Questions About A Cure for Trigeminal Neuralgia Inspire New Genetics Study
Treating Trigeminal Neuralgia Through Innovation and Expertise.

The Neuroscience Institute at Florida Hospital Orlando is home to one of the largest and most experienced teams of neurosurgeons in the Southeastern United States, performing innovative less invasive surgical approaches for the treatment of trigeminal neuralgia. Patients suffering from this condition have access to techniques like endoscopic microvascular decompression and Gamma Knife® radiosurgery, as well as a program care coordinator who will guide them through every step of the treatment process.

Melvin Field, MD, Physician Leader
Melvin Field, MD, is the surgical director of the Florida Hospital Neuroscience Institute and physician leader of the Minimally Invasive Brain Surgery Program, specializing in the treatment of brain and neurovascular compression syndromes through innovative minimal-access techniques like the endoscopic microvascular decompression approach.

Brandi Ligon, BSN, RN, CNRN, Care Coordinator
Brandi is the care coordinator for the Minimally Invasive Brain Surgery Program and helps navigate patients through the treatment process from scheduling appointments and tests, to coordinating care between multiple physicians, and addressing patients’ questions and concerns.

To contact our care coordinator or to schedule an appointment, call (407) 303-7944 or visit FloridaHospitalNeuro.com.
**Cover**

**Questions About Cure for Trigeminal Neuralgia Inspire New Genetics Study**

By Facial Pain Research Foundation. Arline Phillips-Han reports on a groundbreaking study being funded by the research division of TNA-FPA to determine whether a genetic abnormality may heighten susceptibility to chronic facial pain. *Page 15*

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**Sage Advice From a Veteran**

Pat Akerberg, an Ambassador on TNA’s Facial Pain Network writes about how to use the FPN to become a more educated and empowered patient, able to effectively advocate for your treatment.

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**Maintaining a Positive Attitude**

Deborah Barrett, PhD, Associate Professor at UNC, psychotherapist and chronic pain sufferer on how to manage your pain on a daily basis when there is no cure or effective treatment available.

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**National Conference San Diego, CA Registration Form**

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**Regional Conference Richmond, VA Registration Form**

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**Clip-out 2013 calendar**

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**I Belong to a Club No One Wants to Join**

This issue’s Support Group News column is given over to Anne Ciemnecki an accomplished policy researcher and TNA Support Group Leader. Anne writes an inspiring article about her journey as a third generation trigeminal neuralgia patient.

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**In Every Q**

**From the Chairman of the Board**

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**Renewals, New Memberships and Memorial Tribute Fund**

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**Support Group News**

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**Tic Talk - A Surgical Procedure That is Best suited to You!**

*Page 12*
In this first column as the new Chairman of the Board, I begin by thanking Roger Levy whom I succeed and who served our organization vigorously and creatively for 12 years. Thank you to Roger for all of your efforts. I look forward to working with our fine CEO John Koff and our dedicated Board to continue to help those with neuropathic facial pain.

Here is a sketch of what TNA: The Facial Pain Association is doing. Our staff responds to 25 to 30 calls from patients per week, we assist 35 regional support groups, we hold telephone-based meetings for support group leaders and young patients, and we will hold conferences during 2013 in Richmond and San Diego. Our book Striking Back remains in demand. On the Internet, TNA runs the Facial Pain Network with over 2,200 members and the Network has links to Facebook and Twitter. Our website is receiving over 1,000,000 visits per year. You are receiving the TNA News Wire and the TNA Quarterly by mail or electronically to keep you up to date with news and perspective.

Regarding research, our Patient Registry has data on 2,700 patients and TNA’s Facial Pain Research Foundation is funding early-stage projects that researchers expect to yield major advances in pain treatment.

We will not rest. Coming months will bring new focus to our efforts to educate front-line healthcare professionals in diagnosing neuropathic facial pain disease. Facial pain disease is rare; the annual incidence of classic trigeminal neuralgia averages approximately 4.3 per 100,000 people and very little data exist on the incidence of other neuropathic facial pain diseases. The healthcare professionals who many of you visited first about that excruciating pain may have received little training in these diseases and many of those professionals see only a few cases in a career – that makes fast and accurate diagnosis a challenge. We have heard from too many patients who spent years in pain, and who paid for costly and ineffective procedures, until their disease was correctly diagnosed. TNA-The Facial Pain Association is giving extra attention to helping professionals to speed correct diagnosis so that patients have a minimum of unproductive procedures and can proceed to make well-informed treatment decisions as fast as possible. Our staff, physicians and dentists on our Medical Advisory Board, and key members of our Board of Directors are working to improve initial education, continuing education and general awareness of the symptoms of neuropathic facial pain diseases among those healthcare professionals who patients visit first. Stay tuned, this is just one of the initiatives in our plans.

Jeffrey Bodington, Chairman of the Board
TNA – The Facial Pain Association
Does your diagnosis and some of what you’re reading online scare and worry you? If so by joining the FP Network, you are already making your first wise decision. Most of us on the FP Network have shared the same fears, questions, and doubts. So we understand, are willing to be your support network, and share our experiences, hope, and strength. It’s important that you keep the faith and rely on the fact that relief is possible. Here are a few hard won lessons that I’ve learned and can share with you:

Don’t let fear run the show. If you let it, this will actually make the TN pain worse due to the stress involved and can undermine your judgment if you allow it to. Some medications can add to that effect because they are strong and sometimes cause one to feel “off center”. Anxiety actually undermines a person’s ability to gain clarity at a time when it’s needed most.

**Have an advocate.** Besides yourself, it’s so important to have an advocate helping you along the way (a friend, family member, partner, TN support network, etc.). I have my husband who has been a great supporter and advocate. But because I hadn’t joined the FP Network before my MVD, I didn’t have the benefit of a well informed support network until afterwards. If I had that network to tap into upfront, I believe I would have had a different outcome.

**Slow down/take your time.** Many of you may be working, have families to raise and support, live alone, etc., and the sense of urgency to get the pain under control.

“Sage Advice” . . . continued on page 4
control quickly might lead you into making hasty decisions. There are many options to consider that require an understanding of the benefits and risks. Experience suggests more than one consult with expert practitioners who have proven track records. TN pain and the anticipation of it are frightening. As difficult as that fear is, it’s so important to take time to gain confidence that any action being taken has the best odds of being right for you.

**Become well informed.**

Do a solid amount of reading (Striking Back), research, networking, and physician interviewing before you make any surgical or treatment decisions. Ask questions, don’t hold back. If your questions aren’t received well, I believe that’s a caution light. The decisions you may make will impact your life going forward. I did the appropriate research, but did not have the benefit of networking with a group of experienced TN’ers with valuable experience. For instance, I assumed there would be responsible, committed aftercare with my MVD, only to find out just the opposite when complications occurred. My choice would have been different if I had known that upfront.

