

The Carousel Network

Chronic Neuroimmune Diseases

Information & Support For Sonoma County

Chronic Fatigue Syndrome (CFS/CFIDS) • Fibromyalgia (FM)

Multiple Chemical Sensitivities (MCS) • Lyme Disease

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From the editor

Dear Friends,

For the past two years, I have thoroughly enjoyed my tenure as your newsletter editor. By researching and putting together information for the newsletter, I have learned much about the ailments which afflict so many of us. I thank you for your contributions to the newsletter. I have also sharpened my computer skills, and learned a bit more about graphic design and document production as well!

However, due to the needs of my family, I find that I must limit my outside activities. So I am handing over the reins of the newsletter to Pat O'Hara. Some of you may recall that she has stepped in as guest editor for a couple of editions of the newsletter this year, and did a good job in putting together useful information in a readable format. I have no doubt that, as time goes on, she will continue to provide you with the quality of newsletter that you have come to expect.

As for me, I will still be around. You will still see me occasionally at meetings, and don't be surprised to see my name on an article or two in the newsletter from time to time. I am still participating on the TCN Board of Directors as a Member-At-Large, and expect to stay involved in the business of running the group for

some time to come. Take care, have a super New Year in 2005, and I look forward to seeing you all at a future meeting!

- Carol Hansen

TCN Board of Directors Election Results

The votes have been counted and the results are in! Of 71 ballots that were delivered to members in their November/December newsletter, 24, or 34% were returned. The ballots were processed and votes counted and verified by two independent and impartial vote counters, following strict procedures which ensured accountability and accuracy of the count. And the winners are (drum roll, please):

President:	Jerry Sundahl
Vice President:	Pat O'Hara
Treasurer:	Dolores Rhoads
Members At Large:	Loretta Beach
	Carol Hansen
	Cynthia Johnson

Congratulations and our thanks go to the winners for volunteering to take on the challenges of running our organization, thanks to all of the members who took the time to cast their ballots, and a special thanks to Jill and Laurel Anderson, who gave up precious school vacation time during the week before Christmas to count the votes for us!

Documents related to the election, including ballots, vote counting procedures, and ballot tallying sheets will be made available for review to interested TCN members upon request. Members requesting to view these documents should contact the Elections Coordinator at elections@cndsinfo.net, or by calling (707) 324-8881.

Pharmaceutical companies helping patients get their medicines

Richard J. Sagall, M.D., www.needymeds.com

It's a choice no one should have to make—pay rent and buy food or get prescriptions filled. Yet all too often it a choice Americans, particularly older Americans, have to make.

Over 40 million Americans have no health insurance, and millions more have limited coverage. Many Americans just can't afford health care, and, if they can, they don't have the money to buy their medicines.

Patient assistance programs

There is help available for many people who can't afford their medicines. These programs, frequently called patient assistance programs (PAPs), are designed to help those in need obtain their medicines at no cost or very low cost.

Many, but not all, pharmaceutical companies have PAPs. The manufacturers who have programs do so for various reasons. Some believe that they have a corporate social obligation to help those who can't afford their products. Others believe it's a good marketing tool. As one PAP director once told me, many people who can't afford their medicines now go on to obtain some type of coverage. And when they get this coverage, the companies want the patient to remain on their products.

In 2002, PAPs helped over 5 million people. The programs filled 14.1 million prescriptions with a total wholesale value of over \$2.3 billion.

The basics of the programs

All PAPs are designed to help those in need obtain their medicines. Since each pharmaceutical company establishes its own rules and guidelines, all are different. All have income guidelines—but they vary considerably. Each company selects which drugs are available on their programs and how long a person can receive assistance.

How PAPs work

Although no two programs are exactly the same, most require that the applicant complete an application form. The amount of information required varies. Some programs require detailed medical and financial information, others very little. All require a doctor's signature. Certain programs require the doctor [to] complete a portion of the form, while others only need a signed prescription.

Most send the medicines to the doctor's office for distribution to patients, while others send the medicine to a pharmacy. A few send a certificate the patient gives to the pharmacist.

Some patients need drugs for a long time. Most programs that cover medicines used to treat chronic diseases offer refills, but not all programs.

What medicines are covered

The pharmaceutical companies decide if they will have a PAP and, if they do, which of their medicines are available through the program. Some include many or all of the medicines they make while others include only a few. The reasons for their decisions are not something they reveal. None include generic medicines in their programs.

