

YELLOW PAGES OF SLEEP, MOOD & PERFORMANCE

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SLEEP & HEALTH

9700 North Kenton Ave., Skokie, IL 60076 Tel. 847.673.7660 Fax 847.673.8719 E-mail: sleephealth@aol.com

THE DEFINITION OF GOOD HEALTH:
RESTFUL SLEEP AND PRODUCTIVE ALERTNESS

SLEEP HEALTH IS A NATIONAL PRIORITY

By: *Dr. Alexander Golbin*

“There is no part of society where sleep disorders and sleep deprivation are not serious problems and there is no component of society where there is adequate awareness about sleep disorders and sleep deprivation.” This is a statement by “The Father of Sleep Medicine,” Dr. William C. Dement, Chairman of the National Commission of Sleep Disorders Research and Director of Stanford University’s Sleep Disorders Center. With the pivotal role of Dr. Dement’s public advocacy, awareness about sleep disorders became a major public health issue and the focus of a national movement.

According to epidemiological studies, between 25 and 80 million people in America are suffering from severe sleep disorders. Surveys by the Gallup Poll organization concluded that about 36 percent of all adults complain of sleep problems. The social cost is tremendous and seldom fully appreciated. In 1990 alone, the direct cost of sleep disorders and sleep deprivation was estimated at \$15.83 billion—greater than that of AIDS and cigarette smoking. According to the Highway Safety Commission, 40,000 people die and another 250,000 are injured annually in sleep related injuries on the nation’s roads.

In recent decades, the government has taken

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WELCOME TO CHICAGO

The 17th Annual Meeting of the Associated Professional Sleep Societies returns to the great city of Chicago, from June 3rd through June 8th, 2003. The meeting commemorates the 50th anniversary of the discovery of REM sleep by Eugene Aserinsky and Nathaniel Kleitman at the University of Chicago. It is also a historic joint meeting with the World Federation of Sleep Research Societies. This combination of special circumstances ensures that this will be the biggest APSS meeting ever. The scientific program will include sessions designed to highlight the progress made in the fields of sleep science and sleep medicine since the discovery of REM sleep, beginning with the scientific keynote presentations by William C. Dement, M.D., Ph.D. and Michael Jouvet, M.D. at the opening session. The program will also feature presentations of the best and most recent basic and clinical sleep science from around the world.

PEOPLE OF THE MONTH



Dr. Roger Broughton
A Star of Sleep Medicine
Founder of Canada’s first sleep
medicine clinic

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Dr. William Charles Dement
Father of Sleep Medicine
Founder of the world’s first sleep
medicine clinic

See Page 3



Michael J. Thorpy, M.D.
Director of the Sleep-Wake
Disorder Center at Montefiore
Medical Center in New York

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CHILDREN & FAMILY

BEDTIME PROBLEMS IN CHILDREN

By: Boris Lelchuk, M.D.

Bedtime problems in children are known to many parents. They are different in each age group and take many forms. In infants, there are problems adjusting to external clocks, difficulty with transitions from wakefulness to sleep, and internal problems (colic, teething, etc.). In older children, there can be problems with limit setting, presleep hyperactivity, mood swings, agitation and confusion with body needs. In adolescents, it is an evening increase in energy, an urge to socialize and a heavier workload. In many situations, unfortunately, bedtime becomes a war zone and a power play.

Almost all parents agree that over permissiveness or military type discipline does not work. What is left is an ability to observe and understand the child's particular needs and wisely use a "soft", but "firm" age appropriate approach to set limits.

An age appropriate approach means that it would be ridiculous to start disciplining a four-month-old infant who is unable to fall asleep and gets on the parents nerves with his insistent crying. When the child is one-year-old; however, you can start being somewhat



more adamant about bedtime routine. The earlier parents develop comfortable presleep rituals, the easier it will be for the child to internalize them.

Many children also have their own rituals based on their specific internal needs: some rock or sing, others cannot fall asleep without holding a parent's hand, still

others need to toss for a minute. These children will quickly "train" parents to follow their rituals. If the rituals are acceptable, parents just follow them to make children fall asleep. If the child's behavior is not acceptable, do not fight, but learn to prevent it. For example, when a 3-5-month-old baby is crying and cannot fall asleep, and you observe multiple arm and leg jerking, try to reinstate the pacifier and do not be afraid to softly swaddle the child, because at that age, such movements are frequently involuntary and wake them up like sleep starts in adults.

An older child's sleep onset may be associated with certain objects (i.e. blankets, toys), or they may need to rock or have lights or music. A shower or a drink of a sweet juice might help presleep hyperactivity in preschoolers. Physical contact, such as hugging or back patting, a presleep talk, story telling or a lullaby may help with anxiety.

Children need firm enforcement of schedules, but with teenagers, a more "diplomatic" method may be needed to make them follow the rules.

Good luck! If you need additional assistance, talk to a Child Psychiatrist or Sleep Specialist.

NIGHT TERRORS IN CHILDREN— THE SLEEPING "HURRICANE ANDREW"

By: Alexander Golbin, M.D.

Andrew's parents brought him to a psychiatrist out of desperation. Although they loved him dearly, his parents had taken to calling him "Hurricane Andrew", because of his severe sleep disturbance.

"We can't take it anymore," they cry. "During the night, in the middle of a restful sleep, he suddenly starts to scream bloody murder. The entire apartment building is awakened. He fights, kicks and screams in a high-pitched voice. He sweats, looks around wildly, and doesn't seem to recognize anyone. A short time later, he calms down by himself and goes back to bed. After that he is okay, but we cannot go back to sleep, we lay in bed waiting for another episode. In the morning, he does not remember anything. This happens several times a night, every night.

This is a typical story of a child with what is referred to in Sleep Medicine as night terrors.

Night terrors are a part of a large group of paroxysmal phenomena. The term "paroxysm" originated from the Latin word paroxysms, which means "sudden attacks". This is a key word joining very different phenomena into one group. In the course of a seemingly calm sleep, there is the sudden appearance of a symptom with a short-lived, but dramatic outburst, after which the person returns to a quiet sleep or simply wakes up. The next day, the person has no recollection of his nighttime activity.

Some of the most well known paroxysms are: night



terrors, nightmares, sleepwalking and sudden somatic symptoms, such as headaches, stomachaches, bedwetting, nocturnal asthma attacks and complex activity in which the person is reacting to his dreams.

There are two points that should be remembered:

The mild intensity and frequency of many paroxysmal phenomena are a normal and necessary part of their development. Thus, overreactions are not helpful and might actually aggravate the problem.

If this phenomenon becomes more frequent and increases in intensity, do not hesitate to seek immediate help. In adolescents and especially in adults, paroxysmal phenomena are not always benign, but treatment is available.

If you or someone you know has similar problems, look for help. To find a sleep specialist in your area, please, contact us.

Sleep Health is a National Priority

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important steps to meet the challenges of addressing sleep health needs. In 1988 the Congress of the United States passed legislation creating The National Commission on Sleep Disorders Research. Seventy-three Sleep Disorder Diagnostic Codes were added to the International Classification of Disorders (ICD-9). The American Academy of Sleep Medicine trained hundreds of physicians in Sleep Medicine, and Sleep Centers were opened in almost every hospital throughout the country. In serving the needs of Sleep Medicine, an immense new industry was born, the sleep industry, whose scope soon necessitated the creation of the International Sleep Product Association. Multiple patient support groups and associations sprung up, such as the National Sleep Foundation, American Insomnia Association, Narcolepsy Network, Northern Illinois Restless Legs Support Group, The American Sleep Apnea Association and many others.

On the national level we can see tremendous progress in terms of education, research and industry development. The next challenge we face is translating national support into positive change on the local level. Information about sleep hygiene, sleep disorders, different sleep centers and their specialization, and different sleep products has become more available, but mainly through the medium of specifically focused sources. Sleep and Health periodical does its best to simplify the task of seeking out information you need by providing you with a more integrated review of the entire field of Sleep Medicine.

SLEEP and HEALTH is celebrating its 2nd birthday!

PEOPLE OF THE MONTH



Dr. Roger Broughton *A Star of Sleep Medicine* Founder of Canada's first sleep medicine clinic

By: Deena Sherman

Everyone in the field of Sleep Medicine knows the name—Dr. Roger Broughton—if they don't, they don't know Sleep Medicine.

Roger Broughton has been continuously active in both sleep medicine and sleep research longer than anyone else in North America—over forty years. Broughton, 66, is quick with a story and young at heart...in February he married French psychiatrist, Marie-Jose Dealberto.

Broughton opened Canada's first sleep medicine clinic in 1968. He worked at the University of Ottawa for 33 years until his retirement last year and continues clinical work and research at the Ottawa Hospital. His achievements in sleep are numerous. He has published extensively, (including 11 books) and was awarded Career Investigator of the Medical Research Council of Canada over a 29-year span until the program terminated. He is a past president (1972-75) of the Sleep Research Society, founding president (1986) of the Canadian Sleep Society and a recipient of the William C. Dement award for lifetime achievement from the American Academy of Sleep Medicine.

Dr. Broughton's Theory of Parasomnias as partial arousals, proposed in 1968, was a real breakthrough and still holds true today.

