



ABN 33914 644 101

SUPPORT GROUPS : Sydney, Newcastle, Brisbane, Sunshine Coast, Melbourne, Canberra.

July 2004

A Reflection of Life

*All the world's a stage,
And all the men and women merely players:
They have their exits and their entrances;
And one man in his time plays many parts,
His acts being seven ages. At first the infant,
Mewling and puking in the nurse's arms.
And then the whining school-boy, with his satchel
And shining morning face, creeping like snail
Unwillingly to school. And then the lover,
Sighing like furnace, with a woeful ballad
Made to his mistress' eyebrow. Then a soldier,
Full of strange oaths and bearded like the pard,
Jealous in honour, sudden and quick in quarrel,
Seeking the bubble reputation
Even in the cannon's mouth. And then the justice,
In fair round belly with good capon lined,
With eyes severe and beard of formal cut,
Full of wise saws and modern instances;
And so he plays his part. The sixth age shifts
Into the lean and slipper'd pantaloon,
With spectacles on nose and pouch on side,
His youthful hose, well saved, a world too wide
For his shrunk shank; and his big manly voice,
Turning again toward childish treble, pipes
And whistles in his sound. Last scene of all,
That ends this strange eventful history,
Is second childishness and mere oblivion,
Sans teeth, sans eyes, sans taste, sans everything.*

W. Shakespeare. -AS YOU LIKE IT

Conference Funds . Our sincere thanks to

Mr. John Fraser Pty Ltd. - \$1000 contribution

Mr. Bob Harrison - \$500 contribution

President Report

Although we are an association formed to provide support for sufferers of Trigeminal Neuralgia, we also provide support for those who suffer other types of face pain. In 2003 we received 123 inquiries, present data shows that by May 2004 we received a further 56 new contacts. This indicates we are on course for another 120ish people who would contact TNA Australia by the end of the year. I am sure with improvement to our modes and areas of out reach we will touch more lives in the future.

Our main arm of reaching out is via the local community papers. Both websites, ours and TNA US, also play a significant role. Lately, we have also enjoyed the support from various doctors who see the value of support group and have referred their patients to the Association. The main areas of our out reach lies in Sydney, Brisbane and Melbourne.

Currently we send out 320 newsletters each month. Of the 320 recipients, 105 have yet to pay their membership fee. (the above figures do not include the professionals.) When you multiply \$20 by 100 members – it amounts to \$2000. This \$2000 deficit has to be filled. If it is not coming from your pocket – it simply means someone else is paying your share. We have been fortunate that there has been generous donations made to the Support Funds and this has helped make ends meet. We are a self support non profit making organisation and we not receive any funds from the government.

From the Treasurer's report – you will note that the main bulk of our expenditure is from photocopying and postage. I would also like to make it clear that each time I travel to support groups, the expenses have been from my own pocket. The Association simply cannot afford nor is able to sustain such extra cost.

However, if each were to pay his/her own dues, the money in the Support Fund would then be used to take on projects that would further promote the awareness of TN. It means we will be able to do more for you and other face pain sufferers.

There are 6 TNA Support groups -

Sydney - September 2000
Melbourne - December 2001
Brisbane - January 2002
Newcastle - April 2003
Canberra - November 2003
Sunshine Coast – February 2004

In keeping with the goals and mission of the Association, TNA Australia will hold a national conference in August 2005. This conference will boast of international and local experts. If these wonderful doctors can put aside their time and at their own expense for you, I hope YOU can appreciate it. YOU who screamed for help – “what pain is this I have that nobody knows” - this conference is planned for you. The purpose is to empower you with information so that you can take control of your pain. See you at the Conference . ☺

In conclusion I would like to thank all of you for your support and the committee for their diligence.

Thank you.

Irene Wood
President.

Treasurer Report

INCOME AND EXPENDITURE 1-1-03 TO 31-12-03

Bank Balance brought forward 1-1-03		\$ 2205.89
Income		
Donations	\$ 996.45	
Membership Fees 2003/4	\$4665.00	
Gifts to Support Fund	\$ 855.00	
Bank fees refunded	\$ 41.35	
Interest	<u>\$ 6.53</u>	
		\$ 6564.33
		<u>\$ 8770.22</u>
Expenditure		
Adaptor Plugs US/AU	\$ 25.90	
Bank charges	\$ 30.01	
Legal Fees	\$ 159.00	
Rental of equipment	\$ 320.00 (data projector and video cam.)	
Video Tape transfers	\$ 349.40	
Postage	\$ 2308.80	
Photocopying	\$ 3093.80	
Stationery	\$ 253.92	
Rent of Hall	\$ 18.00 (Canberra)	
Telephone Calls	\$ 12.20	
		<u>\$ 6571.03</u>
Balance carried forward		<u>\$ 2199.19</u>

Unfortunately I have not received the Minutes of the Annual General Meeting held on Saturday June 5 2004 at Winston Hills Public School. The Secretary is away on holidays.

