
Experience reports about the efficiency of Thevo-mobility beds for Parkinson's patients

Management and execution:

Ute Geitmann

Institute IGAP, functional management care division

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IGAP

Institute for Innovations in
Healthcare and
Applied Nursing Science

nursing-science

Sleep disorders in Parkinson's Disease

In a large-scale study, patients suffering from Parkinson's Disease were asked which symptoms effected their quality of life the most. First was depression, followed by sleep disorders and then the patients listed illness-related dependency and physical symptoms.

Sleeplessness worsens physical symptoms and causes daytime fatigue, which negatively effects quality of life. Restorative sleep provides improvement of the entire pathology. In 1999, the European Parkinson's Disease Association assumes that more than 90% of Parkinson's patients also suffer from problems with sleep.

Causes

Parkinson's causes various sleep problems that could be caused by the disease or by therapy.

In the study above, more than 70% of patients suffer from different nightly sleep problems, as shown in this table:

Frequent urination at night	79%
Immobility in bed, difficulties turning	65%
Leg cramps	55%
Vivid dreams, nightmares	48%
Dystonia, uncontrolled movements	34%
Leg movements	33%
Tremors during sleep	27%
Hallucinations	16%

Other patient surveys revealed that approximately two-thirds of Parkinson's patients suffer from sleep problems and one-third of those patients require medication. These nightly sleep problems, which can also include sleep apnea, can result in daytime fatigue, which can cause nodding off during the day.

The causes of these nightly sleep problems and day time fatigue may be rooted in the medical therapy of Parkinson's.

Types of sleep problems

- Problems falling asleep
- Waking up early
- Motor syndromes during sleep (tremors or abrupt movements)
- Frequent, short phases of being awake (fragmented sleep)
- REM sleep behavioral disorder: Typically, muscles are completely relaxed during REM sleep, but if a neurodegenerative disease like Parkinson's is present, the person may scream, speak, or move heavily during REM sleep, resulting in injury.
- Momentary nodding off in the daytime

Frequency of different sleep problems in Parkinson's patients:

(Multiple problems possible)

- 64% difficulties falling asleep
- 73% problems sleeping through the night
- 93% daytime fatigue
- 63% nightmares/vivid dreams
- Up to 30% sleep attacks (suddenly falling asleep in the daytime)

Periodic limb movements, or PLM, also occur often. The patient won't recognize PLM as the cause of their waking, but their partner can learn to recognize the disorder.

Sleep case history

Patients were asked 22 questions to create a targeted treatment of their sleep problems. Here are a few examples:

- Is turning in bed difficult?
- Is mobility in general poor at night?
- Do you remain in the same position throughout the night?
- Do you suffer from back pain at night?

Diagnosis and treatment

To make a diagnosis for sleep disorders, doctors need to gather a case history for the patient, perform a physical examination, and interview the family. The Parkinson's Disease Sleep Scale (PDSS) is a specially developed questionnaire on sleep quality that will help to identify the disease specific aspects of the sleep disorders the patient suffers from.

Once diagnosed, treatment can begin.

From the start of treatment, a vicious cycle is created. Dopaminergic medication can cause sleep problems, but a lack of medication can result in muscle stiffness (rigidity) or immobility (akinesia).

Conclusion:

The results of these studies are as follows:

- Normal mattresses do not allow for the patient to gain perception impulses by moving themselves, which results in immobility and rigidity.
- Parkinson's causes REM sleep behavioral disorder.
- Micro-Stimulation may provide relief for the periodic leg movements (PLM) that make a Parkinson's patient startle.
- Back pain can be reduced by sleeping on a Thevo mattress. Anatomical positioning will reduce muscle stiffness and nagging pain.

Ute Geitmann
Institute IGAP
2010-01-25

Source: Extracts from: www.parkinson-web.de

Movement symptoms

Bradykinesia, Hypokinesia, Akinesia

Bradykinesia is distinguished by slowness of movement. Hypokinesia refers to decreased bodily movement.