Broughton was born in Montreal, to Edith Olwen and James (Jimmy) William Broughton. One could say that Broughton was born with a "science spoon" in his mouth. British born, James Broughton, was a world authority on organic chemistry and director of a laboratory at the National Research Council of Canada.

Having completed his medical degree at Queens University in Kingston, Ontario, Broughton specialized in neurology in Saskatoon. During this time, Dr. Broughton substituted for a doctor in a near-by town, which allowed him to earn enough money to travel Europe where he planned to do research in neurology.

After arriving in England, Broughton chose to work for renowned epilepsy professor, Henri Gastaut, in Marseilles, France. It was via the work on epilepsy that Broughton's interest in sleep evolved—eventually taking over his life's work completely. Gastaut asked Broughton to study whether epileptic children who were having bedwetting or sleepwalking events at night, were having them as part of an epileptic seizure. The answer would affect how the children were treated. (As it turned out, most were having these events outside the seizures.)

Broughton continued to study epilepsy and sleep concurrently for ten years. During that time he made a significant imprint on the epilepsy world. His achieve-

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Dr. William Charles Dement *Father of Sleep Medicine*

By: Deena Sherman

It's hard to imagine a time in sleep research when there were no EEG machines, when polysomnography did not exist and when standard tests, such as the sleep latency test were not yet on the radar screen. That there were different stages in sleep was knowledge yet to be discovered and overnight sleep studies, where they existed, involved a researcher

simply watching a patient sleep.

The man who was instrumental in changing it all, William Dement, M.D., Ph.D., 75, a pioneer in the field, breaking new ground at every turn. It is this that earned him the title "Father of Sleep Medicine".

"I have loved being a pioneer and a leader. There were no precedents or guidance," he said. "Everything had to be established. For example, we did not know that every person had sleep stages just as they have ten fingers."

Dement has been a party to most of sleep medicine's firsts: The recognition of rapid eye movement (REM) sleep, seeing the cardiovascular significance of sleep apnea, the acknowledgment of narcolepsy as an important illness and recognition that everyone has sleep stages.

He started the first sleep disorder clinic in the world and helped develop polysomnography, as well as sleep latency tests. Watching people sleep all night, rather than diagnosis ending when the lights went out, also has his fingerprints and he also fought to study women, children, infants, and even dogs.

Dement had his hand in the establishment of many societies, organizations and journals, all of which facilitated the push forward of the science of sleep. These include The Academy of Sleep Medicine, The Board of Sleep Medicine, which examines physicians who wish to specialize in sleep medicine and certifies them, the National Sleep Foundation, which promotes education and he is founding co-editor of the premier scientific journal, "Sleep".

Dement is the author or co-author of approximately 500 scientific publications, including the popular overview of sleep, *Some Must Watch While Some Must Sleep*, the authoritative textbook for medical professionals, *Principles and Practices of Sleep Medicine*, the Portable Stanford *The Sleepwatchers*, and most recently *The Promise of Sleep*.

Dement's other huge achievement—his promotion of public education on sleep disorders.

"Research is a fraud if the benefits do not reach the public. Millions of lives could be saved if people only knew about sleep disorders," he said. Dement attributes 38,000 cardiovascular deaths in 1999, to sleep apnea. He says those lives could have been saved if they could have been treated for sleep apnea. "At least half a million

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Michael J. Thorpy, M.D. *Director of the Sleep-Wake Disorder Center at Montefiore Medical Center in New York*

By: Dr. Alex Golbin

It is difficult to believe at first, that this friendly gentleman with a soft voice and charming New Zealand accent is one of the creators of the rigorous policies and regulations that have made sleep medicine a strong science and a respected practice.

Dr. Michael J. Thorpy, native New Zealander, absorbed knowledge from many cultures. He graduated from the University of Otago Medical School (New Zealand), worked as a neurologist in Bombay, India; London, UK; Syracuse, NY and finally went on to become the Director of the Sleep-Wake Disorder Center at

Montefiore Medical Center in New York.

Under his leadership, the Committee for the Diagnostic Classification of Sleep Disorders, in coordination with the American Psychiatric Association (DSM III and DSM IV revision groups), developed an International Classification of Sleep Disorders, the current bible for sleep specialists. As a member of the Governmental Affairs Committee, as a Chairman of the Standards of Practice Committee and, currently, as Chairman of the American Academy of Neurology, Dr. Thorpy uses his organizational skills to promote sleep medicine as an issue.

Dr. Michael Thorpy is one of the most eloquent spokesmen for Sleep Medicine. He has had over 100 national and international television, radio, newspaper and magazine interviews including the "Today Show", "Phil Donahue", "20/20", The *New York Times*, *Washington Post*, *USA Today*, etc. Dr. Thorpy has published approximately 50 scientific papers, 22 chapters and 14 books. His "Sleep Multi-Media", a computerized textbook of sleep medicine, is the most respected textbook in the field and already has five editions. He has the talent to unite specialists from very different fields under the umbrella of Sleep Medicine. In addition, he is vigorously attentive to his patients, students, and colleagues, a devoted family man and an excellent athlete, Dr. Michael Thorpy is admired by everyone who knows him.

ASK DR. SLEEP

NIGHT SWEATS (HYPERHYDROSIS)

Dear Dr. Sleep:

I am a 25-year-old female, and for the last 3 years I have been waking up drenched. I sweat so much it wakes me up. I have tried fans, sleeping without covers and various other things...none were effective. What causes this and what can I do?

Sincerely,

Wet and Wondering

among Japanese, sleep hyperhydrosis is 20 times more frequent than in Caucasians.

Stress related hyperhydrosis (excessive sweatiness) has many forms. There are two-dozen disorders that lead to excessive perspiration including genetics, hyperthyreosis, chronic infections, drug-related sweating and even bloody sweats (haemothidrosis). Most common is axillar hyperhydrosis, which seems to be the case here; the person awakens drenched (probably caused by stress). The good news is that treatment is available. There are specific methods and medications to treat it. Never try self-treatment or medicines that helped your friends; this could lead to serious complications. Consult your doctor or sleep specialist for help.

Dear Doctor Sleep:

I am a graduate student at the University of Illinois and I have Chronic Fatigue Syndrome. It may seem as if these two statements cannot exist in the same sentence, but I

CHRONIC FATIGUE SYNDROME

have found that they can. I liken it to shoveling snow off your driveway with a spatula. Not the easiest task in the world, but with a little planning and effort, it can be done.

The hardest part about having CFS in college is not about letting your advisor or colleagues know your condition, but admitting to yourself that you have this con-

dition. I have found that while associates may not understand exactly what I am going through, they show concern and support when needed. They seem to understand that I am not lazy, but generally fatigued. I have had a harder time learning to pace myself through the day, eating at regular intervals, and allowing myself to rest when I am tired. Finding quiet moments daily has helped me to focus on the tasks at hand and rest when I need it.

Signed,

Learning More Every Day

Dear Learning More Every Day:

Chronic Fatigue Syndrome (CFS) is a modern problem that many young people face. Slow, increasing, debilitating fatigue that does not improve after exercise, is a major barrier for learning or job achievement.

Frequently it is associated with troublesome aches and pains all over the body (fibromyalgia). Doctors are still searching for the cause, but what is known is that the sleep mechanisms are not working properly; sleep is not restful and actually more tiresome. A person who suffers from CFS is not lazy, but a very hard worker, because it takes great effort to overcome the fatigue to do even simple tasks. These people should be respected and helped.

If you or someone you know has these symptoms, contact your doctor or a sleep specialist.

For more information about CFS and treatment, refer to our website at www.sleepandhealth.com.

WHO IS DR. SLEEP?

By: M. Givan

Dr. Alexander Z. Golbin, M.D., Ph. D., clinician and educator, is one of those people who feels compelled to follow a dream and to achieve the dream against daunting odds. Born as a Russian Jew in Leningrad (St. Petersburg) and raised in post-war misery, he experienced first-hand the difficulties of survival without his father, who was a surgeon killed in the war. His mother, also a physician, returned from military duty when Alex was 7-years-old.

Dr. Golbin graduated medical school and was accepted to the Fellowship of the Academy of Science in Leningrad. Instead of attending the Fellowship, by the personal order of the regional party leader, he was sent to practice medicine in Siberia. This was the time and the place, where I became "a real doctor," says Golbin. It was the "Archipelago Gulag" era when the best people and the best doctors were imprisoned or forcefully settled. [He recalled this time as his "University of Survival."]

It was there in Siberia, where he witnessed the sudden death of a boy in his sleep. He was found dead only a few minutes after a normal medical exam. Since that time, the dream to discover the secrets of sleep disorders became the passion of Dr. Golbin's life.

At age 27, he earned a Ph.D. in the Neurophysiology of Sleep from the renowned Pavlovian Institute of Experimental Medicine and went on to become Director of the first Sleep Center in Leningrad's Center for Neurotic Children

and later, Chief Neuropsychiatrist for the families of sailors for the entire Northwest Region of the USSR.

Refusing to be a party member and KGB informer, Dr. Golbin was forced to immigrate.