**Know how to describe your pain.** It’s extremely important that you learn to describe your pain well to those working to treat you. Is it stabbing, shocking (electrical), burning, intermittent, constant, what # on a scale of 1 to 10, and where? It’s not easy, but you’ll need to learn how to be your own best advocate. Sometimes it helps to keep a daily log so you can better remember and describe the pain patterns. Often you’ll be assessed by how you look too, which can work against you if you look OK and can’t describe your hidden pain well.

**Seek a clear diagnosis before taking action.** Different treatments and/or medications have varying degrees of success, depending upon your diagnosis. There are first line protocols to be followed upfront in order to determine your diagnosis that involve a particular kind of MRI/MRA and trial medication(s). All too often new members coming aboard aren’t really clear about their diagnosis, have a hard time describing the type of pain they are experiencing, and yet are prematurely considering surgery or other destructive procedures.

**Medications and CAM.** If the first attempts at a medication don’t work, don’t give up and assume that you have no choice but surgery. There are a number of medication combinations to try before you give up on medications. If I had known about upper cervical chiropractic back then, I surely would have tried it before any invasive procedure. It’s an alternative treatment that has helped a number of people with TN, as has acupuncture. Even if the cost is out of pocket, the key advantage of being less risky speaks for itself.

**One size does not fit all.** When you hear about or read of someone’s experience on the FP Network, it DOES NOT mean that you will have the same experience or reaction. We are each so unique with very different medical histories. A medication (or treatment) that works for one person may not for another person, and vice versa. In general, pay attention to the odds of those things that research indicates are more successful and ask others about their experience and any complications involved with those with lower odds.

**Get more than one opinion.** It took seeing 5 neurologists in my area before I found one who was familiar with TN. If it comes time for you to consider a
Dr. Sumeer Sathi is a Harvard educated and trained neurosurgeon. He completed a fellowship with Dr. John Tew, one of the pioneers in treating facial pain, at Mayfield Neurological Institute in 1995. He has been in practice in Suffolk County Long Island for 16 years with privileges at Long Island Gamma Knife. Dr. Sathi serves as the Chief of Neurosurgery at St. Charles, John T. Mather and Brookhaven Hospitals. He is also a clinical assistant professor at the Department of Neurological Surgery, Weill Cornell Medical College. Multidisciplinary treatment options for treating facial pain including interventional pain management, microvascular decompressive surgery and gamma knife radiosurgery are offered.

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“Sage Advice” continued from page 4

treatment or surgery, make sure to get more than one expert opinion. Many of the top surgeons will do phone or Skype consults which helps with making that happen. Try not to wait until you're at the end of your rope to get more than one opinion; otherwise, you'll be likely to opt for local convenience (which may or may not be your best choice) vs. track record of successful outcomes. You'll also need to understand what your insurance will cover, etc.

Trust your instincts. You know yourself the best. If in doubt, wait until you come to a place of your own internal peace with any treatment decision you may make because research suggests that a person's mental and emotional state do matter.

Modify your expectations. TN changes things, for you and for others around you. Some people will have empathy and be understanding, some may not believe you entirely, some will be wonderfully supportive, and others may be pretty disappointing. While some reactions may hurt, the truth is that they are not about you! If we are limited and can't work, get out, have pain when talking or trying to eat, or can't drive, we can feel pretty isolated. Because TN is an invisible disease, we are often misunderstood and don't look nearly as bad as we actually feel. To expect yourself to still function in the same ways that you did before TN will only set you up to judge yourself as falling short. Instead, find ways to lighten up on and distract yourself. Stress is a pain trigger, so it's important to minimize your mental and emotional distress.

Express yourself/don't hold it all in. As hard as it is, it ends up being very helpful to reach out, share your thoughts and feelings, and ask for help if/when you need it. Those with experience don't feel put upon, but instead are glad that their experience might help someone else have a better one. Sharing with a support network gives us a place to "belong". It helps to take the edge off because they are people who truly 'get it'. I'm very grateful for the special friendships and circle of support developed with other members who cope with similar issues. Learning from each other, caring, and sharing with people from all over (whom I otherwise would have never met) has been a true lifeline.

Hang in there! Remember, most people now free of TN pain are out there living their lives and aren't posting on the FPNetwork. So my best advice to you is to take things one day at a time, believe that something positive is possible, and know that you are not alone in this journey. To join the conversation on the TNA Facial Pain Network go to: www.fpa-support.ning.com.

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Michigan Neurology Associates, P.C.
Maintaining a Positive Attitude

By Deborah Barrett, PhD, MSW, LCSW

Part of TNA's mission is to provide information and offer support. In fulfilling this mission we are continually looking for ways of coping with neuropathic facial pain. Until a cure is found, it is important to keep a positive attitude. Facing pain everyday makes this very difficult to do. Sometimes we must reach out to a fellow sufferer of pain to find new ways of coping. One such person is Deborah Barrett, PhD, MSW, LCSW. Dr. Barrett draws from her professional experience and “the empathy that comes from life in the pain trenches.” She is a clinical associate professor in the School of Social Work at the University of North Carolina at Chapel Hill, and a psychotherapist in private practice. She has published self-help articles on fibromyalgia and other chronic pains as well as scholarly papers on health and illness, global culture, and public policy. She has written a new book “Paintracking” and shares her knowledge in coping with pain.

Maintaining a Positive Attitude

"Have a positive attitude." How many times have we heard that one? While our emotions can not cause fibromyalgia or chronic fatigue syndrome, they no doubt affect our symptoms. But how can we maintain good thoughts when our bodies feel so lousy? This challenge, of course, does not pertain exclusively to chronic illness, but to any time when things do not go as we wish. But in the case of ongoing illness, seeing the positive presents a continuous struggle.

Yet our moods are not perfectly correlated with our physical state. Most likely we can all recall times that despite much pain or fatigue, we were able to cope and even achieve high spirits. Perhaps the weather was perfect, good friends visited, we just accomplished something or helped somebody, making
us feel good about ourselves. Other times, depression seems to take hold even when our physical discomfort is at a manageable level. Why is this? Answering this question is the key to finding optimism.

To me, the vicissitudes of fibromyalgia feel like a swim in the turbulent sea -- sometimes it seems we have fallen and the waves continue to crash on our heads, as we fight to rise, only to be knocked down yet again. But that same ocean sometimes allows us to find a wave we can ride smoothly to the shore.

What can we do when we feel under the waves? How can we find the strength to climb back on top, and the patience to know that we will? Here are ten cognitive exercises I use to maintain the most positive attitude I can:

1. Expect bumps! It is important to acknowledge that we will sometimes feel down. Who wouldn’t in our condition? But by expecting rather than dreading down time, such periods become more tolerable. In addition, recognizing that we will have blue periods helps keep them in perspective. We will be able to say to ourselves, “I was depressed before, and got out of it; this time, too, it will pass.” It is easy to forget that before our illness, there were times we felt down. Now these periods are wrapped up in our medical problems; but everyone gets depressed some of the time. After accepting that we will sometimes feel sad, and even experience self pity, we can concentrate on ways to shorten these periods and make them fewer and farther between.