Akinesia is a high-level physical inactivity up to complete immobility (despite normal muscle strength). Initiating movement is disturbed, as well. Akinesia affects the targeted and random processes of the transverse muscular system. In everyday usage there is often no sufficient distinction between these terms, e.g. the terms Bradykinesia and Hypokinesia are often used for milder forms of Akinesia.



Bradykinesia and Hypokinesia are the most affecting disorders and present the following problems:

- Reduced mimics and gestures
- Reduced resonance of arms
- Hoarse, whispering voice
- Monotone voice
- Less frequent swallowing (resulting in salivation)
- Shrinking letters during writing
- Reduced fine motor hand movements
- Disturbed, quick alternating movements
- Walking with small steps, poor rolling of feet during walking
- Dragging one leg behind oneself
- Difficulties initiating movement, leaning forward when walking
- Falling backwards (partial disturbances of balance)
- Posture disturbances (rolled posture)
- Difficulties getting up
- Difficulties turning in bed

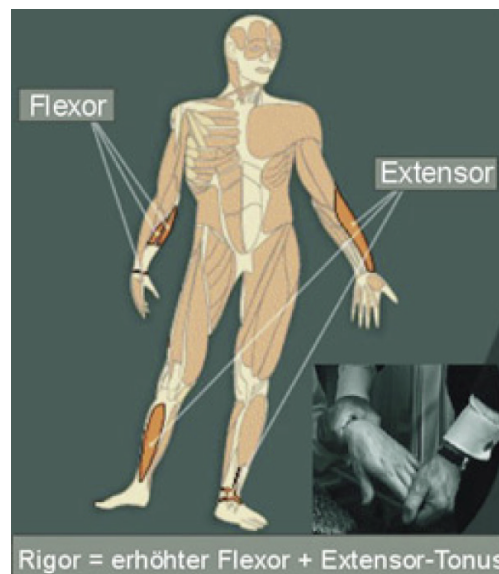
Hypokinesia normally starts on one side of the body and remains restricted to this side for quite a long time. If medication is suddenly discontinued or if the person gets seriously ill, a so-called akinetic crisis may be the consequence in Parkinson's patients. It is distinguished by immobility, impossibility to speak or swallow and high fever. These are life-threatening complications. Amantadin infusions or Apomorphine injections help to tackle the crisis.

Rigor

The simultaneously increased tone, i.e. increased tension, in the antagonistic muscles (muscles acting in pairs, e.g. flexors and extensors) is also termed rigor or muscle stiffness.

Rigor must be divided from the spastic hypertonia, which has other causes. Patients experience rigor as sensation of stiffness in arms and legs. If someone tries to move, e.g. the arm of the patient, they sense a strong resistance in all directions.

Furthermore, a gear phenomenon is present, i.e. movement only in a jerky and abrupt manner. Rigor and gear phenomenon may be provoked during examination by the patient making a fist with the other hand. Proprioceptive muscle reflexes often are increased on the affected side.



Shaking = Parkinson's?

October 2006 / Dr. Ferenc Fornadi, Gertrudis-Klinik Biskirchen, Germany

Definition of different tremor diseases



The term "tremor" is used for shaking in medical language. Tremor is defined as random rhythmic movement of one or more body parts (= oscillation). Tremor is just a symptom and its causes are manifold.

Shaking most commonly is associated with Parkinson's disease. Consequently, when shaking occurs one primarily has this disease in mind. In many cases a possibly long-term, unnecessary, and ineffective Parkinson's therapy is initiated. To avoid such a misdiagnosis, differentiating the different types of tremor is of great importance.

Types of tremor

Differentiation of the types of tremor is made on the basis of following criteria:

1. Frequency: low frequent: 2-4 Hz, medium frequent: 4-7 Hz, high frequent: >7 Hz
2. Particular localization: Head tremor, tongue tremor, vocal cords tremor, lower jaw tremor, hand tremor, leg tremor.
3. Particular trigger situation: Standing, writing, playing violin.
4. Activation conditions: Rest, holding, action and voluntary movement. Consequently we distinguish between rest tremor, postural tremor, action tremor, and intention tremor.

