



Trigeminal Neuralgia Association of Canada

December 2012 Newsletter

Support Group



Eastern Ontario Support Group

Meeting in Ottawa, Brockville, or somewhere in between, our group consists of people from Kingston through to Cornwall and north to the hills of Gatineau! We are a group of people who enjoy coming together to encourage and support each other along the journey of TN. We swap stories, laugh, and even cry at times. We share news on where we are at in our TN journeys and what paths we have travelled. Most of all we are always open and looking to welcome new members to our group.

Our group is open to individuals with TN as well as their friends and family.

Next meeting February 2013.

For more information and the time place of our next meeting please contact Jane at cmusicstudio@cogeco.ca or by calling 613.936.6977

Vancouver and Lower Mainland Support Group

We had a good meeting on December 1st at the G.F. Strong Rehab Centre. We're able to meet at the centre thanks to the management and the support of neurosurgeon Dr. Honey in finding us a free place to meet. It's especially suitable as it's wheelchair friendly and we have some members with MS. About 20 people attended the meeting and there were several newcomers. Pharmacist Melanie Johnson talked to us about medication and her input was welcome and enabled people to ask questions. We all enjoyed meeting each other and there was much discussion during the break and around the table. We're planning another meeting for the Spring, probably without a speaker as we all have so much to say to each other. If you'd like to get in touch please call or email me:

Ann Hopkins 1 604 741 0662;
annhopkins@dccnet.com

Lethbridge Support Group

Coordinator Marion Guzik

The Lethbridge Support Group meets every second Saturday of the month at 2:00 p.m. in Rm A, Lethbridge Senior Centre, 500 - 11th Street, S., Lethbridge, AB.

Coordinator: Marion Guzik, past president / founder TNAC

email mguzik@telus.net Phone: 403-327-7668

London Support Group

Are you in the London, ON area? We have a new support group serving Western Ontario.

Contact Name: Elizabeth Galbraith
Tel: 519.471.3439
energyworksnaturally@bell.net
www.tnsupportlondon.ca





TNAC PRESENTS

Saturday January 26, 2013

4PM EST

AN OVERVIEW OF TRIGEMINAL NEURALGIA MANAGEMENT

By

Anthony M. Kaufmann, MD,
BSc(Med), MSc, FRCSC

Associate Professor, Section of
Neurosurgery Director, Centre For
Cranial Nerve Disorders, Winnipeg, MB

Registration is LIMITED
**TO REGISTER
GO TO:**

www.tnac.org

Registration for TNAC
members (**free**) begins
January 2, 2013, 12 noon
PST

*Registration for non-TNAC members
(cost \$10) open Jan. 15, 2013*

A webinar is a seminar that is
presented on the internet. You do not

have to leave your home to attend.
All you need is to register and then,
at 4PM on Saturday January 26,
2013 go to the URL (www.xxxxx) that
we email to you, turn the speakers
on your computer on, and you can
listen in to hear Dr. Kaufmann speak
about TN. You will be able to type in
questions during the webinar which
he will answer at the end (time
providing) so the presentation will be
interactive.

You MUST register in order to
participate. Registration is free for
TNAC members and TNAC
members have two weeks to register
before we open registration to the
general public. Registration spots are
limited. Once we are full we will have
to close the webinar room.
Registration will be on a first come
first serve basis starting with TNAC
members. If you are not a TNAC
member and would like to join please
go to www.tnac.org and download a
membership form. You can pay your
membership fee online by paypal.

To register go to www.tnac.org as of
January 2, 2013 (12 noon PST)

About Dr. A. Kaufmann:

Dr. Anthony Kaufmann is a graduate of
the University of Manitoba School of
Medicine where he also completed his
neurosurgery residency and received his
Masters of Science Degree in Surgery.
During his training, he received several
research and achievement awards, as
well as athletic scholarships and
basketball All-Star awards.

In 1994 he accepted a position as
Assistant Professor of Neurological
Surgery at the University of Pittsburgh
Medical Centre, and specialized his
practice in cerebrovascular and cranial
base neurosurgery. He was a member
of the "Stroke Team" at the Pittsburgh
Stroke Institute. Dr. Kaufmann also

developed a special interest in cranial
nerve disorders and microvascular
decompression surgery, while working
with the Pioneer in this field, Dr. Peter J.
Jannetta.

