TRIGEMINAL NEURALGIA ASSOCIATION
Australia, Incorporated

ABN 33914 644 101

SUPPORT GROUPS : SYDNEY, NEWCASTLE, MELBOURNE, BRISBANE & CANBERRA.

December 2003 / January 2004

Are we a group of miserable people getting together to be more miserable ?

My challenge is for you to attend our meetings and learn for yourself.
We need clinicians to allay such misconception not create it. Perhaps the recount of members' experience will help mitigate such miserable speculation.

What was your first reaction at the thought of a support group meeting? eg: did you think it would be a waste of your time? Did you think it might be miserable people getting together to be more miserable?

1. I was exited to hear there was a group and that I may find more info about TN. Never crossed my mind that there would be miserable people there (AND THERE ARE NONE)
2. My first opinion was the people I would meet would have the same complaints as I have. They at least would understand how I was feeling and would treat me as they themselves would expect to be treated, not labelled as a winger.
3. Great! A chance to find out how other sufferers manage their tics
4. I hoped a support group would help me manage my TN.
5. Here was the opportunity to discuss my condition with others like me.
6. Hooray someone else who knows what I'm going through.
7. One of hope, was a little nervous.

What were your feelings after your first attendance?

1. Relieved to know that I was not the only sufferer.
2. I enjoyed the first meting and it was as I had expected, people talking and exchanging information and understanding how we all felt.
3. I was amazed at the number of sufferers with TN and other Facial pain.
4. It has been a great comfort to me and has made me feel that I am not a freak with a strange pain and the speakers are just super.
5. I'm not alone. Some people are suffering more than me. I have some experiences to share with others that could help them. There is a lot to learn about TN and info is available from a variety of sources. I am the one who needs to evaluate and select info that is relevant to my TN.
6. After my first meeting I was so happy to find other people with similar problems
7. I realised I needed to be part of the group on a long term basis for my own good and to be able to help others, if possible.
8. Most people at the earlier meetings were glad to know that they were not on their own or just "going mad". After our first meeting I felt that it was well worth reaching out to people and also that the information on treatment that can be given to new sufferer is a lot more than we could get 30 years ago.
9. Relief to find I was not alone.

What are your feelings now about support group meetings ?

1. VERY Informative and VERY interesting.
2. Support meetings are exactly that. Support and ongoing concern for each other
3. I still think it is an excellent idea as the people do understand and support each other, also you are kept up to date with new treatments and medications.
4. My current feelings are that it is a wonderful organization and the variety of Guest Speakers has given me a broader understanding of possible causes and treatments.
5. If I had access to a support group I would not have had teeth removed, not delayed MVD for so long, would have followed all possible means to improve the health of my nerve.
6. I think that one of the most frustrating things before and after *Name* 's RF procedure was the omission by the medical people to provide information on the prominence of TN and that there were other sufferers out there.

Knowing at the time that there were others would have helped *Name*, I am sure in coping with her pain and sensations. It would have been beneficial to have been able to make contact with some of these. As it was we battled on in the belief that *Name* had this affliction on her own. This belief continued for several years until I searched the internet in 1991 /2 and found the TNA in USA and the TN-L site. I believe that all medicos should be made aware of the local support group and make sure that any sufferers they see are provided with details. It is then up to the individual to decide whether to follow up.

There you go doc – from people in the know.
Irene Wood.

TRIGEMIANL NEURALGIA ASSOCIATION AUSTRALIA
SPECIAL GENERAL MEETING
8 NOVEMBER 2003 AT 2 P.M.
WINSTON HILLS PUBLIC SCHOOL, WINSTON HILLS, N.S.W.

PRESENT: Margaret Wilson (Chairperson), 28 members & guests

Minutes of the previous meeting held on the 4th October 2003 was read by the Secretary.

SPECIAL RESOLUTIONS

The Meeting was chaired by Margaret Wilson. The purpose of this meeting was to vote on the following resolutions :-

RESOLUTION 1

That Paragraphs 1, 2 & 3 of Section 14 of the Rules of the Association be deleted and replaced as follows :-

Paragraph 1 - The Committee is to consist of :

a) The President,
b) Office Bearers of the Association, and
c) 3 Ordinary Members

each of whom (except the President) is to be elected at the Annual General Meeting of the Association under Rule 15.

Paragraph 2 – The Office-bearers are to be :

a) The President
The member appointed to the office as President is subject to these rules. - To continue in office permanently until retiring, either of their own accord in which case it must be made in writing to the secretary, or until a new appointment is made by the members passing a "Special Resolution",
b) The Vice-president,

c) The Treasurer, and
d) The Secretary

Paragraph 3 – Each member of the Committee (excluding the President) is subject to these rules – to hold office until the conclusion of the Annual General Meeting following the date of the member's election, but is eligible for re-election.

RESOLUTION 2

That Irene Wood be appointed as the President.

Notices and proxy forms were sent to 232 members. At least 174 votes (75%) are required to vote 'Yes' in order to pass the resolutions.

Results of the voting were as follows :-

Resolution 1

Proxies directed to the Chairperson to vote for 'Yes' -	171 votes
Proxies directed to Irene Wood to vote 'Yes'	5 votes
Total	176 votes

Resolution carried.

Resolution 2

Proxies directed to the Chairperson to vote for 'Yes'	176 votes
Proxies directed to Irene Wood to vote 'Yes'	5 votes
Total	181 votes

Resolution carried.

Congratulations were sent to Irene Wood.

Kim Koh
Secretary.