2. Track the changes. Keeping track of moods helps put ups and downs into perspective. During your best times, make a conscious attempt to capture the feeling. Leave notes on your wall attesting to the way you feel. Living with chronic illness easily creates a Jekyll-and-Hyde persona, where your optimistic self and your flare-up self are not sufficiently acquainted. When we feel bad, it becomes quite difficult to imagine that things can be otherwise. Similarly, during times of improvement, it’s amazing how quickly we may forget how bad a previous period was, making subsequent flare-ups not only intolerable but shocking. Counting and measuring the duration of the bad times -- as well as the good ones -- can put them into perspective. It may be that over time, our worst occurs about once a month, although it feels much more frequent. This knowledge is empowering, because we can remind ourselves that a bad flare is, for example, our monthly temporary setback, and find ways to ride it out until our baseline returns.

“Positive Attitude”...continued on page 8
3. Stockpile fun distractions. We all need to keep lists handy of the things that make us happy. One of the cruelties of our condition is that when we need distractions most, we are least equipped to seek them out. For this reason it is important to compile a list of our favorite activities when we are feeling optimistic to be used when we most need them. People with fibromyalgia often describe how even their worst pain can be put on a back burner, so to speak, when they become engrossed in an activity. This is not only a psychological but a physiological response: our brains can only process so much input at once. When we are engrossed in a beautiful movie, talking to a good friend on the phone, or listening to our favorite music while lying on a heating pad or in the bathtub, we can trick our pain receptors into leaving us alone! Meanwhile improvements in spirit have an added impact on our entire well-being. Laughter is good medicine; while dwelling on our troubles tends to compound them.

4. Shape your perspective. Is the glass half empty or half full? Perspective determines, quite literally, how we view the world. Having a chronic illness creates an ambiguous construction of reality for us. Am I, for example, a successful cripple or an unsuccessful professional? In American culture, much emphasis is placed on independence, individualism, and achievement. Through this lens, developing a condition that makes us feel more dependent and less productive is likely to be a huge disappointment. Yet as we get older, it becomes more likely that we, or somebody close to us, will experience debilitating problems. People are often forced to adapt to sudden, new conditions by adopting a perspective that accommodates change. Our perspectives are shaped by the comparisons we make and the expectations they create. Consider, for example, the immigrant who had been practicing medicine in his home country, but flees to the US to escape a repressive political regime. Here he works as a janitor; after years of medical study, he has lost a prestigious and rewarding occupation. Yet he is thankful for the opportunity to work and wakes each day driven by hope, perhaps, of a better future for his children. Yet his difficulties are also quite apparent. What keeps his spirits up and makes him thankful rather than bitter? His perspective.

5. Create a new self. If we hang on tightly to the “old self” we were, finding the value of our “new self” becomes increasingly difficult. (“We may even exaggerate how fit that person was: “I didn’t need any sleep, I never felt bad, I could do anything!”). This does not mean we should totally discard our
previous conception of self; rather, we need to find a way to integrate the two. In other words, we should seek to find in our new bodies new ways to enjoy and experience the things that we had done before. Consider all the aspects of yourself that you like, and the things that you most want to do; then step by step, find ways to achieve as many of these as you can. At the same time, recognize that our expectations must shift so that we can once again meet them.

6. Don't forget the good stuff. While the physical symptoms of fibromyalgia can feel all-encompassing, there are other parts of our life—our social relationships, passions, family—that also exist. By focusing on the positive aspects of our life, we become more aware of how many there are: the friends that stuck by us, the things we still enjoy, and the accomplishments we have been able to make, however small, under very different conditions. Because each task now represents a challenge, we should celebrate whatever we manage to accomplish. As we have been told many times, if we shorten the list and pace ourselves whatever we do eventually adds up to something to be very proud of.

7. “Oy, it could be worse.” (The Jewish mantra). As comparisons shape our view, it is helpful to find comparisons that will provide a fuller appreciation for what has befallen us. OK, the “eat because children are starving in (fill in the developing country)” did not work for you as a child. But try to think of it this way: Many bad things happen in the world. The odds are that some of them will happen to us. Not because of anything that we have done, but because, as the saying goes, shit happens. It takes only a short view of the evening news to remind ourselves of the horrors occurring every day. So, this is what has happened to us. We too were caught. Let us examine what we have: (a) We know our condition is not terminal, so we need not begin contemplating our pending mortality. (b) As bad as we sometimes feel, our underlying condition is not going to get worse. We have already experienced the worst, and, to our credit, have gotten through it. (c) Although few people achieve permanent remission, many improve significantly. As we understand how our actions and emotions influence our general well-being, we can find ways to partake in more and more activities.

8. Keep the hope alive! There is so much room for hope. It has only been since the 1990s that our condition has acquired any legitimacy from the medical community. We are in a far better position than the generations before us who suffered without ever receiving validation. We know much more about the important roles of exercise, medication, stretching, pacing and meditation to bring relief and a sense of control. Furthermore, as medical research increases, it is only a matter of time before better therapis (and perhaps even a cure!) are introduced.

9. Lean on me! A single most important predictor of how we do is the support network we create. We certainly appreciate what it means when someone helps us when we feel especially lousy. Make sure that, within your means, you continue to be a good friend to those you care about. We still have lots to give. During a good moment, write to a friend that you are thinking about her. Help your family and friends find ways to maintain their relationship with you. Invite them to your place to eliminate traveling (and do not worry what your place looks like! They came to see you, not your housecleaning abilities). Try to be open with family members, while at the same time supportive of their needs. Put yourself in their shoes as often as possible—it can be scary to have someone you love be sick! Also make sure to seek help outside of your immediate circle so as not to drain your closest friends and family. There are now all sorts of support groups, both live and in virtual computer space.

10. Indulge whenever you can. We have lots of time to focus on our thoughts. Most people do not have the luxury of taking time to relax and think. OK, we did not ask for these “time outs.” They are demanded by the needs of our bodies. Nevertheless, we have control over how we use this extra time. Instead of dwelling on what our bodies are not doing, give your fantasy full liberty. Turn these rest periods around to be indulgent time. In our mental playground, we can practice dance steps we used to know (for there will be some times we can dance!). We can use the time to think through problems we face and how we want to spend time when we are feeling ready, or we can analyze a movie we recently saw, say prayers, or mentally write a letter to a friend. The article you are now reading is a product of a spell in the middle of the night, when I lay in bed, unable to sleep. After taking steps to make myself more comfortable, I decided to think about what I would write next. I figured that if I fell asleep, great! But if not, I’d have thought through my next article. It was about this point when I, satisfied, went off to dreamland. *sweet dreams*!