Dr. Kaufmann returned to Canada and
joined the Department of Clinical
Neurosciences at the University of
Calgary in 1997 where he established a
cranial nerve subspecialty clinic. He was
also the neurosurgical representative for
the Calgary LINAC Radiosurgery
Planning Committee and Treatment
Team.

In November 2000, Dr. Kaufmann
accepted the position of Associate
Professor in the Section of
Neurosurgery, University of Manitoba.
He established and is the Director of the
Centre for Cranial Nerve Disorders and
supervisor of the Intraoperative
Monitoring Program in Winnipeg. He
was appointed Co-director of Canada's
first Gamma Knife Surgery Centre, and
is also Co-director of the Centre for
Cerebrovascular Disease.

Dr. Kaufmann is a member of the
Medical Advisory Board for the
Hemifacial Spasm Association, Acoustic
Neuroma Association of Canada, and
Medical Advisor for the Trigeminal
Neuralgia Association of Canada. Dr.
Kaufmann also maintains an active
clinical research program. He has
published over 85 articles, book
chapters, and abstracts and has also
presented over 100 scientific papers and
invited lectures.

Our Second webinar will be:

Saturday March 30, 2013

4:00PM EST

Topic to be announced

Dr. Christopher R. Honey MD,
D.Phil., F.R.C.S © Neurosurgeon

Registration is LIMITED
**TO REGISTER
GO TO:**

www.tnac.org

Registration for TNAC
members **(free)** begins
March 8, 2013, 12 noon
PST

*Registration for non-TNAC members
(cost \$10) open March 22, 2013*

Dr. Honey is Associate Professor of Neurosurgery at the University of British Columbia and Director of Research for the Division of Neurosurgery. He was the President of the Canadian Section of Stereotactic & Functional Neurosurgery for its first seven years. He is on the Board of the World Society of Stereotactic & Functional Neurosurgery and was on the Board of the American Society of Stereotactic & Functional Neurosurgery.

A third webinar, by Dr. M Hodaie, MD (University of Toronto) will follow in June. Details will be shared in the March newsletter.



**Surgical long-term relief available
for facial pain**

Q. I have trigeminal neuralgia. Medications haven't helped. What are my other treatment options? A. Trigeminal neuralgia causes pain in the face. The pain can be so bad that it disrupts a person's life.

You have two trigeminal nerves, one on each side of your face. These nerves detect touch, pain, temperature and pressure. If you pinch your lip, trigeminal nerve endings in your lips send pain signals up the nerve and into your brain, where the pain registers.

In trigeminal neuralgia, a nerve starts to malfunction, registering pain when there's no apparent reason for it. People suddenly have intense, "stabbing" or electrical shocklike facial pain. The pain can be excruciating and can occur anywhere between the jaw and forehead.

The painful symptoms come and go. You may experience repeated painful episodes over days, weeks or months. Then you may enjoy a pain-free stretch of months or years. But then it returns, and you feel betrayed: You thought you were rid of it. You live with the knowledge that it might come back, so even if you are free from pain you are not free from apprehension.

The irritation in a trigeminal nerve is usually near the nerve's origin, deep within the skull. In most cases, an abnormal blood vessel pressing on the nerve causes the irritation. Occasionally, multiple sclerosis can lead to trigeminal neuralgia. In some cases, we just don't know the cause.

Treatment usually begins with the anticonvulsant medication

carbamazepine (Tegretol, others). This drug decreases the ability of the trigeminal nerve to fire off the nerve impulses that cause facial pain. If carbamazepine doesn't help, another anticonvulsant medication may be more effective for you. A muscle relaxant, either alone or in combination with an anticonvulsant, can also help.

Brief use of narcotic pain relievers, such as oxycodone, hydrocodone or morphine, can help manage episodes of severe pain.

You say medications haven't helped you. If you've tried the medicines I've mentioned, then there are other types of treatment to discuss with your doctor:

• **Rhizolysis:** Part of the trigeminal nerve is temporarily inactivated. This may be done using a heated probe, an injection of glycerol, or a tiny balloon inflated near the nerve to compress it. Rhizolysis provides immediate relief for most people, but it doesn't prevent the condition from returning.

- **Stereotactic radiosurgery:** This is a form of radiation therapy in which tiny beams of radiation are used to inactivate part of the trigeminal nerve. This is a newer treatment option, and its long-term success rate is not known.
- **Microvascular decompression:** In this delicate surgical procedure, a surgeon opens your skull and repositions the blood vessel that is pressing on your trigeminal nerve. The procedure has a high

success rate, and most patients gain long-term relief. It has been a really important advance. I just wish it had been available to some of my patients with trigeminal neuralgia 20 to 30 years ago.