Treasurer's Report

The following provides details of income and expenditure for 11 months to 30-11-03

Balance forward 1-1-03		$2205.89
Membership Fees	$3830.00	
Donations	$1606.45	
Other income	$ 14.16	$5450.61
		$7656.50
Expenditure		
Copying/Postage (Newsletters/info packs)	$ 4913.00	
Stationery	$ 253.92	
Videos-Conference	$ 349.40	
Registration Fees	$ 159.00	
Adaptor Plugs	$ 25.90	
Equipment Hire	$ 320.00	
Telephone calls	$ 12.20	$6033.42
Balance carried forward		$1623.08

Frank Martin.
Treasurer.

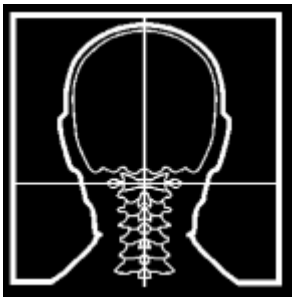
Sydney Support Group
Winston Hills
8 November 2003

Present 32 : I. Wood, J & H Birett, M Wilson, M Hammond, N & J Webb, D. Pratt, V. Rasmussen, R & V Riley, K. & T Koh, N & F Martin, A. Thomas, A & L Porter, J. Weaver, H & K Walmsley, K. Smith, K. Stentiford, T & B Coull, T & J Dewhurst, Joe Ierano.,

Apologies: P.Holmes, S & G Briggs, M. Ahel, E & L Toms,

- ♠ Welcome Terry and Judith, Thelma and Bill. And Joe Ierano
- ♠ Terry's face pain started about 3 years ago. Pain is in his top and bottom gum, chin and the left side of face. Described pain as a nagging ache with sharp shooting. He is taking 1500mg of Tegretol but not sure if they are actually helping. He has trouble eating. What amused / horrified us was the way he could pinch and pull at his cheek.! *Every time he did that I flinched.*
- ♠ Thelma and Bill had travelled all the way from Belmont. Thelma came to share her good news with us. Her MVD is successful. No pain No medication.
- ♠ Kathy brought our attention to TENS machine. She said prior to her MVD she used a TENS machine to help her ease her pain.
- ♠ Vera is looking well and fully recovered from her surgery.
- ♠ Unfortunately SRS doesn't seem to be working for Hilary.
- ♠ Kim S is having acupuncture and she feels it is helping.

Welcome Joe Ierano
Atlas Orthogonal Chiropractic.



The Atlas is a keystone of body function.

Atlas Orthogonal (AO) is a chiropractic technique that specialises in the diagnosis and correction of improper neck function.

The symptoms however, maybe elsewhere in the body but usually can show up as :

A HEAD TILT
UNEVEN SHOULDERS
A SHORT LEG WHEN LYING DOWN
UNEVEN HIPS
TIGHT MUSCLES.

THE MAJOR CHIROPRACTIC PREMISE

1. the nervous system controls and co-ordinates all bodily functions
2. interference to nerve function (including brain and peripheral nervous system incorporating peripheral sense organs such as the eyes, ears and concerning smell) can result in poor health
3. the skeletal system, primarily the spine can interfere with the nervous system via joint subluxation, misalignment or misalignment

THE ATLAS ORTHOGONAL PREMISE

1. the first and second vertebrae in the neck should line up with the skull (occiput) at right angles or orthogonally.
2. if they are not orthogonal, subsequent imbalance of body structure will eventuate due to compensatory changes.
3. compensatory changes are affected by nervous system interference, irritation or dysfunction.

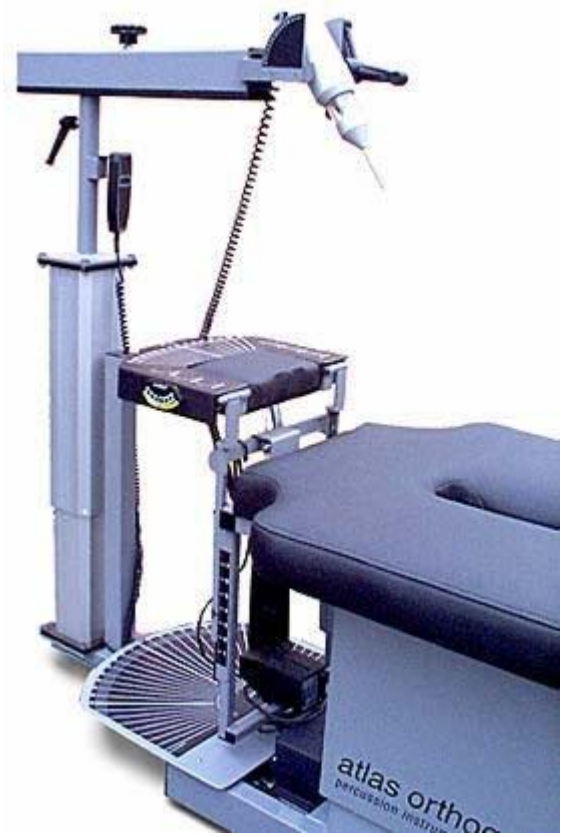
4. this may lead to poor organ function, muscle spasm causing shoulder or pelvic girdle distortion, over time, if not corrected .

Roy W. Sweat, D.C., B.C.A.O., is a 1950 graduate of Palmer College of Chiropractic and has been in practice ever since and currently manages a clinic in Atlanta,Georgia, USA. An associate professor at Life College, he is a noted author of many books on atlas orthogonality and was a presenter of specialized seminars on programs developed by John F. Grostic, beginning in 1960, and on his own atlas orthogonality program, created in 1981. He has designed an atlas orthogonal computerized X-ray analysis program, a chiropractic adjusting instrument and X-ray equipment.

Uniqueness of instrument adjusting

Dr Sweat adjusted by hand for over 20 years, he then switched to instrument for the correction of atlas problems.

After several prototypes, the instrument today is made from a specific metallic density and activated by a solenoid. That is a magnetically activated impact on one end of the stylus that transfers to the end in contact with the skin surface. The force generated on the skin is as little as 3 pounds.
The movement of the atlas bone has been verified on cineradiographic studies.



