



Trigeminal Neuralgia Association of Canada

Winter 2007 Newsletter



Meet the Board!

President and Membership:
Jane McLaren, Cornwall, ON

I am a lifer. I have had TN as long as I can remember though it was not correctly diagnosed until I was 40. As a child I coped by freezing in place and pressing my hand to my head. I thought the pressure of my hand stopped the pain but now know it was just that the pain was short in length. As I got older attacks got longer and more frequent. I was experiencing constant attacks when I was diagnosed. Medication – Tegretol, Neurontin, Topamax – didn't do more than take the edge off and the side effects for me were very difficult. I took up walking to try to get some energy back but eventually had to stop because I never knew when a pain would strike that would knock me off my feet literally. In Sept of 2004 I had a balloon rhizotomy. Though it did help one area the surgery actually caused the TN to get worse and also caused painful numbness and other complications on my face. In April of 2006 I had an MVD. This time things went more my way and I was able to get off all meds. I still deal with jabs of TN at times and also the complications from the balloon procedure but it is great to be without meds. I went walking again and then running. I hope run my first race this spring at Ottawa Race Weekend. It is still quite unbelievable to me that I can do this after the experience of the past few years. But I know that it is the support of others with TN and the sharing of TNAC that helped me to reach this point. I am passionate about helping people who live with TN on a daily basis. I believe we need each other, need to share,

need to support each other ... and together we do make a difference!



(Sept. 2006, summit of Mount Hopkins with Caleb)



Past President, Treasurer:
Marion Guzik, Lethbridge, AB

It was August 15, 1995, 6 p.m. at the Lethbridge Lodge that I had my first experience with a terrible pain on the right side of my face. I thought I was having a stroke, but didn't seek medical advice as the pain went away. Shortly thereafter my husband passed away, and I was again struck with this horrible pain, so I went to my family Dr. and was advised that it was stress related. The pain persisted and I was sent to Dr. Lee, a neurologist in Calgary, who confirmed TN, and thus started the long journey of finding out what this dreadful affliction was all about.

In April of 2000, I was again at the Lethbridge Lodge for a meeting when I turned my head and a ray of sunlight shone in my eye and I had another bad attack of pain. My friend Rene had just installed a computer, and the next day we

set about finding as much info as we could about TN, as I had never heard or knew of anyone who had it.. We found the Trigeminal Neuralgia Association. in a little place called Barnegate Light , New Jersey, and a warm relationship developed. An interview with the Lethbridge Herald was set up and to my amazement, had many calls from others around this area with TN. A Support Group was then formed in 2000 and meetings were held in my home. One of our members had just had an MVD, and gave my name to his neurosurgeon, Dr. Anthony Kaufmann. A great relationship developed and shortly thereafter the Trigeminal Neuralgia Association of Canada was born., with Dr. Kaufmann as Medical Advisor.

I have been on tegretol, trileptal and am now on lyrica, which seems to be helping me a great deal. However, wind and bright sunshine are dynamite for me. I have tried acupuncture, and upper cervical maneuvers, and although I do believe they did some good have sought other methods as, after having 2 heart attacks, and 2 crushed vertebra, am not a good candidate for an operation. I also have had the Yuen Method, of which I owe a great deal of gratitude to Irene Klassen of Regina, who, when in pain, helped me on many occasions, and also to Betty Dingerville , Lethbridge, for her tireless efforts to help me. I have recently been invited and accepted the Truehope EMPowerPlus, (a dietary supplement and nutritional support for mental and emotional well-being) program for TN , with my Doctors' permission. Although I still have periods of pain and breakthrough pain, I am very happy to have the opportunity to try out various methods and hopefully one day, we will all be pain free.



Marion and Friends



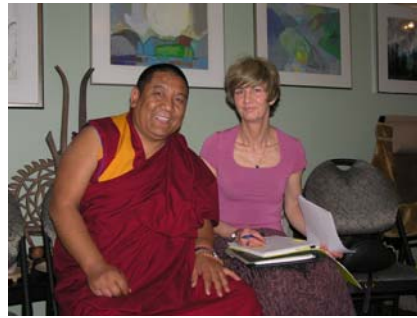
Support Groups

Ann Hopkins, Vancouver, BC

I have two instances of Trigeminal Neuralgia: I've had post herpetic TN for 26 years (in my forehead and eye following a bout of shingles) and Tic Doloureux (somewhat atypical) in the jaw for 20 years. A failed rhizotomy has left me with painful numbness and I had to stop work in 1998 when the Tic resurged. I've not worked since. TN has brought with it new learnings and ways of coping although it really is a diabolical condition.

