POLIO NETWORK NEWS

Summer 1987 **Vol. 3. No. 3.**

Polio Network News, is an international newsletter for polio survivors and support groups, physicians, health professionals, and resource centers, to exchange information, encourage research, and promote networking among the post-polio community through the International Polio Network (IPN).

IPN is coordinated by Gazette International Networking Institute (GINI), which has maintained a worldwide polio network since 1958.

EDITOR:
Judith Raymond

PUBLISHER:
GINI
4502 Maryland
St. Louis, MO
63108 U.S.A.
314/361-0475

ANNUAL MEMBERSHIP:
(Members receive POLIO NETWORK NEWS, and POST-POLIO DIRECTORY:
$5 for polio survivors
$15 for health professionals.
(Add $3 postage outside U.S. & Canada)

DEADLINE for Vol. 3, No. 4, 1987: Oct. 15.

WELCOME . . .

A warm welcome to new staff member Joan Headley, who joined G.I.N.I. on August 17, 1987, as director of G.I.N.I.'s International Polio Network.

Joan, who was disabled by polio in 1948, has been a high school biology teacher in Indiana for 20 years.

Joan is enthusiastic and committed to gathering and sharing information on the late effects of polio to help others as she was helped by the International Polio Network. She looks forward to getting in touch with polio survivors and support groups around the country.

...AU REVOIR

Best wishes and congratulations to Judith Raymond and Dr. D. Armin Fischer who were married on September 14, 1987.

Judith has been with G.I.N.I. for 20 years, as both volunteer and employee. She organized the formalization of the International Polio Network, and has been conference coordinator, along with Gini Laurie, of the 1985 and 1987 polio conferences. She will continue to work for G.I.N.I. from her new home at 4635 Larwin Ave., Cypress, CA 90630.

Armin, chief of chest medicine at Rancho Los Amigos Medical Center in Downey, California, is well known for his knowledge of the breathing and sleep problems of polio survivors.

LETTERS TO THE EDITOR

Cataract Surgery

"I am a quad, use a wheelchair, and am facing cataract surgery. Since it is vital not to strain, and since transfers, etc., require physical exertion, I am at a loss as to how to prepare for this type of surgery. How have others dealt with the procedure?"

Shirley Chapman
68 Pleasant St.
Sharon, MA 02067

Conference Kudos

"You are to be commended for such a productive and informative conference.... I was indeed honored to be present and have the chance to share some of my views on civil rights."

Ted Kennedy, Jr.
Boston, Massachusetts

"I had a most delightful time and truly enjoyed participating with such marvelous people....I felt that the medical information portion of the conference was extremely well presented and very up-to-date scientifically."

David Wiechers, MD
Columbus, Ohio

"This was the first conference my husband and I attended...not knowing what to expect, I must admit we had mixed feelings about going. I knew I didn't want to sit around with a lot of people and reminisce about having polio, but as soon as we arrived it was obvious it was not going to be like that at all. The whole atmosphere was one of up beat activity."

Yvonne Hudson
Winnipeg, Canada

Conference Kudos

"Congratulations on the success of the Fourth International Polio Conference. I felt honored to be an invited speaker.

"I was doing my residency training in Chicago in 1981, and attended the first polio conference. At that time, there was confusion over the causes of new deterioration polio survivors were reporting. It seemed the best approach was to look at the symptoms in a holistic manner and to look for known causes that could be identified, treated, or prevented.

"Then, and still today, there is a lack of clear evidence to explain the cause of this deterioration. It should be appeciated that almost every chronic disability that is associated with long-term survival will have expected deterioration with aging that can be both specific and nonspecific for that disability.

"There was a distinct change in atmosphere at the 1987 conference. There was still the same strong united resolution for the new war against polio, but many people have realized that they also have their own personal battles to fight.

"It is doubtful whether medicine can come up with a vaccine to prevent the late effects of polio. Polio survivors will do what they did during their acute rehabilitation they did not wait for a cure, but assessed what function they had, worked with rehabilitation specialists, and maximized their independence. The emphasis is no longer on what postpolio syndrome is, but what can be done about it."