Terminology:

orthogonal = at right angles, or at 90 degrees
atlas = first vertebra in the spine
axis = second neck vertebra
occiput = base of the skull
subluxation = "sub" (less) "luxation" (energy) literally means a "lack of energy". When the spine is affected by a misalignment then the energy that travels through the nerve is lessened. This causes or contributes to disease.

Atlas (the first vertebra in the neck) Orthogonal (at 90 degrees) recognises the holistic influence that the upper cervical (upper neck) area has on body function.

Chiropractic is not a cure all- BUT, because no part or organ in the body escapes the influence of the nervous system, it can affect many conditions by restoring proper function.

This influence is perhaps greatest at the occipito-atlanto-axial joint complex. That is, the occiput, or base of the skull, on the atlas, which contacts the axis, or second neck vertebra. If the atlas is subluxated (misaligned, not moving correctly, or adversely affecting nerves), then a myriad of health problems may arise.

How is the atlas determined "subluxated"?

- a thorough history and examination is conducted
- this includes scanning palpation, and a leg length check, described below
- a specific set of AO x rays are taken
- the information is presented, along with choices, risks, etc, to the patient who may elect to have it corrected

Is leg length inequality relevant to health?

Recent studies demonstrate that this phenomenon of leg length inequality (LLI) may be involved in spinal pain syndromes.
The patient lies on their back, and doctor contact with the legs and feet is kept to a minimum, the difference in leg length measured. This is measured again when the patient rests after each adjustment, and the chiropractor assess what the change means.

Joe also presented the result of the trial study which involved 4 members from the Sydney support group. This study was over a period of 12 weeks and various rates of adjustments. Two of these have enjoyed some benefits and are still undergoing occasional adjustments. The third has stopped treatment as she doesn't has TN but needed her head adjusted, (some people do anything for free) and the fourth's pain condition did not improve. For more detailed results see the Sydney Support group library / ask M. Wilson.

Thank you Joe for giving up your Saturday afternoon and sharing your valuable time with us. We enjoyed your very informative interesting presentation.

Parkinson's Disease, Meniere's Syndrome, Trigeminal Neuralgia and Bell's Palsy: One Cause, One Correction

by Michael T. Burcon, DC
Reprinted with the kind permission of the author. This article was originally published in *Dynamic Chiropractic*, May 19, 2003.

Abstract
I currently have 16 Meniere's syndrome, two Parkinson's disease, two Trigeminal neuralgia and two Bell's palsy patients under my care. They all have one thing in common: The atlas vertebra is subluxated posteriorly, which has caused the head to project forward, taking away the healthy curve of the neck.
In each patient, the pelvis has twisted to take pressure off the important nerves in the upper neck and brainstem, causing one leg to appear shorter than the other; normal lumbar curvature is compromised; and finally, if not specifically adjusted, the patient compensates by developing an exaggerated curve in the thoracic spine.
I hypothesize that in each patient, kink(s) in the neck inhibited the normal flow of cerebrospinal fluid out of the skull and down the spine; this created excess pressure in the fourth ventricle, causing abnormal function of some of the structures in the midbrain. It also inhibited the flow of blood into the occipital area of the brain by kinking one of the vertebral arteries. Additionally, I suggest that the posterior atlas irritated the anterolateral aspect of the brainstem, irritating any combination of the bottom seven cranial nerves.
All 22 patients improved dramatically after one or two adjustments under cervical-specific chiropractic care. When the atlas returns to juxtaposition, the spinal cord relaxes and actually positions itself lower within the spinal column.

Introduction
Parkinson's disease (PD, *Paralysis Agitans*, or "Shaking Palsy") is an idiopathic, slowly progressive, degenerative central nervous system (CNS) disorder with four characteristic features: slowness and poverty of movement; muscular rigidity; resting tremor; and postural instability. Parkinson's disease is the fourth-most-common neurodegenerative disease afflicting the elderly: It affects about 1 percent of the population over 65 years old, compared with 0.4 percent of the population under 40 years old. The mean age of onset is about 57 years of age. Onset in childhood or adolescence (juvenile Parkinsonism) also occurs.[1]

The etiology and pathophysiology of primary Parkinsonism is loss of the pigmented neurons of the *substantia nigra, locus ceruleus* and other brainstem dopaminergic cell groups. The loss of substantia nigra neurons, which project to the *caudate nucleus* and *putamen*, results in depletion of the neurotransmitter dopamine in these areas.[1]

For 50 percent to 80 percent of patients with PD, the disease begins insidiously with a resting 4- to 8-Hz "pill-rolling" tremor of one hand. The tremor is maximal at rest; diminishes during movement; is absent during sleep; and is enhanced by emotional tension or fatigue. The hands, arms and legs usually are most affected, in that order. The jaw, tongue, forehead and eyelids also may be involved, although the voice is not affected. Many patients display only rigidity and never manifest tremor. Progressive rigidity, slowness and poverty of movement (*bradykinesia*) and difficulty in initiating movement (akinesia) follow.[1]

The face becomes mask-like and open-mouthed, with diminished blinking. Posture becomes stooped. Patients find it difficult to start walking; the gait becomes a shuffle with short steps and the arms are held flexed to the waist and fail to wing with stride. The steps may inadvertently quicken, and the patient may break into a run to keep from falling ("festination"). On examination, passive movement of the limbs is met with plastic, unvarying lead-pipe rigidity; superimposed tremor bursts may give ratchet-like cogwheel quality.[1]

The sensory examination usually is normal. Signs of autonomic nervous system function may be seen. Muscle strength usually is normal. Dementia occurs in about 50 percent of patients; depression also is common.[1]