Activation conditions

The rest tremor is the most common tremor in Parkinson's. It has a frequency of approximately 5 Hz. It primarily occurs at a state of complete relaxation and with droopy arms when standing and walking. Inner tension (e.g. counting backwards), positive or negative emotions, stress, observation, or cold intensify rest tremor. With voluntary movements, especially when initializing movement, shaking stops for a while. In voluntary movements the rest tremor may occur again towards the target. This so-called "landing tremor" must not be confused with the intention tremor. Rest tremor is also termed money counting or pill rolling tremor, due to the typical, rhythmic hand movement.

The action tremor occurs in voluntary movements and can considerably disturb them (spilling liquids, problems writing and controlling cutlery). It generally is a bit faster than the rest tremor, but frequency might be at the same level.

The postural tremor, also termed static tremor, can be observed when arms are held out. Its' frequency is similar to that of the action tremor. Postural and action tremor are typical of the familial essential tremor.

The intention tremor is characteristic of a cerebellum disease, occurs during targeted movements of hands and legs, and the amplitude grows ever larger towards the target.

Tremor syndromes

The different types of tremors, their combination, other symptoms, the anamnestic data, and results indicate the specific tremor syndromes.

Tremor syndromes (diseases)

- Intensified physiological tremor
- Parkinson's tremor
- Essential tremor
- Orthostatic tremor
- Dystonic tremor
- Task-specific tremor
- Tremor in cerebellum diseases
- Holmes tremor
- Palatal tremor
- Medicinal and toxic tremor
- Tremor in polyneuropathy
- Wilson's disease
- Shaking in the elderly
- Psychogenic tremor

Intensified psychological tremor

Even healthy people shake in different situations, e.g. when cold, from excitement, exertion, etc. This so-called physiological tremor can be visibly intensified, especially in the arms-holding-out-test. This shaking is faster (more than 6 Hz). Causes are different; if fixed, the tremor is reversible. It therefore is important to find the trigger of the intensified physiological shaking by diagnostics. The most common causes are:

- Medications (antidepressants, lithium, anti-epileptic agents)
- Hyperthyroidism, drop in blood sugar
- Vegetative dystonia
- Medication or drug withdrawal
- Liver/ renal diseases
- Alcoholism
- Brain injuries (one-sided)

Parkinson's tremor

Different types of tremors occur in Parkinson's disease, although the rest tremor is the most typical sign of Parkinson's. Following combinations of the single tremor types are possible:

Type I, classical Parkinson's tremor

This is a typical rest tremor, which might be accompanied by a posture or action tremor. These tremor types, however, have the same frequency. Shaking diminishes in the transition of rest to holding or action movements.

Type II, rest and posture tremor of different frequencies

This type presents besides the rest tremor, a faster, second tremor type with a difference in frequency of more than 1.5 Hz. (mixed tremor). Some patients have a combination of an essential tremor with a Parkinson's tremor.

Type III, pure posture and action tremor

Some patients have a pure posture and action tremor with a frequency exceeding 5 Hz.

Mono-symptomatic rest tremor

This tremor type often poses diagnostic problems, since other Parkinson's symptoms than the isolated rest tremor cannot be found. L-Dopa-PET-examinations show a disturbed dopamine system in the patients, like in Parkinson's disease. This type of Parkinson's shaking is also termed benign (non-malignant) tremor-dominant Parkinson's Disease.

Classical essential tremor

Termed as familial essential tremor is a disease often presenting a heritable, isolated tremor. In general, the essential tremor is a slow, progressive disease with predominantly posture and action tremor. Occasionally, a resting tremor is present, as well. Shaking might begin early in youth or at advanced age. Approximately 60% of cases have an autosomal dominant inheritance. Most people affected recognize the temporary drop in shaking after consuming alcohol. Hands, head, voice, face, legs and trunk can be affected.