Sometimes a medicine or a certain dosage of that medicine will be on a program, then off, and then back on again. Or one dose of the medicine will be on the program [while] a different dose won't be.

How to learn about PAPs

Your doctor is **not** the best source of information on PAPs. Surprisingly, many doctors don't even know PAPs exist. The same applies for pharmacists. Many social workers know about the programs. Any books in the library on PAPs are probably outdated before they are printed.

The best place to learn about PAPs is the Internet. There are a number of sites that have information on these programs. Many pharmaceutical companies have information on their patient assistance programs on their websites. Unfortunately, it's often hard to find the page that describes their PAP.

Types of websites

There are two types of websites with information on patient assistance programs. Three sites list information on patient assistance programs—NeedyMeds (www.needymeds.com), RxAssist (www.rxassist.org), and HelpingPatients.org (www.helpingpatients.org). There is no charge to use the information. These sites don't have a program of their own nor do they help people get their medicines.

NeedyMeds is self-funded by sales of manuals and other items. The Robert Wood Johnson Foundation supports RxAssist. The Pharmaceutical Research and Manufacturers of America (PhRMA), an association and lobbying group whose members include many of the larger pharmaceutical manufacturers, runs HelpingPatients.org. It only has information on PhRMA members programs. *[Ed: If you don't have access to the internet, you can obtain a copy of PhRMA's Patient Assistance Directory by calling 1-800-762-4636.]*

Then there are a number of sites that charge to help people learn about patient assistance programs and complete the application forms. The charges vary, as does the quality of their services. Some offer a money-back guarantee if they can't get your medicines.

How to use NeedyMeds

I will describe how to use the NeedyMeds site—the one I know most about. RxAssist and HelpingPatients contain similar information.

There are two ways you can check to see if your medicines are available on a patient assistance program. One is to click on the drug list. This brings up an alphabetical list of all the drugs currently on PAPs. Find the medicine you take and click on its name. This will bring up the program page.

On the program page you will learn about the specifics of the PAP—the qualification guidelines, the application process, the information you need to supply, what your doctor must complete, etc. In addition, you will learn if there's a downloadable application on the website or if you must get an application from the company. (Some companies accept copies of their application form while others require you *[to]* complete an original.)

If you know the medicine's manufacturer, you can click on the programs list. From there, you can click on the program you want to learn more about. That should bring up the information you need.

Once you get the information you need, it's up to you to complete the applications, get the necessary signatures, and send the form to the program.

A few tips

The most common problem patients encounter when completing the application forms is lack of physician cooperation. Over and over I hear from people whose physicians just won't complete the forms - or charge to do it. I am asked what they should do.

Here are a couple of suggestions:

1. Make sure you have completed everything on the form you can. Not only should you complete the applicant's section, but anything else you can do. This may include the physician's name and address, phone number, etc.
2. Bring all the information your doctor may need. For example, some programs require proof of income. If so, attach whatever documents are required.
3. Bring an addressed envelope with the appropriate postage.
4. Don't expect your doctor to complete the form immediately. A busy doctor may not have time to read the form while you are in the office.
5. If you encounter resistance, tell your doctor that without his/her help, you won't be able to obtain the medicines he/she is prescribing. Be blunt.
6. If all else fails, you may need to find a physician more sympathetic to your plight and willing to help you.

What if I don't have a computer

Many people without a computer can still use the information available on these websites. Nearly everyone knows someone with a computer—a family member, a neighbor, or a friend. *[Ed: Try networking with your fellow TCN members. Many have computers and are internet-savvy.]* Most public libraries have computers for public use, and people who can help those not familiar with their use.

Summary

Patient assistance programs are not the best solution to the problem of inability to pay for medication. However, it is the best solution for some people. Millions of people use PAPs to get the medicines they need but can't afford. If you can't afford your medicines, a patient assistance program may be able to help you.

Ed: PAP's are worth looking into, no matter what your situation, when faced with the need for expensive medications. The Lyme Times recently reported that some patient advocacy groups have seen families with incomes of \$50,000 or more get free prescriptions.

If you need help with your application, you might try The Medicine Program (www.themedicineprogram.com), a non-profit organization that will act as a patient advocate. For a \$5 fee (refundable if you don't qualify for the free drugs), they will help with the paperwork, and get it to the right pharmaceutical company.

If you find that you cannot obtain free medications, the best advice is to shop around for the best price. Costco sells prescription drugs at just above cost, and you do not have to be a member to shop at their pharmacy. Online pharmacies can also be a source of lower cost prescription drugs.

