Issue 64. October, 2008.

GBS ……..CIDP

INFORMATION

GETTING BETTER SLOWLY
NEWSLETTER OF THE IN GROUP: THE INFLAMMATORY NEUROPATHY SUPPORT GROUP OF VICTORIA INC.
Supporting sufferers from acute Guillain-Barre Syndrome(GBS) & Chronic Inflammatory Demyelinating Polyneuropathy(CIDP)

ANNUAL CHRISTMAS LUNCHEON
And Dutch Auction
Balwyn Library Meeting Room, Whitehorse Road, Balwyn
12.30pm. Please note change of time.

DECEMBER 7TH, 2008.

The fun is on again. Come along to our Annual Christmas Luncheon. RSVP to either Melva Behr 9707 3278 or Jan Pettit 9702 3672 by December 2nd. A small wrapped gift (with an indication of value to aid the auctioneer extraordinaire Ken Clarke), would be appreciated.

ANNUAL GENERAL MEETING HELD 17th AUGUST, 2008

Welcome everybody. It's good to see you all. We have some apologies from Fred Hooten, Barbara & Tom Rivett, Janette and Bernie Pettit, John Burke and Margaret Wilson.

Minutes of 2007 Annual General Meeting - as distributed.
Motion: "That the Minutes of the 2007 Annual General Meeting be accepted."
Moved: Peter McInnes Seconded: Dorothy Brennan. Accepted.

President's Report. – Margaret Lawrence
The 'IN' Group has had a successful year. The Christmas and Winter Luncheons were enjoyed by many Members and proved financially successful. Dr. Andrew Kornburg attended the Christmas Luncheon and we were able to present him with a cheque for $10,000 towards his research. A big "thank you" to our many generous members who made all this possible. Andrew also attended our group outing to CSL where we learnt much about the blood products and enjoyed their kind hospitability. At our general meetings during the year we have enjoyed interesting speakers and one informal meeting where members were able to talk through their problems.

I wish to thank each committee member plus all the other helpers. Everyone is so willing to assist, even in a small way. It makes such a difference to us all. I have had wonderful feedback about our Newsletter, so a special thank you to Melva and her wonderful elf Joe. To CSL and especially Stephen Bowditch, our thanks for your assistance throughout the year and your ongoing help with our Website.

In closing, it is a privilege for me to work with such nice people and I thank you all for another great year.

Treasurer's Report- Doug Lawrence

We are going extremely well with income within this financial year of $9564 made up of subs $2500, donations $3600, the State Government Grant of $1300, a little bit of bank interest and our fundraising. The Christmas Luncheon raised $1118, Winter Luncheon $580, Jewellery sales (for which we say thank you very much to Gwen again because we had a donation last year from you) a further $340 and from our sundry book sales $74. Total income for the year of $9564. Total expenses were $11759. We have had a negative flow of cash of $2193 but that's pretty good considering the $10,000 donation. As at the 30th June we have a bank balance of $7294 which is well on the way towards a further donation this year. Our subs. are now due and I am banking quite considerable amounts and we are now well into the $9000 so we will achieve last year's levels.

I must say thank you to all members for their donations. They are very, very, pleasing. We find donations do exceed subscriptions and we think you are all fabulous. Thank you to all our members, those involved in fund raising, all who give donations, both from here and overseas, as whilst fund raising is our secondary function, it is a very pleasing result.

Motion: "That the Treasurer's Report be accepted."
Moved: Doug Lawrence Seconded: Melva Behr Accepted.

The Committee were all re-elected unopposed. Thank you to all those members. Applause.

General Business.

As you know our Website is way out of date and we had Stephen Bowditch of CSL come and speak to us at our committee meeting. We had another meeting after which Doug did a lot of cutting and pasting and we have now have what we think would be a reasonable website.

This information will be sent to Stephen and then he will meet us again. Our website will be updated and it should be fairly easy to just click on. Hopefully that will be done reasonably soon but it takes a lot to get it all together.

I have sent a little letter to Dr.Andrew Kornburg and Dr. Richard Stark telling them the date of the Christmas Luncheon and hopefully they may be able to come as they are very busy men. A formal invitation will be sent later.