In the US he re-established his medical education, from internship to fellowships in Adult and Child Psychiatry at the University of Illinois, Sleep Medicine at Rush Presbyterian Medical Center and Stanford School of Sleep Medicine, to Chairman of Child Psychiatry and Sleep Services at Cook County Hospital and now Medical Director of the fully accredited Sleep and Behavior Medicine Institute. He has published two books, *Pathological Sleep in Children* and *The World of Children's Sleep*, and is the editor of an upcoming textbook *Sleep Psychiatry*.

The staff of *Sleep and Health* joins Dr. Alexander Golbin in celebrating the 35th anniversary of his medical career, the second birthday of his creation, *Sleep and Health* and the 50th anniversary of his beloved Sleep Medicine.



**A
NOTE FROM
SLEEP & HEALTH**

Sleep and Health wants to hear from you.

Send your comments, suggestions or stories to sleephealth@aol.com

Look for your submissions in future issues of *Sleep and Health*



ALERTNESS•MOOD•PERFORMANCE

WHY DO WE YAWN?

By: Michael Stern, M.D.

Are you ashamed of having irresistible urges to yawn in front of guests or in an important meeting? I was. I thought that it was a sign of disrespect to the speaker or a signal that the speaker was boring and saying nothing of significant importance. Sure enough, I thought the same way when somebody yawned when I gave my own speeches. I would fight the sudden and irresistible urges to yawn in public, but this urge was often stronger than my willpower.

I tried to research ways to fight this problem and I found some very interesting facts. I learned that yawning is a unique breathing act, which is different from the usual practice of breathing. During yawning, the mouth involuntarily opens due to the spasm of mastoid muscles. These spasms, without your permission, force you to take a deep breath. It also involves many other



muscles of your body, such as abdominal muscles. Lung ventilation increases, sending oxygen to the brain. Extra

blood is pushed from the liver and spleen to the brain stem. During yawning, intellectual activity stops and for a moment we cannot think. We usually start yawning when we are very tired, before sleep, when we are too excited, or extremely serious.

There is a yawn center in our brain that makes this act a reflex like coughing or swallowing. The yawning reflex is very contagious, forcing people to imitate it. This phenomenon even has a fancy name: *alolomimea*. "The yawning reflex has a good memory," a German professor, Professor Knoxblat, once told me. Yawning can be easily conditioned to become a bad habit. If you fight the urge to yawn, it will return in a similar situation. Yawning is what your body develops to get a "time out" to recharge for a brief moment. It is a signal that we are running out of gas, it is a signal to rest. This is a great compensatory mechanism, without which we would drop into sleep suddenly without warning, as in patients with narcolepsy.

What is the point of this story? We should not interpret it negatively. It is not a signal about somebody else's stimulus value. It is a signal to yourself that you are very tired. Next time, try to get a good night's rest before an important meeting, so you will not be ashamed when it happens.

Dr. Charles Dement

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have died since I have had the knowledge of what to do to save them," he said.

Likewise, the diagnosis of narcolepsy is extremely slow—up to 15 years from the onset of symptoms. It is another source of frustration to Dement who knows how a patient's suffering could be alleviated with quick diagnosis.

Of the future of sleep research, Dement, who is still very active in the area, says the important thing to find out is what the sleep states—REM and non-REM—do. On a gut level he says he thinks that non-REM sleep is the state that reverses sleepiness, but that has not been proven, he says. He describes REM and being in a dream world as synonymous. "The brain is very active, the way it is when it is awake," says Dement who is famous for the quote: "Dreaming permits each and every one of us to be quietly and safely insane every night of our lives."

When Dement gives lectures he always shows a slide of the Grand Coulee dam, one of the biggest dams in the world. He compares the water being held by the dam wall as the knowledge that is being withheld and the trickle going into the river as what is being allowed out. It is in this area of knowledge transfer that he sees much of his future work (someone's got to do it, he says). He continues to urge a "mainstream federal effort in education of the public in sleep disorders and their dangers."

William Dement retired from the teaching arena at Stanford in March. It was a joyous occasion with the 900 students who took the course plus hundreds more friends and former students packing the Memorial Auditorium. Over 15,000 have taken the class, called "Sleep and Dreams" since he started teaching it 33 years ago. The finale featured members of the Stanford Band playing in their pajamas and students chanting his catch phrase "Drowsiness is Red Alert" appreciatively.

It was a farewell acknowledging a dedicated Stanford teacher who hopes to still make the whole world his class.

SLEEP AND THE SENSES

SLEEP AND THE SENSES

By: Dr. Peter Dodzik

A part of our commitment to new and innovative approaches to sleep, alertness, mood and performance, Sleep & Health has added a new periodic section called "Sleep and The Senses." This section is devoted to coverage of the relations between sensory perception and sleep-wake states.

SLEEP AND SMELL

Proponents of aromatherapy have frequently touted the use of Lavender as an aid to promoting sleep and relaxation. So much so that companies like Johnson & Johnson have developed Lavender baths to aid children in relaxation before bedtime. But does Lavender actually cause any changes in states of arousal or is it just a pleasant fragrance?

According to a 1998 study published in the International Journal of Neurosciences, adults exposed to rosemary showed decreased frontal alpha and beta power, suggesting increased alertness. They also had lower anxiety levels and performed math computations faster. Adults exposed to lavender showed increased beta power, suggesting increased relaxation. They performed math computations, not only faster, but also with fewer errors and had less of a depressed mood.

Since biblical times, other sources have sighted the use of Lavender as a relaxation aid. Lavender has been used in the treatment of headaches due to muscle tension and as an aid in healing minor cuts or abrasions. According to some research, lavender essential oil may be as effective as certain barbiturates in treating sleep disorders.

How to Use Lavender

The following are recommended adult doses for lavender:

- Tea: 1 to 2 tsp whole herb per cup of water.
- Tincture (1:4): 20 to 40 drops three times a day.
- Inhalation: 2 to 4 drops in 2 to 3 cups of boiling water; inhale vapors for headache, depression, or insomnia.
- Topical external application: lavender oil is one of the few oils that can be safely applied undiluted. For ease of application, add 1 to 4 drops per tablespoon of base oil.





DRAMATIC PARASOMNIAS

NOCTURNAL EATING SYNDROME

By: Dr. Alexander Golbin

Nocturnal Eating Syndrome is a serious medical problem that needs proper diagnostic evaluation. Treatment is available.

In the middle of a bitter divorce a 49 year-old physician suddenly found himself waking up in his kitchen, in the middle of the night, consuming large amounts of food from his refrigerator. He had no memory of walking to the kitchen, he ate normally and was not hungry. These episodes began happening with increased frequency and eventually were a nightly ordeal. He was consuming food, which he did not like or food that was not completely cooked. Within 6 months, he had gained 35 pounds and began to show signs of depression.

This man is suffering from a sleep-related disorder

called Nocturnal Eating Syndrome (NES). According to the recent international Classification of Sleep Disorders, NES is characterized by recurrent awakenings associated with eating or drinking. Stunkord, Grace, and Wolff first described NES in 1995. They studied a group of obese adult patients with nocturnal hyperphagia (overeating), insomnia, and daytime anorexia. These researchers believed that the disorder could be linked to the cause of the patients' obesity and represented a response to stress factors. However, in spite of increasing worldwide interest in eating disorders in general and the disease's relevance to obesity, NES is still largely unknown to the public.

Recently, large studies on NES were performed in Italy by the University of Rome, as well as by a Minnesota group of scientists. They discovered that, on

average, patients with NES have the onset of the disorder at about 37 years of age and have 3 or 4 episodes per night. The ratio of men to women is about equal. Possible factors include transitional life events, such as divorce or other stress related issues. Most people with NES awaken during nocturnal episodes exhibiting compulsive behavior to obtain food. Sometimes they are not completely awake, which is evidenced by their display of unrestrained compulsive and aggressive behavior, in contrast to their daytime personality. The food seeking drive is described as an urgent-abnormal need to swallow food with an absence of real hunger. Large amounts of food can be ingested during the night. One person described her typical nocturnal meal as consisting of 6 slices of cake, 2 fruits, 1 large chunk of cheese and 2 large cups of milk.

Research has led to a description of thirteen noticeable features of Nocturnal Eating Syndrome:

1. No complaints of abdominal pain or nausea.
2. A rapid (automatic) rise from bed and rush to the kitchen with a wide range in the level of consciousness.
3. No expression of hunger.
4. A tendency to drink thick fluids or consume thick food.
5. No alcohol consumption.
6. Consumption of foods that are not of their preference during the daytime.
7. Never purge.
8. Only 20% are smokers.
9. Eating did not change during weekends or vacations.
10. Usually develops from occasional nocturnal eating to nightly events.
11. Medical and neurological evaluations usually were unremarkable.
12. Psychiatric problems, including bulimia or anorexia were not typical, except for some kinds of depression.
13. All patients are well functioning adults.

It is important to emphasize that Nocturnal Eating Syndrome does not mean that the person is mentally sick or weak. NES is predominantly a medical problem associated with sleep disorders, such as parasomnias. Thirty to sixty percent of patients have other sleep disorders including somnambulism, for example. An identified part of the brain is responsible for NES, the hypothalamus. Methods of controlling the disease have been found, and treatment is available. Positive results were obtained by using medications that calm the hypothalamus from different angles: Serotonergic (D-fenfluramine), benzodiazepines (Clonazepam), dopaminergic (Sinemet), or other mixes of medication.