For further information on coping with pain visit: http://www.paintracking.com
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Registration fee includes; conference admission and materials, welcome reception Oct. 4th, continental breakfast Oct. 5th & 6th, lunch Oct. 5th and refreshments.

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__________________________________________________________________________ (relation to patient)

* I am a:
☐ Medical Professional
☐ Patient with classic TN
☐ Patient with other neuropathic face pain
☐ Caregiver
☐ Friend or family member

How did you hear about this conference?
☐ Our website
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☐ Facial Pain Network
☐ Other

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Fax: 352-384-3606
Make sure of your diagnosis

- Talk with your physician about the difference in classic trigeminal neuralgia versus neuropathic facial pain. Many of the treatments for classic trigeminal neuralgia are not effective for other types of facial pain and could even make the pain worse.
- Familiarize yourself with the Classifications for Neuropathic Pain.

Educate yourself

- Talk to others with similar symptoms. The Facial Pain Network is a good place to start www.fpa-support.ning.com
- Search reliable web sites for additional information
  - TNA the Facial Pain Association – www.fpa-support.org
  - Be aware of any site that has testimonials and offers money back guarantees or advertising they can stop the pain of TN.
- Read issues of TNA's newsletter the TNA Quarterly.
- Read all available medical literature such as the Knowledge Base on TNA The Facial Pain Association's website www.fpa-support.org

Recuperation

Consider how much time you can afford to spend recovering from surgery. Recuperation is faster for some procedures than for others.
- Do you have someone you must take care of?
- Do you have someone to take care of your needs while you recuperate?

Willingness to have a major operation

- Consider your general health and ability to tolerate surgical stress
- A MVD is major surgery and requires opening the skull to get to the trigeminal nerve as it exits the brainstem.
- On the other hand, a MVD actually protects the nerve by removing blood vessels that are compressing it.
- Other procedures are deliberately destructive. All of these cause some damage to the nerve in order to disrupt pain signals:
  - balloon compression
  - glycerol injection
  - radiofrequency lesioning
  - radiosurgery

It is often a difficult decision to choose a surgical procedure that is best suited for your facial pain with your unique situation in mind. You are often on medication and are not in a state of mind to make the best decision for yourself. You should not wait until you are in so much pain that your choices are limited. Always have a “Plan B” ready. In TNA’s ongoing effort to present you with choices available to you, we have provided a checklist to help you sort this out.
From all of us at The Facial Pain Association to you and yours warmest wishes for 2013.

John, Cindy, Nancy, Aggie, Lynn & Ron
Branch of the nerve affected
Second and third division basically have the same treatment but if the pain is in the first division you might consider this:

- There is a slight risk that the destructive procedures will leave the cornea of your eye with no sensation.
- The MVD has the highest rate in terms of preserving sensation in the cornea.
- Some physicians recommend the balloon compression for first division pain.
- Glycerol injections are often not effective for the first division.

Facial numbness
The destructive procedures can cause numbness.

- Most people can tolerate it and it’s far preferable to the pain of TN.
- Some patients have found the numbness extremely difficult.

Toleration of recurrence

- TN is more likely to recur with some procedures than others.
- The MVD, which is slightly riskier because it’s major surgery, has the lowest rate of recurrence.

Accepting the risk

- Can you accept the particular risks of the procedure you’re considering?
- Do you know what the risks are?
- People are very different in the way they deal with risks; therefore, this needs to be a personal decision, not a medical one.

Willingness to travel

- If necessary, are you willing to travel to undergo a certain procedure or to see a particular physician?
- Some of the procedures are only offered in certain areas of the country.
- The more experienced physicians may not be in your area.
- Many physicians only offer one or two procedures.
- If the pain returns, do you have a local physician willing to manage the TN?

The decision

Ask all of these questions get complete answers, talk to people who have had the procedures, and get all the other information you can. With your physician, you can make a good decision about which procedure will be best for you.
Three pioneers in pain research are gearing up for an international study aimed at determining whether genetics plays a role in the excruciating facial pain of trigeminal neuralgia. The study begins at a time of increasing scientific evidence that the source of the pain is something more than the well-known injurious compression of the trigeminal nerve.

Trigeminal neuralgia, in its classic textbook form, affects only 10 in 100,000 adults, but its importance lies in its brutal bolts of facial pain that stop life in its tracks and, in rare instances, leads to suicide. The disease affects men, women and children worldwide.

Acting on educated presumptions that there are underlying genetic flaws, the researchers plan a direct chase to find markers of genetic abnormality, such as gene mutation, genetic variance or malfunction, or missing parts of genes that may heighten susceptibility to chronic facial pain.

The project, “In Search of a Cure…Finding the Genes That Predispose to Trigeminal Neuralgia,” will begin in February 2013. It is the fourth project initiated by The Facial Pain Research Foundation, a division of TNA-The Facial Pain Association, in a quest to cure TN and other neuropathic facial pain within ten years. Defects in one or several genes, if found, could provide targets for designing customized drugs or perhaps treatment through gene therapy, which is gaining momentum in the U.S. and is newly approved in Europe.

To patients suffering the lightning-like strikes of electrical pain in the face, the natural question is why me? To health-care professionals hounded by repeated failures in attempts to permanently end this pain, the question means everything. Finding a cure requires a breakthrough in more fully understanding the source of the problem.

The three researchers, widely known in the field of pain research, are joining forces to stop the pain that appears unstoppable in thousands of people worldwide, and they are doing so as volunteers. Project Coordinator Marshall Devor, Ph.D., who is The Alpert Professor of Pain Research at The Hebrew University of Jerusalem, says his reason for working pro bono goes back to his student years when he decided what he wanted to achieve in life would not be about making lots of money, but about solving human problems. He sees trigeminal neuralgia as “an immensely intriguing intellectual challenge, given its strange peculiarities—an electrical shock going off in your head, the pain often triggered by a light touch!” Yet he expresses optimism: “A cure for classic trigeminal neuralgia (TN1), which will prevent or modify the disease rather than just suppress the pain, is theoretically possible. Progress in understanding TN is also likely to have implications for other neuropathic pain conditions.”

Devor is joined in project leadership by principal investigators Ze’ev Seltzer, D.M.D., professor of genetics at the University of Toronto Center for the Study of Pain in Ontario, Canada, and Kim Burchiel, M.D., the John Raaf Professor and Chairman of the Department of Neurological Surgery at the Oregon Health and Science University in Portland. Physician/Scientist Joanna Zakrzewska, M.D., of London, the Foundation’s international neuroscience coordinator, recruited all three premier scientists to the project and will serve as senior consultant.

The Facial Pain Research Foundation is leading a campaign to raise $616,750 in donations to fund operational expenses involved in probing the genes of 500 patients with the extreme pain of TN1.

