms, medications may be less effective than when they were initially started, may develop side effects from medications, or experience unpredictable dose failures and on/off states after taking medications. Medication absorption and metabolism can also be affected by ingestion of food (especially high protein meals) or activity/exercise which also contributes to unpredictable symptom response. Deep Brain Stimulation is constantly on, therefore, provides continuous benefit and decreasing the fluctuations of symptoms and medication side effects. DBS therapy provides benefits similar to symptoms that are improved with medications (symptoms that respond to medications will respond to DBS therapy). DBS therapy doesn’t replace PD medications, but often medications can be significantly reduced.
Beating Parkinson Disease

Kellie Barry

When I heard the doctor diagnose me with Parkinson’s Disease nearly twenty years ago, the first thing that popped into my head was the picture of a fragile elderly man lying in his bed, drooling as his nurse spoon fed him thickened juice and warm cereal. I certainly never pictured myself as a healthy, vibrant “mature” woman with five beautiful grandchildren. Here’s my story and “where I am today.”

Prior to my diagnosis, I watched a dog agility competition on Animal Planet which haunted me; day and night all I could think about was seeing the relationship that existed between a human and their dog. I obsessed over the subtle cues understood only by the handler and dog. I went on a mission to find the “perfect” agility dog. That’s when Elijah and I found one another. He was everything I wanted in an agility partner; he was fast, happy, agile, smart, intuitive, a beautiful example of his breed.

As we met more and more people in the world of agility, the inspiration that there was a need for a canine sports massage therapist occurred to me. So, with Elijah by my side I became a certified canine massage therapist - I called my business “Petsqweezers” and Elijah and I found ourselves on the go constantly.

While I enjoyed meeting new people and helping countless dogs recover from health complications and sports injuries, my dream of running my dog in agility still nagged at me. We took lessons in agility from a lady in exchange for massages on her border collies. Despite her expert teaching there was something wrong with our execution of the sport. I wasn’t able to give Elijah the subtle cues I had been taught. During one of my massage appointments I met a dog groomer. We became friends and I opened a very successful dog grooming business.

Then my world began to fall apart when my father was diagnosed with terminal lung cancer. He died 10 months later on December 19th; we buried him the night before Christmas Eve which was Dad’s and my favorite holiday. It was a stressful time for everyone in my family, and although everyone commented on the tremor in my left hand nobody thought anything about it.

Even the first neurologist I saw said it was due to stress. He told me to learn to relax and I would be fine.

Elijah and I continued to find it harder and harder to accomplish our lessons in agility. My body wasn’t moving like it used to. Elijah started to hesitate when we ran, unable to decipher my faulty cues. I decided to quit agility.

If that wasn’t difficult enough for me to give up, I closed my grooming shop. I just couldn’t get my hands to work like I needed them to. My legs and feet felt like I was trapped in a nightmare trying to run but couldn’t.

That’s when my best friend put me in touch with the movement specialists at UNMC. To avoid sounding like a line from a hallmark movie, they really have saved my life. I was completely crushed and strangely relieved.
at the same time when I got my diagnosis. I finally had a name to call my “condition”.

After my diagnosis I tried to get back to life as normal as I could make it. The drugs prescribed worked well. But with the effectiveness of the drugs came the side effects. Dyskinesia became my nemesis. I would sit in my chair every morning with my coffee in one hand and my pills in the other knowing that as soon as the drugs took effect that my body would betray me once again writhing and jerking uncontrollably. I’m not going to sugar coat things, I considered ending my misery.

I confided in my Movement Disorder Specialist and he suggested I would be an excellent candidate for deep brain stimulation surgery. I was hesitant at first. Then I was downright terrified. No anesthesia? Wide awake? Shave my head! That was the straw that broke this camel’s back. I drew the line. I took to the internet and You Tube to prove my point that nobody was going to do that to me! While trying to find the right video to defend my case against the surgery I watched countless stories of people who had it and we’re getting some relief of their symptoms. Slowly but surely I cautiously started to consider maybe the Doctors were trying to help me. I started to consider maybe, just maybe, they knew what they were talking about.

Once I made up my mind to have the surgery there was no stopping me. I had to do some fast talking to convince my Doctor to go ahead with it after being so against it at first. I had the surgery on November 21, 2013. They activated my DBS January 2014. It was not an immediate miracle. It took time and patience on everyone’s part to get me where I am today.