If you, a family member or friend display nocturnal eating symptoms, be aware of the possibility of sleep related Nocturnal Eating Syndrome. Seeing a doctor is highly recommended under these circumstances.

YOUNG DIABETICS DYING IN SLEEP... WHAT ARE THE CAUSES?

By: Michael Zaler, M.D.

A fourteen-year-old boy has a very good day. His soccer team won in a regional competition and everyone made note of his contribution to the team's success on the field. He came home in high spirits, feeling slightly tired. He took his insulin for his stable diabetes, but did not have time to eat his usual snack. He took a shower, ate some fruit and went to bed, making plans for the next day. He had a lot of things he needed to get done. The next morning when his parents went into his room to wake him, they found him dead.

Why? What caused this young athlete to die so suddenly in his sleep? This phenomenon is known as the "Dead in Bed Syndrome." Sudden unexplained death in sleep is not a rare occurrence, sudden death of infants in sleep (SIDS), sudden death of teenagers in sleep (Dead in Bed Syndrome), sudden unexpected death of healthy adults (SUDS). These tragic phenomena have been known to physicians from around the world for years, but only recently have they recognized the magnitude of the problem and begun to dedicate major efforts to uncover the causes.

The definition of sleep as rest was dismissed with the discovery of REM sleep about 50 years ago. We now know that sleep constitutes a complex process with cyclic waves of reorganization. These waves may at times be quite stormy. Biorhythms of different body systems go through cycles of synchronization, over-synchronization (similar to resonance in mechanics), or they get out of sync. In sleep, we are programmed to become restored...or to die.

In Great Britain (1989), Drs. R.B. Tattersall and G.V. Gill observed 22 cases of death in sleep of young athletes with uncomplicated diabetes. The researchers suggested the phrase "Dead in Bed

Syndrome." A nationwide study set up in Norway for a 10-year period (1981-1990), reported 240 deaths, from various causes, in young diabetic patients. Another study in Great Britain focused on factors contributing to the deaths of 448 diabetic patients in 1976. From the Norwegian and British data, it appears that the Dead in Bed Syndrome amounts to 5-6% of all deaths in diabetic patients under the age of 40.

The main cause of this dreadful syndrome is a sleep disorder. British researchers, R.J. Weston and G.V. Gill, discovered that in some people with chronic conditions, such as diabetes, the autonomic nervous system is unstable and overactive. This is called autonomic neuropathy. Glucose blood levels become more significant, thus causing nocturnal hypoglycemia, as well as an unstable level of potassium and calcium (hypokalaemia and hypoglycemia). This increases the risk of heart arrhythmias, which may be fatal. These sleep-related turbulences of metabolism are common for many disorders and usually lead to moderate symptoms such as chest pain, heart palpitations, terrible dreams, morning headaches and fatigue. To prevent the deterioration of these sleep-related symptoms, it is important not to ignore them, but to inform your doctor about them immediately, follow up scheduled treatment and consult a sleep specialist to evaluate the results of your sleep study.

The good news is that specialists in sleep medicine now know what causes the problem and how to prevent it from deteriorating and becoming life threatening.

The information in this article is not an advertisement. Consult your physician. Self-treatment may be dangerous.



TRADITIONAL & ALTERNATIVE MEDICINE

EPHEDRA: DANGEROUS OR SAFE?

By: Mark Jacobs, R.Ph.

Arshad Gazi, Pharm D. Candidate
University of Illinois

Ephedra is available in many forms, in herbal products such as teas, diet aids and bodybuilding products. The Chinese have used this herb for over 5,000 years, to treat asthma and reduce upper respiratory infections. Pseudo-ephedrine is a chemical compound that is similar to Ephedra. Both ephedrine and Ephedra stimulate the sympathetic nervous system, causing vasoconstriction of the blood vessels in the lining of the nose. They also dilate the bronchial tubes and stimulate the heart.

Known for the sense of well being reported by its users, the herb tea has been used as a health tonic, a natural stimulant and an appetite suppressant. Believed to be a powerful fat burner, weight watchers have noticed that it makes the body heat up and burn fat (this is known as the thermogenic effect). Ephedra has the ability to open up the adrenergic receptor sites (switches) found primarily in the heart and lungs, thereby increasing the metabolic rate and calorie consumption. The net result is release of fatty acids from stored fat cells and a quicker consumption of the fat into energy. When Ephedra is combined with a modest amount of caffeine as found in green tea extract or Guarana, the thermogenic effects can be improved as much as 20% (optimum ratio of ephedra to caffeine is 20mg to 200mg taken 3 times a day). Ephedra also tends to increase the contractile strength of muscle fibers.

There are four different members in the ephedrine family. The different forms vary in their effects: Nor-pseudo-ephedrine, nor-ephedrine and ephedrine show predominantly amphetamine-like effects. Nor-pseudo-ephedrine can be found in

over the counter drugs that are used as an appetite suppressor. Pseudo-ephedrine, the fourth member, is weaker than the others, but still exhibits amphetamine-like effects and has similar dangers. Its main effect is decongestion due to its vasoconstrictor results. While this can promote drying of the mucous membranes, it can actually precipitate things like a runny nose if one is suffering from congestion.

A serious problem, which exists in nearly all herbal and vitamin products, is label uniformity and content accuracy. Many product labels may specify a certain grade and/or quantity of a product (e.g., Ephedra), but after a chemical analysis, a large variation may be seen. Because of these unknowns, the consumer must be extremely careful before using such products.

It is important to take these drugs as directed by the product label in order to avoid catastrophic events. Over the last few years, several athletes have died after taking too much Ephedra. It is time that the U.S. government allows the Food and Drug Administration (FDA) to take control over vitamins, herbs, diet aids and other products to ensure safety and efficacy. At the very least, the FDA should mandate product label accuracy and integrity. In theory, this would increase safety margins and therefore decrease possible morbidity/mortality.

According to industry estimates, Americans use more than 3 billion doses of ephedra products each year to alter their weight or sports performance. The Food and Drug Administration is calling for bottles of the popular herb to bear warning labels informing the public that the pills can cause heart attacks, strokes or even death. It would also carry a warning for athletes, stemming from the circumstances surrounding the death of Baltimore Orioles pitcher, Steve Bechler.

The FDA can remove the product from the market only if they can prove that it presents risk to public health.

KAVA KAVA

By: Dr. Peter Dodzik

Kava Kava is an herb that is a member of the pepper family, which grows as a bush in the South Pacific. It is said that the explorer Captain James Cook gave this plant the botanical name of the "intoxicating pepper". However, Kava has been used for over 3,000 years for its medicinal effects as a sedative, muscle relaxant, diuretic and as a remedy for nervousness and insomnia.

People in the South Pacific use the herb in traditional social gatherings as a relaxant and in cultural and religious ceremonies to achieve a higher level of consciousness. The roots can be made into a mildly narcotic beverage that is comparable in effect to popular cocktails consumed during western gatherings. Kava Kava has been used in Europe as a nonprescription drug to reduce anxiety. Kava was first mentioned in scientific records in 1886 and it is gaining popularity in the US for its relaxing effects. Kava also is effective as a pain reliever and can be used instead of aspirin, acetaminophen and ibuprofen.

Recent clinical studies have shown that the herb kava is a non-addictive anti-anxiety medicine and some studies have indicated that it is as effective as prescription anxiety agents containing benzodiazepines, such as Valium. According to herbalists, while benzodiazepines tend to promote lethargy and mental impairment, kava has been shown to improve concentration, memory and reaction time for people suffering from anxiety.

Kava is mildly narcotic and produces mild euphoric changes characterized by elevated mood, fluent and lively speech and increased sense of sound. Higher doses can lead to muscle weakness, visual impairment, dizziness and drying of the skin. Long-term use of the herb can contribute to hypertension, reduced protein levels, blood cell abnormalities or liver damage. Alcohol consumption increases the toxicity of the pharmacological constituents. It is not recommended for those who intend on driving or in situations where quick reaction time is required.

Please consult your physician before using any herbal or over-the-counter medicines to determine if they are safe for your use.

Kava Kava



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ART & SLEEP

By: Deena Sherman

If you are visiting Washington before November 30, be sure to take in the exhibition, *Insomnia: Landscapes of the Night*, currently on at the National Museum of Women in the Arts.

The show features 30 women artists united by their sleeplessness and bound by the creativity that results. The 53 pieces include paintings, drawings, prints, installations and artist's books. Though they vary greatly in their medium, they all explore the influence of the night on perception, imagination and the creative process.

Six out of every 10 insomniacs are women. The idea for the exhibition was probably thought up during the night by curator Krystyna Wasserman, who is herself an insomniac. It took Wasserman three years to collect the pieces, researching it by visiting artists' studios and exhibitions tries. She says putting the show together was cathartic.

"I wondered what artists did during the night when they don't sleep," said Wasserman. "I found nighttime wanted to por-arily a horrifying time, but that it can be a creative experience," she said.