The essential tremor often is confused with Parkinson's disease. The most important distinctive features are stated in the table below:

	Parkinson's shaking	Essential tremor
Type	Mainly during resting	Mainly posture and action tremor
Frequency	5/sec.	8-10/sec.
Heritability	Very rarely	60% familial
Starting age	From 50-60 years	Often under age 20, also possible later
Progression	Faster	Slower
Symmetry	On one side of the body	On both sides of the body
Writing	Shrinking	Shaky
Language	Hoarse, soft	Shaky
Head-shaking	Rarely	Often
Lower jaw-shaking	Typical	Non-typical
Other symptoms	Almost always existing	No
Alcohol	No effect	Typically dampens effect
Dopaminergic	Effective	No effect

Primary orthostatic tremor

The so-called orthostatic tremor is distinguished by difficulties in standing, also occurring during walking and possibly causing falls from a standing position. Patients are free from symptoms when sitting or lying down. Typically there is a visible or palpable shaking of leg muscles. Tremor examination via electromyography shows a fast symmetric leg tremor when standing with a frequency of 14-18 Hertz.

Some patients have other neurologic disorders, as well, just as Parkinson's or restless legs.

Dystonic tremor

This syndrome has a tremor in one extremity or part of the body, presenting at least minimal signs of a dystonia (centrally caused tension of muscles). Shaking is variable and irregular in amplitude and frequency. Frequency is below 7 Hz, shaking is posture and action tremor, no rest tremor. Typical appearance is the dystonic head tremor with torticollis.

Task-specific tremor

The task-specific tremor occurs, e.g. in professional musicians or athletes. Tremor normally occurs only during specific activity. Writing and speaking belong to motor activities, which may be affected, as well (isolated voice tremor, primary writing tremor). In some patients the tremor occurs only in certain postures of extremities (posture-specific tremor).

Tremor in cerebellar diseases

The so-called cerebellar tremor is a one-sided or both-sided intention tremor with a frequency below 5 Hz. A hold tremor is possible, too, but no rest tremor. Other cerebellar symptoms are always present. Most frequent case of this tremor type is multiple sclerosis.

Holmes Tremor

This tremor syndrome contains a rest and intention tremor and-, less often a posture tremor. This tremor is not as rhythmic as the other types of shaking and presents a slow frequency below 4.5 Hz. The case history or MRT-pictures show a lesion of the brainstem (stroke). The tremor occurs after a stroke for up to 2 years.

Soft palate tremor

The rare soft palate tremor may occur in 2 types. There is a symptomatic type, caused by change in the brainstem or cerebellum. The essential type presents no changes in MRT. Rhythmic movements of the soft palate distinguish this tremor type. Patients feel an ear clicking.

Medicinal or toxic tremor

Tremor is regarded medicinally induced, if occurring in temporal relation with medication, and shaking is the potential side effect. Toxic tremor types occur after acute or chronic intoxications. The medicinally induced tremor may differ considerably. Clinical picture depends on the group of medication. Enhanced physiological tremor, classical tremor, cerebellar tremor may occur.

Tremor in polyneuropathy

Chronic severe inflammation of periphery nerves (poly neuropathy) may rarely cause a tremor.

Wilson's disease

Wilson's disease is a disorder in copper metabolism, causing changes of liver and brain. One symptom of this disease is rough shaking, termed as wing-flapping.

Shaking in the elderly

The so-called shaking in the elderly often is a non-heritable late-onset of the essential tremor.

Psychogenic tremor

There is no organic disorder in the nervous system in the background of the rarely occurring psychogenic tremor.

This short description of diseases, having a tremor as symptom, shows-, that shaking does not conclude Parkinson's disease in all cases.

October 2006 / Dr. Ferenc Fornadi, Gertrudis-Klinik Biskirchen , Germany

(www.parkinson-web.de)

Experience report ThevoCalm testing with Mr. E

Mr. E. is 86 years old and resident of a care community. He suffers from Parkinson's Disease.

