Your Questions Answered

PARKINSON'S

Q Parkinson's is affecting my speech. What can I do about this?

DR. LISA M. SHULMAN ADVISES:

A People with Parkinson's disease often develop speech problems. The most common is reduced volume of speech, but slurring can also occur. Because Parkinson's slows down body movements, it reduces facial expression and diminishes body language—both of which exacerbate communication problems. People with Parkinson disease often aren't aware that they are speaking in an unusually soft voice.

One option for these problems is the Lee Silverman Voice Treatment (LSVT), a specialized speech therapy program that focuses on training people with Parkinson disease to amplify their voice. Studies have shown that this program is effective. Since LSVT requires special training, ask your neurologist or local speech therapist if she is aware of therapists who have received the LSVT training.

At times, a soft voice or slurring may also be corrected by Parkinson's disease medications such as levodopa or the dopamine agonists. These drugs reduce the slowness and stiffness associated with the disease and may amplify the forcefulness of the voice. Sometimes, when someone is already on a lot of medication, his or her speech may become unusually rapid and garbled. This can occur in tandem with involuntary restless movements (known as dyskinesia) as a result of long-term therapy with medications for Parkinson's. To sort this out, it helps to record in a diary the times of day your speech is most affected. You can then observe how your speech is affected by the timing of your Parkinson medications. With this information your neurologist will be able to give you the best possible advice.

Lisa M. Shulman, M.D., is associate professor of neurology at the University of Maryland School of Medicine and co-director of the University of Maryland Parkinson's Disease and Movement Disorders Center.

SLEEP

Q I've read that the sleep drug zolpidem (Ambien) is causing some people to do outrageous things while sleeping, such as driving and binge eating. Should I stop taking this drug?

DR. MICHAEL THORPY ADVISES:

A No. There have only been a few cases of people who have taken zolpidem and reported an abnormal response. Therefore, your decision to stop the medication should only be guided by your physician.

Keep in mind that with zolpidem, you need to be prepared for seven to eight hours of sleep. Unfortunately, some people take the drug before they're ready for bed. One common scenario is that a person will be out late at night and think, "It takes a little while for the drug to kick in, so if I wait until I get home to take my sleeping pill, I'm not going to get enough sleep before I get up in the morning." The person will then take the drug before he or she even gets home. This is not appropriate. You should only take a sleep med around the time you plan to turn in for the night, and you need to be in the appropriate environment for sleeping. If not, there is a chance you will do things and then have no memory of doing them.

When people do these "outrageous" things—drive in their sleep, for instance—they are actually awake and alert. People taking drugs like zolpidem aren't getting into accidents because they're driving while sleeping. The problem is that the next day, they have no memory of having driven. So-called "Ambien drivers" and "Ambien eaters" are experiencing amnesia brought on by drug-induced sleep. Sleep can sometimes cause a kind of amnesia regardless of whether one takes a sleep med, but it is possible that zolpidem adds to the effect.

Michael Thorpy, M.D., is an associate professor of neurology at the Albert Einstein College of Medicine and director of the Sleep Disorders Center at Montefiore Medical Center in the Bronx, NY.

ADHD

Q Are there any effective alternatives to medication for my son's attention-deficit disorder?

DR. LAWRENCE BROWN ADVISES:

A A diagnosis of ADHD (attention-deficit hyperactivity disorder) implies significant difficulties with attention, hyperactivity, or impulsivity in multiple settings—difficulties that go beyond appropriate development expectations for that child, interfere with the child's life, and cannot be medically explained in any other way.

A child who is having academic trouble should first be evaluated with psychoeducational testing and treated with learning support. Even when a child fulfills all of the criteria for ADHD, medication should not be the first or only treatment. Behavioral management in school may include selective seating and a behavior chart using appropriate rewards and consequences. The behavioral approach is even more important for preschoolers because hyperactivity and social difficulties are less likely to be specific to ADHD at that age. If behavioral management hasn't completely resolved the child's problems, pharmacological treatment is by far the most effective approach, and it has a long history of safety and efficacy.

If you are trying to avoid stimulants or other medications, there are alternatives. Some studies have shown that a diet that eliminates foods containing dyes and preservatives may control ADHD symptoms, especially in younger children from families with a history of food allergies and migraine.

You could also try relaxation training and other mind-body approaches. Most other alternative approaches should be avoided because they remain untested or unproven. These include dietary supplements (essential fatty acids or herbal preparations), homeopathy, biofeedback, massage, vestibular training, and antifungal therapy. Megavitamins are probably ineffective and possibly dangerous, as they can cause nerve injury and liver damage. Lead chelation, thyroid treatment, and nutrient replacement may also be ineffective or dangerous except for those rare children whose ADHD symptoms are actually caused by lead poisoning, thyroid disease, or nutrient deficiencies. Non-traditional therapies may delay appropriate treatment and many have their own risks, so speak to your neurologist before experimenting with any of them.

Lawrence W. Brown, M.D., is associate professor of neurology and pediatrics at Children's Hospital of Philadelphia.

LYME DISEASE

Q What kinds of neurological problems can be caused by Lyme disease?

DR. JOHN J. HALPERIN ADVISES:

A The typical starting point of Lyme disease is a bite by a small hard-shelled tick. The wound often goes unnoticed because ticks are small and inject local anesthesia when they bite. The hallmark sign of the disease is a red skin rash called *erythema migrans*. The rash can appear any time within the first 30 days after the bite. When an infected tick bites, it can inject Lyme bacteria (known as *Borrelia burgdorferi*) into the skin. As the bacteria spread from that primary site, they may cause flu-like symptoms, including a low-grade fever, aches and pains, and a headache.

What happens next depends on where in your body the bacteria go and how you react to them. About 10 percent of infected people will get meningitis, which can include a severe headache with flu-like symptoms. If left untreated, this bacterial infection can cause loss of muscle tone on one or both sides of the face (thankfully, this facial nerve paralysis is almost always reversible). Between 5 and 10 percent of people will experience pain in the distribution of a nerve root (called *Lyme radiculitis*) either in a limb or in the chest and abdomen. This feels similar to when you get a pinched nerve in your neck or back, except with Lyme disease, the pain is due to inflammation instead of pinching. Also, patients with a Lyme infection that has been left untreated for many months or even years can get arthritis.

Some people will also experience encephalopathy as a general reaction to the infection. You may feel mentally drained, lethargic, and unable to concentrate. About one person in a million will get brain or spinal-cord inflammation, which can cause more severe neurologic problems but is usually responsive to treatment.

Remember that ticks only bite when the weather is reasonably warm, so these symptoms will usually occur between spring and fall and only in defined geographic regions. Ticks live in grassy regions—such as suburbs and rural areas—along the eastern seaboard, in the Midwest, and in Northern California.

John J. Halperin, M.D., is medical director of the Atlantic Neuroscience Institute and chair of neurosciences at Overlook Hospital in Summit, NJ.

DO YOU HAVE A QUESTION TO ASK THE EXPERTS?
Send it to neurologynow@lwwny.com