The exhibition features 91-year-old artist, Louise Bourgeois, who has pro-

ART,

Women



**BARBARA LEVENTHAL-STERN'S
THE MERMAID'S PROOF, 1997.**

War and violence, so much a part of our collective history, have seared the memory of Barbara Leventhal-Stern, often making sleep impossible. The Mermaid's Proof evokes the horrors of the Holocaust, a mind-numbing reality made surreal by its monstrosity. Leventhal-Stern's mermaid sleeps atop a pile of discarded shoes, remnants of those who lost their lives in the concentration camps. She is embraced by a tiger—Leventhal-Stern's indictment of humanity's brutality. The tiger is not the beast here.

and Sleep



Photographed by: Lee Stalworth

Bonnie Lee Holland's Bedroom (1997-2002) installation is about the desire for love—another cause of insomnia. Here, a bed constructed of cardboard boxes, garbage bags, and discarded newspapers is covered with a quilt stitched from the personals as well as specific articles about aging, women's perceptions of themselves and relationships found in The New York Times, The Wall Street Journal, and The Washington Post. Their directness and simple messages to potential respondents appeal to lovelorn readers. While newspapers have primarily an ephemeral value for most, Holland's use in Bedroom gives them an intrinsic value as art. The bedroom quilt is a fantasy, but one tainted with strong feelings and acute observations of how love is lost and found. Sewn by the artist during sleepless nights, the quilt reconfigures words and images in a formal design that bares the artist's soul. A night table perched on a pile of romance novels adds to the atmosphere of anticipation. The empty bed is an invitation to love.

Bonnie Lee Holland was born in Chicago. She describes her insomnia as a rich place, a place full of ideas and for thinking things out.

duced her own collection called "The Insomnia Drawings", one of which is on exhibit at the National Women's exhibition.

"The state of being asleep is a paradise...a paradise that I can never reach," said Bourgeois, who revisits major themes from her life's work in her nighttime chronicles. On more than 220 scraps of paper, using blue, black, and red ballpoint pens, she has kept a visual and verbal diary of her sleepless nights between November 1994 and June 1995, and again in 2000 and 2002.

"I still try to conquer the insomnia, and to a large extent I have done it; it is conquerable. My drawings are a kind of rocking and stroking and an attempt at finding a kind of peace. Peaceful rhythm like rocking a baby to sleep," she said.

Genie Shenk's artist's books in the exhibition record her dreams from 1998 to 2001. Shenk has been an insomniac since she was a child.

"Even now," the artist says, "getting to sleep is like descending a very long and winding staircase; a single unexpected noise can send me back to the beginning."

Shenk's most productive hours are those before dawn—a time, she says, for drifting in and out of dreams, entertaining outrageous images, and exploring the unconscious.

Wasserman puts it aptly: When darkness envelops the world and the sky is aglow with stars, instead of falling asleep, the artists fall into the warm embraces of their muses. After a night spent working on their creations, these women find that they can finally rest."



SLEEP MEDICINE PRESENTS...

Do You SLEEP WELL?

By: Lena Belsky

There are at least 84 sleeping and waking disorders that lead to a lowered quality of life and are dangerous to your health. Sleep disorders include:

- Difficulty falling asleep or maintaining sleep (persistent insomnia)
- Snoring and Breathing stops and restarts (Sleep Apnea Syndrome)
- Nocturnal chest pain and heart arrhythmias in sleep
- Excessive daytime sleepiness, chronic fatigue, falling asleep while driving
- Morning headaches, depression and even weight gain
- Sleepwalking, bedwetting, nightmares...and many others.

An interest in sleep and dreams has existed since the dawn of recorded history. Sleep Medicine, as a separate field of medicine; however, began just 50 years ago when two American doctors discovered the REM stage of sleep, which they called "paradoxical sleep." In this stage of sleep, almost everything that we thought we knew about sleep, became just the opposite; eyeballs started to jerk, heart rates quickened without apparent reason, brain waves became similar to active thinking, metabolism sped up; in short, all body functions became irregular, out of sync, and surprisingly active.

So sleep is not just a "time out" from daily life. It is an active state, important for renewing our mental and physical health each day of our life. Statistics say that more than 100-million Americans, of all ages, fail to get a good night's sleep.

The clinical recognition of the unusual pathology of sleep led to the recognition of Sleep Medicine as a respected medical field. Sleep Medicine is still a growing field, new subdivisions have appeared, such as Sleep Dentistry, Forensic Sleep, and Sleep Psychiatry.

During these fast growing years, many Sleep Centers opened across the country, one of them, the Sleep and Behavior Medicine Institute (SBMI), fully accredited by AASM and affiliated with several hospitals, opened a second location in Bannockburn, Illinois several months ago. (The original location of SBMI is located in Skokie and has been successfully treating patients with sleep



disorders for 6 years.)

The Sleep and Behavior Medicine Institute is dedicated to the diagnosis and proper treatment of sleep disorders. The Bannockburn location is unique, first of all, because of the team of professionals who work at the facility including psychiatrists, pulmonologists, cardiologists and psychologists. Additionally, it has state of the art equipment, which allows diagnosis of all sleep disorders that afflict children and adults. SBMI offers the patient immediate treatment after diagnosis and stays in close communication with the patient's referring and primary care physicians.

In just a short time, the Bannockburn Sleep Center team will have an ailing patient scheduled for a Sleep Study, (Polysomnography Overnight Test), in a furnished, modern facility and on their way to successful treatment for their sleep disorder. The Bannockburn location of SBMI is fast becoming one of the most popular sleep centers in the area. Patients are coming from all of the neighboring suburbs—Highland Park, Lake Forest, Deerfield, Northbrook, and others.

All of the physicians on staff at SBMI are board certified sleep specialists by the American Academy of Sleep Medicine. The Medical Director and founder of SBMI is Alexander Golbin, M.D., Ph.D., a well known Sleep Specialist and Psychiatrist in the Chicago area. He is currently an Assistant Professor of Psychiatry at the University of Illinois and was the former Chairman of Child Psychiatry and Sleep Services at Cook County Hospital for

12 years. He specializes in the diagnosis and treatment of insomnia, parasomnias and pediatric sleep disorders.

In addition to Dr. Golbin, the team at

the Bannockburn Sleep Center includes two Pulmonologists from the group Pulmonary Physicians of the North Shore, also located in Bannockburn. Neil S. Freedman, M.D., is board certified in pulmonary, critical care and sleep medicine. He came to the North Shore area from the faculty of the prestigious PENN Center for Sleep Disorders at the University of Pennsylvania School of Medicine in Philadelphia. Dr. Freedman continues to lecture on a national level for the American College of Chest Physicians on various sleep-related topics. He is also the Editor of the Pulmonology section of "Sleep & Health". Finally, Scott Field, M.D. is the newest addition to the sleep care team at SBMI. He is board certified in pulmonary, critical care and sleep medicine.

Early observations of Sleep Pathology are very important. Fortunately, working closely with your healthcare professional can solve your sleep problems.

SLEEP AND BEHAVIOR MEDICINE INSTITUTE & PULMONARY PHYSICIANS OF THE NORTH SHORE Accredited by the American Academy of Sleep Medicine



Neil Freedman, M.D.
Diplomate of The American
Board of Sleep Medicine



Alexander Golbin, M.D., Ph.D.
Diplomate of The American
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SLEEP NEWS FROM AROUND THE WORLD

SLEEP AND MEMORY IN ELDERLY



By: Leonid Kayumov, Canada

SLEEP DISRUPTION IN ELDERLY

It has been well established that the prevalence and intensity of many sleep disturbances increase with age. Occasional sleep complaints are noted by 40% of older individuals. Disruption of sleep in those greater than 60 years of age may be a result of retirement, changes in social patterns, death of a spouse or close friends, increased prescription and over-the-counter medication use and/or changes in circadian rhythms. In this population, night sleep is shorter and less consolidated in comparison to younger adults. Older adults also have an increase in waking after sleep onset and sleep fragmentation. A common sleep complaint in older adults is insomnia. Factors that can disrupt sleep are nocturia, leg cramps, pain, coughing or difficulty breathing, temperature sensitivity and dreams. Other contributing factors may be increased incidence of physical or mental disorders, declining physical activity, excessive sleep during the daytime, poor sleep hygiene, caffeine or alcohol consumption and poor diet habits in old age.

As one ages, changes during sleep can be observed. These modifications include a reduction in amplitude and incidence of the delta waves during slow-wave sleep (SWS) a decrease in stages three and four (SWS) of the sleep cycle, an increase in the fragmentation of sleep, and daytime sleepiness.

Changes in the circadian rhythms of older adults also seem to play a role in their sleep disturbances. Less regularity in bedtime, awakening time and mealtime as a consequence of retirement, may lead to circadian rhythm disturbances. Older individuals also have the tendency to phase advance, i.e. to go to sleep early and awaken early.

Fragmentation of nocturnal sleep is a major cause of excessive daytime somnolence (EDS). Evidence indicates that poor sleep and sleep disorders may be the cause of

EDS. For example, sleep-related disturbances of breathing causes poor sleep and are the largest group of disorders causing EDS. EDS also results from fragmented sleep, which is common in older adults. Complaints include daytime napping, tiredness and daytime drowsiness. However, increased daytime napping in older adults can lead to frequent awakenings at night and poorer sleep.