Another source of low-cost prescriptions is Joseph DeCuir, a Los Angeles pharmacist. As a way to memorialize his teenage daughter who recently died of leukemia, Joe is offering prescription drugs to people with CFS and FM at considerable savings. He accepts all major credit cards and money orders, but does not process insurance claims. To check prices, call 1-888-272-9836 (or 9837 or 9834). For more information, go to www.immunesupport.com/shop/pharmacy.

From the newswires

Excerpted and summarized by P. O'Hara

PFIZER REPORTS DATA SHOWING CELEBREX HEART ATTACK RISK; DOES NOT PLAN TO PULL THE DRUG OFF THE MARKET AT THIS TIME

CNN/Money (money.cnn.com) reports that, following on the heels of the Vioxx recall three months ago, new data from a National Cancer Institute study shows that Celebrex more than doubled the risk of heart attack in patients using the drug in a long-term cancer study. Patients in the study were taking 400-800 mg of Celebrex daily (compared to the FDA approved dosage of 100-200 mg per day for arthritis and pain). Another cancer study showed no problem with the drug.

The trial where problems were noted was terminated. Pfizer called the results of the trial “unexpected,” and will not be taking Celebrex off the market at this time. Patients are being advised to seek the advice of their doctor before discontinuing use of the drug.

In related news, the U.S. House Energy and Commerce Committee has expressed concerns about Pfizer’s statements in recent weeks concerning the safety of Celebrex, and has requested documents from Pfizer related to both Celebrex and Bextra, another drug in the same class of drugs. Although Pfizer has reported that Bextra might raise heart attack risk in patients having heart bypass surgery, it issued several statements, one as recent as Nov. 30, vouching for the safety of Celebrex.

UNUM-PROVIDENT ACCEPTS MULTI-MILLION DOLLAR SETTLEMENT

The CFIDS Association of America (www.cfids.org) reports that Unum-Provident, the nation’s largest disability carrier, will pay \$15 million in fines, and be forced to re-examine 200,000 denied claims as part of the settlement of a lawsuit claiming that the Unum corporate environment encouraged looking “for every technical legal way to avoid paying a claim.” If you have been denied

benefits under a Unum-held policy, please see your disability attorney. For details about the reconsideration process, go to http://www.unum.com/newsroom/news/corporate/11032004_settlement.aspx

FEDERAL LOW COST DRUG PROGRAM DEADLINE EXTENDED

The Medicare Replacement Drug Demonstration application deadline has been extended. This program aims to provide low-cost drugs to people with cancer and other serious illnesses. The Bush administration planned a lottery to fill the 50,000 available slots, but fewer than 7,000 had applied as the original Sept. 30 deadline approached.

According to the New York Times, potential applicants reported difficulty getting information about the program before applying, and that the application forms were too complicated.

The demonstration program covers 30 drugs for cancer, rheumatoid arthritis, osteoporosis, multiple sclerosis and a few other diseases. (Check for updates, as new drugs are being added to the program.) Some drugs can be taken at home, as a replacement for drugs that have historically been covered by Medicare only when given in a doctor's office. The demonstration program is scheduled to run through Dec. 31, 2005, after which time the new Medicare drug benefit program begins.

For details about the program, call 866-563-5386 or go to <http://www.cms.hhs.gov/researchers/demos/drugcoveredemo.asp>

VA SHIFTS GULF WAR ILLNESS STUDIES AWAY FROM STRESS

The Associated Press reports that the Veterans Affairs Dept. will set aside up to \$15 million a year for research into Gulf War illness, and that none of the money will be used to fund studies that propose stress as the only explanation for the ailments. The Research Advisory Committee on Gulf War Illness spent the past two years reviewing recent studies and recommended that the VA abandon stress studies and focus on toxic substances veterans encountered.

"We must embrace the possibility that unconventional theories, given the time and resources to test them, may lead the way to resolving and understanding the unforeseen and unsuspected battlefield conditions that existed in 1990, 1991 and which may have tunneled silently into the bodies of Gulf War veterans," said Veterans Affairs Secretary Anthony Principi.

Gut feeling

Health Sciences Institute e-Alert, October 27, 2004

The next time you're at the store or in a theater or any crowded place, look around you and consider this: About one out of every five people may be having abdominal pain. More specifically, about 20 percent of the population

experiences irritable bowel syndrome (IBS), with irritating symptoms such as diarrhea, constipation, gas and bloating. Hopefully you aren't one of those one-in-five. But if you are (or know someone who is), then you'll be interested to know that a long-time researcher of IBS believes that the last symptom on that list—bloating—may be the key to understanding one of the primary causes of IBS, which could lead to more effective treatment.