William Waring, MD
Univ. of Michigan
Medical Center
1500 E. Med. Ctr. Dr.
Ann Arbor, MI 48109

FATIGUE

by Peter Gow, MB,ChB, BMedSc, FRACP

Fatigue is a common symptom in those persons suffering from the late effects of poliomyelitis, otherwise known as postpolio syndrome. However, fatigue can mean different things to different people. To the person, it can mean a feeling of lassitude, tiredness, or a heavy sensation in the muscles. To the scientist, it can mean a reduced capacity to perform repetitive movements or to maintain sustained contractions of the muscles that can result in a feeling of weakness. To the neurologist, it means the inability to develop the appropriate force in a brief effort. The latter is often normal in persons with postpolio syndrome, at least to clinical testing, and can lead to accusations by the doctor that the problem is caused by lack of motivation, rather than by neurological function or muscle physiology.

Although much excellent research has been done on the subject of fatigue, I should like to suggest areas in which further research might be attempted, preferably comparing persons who had poliomyelitis experiencing the late effects with a control group of polio survivors who are not experiencing the late effects.

First, does the fatigue relate to the sensation in the mind, perhaps amplified by the fear that the devastating illness which we thought we had overcome might be returning with all its attendant difficulties?

Answering this question will require the research subjects to perform the same amount of work, and to record the amount of "perceived exertion" both during the exercise session in which the work is performed and the day after, since the latter is often the time the fatigue is experienced.

Second, does anxiety contribute to the sensation of fatigue, and could this relate to the production of stress hormones, such as adrenaline, or the development of waste products of muscle metabolism, such as lactate?

The amount of work able to be performed before the development of fatigue and the perceived exertion for a given amount of work can be recorded on days when the fatigued person is feeling measurably anxious and days when he or she is not to determine the degree of fatigue which is contributed to by this factor.

Third, does the sensation of fatigue relate to the reduction of signals being transmitted by the nervous system and the ability of muscles to respond to these signals?

Much electrophysiological research is done on people who are refreshed when they enter the laboratory, not when they are feeling tired after performing fatiguing activity. Before and after studies are required to determine the degree of falloff in function after a set amount of work, followed by estimations of the rate of recovery to normality once fatigue of the transmission system and muscle has occurred.

Fourth, does fatigue relate to an imbalance between energy in put and output with reduction in energy reserves?

People who have previously had poliomyelitis may well use more energy than other people to overcome the mechanical disadvantages which might have occurred as a result of muscle wasting or impairment, including the muscles involved in respiration.

Continued

Pain and resultant muscle tension can also lead to increased energy usage, as can smoking, vigorous exercise, anxiety, and reduced blood sugar levels, which increase the hormones adrenalin and noradrenalin. This introduces the importance of nutrition which is the other half of the energy equation. Inadequate caloric intake leads to limited energy reserves of muscle glycogen, which may be already reduced by decreased muscle bulk as a result of the previous poliomyelitis.

Underweight people do not have the same energy reserves from fat as those people with more adipose tissue, but overweight people are equally disadvantaged in that the energy reserves have to go further. Research into the energy balance and reserves of energy stores, such as muscle and liver glycogen, may result in useful information.

This report does not solve the problem of fatigue in persons experiencing the late effects of poliomyelitis. However, it is hoped that the problems to be overcome have been more clearly defined by posing questions which when answered may well provide insight into the mechanism of fatigue, and thus lead to effective measures to overcome this underrated, yet troublesome, symptom.

Address: Peter Gow, MB,ChB, BMedSc, FRACP, Middlemore Hospital, Private Bag, Otahuhu, Auckland 6 New Zealand.

New Super-Vaccine for Polio

by Charles Marwick

The FDA is preparing to license a super-powerful inactivated polio vaccine.

It will almost certainly renew the debate about the comparative value of dead and live polio vaccines that so enlivened the 1960s.

The prospect has prompted public health authorities to ask the Institute of Medicine (IOM) to review US polio vaccination policy. Dr. Enrequeta Bond of the IOM says plans are in hand to discuss the issues this fall or possibly early next year.