I joined TNAC and volunteered for the board because I feel that the organization is so valuable. When I acquired my two different bouts of TN at two different times there was absolutely no information geared to the public available. My GP knew little about it and the information he gave me was misleading. There was no internet and nothing that I could source in public libraries on TN. I've learned so much from the TN organizations. It's essential that we self-manage this chronic condition to the best of our ability.

As someone who used to work in communications and corporate public relations I believe that good information is essential when it comes to making treatment decisions. Organizations like TNAC which are dedicated to disseminating information about TN enable us to make better choices. And that's why I hope to contribute to TNAC as a board member.



taken a year or so ago with the Lama Geshe Lodoe Gyatsoe



Advocacy

Joya Dickson, Delta, BC

I was diagnosed with TN very quickly by a dental specialist, and within a few weeks a Vancouver Neurologist Dr. Milton Wong had the pain under control with a combination of Neurotin and Dilantin. After 5 years when I had experienced no symptoms for 6 months I was able to stop all medications. For a further six months I was totally pain free.

In Dec 2005 I flew to New Zealand and had a bad reaction to what I thought was a flu shot. In early January/2006 my husband and I returned to Vancouver from a long flight from Sydney Australia and the day following our return TN hit me so severely I though the pain would take me to the moon.. Continual bouts of lighting lasting more than an hour at a time day and night left me feeling totally drained, I was unable to move when the pain occurred.

My Neurologist prescribed the same drug combination without any results, the pain intensified. We tried alternate combinations of drugs but without results. TN simply got worse; it became unbearable as we all know. Following an episode of strikes my husband took me to emergency because the lighting flashed went on relentlessly non stop for two hours. Fortunately the admitting nurse was aware of TN and she deemed my admittance an emergency and a doctor attended me within minutes, one shot of morphine and within a few minutes RELIEF. At this stage liquid morphine was the only drug that basically gave any relief; this was not the way I wanted to exist.

My doctor insisted I research the different surgical options that were suitable for me, at this stage I was sold on radiation but he wanted me to review all options considering my age and health issues. (I'm a devil for punishment having successfully survived two cancer surgeries). I opted for a Rhizotomy and my family doctor agreed I had made the right choice. The research was simplified with the help from "Striking Back" a fantastic book available through TN Canada.

Dr. Honey, the only Neurologist in Vancouver who actually performs this procedure was very kind and somehow was able to find surgery time within an acceptable time frame. I am eternally grateful. to Dr Honey, he gave me my life back, following the procedure I was instantly pain free.

I've resumed my home based media business; I walk an hour every day along the sea front just south of Vancouver and simply love life

My husband was responsible for ensuring my daily intake of vegetables and fruits by liquefying these foods to sustain my health. I lost 40 pounds within the 6 months prior to the procedure because it was so painful to chew or at times open my mouth.

.. My husband deserves a medal for his patients and constant care, family and good friends are so important to help us through these unbearable times.

I'm the youngest of five children and the third child to suffer with TN, it's interesting to note this ailment alternated with the siblings, the eldest, middle and youngest child all suffered with TN; two children were spared thank goodness. My brother had an MVD in his early 60's; my sister opted for a Rhizotomy also in her early 60's and remains pain free after 15 years.

Attend your support group meetings so that you can learn more about this ailment and spread the word that we need support to raise funds for research.



Joya in her Garden



How YOU can help

Volunteering with TNAC does not mean committing to countless hours of work. There are many ways you can help out including:

Join the Board – we have room for two more members. We are looking for someone who would like to take over as treasurer and people who are simply willing to help out.

Webmaster – are you a techie? We have room for someone to help with our website.

Newsletter: Do you like to create and write? We would love to have someone take over the newsletter and its production. Or you could contribute an article for the newsletter – your story with TN, a treatment you have benefited from, etc.

Support Groups: Would you like to be in a support group but there isn't one in your area? Why not start one! Ann has great information to help you start a support group. You can start one in your city or a regional group. Even an online chat group! Let us know what you think!

If you are interested in helping out in any way contact Jane!

Depression and pain

Hurting bodies and suffering minds often require the same treatment.

(This article was first printed in the September 2004 issue of the Harvard Mental Health Letter. For more information or to order, please go to <http://www.health.harvard.edu/mental/>.)