“We aim to obtain a genetic profile that will lend itself to finding an end to TN pain,” says Michael Pasternak, Ph.D., of Gainesville, Fl,
founding trustee and former president of TNA. “We want to exploit knowledge of the pattern of genes in a way that will prevent the disease. The genetic patterns of these 500 patients will be painstakingly defined through analysis of DNA extracted from samples of their saliva.”

Why so few individuals are prone to the devastating pain of TN has stymied health-care professionals ever since the disorder was first described in the second century A.D. Although significant advances have been made in medications and surgery for the disease, some patients are unresponsive to treatment and pain recurs in a large percentage of other patients within months or several years after treatment. In either case, the resurgent pain typically worsens with time. Standard treatment starts with medication, but the selection of a drug is a trial and error process, since there is no way to determine in advance which drug will help an individual or may cause bothersome or intolerable side effects. In many cases, medications provide only transient benefits.

“Probing the genes of individuals with the pain of TN1 is the most direct route to finding the answers we seek,” says Devor. “If my hypothesis is correct—that only a few abnormal or malfunctioning genes are involved in patients with TN1—there is a high likelihood that the project will reveal these genes and ultimately the disease-causing mechanisms involved. No other plausible explanation has been presented for why it is that although many people have trigeminal root compression, this extreme facial pain attacks very few of them.”

Devor, a veteran of 40 years in pain research and winner of Israel’s prestigious 2012 EMET Prize for Art, Science and Culture, says a lot of the technology applied in the 13-year federally funded Human Genome Project will be applied in the study of TN. “Compared to the high cost of that massive genome project, ours will be cheap,” he says. “The knowledge we obtain is expected to help us better understand not only TN, but also non-trigeminal facial pains and nerve-related pains in other parts of the body.”

The first year of the project will be devoted to enrolling qualified patients who will contribute saliva samples for DNA analysis. The researchers will compare the newly collected genetic data to the same type of data obtained from people without TN in previous genetic studies and now readily available in the medical literature.

“If only a few gene abnormalities are found in the DNA samples from the 500 TN patients, the question about the role of genetics can be answered in this study,” Devor says. “But if we find many gene variances, in which each defective gene makes just a small contribution to the disease process, more samples would be needed for analysis. If no particular gene has a strong effect on the risk of developing TN1, the identity of many weak genes is unlikely to benefit patients except perhaps in the distant future.”

Prevention of the disease is as critical to the researchers as finding a cure. As Devor has explained to trustees of the Foundation, “If we identify genetic defects linked to TN1, we can test relatives of the patients, and if we find they have the same genetic pattern, we would then seek ways to keep them from developing the disease.”
More than a decade ago, the Center for Cranial Nerve Disorders at Allegheny General Hospital was making history with leading-edge surgical treatments for trigeminal neuralgia. Today, that legacy continues at AGH’s Neuroscience Institute. Neurosurgical innovator Dr. Peter Jannetta continues to make key contributions to the Institute while neurosurgeons Dr. Khaled Aziz and Dr. Jack Wilberger provide the best care for patients with cranial nerve dysfunction. Staffed by experienced physicians, nurses and neurointensivists with access to a new intensive care unit at a world-renowned academic institution, the Neuroscience Institute is still leading the way to improve outcomes for the patients of western Pennsylvania.

To find a physician at the Center for Cranial Nerve Disorders, call 412.DOCTORS (362.8677).
Changing Paradigm

Eye-opening human brain imaging studies by co-principal investigator Kim Burchiel, M.D. provide compelling reasons to delve into genetics to find out what distinctive problem in TN1 patients may explain why they are selectively attacked by chronic facial pain.

In a tone of obvious frustration, Burchiel says a lot of what he was taught about trigeminal neuralgia as a resident in neurosurgery has been found not true in the light of his 32 years' neurosurgical experience. "Things simply do not add up." He says traditional concepts about the trigeminal nerve are cast into question by human brain images recently obtained through a combination of magnetic resonance imaging (MRI) and cerebral angiography. His own imaging studies using an MRI-MRA system developed at the Oregon Health and Science University, confirm that nerve compression is not the only thing going on that is linked to facial pain.

Through his studies of super-sharp 3-D human brain images in patients with and without TN, Burchiel found that close to 17 percent of mature adults have trigeminal nerve compression, but no facial pain. Since only 0.01 percent of people suffer from TN1 pain, it appears that most people (94 percent) with trigeminal nerve compression escape pain. In addition, an estimated 10 to 20 percent of individuals newly diagnosed with TN do not have nerve compression.

Burchiel now wonders why the disease does not affect more people.

He notes that OHSU's imaging system, which he has used

“Burchiel found that close to 17 percent of mature adults have trigeminal nerve compression, but no facial pain”

Facing the Future

Neurosurgeon Stephen Griffith, M.D., treats patients of all ages using surgical or non-surgical treatment tailored to each patient's unique needs. Using state-of-the-art diagnostic technology, including 3-D MRI/MRA, he provides the full array of leading-edge treatment options, including microvascular decompression, internal neurolysis, and radiofrequency gangliolysis. And with the support of the team of experts at Saint Luke's Neuroscience Institute, he offers coordinated, world-class care designed to help his patients experience a future without pain.

At Saint Luke's Neuroscience Institute, we offer comprehensive evaluation, diagnosis, and treatment of all types of facial pain

Stephen Griffith, M.D.

Saint Luke’s Neuroscience Institute

For more information or to make an appointment, please call 816-932-2700.
4401 Wornall Road, Kansas City, MO 64111
saintlukeshealthsystem.org
routinely for the past five years, yields high-resolution views of the entire region of the trigeminal nerve and surrounding blood vessels. The images help him determine who has trigeminal nerve compression and who is a candidate for microvascular decompression (MVD), the gold-standard corrective surgery for classic TN.

“Our studies indicate nerve compression is a very partial and unsatisfactory explanation of the facial pain disorder,” he says. “The disease probably results from many factors. If the classic type 1 form of TN is solely related to compression of the trigeminal nerve, why does it ever come back? That idea is another bit of heresy!”

In their project proposal, Devor, Seltzer and Burchiel hypothesize that a genetic co-factor is the most likely explanation of why only one in every 2,000 people with trigeminal nerve compression also has TN1.

“If we can link TN1 to known gene sequences, enzymes or structural membranes, we will have discovered what predisposes a person to chronic facial pain,” Burchiel says. He is preparing to carry out the first phase of the genetic study in 50 TN1 patients at the Portland campus, and will later enlist 9 to 10 other medical research centers as partners in the larger study. Preference will be given to enrolling young patients, based on the assumption that if a person developed TN1 at a young age, he or she is more likely to carry variant genes of major effect.