The new killed virus vaccine is highly immunogenic. It needs only two doses to induce antibody levels that parallel those obtained with the oral vaccine, although three doses are likely to be recommended when the vaccine is licensed. This compares with the four doses needed to provide protection with the currently available old-fashioned Salk vaccine. Like the Salk vaccine, it is given by injection.

The necessity of only two doses is of lesser importance in the US where immunization services are widely available and access to immunization is not a serious problem. However, it is of considerable interest in third world countries where it is not always easy to get repeat visits for immunization and where adequate refrigeration to store the live virus vaccine may be impossible, says the CDC's Dr. Roger Bernier.

Two manufacturers have applied to the FDA for licenses for this vaccine, the French company Merieux Institute with offices in Miami, and the Canadian concern, Connaught Laboratories with facilities in Stillwater, PA. Merieux's vaccine was licensed in France in 1982. There are slight differences between the way the two companies manufacture their product, but they are similar in terms of their ability to induce protective antibody.

In a study headed by Dr. A. Marshall McBean of Johns Hopkins University, more than 1000 children were used to compare these killed vaccines with the oral agent. All who got the enhanced potency vaccine had significantly higher antibody levels against all three poliovirus types compared with those receiving the oral polio vaccine.

Safety is one of the over-riding concerns that the IOM will certainly take up. There are in the US between five and ten cases of vaccine-induced paralytic polio every year with the live oral vaccine. Virtually all the vaccine used here is the live virus agent. By comparison, there have been no reports of polio associated with the use of killed vaccine. So, in theory, use of the inactivated vaccine could totally eliminate the problem of vaccine-associated polio.

However, long-term efficacy with the new "super-Salk" vaccine has yet to be demonstrated. Even though the enhanced potency of inactivated vaccine is at least as good as — and maybe even better than — the live virus agent at inducing antibody, this says nothing about the persistence of antibody with the killed vaccine. The fact that the live virus vaccine has been so successful in virtually eliminating polio in America makes it unlikely that routine vaccination with the present live virus vaccine will be abandoned, says the CDC's Dr. Bernier.

With the advent of the new inactivated vaccine, however, the way is open to develop new strategies regarding polio immunization. One is an immunization schedule that combines both the killed and the live virus vaccines, thus taking advantage of what both vaccines have to offer. The idea is that if the live virus vaccine doesn't work, the killed virus will. The concept has been tested in Israel with some success.

Another possibility is to combine the inactivated vaccine with the new acellular pertussis vaccine currently being tested. If these vaccines can be safely and effectively combined with the inactivated polio vaccine, it may encourage use of this vaccine.

No matter when the new Salk vaccine is licensed, public policy regarding polio immunization is unlikely to change until the IOM has held its workshop. Oral polio vaccine is still the vaccine of choice for routine immunization of infants and those less than 18 years of age. The present inactivated vaccine is recommended only for those adults at high risk for disease and for immunosuppressed individuals who cannot tolerate live virus and their household contacts.

Reprinted with permission from The Double Helix, August 1987

INFLUENZA GUIDELINES

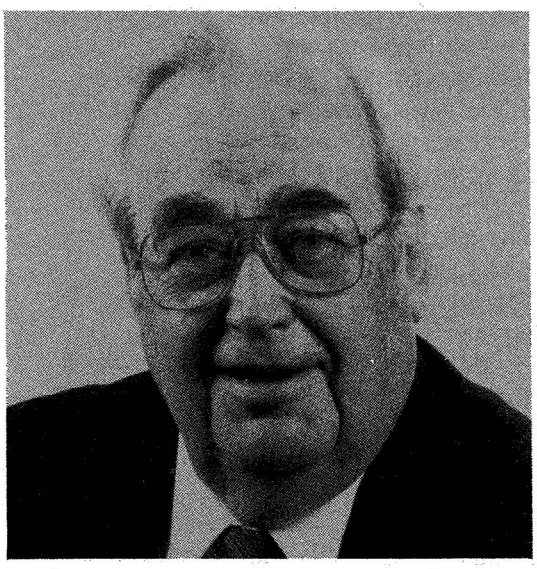
New 1987-1988 government guidelines for influenza prevention recommend vaccination for certain target groups.