Dr. Komaroff is a physician and professor at Harvard Medical School. Go to his website to send questions and get additional information: AskDoctorK.com.

<http://www.dailyherald.com/article/20121001/entlife/710019973/print/>



Trigeminal Neuralgia: Radiosurgery Before Microvascular Decompression

The above study shows that microvascular decompression can be done successfully with a good chance for pain relief and with a relatively small risk of complications whether or not patients have had a prior radiosurgery procedure. This supports the idea that many patients could have a minimally invasive procedure such as radiosurgery as an initial procedure. Should pain recur, they could have another procedure, which could still be minimally invasive such as a repeat radiosurgery or a needle rhizotomy or, if they choose, the more invasive microvascular decompression. If a minimally invasive procedure were chosen as the initial procedure, many patients would never need a microvascular decompression.

The advantage of microvascular decompression is that it probably has a greater chance of relieving pain without the need for medicines than

do the lesser invasive procedures (2), and it is less likely to cause numbness, especially the bothersome kind. Nevertheless, microvascular decompression is not always accomplished without denervation, and the better results seen in the post radiated group (4), where there was also more post-operative denervation, suggests that pain relief in microvascular decompression is sometimes caused by denervation. Even though microvascular decompression can often be done safely, the risk of complications including severe problems are much greater than with less invasive procedures.

Another apparent advantage is that pain relief tends to occur immediately after microvascular decompression while it is usually delayed a few weeks following radiosurgery. However, full recovery from microvascular decompression often takes a few weeks, while patients undergoing radiosurgery can resume normal activities the next day. In addition, those patients undergoing microvascular decompression who have complications, such as cerebrospinal fluid leak, infection, meningitis, diplopia, cerebellar edema or hemorrhage or hearing loss may recover, but during the several weeks they take to recover, they have limitations that often prevent them from resuming fully their preoperative activities. As is the case for all neurosurgical procedures for trigeminal neuralgia, as well as microvascular decompression, not all patients are relieved and the chance of recurrence continues as long as patients are followed.

The study reported in World Neurosurgery (4) involves patients with typical trigeminal neuralgia that corresponds to Burchiel class 1

(TN1) and 2 (TN2) (3). TN1 refers to those with spontaneous face pain where more than 50 percent of the pain is episodic and TN2 where more than 50 percent of the pain is constant as reported by the patient. While some patients with typical trigeminal neuralgia have constant pain that they report as being more than 50 percent of their pain, there are many patients with constant pain that is more than 50 percent of their pain who do not have typical trigeminal neuralgia. Patients with typical trigeminal neuralgia who have constant pain usually had typical paroxysmal, triggered pain before they developed constant pain; their constant pain is markedly improved when they hold completely still even for a few minutes; and their constant pain is (or was) relieved by carbamazepine or oxcarbazepine. These patients, when their pain is medically intractable, are good candidates for neurosurgical intervention as they are likely to respond well to either radiosurgery, needle rhizotomy or microvascular decompression.

Patients with atypical trigeminal neuralgia (often with constant pain that is not relieved by holding completely still or taking carbamazepine and may have been present from the very beginning of symptoms) respond less well to microvascular decompression (6), radiosurgery or needle rhizotomy than those with typical trigeminal neuralgia.

Several other factors have been associated with a worse chance of long-term pain relief following microvascular decompression: these include female gender, venous compression of the trigeminal root entry zone, and duration of preoperative symptoms exceeding 8

years (1). The study in World Neurosurgery (4) shows very good results in patients with a previous Gamma Knife radiosurgery even though they had a long duration of preoperative symptoms (median of 8 years). This would further argue against the need for an early microvascular decompression.

Most of the radiosurgical literature for trigeminal neuralgia involves Gamma Knife radiosurgery although there are some studies showing that Linac systems can also deliver safe and effective treatment for trigeminal neuralgia. Initially it was shown that pain relief was more likely when at least 70 Gray maximum was given to the cisternal trigeminal nerve (5). Most centers using Gamma Knife radiosurgery now deliver maximum doses between 75 to 85 Gray. An additional factor that will affect pain relief as well as complications is the proximity of the radiation to the dorsal root entry zone of the brainstem, as a smaller dose delivered here is probably as effective as a larger dose delivered further away from the brainstem. Special care must be taken especially when there is a small trigeminal cistern, which usually occurs in younger patients who have less brainstem atrophy. It is relatively easy under these circumstances to give a higher dose to the brainstem than otherwise anticipated and to risk major trigeminal denervation; it may be better to either decrease the maximum dose, or move the isocenter further away from the brainstem.