The standard medical treatment for PD has been the administration of the drug Sinemet, which combines Levodopa (a short-acting drug that enters the brain and is converted into dopamine) and Carbidopa (which enhances Levodopa's action in the brain). Several neurosurgical techniques also exist, including thalamotomy (destruction of the ventral thalamus to control tremor); pallidotomy (destruction of the posterior ventral *globus pallidus* to control hyperkinetic symptoms); and deep-brain stimulation (electrode implantation for patient-controlled stimulation of the thalamus to control tremor). While medication and surgery may control symptoms temporarily, neither stops or reverses the progressive degeneration of the substantia nigra.[2]

B.J. Palmer reported the use of upper-cervical chiropractic care with PD patients as early as 1934. In his writings, he referred to patients with shaking palsy and listed improvement or correction of symptoms such as tremor; shaking; muscle cramps and/or contracture; joint stiffness; fatigue; lack of coordination; difficulty walking, or inability to walk; numbness; pain; and muscle weakness. His chiropractic care included paraspinal thermal scanning using a neurocalometer (NCM); a cervical radiographic series to analyze the upper-cervical spine; and a specific upper-cervical adjustment performed by hand. Erin L. Elster, DC, found no other references for the chiropractic management of PD patients, prior to her study on 10 PD patients in the year 2000, utilizing modern upper-cervical chiropractic care.[2]

Three-month re-evaluations revealed substantial improvement in subjective and objective findings in six of the 10 patients, and mild improvement in two patients. The findings of the other two patients, both over age 65, remained unchanged. According to the Unified Parkinson's Disease Rating Scale (UPDRS), six of 10 patients showed overall improvement ranging from 21 percent to 43 percent after three months of upper-cervical chiropractic care.[2]

Meniere's syndrome is characterized by vertigo or dizziness, and some combination of four associated symptoms: nausea, inner-ear pressure, low-frequency hearing loss and tinnitus. The cause of Meniere's syndrome is unknown and the pathology is poorly understood.[1] The attacks of vertigo appear suddenly, last from a few to 24 hours, then subside gradually. The attacks are associated with nausea and vomiting. The patient may feel a recurrent feeling of fullness in the affected ear, and the hearing in that ear tends to fluctuate, but worsens over the years. Tinnitus may be constant or intermittent.

Trigeminal neuralgia (*Tic Douloureux*) is a disorder of the trigeminal nerve producing bouts of severe, lancinating pain lasting seconds to minutes in the distribution of one or more of its sensory divisions, most often the mandibular and/or maxillary. The cause is uncertain. Recently, surgery at autopsy suggests that this condition is essentially a compressive neuropathy of the brainstem.[1]
Bell's palsy is a unilateral facial paralysis of sudden onset and unknown cause. Pain behind the ear may precede the facial weakness that develops within hours, sometimes to complete paralysis. The mechanism is presumed to involve swelling and compression of the facial nerve. (1)
In addition to the upper-cervical chiropractic care based on the research of B.J. Palmer, with the assistance of Lyle Sherman, DC (later refined by William G. Blair, DC), I have added the lower-cervical research and adjustment utilized by Walter Vern Pierce, DC, into a technique that I refer to as "cervical-specific chiropractic."[3]
In my previous research with cases involving brainstem irritation (Meniere's disease, Trigeminal neuralgia and Bell's palsy), I discovered that the main cause was cervical trauma. The trauma forced the top cervical vertebra (atlas) to subluxate posteriorly, with laterality on the opposite side of the patient's symptoms (i.e., if the patient had fullness and gradual loss of hearing in the right ear, the atlas listing would be posterior and inferior on the left [PIL]). These same findings are substantiated by my Parkinson's research.[4]

Methods

My technique is based on the work of B.J. Palmer, as developed at his research clinic at Palmer Chiropractic College in Davenport, Iowa, from the early 1930s until his death in 1961.[5-7] I have also studied the vertebral subluxation pattern work of B.J.'s clinic director, Lyle Sherman, DC, for whom Sherman College of Straight Chiropractic, is named.[8]
A detailed case history is taken on the first visit, followed by a spinal examination. First, the patient's cervical spine is graphed, using an advancement of the dual-probed NCM first used by B.J.[9] Next, cervical motion palpation is performed, noting any aberrant motion of the vertebrae.
Detailed leg checks are performed on each patient visit, utilizing the work of J. Clay Thompson, DC, and Clarence Prill, DC.[10] With the patient prone, an apparent short leg often is noted. The patient is instructed to turn his or her head to the right. If the short leg becomes more balanced, a right cervical syndrome is listed. The patient is then instructed to turn the head to the left. If the short leg becomes more balanced, a left cervical syndrome is listed. If both movements lengthen the short leg, a bilateral cervical syndrome is listed.
Modified Prill leg checks are used to determine the major cervical subluxation. The top four cervical vertebrae are tested as instructed by the Blair Chiropractic Society. They are referred to as "modified" because Dr. Prill uses the arms to detect imbalances, whereas Blair chiropractors use the legs. Patrick J. Sweeney, DC, and I refined the tests for the bottom three cervical vertebrae.
Atlas (C1) is tested by instructing the patient to "gently and steadily raise both feet." The doctor resists by holding the heels of the feet with his open hands. If the short leg stays short or becomes shorter, it is listed as a positive test for nerve interference at the level of C1. It is postulated that the flexion and extension of the leg correlates to the flexion and extension of the head, 50 percent of which occurs at the atlas.
Axis (C2) is tested by instructing the patient to "gently and steadily pull the feet together," while the doctor resists foot rotation. The rotation of the feet correlates to the rotation of the head, 50 percent of which occurs at axis. The third cervical vertebra is tested by having the patient pull his or her legs together; C4 is tested by having the patient pull the legs apart.
The fifth cervical is tested by having the patient raise both arms while the doctor holds the biceps. The patient raises his or her arms while the doctor holds brachioradialis muscles to test C6, and pushes the arms down while the doctor holds the triceps to test C7.
Three cervical X-rays are then taken to get listings for the segments that test positive and to check for contraindications to adjusting: lateral, A-P open-mouth and nasium. The lateral is used to check for a posterior kink in the lower cervicals; the A-P is used to check for translation, usually the result of a