Uncomfortable expanding

Without knowing anything else about it, when you see the term "bacterial overgrowth," you know that something not very good is afoot. Henry C. Lin, M.D., is a gastrointestinal specialist and an associate professor of medicine at the University of Southern California. For well over a decade, Dr. Lin has devoted his research efforts to finding a single factor that might tie together the symptoms of IBS. He now believes that bacterial overgrowth may be that factor. And the key is bloating.

Over the years, Dr. Lin noted that almost all of the IBS patients he treated reported post-meal bloating. This prompted him to focus his research on gas caused by gut bacteria that ferments food in the intestinal tract. Bacteria perform useful functions in the large intestine, but Dr. Lin suspected that the bacteria might be migrating to the small intestine, triggering gas, bloating and flu-like symptoms that often accompany IBS. After a breath-test study indicated that a large majority of IBS patients experienced small intestinal bacterial overgrowth (SIBO), an antibiotic trial helped confirm the results. In that trial, IBS patients received either an antibiotic or placebo. About 75 percent of the subjects who successfully eliminated SIBO with antibiotics reported a significant improvement in IBS symptoms.

Good guys vs. bad guys

The use of antibiotics in Dr. Lin's study may have been helpful in demonstrating how bacteria play an important role in prompting IBS symptoms, but that doesn't necessarily mean that the best course of treatment is antibiotics (which are already over-prescribed, making some of them ineffective against certain bacteria).

I asked HSI [*Health Sciences Institute*] Panelist Allan Spreen, M.D., to take a look at Dr. Lin's study. He told me he wasn't aware of the theory that connected bacteria to IBS, but found it to be reasonable. In an e-mail he wrote: "I do feel there's something to the research; I just hope it doesn't mean a quickie, antibiotic-related 'cure' is coming. Antibiotics, of course, might help to immediately lower the 'bad guy' bacteria count, and therefore help a person feel better, while simultaneously killing 'good guys' and causing more trouble down the road."

In several e-Alerts, Dr. Spreen has written about the necessity of probiotic organisms. In a healthy individual, these beneficial bacteria inhabit the digestive tract in massive numbers, crowding out harmful bacteria, aiding digestion, and supporting immune function. This healthy "gut flora" produces valuable nutrients

(including certain B vitamins and omega-3 fatty acids), digestive enzymes like lactase, and immune chemicals that fight harmful bacteria and even cancer cells.

But this critical ecosystem is fragile and easily disturbed. For instance, poor nutrition, steroid drugs, chemotherapy and some types of antibiotics can completely kill off the beneficial bacteria in the gut. And when the number or activity level of your good bacteria drops too low, it opens the door for harmful bacteria to proliferate, allowing the opportunity for diseases such as IBS to develop.

Striking the balance

I asked Dr. Spreen if Dr. Lin's research might indicate that probiotic supplements would be a good treatment for IBS, and he replied, "I absolutely would be giving probiotics for such a problem, along with any agents that might assist strengthening the intestinal wall, such as FOS (fructo-oligo-saccharides), which helps the 'good' bugs to reestablish, aloe juice, which has a long history of calming bowel problems, essential fatty acids, and digestive enzymes (which are usually underproduced in such situations)."

Just one question: Fructo-oligo-WHAT? This was a new one to me. But a little research revealed that FOS is simply a natural fruit and vegetable fiber that promotes the growth of beneficial bacteria.

Meanwhile, sufficient amounts of intestinal flora can be maintained through dietary sources such as cultured products (yogurt and kefir), and lignans (flaxseed, carrots, spinach, cauliflower, broccoli, millet and buckwheat). But while the digestive tract can be "re-colonized" by introducing enough good bacteria to overpower the bad bacteria, dietary sources alone can't provide organisms in the vast numbers required to correct a serious imbalance. For this, a high-potency probiotic nutritional supplement is necessary. But one word of caution: Bacterial imbalances in the intestine should not be taken lightly. So talk to your doctor or a health care professional before using a probiotic supplement to address IBS or any other chronic digestive problems.

Sources:

1. "Small Intestinal Bacterial Overgrowth: A Framework for Understanding Irritable Bowel Syndrome" *Journal of the American Medical Association*, Vol. 292, No. 7, 8/18/04, jama.ama-assn.org.
2. "Bacteria May Be the Cause of IBS" Alicia Di Rado, University of Southern California press release, 8/25/04, usc.edu.