There is no simple formula for the best treatment that fits all patients with trigeminal neuralgia. Although microvascular decompression is an excellent procedure, the minimally invasive techniques of needle

rhizotomy and radiosurgery present a very attractive alternative, especially as an initial procedure.

Source: <http://trigeminalneuralgia-ronaldbrismanmd.com/Radiosurgery.html>



Update on TN Research around the World

The Facial Pain Research Foundation's first international research project to find a cure is underway and it seeks to discover the answers to "Why Me?" and lead scientists to developing a cure. The Foundation's Trustees are excited to announce their fourth research project entitled "In Search of A Cure...Finding the Genes That Predispose to Trigeminal Neuralgia". Its goal is to identify the genes that make people susceptible to TN or cause the pain and then move toward prevention and cure.

Dr. Douglas Anderson, Foundation Trustee and Director of Research Programs, first presented the concept that there was likely a genetic basis for TN at the 2004 TNA National Conference in Orlando. He always found it odd that the anatomies of compressed nerves/lesions were seen in a significant number of individuals, but only a few had TN. He always harbored the idea of identifying a genetic profile in TN patients that would lead to ending the painful condition. Anderson says "If there is a history of a member of your family having TN, other members of your family could be screened and hopefully the condition could be prevented by having the genetic

pattern altered so the pain will not develop."

Dr. Joanna Zakrzewska of London England, the Foundation's International Research Coordinator, asked Dr. Marshall Devor in March 2012 to prepare a research project proposal to seek a cure for TN and present it to the Foundation. After seven months, the researchers and the Foundation Trustees have approved the research project and are excited about moving forward. The three Principal Investigators of the project are Dr. Marshall Devor, Dr. Kim Burchiel, and Dr. Ze'ev Seltzer.

The team of international scientists is led by Principal Investigator pain research pioneer *Dr. Marshall Devor* of the Hebrew University of Jerusalem, Israel. The award winning scientist has had an outstanding career in pain research. He has contributed an outstanding body of research, authoring several hundred papers over 40 years and has been described as one of those "who view excellence as a way of life and the fulfillment of human potential as essential to creating a better world for future generations."

Dr. Kim Burchiel is the Chairman of the Department of Neurological Surgery at the Oregon Health & Science University in Portland, Oregon. Burchiel has been a long time member of the TNA Medical Advisory Committee and performed hundreds of TN surgeries. A successful researcher, he has been a national leader in the treatment of orofacial pains including TN. The first step of the research project, phenotyping and DNA collection, will

be the responsibility of Professor Burchiel at OHSU. He is a leading authority in the phenotyping of facial pain conditions and author of the most widely accepted TN classification scheme. Dr. Burchiel has said: "this research project could be the most important pain study ever attempted" and he is very hopeful that it will lead to a cure for TN and related neuropathic pain.

Dr. Ze'ev Seltzer, Professor of Genetics at The University of Toronto, Canada is also an award winning scientist. He has dedicated his career to the study of pain. Seltzer says "I am looking forward to be a Co-Principal Investigator in the TN project, bringing 35 years of studying the neurobiology of pain." Having had many competitive grants and honors he has an outstanding track record of productivity in the field of pain and pain genetics. Seltzer also says "The goal to find a cure is achievable...our best salvation may come from genetics".

Consultants to the research project include: *Dr. Joanna Zakrzewska*, Eastman Dental Hospital, London, England...*Professor Ariel Darvasi* and *Dr. Sagiv Shifman*, Hebrew University of Jerusalem, Israel...and Dr. Scott Diehl, University of Medicine and Dentistry, New Jersey

Source: Research Foundation Newsletter



Contacting TNAC

For information on membership or general information:
president@tnac.org
613.936.6977

TNAC, 1602 Walton Street
Cornwall, ON, K6H 1W2
For information on support groups:
support@tnac.org

For information on advocacy:
advocacy@tnac.org
Do you have an article for the newsletter? Do you have a topic you'd like covered? Do you have a drug you'd like profiled? Please let us know.