He is well-oriented and presents no dementia-affected changes. The slower response time related to M. Parkinson's may assume a mental slowdown at times. However, this is not proven. Mr. E. clearly expresses his wishes and does not permit others to decide for him.

He makes the nursing staff explain all measures and considerations for the improvement of his care. If he considers them to be plausible, he agrees.

He clearly expresses and describes his illness-related impairments.

In addition to Parkinson's Mr. E. also suffers from macular degeneration. So, he is legally blind.

Mr. E. has sleeps badly. He complains about back ache and pain in the shoulder-arm area. He complains about pain when lying down, caused by his inability to change position. The pain described is one reason for his poor sleep at night. Pain is not limited to certain body parts. He describes pain all over his body. The nurse management describes him as "The princess and the pea", to underline that even supposed little things may create pain.

Mr. E. has no pronounced tremor. Rigor (muscle stiffness) presents, depending on the structure of the day, as follows: He describes a gain in weight of, e.g. his feet, a drinking glass or the rollator.

He wants to lift these objects. However, his attempts to do so become increasingly difficult, since muscles become stiff during his attempts. He describes this as a gain in weight of the objects.

This problem is present at night, as well. He cannot make big changes of his position and needs to be re-positioned. However, he can make little movements, like slight gravity shifts. But even these movements are often difficult because of the gain in weight he describes.

The slight gravity shifts have a positive influence on his pain from lying down.

Based on this background, Mr. E. was provided with a Thevo-therapeutic bed on a trial basis on 2010-02-24, to see if it provided relief.

Just 2 weeks after sleeping on the Thevo-therapeutic bed a more than significant change could be noticed. The nurse management in charge reported that already after a few days, Mr. E. had a considerably better sleep, and still has. It is clearly recognizable that he is more relaxed in bed and sleeps at night. Pain seems to be barely perceivable any longer. Asking him showed that he no longer expresses the weight gain mentioned before. He states that he sleeps better.

He still needs to be repositioned, since independent position changes are still lacking. It can be assumed that he is able to make slight gravity changes and thus has a better sleep.

Mr. E. stated he feels better in the morning and starts the day quicker. He does not want to lose this Thevo bed.

Bremervörde, 2010-03-23

Experience report ThevoCalm testing with Mr. S., August 2010

Mr. S. has had Parkinson's for 16 years, is medically adjusted and provided with an impulse generator for deep brain stimulation since April 2009.

Because of this, external persons cannot recognize any tremor.

He often has a restless sleep at night and describes situations which make him wake up because of his intense movements, like hitting the wall with his arm or kicking. He also complains about strong back ache after lying down for longer periods. He has problems getting out of the bed – especially in the morning.

He tries ThevoCalm.

In the course of testing he starts to fall asleep more easily and sleep through the night. Intensive movements, occurring leg movements and leg cramps decline in the course of testing as well as nightmares described before.

Upon completion of the test he states that he lies considerably calmer and that intentional movements were easier to perform. Position changes in bed were easier to make. "It simply was different" is his positive feedback. Painful muscle tension was considerably reduced, so Mr. S. could sleep longer and better. Being able to move much better is one main aspect for him. Especially getting up in the morning is much easier now. "I just couldn't get out of bed before. I literally was stuck in the mattress."

Mr. S., weighing 86kg, initially was provided with ThevoCalm 80. He complained about sinking into the mattress too much and about difficulties moving. Also restless dreams, often accompanied by occurring movements, become more frequent.

By providing him with ThevoCalm 140 problems decreased and he can again move better.

Bremervörde, 2010-10-04

Experience report ThevoCalm with Mr. B., September 2010

Mr. B. is a medically adjusted Parkinson's patient. He is impaired in his movement due to visible muscle shaking including muscle stiffness. He reports that he very much depends on his daily schedule. He is still working as a freelance insurance broker. However, he now needs to employ a co-worker, since he "never can rely on his form of the day".

Mr. B., 87kg, tries ThevoCalm 80 first, but after two days he reports that he cannot sleep. Muscles are increasingly tense, and he suffers strong neck pain.

