



WESTERN NEUROPATHY ASSOCIATION

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Issue 08
Volume 21

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WESTERN
NEUROPATHY ASSOCIATION
3620 American River Dr., Suite 230
Sacramento, CA 95864
888-556-3356
admin@WNAinfo.org
www.WNAinfo.org

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Neuropathy Hope

Hope through caring, support, research, education, and empowerment

A newsletter for members of Western Neuropathy Association (WNA)

For something new, this issue has descriptive articles on three types of neuropathies – neuropathy due to Covid-19 (yes, it’s now officially a cause), neuropathy due to diabetes and neuropathy due to chemotherapy. Read on to determine their differences and similarities.

GUIDANCE STATEMENT ON THE ASSESSMENT AND TREATMENT OF NEUROLOGIC DYSFUNCTION IN PATIENTS SUBSEQUENT TO COVID-19

American Academy of Physical Medicine and Rehabilitation, 2023 ¹

Neurological symptoms occur in approximately 80% of hospitalized patients during the acute phase of COVID-19 infection. The most prevalent neurologic symptoms that remain after 3–4 weeks from the initial infection include “brain fog” (81%), headache (68%), numbness/tingling (60%), dysgeusia/loss of sense of taste (59%), anosmia/loss of sense of smell (55%), and myalgias/muscle pain (55%). This guidance statement focuses on the neurologic sequelae of PASC (post-acute sequelae of SARS-CoV-2/COVID-19 infection), including headaches, neuropathies and neuropathic pain, muscular pain/weakness and tremors, and cranial nerve conditions. (Editor: I have included only the guidance assessment and treatment of neuropathy and neuropathic pain, i.e., Table 9)

This is guidance for physicians to use for treating their patients that have neuropathy caused by Covid-19.

Assessment And Treatment Of Neuropathy And Neuropathic Pain

Signs:

- Weakness
- Gait instability
- Sensory testing abnormalities
- Muscle atrophy
- Change in mobility

Symptoms:

- Numbness
- Sensory changes
- Nerve pain
- Burning
- Tingling
- Fall
- Vibration
- Sharp shooting pain
- Hypersensitivity to touch
- Temperature instability with hot/cold feeling
- Phantom pain or sensations/itching

Patient History and Evaluation:

- Assess for a personal history of diabetes, chemotherapy, alcohol use, autoimmune disorders, peripheral nerve injury or compression
- Assess for prolonged hospital stay, hospital stay including intensive care unit stay and/or prone positioning
- Manual muscle testing, with a focus on pattern of weakness (ie, proximal versus distal vs. focal vs. nerve distribution vs. dermatome)
- Sensory testing including light touch, pinprick vibration, proprioception, temperature
- Muscle stretch reflex testing
- Gait assessment, tandem gait
- Postural stability and alignment, dynamic balance (sitting or standing)

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PERIPHERAL NEUROPATHY SUPPORT GROUPS SEPTEMBER 2023 SCHEDULE

Encourage, inform, share, support, and hope.

Join a meeting to help others, learn something new, and/or share experiences.

In-person or virtual – connect to others with peripheral neuropathy

2023 WNA Board of Directors

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Katherine Stenzel
Editor

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September 2 Houston TX Support Group – Quarterly Meeting
1:00pm-3:00pm Central, Memorial Drive United Methodist Church
12955 Memorial Drive, Houston, TX 77079, Room DS100, enter at back (south) of building
Host - Katherine Stenzel, klstenzel@hotmail.com

September 9 2nd Saturday Virtual Support Group
11:00am-1:00pm Pacific/1:00pm-3:00pm Central, Meeting ID: 856 7106 1474, Passcode: 114963
Host – Katherine Stenzel, klstenzel@hotmail.com, contact Katherine for Zoom link

September Santa Cruz CA Support Group
1:00 pm Pacific, Trinity Presbyterian Church, 420 Melrose Avenue
Host - Mary Ann Leer, (831) 477-1239