Lacosamide Good in Trigeminal Neuralgia

The anti-epileptic agent lacosamide (Vimpat) appears to give relief to patients with refractory trigeminal neuralgia, researchers reported here.

Principal investigator Jeffrey Cohen, MD, an attending neurologist at Beth Israel Medical Center in New York City, looked at the drug in a pilot study of 11 patients – some of whom had failed to get relief even after surgical procedures.

Cohen, a member of the medical board of TNA—The Facial Pain Association, and neurology resident Shivang Joshi, MD, lead author, found that several patients achieved relief for more than a year with lacosamide and one achieved complete resolution of pain.

For seven of the 11 patients they had results from a Barrow Neurological Institute Pain scale, and five of those seven patients achieved some degree of pain relief, they reported in a poster presentation at the American Academy of Neurology meeting.

"Some of our patients had been in pain from trigeminal neuralgia for as long as 22 years, Joshi told *MedPage Today*."

"In this small case series of patients with refractory trigeminal neuralgia, a majority of the patients responded at least initially, despite multiple previous medication trials and surgical procedures in some, he said."

In addition to surgical treatments that still did not relieve pain, the patients had been treated with a variety of drugs: anesthetics, anti-epileptics, opioids, nonsteroidal anti-inflammatory drugs, triptans, tricyclic antidepressants, and other medications. "These were truly refractory patients," Joshi said.

The dosage of lacosamide was not standard, but averaged around 200 mg a day.

Four of the patients were able to take lacosamide as an add-on therapy without experiencing further adverse effects; five other patients complained of dizziness; one patient reported fatigue and the other patient complained of constipation.

Image studies were performed in 10 patients, and these were negative in eight; two patients were observed to have meningiomas that could have caused the trigeminal nerve pain.

One 25-year-old man with right side trigeminal neuralgia did not receive any relief from treatment with lacosamide. An 80-year-old man and a 77-year-old man said that the treatment provided pain relief for two months; a 47-year-old woman reported 9 months of pain relief, and an 88-year-old woman reported 11 months of pain relief. The other six patients reported they have had relief of pain from 2 months to 12 months, and that relief is ongoing.

The median age of the patients in the study was 63; the mean duration of neuralgia was 10 years.

Shirin Issa, MD, assistant professor of neurology at the Montefiore Medical Center in Bronx, N.Y., told *MedPage Today* that lacosamide might be helpful for some of these patients who have no treatment options available. The use of lacosamide is attractive, she suggested, because the side effects are minimal. "We are interested in trying it in our patients," she said.

Action Points

Note that this study was published as an abstract and presented at a conference. These data and conclusions should be considered to be preliminary until published in a peer-reviewed journal.

In this very small, retrospective chart review, lacosamide, which selectively enhances slow inactivation of voltage-dependent sodium channels, was associated with some response in most patients with refractory trigeminal neuralgia.

Cohen and Joshi believe their results deserve to be pursued in a larger study. "Lacosamide was well

Primary source: American Academy of Neurology Source reference: Joshi S and Cohen J, "Lacosamide as adjunctive therapy for refractory trigeminal neuralgia" *AAN* 2012; Abstract P03.224.



Natural Support for TN

By SUZY COHEN - For the Herald & Review

I'd like to offer you a few inexpensive over-the-counter solutions to ease neuropathic pain. The supplements that I recommend help shuttle more oxygen to your cells, reduce inflammation, protect the myelin

wrapper around your delicate nerves, quench toxic free radicals and reduce protein kinase C (PKC). These could all be taken together:

* Alpha Lipoic Acid. This antioxidant squashes free radicals that attack your myelin sheath and fray your nerve wiring. You may notice effects in a few days, though most people require several weeks. Try 200mg to 250mg two to four times daily, or half that dose if you take R lipoic acid. To boost this antioxidant's effect, take it with fish oil, krill oil or DHA extract (about 500 mg) with food.

* Curcumin. Found in the spice turmeric, this supplement reduces blood sugar. Curcumin chases away a pain-causing chemical, TNF, as well as nitric oxide. It helps cool the burn you feel in your nerves. Cook with turmeric, but also take a supplement, 500mg twice daily. Effects take about a month.

* Methylcobalamin (B12). When your body starves for B12, you lose the myelin sheath and your nerves short circuit. This can cause neuropathy and depression. There are dozens of drug muggers of B12, including the diabetic medications that you take as well as processed foods, sugar, antibiotics, estrogen hormones and acid blockers.