“Devor, Seltzer and Burchiel hypothesize that a genetic co-factor is the most likely explanation of why only one in every 2,000 people with trigeminal nerve compression also has TN1”

“Genetics”…continue on page 20
Expectations for Success

Genetics Professor Ze’ev Seltzer, Ph.D., in his 36th year of research on the neurobiology of pain, predicts, “We believe we can come up with a cure in eight years, provided we have funds to complete all three phases of the study”. The stages include initial DNA analysis from the saliva samples of 50 TN patients, aimed at demonstrating feasibility of methods, to be followed by the enlisting of additional 450 qualified patients representing various ages and ethnic backgrounds, who will provide samples of their saliva for DNA analysis. The most critical aspect will involve the use of automated systems to perform genomic analysis of known elements within the DNA, followed by close examination of gene sequences in an effort to determine their function.

“If, in probing the genetic makeup of TN patients, some abnormality pops up that is different from the genes in people who have vascular compression of the trigeminal nerve but no pain, we may be able to stop or mute the pain.”

Yet a lot of what was once considered ‘junk DNA’ is not junk at all, but does have some function. Our effort to identify gene defects that affect a person’s vulnerability to TN pain can be compared to looking for a needle in a very large haystack.”

Seltzer likens the study to “a great adventure story” for which he envisions a practical outcome. He expects what is learned about the genetics of TN1 will lead to development of diagnostic kits that can be used to guide treatment choices when a person in pain first enters a clinic or hospital emergency room. To reach such a goal, he says a holistic approach is needed to focus not only on the pain and the genes linked to it, but also the full scope of a patient’s life to understand pain tolerance, stresses and factors affecting ability to cope with pain, environmental factors that may contribute to depression, anxiety, other health or family problems. To this end, Seltzer plans to implement questionnaires that will provide extensive information on a patient’s pain and lifestyle.
“The resulting patient profiles may help us better design treatments that address the pain problem a patient has or may develop,” he says.

“This is the most important study to be undertaken regarding trigeminal neuralgia and other painful conditions affecting the nervous system,” says Seltzer. His productive scientific work provides an ideal background for exploring the genetics linked to TN and other neuropathic facial pain disorders. He has developed several animal models of painful nerve-related diseases and authored many journal articles and book chapters reporting his findings on the genetics of neuropathic pain.

Seltzer has good reason to expect useful results. In two of his published studies, he and his colleagues reported they used a gene they had discovered in mice and rats in subsequent models of neuropathic pain to test whether they are relevant to human medicine. They discovered that the gene found in the rodents does have clinical relevance. He also was the principal investigator in a newly ended five-year project funded by The National Institutes of Health, in which researchers mapped the genome of the mouse to define the role of genes in the spread of neuropathic pain following injury to the trigeminal nerve system. His team currently studies the genetic abnormalities that predispose carriers to develop chronic pain following limb amputation and mastectomy.

Forecasts for Enduring Pain Relief

In light of relentless, treatment-resistant facial pain that many trigeminal neuralgia patients struggle with every day, the announcement of a first-of-its-kind probe of genes related to classic TN prompts excitement among people who know the limits of contemporary medicine related to pain.

Roger Levy, a founding trustee of The Facial Pain Research Foundation and immediate past chairman (12 years’ service) of the TNA-FPA Board of Directors, says, “There is no doubt in my mind that this is potentially the most exciting opportunity for helping patients since neurosurgeon Peter Jannetta performed the first MVD in 1966. If you want to win, you need to pick the best team you can, and this is what we’ve done.”

For University of Florida neuroscientist Douglas Anderson, Ph.D., Foundation trustee and director of its research programs, the study is the next scientific frontier in which to seek cause and solution for TN. As guest speaker at the 2004 TNA conference in Orlando, he pointed out how odd it is that the anatomy of compressed nerves has been found in a significant number of people, but only a few have TN. In visionary fashion, he encouraged the Association to embark on genetic research.

“We are moving forward with a sense of urgency, almost as if flying on a magic carpet, to realize our dream of finding a cure”

“Before you can begin to correct the problem, you have to define the cause,” Anderson says. “If, in probing the genetic makeup of TN patients, some abnormality pops up that is different from the genes in people who have vascular compression of the trigeminal nerve but no pain, we may be able to stop or mute the pain. The situation is like being in a room with a number of locked doors. Without a key (i.e. knowing the right gene), there is little or no chance that the correct exit door can be found. However, if one has a key, this key can be tried in doors until the right door is identified. Finding the genes involved will reveal a lot that can aid the development of treatment.”

“We are moving forward with a sense of urgency, almost as if flying on a magic carpet, to realize our dream of finding a cure,” says Writer-Publisher Myron (Mike) Hirsh of Naples, FL, also a Foundation founding trustee and former president of the TNA-FPA. “We see a rapid pace of change in genetics research in many parts of the world as men and women of science, who have devoted years of their lives to this field of study, are learning how genes affect our health and how they can replace genes to maintain our health. We are absolutely blessed to have recruited three of the world’s best-known pain scientists to help us reach our goals to help those who suffer.”

Follow the progress of and help support this FPRF research project at www.facingfacialpain.org. Direct your comments, questions to: info@facingfacialpain.org..
The following individuals joined or renewed their TNA membership

September 2012
Veronica Barnett
Joan Duckworth
Michael Foley
Myron Hall
Arlyn C. Hemme
Thomas Houle
Julie Hulcher
Roslyn Apt Johnson
Yvonne Lewis
Karen Mahoney
Elizabeth A. Morris
Michael Phelan
Lawrence Robbins
Joanne Thompson
Laurel Walton
Rita Welz
Ethel Wheeler

October 2012
Arin Darst
Jerrtie Fowler
Marian Gemmell
Carol Granger
Diana Manzo
Kurt Meehan
Glorianna Otero
Jorge Carlos Perez
Phillip and Therese Richardson
James Ungaros

November 2012
David Banks
Katherine Cantrell
Steve Denny
Donna Etter-Williams
Trish Fletcher
Judy Folkmanis
William Innocent
Wendy McAninch
Michael and Marie Moller
Jeanette Praetorius
Lillian Seldeen
Janet Taylor
Delores H. Zimmerman

Lifetime 2012
Claude and Jean Aldridge
Linda Lee Alter
Gwen Asplundh
Denise Ayers
Millard Battles III
Susan Berrodin
Jeffrey Bodington
John Boettner
John Bogle
Jeffrey Brown
Karen Burris
Ken Casey
Nell Channell
Brent Clyde
Allan Cohen
Douglas & Joy T. Daugherty
Janis Eisel

Dorothy Erwin
Virginia Frazier
Steven Giannotta
Mary Glynn
Denise Gorman
Ron Greiser
Henry Gremillion
Suzanne Grenell
Betty Hare
Peter Jannetta
Dana Langerman
Nancy Montag
Franklin Naivar
Brenda Petruska
Patti Jo M. Phillips
Gayathri Rao
Gary Redwine
Aaron P. Running
K Singh Sahni
Philip Sine
Ronald Streich
Patty Sublett
Lori Sunderland-Klassen
Julie Thomas
Tom and Susie Wasdin
Christy West
Karen Wilson
Cheryl Wruk