September 20 3rd Wednesday Virtual Support Group
10:00am-noon Pacific/12:00pm-2:00pm Central, Meeting ID: 833 4473 0364 / Passcode: 341654
Host – Glenn Ribotsky, glennraj@yahoo.com, contact Katherine for Zoom link

September 20 3rd Wednesday CIDP and Autoimmune Virtual Support Group
3:00pm-4:00pm Pacific, 5:00pm-6:00pm Central
Host - John Phillips, johnphillips.wna@gmail.com, contact John for Zoom link

September 23 4th Saturday – Virtual Open Discussion
11:00am-1:00pm Pacific/1:00pm-3:00pm Central, Meeting ID: 851 7949 9276 / Passcode: 159827
Host – John Phillips, johnphillips.wna@gmail.com, contact Katherine for Zoom link

Auburn CA Support Group – No meetings in July, August and September
Host - Sharlene McCord (530) 878-8392; Kathy Clemens (916) 580-9449, kaclemens@earthlink.net

FROM THE PRESIDENT Pam Hart, WNA President

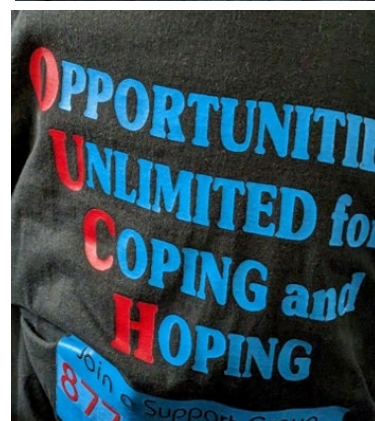
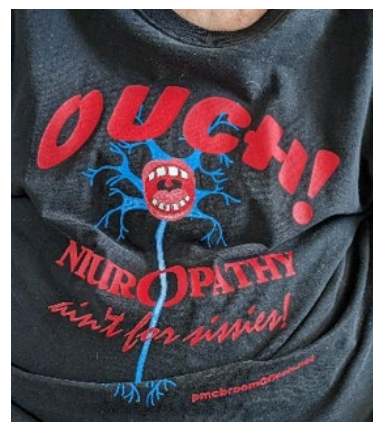
For those of you attending the Gala, I want to apologize for the poor sound quality of the message from Bev, our past president and founder. It was wonderful to see her and learn that she is continually improving, and wonderful to see her participate.

She was talking about the T-shirt she had on. As you can see it says “OUCH, Neuropathy ain’t for sissies”. This is the original design that she borrowed from the Dallas-Ft. Worth group over 20 years ago and it really packs a punch of a message! Bev wore this shirt often and was really able to reach people.

What you weren’t able to see was the back of the shirt that explains the “OUCH”; **O**pportunities **U**nlimited for **C**oping and **H**oping. This message is still true today. This is why we offer support groups. Every time the support groups meet, a nugget of information is passed on to a new member – or an old nugget is shared and expanded upon.

When you become a WNA member, you should receive a WNA pin and card. This is the way we are trying to reach people now, a little more subtle, but if just wearing the pin can cause people to ask you questions, then the effort is worth it. Let’s all be ambassadors for WNA!

Pam



VIRTUAL GALA 2023 - RECAP Katherine Stenzel, Director, Editor

I love it when an idea works! Earlier this year, the Virtual Gala was simply an idea on how WNA members and friends could come together and have fun. And we did! Gala attendees danced to the YMCA song using their arms to keep the beat. They wore their finest and funniest costumes for the Best Dressed Contests and surprised us with their ingenuity. New 'Neuropathy Awareness' items were introduced at the event and distributed to door prize winners, Contest winners, Virtual Bingo winners, and those who donated a total of \$2,230.00 to enable WNA's mission.

Our website has a more detailed recap including screen shots of dancing to YMCA. Check it out at pnhelp.org, then hover your mouse over ABOUT US, and click on VIRTUAL GALA 2023.

I personally thank everyone who donated money to the cause. And a big thank you to all that made the event successful.