ThevoCalm 80 is exchanged against ThevoCalm 140.

After the first night Mr. B. reported a better lying quality and relaxed neck muscles.

During the trial he reported that position changes are easier. Gravity shifts or micromotions are facilitated, despite muscle shaking. Even complete position changes are easier for him to do.

He falls asleep much easier.

The improved positioning unfortunately does not influence the tremor. So, he still wakes up at night from shaking and leg cramps.

Nevertheless, Mr. B. states that he sleeps better through the night and is less tired during the day. He has the subjective impression that vitality increased due to his improved sleep. Daytime activities are facilitated and he reports higher concentration.

Bremervörde, November 2010

Ute Geitmann

Experience report ThevoCalm,
Mrs Kunze (coordinates local Parkinson group together with husband), Rendsburg

*1. How often do sleep disorders and Parkinson's coincide? How severe are the symptoms?
What are the causes?*

In my conversations I often hear that sleep problems are very widespread amongst Parkinson's patients. The sleeplessness causes a deterioration of the physical symptoms and impairs the quality-of-life due to the daytime tiredness. Overall I sleep very restlessly, my husband even says that I thrash about and shout loudly. With me it especially comes to sleep disturbances in the REM phase.

The beds and mattresses on which I have slept up to now were not able to process this restlessness and I regularly woke up. On top of that, in the morning I had back pain. But this is nothing unusual for someone with Parkinson's. The therapy mattress from Thomashilfen has helped to significantly alleviate my pain and restlessness.

2. What are the convincing arguments in favor of this special mattress?

The therapy mattress from Thomashilfen absorbs all movements and gently cushions them. It adapts well to me, and above all, it follows all my movements. In spite of this adaptability the mattress gives me sufficient support so that my mobility is ensured. I can turn around and easily get out of bed in the morning. The shoulder area yields easily and I no longer have to worry about tension.

In the morning I don't even want to get up, that is how enjoyable it is to lay on the ThevoCalm. When I do get up, I am well rested and more balanced during the day. I need my strength. As regional manager of a Parkinson Group, I organize various events and training courses where members are provided with the latest information in Rendsburg / Schleswig-Holstein. I have to look after the interests of those afflicted with Parkinson's. My nightly rest has improved, the sleep is more intensive, better and I am more rested in the morning.

3. How did you find out about this mattress?

At last year's delegate congress of the German Parkinson's Association (dpv, Deutsche Parkinson Vereinigung e.V.) in Kassel. Thomashilfen exhibited a mattress and offered it for testing at home. I was happy to accept the free offer. Since the trial, I sleep better, am more relaxed, and more vital during the day.

During the consultation I was interested in the construction of the mattress with the "wing springs." Apparently the wings springs do something so that I can sleep better. That's good enough for me.

4. Do you wake up in pain anymore?

I often used to have pain, especially in the morning. Since Thevo, I get up in the morning without back pain.

Bremervörde, June 27, 2013

Experience report ThevoCalm accompanied testing, R.G. hospital nurse

The mattress for those afflicted with Parkinson's arrived last week for testing.

It is surprisingly light in weight and easy for one person to unpack. An elevated position of the upper body is still possible as the product can simply be placed on an existing slatted or electric frame.

The water resistant and air permeable coating of the upper side of the mattress is also a perk.

The cover protects the inexpensive foam against unwanted wetness. I noticed that the afflicted person not only appears to have slept more deeply, but during the nightly visit to the toilet is in comparison „not so shaky;“ the gait pattern appears to be smoother.

Of course this is only an initial impression. In practice it needs to be shown how the mattress performs when subject to wear and tear after getting in and out of bed.

My wish would be that with a new purchase, which will certainly be necessary after 10 years, a „repurchasing discount“ is addressed. A purchase, as soon as the decision about the size of the new bed has been made, will certainly be undertaken by the afflicted person.

R.G. hospital nurse

At the request of R.G. the address and name are not mentioned here, but are however known to Thomashilfen.