"T-bone" automobile accident; and the nasium is used to determine the atlas listing, utilizing the Blair theory of upper-cervical subluxation. There are only four atlas listings in Blair work. Dr. Blair's research demonstrated that there is no pure lateral movement at C1. The atlas will tend to articulate properly on one condyle while partially slipping off from the other.[11]

If the atlas subluxates anteriorly, it must move superiorly, due to the "rocker" shape of the articulation. If it tracks on the left, the atlas will show an overlap on the right articulation on the nasium. This is listed as an "ASR" (anterior and superior on the left). If it tracks on the right, it will overlap on the left ("ASL"). Anterior listings are more common and tend to be less symptomatic than posterior listings. Typically, a posterior atlas subluxation is the result of head, neck or upper-back trauma. If the atlas subluxates posteriorly, it must also move inferiorly. If it tracks on the right, it will underlap on the left. This listing is "PIR" (posterior and inferior on the right). If it tracks on the left, it underlaps on the right, and is listed as "PIL."

I postulate that one reason a patient can have a problem on the opposite side of his or her posterior listing is that this is the side at which the atlas is not articulating properly with the occiput. Over time, this can cause irritation in that area, leading to inflammation and eventually scarring. I feel the vertebral artery often is kinked on that side, adding to the problem. One thing I'll never forget from cadaver dissection is how every structure seemed to be fighting for its space within the human body. This was especially true at the surprisingly small junctions between the skull and the upper cervicals, and the junction between the base of the neck and the thorax.

No adjustment is given on the first visit. A pattern of subluxation must be established on the second visit; patients are checked on subsequent visits. If the pattern has not returned, no adjustment is given. The atlas is always the first segment adjusted. The technique used varies, depending on radiographic analysis. If the major misalignment is translation, a side-posture toggle-recoil technique is used ("hole in one"). If the major component of the subluxation is posteriority, a prone position is used. A drop mechanism is used on all adjustments.

If, after the atlas holds, positive tests persist in other cervical segments, those vertebrae are adjusted. Again, both side-posture and prone positions are used on the lower cervicals. Patients rest for 15 minutes after every adjustment, then are checked. Patients are released only after their legs present balanced.

The UPDRS is used on every visit to graph any improvement in symptoms. Thirty-one separate areas are graded, covering mentation, behavior and mood, activities of daily living and motor examination. Each area is graded 0 for no problem; 1 for a mild problem; 2 for a moderate problem; 3 for a severe problem; or 4 for a persistent problem.

Case Reports

Case #2

History: A 21-year-old female college student employed as a receptionist in a medical office. She had been taking Tegretol and Neurotin for the previous year after being diagnosed with **Trigeminal neuralgia**. She was doing poorly in school, which she attributed to the effects of medication use. She was diagnosed with scoliosis at age 9. Her mother reported that her delivery was difficult. She denied being in any auto accidents, but she did play contact sports in high school.

Examination: Leg checks showed a three-quarter-inch right pelvic negative (RPN), one-inch bilateral cervical syndrome, and positive C1 and C5 Prill tests. She had limited range of motion on bilateral cervical rotation and left-lateral cervical flexion.

Her left ear was noticeably higher than her right. X-ray showed a PIL atlas, body left axis and posterior C5.

Intervention and Outcome: Subjective findings included lightheadedness from medications; stabbing, burning and throbbing right maxillary pain; and low-back pain. I adjusted her atlas PIL using the side-posture toggle-recoil technique. She reported dizziness on her next visit. I adjusted C5 after it tested positive for nerve interference. On her third visit, I adjusted her sacrum; on her fourth visit, she presented balanced and pain-free and was not adjusted.

She discontinued her medications and held her atlas adjustment for eight months. She lost her adjustment when she received a neck massage. Her second atlas adjustment has held for 16 months.

Case #3

History: A 46-year-old married Caucasian female diagnosed with **Trigeminal neuralgia** (left mandibular); Sjogren's syndrome; irritable bowel syndrome; erythema multiforme; allergies; and Raynaud's phenomon. She reported whiplash stemming from a rear-end automobile collision in 1998.

Examination: A half-inch right pelvic positive (RPP) and positive Prill tests for C1 and C5 were noted, as was limited range of motion for left lateral cervical flexion. X-rays showed evidence of atlas PIR and C5 posterior subluxations. She was hoarse, which was later diagnosed as a staff infection of her lungs.

Intervention and Outcome: The atlas and C5 were adjusted on the first visit. The fifth cervical and fifth lumbar were adjusted on the second visit. The axis and sacrum were adjusted on the third visit, and C5 and the sacrum on the fourth. She presented balanced and pain-free on the fifth visit, after two months of specific care. She is still holding her balance after two months.

BRISBANE SUPPORT GROUP

30 Ridley Rd., Bridgeman Downs.

DATE. 8/11/03

ATTENDANCE 23. Anna McRobert, M & C. Brown, B.McKendry, T Ashdown, M. O'Reilly, H & E Columbine, S Peace, J McGuigan, S Thompson, F Lambert, J Franks, Y Pirsic, J & M Worthington, K & H Washington, T & S Miller, J & H Browne, and L.Curtain.