Katherine



Virtual Bingo Wheel

Guidance Statement On The Assessment And Treatment Of Neurologic Dysfunction In Patients Subsequent To Covid-19 – Continued from page 1

Additional Studies to Consider for Differential Diagnosis:

- Consider creatine phosphokinase, ferritin level, HIV and rapid plasma reagin, serum protein electrophoresis with immunofixation, methylmalonic acid may be considered in specific populations.
- Consider electromyography/nerve conduction studies (EMG/NCS) testing to identify and classify focal or diffuse neuropathy (motor/sensory, axonal/demyelinating)
- Consider small fiber neuropathy skin biopsy for intraepidermal nerve fiber density (may be done by neurology and trained internal medicine or dermatology clinicians)
- Magnetic resonance imaging of spine can be considered in selected cases based on EMG/NCS or for presence of cord involvement (sensory level, bowel/bladder changes, increased reflexes) or look for root enhancement in polyradiculoneuropathy (chronic or acute inflammatory demyelinating polyneuropathy)

Initial Treatment Approach:

- Consider use of pain management strategies for neuropathic pain (gabapentin, Lyrica, Cymbalta, Nortriptyline, topical capsaicin, dry needling, heat, ultrasound)²
- Consider use of "Evidence-based pain medicine for primary care physicians" as an evidence-based resource for pain management.³

Referral Options:

- Refer to neurology for significant neuropathy, progressive weakness, or worsening gait instability
- Refer to pain management for severe symptoms that do not respond to first-line medication therapy

- Refer to orthotist for joint protection or stabilization; compression garments
- Refer to physical therapy for strengthening, balance retraining, gait training, stretching (muscular and neural tension), Aquatic therapy and patient education on pain.
- Refer to occupational therapy for desensitization, functional skills training including safety and compensatory strategies for sensory changes, stretching (muscular and neural tension), and patient education on pain.
- Refer to speech language pathology/therapy for focal exercises for facial or cervical muscles, dysphagia therapy, voice.

REFERENCES

- ¹ Esther Melamed MD PhD et al. Multidisciplinary collaborative consensus guidance statement on the assessment and treatment of neurologic sequelae in patients with post-acute sequelae of SARS-CoV-2 infection (PASC). American Academy of Physical Medicine and Rehabilitation. 2023; 1-23. doi:10.1002/pmrj.12976
- ² Moisset X, Bouhassira D, Attal N. French guidelines for neuropathic pain: an update and commentary. Rev Neurol (Paris). 2021;177(7):834-837. doi:10.1016/j.neurol.2021.07.004
- ³ Owen GT, Bruel BM, Schade CM, Eckmann MS, Hustak EC, Engle MP. Evidence-based pain medicine for primary care physicians. Proc (Bayl Univ Med Cent). 2018;31(1):37-47. doi:10.1080/08998280.2017.1400290

Health Care Challenges Websites (updated)

SHIPs

State Health Insurance Assistance Programs
www.shiphelp.org
(877) 839-2675

Help for navigating the complexities of Medicare. Search the website for your specific state program.

Medicare Rights Center

www.medicarerights.org
(800) 333-4114

Non-profit that works to ensure access to affordable health care for older adults and people with disabilities.

Medicare

www.medicare.org
(800) MEDICARE
(800) 633-4227

Get started with Medicare, options, news.

Benefits and Insurance for People with Disabilities

www.usa.gov/disability-benefits-insurance
(844) USAGOV1
(844) 872-4681

For those with a disability, learn how government programs and services can help in your daily life.

WHAT IS DIABETIC NEUROPATHY?

Diabetic neuropathy is when diabetes causes damage to your nerves. It can affect different types of nerves in your body, including in your feet, organs and muscles.

Nerves carry messages between the brain and every part of our bodies so that we can see, hear, feel and move. They also carry signals to parts of the body such as the heart, making it beat at different speeds, and the lungs, so we can breathe. Damage to the nerves can therefore cause serious problems in various parts of the body for people with type 1, type 2 or other types of diabetes.