Pain, especially chronic pain, is an emotional condition as well as a physical sensation. It is a complex experience that affects thought, mood, and behavior and can lead to isolation, immobility, and drug dependence.

In those ways, it resembles depression, and the relationship is intimate. Pain is depressing, and depression causes and intensifies pain. People with chronic pain have three times the average risk of developing psychiatric symptoms — usually mood or anxiety disorders — and depressed patients have three times the average risk of developing chronic pain.

Medicating pain and depression

Almost every drug used in psychiatry can also serve as a pain medication. Relieving anxiety, fatigue, depression, or insomnia with mood stabilizers, benzodiazepines, or anticonvulsants will also ease any related pain. The most versatile of all psychiatric drugs, the antidepressants have an analgesic effect that may be at least partly independent of their effect on depression since it seems to occur at a lower dose.

The two major types of antidepressants, tricyclics and selective serotonin reuptake inhibitors (SSRIs), may have different roles in the treatment of pain. Amitriptyline (Elavil), a tricyclic, is one of the antidepressants most often recommended as an analgesic, partly because its sedative qualities can be helpful for people in pain. SSRIs such as fluoxetine (Prozac) and sertraline (Zoloft) may not be quite so effective as pain relievers, but their side effects are usually better tolerated, and they are less risky than tricyclic drugs. Some physicians prescribe an SSRI during the day and amitriptyline at bedtime for pain

patients.

Both drug classes act in brain pathways that regulate mood and the perception of pain. Tricyclics heighten the activity of the neurotransmitters norepinephrine and serotonin; SSRIs act more selectively on serotonin. Some researchers and clinicians believe that a newer antidepressant which acts strongly on both neurotransmitters, the so-called dual action drug venlafaxine (Effexor), is superior to both tricyclics and SSRIs for treating pain. So far, the evidence is inconclusive.

Physicians and psychiatrists are also considering the uncertain potential of the anticonvulsant drug gabapentin (Neurontin) and drugs that block the activity of substance P, another neurotransmitter involved in the regulation of both pain and depression. Electroconvulsive therapy, a standard treatment for severe depression, may have independent analgesic effects.

The association of depression with migraine headaches, which affect more than 10% of Americans, is especially close. One study found that over a two-year period, a person with a history of major depression was three times more likely than average to have a first migraine attack, and a person with a history of migraine was five times more likely than average to have a first episode of depression.

In somatoform disorders, including hypochondria, according to one theory, depression and anxiety are converted into physical symptoms. But often, when low energy, insomnia, and hopelessness resulting from depression and anxiety perpetuate and aggravate physical pain, it becomes almost impossible to tell which came first or where one leaves off and the other begins. In a statement by the International Association for the Study of Pain, pain is defined as "an unpleasant sensory or *emotional* experience associated with actual or potential tissue damage or *described in terms of such damage.*"

Brain pathways

The convergence of depression and pain is reflected in the circuitry of the nervous system. In the experience of pain, communication between body and brain goes both ways. Normally, the brain diverts signals of physical discomfort so that we can concentrate on the external world. When this shutoff mechanism is impaired, physical sensations, including pain, are more likely to become the center of attention. Brain pathways that handle the reception of pain signals, including the seat of emotions in the limbic region, use some of the same neurotransmitters involved in the regulation of mood, especially serotonin and norepinephrine. When regulation fails, pain is intensified along with sadness, hopelessness, and anxiety. And chronic pain, like chronic depression, can alter the functioning of the nervous system and perpetuate itself.

The mysterious disorder known as fibromyalgia may illustrate these biological links between pain and depression. Its symptoms include widespread muscle pain and tenderness at certain pressure points, with no evidence of tissue damage. Brain scans of people with fibromyalgia show highly active pain centers, and the disorder is more closely associated with depression than most other medical conditions. Fibromyalgia could be caused by a brain malfunction that heightens sensitivity to both physical discomfort and mood changes.

Depression, disability, and pain

Depression contributes greatly to the disability caused by headaches, backaches, or arthritis. People in pain who are also depressed become extremely heavy consumers of medical services, even if they have no severe underlying illness. But that doesn't mean they receive better treatment; studies show that they actually use fewer mental health services than other patients with mood disorders. According to some estimates, more than 50% of depressed patients who visit general practitioners complain only of physical symptoms, and in most cases the symptoms include pain. Some studies suggest that if physicians tested all pain patients for depression, they might discover 60% of currently undetected depression.