Apologies: A. Cheras, F Kent, V Taafe. Please forgive me if I've omitted to put you down.
Hope no one thinks we are a miserable group of people getting together to put people down! .☺

AGENDA. Anna McRobert, kinesiologist, attended as a guest speaker. There was quite a lot to take onboard but I'm sure everyone had at least a couple of things they could take away and find helpful. Her notes to accompany the presentation follow to refresh our memories and enlighten those who couldn't make it.

'Kinesiology uses muscle testing to identify where the body needs support and what kind of support will work in each individual situation.

The word kinesiology comes from the Greek kineo, to move and -ology, the study of or the science of, so literally means the study of movement of the body. Kinesiology is also a modality, a method of procedure in natural therapies that uses muscle testing as biofeedback, trusting the body's own muscle response to indicate what correction will reduce stress and bring positive changes in the body.

We are all very familiar with the language of muscles. When receiving bad news we often "go weak in the knees" and have to sit down. Receiving good news we may "jump for joy". Positive feelings keep our muscles strong and even add more energy to them while negative feelings drop our energy and reduce the ability of muscles to do their job.

Kinesiology was created in the 1960s by George Goodheart, a chiropractor, combining the Western approach of physically testing muscles and the Eastern understanding of the energy meridians, which flow in the body to all organs and functions in a continuous cycle. The Chinese relate to pain as a build up of energy that is blocked and cannot flow on and that by releasing the block or drawing the excess energy into depleted areas, using acupuncture or acupressure, pain can be reduced.

Touch For Health is a system of Kinesiology developed by John Thie, also a chiropractor, for lay people to learn in a workshop format how to use muscle response to help themselves and their families maintain health and well being. It is also a foundation program for professional kinesiology training.

A Touch For Health balance consists of testing fourteen muscles and correcting as needed. This moves and re balances the energy similar to acupuncture but without using needles. Many of the correction techniques can be used on yourself to reduce pain even when there is no one to test the muscles before and after applying the corrections as would happen in a class or consultation.
One muscle can he tested to indicator a general reaction to different forms of stress, or a series of muscles can be tested to give feedback from different areas of the body and from different organs.

Pain is not just physical. Mental and emotional pain is also part and parcel of the human experience and is just as clear a signal that healing is required. Every physical pain will initiate a mental conversation about the pain, "Oh no, what's this", "where did the pain come from", "what does it mean", "how long will it last", "how serious is this". Depending on this self talk, the meaning put on the experience, and the degree of alarm, an emotional reaction will be triggered along with the change in the body chemistry. This instantaneous cross linking of physical to mental to emotional docs not have to start with physical pain. Being emotionally upset changes the biochemistry, influences the self talk, effects muscle tone and tension and can lead to physical pain just as readily.

Any form of stress can make us even more sensitive and more likely to trigger or increase unresolved distress and pain. Foods that put a stress on the digestive system can be part of increasing sensitivity to pain as the body directs extra energy to the digestive process taking energy away from balancing or healing tasks. Not enough sleep or time for self, a noisy or chaotic environment, an over crowded schedule, dreading a coming confrontation, even windy weather or glare can all contribute to lessen tolerance, reduce our buffer zone, put us on edge, tense up muscles and trigger off the most sensitive aspect of our body.

Reducing stress expands our ability to handle pain by reducing the incidence or intensity of the pain or eliminating it altogether. Certain foods or supplements or herbs can have a calming effect on the nervous system and relax muscle tension, as can certain music and even particular colours. Muscle testing can identify these supports relative to a specific pain as readily as finding appropriate Kinesiology corrections such as points to hold or stimulate, meridians to activate or sedate.
Some of the benefits of Kinesiology balancing commonly experienced are an energy lift, feel better, body/brain communication heightened showing as improved muscle performance and better physical co-ordination, pain reduced, less eye strain, emotional stress released, increased mental focus, enhanced injury and health recovery, support to change unprofitable habits, establish new patterns of behavior, testing for food intolerance and better nutrition, enhanced general well being

We are whole multi dimensional human beings and respond well to a holistic approach to any imbalance. No matter what part of the body is in distress the whole body must compensate for the disturbance. Learning to communicate with our own body through muscle testing puts us back in the drivers seat for finding what we individually need to create the internal and external environment that reduces stress and tension and supports the natural healing process."
We started the meeting with everyone introducing themselves and their TN experiences of late. It was wonderful to hear some people are feeling well or their pain is at manageable levels. We all really felt for those who have not had such a good time lately. If anyone can understand, I guess many of us can. I hope you found some help and support from coming along. A big effort when the pain is bad.

- Audrey's TN and MS have not been too good. Her Neurontin had to be increased and Endep introduced in the hope of settling it down. What seems to have helped in the end is Zostrix cream. It is very heartening to hear Zostrix can help those with TN and MS. Keep us posted Audrey.
- Howard goes to Sydney on the 21/11 to have an MVD. We'll all be thinking of him and willing a successful and speedy recovery.
- It's great to hear Fred is doing so well with Zostrix. He is off all meds at the moment. Maybe those beautiful strawberries he grows help too.

- Shirley has had a bad patch but it seems to settling down after hr Dr. adjusted the medication dose up again.
- Poor Beryl is having a bad time. She had been going well for quite a long time and now it has hit again. I hope the information shared at the meeting can help get the pain back to manageable level.
- Sue found out that she is actually suffering from Cluster Headaches. Never the less that means terrible pain in the head Sue and you are welcome to remain involved. We are a support group for head and facial pain. Your offers to help are extremely welcome.
- A new member Doug couldn't come to this meeting as he was in hospital after having a glycol injection. It's wonderful to hear that he has pain relief now. I hope he will be able to come to the January meeting and tell us all about his experiences.

Due to special events being held at the church we had a geographically intriguing meeting. We initially gathered in the back of the church, climbed the stairs to the choir loft for the presentation and finished up at the hall for afternoon tea. Well we can't complain about getting bored with the venue! Thank you all for helping with afternoon tea and cleaning up.