The newest batch of influenza vaccine provides protection against 3 viruses now circulating, including Taiwan A.

According to the Center for Disease Control (CDC), the main target groups are adults and children with chronic disorders of the cardiovascular pulmonary systems requiring regular medical follow-up, and residents of nursing homes with chronic medical conditions.

Polio survivors should check with their personal physicians about influenza vaccination.

SPENCER RETIRES AT T.I.R.R.



William Spencer, MD, founder of The Institute for Rehabilitation and Research (T.I.R.R.) in 1959 in Houston, retired in June 1987.

Dr. Spencer is lauded and revered as an "old" respiratory polio doctor from the 1950s epidemics at the Southwestern Poliomyelitis Respiratory Center - Jefferson Davis Hospital.

Dr. Spencer is the author of Treatment of Acute Poliomyelitis, published in 1954.

He is one of a small circle of physicians who have earned an "R.D." degree - Real Doctor.

WARNING: ANTI-DIARRHEAL MEDICINES CONTAINING NARCOTICS

Pulmonologists and respiratory therapists are becoming increasingly concerned about the use of anti-diarrheal medicinces containing narcotics by individuals with paralysis of the trunk muscles or diaphragm.

These medicines may decrease the respiratory drive, especially in debilitated people who may be more sensitive to respiratory depressant effects. These people may also have less body mass that could possibly cause them to have a stronger adverse reaction to the medicine.

"Travellers with disabilities are urged to carefully read the labels on anti-diarrheal medicines that often contain narcotics, such as Lomotil, paregoric, etc.," says Susan Sortor, RRT, Dallas Rehabilitation Institute. Sortor has treated two polio survivors who returned from Mexico in respiratory distress as a result of taking Lomotil without realizing that it contained a narcotic.

Oscar Schwartz, MD, St. Mary's Health Center in St. Louis, advises that travellers take along Pepto Bismol or Kaopectate. If the diarrhea lasts longer than 48 hours, one should see a physician due to the risk of dehydration.

POST-POLIO BIBLIOGRAPHY

Recently published:

"Late Denervation in Patients with Antecedent Paralytic Poliomyelitis" by Neil Cashman, Riccardo Maselli, Robert Wollmann, Raymond Roos, Roberta Simon, and Jack Antel. The New England Journal of Medicine, July 2, 1987, Vol. 317, No. 1. Pages 7-12.

Nutrition for Polio Survivors

by Charlotte Gollobin, MS

During G.I.N.I.'s Fourth International Polio and Independent Living Conference in June 1987 in St. Louis, I discovered that most polio survivors do not have good diet regimens. Weight control and nutrition should be important parts of everyone's lives, but especially of polio survivors, many of whom are inactive, overweight, and perfect candidates for heart disease and other debilitating illnesses.

If one is overweight, one can begin to lose weight by cutting caloric intake by 3500 calories/week (500 calories/day). Diets high in fat cause increased weight, and the American Heart Association now recommends that diets contain no more than 30% of calories as fat.

However, some fat is beneficial. Fish contains oils that help lower triglycerides and prevent platelets from clumping, thereby lowering the risk of heart disease and atherosclerosis. Although olive oil doesn't lower cholesterol levels, it improves the ratio between high and low density lipoproteins and total cholesterol, thus lowering the risk for heart disease.

When one counts calories, one should be aware of portion sizes. It is helpful to learn what portion sizes look like so that when preparing food or dining in a restaurant, one knows how much to allow oneself to eat.

Protein and carbohydrates contain 4 calories per gram, and should be important parts of one's diet, especially complex carbohydrates, such as those found in vegetables, fruits, whole grains, and legumes. These foods also contain dietary fiber.