Ed: If you think you have IBS, or have been diagnosed with it, you may want to investigate food intolerance as a source of your discomfort. Look for more on this topic in future issues.

Consumer Reports offers free online drug reports
www.crbestbuydrugs.org

Consumer Reports (CR) offers a website where consumers and doctors can obtain free reports and information to guide them in making more cost-effective prescription drug choices (www.crbestbuydrugs.org). The reports combine expert medical reviews of the scientific evidence on drugs with their prices.

The reports compare drugs in the same category—that is, drugs in the same class that are used to treat the same condition or illness. Analysis of the evidence on effectiveness and safety of the drugs is conducted by Oregon Health & Science University, which has no financial interest in any pharmaceutical company or product. Drug prices are national averages, obtained from a healthcare information company that tracks the sales of prescription drugs in the U.S. For each category, CR lists “best buy drugs,” which must be in the top tier of effectiveness in their category, have a safety record equal to or better than the others, and have an average cost for a 30-day supply which is substantially lower than the most costly drug meeting the first two criteria.

Three reports are currently available—statins used to treat cholesterol, NSAIDs (non-steroidal anti-inflammatory drugs) used to treat arthritis and pain, and PPIs (proton pump inhibitors) used to treat heartburn, ulcers and GERD (gastroesophageal reflux disease). CR plans to add approximately one new drug report per month for the next couple of years. They plan to continue to monitor the scientific evidence and prices, and provide updates as new evidence emerges, or as new drugs or generics become available.

Pain and depression are unfortunate bedfellows

The Cleveland Clinic HealthEXTRA Newsletter, November 2004

www.clevelandclinic.org

New research is bolstering the case for prescribing antidepressants to people with chronic pain to help them better deal with their discomfort. It's also shedding new light on the relationship between pain and depression. Indeed, what medicine is increasingly coming to understand is that pain and depression are linked and that it is possible that one condition may cause the other. Moreover, it is highly probable that pain can worsen the symptoms of depression and vice versa.

"A person who has been suffering from chronic pain for more than five years, and can't work, has lost the desire for socialization, has no opportunities for recreation and no sex life will get pretty depressed," says pain specialist Edward C. Covington, M.D., director of the Cleveland Clinic Chronic Pain Rehabilitation Program. Conversely, one who deals with melancholy by withdrawing from physical and social activities is likely to develop aches and pains. "If your life is empty, pain will fill it up," says Dr. Covington. "Don't stay home and sit in the recliner and watch TV all day, because that's guaranteed to lead to a life of pain and depression."

Painful facts

Clinical depression produces many symptoms—sleep loss, irritability, dietary changes, reduced productivity; but its primary effects include intense sadness and significant loss of enjoyment for life that persist for more than two weeks. Untreated, an episode of depression typically lasts approximately 6 months, but it can also last years. Depression affects relationships, energy levels and the desire to perform normal daily activities. And a growing body of evidence is demonstrating the unfortunate and often complicated link between depression and pain.

- In a 2004 study of more than 118,000 household residents, Canadian researchers showed that when compared with individuals who have no back pain, those who did were more likely to experience depression. The researchers also showed that the rate of major depression was related to the level of pain experienced—the greater the severity, the greater the likelihood of depression symptoms.
- In 2003, researchers from Stanford, California showed that compared with individuals who have no symptoms of depression, those with major depression are more than twice as likely to have a chronic painful physical condition, for instance persistent headache or low back pain.
- A 1992 report from *The Journal of Gerontology* reported that the onset of depression was significantly higher in patients whose chronic pain caused a loss of independence or mobility and thereby decreased participation in social activities.
- According to a report released in 1997 by the Academy of General Dentistry, "the 50 million people in America who suffer from chronic facial pain, including temporomandibular disorders (TMD), are likely to suffer depression as well and should be screened for depressive symptoms during their health evaluation."

Dr. Covington says that in addition to demonstrating the many different ways pain and depression can be linked, these and other studies serve as a reminder for patients and physicians of the importance of investigating whether one or the other condition is present in patients who complain of pain or in whom depression has been diagnosed.

Chicken or the egg? Pain or the depression?