FINANCES : A gold coin donation was taken and $49.00 was collected. Many thanks to you all. After petty cash payments and a $50.00 donation for venue use during the year we are left with a balance of $197.

NEXT MEETING: **Please note.** Our next meeting will be on the **Third Saturday of January 17/01/03 at 1.30pm**. The extra week helps accommodate the holiday season. The venue is 30 Ridley Rd., Bridgeman Downs. ***Your SECOND Anniversary.***

Lesley Curtain

Dear Howard

REV. ROD. CASTEN : Ps.121 verses 1 and 2

'I will lift my eyes to the hills ..... My help comes from the Lord.'

In the ups and downs of life (pain and problems), God's hand is there to lift us up and keep us up if we will only let Him.

God bless.

NEWCASTLE SUPPORT GROUP

Mater Hospital, Saturday 22nd November.

In Attendance : Monica, John and Helen, David, Barbara, Helen, Laura, Jenny and son James, Phil.
Meeting started 1:20pm, completed 2:45pm .
This was our first meeting at the Mater Hospital, many thanks to Mr Pillay for organising the room.
The meeting was very informal, had hoped to show a video, but no television was available; next time.
$11.70 was collected at the meeting, which will go towards postage etc

- Monica is controlling her pain with a varying dose of 100 - 200mg tegretol, 3 times daily.
- John is currently on a drug therapy to try to break the cycle of migraines, which will hopefully break the neuralgia as well.
- David is currently pain free and drug free.
- Barbara always has pain in her right side face. She has a renewed vigour to try and find some more answers. Tegretol does not work for her.
- Helen had MVD 15 years ago and doing well.
- Laura had MVD 1 year ago and also doing well.
- 4 year old James has been started on Tegretol from July and is a new child.
- Phil is up to 1200mg Tegretol, still break through pain, but MVD scheduled end of November.

A couple of interesting points arose in our discussions.
Two people could trace back through their family tree and remember a mother and/or grandmother with face pain or nerve related condition. (neuralgia and epilepsy).
One person found by altering diet, exercising, losing weight and concentrating on lowering blood pressure, the pain went away. There was an admission that it could be coincidence, but the healthier habits may have been a contributing factor. It is certainly worth pondering.
One person believes stress is definite factor in her attacks.
We also discussed the idea of **taking control** of the condition. Most of us have found that doctors do not have the answers we are looking for, through no fault of theirs; not a lot of people know about this condition. It is therefore up to us to insist upon the next step. The GP's have the keys to open many doors and through developing a good relationship with them, they are ready to help you get to the next step. If you are not getting anywhere, insist upon seeing a neurologist, neurosurgeon etc. Don't stop at just one, get another opinion. Gather as much information as possible.

We discovered that the pharmacology unit at the hospital is heavily involved with the Government Pharmacy advisory, therefore we hope to have a speaker at the next meeting to answer any questions about drugs you may have.

NEXT MEETING : SATURDAY 14 FEBRUARY 2004

MATER HOSPITAL, off MAUD St NEWCASTLE 1:00PM
ROOM TO BE ADVISED - MEET AT DAFFODILS CAFE FIRST

Best of luck to everyone.
Best wishes for Xmas and the New Year.

Phil Leaver

CANBERRA SUPPORT GROUP

WESTON CREEK COMMUNITY CENTRE
1 – 3 PM

It was a shame that it was so small but at least it is a start. Thanks for making the effort to come all this way for such a short time.
Present: I. Wood, D..Humphery, C. Aronsen, P. Brown.
Apologies: M. Whiddett, P. Roache, P. Holmes.

- Peter B. - had TN for 12 months and was in such pain that his doctor prescribed morphine. After initially being told that there was nothing that could be done about his condition, P had an MVD in July and is now completely pain free. Very happy with result and the only side-effects have been in relation to withdrawal from the morphine.
- Diane H. - Also had an MVD in July. Is pain free since the operation and off all medication. Diane had TN for 3 years and tried everything from acupuncture to cranial osteopathy, as well as being on Neurontin, Epilem and Endep. Nothing was holding the pain so she opted for surgery. Has numbness on the right side but this is slowly disappearing. Very tired since the operation; had a herpes outbreak near the eye the day after surgery so this might explain slower recovery.
- Constance A. - Constance has had TN since the '70's and had the nerve cut back then. She now has permanent numbness on the left side of face and yet still has quite a lot of pain. Pain can be triggered by brushing her hair or cleaning teeth. Is on a number of medications as well as Zostrix. She has had 2 MVD and a couple of RF but that was done quite a long time ago. Has had periods of being pain free after each intervention but pain has always returned.

Diane Humphery.

Diane will be moving north soon and we wish her all the best. It was great to see all of you again.

Next meeting : 27 March 2004. 1 – 3 pm

Correspondence Corner.

Alison M. : I only get my TN after 7pm.Does anyone else say that theirs is the same time every day(and its not dinner) It's in my jaw/teeth/under left eye. Always in same place. Am having acupuncture weekly. Appreciate an email buddy. Promise I won't swamp them or sell Avon! - as I can't make the meetings. *Worth a second opinion? One of the feature of Cluster headaches - Attacks tend to recur at the same time each day and are notable in that they often occur at night, awakening the patient from a sound sleep. A seasonal preponderance occurs, with cluster phase often occurring in the spring or autumn months.*

Anne P. - has zostrix sent over from New Zealand so I am using that as often as I can - have been pain free for 3 days but it is threatening again.

Trevor G. - " I have started using geranium oil about 2 weeks ago, I am not in a position to give a positive answer yet, but I have had some relief sometimes and other times like today no relief. Maybe it was just luck I had relief sometimes ??? *Geranium oil - improves circulation, and **emotions/mind:** stimulates the adrenal cortex, helps to combat stress and depression. "both sedative and uplifting" **caution**: it can lower blood sugar level, so it is best avoided by hypoglycemia sufferers.*

Audrey C. - has MS /TN. Uses Zostrix to relieve her pain.