MEMORY IMPAIRMENT IN ELDERLY

Learning new information is altered in those over 60. Remote memory remains unaltered until approximately the mid-70s, but recent memory is impaired after that age. Both speed of processing new information and speed of learning is retarded. This can result in impairments in naming people and common objects.

Evidence suggests that poor sleep may impair memory. Sleep plays a potential role in retention of memory and learning new tasks. It has been proposed that sleep plays a major role with regard to newly acquired neural information. The study of the effects of sleep disturbances on memory is significant, because if sleep is relevant to memory processes, then disrupted sleep might be deleterious to older adults. One study found that subjects who learned a list of words and slept prior to re-testing performed better on recognition tasks, in comparison to subjects who remained awake during the delay.

Recent research on animals has noted that neurophysiological mechanisms occurring in SWS may serve memory processes. Thus, the natural decrease in the amount of SWS as one ages may be one of the contributing factors in their memory impairments.

Research indicates that older adults and sleep deprived individuals (young and old) showed memory deficits in cued recall of weakly related pairs of words. Other studies suggest that learning and memory can be impaired by sleep loss. Sleep restriction has been shown to have negative effects on sleepiness and cognitive performance.

Investigations of the role played by sleep in information processing have consistently illustrated that the retention of information is better when the memory storage is followed by a period of sleep than of waking.

Impressions

UNITED STATES

Dr. William Dement praises others' efforts to educate the public on the dangers of sleep deprivation. He says he is very impressed with *Sleep and Health*, saying it is "damn good, the best thing of its nature around."

*William Dement, M.D., Ph.D.
Father of Sleep Medicine*



GERMANY

I regularly receive your journal, "SLEEP & HEALTH." First of all, I would like to congratulate you for this informative and scientific paper, which is very useful for answering topical questions. The journal is a well-selected mixture of news, entertainment and scientific information. In addition, your journal gives very good tips e.g. how to treat screaming babies etc. and is therefore well accepted within family life.

Snoring and apnea are common and serious problems. In your journal, experts give detailed suggestions for treatment and information about products and medications. A wonderful section, which is often mentioned by my colleagues, is "Ask Dr. Sleep". This column is very valuable and allows one to get short, precise answers on serious problems. The "Sleep Information & Services Directory" is also very helpful for finding the right specialist.

I also enjoy the "People of the Month" articles; it gives the featured people the opportunity to publish something about their activities. Thus, a great deal of new and valuable information about sleep is distributed throughout the medical community.

In Germany, such an excellent source for answers from specialists about the serious problems of "SLEEP" does not exist; therefore, we always enjoy getting our copy of this monthly journal. We consider Sleep & Health, more or less mandatory for our monthly reading and recommend it highly to colleagues. This journal has my most sincere approval.

*Prof. Armin Dieterich, M.D., PhD, FACC, FESC
Vice President of R&D PAREXEL International*



ISRAEL



I highly appreciate the appearance of "Sleep and Health" as a unique opportunity for informal, free, open and flexible collaboration between specialists in sleep psychophysiology, psychiatrists and specialists in general medicine. Such collaboration and an exchange of professional information are especially important for the prevention and treatment of psychosomatic diseases. In addition, *Sleep and Health* provides a source for the direct communication between general readers and specialists in sleep medicine in order to elucidate the typical sleep related problems and to make people less anxious about these problems.

*Vadim S. Rotenberg, MD, PhD, DSc., Senior Lecturer at Tel-Aviv University,
biography in "Marquis Who is Who in the World".*

NEWS FROM RESEARCH



RESEARCH DIGEST

Clinical impact and variable distribution of sleep disorders among the epilepsies: It is important for clinicians to view epilepsy in the 24-hour sleep-wake cycle. The major sleep disorder, Obstructive Sleep Apnea (OSA), has been found to be one of the most common sleep disorders in patients with epilepsy. OSA is the cessation of airflow during sleep, because the tongue falls back in such a way that it prevents air from passing through. It lasts at least 10 seconds. Individuals with OSA cannot stay asleep for longer than 30-90 seconds.

Periodic Limb Movement Disorder (PLMD) is another major sleep disorder that can be associated with sleep deprivation and excessive daytime sleepiness. PLMD is defined as periodic episodes of repetitive jerking of the legs, and sometimes the arms, during sleep. Each jerk lasts 0.5-10 seconds and with a typical interval of 20-40 seconds.

Researchers from Tufts University Medical School studied 630 patients to determine the prevalence and severity of OSA and PLMD of sleep. Out of the 630 patients seen, 37% (233) complained of disruptions in their sleep patterns.

The researchers found that 5% of the original population base of 630 had OSA of a moderate to severe degree. They also found that 4% of the population base had moderate sleep disruption that was associated with PLMS. OSA markedly disrupts the sleep architecture of epileptic patients and those with OSA are at an increased risk for higher seizure rates when compared with those in the control group.

Sleep architecture of patients with PLMS was also

altered. The PLMS patients also showed a trend toward increased seizure rates when compared with the controls. They also found that the sleep architecture was most severely disrupted in the OSA group and less so in the PLMS group.

Clinical Updates in Neurology

By: Christopher Naccari, *CNS Spectrums* – May 2003

Anxiety in women appears to be influenced by genetic factors, reported a study in the March *Psychiatric Genetics*. Researchers used DNA analysis, recordings of brain activity, and psychological tests to determine that Caucasian and American Indian women, with the same gene variant, had similarly high scores on tests that measure anxiety. The women also had similar EEGs that showed characteristics of anxious temperament. Researchers investigated a gene that encodes the enzyme catechol-O-methyltransferase (COMT), which

is responsible for norepinephrine metabolism. They found that women who shared the inherited genotype for the polymorphism COMT Met158/Met 158 were among those who tested highest for anxiety.

Neuro Psychiatry Review – April 2003

People who describe themselves as highly stressed have a higher risk of fatal stroke than those who say they are stress free, according to a report in the March 14 *Rapid Access Stroke*. Investigators used data from the Copenhagen City Heart Study, which asked participants to report their stress intensity; in 13 years of follow-up, 22% of the participants had a fatal stroke. The risk of fatal stroke was 89% higher for those who reported a high level of stress compared with those who reported not having stress. Stressed people have more cardiovascular problems, are less active and drink more.

Neuro Psychiatry Review – April 2003

SNORING AND APNEA TREATMENT

Dentists Give Patients Comfortable Choices

By: Dr. Ira Shapira

The good news is that there is now an excellent alternative to CPAP for most patients, the intraoral dental appliance. These are appliances that a patient can wear comfortably in their mouth that maintains airway patency while they sleep without noisy compressors, tubes, straps or masks. Most patients who have tried an oral appliance prefer it to CPAP, though it may not be successful for everyone. Sleep physicians who used to routinely prescribe CPAP and BiPAP as the first mode of treatment are finding that their patients prefer intraoral appliances and are often prescribing them as the initial treatment for mild and moderate apnea. Patients with severe apnea will usually be tried on CPAP initially, as it is still considered the gold standard of sleep medicine, but that may be changing. Even patients with severe apnea are now being treated with appliances that are titratable in the lab and may be as effective as CPAP.

There are two basic types of sleep appliances that dentists make for treating snoring and apnea. The mandibular advancement (MAD) type is by far the most comfortable and the most commonly used appliance. There are many variations of the appliance, but the basic mechanism of how it works is always the same. During apnea or hypopnea events, the airway collapses during inspiration due to the vacuum created when breathing in and the looseness of the tissues. The MAD brings the lower jaw forward several millimeters; this widens the airway and brings the tongue forward. This allows the air to flow unimpeded into the lungs. Tightening of the soft palate by activating the palato-glossal muscles makes many surgical procedures that reduce the soft palate unnecessary (i.e. LAUP, UP3 or somnoplasty). The best of this group of appliances are those that are easily adjusted so that the patient has maximum comfort and control of sleep disordered breathing. This author

prefers to use the TAP appliance as initial treatment, because of the ease of adjustment with the appliance in the mouth. This allows experienced sleep technicians to adjust the appliance while the patient is sleeping to eliminate sleep disordered breathing and snoring. The patient can then maintain this titrated position. This same adjustment can be used as a volume control for the mate of the patient on a nightly basis, as needed.

The second major type of appliance is the tongue-retaining device that was the first well-tested appliance. It can be used by anyone, but is primarily used for edentulous patients and patients with severe periodontal disease. It works by holding the tongue forward in a small bulb by suction. One big disadvantage is that it is very difficult to titrate for a specific patient. It is also useful in some patients with severe TM joint problems who cannot tolerate other appliances. It is important to note that dentures can also serve as sleep appliances. An article in *Lancet* revealed increased severity in patients who slept with their dentures out.

There are also combination appliances that can be made that use an intraoral appliance to hold a mask or nasal pillows in place without the use of straps and allow the elimination of annoying air leaks. It is also possible to use a MAD to lower the pressure necessary to maintain an airway with CPAP.

Appliance therapy may become the first line of treatment for snoring and mild to moderate apnea and a realistic option for some patients with severe sleep apnea. It is important to clarify that these appliances must be used in a similar manner to CPAP. Efficacy of treatment and appropriate titration must be confirmed by overnight polysomnography. Further, it is important to note that, while a dentist may manufacture and deliver the appliance and deal with dental issues, it is always the sleep physician that makes the diagnosis and determines efficacy of treatment.