Diets high in fiber are associated with lower incidence of diabetes, appendicitis, hemorrhoids, diverticulitis, and colon cancer. High-fiber diets can lower cholesterol levels, slow the release of sugars into the blood, and prevent constipation. The amount of fiber per day one needs is 25-35 grams. The most popular fiber foods include:

Food (½ cup cooked)	**Fiber (grams)**
All Bran w/extra fiber	13.0
100% Bran	9.1
Kidney beans	5.8
Pear	4.6
Sweet potato	4.2
Peas	4.1
Potato, baked	3.8
Apple w/skin	3.5
Orange	2.6
Rice (brown)	2.4
Carrots	2.3
Broccoli	2.0
Spaghetti	.8

Pasta is a favorite fiber and complex carbohydrate food because it is healthy and not very high in calories if one avoids the creamy sauces. Pasta has been a staple of the Mediterranean diet for centuries, a diet that contains many foods known to help prevent heart disease. The Mediterranean diet consists of vegetables, fruits, fish, olive oil, small amounts of meat, pasta, bread without butter, and low-fat cheeses.

Everyone should be aware of the amount of salt ingested. The amount of natural sodium in most foods is more than enough without adding salt. Too much sodium can cause water retention as well as hypertension.

When one reduces the amount of calories, one also lowers the total food intake and therefore decreases the amount of essential nutrients ingested. Many people in the United States are marginally deficient in calcium, zinc, iron, magnesium, Vitamin A, B-6, and C. Certain age groups are more deficient in certain vitamins than others, and it is reasonable to suspect that polio survivors may be even more deficient. (I am not aware of any research being conducted on nutrients in relation to the late effects of polio.)

Reprinted with permission from Rehabilitation Gazette, Vol. 28, No. 1, 1987.

A multiple vitamin/mineral supplement each day can guarantee that one is receiving the recommended dietary allowance (RDA), but that is to supplement the diet, not replace it.

A multivitamin can provide vitamins such as Vitamin A, C, and E, that prevent the destruction of tissue. Oxygen, while buring the fuel from the food we eat to provide energy, can form destructive materials in the body. Vitamins A, C, and E, can prevent such formation.

Carpal tunnel syndrome is a common ailment among polio survivors. New research indicates that certain B vitamins can be very effective in treating carpal tunnel syndrome if caught early enough.

Vitamin/mineral supplements should have 100% of the RDA for all listed ingredients. A good checklist should include Vitamins A, C, D, E, K, B-1, B-2, B-6, B-12, biotin, folic acid, niacinamide, and pantothenic acid. Minerals should include calcium, phosphorus, iodine, iron, magnesium, copper, manganese, potassium, chromium, molybdenum, selenium, and zinc.

Exercise should also be an important complement to any diet program. Even simple range-of-motion and stretching exercises can help burn off calories because they increase the metabolic rate. New research indicates that this increased rate continues for several hours after the actual exercise activity.

Polio survivors, as well as individuals with any disability, need to be especially careful of diet regimens. With advancing years, eating well and preventing extra weight from slipping on will aid polio survivors in maintaining fully functional weightbearing joints.

RECOMMENDED READING:

Brody, Jane. *Jane Brody's Nutrition Book.* New York, Bantam, 1982.

Hausman, P. *The Right Dose.* Emmaus, Pennsylvania, Rodale Press, 1987.

Address: Charlotte Gollobin, MS, 11510 Old Georgetown Rd., Rockville, MD 20852.

PATHOLOGIC STUDY OF SPINAL COLUMNS OF POLIO SURVIVORS

The Department of Neuropathology at the Armed Forces Institute of Pathology is interested in studying autopsy material from persons with progressive post-polio muscular atrophy (PPMA) to make clinicopathologic correlations, and to distinguish between PPMA and motor neuron disease.

The entire central nervous system (brain and full length of the intact spinal cord) and a detailed clinical history, including the exact dates of onset and detailed neurological findings documenting the paralytic disease should be sent to G. Pezeshkpour, MD, Armed Forces Institute of Pathology, ATTN: AFIP-RRR, Washington, DC 20306-6000.

Write Dr. Pezeshkpour at the above address or call at 202/576-2928.

SOCIAL SECURITY ISSUES POST-POLIO GUIDELINES

At long last, the Program Circular on the late effects of poliomyelitis and the Program Operations Manual System for medical evaluation of the late effects of poliomyelitis were issued in July to the district offices and the state agencies.

This is a monumental achievement, and should ease the way for polio survivors applying for social security disability.

Credit, praise, and thanks go to Marge Torre of Philadelphia and Jane Dummer of Baltimore for their perseverence.