Pain slows recovery from depression, and depression makes pain more difficult to treat; for example, it may cause patients to drop out of pain rehabilitation programs. Worse, both pain and depression feed on themselves, by changing both brain function and behavior. Depression leads to isolation and isolation leads to further depression; pain causes fear of movement, and immobility creates the conditions for further pain. When depression is treated, pain often fades into the background, and when pain goes away, so does much of the suffering that causes depression.

Treating pain and depression in combination

In pain rehabilitation centers, specialists treat both problems together, often with the same techniques, including progressive muscle relaxation, hypnosis, and meditation. Physicians prescribe standard analgesics — acetaminophen, aspirin and other nonsteroidal anti-inflammatory drugs, and in severe cases, opiates — along with a variety of psychiatric drugs (*see "Medicating pain and depression" box above*).

Physical therapists provide exercises not only to break the vicious cycle of pain and immobility but also to help relieve depression. Cognitive and behavioral therapies teach pain patients how to avoid fearful anticipation, banish discouraging thoughts, and adjust everyday routines to ward off physical and emotional suffering. Psychotherapy helps demoralized patients and their families tell their stories and describe the experience of pain in its relation to other problems in their lives.

Pain specialists can improve their practice by learning more about the interactions among psychological, neurological, and hormonal influences that link pain and depression. *Why do some people recover from injuries without pain while others develop chronic symptoms, and how is that process related to depression and anxiety? How do psychotherapy and antidepressant drugs affect brain function in depressed people with chronic pain? What kinds of psychotherapy are helpful for them, and how long should psychotherapy continue? In investigating these questions, and in all treatment of both pain and depression, the goal is not just comfort or the absence of*

symptoms but restoring the capacity to lead a productive life.



Support Group



Eastern Ontario Support Group

Starting this spring meetings will begin for the NEW Eastern Ontario Support group. This group is open to anyone living in the Eastern Ontario Region (Kingston to the Quebec Border, Ottawa Valley south to the NY Border) and even to people in Montreal area if you'd like to meet with us! We will alternate meeting locations to limit travel for people. In talking with people I've discovered there are a few people in several areas who would like to get together but not enough to start a group in one city. So we have decided to join forces and meet as a region! Interested? I have several names already ... why not add yours to my list. Let me know and I'll contact you with the time and date of our first meeting! I look forward to meeting all of you!!!

Jane

Vancouver and Lower Mainland Support Group Update

Coordinator: Ann Hopkins

About 13 people attended our meeting on January 27th. Although I have more than 80 people on my email list for the support group we are scattered all over Vancouver's Lower Mainland in various cities which means that many have a long drive to get to the meeting. We're grateful to neurosurgeon Dr. Honey for helping us to book the G.F. Strong Rehab facility as we can meet there at no charge and it's very wheelchair accessible which is helpful for members with MS.

We welcomed three new attendees to the group, two of whom were from far flung Abbotsford and Maple Ridge. Good news from new member Grace Thomson: she is to have an MVD on February 23. Our best

wishes for successful surgery and freedom from pain - forever!

I am always available for phone and email support so please don't hesitate to get in touch with me if you need someone to talk to or are feeling isolated. Bruce Smillie is also a contact person (Ann Hopkins: annhopkins@shaw.ca, 604 732 1673; Bruce Smillie 604 594 4231.)

The group decided to meet quarterly instead of alternate months. Fewer larger meetings were preferred and the new schedule for 2007 is as follows: Please mark your calendars:

2007 Vancouver Support Group Meetings

G.F. Strong Rehab Centre (Laurel @ 26th one block east of Oak)
Social Services Seminar Room 109
1 pm to 4 pm

April 28
July 28
October 27

Lethbridge Support Group

Coordinator Marion Guzik

Another successful meeting of members and their spouses, a newcomer and potential member, was welcomed at our first meeting on January 13th, 2007. Happy Birthday Wishes and Congratulations went out to Zennon Malec on the 3rd Anniversary of his being pain free. Best Birthday present you could have ever received Zennon.

Although it was our annual Christmas Party, a brief Support Group meeting was held. As you are all aware, I have stepped down as President of the TNAC and a new board has been appointed: Jane McLaren of Cornwall, ON., President and Membership, Joya Dickson, Public Awareness and Fundraising, Marion Guzik, Treasurer and Past President, Ann Hopkins, Secretary and Support Group Leaders.