Although research underscores the link between chronic pain and depression, no one really knows why one condition gives rise to the other. Dr. Covington believes that people with chronic pain are either unaware that they may be depressed, or they choose not to seek treatment for their depression. But those patients, he says, should not be expected to deal with either condition by keeping a stiff upper lip. Ideally, they should seek professional medical treatment—therapy, medication or both—for both conditions. "Going to see a pain doctor for pain without seeing a psychiatrist for depression won't work," says Dr. Covington. "You've got to pay attention to both diseases."

Psychiatrist Donald Malone, M.D., section head of Cleveland Clinic adult psychiatric services, says depression can amplify pain; greater pain intensity then leads to the feeling that the individual has less control of life, which then leads to a deeper depression. "It's a vicious cycle," says Dr. Malone. "Pain can feed on deep, deep feelings of sadness, remorse or the like."

New hope

Antidepressant drugs can help correct chemical imbalances in the brain caused by abnormal levels or actions of the neurotransmitters (brain chemicals) serotonin and norepinephrine. Thus antidepressants can help improve mood and outlook in people feeling "blue" or depressed. But research has also shown that some antidepressants can help reduce the severity of physical pain, which suggests a role in the treatment of depression associated with pain. Drs. Covington and Malone suggest that antidepressant medication can be used to treat both depression and chronic pain.

For instance, the antidepressant venlafaxine (brand name, Effexor) has been shown to provide relief for people experiencing chronic pain, says Dr. Malone. Drugs such as Effexor increase levels of serotonin, which can dull pain receptors. Just taking drugs, however, will not help a person overcome issues that have arisen due to long-term suffering from chronic pain, such as low self-esteem, loss of sex drive and retreating from social and recreational activities. Getting back on track should involve key lifestyle changes (e.g., starting an exercise regimen, getting involved in a social activity at least once per week, etc.) combined with "talk" therapy to help guide, counsel and motivate patients and to document their progress.

Getting mobile, in fact, is key. "It may seem hard at first, but a person must try to become as active as possible," says Dr. Malone. "Exercise is the best antidepressant I know of." He says that exercise—from lifting weights to water aerobics to walking—can increase the release of endorphins, neurotransmitters believed to have pain-relieving and mood elevating properties. Dr. Covington agrees that exercise can play a role in helping people manage depression: "Exercise is one of the most powerful forms of psychotherapy for anyone, including people with chronic pain." Both physicians recommend consulting first with a physician before embarking on an exercise regimen.

Dr. Covington also says that meditation, yoga and biofeedback can help a person dealing with pain and depression regain a sense of control over life. "I've seen significant pain reduction among a number of patients with fibromyalgia, a musculoskeletal disease that causes stiffness in joints," he says. "These patients go to Target, buy a yoga videotape and start doing the exercises at home."

Dr. Malone agrees that exercise is beneficial to pain sufferers because it helps elevate mood. But the first step toward physical wellness, he believes, is mental wellness. "A patient must have some self-motivation," he says. To break the downward spiral of a depression that causes or is caused by pain—which can create further pain or depression—a combination of therapy and

antidepressants may be the boost that can help a patient overcome a painful existence.

References:

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2. Ohayon MM, Schatzberg AF. Using chronic pain to predict depressive morbidity in the general population. *Arch Gen Psychiatry*. 2003 Jan;60(1):39-47.
3. Williamson GM, Schulz R. Pain, activity restriction, and symptoms of depression among community-residing elderly adults. *J Gerontol*. 1992 Nov;47(6):P367-72.
4. Academy of General Dentistry website:
www.agd.org/consumer/topics/tmj/main.html.
5. The Cleveland Clinic Pain Management Department website:
www.clevelandclinic.org/painmanagement.

'Feed a cold' is good advice

BBC, January 11, 2002 news.bbc.co.uk

Feed a cold, starve a fever? Experts say that when sickly patients are told to "feed a cold, starve a fever", they may be receiving scientifically valid advice. Dutch scientists have conducted small-scale experiments which suggest that both approaches are the best way of priming the immune system to cope with different infections.

The research, reported on the New Scientist website, found that the different approaches may activate different types of immune cell. Six volunteers were recruited for the trial, and told to fast overnight before coming for tests.

Liquid lunch

On the first occasion they were given a meal in liquid form, and on another day were simply given water to fill their stomachs. Six hours after each experiment, their blood was tested for signs of an immune response. After the liquid meal, levels of a body chemical called Gamma interferon had multiplied by four. This chemical indicates that the body is using a type of immune response designed to kill cells which have become infected, and tends to be directed at viral infections.

Bacterial attack

The water-only diet, however, produced almost a fourfold increase in levels of a different chemical, called interleukin-4. This is a sign of an immune response which launches attacks on invaders lurking outside the cells. Most bacterial infections require this kind of response.