See the following pages for the full text of the Program Circular.

SSA PROGRAM CIRCULAR

Disability

No. 04-87-OD **Date:** July 2 1987

Division of Medical and Vocational Policy, Office of Disability

LATE EFFECTS OF ANTERIOR POLIOMYELITIS (POLIO)

Introduction

Anterior poliomyelitis (polio) is caused by viruses which may destroy motor nerve cells in the spinal cord and brain stem. Permanent paralysis may result. However, with the advent of vaccines in the mid-1950's, the widespread polio epidemics in the United States were sharply reduced. For years, this disease has been viewed as conquered in most industrialized countries.

Until recently, it had been the belief of polio survivors and many physicians that muscle residuals remain stable after the initial recovery period; however, there have been reports from polio survivors of increasing weakness and functional limitations. Concern has been expressed over the reason for these new problems, their severity, and how they can be treated.

The purpose of this program circular is to alert SSA personnel to this new set of functional problems some polio survivors are experiencing so you are aware of these during the claims process (e.g., interview and disability determination phases).

Incidence

Precise data are not available, but it is estimated that there are at least 300,000 polio survivors now living. Further, it is estimated that at least 25 percent of surviving polio-paralyzed individuals are experiencing additional, new functional problems. Usually, these problems develop many years (20-40) after the onset of the acute illness.

Distribution: All holders of POMS Part 4,
Chapter 245, Subchapter 80

Social Security Administration
Office of Policy
SSA Pub. No. 64-044

Destruction Date: December 31, 1987

Distributed on list

H20/PSC

To adjust quantity requirements, submit form SSA-1296, "Request for Address or Distribution Change", using the list number on the address label.

New Functional Problems Being Experienced

The functional problems reported are fatigue, weakness, joint and muscle pain, breathing difficulty, and intolerance of cold. There may be increasing weakness or pain in a muscle already paralyzed or in muscles not previously affected. The severity of problems may range from a modest worsening to a progressive postpolio muscular atrophy. The etiology of these new problems is not yet fully understood, and there is no specific treatment for the progressive functional problems.

The late effects of polio are causing increasing problems in activities such as lifting, bending, prolonged standing, walking, climbing stairs, pushing a wheelchair, transfers (e.g., from wheelchair to toilet) sleeping, swallowing, dressing, and any activity requiring repetition and endurance.

Many polio survivors who thought they were in stable condition have had to start using or add to previous use of bracing, canes, crutches, wheelchairs or breathing aids. Ability to continue with customary activity, including work, has been curtailed for many of these individuals. Functional abilities which may have been limited, but stable for many years, are now being lost.

Evaluation of Late Effects of Polio

It is important for the field office interviewer to be aware that polio survivors are filing for disability benefits based upon these new functional problems (claimant may refer to these as postpolio syndrome). The interviewer should carefully record information the claimant provides about the condition and his/her observations of the claimant. This information will be valuable to the disability determination services in developing and evaluating the case.

Section 11.11 of the Listing of Impairments provides the specific guidelines for evaluating impairment severity for polio. The listing can be met if there is persistent difficulty in swallowing or breathing, unintelligible speech or significant and persistent disorganization of motor function in two extremities, resulting in sustained disturbance or gross and dexterous movements, or disorganization of gait and station.

To augment these criteria, we are planning to issue a Program Operations Manual System section (Part 04, Chapter 245, Subchapter 80--Specific Evaluation Instructions/Neurological) which will describe documentation of the late effects of polio, evaluation, to include meeting or equaling the listing, evaluation of residual functional capacity when Listing 11.11 is not met or equaled, onset, medical diaries and diagnosis coding.

G.I.N.I.'S POLIO CONFERENCE ATTRACTS 747

They came from 18 countries and from all across the United States to St. Louis, June 4-7, 1987, to attend G.I.N.I.'s Fourth International Polio & Independent Living Conference.

Polio survivors, physicians, health care professionals, equipment dealers, and other persons with disabilities filled the Sheraton Hotel's ballroom. More than half of the speakers and the participants were wheelchair users, and many used portable ventilators.