Just for your information :

The Committee

Executive Members

President : .Irene Wood

V President: Margaret Wilson

Secretary : Kim Koh

Treasurer : Frank Martin

Non –executive members

Kim Smith

Norma Martin

Terry Dewhurst.

**Sydney Support Group
Winston Hills Public School
5 June 2004**

Welcome Dr. Russell Vickers.

Present :46. Irene W, Jeanette B, Henry B, Diane B, Terry B, Frank M, Norma M, Bruce C, Roy W, Joan W, Sheryl C, Rod C, Pamela C, Jocelyn S, Oscar S, Anne P, Laurie P, Elizabeth T, Lloyd T, Kim S, Blanche S, Max S, John W, Nola W, Judy McM, Stewart B, Bill G, Jenny B, Jenny W, Mark W, Carole McD, Ceclia C, Marie H, Marlene Y, Russell V, Tony K, Bruce H, Joyce H, Kim K, Terry D, Judith D, Matt S, Robin S, Hilary W, Keith W, Audrey T.

Apologies: Margaret W, Doug W, Gavin L, Barbara C, Robert C, Thelma D and friends, John W, Stephanie R, Vern R, Vera R.

Welcome to all first time attendees. We had 6 new faces and unfortunately we did not have the chance to care and share with them. We had decided to try a new format for this meeting, deciding to let the speaker present his talk first then we would reconvene, after a quick cuppa, in a circle to care and share. Unfortunately we could not start on time all due to The Radio mob was late in leaving and by the time we got organized - it was 2:15 pm. We decided then to hand the meeting over to Dr. Vickers. I am sure all that were present enjoyed and benefited from Dr. Vickers talk. Below are my notes on Dr. Vickers talk. – any error is strictly mine.

Dr. Russell Vickers
Pain Management and Research Centre
Royal North Shore Hospital

Dr Vickers spoke on Temporomandibular Disorder, Neuropathic Orofacial Pain (Phantom Tooth Pain /Atypical Odontalgia) Neuropathic Facial Pain, and Trigeminal Neuralgia

He said patients are often referred to him as a last resort. He would prefer to see it as the first resort so that a good diagnosis is made and treatment can then be directed at the problem. He relies very much on how they describe their pain to make a diagnosis. The orofacial region is one of the most complex anatomical regions of the body.

Signs and symptoms of TMD - facial muscle tension and spasm, bruxism, restricted oral opening, (2 fingers width) Temporomandibular joint pain, frequent headaches and neckache.

I think he said about 80% of the general population experienced one or more signs or symptoms of TMD. Most TMD symptoms are temporary and fluctuate over time, requiring little or no professional intervention..

Splints or expensive orthodontics to change the bite or reposition the jaw is not at all necessary.

He had a table that showed the pain intensity of various orofacial conditions. Using the Visual Analog Scales (VAS) and the McGill Pain Questionnaire (using the total pain rating index PRI – MPQ) we were shown the different ratings and scoring of different types of pain. It was interesting to note that Trigeminal Neuralgia is the highest ranking pain of all the different pains. *I think TN scored around 28*
An example of the table below:

Relative Pain Intensity of Various Pain Conditions measured by numerical rating scale and McGill Pain Questionnaire.

Pain Condition	NRS (0-10)	PRI (T) - MPQ
oral pathology ^a	7	27.0
tension headache (psychiatric patients) ^b		27.0
Temporomandibular disorder (TMD) ^a	8	26.8
Atypical facial pain (AFP)-TMD ^a	7	26.5
back pain ^c		26.3
cancer pain ^c		26.0
Atypical odontalgia (AO)-TMD ^a	7	25.1
phantom limb pain ^c		25.0
tension headache (general practice pts) ^b		21.4
acute "toothache" ^d		19.5
arthritis ^c		18.8
AO ^a	7	18.0
menstrual pain ^c		17.5
AFP ^a	7	15.6

^a Vickers et al. [1998], ^b Hunter et al. [1981], ^c Melzack [1975], ^d Grushka et al. [1984]

Sex Differences in Orofacial Pain

Gender appears to play an important role in the increased prevalence of orofacial pain conditions that involve neurobiological and psychological aspects.