Dr. Roger Broughton

Continued from page 3

ments include a book on epileptic seizures that he co-authored with Gastaut, as well as a dictionary of epileptic terms that he co-authored for the World Health Organization that was translated into many languages.

Returning to Canada in 1964, at age 28, Broughton joined the Montreal Neurological Institute.

Dr. Broughton became an assistant professor at age 29 at McGill where, while on staff, he did a PhD. He returned to Ottawa in 1968, when he joined the Department of Medicine of the Ottawa General Hospital and the University of Ottawa.

Broughton is proud that all of his funding has come from Canada. He is quick to point out that Canada has an exceptional number of highly regarded sleep researchers especially in relation to its population.

Broughton has three children. They are Lynn, who works for the United Nations Association, Michael who is a high tech computer systems programmer, and Kathy who is a physiotherapist specializing in equine as well as human physiology.

The staff of Sleep & Health wishes Dr. Roger Broughton continued success and fulfillment in his research and personal life for many years to come.

ODDS & ENDS

The Story of Father's Day

Father's Day, contrary to popular misconception, was not established as a holiday in order to help greeting card manufacturers sell more cards. In fact when a "father's day" was first proposed there were no Father's Day cards!

Mrs. John B. Dodd, of Washington, first proposed the idea of a "father's day" in 1909. Mrs. Dodd wanted a special day to honor her father, William Smart. William Smart, a Civil War veteran, was widowed when his wife (Mrs. Dodd's mother) died in childbirth with their sixth child. Mr. Smart was left to raise the newborn and his other five children by himself on a rural farm in eastern Washington state. It was after Mrs. Dodd became an adult that she realized the strength and selflessness her father had shown in raising his children as a single parent.

The first Father's Day was observed on June 19, 1910 in Spokane Washington. At about the same time in various towns and cities across America other people were beginning to celebrate a "father's day." In 1924, President Calvin Coolidge supported the idea of a national Father's Day. Finally in 1966, President Lyndon Johnson signed a presidential proclamation declaring the 3rd Sunday of June as Father's Day.

Father's Day has become a day to not only honor your father, but all men who act as a father figure. Stepfathers, uncles, grandfathers, and adult male friends are all to be honored on Father's Day.



QUOTES ABOUT DAD

"I cannot think of any need in childhood as strong as the need for a father's protection."

— Sigmund Freud

"I watched a small man with thick calluses on both hands work fifteen and sixteen hours a day. I saw him once literally bleed from the bottoms of his feet, a man who came here uneducated, alone, unable to speak the language, who taught me all I needed to know about faith and hard work by the simple eloquence of his example."

— Mario Cuomo

"If the new American father feels bewildered and even defeated, let him take comfort from the fact that whatever he does in any fathering situation has a fifty percent chance of being right." — Bill Cosby

"Blessed indeed is the man who hears many gentle voices call him father!" — Lydia M. Child

LETTERS TO THE EDITOR

Dear Editor,

As an ex-Chicagoan, I was glad to hear about the *Sleep & Health* issue that will mark the 50th anniversary of Sleep Medicine. In those decades we have learned much about the sleep process, sleep disorders, the mysteries of dreaming, and the dangers of sleep deprivation. I lived a couple miles from the University of Chicago, where sleep research was in progress. In the 1950s I was a young mother who also did a little bit of "sleep research!" I soon discovered what a difference even a short nap made in my productivity. On the days that I could take my "twenty minutes," I was more energetic, efficient and patient!

So I was delighted to find your very first issue of *Sleep & Health!* At last—ready answers to our questions—from noted authorities! After reading the next few copies of *Sleep & Health*, I was even more impressed! This was a newspaper worth subscribing to—and more. I was eager to share it with interested family members and friends. I think it was one of the most appreciated gifts I have given.

So it's a pleasure to send you Happy Anniversary wishes for this excellent newspaper. May you and your *Sleep & Health* have many more Happy Anniversaries! Best wishes to you and your efficient staff.

Natalie Seliber - Burlingame, California

Dear Editor;

I have been an avid & appreciative audience member ever since a friend introduced me to the magazine. I want to commend you on your efforts to keep the public informed about what leads or maintains good health whether cutting edge or tried and true. I

Continued on page 13



by Langston Hughes

*Hold fast to dreams
For if dreams die
Life is a broken-winged bird
That cannot fly.
Hold fast to dreams
For when dreams go
Life is a barren field
Frozen with snow.*

BRIDGES & CROSSROADS



SHEEP NO LONGER EMPLOYED FOR SLEEPLESS NIGHTS

Researchers at Oxford University in London, England have discovered that the traditional cure for sleeplessness, which is believed to date back to the early 19th century, does not work because it is just too boring to fully distract the mind from problems and concerns.

In a recent experiment, 50 insomniacs were asked to try different techniques to see which helped them to fall asleep more quickly. The first group imagined a relaxing, tranquil scene like a waterfall or a beach; the second group tried counting sheep; a third were left to use their strategies.

Those who conjured up the relaxing scene fell asleep more than 20 minutes earlier than if they did nothing. Those who counted sheep and the controls took slightly longer than normal to drop off.

"Picturing an engaging scene takes up more brain space than the same dirty old sheep. Plus it's easier to stay with it because it's more interesting," reported Allison Harvey, who co-conducted the study with Suzanna Payne, for *New Scientist* magazine in which details of the research were published in January, 2002.

However, the researchers found that a new method for beating insomnia, "thought suppression," was also

ineffective. The idea is to block an anxious or negative thought by burying it as soon as it occurs to achieve a relaxed state of mind that leads to sleep. Dr. Harvey found that the "suppression" group took 10 minutes longer to nod off than if they did nothing. These results replicated a psychological study in which telling someone not to think about polar bears only encourages them to think even more about them.

One in 10 people suffer from chronic insomnia,



Photo by Matt Pranger

and scientists estimate that sleeplessness costs the U.S. economy \$35 billion a year in absenteeism and accidents.

"These studies represent an innovative approach to the management of insomnia," sleep researcher

Charles Morin, from Laval University, Quebec, told *New Scientist*.

Morin said the finding about the suppression technique did not surprise him. "The more you fight those intrusive thoughts, the more they want to come back." Tackling the underlying source of worry is the only solution to insomnia, he recommended.

Adopted from *CNN*, January 24, 2002

Letters to the Editor

Continued from page 12

especially enjoy the writings of your various guest columnists, the staff and the great articles by guest authors. I learn something from every issue, then pass them on to family & look forward to receiving new issues. Sleep & Health is a most interesting, compelling, well-written and enjoyable newspaper. Please keep up the good work of educating the public and much continued success. Thank You.

Sincerely,
Gertrude Bobrow

Dear Editor:

A friend recently gave me a subscription to the magazine "Sleep and Health." When I mentioned how much I was learning and enjoying all the articles, my friend suggested I might let this be known to you. I am amazed, mostly to find the openness that people now feel in expressing and discussing their various problems and that it can and does cross boundaries in all ages and aspects of life. Thank you for spreading the word and making us laymen more knowledgeable.

Eloise Foster, Deerfield, Illinois

FAMILY VIOLENCE AND CHILD ABUSE RELATED TO SLEEP DEPRIVATION

By: Alexander Golbin

"Sleep is a twin of death"
—Homer, *Iliad*

Working at the Cook County Hospital Emergency Room, I was surprised to find that many cases of family violence and child abuse were brought to the hospital during the night. In one case, the mother of an eight-year-old anorectic child put him into the shower and, being very sleepy, turned the knob for the hot water on, burning the child. In another case, sleep deprived parents started a quarrel, in the middle of the night, which ended up in a brutal, violent rage.

Sleep related family violence and child abuse related to sleep deprivation was described in detail in 1888 by physician and writer Anton P. Chechov in a series of short stories, based on real cases. In one of the stories, "Sleepy Head," he describes a true story of a 12-year-old servant girl who was forced to be a 24-hour nanny for an infant. After several sleepless nights, she became confused, started to hallucinate and killed the baby.

The following is an excerpt from the story written by

A.P. Chechov:

"...At last, tired to death, Varka does her very utmost, strains her eyes, looks up at the flickering green patch, and listening to the screaming, finds the foe who will not let her live.... That foe is the baby.... She laughs. It seems strange to her that she has failed to grasp such a simple thing before. The green patch, the shadows, and the cricket seem to laugh and wonder, too. The hallucination takes possession of Varka. She gets up from her stool, and with a broad smile on her face and wide unblinking eyes, she walks up and down. She feels pleased and tickled at the thought that she will be rid of the baby that binds her hand and foot... Kill the baby and then sleep, sleep, sleep..."

Laughing and winking and shaking her fingers at the green patch, Varka steals up to the cradle and bends over the baby. When she has strangled him, she quickly lies down on the floor, laughs with delight that she can sleep, and in a minute is sleeping as soundly as the dead.

Anton Chekhov Short Stories, *Sleepy Head*, 1888

Two centuries ago it was known that violence and sleep deprivation go together.

Now, modern science tells us why. Who will tell us how to cure it?