CAUSES OF DIABETIC NEUROPATHY

Neuropathy is one of the long-term complications of diabetes. Over time, high blood glucose (sugar) levels can damage the small blood vessels that supply the nerves in your body. This stops essential nutrients reaching the nerves. As a result, the nerve fibers can become damaged, and they may disappear. This can cause problems in many different parts of your body, depending on the type of nerve affected.

TYPES OF DIABETIC NEUROPATHY

There are three main types of diabetic neuropathy:

- Diabetic sensory neuropathy
- Diabetic autonomic neuropathy
- Diabetic motor neuropathy

People with the condition could have just one or any combination of the types.

Diabetic sensory neuropathy

Sensory neuropathy is damage to nerves that tell us how things feel, smell and look. It affects the nerves that carry messages of touch, temperature, pain and other sensations from the skin, bones and muscles to the brain. It mainly affects the nerves in the feet and the legs, but people can also develop this type of neuropathy in their arms and hands.

The main danger of sensory neuropathy for someone with diabetes is loss of feeling in the feet, especially if you don't realize that this has happened. Loss of feeling is dangerous because you may not notice minor injuries, for example if you step on something sharp while barefoot or get a blister from badly-fitting shoes. If ignored, minor injuries may develop into infections or ulcers. That's why it's important to look after your feet when you have diabetes.

Symptoms of sensory neuropathy in feet, legs, hands and arms:

- tingling and numbness
- loss of ability to feel pain
- loss of ability to feel changes in temperature
- loss of coordination – when you can't feel the position of your joints
- burning or shooting pains – these may be worse at night

Diabetic autonomic neuropathy

Autonomic neuropathy is damage to the nerves that carry information to your organs and glands. They help to control functions we don't even have to think about like your stomach emptying, how regularly your heart beats, and how your sexual organs work.

Examples of autonomic neuropathy:

- gastroparesis – when food can't move through the digestive system efficiently. Symptoms of this can include bloating, constipation or diarrhea.
- loss of bladder control, leading to incontinence (not being able to control when you pee)
- irregular heart beats
- problems with sweating - either not being able to sweat properly and intolerance to heat, or sweating related to eating food (gustatory)
- impotence (inability to keep an erection).

– Continued on page 5

■ **DIABETIC NEUROPATHY - RELIEVING PAIN** Mayoclinic.com, Diabetic Neuropathy

Many prescription medications are available for diabetes-related nerve pain, but they don't work for everyone. When considering any medication, talk to your health care provider about the benefits and possible side effects to find what might work best for you. Pain-relieving prescription treatments may include:

Anti-seizure drugs. Some medications used to treat seizure disorders (epilepsy) are also used to ease nerve pain. The ADA (American Diabetes Association) recommends starting with pregabalin (Lyrica). Gabapentin (Gralise, Neurontin) also is an option. Side effects may include drowsiness, dizziness, and swelling in the hands and feet.

Antidepressants. Some antidepressants ease nerve pain, even if you aren't depressed. Tricyclic antidepressants may help with mild to moderate nerve pain. Drugs in this class include amitriptyline, nortriptyline (Pamelor) and desipramine (Norpramin). Side effects can be bothersome and include dry mouth, constipation, drowsiness and difficulty concentrating. These medications may also cause dizziness when changing position, such as from lying down to standing (orthostatic hypotension).

Serotonin and norepinephrine reuptake inhibitors (SNRIs) are another type of antidepressant that may help with nerve pain and have fewer side effects. The ADA recommends duloxetine (Cymbalta, Drizalma Sprinkle) as a first treatment. Another that may be used is venlafaxine (Effexor XR). Possible side effects include nausea, sleepiness, dizziness, decreased appetite and constipation.

Sometimes, an antidepressant may be combined with an anti-seizure drug. These drugs can also be used with pain-relieving medication, such as medication available without a prescription. For example, you may find relief from acetaminophen (Tylenol, others) or ibuprofen (Advil, Motrin IB, others) or a skin patch with lidocaine (a numbing substance).