Bremervörde, July 25, 2014

Experience report ThevoCalm, Mr. Bente Andersen, Copenhagen

„The last year I have had problems with my sleep. Usually I woke up after 4 hours of sleep, and so could not fall asleep again. This meant that the entire next day I could barely stand up and sleep. When I sat in a chair, I could suddenly fall over, and if I sat with something in his hand, dropped it on the floor. And it goes beyond one's entire well-being, if you sleep too little. In March there was with the magazine Parkinson Recent included an advertisement for ThevoCalm mattresses - including a Parkinson mattress. I decided to test it - and I have no regrets.

Already the first night I slept 7 hours - and since then I slept between 5 and 7 hours each night. If I had previously had to get up to go to the bathroom, I could not fall asleep again. But now I can get up, go to the bathroom, and go to bed and fall asleep again. I feel that my body is more rested, I can overcome more everyday. My friends and family say “ you have come to look better” and it is certainly not so bad.

All in all I can recommend ThevoCalm Parkinson mattress.“

Copenhagen, 21. April 2015

Experience report ThevoCalm, Michael Melcher, Young & Parkinson

One would think that we Parkinson's patients would be happy.

After all, we get much more out of life. We have the sunny days for our commitments. Then, when the moon shines, the new day starts. We have time to meet our friends on chats, paint pictures, or knit. So, we get a lot more out of our day due to our interrupted sleep.

Unfortunately, it is not that simple. We know the meaning of too little sleep from experience. We are imbalanced and toward lunchtime, we become tired and reach our limits or slow down.

I have tried many things, since I still work.

My doctor gave me natural sleep aids, which unfortunately did not help. Calming tea or walks in the evening also failed to significantly lengthen my sleep phases. My sleep phase was usually over around 3:00 AM, so I would watch TV, paint, read or chat just to keep busy. Around 6:00 AM, I would feel tired again. This was not good for my work life, since that's when the alarm rings and I have to get ready to go.

Four hours of sleep or sometimes even five hours is just not enough in the long term.

At Tulip (German Parkinson's Gala) in Berlin, I found Thomashilfen, which offers mattresses specifically for persons who have Parkinson's.

Their friendly advice and uncomplicated atmosphere encouraged me to call the company and ask about testing the mattress. It was very helpful for me in my search for restful sleep

After a very friendly conversation and a match of personal data (weight, bed size), the mattress was delivered to me within a week.

It was pointed out to me that the first three to four nights may feel unfamiliar. This was indeed the case.

I have now been sleeping on the mattress for three weeks and have sleep times of at least seven hours. Yesterday, I even made it to ten hours. Getting up in the morning is also a lot easier for me, since my body is relaxed and rested.

The only problem I battle now is getting my body accustomed to sleeping through the night. I still wake up around 3:00 AM, but force myself to stay in bed. I drink a sip of water, turn over and keep on sleeping.

I have firmly decided to buy the mattress. I'm a little mad at myself for not having done so sooner.

I can only recommend it, based on my experience.

Thank you, Thomashilfen!!

A well-rested Michael Melcher

Experience report ThevoCalm, Shay Healy, Ireland

Shay Healy Sleeping Soundly Again on the Thevo Mobility Mattress

For the past two months I have been testing a mattress designed especially for people with Parkinson's. It is geared to make sleeping more comfortable and ameliorate pain in the morning. It was and has been beneficial across a range of the complications of Parkinson's. There's a special mattress for wheel-chair users and even one for those with dementia.

As a final test, I slept last night in my old mattress and when I got up this morning, „Jaysus the pain“ is all I can say.

The difference between my old mattress and my new one is inestimable.

They are called Thevo Mobility mattresses and what happens is when your body moves, the mattress automatically counters the move and puts you back on an even keel.....

Stay sane
Shay Healy

IGAP

Institute for Innovations in Healthcare
and Applied Nursing Science

Stader Str. 8 · 27432 Bremervörde
Tel.: 0 47 61/8 86 74 · Fax: 0 47 61/8 86 69
www.igap.de · info@igap.de