Happy Birthday St. Petersburg



Chicago's sister city, St. Petersburg, Russia is celebrating its 300th birthday this month. Just like our own beautiful city of Chicago, St. Petersburg is called "The Windy City", it is also known as "North Venice" for its beauty. St. Petersburg's symbol of the lion denotes the "Northern Guard," always alert, just as the city itself stands guard over all of Russia.



TRAVEL

THE "UPS AND DOWNS" OF MOTION SICKNESS

By: Marci Givan

I ran down the hall to open the door, anxious to greet my father returning from a business trip, but I couldn't have known what waited for me on the other side of that door. There he was, my father, standing in the hallway of our apartment building, clothes in hand, sporting a pea green tinge to his skin.

This was my first indication that our family had some trouble with motion sickness. My father, sister and myself have suffered for years, trying everything on the market to help our motion sickness in planes, automobiles, and even, in my father's case, the merry-go-round at Kiddieland.

With summer travel just around the corner, I thought I would take a look at what, if anything is new and effective in treating the discomfort of motion sickness.

Motion sickness is caused by the motion associated with travel by ship, air, car or any activity that is accompanied by irregular motion (i.e. the merry-go-round). Symptoms may include nausea, sweating, salivation and drowsiness.

TRADITIONAL TREATMENTS:

The conventional medicines for nausea and vomiting are ineffective against motion sickness. Conventional antihistamines, used for allergy (Stugeron, Antivert, Bonine, Sea-legs, Dramamine), have limited anti-motion sickness effect. Incidence of drowsiness and other side effects is variable and is related to the dose taken.

The Hyoscine (Scopolamine) patch appears to be the most effective anti-motion sickness medication available and the only thing that has ever worked for me. Its side effects include drowsiness, dryness of the mouth, constipation and blurred vision.

The antihistamine, Promethazine (Phenergan, Avomine), is the preferred drug for NASA astronauts who suffer microgravity motion sickness, which is reportedly worse than seasickness. Studies have demonstrated that the potential for drowsiness is less than that from motion sickness itself. Astronauts are more alert, more attentive and able to perform tasks more effectively when using Promethazine.

NON-PHARMACOLOGICAL TREATMENTS:

- Wristbands: The Royal Navy has investigated wristbands applied to pressure points. No significant effect beyond a placebo could be attributed to them.

- Don't travel on an empty stomach; this seems to promote symptoms. If you feel yourself becoming nauseated, keep your head stationary. A stable head position is very important in controlling motion sickness, because your inner ears contain the balance "gyroscopes" that monitor and coordinate motion and body position.

- Focus on one object; keep your eyes on the horizon, or just above the horizon line.
- Increase ventilation, decrease food intake and avoid alcohol.
- For those interested in natural remedies, ginger

root may offer some benefit.

THE "DON'T KNOCK IT UNTIL YOU TRY IT" TREATMENTS

The following treatments that I came across in my search are alternate treatments, they may sound strange, but you never know what will work so, "don't knock it until you try it."

- Fresh air may help. If possible, open a window or take a walk outside (not recommended for air plane travel).

- Day-old, unsalted popcorn is an inexpensive way to combat motion sickness. Ideally, the traveler should eat the popcorn 1 hour before or 2 hours after ingesting fluids.

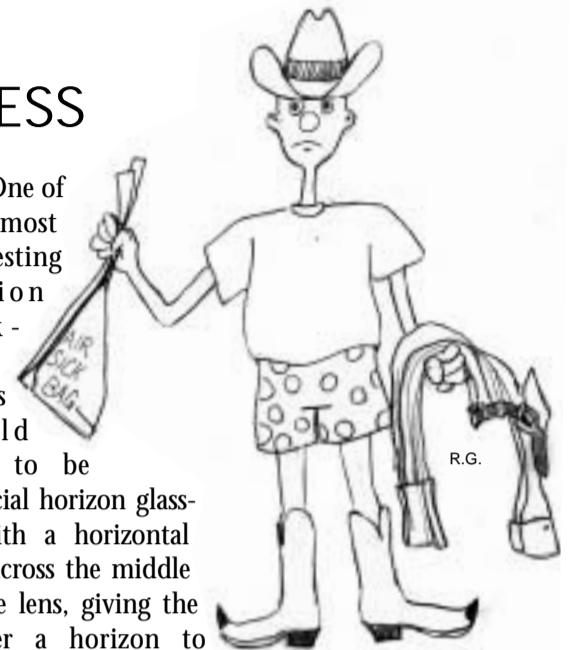
- Try eating olives or sucking on a lemon; these foods make your mouth dry and help diminish nausea. Soda crackers may help absorb excess saliva and acid in your stomach. If you feel sick, try a drink of ginger ale (made from real ginger) or any carbonated cola drink.

- Try holding your breath as you exhale slowly or place anything cold on your chest. This is said to diminish symptoms of nausea.

- One of the most interesting motion sickness cures would have to be artificial horizon glasses with a horizontal line across the middle of the lens, giving the wearer a horizon to always see in front of them.

I hope my little summary of what is what in the world of motion sickness helps when you set out on your summer travel plans. If any of you have other treatments that you find helpful, write or email me at *Sleep & Health*. I am always looking for new possibilities.

Happy Traveling.



HYPNOS – THE ANCIENT GOD OF SLEEP

By: Marc I. Oster, Psy.D., ABPH, President of the American Society of Clinical Hypnosis

"I don't know if I was hypnotized. I think I was simply sleeping while you were talking." This is probably one of the more common responses I receive from patients who experience hypnosis for the first or second time. Why is that?

This, I believe, stems from several confusing, and yet opposing, ideas. At the simplest level, the root for hypnosis is "hypnos". This comes from the Greek and means "sleep". Just because the first confusing experience came from ancient times, doesn't mean we cannot, in modern times, expand on the confusion. In medicine we have medications that are intended to help people fall asleep or stay asleep. These are called "hypnotics"—sleeping medications.

As the practice of hypnosis (as we know it today) spread and gained popularity, a name or term had to be selected. James Braid, who saw the patient's experience a lot like an induced sleep, chose the term, "hypnosis" or to sleep. When we observe a hypnotized subject, Braid's term makes sense. The person in, not under, hypnosis appears to the observer as sleeping. They are motionless, quiet, their breathing is slow and shallow, their heart rate has dropped as has their blood pressure, and their eyes are closed. Looks like sleep, right? Not necessarily. Think back to the last time you observed a person sleeping. They show all the traits I just described, and more—they might snore, breath heavily at times, move around a lot, and the most common difference, sleepers usually don't wake up when you softly whisper to them, "wake up." The hypnotized person almost always responds accordingly.

But how do we know they aren't asleep? Besides the behavioral observations I mentioned above, the EEG patterns of someone sleeping, relaxing, meditating and in hypnosis are all different. The hypnotized brain is not just like the sleeping brain. In fact, even though the hypnotized person appears just like a sleeping person, the hypnotic experience is a very active one. Think of hypnosis as a very mentally active and highly focused state. It is like a hypervigilant state. Their attention is so focused on an idea or theme, like a laser beam, that their other body systems slow or quiet down, looking like sleep.

One of my favorite examples was a middle aged professional woman who suffered certain medical symptoms and psychological symptoms. She saw another psychologist for years and I was asked to assist, using hypnosis to address specific medical symptoms. Following each and every hypnosis session the patient insisted that nothing happened, she was just relaxing while I talked or maybe fell asleep at times. Nothing I could say or do would satisfy her complaints. Finally, I had to ask her why she came to see me, weekly, for several months. She told me it was her medical problem. That's right, I said. I then asked her the status of her medical symptoms. "They're gone." Does it really matter if she was sleeping or not. Probably not, but she wasn't asleep. This is because, in part, hypnosis, in spite of the origins of the term, is not the same as sleep.



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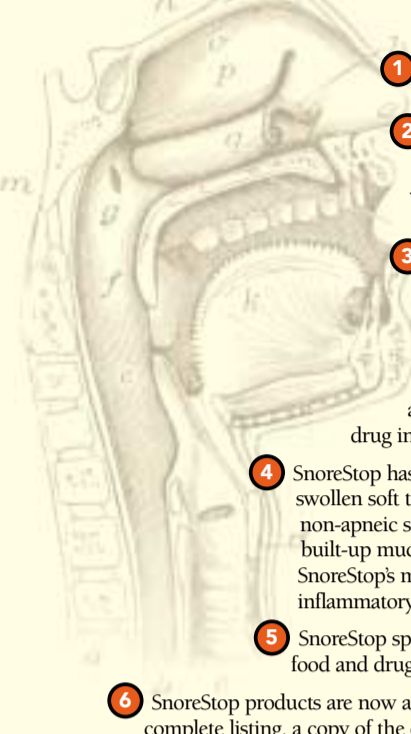
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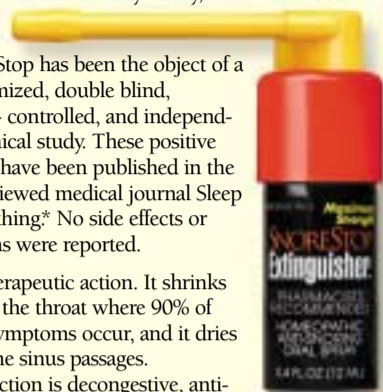
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