* Thiamine. A glass of wine every night can steal this nerve-protective nutrient. Candida overgrowth can snatch it, too. Run low on thiamine and you will absolutely suffer with bizarre neuropathic sensations. I'd suggest about 50 to 100 mg daily for a few months, along with a low dose B-complex so you have all the other Bs on board.



PAYPAL

Did you go to the TNAC website looking for the paypal link to renew or sign up for a membership? Did you look and look and not find it?

We apologize for the delay in having the paypal system for payment up and running. It was much more complicated than we anticipated. However with much thanks to Joya Dickson, our treasurer, we are pleased to let you know that TNAC is now set to accept membership dues, new and renewals, as well as TNAC donations, by paypal.

MEMBERSHIP (new or renewal)

Go to www.tnac.org

Click on "Join TNAC"

Click on the Green box "Add to Cart" and it will connect you with paypal.

DONATIONS:

Go to www.tnac.org

Click on 'donate'

Click on the Green box 'Donate' (under the words 'donate online') and it will take you directly to paypal. If you do not have a paypal account you will have to set up a paypal account. If you do have a paypal account you simply need to login and you are set to go.

Don't want to use paypal? Just print the membership application and you can mail a check to TNAC. Both methods are perfectly fine.

TNAC continues to support research into diagnosis and treatment of trigeminal neuralgia across Canada. We rely on your donations to assist us in supporting people across Canada diagnosed with TN as well as researchers working towards better treatment and hopefully some day an end to TN. Please consider

donating to TNAC. TNAC is a registered charity with CRA and we do receipt all donations.

Ideas for donations include asking for donations to TNAC instead of Christmas or birthday presents, mentioning TNAC in your will, holding a fundraiser for TNAC in your neighbourhood.



MESSAGE FROM THE TREASURER

On behalf of the executive committee I would like to convey a big thank you to members for renewing memberships and forwarding your generous donations. Donations of course are tax deductible.

TNAC mailed new laminated Emergency Cards together with renewal receipts this summer. If the card was not included in your mailing kindly e-mail me at Joya@telus.net, or drop me a line to receive this card.

Thanks to all those members who send updates and kind messages regarding your progress with TN. One member in Vancouver celebrated her 99th birthday this past August, a belated happy birthday Jean Craig.

Please be advised I will be taking an annual winter trek to the Californian Desert from mid Dec to early February, my mail box will be cleared daily however receipts will not be issued until my return.

Season Greetings.



THANK YOU!!!

TNAC would like to thank everyone who donated both financially and with their time in 2012 in support of TN. I would especially like to thank Ann and Joya, my two fellow board members, for their time, work, and encouragement, as we together work to move TNAC into 2013. Joya is our treasurer. She spends many hours each year sending out new member information packages, member renewal notices, tax receipts, as well as working on our annual tax return with CRA. Ann helps me with the newsletter including the mailing of the newsletter. She helps people who are interested in setting up new support groups and also speaks and emails those who have questions about TN. Both of these women volunteer their time to TNAC as do I. In fact TNAC is one hundred percent volunteer organized and run.

I would also like to thank Marion and Elizabeth for their work as support group leaders. Your time with members in your community is greatly appreciated!

If you would be interested in starting a support group where you live please let us know. Support groups do not have to be large groups or formal meetings. They can be small groups of even 3 or 4 people who get together for coffee to talk, share, and encourage each other. Groups may also be larger and meet on a formal basis with speakers presenting on topics related to TN. Basically you are able to develop the structure and format of the group in order to develop a group that meets the needs of the people in your community!

We also know that in some areas there are just not enough people for a group to get together. Ann and I are available to provide phone or email support to people across Canada who need someone to talk to about trigeminal neuralgia.

In an effort to support people across the country and provide increased access to information on TN we are excited to have Dr Kaufmann, Dr Honey and Dr Hodaie offer to donate their time to TNAC in 2013 in presenting webinars for our members. I encourage you to take advantage of this opportunity to listen to these doctors and to learn more about TN. If you know of anyone with TN who could benefit from this opportunity please do encourage them to join TNAC and be a part of this great opportunity.

Thank you again to the TNAC board and our support group leaders!

Jane McLaren, TNAC Board
President



*Wishing you a Merry
Christmas and a happy and pain
free new year!*

Ann. Jane and Joya
TNAF Board of Directors