Dr. Gijs van den Brink of the Academic Medical Center in Amsterdam said: "To our knowledge, this is the first time that such a direct effect has been demonstrated."

Food supplement

The findings do not totally support the old wives' tale—although colds are caused by viruses, so is flu, which is likely to cause a raised temperature. Dr. van den Brink speculated that the immune response may be an energy-saving tactic by the body, responding immediately to bacterial infections, but waiting until more energy is made available before taking on viruses. He said: "Certain foods could be given to critically-ill patients to stimulate the right immune response." He suggested that glutamine, found in milk, meat and some nuts, boosts the "anti-viral" immune response.

Article citation:

Feed a cold, starve a fever? *Clin Diagn Lab Immunol.* 2002 Jan;9(1):182-3. van den Brink GR, van den Boogaardt DE, van Deventer SJ, Peppelenbosch MP. PMID: 11777851.

Acid washed

Health Sciences Institute e-Alert, November 4, 2004, www.hsibaltimore.com

"Killing off (stomach) acid, however it's done, is a serious mistake with long term consequences if pursued over time. Poor digestion is the genesis of all sorts of problems."

That quote—from HSI [*Health Sciences Institute*] Panelist Allan Spreen, M.D.—appeared in the e-Alert "Fire Down Below" (12/23/02). And I immediately recalled Dr. Spreen's words when I came across an astonishing study last week that demonstrates how several popular heartburn medications may sharply increase the risk of pneumonia.

The tradeoff

The new study appears in an October issue of the *Journal of the American Medical Association*, and was conducted by researchers at a university medical center in the Netherlands. The Dutch team evaluated data collected from the medical records of more than 360,000 patients enrolled in a primary care database. Each subject had been enrolled for a minimum of one year.

The researchers concluded that the use of drugs to suppress gastric acid quadrupled the risk of pneumonia compared to patients who didn't use the drugs. That's right: Four TIMES the risk!

The drugs analyzed in this study were from two different classes: proton pump inhibitors (for acid reflux) and H2 receptor antagonists (for heartburn). Here are the familiar brand names in these two classes:

- Proton pump inhibitors: Nexium, Prilosec, Prevacid, Protonix, Aciphex
- H2 receptor antagonists: Pepcid, Zantac, Tagamet, Rotane, Axid

And to make matters worse, some patients are not even taking these drugs to address heartburn or acid reflux. As one doctor told WebMD, many physicians who prescribe nonsteroidal anti-inflammatory drugs (NSAIDs) to address arthritis pain, also prescribe acid-suppressing drugs to offset the risk of ulcers.

The justification for using these drugs is based on the completely wrongheaded belief that stomach acid is bad. Which overlooks the obvious: Stomach acid is there for a reason. You can't digest food without it! No wonder Dr. Spreen calls acid suppression "a serious mistake with long term consequences."

Acids rising

So, how might an acid-suppressing drug increase the risk of pneumonia? The Dutch study doesn't answer that question, which opens the door to some interesting speculation.

In the WebMD article about the study, David Peura, M.D., who is a spokesman for the American Gastroenterological Association, observed that untreated acid reflux is known to increase the risk of pneumonia. Noting that subjects in the study who received the highest doses of acid-suppressants had the highest risk of pneumonia, Dr. Peura asked this hypothetical question: What caused the pneumonia; the acid reflux, or the drug to treat acid reflux?

When I asked Dr. Spreen for his insights on this matter, he suggested that the drug itself doesn't cause pneumonia, but rather sets the stage for stomach acid to create problems. But if the drug suppresses acid, how can acid be the cause of the pneumonia risk? Dr. Spreen explains:

"When acid is reduced (which makes you feel better for awhile), it also loosens the gastroesophageal (GE) sphincter, the 'door' that's supposed to close between the stomach and the esophagus when digestion is going on (or trying to, anyway). The body is trying to insulate the esophagus from the acid. But if there's no longer much acid, why waste all that energy and effort?"

"So, the sphincter loosens, permitting what little acid remains to slip up into the esophagus. This is where the 'heartburn' and esophageal damage (Barrett's esophagus) come from, and the subsequent need for more 'anti-acid' therapy. See where this is headed over the long run?

"If the acid migrates far enough (and I believe it does in these cases), it reaches the junction where the lungs branch off, and there's the rub. Even the tiniest amount of acid is highly irritating to such membranes, and subsequently a source for trouble to start, including infection."