Gender bias in chronic pain (orofacial region)
(International Association for the Study of Pain, 1994)

Female Prevalence	Male Prevalence	No sex prevalence
Migraine with aura	Migraine without aura	Acute tension H/A
Chronic tension H/A	Cluster H/A	Maxillary sinusitis
Cervicogenic H/A	Post traumatic H/A	Acute pulpitis
Trigeminal		Cracked tooth
TMD		syndrome
Occipital neuralgia		Dry socket
Periodontitis		
Atypical odontalgia		
Burning mouth / tongue		
Carotidynia		
Chronic paroxysmal hemicrania		
Temporal arteritis		

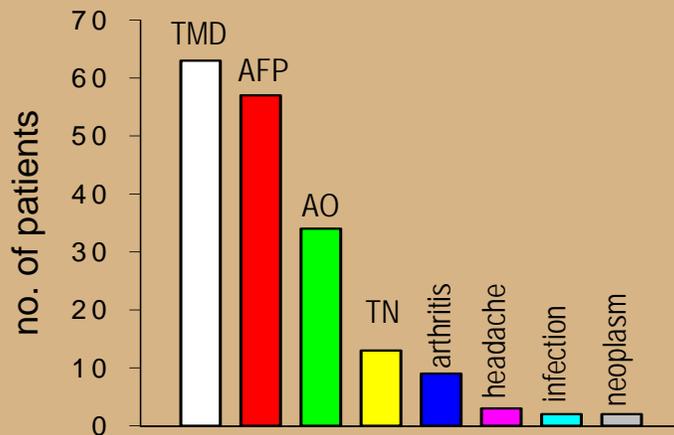
Chronic pain involves nociception and / or neuropathy, pain, suffering and pain behaviour. The pathophysiology of neuropathic pain is complex and involves deafferentation, nerve sprouting, neuroma formation, sympathetic efferent activity and centralisation.

PERSISTENT (CHRONIC) OROFACIAL PAIN – MAJOR CATEGORIES

Diagnosis of Chronic Orofacial Pain

(n=185)

Vickers & Cousins Aust Fam Physician 1994;12:2315)



- TMD – temporomandibular disorder
- AFP – atypical facial pain (neuropathic orofacial pain with significant psychological factors), discontinued term
- AO – atypical odontalgia (neuropathic oral pain / phantom tooth pain)
- TN – trigeminal neuralgia
- Arthritis – rheumatoid (both temporomandibular joints) and osteoarthritis (single TMJ from trauma)
- Headache (undiagnosed) – 1 migraine, 1 cluster (both referred by dentists)
- Infection (undiagnosed) - 2 impacted and infected wisdom teeth (both referred by doctors)
- Neoplasm (undiagnosed) – 1 nasopharyngeal cancer, 1 antral cancer (1 referred by doctor and 1 referred by dentist)
- All patients referred to pain clinic from medical and dental practitioners
- Duration of pain 3 months to 72 years

Table showing the frequency of signs and symptoms in a group of chronic TMD patients (n=30, female:male, 21:9; age range 24-84 years, mean=45 years; duration of pain 4 months-23 years, mean = 6 years) [Vickers et al. 1994].

Signs and symptoms	Frequency (%)
Pain in the face / jaw region	89
Neck pain	78
Headaches / earaches	78
Clicking of the jaw joint(s)	68
Muscle tension in the jaw region	68
Restricted opening of the jaw	64
Difficulty in chewing	61
Toothache / tooth sensitivity	54
Dizziness	50
Bruxism	50
Sore tongue / gums	46
Locking of the jaw	46
Swelling in the face /mouth	43
Difficulty in breathing through the nose	43
Tinnitus	39
Tingling sensation in the face	39

Numbness in the face / mouth	36
Unpleasant taste	21
Teeth chipping / wearing down	14

We were extremely interested in the case study he presented for each orofacial pain. He also confirmed that stress can exacerbate pain.

It was a very informative and enjoyable afternoon. We thank Dr. Vickers for his interest and support. Dr. Vickers has also kindly given us a CD containing his work on Orofacial Pain. This CD will be available in your Support Group Library soon as I can make copies of them. (*with Dr. Vickers' permission of course.*)

Irene

MELBOURNE SUPPORT GROUP

At "Ringwood Room"
Ringwood Library, 1.30 p.m.