2013 Conferences

Richmond, Virginia
Regional Conference
May 11, 2013
1-Day Conference

San Diego, Calif.
National Conference
October 4–6, 2013
3-Day Conference
TNA’s Memorial Tribute Fund

There are special people in our lives we treasure. Increasingly, TNA supporters are making gifts in honor or in memory of such people. These thoughtful gifts are acknowledged with a special letter of thanks, are tax-deductible, and support TNA’s growing initiatives on behalf of TN patients and families. We are delighted to share recent Memorial Tribute gifts received as of November 30, 2012:

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This issue’s SGN column is written by Anne Ciemnecki. Anne is a Senior Fellow at Mathematica Policy Research based in NJ and an expert in interviewing methods for people with disabilities. Anne is also a face pain patient and a regional TNA support group leader. Here is her story.

I am a wife, a mother, and grandmother. I am a best friend. I am a senior fellow at a prestigious research corporation. I sit on the community advisory board of our county’s agency to support victims of sexual assault and domestic violence and am a member of their crisis response team. I am the president of a unique animal shelter, and the handler of the country’s twelfth highest rated therapy dog. I tutor homeless children and I am the treasurer of a civil rights organization. I am a potter who donates all my work to charitable organizations. I look forward to a comfortable, busy retirement in a few years. Yet, I belong to a club no one wants to join. I am a third-generation trigeminal neuralgia patient.

Tears rolled down my grandmother’s cheeks when she learned that my mother suffered from severe, electric shock-like, stabbing pain on one side of her face. My grandmother’s repeated alcohol injections provided only temporary pain relief. The harsh drugs, processed through her liver, caused the drug-prescribing physician, to insinuate that she abused alcohol as she slowly slipped away from us due to irreversible cirrhosis.

My mother’s pain was unrelenting. Eating, face washing, tooth brushing, and venturing into the slightest breeze caused lancinating pain on the right side of her face. Living on more than 1,650 milligrams of Tegretol® (carbamazepine) daily, she was one of the unlucky 0.1 percent who developed Crohn’s disease after long-term use. The multiple conditions left her bed-bound. My memories were of my mother in constant pain, pulling teeth and undergoing extensive dental procedures. She had two rhizotomies, three years apart with short-term relief after each one. After the first, the pain returned on the left side of her face. After the second, the pain made its way back to the right side, this time in the ophthalmic rather than the maxillary division of the nerve. She died just before her 70th birthday, simply worn out.

My journey began in 1991 at 40 years old. It took 11 years for a trigeminal neuralgia diagnosis to surface. I had a root canal, an apicetomy, and frightening memories of my mother’s dental experiences. My family history hindered the diagnosis. Doctors did not believe trigeminal neuralgia was hereditary; and my symptoms were atypical. The stumped doctors implied the pain was “all in my head” (which it was). I was compared to Hans Christian Andersen’s The Princess and the Pea. When I asked a
doctor for a handgun instead of another misdiagnosis and useless prescription, he thought I was suicidal. (Actually, I was homicidal!) I tried every drug (including methadone) along with acupuncture, Reiki, and psychotherapy. A business trip brought me to Los Angeles and divine intervention brought me to Dr. Steven Graff-Radford at Cedars-Sinai Medical Center. Within 10 minutes, Dr. Graff-Radford hypothesized that I had an unusual presentation of classic trigeminal neuralgia. An MRI indeed revealed a vessel compressing the nerve, and I was on my way to an MVD. I recovered quickly and enjoyed nearly five years of relief. By 2007, the beast returned with a vengeance. The latest pain was worse than before and had spread to the entire right side of my head. After another trip to see Dr. Graff-Radford, I had an experimental gamma knife (to the sphenopalatine ganglion) which relieved the head pain. Three months later, I had another MVD. The surgeon found three more compressing vessels. The second MVD left me with a small burning spot on my palate that feels like a “pizza burn.” At best it is annoying. At worst, its unrelenting presence can drive me batty. I control it with a neurosensory stent to which I apply a compounded gel and 40 milligrams of Cymbalta along with .75 milligrams of Clonazepam daily. I still take 300 milligrams of Trileptal a day for prevention. This small amount of medication allows me to function and still gives me latitude to increase if the pain flares up. For me, flare ups occur during April and October and when barometric pressure changes. Fortunately, Dr. Gary Heir, at the University of Medicine and Dentistry of New Jersey, works closely with Dr. Graff-Radford to coordinate my care. Dr. Larry Arbeitman, who has spoken twice at the New York Regional Conference does upper cervical chiropractic adjustments every other week to keep me balanced and focused on being well.

Trigeminal neuralgia has been in my life for half a century. With advanced imaging technology, and increased awareness and options, I am better off than my mother or grandmother. Through the years, I have learned two important lessons. First, trigeminal neuralgia is a chronic condition. Pain episodes and flare ups are not a series of acute events. I need to take medication daily. I have learned my pain triggers and avoid them. I do not drink iced beverages or go outdoors without a scarf to block cool breezes. The second thing I learned is the importance of excellent support. We all need someone to lift our spirits, go to the doctor with us, or kick our behinds when we are pouting too much. My husband is a doer. As an engineer, he likes to fix things and solve problems. He will be the first person to tell you that my best friend, Karen Cybulski, is better at the social and emotional support that I need. Karen earned a Master’s degree in Behavioral Neuroscience so she understands much of the information the physicians share. She will never turn down the opportunity for a mini-vacation to Los Angeles to visit Dr. Graff-Radford. It is Karen who comes to all the regional and national conferences with me.

Anne, Bessie and Karen

“Support Group News” . . .continued on page 26
I have wanted to lead a support group for the past five years. I knew that the group needed to include caregivers as well as patients. I also knew that a co-leader like Karen would enrich the experience for all participants. Dr. Arbeitman generously helped us get the group started and donates his office space and publicity. We call ourselves “The Central New Jersey Support Group for Facial Pain Patients and People who Care.” Eleven people attended the first meeting which was an introductory and agenda setting gathering. It was a stormy night with lots of local flooding and power outages. Not everyone who planned to attend could. The office lost power and the group kept going by the glow of the emergency lights in the office. We are hoping for better weather conditions at our second meeting in December when Dr. Jack Kirschenbaum will demonstrate therapeutic touch. A welcome guest at all our meetings is Bessie, my Bright and Beautiful certified therapy dog who can make anyone feel better with her deep brown eyes and a playful wag of her tail.

Karen and I hope to see you all at the National Conference in 2013 in San Diego. We would like to shake your hand or give you a hug. But before we hug, you can be sure we will ask, “Which side?”