Diane B – "still recovering from surgery and am looking forward to being pain free and drug free."

Robyn T- thought I'd let you know that I don't have TN (thank goodness, and my deepest sympathies go out to all of those who do). My dentist finally found a tooth with an exposed nerve which was being aggravated by the wisdom tooth beside it (bottom left). He did a temporary job on it (till I could have both teeth extracted) and all was great for a week or two when the pain returned. You wouldn't believe it but there was a tooth on the top left that also had a dying nerve - so he patched that one up too. I was finally able to get the three buggers out two weeks ago and have had no pain since. I haven't taken tegretol for a few months now and I'm pretty confident that all my problems are over.
Even though 3 doctors diagnosed TN, I am very thankful that it wasn't the case. *Great News! That's why we sing: "Not all face pain is Tic Douloureux, Check all the Symptoms if I were you, Doc's diagnosis might not be true, Be very careful my Darling!." Tune: Skip to the Lou My Darling.*

MATT. N - Matthew has had a pretty bad time over the last couple of months. He is now on a fair mix of medications: Tegretol 600mg:Neurontin 1800mg: Indocid 50mg: Endep 62.5mg. He has Endone as required. He is about to begin Topomax and withdraw Indocid. Then, if all goes well, we can begin to withdraw Neurontin. I guess only time will tell! *Matt is 14 and his pain is also affecting his schooling.*
Nancy.B. - Unfortunately in the last four weeks I have been feeling the ominous shooting pain when I brush my teeth on one side and each day it "twangs" a bit more. I am keeping my fingers crossed that it will go away as I DO NOT want to take the tegretol - can't function normally when I take it and it makes me feel sick (just like morning sickness when I was pregnant) last time I took it I lost 11/2 stone! Hopefully it will go away.
Some members have found that having food in the stomach prevents that "sick" feeling. Some have found that milk thistle have helped offset the sick feeling. Hoping won't do any good. Otherwise, go back for your chiro treatment. This must mean your alignment needs adjusting.

Valeire D. - July last year a New Zealand doctor recommended the homeopathic remedy ACONITUM for an awful bout of trigem. It worked like magic; in fact I haven't had pain since, but the past two weeks have been so stressful, and the shocking pain returned yesterday (I began to believe I was cured!) Well, I remembered I had half a bottle wrapped in black plastic, in the fridge - by today the pain has gone (though I can still feel where it was) and am taking it easy. I took 15 drops in water every hour four times and again this morning. No side effects and no pain. - *Excellent.*

Davina H. is back in Adelaide**.** Wrote to say that she is fine and no pain at all. "Please thank everyone for praying for me and the surgeon." *Thanks for the card. We are very happy for you.*

Guy W – have no success with the vitamin B12 injections and magnesium tablets. I am battling on at the moment with the Tegretol. The pain mainly occurs when I touch or wipe my nose or when I first start to eat. *Sorry to hear that.*

Norma M is back in hospital. Over the weekend became worse and by Monday infection became obvious. Went onto antibiotics on Monday but overnight wound started to weep and Dr put her into Blacktown hospital yesterday. *Our best wishes, thoughts and prayers for a speedy recovery*

Dear Friends, It is time again to renew your membership. We are a self-funded non profit organisation (in other words we DO NOT get a single cent from the government.) Your membership fees and any donation will ensure that our work goes on. We have decided to keep membership fee to $20 per annum. I trust you have enjoyed the newsletters and have found them to be of help and interest. The purpose of the newsletters is to disseminate information, but if you have financial difficulty please let us know, so that we will continue sending you the newsletters. We take your non response as "No thank you." Membership is essential if we want to impress Canberra.

Irene Wood.
President.

NEXT MEETING : 2004

Brisbane : 17 January 1:30 – 4:00pm
30 Ridley Rd., Bridgeman Downs.
Support group leader : **Lesley Curtain** 3264 2838

Sydney : 7 February 2 – 4:30pm **Winston Hills Public School**
Junction Rd WISNTON HILLS.
Support group leader : **Irene Wood** – 45 796 226

Newcastle: 14 February 1:00 pm **at Mater Hospital**
Address: Mater Hospital, Maude Street Newcastle
Support group leader: **Phil Leaver** : 0438 275 965

Melbourne: 14 February 1:30 – 4 pm **"Ringwood Room"**
Ringwood Library
Support group leader : **Joan Thompson** – 9725 3808

Sunshine Coast: 28 February 1 – 3:30 pm
Venue to be announced
Contact Irene Wood. 02 45 796226

Canberra 20 March 2004 1 – 3 pm
Weston Creek Community Centre.
Contact Irene Wood. 02 45 796226

Santa was very cross. It was Xmas Eve and nothing was going right. Mrs. Claus had burned all the cookies. The elves were complaining about not getting paid for the overtime they had while making the toys. The reindeer had been drinking all afternoon and were dead drunk. To make matters worse, they had taken the sleigh out earlier and had crashed it into a tree.
Santa was furious. "I can't believe it! I've got to deliver millions of presents all over the world in just a few hours - all of my reindeer are drunk, the elves are on strike and I don't even have a Christmas tree! I sent that stupid Little Angel out hours ago to find a tree and he isn't even back yet! What am I going to do?"
Just then, the Little Angel opened the front door and stepped in from the snowy night, dragging a Christmas tree. He says, "Yo, fat man! Where do you want me to stick the tree this year?."
And thus the tradition of angels atop the Christmas trees came to pass. ☺

MERRY CHRISTMAS AND HAPPRY NEW YEAR.