12th June, 2004

Present: (10) Nancy Bartholomew; Monique Butler; Joy & Alan Collard; Kath & John Cripps; Pat O'Grady; Beryl Owers; J. & N. Thompson.

Apologies: Bernadette & Les Barlow; Alma England; Thelma Rolston;

Treasurer's Report: Tom reported a balance of \$188.15.

We now have an entry in the "Maroondah 2004-2005 Community Guide to Services" (page 36), published by the Maroondah City Council.

- Kath has had further cranial chiropractic treatment which has had a positive effect and hence she is now having far less pain.
- Nancy learnt that her chiropractor, Frank Pederick (now retired), has written a paper on the cranial chiropractic treatment he used for her TN, to be published in an appropriate journal.

Dr. Pauline Walsh, Chiropractor, gave us a talk based on how the nervous system functions, and how chiropractic can improve this, by corrective adjustment to the spine, when malfunction of the nervous system occurs. Pauline first learnt of TN during her 16 years of nursing. From the TN patients who came to the hospital she learnt that chiropractic can help alleviate TN pain in many cases. Pauline graduated as a Chiropractor after a further five years of studying Anatomy, Physiology, Diagnostic Science and Chiropractic. She showed, by diagrams, the position of the Trigeminal Nerve in relation to the cervical spine, and explained that correction of a sub-luxation can help remove a problem which has been causing pain. Sub-luxation of the spine can be caused by a problem anywhere in the nervous system -- which is why, for instance, some pain in the neck can be traced to, say, a need for correction in the lumbar region. Sometimes only *fractional* changes are all that are necessary to get the spine to function correctly again.

Note: Luxation = dislocation. Sub-luxation = 'less than' or 'smaller than' a dislocation.

We thanked Pauline for her enlightening talk, and we all talked further over afternoon tea. Thank you to all those who helped provide refreshments, and/or cleared up afterwards.

Next Meeting: Saturday, 12th June, 2004, 1.30 p.m.

Joan Thompson

For Your Information

Many rang to ask : - so here it is again.

Methylcobalamin

Methylcobalamin is a type of Vitamin B12. Vitamin B12 comes in several kinds including hydroxy-, cyano-, and adenosyl-, but only the methyl form is used in the central nervous system. Deficiency states are fairly common and vitamin B12 deficiency mimics many other disease states of a neurological or psychological kind, and it causes anemia. Cyanocobalamin (the kind in vitamin supplements) is converted by the liver into methylcobalamin but not in therapeutically significant amounts. Vitamin B12 deficiency is caused by a wide range of factors including low gastric acidity (common in older people,) use of acid blockers such as *Prilosec*TM or excessive laxative use, lack of intrinsic factor, poor absorption from the intestines, lack of Calcium, heavy metal toxicity, or excessive Vitamin B12 degradation. Methylcobalamin donates methyl groups to the myelin sheath that insulates nerve fibers and regenerates damaged neurons. In a B12 deficiency, toxic fatty acids destroy the myelin sheath but high enough doses of B12 can repair it.

DOSE

For every day prevention take 1 mg (or 1000 mcg) daily under the tongue. *Your compounding Pharmacist should be able to compound this into lozenges or some other sublingual form.*

*Or talk to **Bob Harrison 02 95247200***

Pathophysiology of Peripheral Nerve Injury: A Brief Review

Posted 06/09/2004

Mark G. Burnett, M.D., Eric L. Zager, M.D., Department of Neurosurgery, Hospital of the University of Pennsylvania, Philadelphia, Pennsylvania

Abstract and Introduction

Abstract

Clinicians caring for patients with brachial plexus and other nerve injuries must possess a clear understanding of the peripheral nervous system's response to trauma. In this article, the authors briefly review peripheral nerve injury (PNI) types, discuss the common injury classification schemes, and describe the dynamic processes of degeneration and reinnervation that characterize the PNI response.

Introduction

After a nerve is injured in the periphery, a complex and finely regulated sequence of events commences to remove the damaged tissue and begin the reparative process. Unlike cellular repair in other areas of the body, the response of the peripheral nerve to injury does not involve mitosis and cellular proliferation. Our understanding of the peripheral nerve regeneration process has increased significantly during the past several decades concurrent with advances in cellular and molecular biology. We now see that a nerve's response to injury is not simply localized at the site of damage but involves the cellular bodies located in the spinal cord and ganglia as well. Critical roles are played by Schwann cells as well as macrophages and inflammatory cells. The importance of neurotrophic factors has also been elucidated. We provide a review of PNI and repair processes and illustrate the remarkable cooperation between destructive and restorative forces that must occur if proper nerve regeneration is to take place.