**Affirmation**

*We don’t get a choice about what hand we are dealt in this life. The choice we have is our attitude about the cards we hold and the finesse with which we play our hand.*
Face Pain Patients:

Help us learn the real cost of this disease.

If you are a face pain patient, please go to www.fpa-support.org and click on the Patient Registry link at the top on the page to complete the Patient Registry Questionnaire.

This simple action will take only minutes of your time, but will help us gather definitive data to measure the effectiveness and cost of various treatment modalities.

By providing your answers, you can help us to empower patients and educate policymakers.

It is crucial to gather data so that we can play an important role as an advocate for facial pain issues, and win the battle against neuropathic face pain.

Your information will be stored securely, and you can save a questionnaire in progress. Return as many times as you need to, to finish and update answers.

Complete the TNA Patient Registry Questionnaire today and take an active role in the battle against trigeminal neuralgia and related face pain conditions.

www.fpa-support.org/patient-registry.com

RACE TO SAVE FACE

the next
RACE TO SAVE FACE
is a 5K run & 2 mile walk
sponsored by Pi Kappa Alpha &
The Facial Pain Research Foundation
Saturday, Feb 9th, 2013
SW Recreation Center, Lake Alice
University of Florida, Gainesville, FL

If you are interested in starting a RACE TO SAVE FACE in your community please contact Pam@FacingFacialPain.org
Healthy Recipes for the New Year

Inspired by diet guidelines from "Facing Facial Pain" by Dr. Gerald and Emily Lemole

**Sweet Potato and Cranberry Hash**
3 Sweet potatoes (2 lbs.)
3 T. Butter
1 Fuji Apple, peeled, cored, and cut into ½-inch cubes
½ Cup green onion
1 Cup fresh cranberries, coarsely chopped
¼ tsp. ground cinnamon
Pinch of ground allspice
Serves 6

Place a rack in the middle of the oven and preheat the oven to 350°F.

Set the sweet potato directly on the rack and bake until they still feel slightly firm when pressed, 50 - 55 minutes. Remove from the oven and let cool to room temperature. Place potatoes on plate, cover loosely and refrigerate overnight. The next day peel the sweet potatoes, cut them into 1 inch pieces.

In a nonstick frying pan over medium-high heat, melt 2 tablespoons of the butter. Add the apple cubes and sauté, until the butter browns and the apple cubes start to caramelize. Add remaining 1 tablespoon of butter, when it melts stir in the green onion and cranberries and cook until the green onion wilts. Stir in spices, add sweet potatoes and cook until the sweet potatoes are heated through.

**Salmon with Green Lentil Ragout**
1 Cup French Lentils
2 Cups Reduced-Sodium fat free chicken broth
½ Cup chopped shallot
1 small carrot, peeled and finely chopped
1 boiled potato, peeled and cut into ½” cubes
1 tsp. canola oil
1 salmon filet 1 – 1 ¼ lb., skin removed and cut into 4 pieces
Serves 4

Next to soybeans, lentils have the highest protein count of all vegetables.

Rinse lentils, place them in a saucepan, add 3 cups water. Bring to a boil over medium heat, cover and cook until lentils are tender but not soft, 45 - 50 minutes. Drain and set aside.

In a saucepan over high heat, bring stock to a boil. Continue to boil until it is reduced to 1 cup. Remove from heat.

In a nonstick frying pan over medium-high heat, warm ½ cup of concentrated stock until it bubbles. Mix in shallot, carrot, and potato, cook until the liquid has almost evaporated. Pour in the remaining stock and add the cooked lentils. Simmer over medium heat until the potatoes are tender. Season to taste. Remove from heat. Lentils can be made ahead and reheated.

Preheat oven to 375°F. To prepare salmon: heat canola oil in an oven-proof skillet. Season flesh side of fish, place seasoned side of fish into the hot oil, cook until crisp and well browned, about 8 minutes.

Place skillet in preheated oven for 5 - 8 minutes, fish should be firm to the touch when fully cooked. **NOTE: be sure not to grab the hot handle once the pan is out of the oven!!**

Divide the lentil mixture with some of the liquid in the pan, place salmon pieces (seasoned side up) on top of lentils. Serve at once.

High-fiber foods have the added benefit of being an excellent sources of antioxidants and folate.
Indiana’s leader in Trigeminal Neuralgia treatment

Goodman Campbell Brain and Spine is among the leading neurosurgery practices in the United States, offering the most advanced treatments for trigeminal neuralgia and other disorders of the cranial nerves. Goodman Campbell operates the department of neurological surgery at Indiana University School of Medicine.

We offer the latest treatments and procedures to provide the best options to patients:
- Microvascular decompression surgery
- Gamma Knife radiosurgery
- CyberKnife availability
- Novalis shaped-beam therapy
- Balloon compression
- Glycerol & radiofrequency rhizotomy
- Interventional pain management
- Medical therapy

For more information, call (317) 396-1300 or 1 (888) 225-5464.

Of the 40 physicians that are part of Goodman Campbell, the following six surgeons specialize in treating trigeminal neuralgia:

Nicholas Barbaro, MD
Aaron Cohen-Gadol, MD
Troy Payner, MD
Mitesh Shah, MD
Scott Shapiro, MD
Thomas Witt, MD
World Class Trigeminal Neuralgia Facial Pain Program

The New York Area’s Experts

Neurological Surgery, P.C., is a national leader in the treatment of trigeminal neuralgia and face pain. Trigeminal Neuralgia is a disease in which patients get sharp intermittent pains in their face. There are several different treatment options available for treating this disease including medication and five different surgical procedures: percutaneous rhizotomy (radiofrequency, glycerol, and percutaneous balloon compression), a technique pioneered by Dr. Jeffrey A. Brown, stereotactic radiosurgery (Gamma Knife® and CyberKnife®), and craniotomy (microvascular decompression). Balloon compression, radiofrequency, and glycerol rhizotomy, Gamma Knife and CyberKnife are all outpatient procedures. Any one of these procedures may be the best choice for a particular patient.

Dr. Michael Brisman, Dr. Jeffrey Brown and Dr. Alan Mechanic perform all of the different procedures for trigeminal neuralgia, and are leaders in the field of face pain surgery.

Dr. Brisman is Chief of Neurosurgery at Winthrop-University Hospital and Co-Medical Director of the Long Island Gamma Knife at South Nassau Communities Hospital.

Dr. Brown is Northeast Regional Director and immediate past Co-Chairman of the Medical Advisory Board of TNA-The Facial Pain Association.

Dr. Mechanic is the Chief of Neurosurgery at Huntington Hospital in Huntington, NY and the Chairman of the Nassau Surgical Society Section of Neurosurgery.

For more information about trigeminal neuralgia and face pain or to make an appointment, please call (516) 255-9031.

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