Diabetic Neuropathy (Nerve Damage) – Continued from page 4

Motor neuropathy

Motor neuropathy affects the nerves that control movement. Damage to these nerves leads to weakness and wasting of the muscles that receive messages from the affected nerves.

Nerve damage can lead to problems such as muscles weakness, which could cause falls or problems with doing tasks like fastening buttons, and muscles wasting where muscle tissues is lost because it's less active. It can also lead to muscle twitching and cramps.

CAN DIABETIC NEUROPATHY BE REVERSED?

No, diabetic neuropathy can't be reversed (but the symptoms can be treated). Once the nerves have been damaged, they cannot repair themselves. But careful diabetes management including keeping your blood sugars as close to target as possible, and managing blood fat levels and blood pressure can prevent the damage from happening or prevent further damage if you already have some of the symptoms.

TREATMENT FOR DIABETIC NEUROPATHY

There are many treatments available to relieve the symptoms caused by neuropathy. This may include medication for nausea and vomiting, painkillers for sensory neuropathy or treatment to help with erectile dysfunction.

Keeping your blood sugar levels within your target range and also your blood fat levels (cholesterol) and blood pressure can also help to improve the symptoms of neuropathy and reduce the progression of the nerve damage.

DIABETIC NEUROPATHY PAIN

Why is diabetic neuropathy so painful?

The nerves carry chemical messages to and from the brain about what we can feel. When the nerves are damaged these messages cannot be sent properly which leads to a change in sensation or feeling. This can lead to feelings of numbness, tingling, burning, discomfort or shooting pains.

Sometimes these sensations can be worse at night. We are not sure exactly why this is, but could be to do with cooler temperatures in the evening, stress at the end of a long day and fewer distractions in the evening meaning you notice the pain more.

Living with any type of long-term pain (whether you can always feel it or you regularly get periods of pain), can be very distressing and have a negative impact on your mental health and general wellbeing. If you are experiencing regular or frequent pain which you are struggling to cope with you should contact your healthcare team for advice and support.

CHEMOTHERAPY-INDUCED PERIPHERAL NEUROPATHY TREATMENTS (PART 1 - MEDICATIONS)

Aranke M, Kolcun G, Huh B, Javed S. Chemotherapy-Induced Peripheral Neuropathy Treatments. *Pract Pain Manag.* 2023 January/February;23(1).

INTRODUCTION

Chemotherapy-induced peripheral neuropathy (CIPN) affects between 40% and 70% of individuals undergoing chemotherapy and may significantly affect quality of life by worsening symptomatic clusters, such as psychological distress, fatigue-related pain, and abdominal discomfort.

There are several proposed mechanisms for CIPN. These range from the pharmacological effects of various antineoplastic agents to patient-specific genetics and comorbidities. For instance, individuals with the gene for Charcot-Marie-Tooth disease may have single nucleotide polymorphisms that cause a delayed processing of chemotherapeutic agents leading to nerve damage.

A host of treatment and prevention modalities have been studied for CIPN, but there is still no clear preventive or treatment option. A majority of current treatment modalities center on pharmaceutical regimens rooted in duloxetine and opioids, which come with their own well-known variety of adverse effects. Although conservative management with multimodal pain control and physical therapy serves a purpose as first-line therapy, a growing body of evidence supports the use of spinal cord stimulation (SCS) and dorsal root ganglion (DRG) stimulation both as an adjuvant treatment to conservative management and as second-line therapy for treatment-resistant CIPN. (Part 2 – SCS and DRG – Neuropathy Hope October issue)

This section of the literature review summarizes the current state of treatment modalities for CIPN of medication management and alternative treatments.

MEDICATION MANAGEMENT FOR CIPN

There are currently no FDA-approved medication for CIPN prevention or treatment; duloxetine is the only pharmacologic that has shown any therapeutic potential. The limited treatment options surrounding CIPN may be a result of this condition's multifaceted pathophysiology, unknown pathogenesis, and variable clinical presentation. Several classes of medications discussed below were initially thought to be beneficial, but further investigations have shown limited therapeutic value.