Basic Injury Types

Basic Injury Types

Before discussing the pathophysiology of PNIs, it is important to provide a brief description of the basic injury types seen in clinical practice.

Stretch-related injuries are the most common type. Peripheral nerves are inherently elastic because of their collagenous endoneurium, but when traction forces exceed the nerve's capacity to stretch, injury

occurs.^[17] If the force applied is great enough, a complete loss of continuity may occur as in a brachial plexus avulsion. More often, however, continuity is retained. Injuries of this type can be seen in isolation (for example, in Erb palsy and similar brachial plexus birth-related injuries) or in association with extremity fractures at points where nerves and bone are in close approximation (for example, in radial nerve injury following humeral fracture).

Lacerations such as those created by a knife blade are another common PNI type, comprising 30% of serious injuries in some series.^[5] Whereas these can be complete transections, more often some nerve element of continuity remains. Because most research models involve a laceration- type injury mechanism because it is easily reproduced, the details of nerve degeneration and regeneration discussed in this article are perhaps most representative of this injury type.

Compression is a third common type of PNI. These injuries include the "Saturday Night palsy" due to radial nerve compression as well as entrapment neuropathies and do not involve a severance or tearing of the neural elements. Total loss of both motor and sensory function may occur, but the pathophysiology responsible for these deficits is unclear because complete nerve continuity is maintained. Two pathological mechanisms are believed to be involved in these injuries: mechanical compression and ischemia. Discerning which mechanism is more important in compression injuries has been difficult. The authors of tourniquet experiments performed in the 1930s demonstrated that, at least in short-term compression, ischemia and not the pressure itself causes the resultant physiological conduction block.^[8] Exactly how short-term ischemia induces such a block has not been determined, but large myelinated fibers appear to be more susceptible to ischemic effects than smaller unmyelinated ones. Little or no histological change is seen as a result of such injuries, and the effects appear to be reversible unless ischemia persists for more than approximately 8 hours.

Mechanical deformation is thought to be the primary mechanism in the more severe cases of compression injury such as in Saturday Night palsy in which function may be lost for weeks and full recovery does not always occur. Experiments involving a pneumatic cuff to recreate this sort of compression injury have and shown that nerves undergo degenerative changes at the edges of the compressed area and not under the center of the cuff where ischemia is most severe.^[10] Ultrastructural examination of the nerves has demonstrated that the axoplasm and myelin beneath the cuff were pushed away from the point of greatest compression and toward the edges of the cuff, reinforcing the finding that mechanical deformation is responsible in these injuries.^[11]

[Nerve Injury Classification](#)

[Neural Response to Injury](#)

[Nerve Regeneration](#)

[Neurotrophic Factors](#)

[Conclusions](#)

To read the rest of the article go to : [medscape.com](http://www.medscape.com) (you will need to log in)
<http://www.medscape.com/viewarticle/480071?src=mp>

NEXT MEETING : 2004

Brisbane : *31 July 1:30 – 4:00pm*
30 Ridley Rd., Bridgeman Downs.
Support group leader : ***Lesley Curtain*** 3264 2838

Sydney : *7 August 2 – 4:30pm Winston Hills Public School*
Junction Rd, WISNTON HILLS.
Guest Speaker : Mr. Glenn Turner
Support group leader : ***Irene Wood*** – 45 796 226

Newcastle: *14 August. 1:00PM – 4:00PM*
Guest Speaker : LORETO WHITNEY, kinesiologist and homeopathy
TUTORIAL ROOM, LEVEL 6 MATER HOSPITAL
Lorna Street (Off Maud St.) Newcastle.
Meet at Daffodils Caf  before heading up stairs.
Support group leader: ***Phil Leaver*** : 49 387361 or 0427 571700.

Melbourne : *14 August 1:30 – 4 pm "Ringwood Room"*
Ringwood Library
Support group leader : ***Joan Thompson*** – 03 9725 3808

Sunshine Coast : *August 1:30 – pm FRED MURRAY BUILDING,*
CURRY STREET, NAMBOUR
Support group leader : ***Marcella McSweeney.*** 07 5446 1642

Canberra : *16 October 1- 3:30 pm -*
Weston Creek Community Centre
Contact ***Irene Wood.*** 02 45796 226

GOD BLESS

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