"The excitement and spirit of the conference attendees was almost palpable," says Conference Coordinator Gini Laurie. "The mutual respect between the physicians and health professionals on the panels and the audience was another conference highlight."

Conference sessions covered the latest treatment and research findings on muscle weakness, pain, fatigue, sleep and breathing problems, exercise, nutrition, bracing, and seating.

Polio experts included Augusta Alba, MD; Frederick Maynard, MD; Jacquelin Perry, MD; Richard Owen, MD; Neil Cashman, MD; D. Armin Fischer, MD; Lauro Halstead, MD; Ernest Johnson, MD; David Wiechers, MD; Hugh Newton-John, MD; and Geoffrey Spencer, OBE.

Polio survivors on each panel presented personal perspectives on the late effects of polio. A special session on face masks for night ventilation was packed with polio survivors demonstrating masks they had designed themselves.

The psychological aspects of disability and the problems of coping with the late effects of polio many years after the acute stage were discussed in several panels and workshops on coping relationships with family members, friends, and attendants.

"It will take some time for me to absorb all the information, experiences, and feelings of your marvelous conference. And the inspiration of being with so many who have not let their disabilities prevent them from living active, loving, joyous lives is beyond description," states Charlene Bozarth, chair of the Michigan Polio Network.

Cultural attitudes towards disability around the world provided an international forum for leaders of disability groups from the following countries: Australia, Austria, Brazil, Canada, China, Denmark, El Salvador, England, West Germany, Japan, Mauritius, Netherlands, New Zealand, South Africa, Sweden, Taiwan, U.S.A., and Zaire.

The conference celebrated the 10th anniversary of the implementation of Section 504 of the Rehàbilitation Act of 1973 - the bill of rights for persons with disabilities.

Ted Kennedy, Jr. was among the keynote speakers at the conference banquet, as well as Justin Dart, Jr., Commissioner of the Rehabilitation Services Administration, and Eunice Fiorito and Judy Heumann, both activists in the disability rights movement.

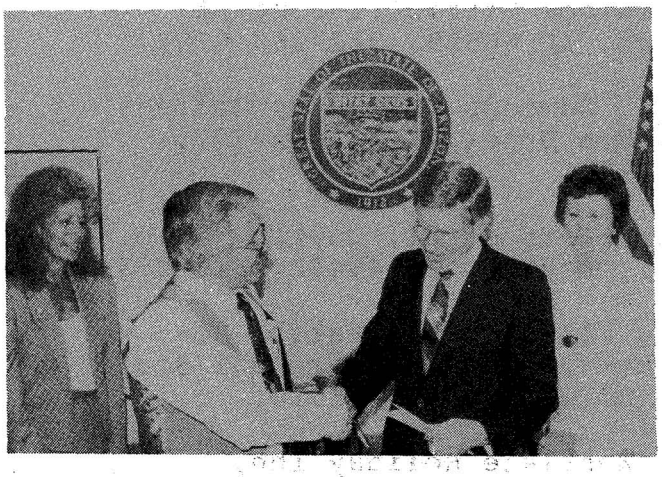
Proceedings of the conference will be published in 1988, and can be ordered now for $16 postpaid from G.I.N.I.

Plans are already underway for the 1989 polio conference in St. Louis. Save these dates: May 31-June 4, 1989.

NATIONAL POLIO WEEK, JUNE 1987

Representative Richard Gephardt (D-MO) introduced House Joint Resolution 253, proclaiming June 1-7, 1987 as "National Polio Awareness Week."

Many polio support groups across the country urged the governors of their states to proclaim "National Polio Awareness Week." Here are photos of two successful groups - California and Arizona.



L to R: Carole Green, polio survivor; Ernie Anderegg, polio survivor; Arizona Governor Evan Meacham; and Joanne Yager, polio survivor.

Standing L to R: Lee Agnew, polio survivor; Cathie Wright, California Assemblywoman; Roberta Rak, polio survivor; and Peter Ciciarria, Rotarian.
Seated L to R: Lee Seitz and Rick Ames, polio survivors.

POST-POLIO RESEARCH

Patricia Outland, doctoral candidate at Adelphi University's clinical psychology program in Garden City, New York, gathered data for her doctoral dissertation at G.I.N.I.'s Fourth International Polio & Independent Living Conference in St. Louis in June 1987.