Between a rock and a hard place

It's obvious from the popularity of acid-suppressing drugs that there are plenty of people who suffer from occasional heartburn or chronic acid reflux. Leaving the production of excess acid unchecked is not only painful, but also dangerous. But suppressing the acid can create dangerous problems as well, and pneumonia risk is just one of them.

In an e-Alert I'll send you next week, I'll review Dr. Spreen's simple, inexpensive and effective way to treat gastroesophageal problems without suppressing acids.

[Ed.: To subscribe to Health Sciences Institute e-Alerts, go to www.hsibaltimore.com and click on 'Subscribe.']

Sources:

1. "Risk of Community-Acquired Pneumonia and Use of Gastric Acid-Suppressive Drugs" *Journal of the American Medical Association*, Vol. 292, No. 16, 10/27/04, jama.ama-assn.org.
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DETECTION OF ENTEROVIRUS IN HUMAN SKELETAL MUSCLE FROM PATIENTS WITH CHRONIC INFLAMMATORY MUSCLE DISEASE OR FIBROMYALGIA AND HEALTHY SUBJECTS.

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J. Med. Virol. 71:540-547, 2003.

ABSTRACT: Enterovirus RNA has been found previously in specimens of muscle biopsy from patients with idiopathic dilated cardiomyopathy, chronic inflammatory muscle diseases, and fibromyalgia or chronic fatigue syndrome (fibromyalgia/chronic fatigue syndrome). These results suggest that skeletal muscle may host enteroviral persistent infection. To test this hypothesis, we investigated by reverse transcription-polymerase chain reaction (RT-PCR) assay the presence of enterovirus in skeletal muscle of patients with chronic inflammatory muscle diseases or fibromyalgia/chronic fatigue syndrome, and also of healthy subjects. Three of 15 (20%) patients with chronic inflammatory muscle diseases, 4 of 30 (13%) patients with fibromyalgia/chronic fatigue syndrome, and none of 29 healthy subjects was found positive. The presence of VP-1 enteroviral capsid protein was assessed by an immunostaining technique using the 5-D8/1 monoclonal antibody; no biopsy muscle from any patient or healthy subject was found positive. The presence of viral RNA in some muscle biopsies from patients exhibiting muscle disease, together with the absence of VP-1 protein, is in favor of a persistent infection involving defective viral replication.

THE CLINICAL COURSE OF INTERSTITIAL PNEUMONIA ALIAS CHRONIC FATIGUE SYNDROME UNDER THE CONTROL OF MEGADOSE VITAMIN C INFUSION SYSTEM WITH DEHYDROEPIANDROSTERONE-CORTISOL ANNEX.

Kodama M, Kodama T.; Kodama Research Institute of Preventive Medicine, Chikusaku, Nagoya 464-0005, Japan.

Int J Mol Med. 2005 Jan;15(1):109-16.

DIFFERENTIAL-DISPLAY PCR OF PERIPHERAL BLOOD FOR BIOMARKER DISCOVERY IN CHRONIC FATIGUE SYNDROME.

Steinau M, Unger ER, Vernon SD, Jones JF, Rajeevan MS.; Division of Viral and Rickettsial Diseases, National Center for Infectious Diseases, Centers for Disease Control and Prevention, 1600 Clifton Rd., MSG-41, Atlanta, GA 30333, USA.

J Mol Med. 2004 Nov;82(11):750-5. Epub 2004 Nov.

MANAGEMENT OF FIBROMYALGIA SYNDROME.

Goldenberg DL, Burckhardt C, Crofford L.; Department of Rheumatology, Newton-Wellesley Hospital, Newton, Mass 02462, USA.

JAMA. 2004 Nov 17;292(19):2388-95.

CASE-CONTROL STUDY OF MULTIPLE CHEMICAL SENSITIVITY, COMPARING HAEMATOLOGY, BIOCHEMISTRY, VITAMINS AND SERUM VOLATILE ORGANIC COMPOUND MEASURES.

Baines CJ, McKeown-Eyssen GE, Riley N, Cole DE, Marshall L, Loescher B, Jazmaji V.; University of Toronto, 12 Queen's Park Crescent W, Room 401C, Toronto, Ontario, Canada M5S 1A8.

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Johnson L, Stricker RB.; California Lyme Disease Association, Ukiah, CA 95482, USA. lbj1@pacbell.net

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Have great, secret, big, fat hopes for yourself.
— Gloria Vanderbilt, in *Glamour*



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