Where am I today? I’m studying for my first degree black belt in taekwondo. That’s where.
Parkinson’s Nebraska Laces Up for the 2020 UNMC Skate-a-thon for Parkinson’s

Parkinson’s Nebraska (www.parkinsonsnebraska.org) is preparing for its annual fundraiser in partnership with the UNMC. The 2020 UNMC Skate-a-thon for Parkinson’s is a 24-hour family-friendly event.

The Skate-a-Thon is held in memory of its founder, Colleen Wuebben. When Colleen was diagnosed with Parkinson’s disease in 2005, there were no specialized Parkinson's services available. She held the first Skate-a-Thon by flooding her backyard to make an ice rink and raise money to fund Parkinson’s exercise classes in Omaha. Colleen passed away in 2013, but her family has kept the tradition alive. This marks the ninth year Parkinson’s Nebraska has partnered with UNMC. This partnership has helped the Skate-a-Thon grow from one family’s backyard tradition into a family tradition for over 500 skaters each year.

The money raised at this event will support Parkinson’s research at UNMC and provide Parkinson’s services such as group exercise classes, support groups, professional trainings and educational presentations. Parkinson’s Nebraska is proud that all money stays in Nebraska to meet the unique and ever-changing needs of people living with Parkinson’s across the state.

Skaters can register as an individual ($15), family ($50), or Rock the Clock team member ($15). Rock the Clock teams are groups committed to having a representative on the ice for all 24 hours of the event. Registration includes ice skate rental and unlimited skating during the event. Tickets are available online at the Parkinson’s Nebraska website. Sponsorship and volunteer opportunities are also available.

Please contact Amber at amber@parkinsonsnebraska.org or 402.715.4707 to learn more about how you can impact the Parkinson’s Nebraska (www.parkinsonsnebraska.org) community.
Upcoming 2020 Events

**Parkinson’s Disease Support Group**

Every Third Friday at 10 a.m.
Fred & Pamela Buffett Cancer Center, 505 S. 45th St., Omaha, NE

**February 21**
Dr. John Bertoni

**March 20**
Dr. Thomas Magnuson

After entering the front of the Fred & Pamela Buffett Cancer Center, walk to the left of the registration desk and you will be directed to the appropriate meeting room which is on the **MAIN FLOOR** (Conference Room 0.12.103). Available parking will be in **GREEN PARKING**, across the street from the Fred & Pamela Buffett Cancer Center – there also is a circle driveway in front of the Cancer Center that can be utilized for dropping off and picking up.

If you are unable to attend the support group, but would like to watch the meeting from your computer, please utilize the following link to watch the meeting live: [https://unmc.zoom.us/j/458974074](https://unmc.zoom.us/j/458974074)

Please contact the Julie Pavelka, with any questions/concerns and RSVP (one week prior to meeting): parkinson.network@nebraskamed.com
Reliable Parkinson Resources

NOTE: This list is not complete, nor is it endorsed by UNMC or Nebraska Medicine

- American Parkinson Disease Association
  www.apda.org
- Davis Phinney Foundation for Parkinson's
  www.davisphinneyfoundation.org
- International Parkinson and Movement Disorders Society (WE MOVE)
  www.movementdisorders.org
- Michael J. Fox Foundation for Parkinson's Research
  www.michaeljfox.org
- Movement Disorder Society
  www.movementdisorders.org
- National Institute of Neurological Disorders and Stroke
  www.ninds.nih.gov
- Parkinson's Action Network
  www.parkinsonaction.org
- Parkinson's Foundation
  www.parkinson.org
- Parkinson's Foundation Heartland Chapter
  www.parkinson.org/heartland
- Parkinson's Nebraska
  www.parkinsonsnebraska.org
- Parkinson's Resource Organization
  www.parkinsonsresource.org
- The Parkinson Alliance
  www.parkinsonalliance.org
- The Parkinson's Disease Foundation
  www.pdf.org
- The Parkinson's Resource Organization
  www.parkinsonsresource.org

To download a copy of ALL Parkinson's Post newsletters, please visit:

www.unmc.edu/neurologicalsciences/news/newsletters