Eighty individuals over the age of 35 participated in filling out a research packet prepared by Outland.

The study focuses on various personality features in two groups of individuals who are experiencing the late effects of polio: those who contracted polio before the age of 6 and after the age of 12. Approximately 50 or 60 more subjects will be needed to complete the project, preferably from the New York metropolitan area.

After the subject pool has been completed, the results should be available within 6 months.

Pat hopes that these results can be useful to individuals who are experiencing the late effects of polio, to support groups, and to health professionals.
Address: Pat Outland, 215 W. 91, Apt. 105, New York, NY 10024.

NOTEBOOK LOST AT CONFERENCE

A white notebook sporting the SUPPOS (Suncoast Post-Polio Survivors) logo that was on display during G.I.N.I.'s Fourth International Polio & Independent Living Conference in June is still missing.

Anyone who might have "borrowed" the notebook is asked to return it to Bonnie Pomeroy Radcliffe, 3301 Bayshore Blvd., Tampa, FL 33606. The notebook contained irreplaceable newsletters and items of historical significance to SUPPOS.

International Polio Network
4502 Maryland Ave.
St. Louis, Missouri 63108 U.S.A.
(314) 361-0475

Address Correction Requested

Non-Profit Org.
U.S. Postage
PAID
St. Louis, MO
Permit No. 1711

1987 CALENDAR

September 12. Post-Polio Conference. Oakbrook Marriott. Contact: Roberta Simon, RN, 7835 Pine Pkwy., Darien, IL 60559. 312/969-0287.

September 12. Polio Survivors Conference. Edmonds Community College, Edmonds, Washington. Contact: Christena Van Driel, P.O. Box 777, Edmonds, WA 98020. 206/778-7505.

September 12. Post-Polio Conference. Marriott Hotel, Dayton, Ohio. Contact: Connie Johnson, 5301 Roxford Dr., Dayton, OH 45432. 513/253-9866.

September 12. Post-Polio Seminar. Idaho Elks Rehabilitation Hospital, Boise, Idaho. Contact: Donna Grummer, Idaho Easter Seal Society, 1627 S. Orchard St., Suite 10, Boise, ID 83705. 208/384-1910.

September 18-19. Post-Polio Conference. Westlake Holiday Inn, Cleveland, Ohio. Contact: Margaret Meyer, SIL, 25100 Euclid Ave., Suite 105, Euclid, OH 44117. 216/731-1529.

September 26-27. Crossing New Bridges II: Looking at the Effects of Polio Then and Now. Medical College of Wisconsin, Wauwatosa. Contact: Beth Fennigkoh, 5109 Russell Ct. East, Greendale, WI 53129. 414/421-9522.

October 9. First Annual Montana/Wyoming Post-Polio Conference. Holiday Inn, Billings, Montana. Contact: Shelley Oksness, Easter Seal Society, 4400 Central, Great Falls, MT 54905. 406/782-3027.

October 9-11. Living Longterm with Disability. Holiday Inn, Monrovia, California. Contact: Martha Griswold, ACSW, LIV Center, 943 E. Altadena Dr., Altadena, CA 91001. 818/798-5320.

October 20. Annual Meeting of the American Congress of Rehabilitation Medicine and American Academy of Physical Medicine and Rehabilitation: Post-Polio Seminar. Marriott's Orlando World Center, Florida. Contact: ACRM, 130 S. Michigan, Chicago, IL 60603. 312/922-9366.

October 30. Post-Polio Conference. Ramada Inn, Meriden, Connecticut. Contact: Kathy Murphy, Gaylord Hospital, Wallingford, CT 06492. 203/269-3344.

November 7. Post-Polio Conference. Civic Center, Augusta, Maine. Contact: Ann Crocker, RFD 3, Box 3770, W. Gardiner, ME 04345. 207/623-2981.

December 11-12. Post-Polio Conference for Health Professionals. Tufts New England Medical Center, Boston. Contact: Pat Andres, RPT, NEMC, 750 Washington St., Boston, MA 02111. 617/956-5846.