We have now received our Federal Incorporation for the Trigeminal Neuralgia Association of Canada 2006, and I am sure Jane would welcome any member in good standing to apply for a position on the Board of Directors.

In Appreciation plaques were presented to Patty Moyer, Mona Leslie, Zennon Malec, John Edwards, (past sec/treas. Don Brewer) for being the first Board Members of the TNAC, as without them the TNAC would not have been born.

Due to the lack of time, our games will be played at another get-together, as everyone wanted to eat all the delicious food that our members brought. I don't think anyone left hungry. It was all so tasty, and thank you one and all.

Bon Voyage to Mona Wells who is headed for Barbados to visit with family members. Have a great time Mona.

Speedy Recoveries to Gwen Edwards and Bernard Bastien who are presently in hospital. Get Well soon as we miss you at the meetings.

Our Deepest Sympathy to Hugh Laycock on the passing of his beloved wife.

Our meetings are held the second Saturday of every month at 2:00 p.m. at the Lethbridge Senior Centre, 1100 11th Street, S. and our next meeting will be held on Saturday, February 10th, 2007. Hope to see you there.



Contacting TNAC

Want to know how to reach us? We can be reached by using the following email addresses:

For information on membership or general information:

president@tnac.org
613.936.6977

TNAC, 1602 Walton Street
Cornwall, ON, K6H 1W2

For information on support groups:
support@tnac.org

For information on advocacy:
advocacy@tnac.org

To reach our past president
treasurer@tnac.org

To talk with someone about TN you can contact any or all of us. We are here to help!



TNAC Pins

TNAC Pins are available for a cost of \$10 including GST, S and H. If you would like to purchase one please contact our treasure, Marion, at treasurer@tnac.org or (403)327-7668.

Ask Dr. Kaufmann

Dr. A. Kaufmann of Winnipeg will answer your questions about TN and its treatment. If you have a question for Dr. Kaufmann please email it to president@tnac.org or mail it to the TNAC mailing address.

Brain Pain 2007 (from TNA)

The 2007 Brain Awareness Week, initiated by the Dana Foundation, is scheduled for March 12th through 18th. TNA's involvement this year will focus on community outreach and is titled "*Brain Pain*." We hope that you and your support group will join us by networking within your own community.

Not only will this provide an opportunity to educate other groups about neuropathic facial pain, including TN, it also presents an occasion to explore partnerships with other organizations in your area. In almost every group of people at least one member knows someone with facial pain. You never know who you'll meet or what will come of it – that's the beauty of networking!

If you want to discuss your ideas or receive additional guidance, feel free to contact Ann at support@tnac.org or (604)732-1673. You can also check out the TNA web link at: http://www.tna-support.org/newlook/sql_files/Brain_Pain_2007/brain_pain_2007.htm



Growing Pains

Thank you for bearing with us as we re group. You most likely will have noticed that the web page has not been updated since December and the message board is no longer active. Getting caught up on the running of TNAC, talking with people across Canada, setting up the membership list, doing a newsletter ... well ... it's all taken some time. Thank you so much for your patience and understanding as we sort things out. There will be some changes to our web site soon. I am not sure if the message board will re appear or not. Please let me know if you feel strongly one way or the other about the TNAC message board. We want to create a site that works for YOU and would love to have your input!

Jane

LIVING ON A SOFT DIET

What is it?

- A soft diet means eating foods that are soft and easy for you to chew or to swallow. Eating soft foods may help if you have problems chewing or swallowing.
- This diet leaves out foods that are high in fiber and foods that cause excess gas. It also leaves out tough or stringy meats, and foods that are hard to cut into bite size pieces.

Care:

- Use a food processor to grind or puree foods to make them easier to chew and swallow. You may need to chop meats or flake fish to make them soft enough to chew.
- Avoid or limit foods in the cabbage family if they cause excess gas. This includes broccoli, cauliflower, cabbage, and brussels sprouts. Cooked dried beans and peas may also cause gas.

Serving Sizes: Use the list below to measure foods and serving sizes. A serving size means the size of food after it is cooked or prepared.

- 1-1/2 cup (12 fluid ounces) of liquid is the size of a soda-pop can.
- 1 cup of food is the size of a large handful, or 8 fluid oz.
- 1/2 cup of food is about half of a large handful, or 4 fluid oz.
- 2 tablespoons (Tbsp) is about the size of a large walnut.
- 1 tablespoon (Tbsp) is about the size of the tip of your thumb (from the last crease).