Anticonvulsants

Although CIPN is a neuropathic pain state, anticonvulsants such as gabapentin have not shown efficacy in its treatment. In a Phase 3 trial of 115 patients, statistically similar changes were seen in symptom severity between the treatment (2700 mg of gabapentin for 6 weeks) and placebo arms. Another trial analyzed 131 patients receiving either lamotrigine (target dose of 300 mg/day) or placebo for 10 weeks. Over the course of the study, pain scores dropped in both the treatment and placebo arms with no statistically significant difference observed between the changes in the two groups. The lack of a significant clinical or statistical difference between these two groups brings the role of anticonvulsants as part of the CIPN treatment regimen into question.

SSRIs and TCAs

Given their already researched efficacy in the management of neuropathy at large (not limited to chemotherapy-induced), selective serotonin reuptake inhibitors (SSRIs) and tricyclic antidepressants (TCAs) have traditionally played a role in the medical management of CIPN. These classes of medications are thought to exert their effects on serotonin and norepinephrine along the descending spinal pain pathways. There are also theories that antidepressants may exert adjunctive benefit through their actions on histamine receptors and sodium channel manipulation.

Specifically for CIPN, duloxetine, nortriptyline, and amitriptyline are the three most well-studied antidepressants based on the authors' review.

Nortriptyline and amitriptyline have shown limited efficacy in the treatment of CIPN.

- Nortriptyline has provided a modest improvement over placebo for paresthesia and quality of sleep
- Amitriptyline has shown no significant benefit over placebo

Duloxetine appears to have the greatest therapeutic potential and as such, is considered a first-line agent for the treatment of CIPN.

- A study of 231 CIPN patients showed significant improvement in average pain scores in the treatment arm (duloxetine 30 mg daily for the first week, then 60 mg for four additional weeks) as compared to the placebo arm.

– Continued on page 7

5 WAYS TO SMILE SO YOU CAN DEFEAT ANXIETY

Mike Sill, SundayScaries.com, July 8, 2023

(Editor – I'm not promoting positive toxicity, but smiling if it feels right to you. For me it's #2 – listening to happy music. I even have a play list of happy songs that I dance to around the house.)

- 1. Practice smiling exercises:** Yep, this sounds super weird. But, if you make a continual effort to smile by looking in the mirror and stretching the corners of your mouth into a smile shape, you'll train the response. Research tells us that even a forced smile can lead to a positive emotional response.
- 2. Listen to happy music:** While we're huge gangster rap fans here at Sunday Scaries, that might not be your best choice for this process. Music has an insanely powerful effect on our mood, so choose tunes that are positive and uplifting.
- 3. Put down your phone:** If the first thing you do in the morning is check your phone, almost unconsciously, try plugging it in another room at night. There are so many notifications and negative news articles that taking a momentary digital detox can help elicit happiness, and in effect, a smile.
- 4. Accomplish an easy to-do list:** You can force fulfillment by writing down some simple tasks to accomplish in the morning. These don't have to be brain bugglers, but instead mindless tasks such as making your bed, organizing your desk or decluttering your bathroom countertop.
- 5. Start the smile domino effect:** This is the most virtuous of all the Ways, because you are starting a chain of smile events that will encourage others to defeat their anxiety. Try smiling at a random person in the elevator or grocery store.

Remember, smiling is contagious, and when your smile elicits a smile in someone else, you'll both smile even more. This encourages human connectivity and a transfer of positive energy. Smiling and laughing with others is the simplest, most key ingredient in defeating anxiety on a constant basis. And here's a quote from Connie Stevens that sums it all up: "Nothing you wear is more important than a smile."

Chemotherapy-Induced Peripheral Neuropathy Treatments (Part 1 – Medications) – Continued from page 6

- A more recent trial of 34 patients yielded similar results with significant decreases in visual analog scale pain scores in the treatment arm (duloxetine 20 mg/day orally for the first week and 40 mg/day for the next 3 weeks) as compared to vitamin B12 (VB12) 1.5 mg/day orally for 4 weeks. The first group of duloxetine showed significant differences with respect to numbness and pain in patients suffering from CIPN caused by oxaliplatin, paclitaxel, vincristine, or bortezomib.