- 1 teaspoon (tsp) is about the size of the tip of your little finger (from the last crease).
- 3 ounces of cooked meat, fish, or poultry is about the size of a deck of cards.
- 1 ounce of cooked meat, fish, or poultry is about 1/4 cup.
- One ounce of hard cheese is about a 1-inch cube.
- A serving of vegetables is 1/2 cup (1/2 handful) cooked.

Beverages: Try to drink 6 to 8 (soda pop can size) glasses of liquids each day.

- Water
- Coffee, tea, or cocoa
- Juices or sports drinks
- Soda pop, bubbly water

Dairy: Eat or drink 2 to 3 servings a day from this list.

- 1/2 cup custard or pudding
- 1 cup milk or milk drinks
- 1 cup milkshake
- 1/2 cup soft ice cream or ice milk without fruit or nuts
- 1 cup yogurt (plain or with soft fruits)
- Do **not** eat the following foods:
 - Yogurt or ice cream with nuts or granola.

Desserts / Sweets: Eat foods from this list if you need them to maintain or gain weight. The foods should not have nuts, seeds, or coconut in them.

- 3 inch size cookie
- 1 whole frozen juice pop
- 1/2 cup gelatin dessert with soft canned fruit
- 1 piece of pastry (like sweet roll)
- 2 inch pie-shaped slice or 3 inch square piece of cake
- Do **not** eat the following foods:
 - Hard candy
 - Peanut brittle or toffee
 - Taffy

Fats: Eat 1 to 3 servings a day from this list.

- 1 teaspoon (tsp) butter or margarine
- 1 teaspoon (tsp) oil (any kind, like corn, olive, safflower, vegetable)
- 1 tablespoon (Tbsp) salad dressing
- 1/4 cup strained gravy
- 2 tablespoons (Tbsp) whipped topping or sour cream
- Do **not** eat the following foods:
 - Almonds, peanuts, walnuts
 - Crisp bacon
 - Other nuts and seeds that are hard to chew

Fruits: Eat 2 to 4 servings a day from this list.

- 1/2 cup applesauce or canned fruit without seeds or skins
- 1/2 ripe banana
- 1/2 cup fruit juice
- 1 cup melon cubes
- Do **not** eat the following foods:
 - Dried fruits such as dates or apricots
 - Raw, crisp fruits such as apples

- Raspberries, blackberries
- Stringy fruits such as pineapple or mango

Meats / Protein Foods: Eat 2 to 4 servings a day from this list.

- 2 ounces cheese (in sauces or melted in other dishes)
- 1/2 cup cottage or ricotta cheese
- 2 eggs that have been poached or scrambled
- 3 ounces ground, chopped, or cut in small cubes meat, fish, or poultry (with gravy to moisten)
- 2 tablespoons (Tbsp) smooth peanut butter
- 3 ounces tofu
- Do **not** eat the following foods:
 - Beef jerky, corned beef, or other meats that are tough or stringy
 - Crunchy peanut butter
 - Fried chicken or fish with breaded coatings
 - Hard cheese
 - Overcooked meats or fish that are dry

Soups: Eat up to 3 servings a day from this list.

- 1 cup broth or bouillon
- 1 cup cream soup with soft vegetables
- 1 cup pureed or blended soups
- Do **not** eat the following foods:
 - Soups with tough or large chunks of meat or poultry

Starches: Eat 6 to 10 servings a day from this list. The foods should not have nuts, seeds, or dried fruits in them.

- 1/2 cup cooked cereal, rice, or barley
- 1/2 cup macaroni, pasta, or noodles
- 1/2 cup mashed or cooked potatoes without skins
- 1 cup plain dry cereal in milk
- 1 roll, muffin, pancake, or waffle
- 6 saltine crackers (softened in soup or drinks)
- 1 slice soft bread or 6 inch soft tortilla
- Do **not** eat the following foods:
 - Bran cereals
 - Chewy bagels, French bread, or breadsticks
 - Corn, potato, or tortilla chips
 - Granola cereals with seeds or nuts
 - Popcorn
 - Rye crackers or rice cakes

Vegetables: Eat 3 to 5 servings a day from this list.

- 1/2 cup soft, well cooked vegetables without seeds or skins
- 1/2 cup vegetable juice (like tomato juice)
- Do **not** eat the following foods:
 - Crunchy raw vegetables like carrots, celery sticks, broccoli, or cauliflower

(source HealthTouch)