Opioids

Opioids have classically played a role in the treatment of cancer-related pain, although their effectiveness alone is limited when targeting CIPN pain.

- In patients with neuropathic pain either due to postherpetic neuralgia (PHN), posttraumatic neuropathy, or CIPN, it was found that the **combination nortriptyline–morphine** showed superior efficacy than either medication alone at treating neuropathic pain.
- A similar phenomenon was exhibited when gabapentin was utilized. While observed in patients with non-CIPN neuropathic pain syndromes, those with diabetic neuropathy or postherpetic neuralgia achieved better analgesia with the **combination of gabapentin and morphine** in the treatment of their neuropathic pain, suggesting a possible additive effect between the two medications.

Within the opioid class itself, morphine has traditionally played a role in the management of cancer-related pain and is recommended as a first-line opioid in the WHO Cancer Pain Relief Guidelines.

ALTERNATIVE AND PREVENTATIVE TREATMENTS FOR CIPN

It is worth noting that alternative modalities such as physical or occupational therapy, biofeedback, guided imagery, and acupuncture may be employed for CIPN but often only provide minimal, short-lasting relief.

In our search, no supplemental agents were found to demonstrate outright efficacy in the prevention of CIPN, despite evaluation of many therapies traditionally used in the treatment of neuropathic pain. These include omega-3 fatty acid, alpha lipoic acid, and vitamin E. Of alternative modalities considered, exercise has shown the greatest benefit in patients with CIPN, although exact CIPN-specific exercise prescriptions have yet to be developed.

Overall, given the lack of preventive and therapeutic modalities for CIPN, most of the circulating literature of late has focused on interventional pain strategies that may benefit this patient population. These methods include spinal cord stimulation (SCS) and dorsal root ganglion (DRG) stimulation, which will be reviewed in the October issue of Neuropathy Hope as Part 2 of this article.



WESTERN NEUROPATHY ASSOCIATION

A California public benefit, nonprofit,
tax exempt corporation

3620 American River Drive, Suite 230
Sacramento, CA 95864

Call WNA using our toll free phone number:
(888) 556-3356 • Email: admin@WNAinfo.org

IN THIS ISSUE

Being the Editor for Neuropathy Hope is a lonely job. Just me and my laptop, searching the internet using a variety of word combinations so that I can find interesting articles for my readers, and some new treatments that can give us all hope. After all - that's the title of the newsletter – Neuropathy Hope! I listen to the support group attendees – to their problems, heartaches, and successes – and try to find information for the newsletter that will support their efforts in living with this crappy disease. Every once in a while, someone forwards an article that may find it's way into an issue.

The first six months being Editor, I received 3 or 4 emails about the newsletter. But since then, nothing. I've encouraged two-way communication in a variety of ways and not a single person has responded. So I have to ask – is anybody out there? Is anybody reading these articles? Is this a newsletter that meets your needs?

Now, I do get a lot of pleasure out of researching peripheral neuropathy and understanding the science. I've always loved learning and this job has given me a direction to pursue. But has this transferred to the newsletter? **Are these articles helping you live with your neuropathy? Do they give you hope?** Reach out and let me know.

..Katherine

klstenzel@hotmail.com



Western Neuropathy Association (WNA)

A California public benefit, nonprofit,
tax-exempt corporation.

Katherine Stenzel, Editor
klstenzel@hotmail.com

3620 American River Drive, Suite 230
Sacramento, CA 95864
(888) 556-3356
www.WNAinfo.org

WNA Headquarters: admin@WNAinfo.org

Our mission is to provide support, information and referral to people with neuropathy and to those who care about them, to inform and connect with the health care community, and to support research.

Dues - \$30 a year

All contributions and dues are tax-deductible.

We are supported by dues-paying members, contributions by members and friends, and occasionally, small grants and fundraisers.

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