The Christmas Luncheon will be held on the 7th December and Ken Clarke will do the Auction again.

In closing I do mean what I said in my report that it makes such a difference with all the little bits and pieces that people do as well as the ones who do a great deal. It's running very smoothly I think and thank you for that.

All those present said they loved the fun of the auction so we will continue with that and it is a good money spinner for us.

June Cathcart moved a vote of thanks to all the office bearers for 2007/2008, especially Margaret, Doug and Melva and thanked all the committee members. Peter McInness supported June's remarks with particular emphasis on Margaret and Doug saying, "These people are not directly affected by this situation like the rest of us are in some way and they, along with Melva, do 95% of the work, but particularly the focus in the Lawrence household is a magnificent staging point for an organisation like this and we should be extremely grateful to them". All applauded.

Meeting closed. 1.25pm.

TALK BY MALCOLM LEVY, PHARMACIST (abridged)

I am originally from South Africa but an Aussie now. I was born and bred in a little place called Port Elizabeth in South Africa. **In our final year we had to do a hospital orientation course and the first case we had was a lady, lying on a bed, absolutely paralysed with a nurse giving her a bath (which I found totally undignified for the poor lady) and I said " Well what's wrong with her?" and was told Guillain-Barre` Syndrome. It was my first case study and now here I am at your support group. I tried to find my notes but with immigrating and house moving several times I was unable to find it.**

Pharmacy in South Africa and Australia is very similar. We have a general knowledge. People like us to have specific knowledge and be totally up to date but we just can't do that. I actually requalified in Australia at aged 46 and the head of the pharmacy board said, "It's not important that you know everything about every drug available in Australia, but you need to know where to go to find out about it and that's the big thing. In pharmacies you can walk in and say you're on prednisolone, (we give out

heaps of it), and know most of the side affects no problem, but if you come to me and be specific about a drug your on for your specific condition, **I need to know where to get hold of that information, look it up, and we can do that for you.**

9 times out of 10 you would have more knowledge of your condition than your pharmacist. The doctors who treat you, (even where medications are concerned), know better than we do because they are working with you every day. Our job is to assist the doctor if he asks, as can we look something up for him. I can tell him about interactions, say he might like to consider something, and that is the role of the pharmacist in Australia.

After qualifying as a pharmacist the government then got their bit back and I was given two years of National Service which we had to do in the Armed Forces and to this day I am still a Commissioned Officer in the Medical Corpse. I spent a lot of my time assisting in a war zone operating theatre.

I was then sent to a training camp where young 18 year olds were sent for 3 months. These kids came in the middle of winter, (Melbourne sort of weather), coughing their lungs out. I would walk through the barracks at night hearing these kids and one of the doctors came to me and said "We've got to sort this cough out". I looked in the store and did what we can't do in Australia, made up a cough mixture with a little bit of this and a little bit of that and it sorted the cough out. They said, give us a name for it and I said, "Just call it MMCM". So they would write on the prescription MMCM and the dosage and off they went. Two weeks later I get marched in on orders to the Commander of the camp, an Infantry Officer and he reads out this letter from some mother which says "My son has written to me saying he had this terrible cough and you've given him medicine and I have tried to get it from my local pharmacy and I can't get it. Could you please tell me where I can get MMCM." I'm standing there the Commander says to me "Lieutenant, What is MMCM?", and I said, "Well sir, it's a cough mixture we made up and it's certainly helping the lads". "Yes, Yes," he says, and I'm standing there still under orders and he says "But what is it?" I answered, "It stands for **Malcolm's Magical Cough Mixture".**

Later, I bought a nice little Pharmacy in Port Elizabeth then we decided to migrate to Australia. In Australia we like to be the best, so I had to requalify. It was character building. I had to write certain exams, rewrite one I had done in South Africa, then work for a pharmacist for 6 months, undergo another examination, got through all that and then I was good enough to register here, which I did.

I spent a couple of years working for My Chemist and then moved on to National Pharmacy, then eventually acquired the pharmacy I have now.

Pharmacy in Australia is a serious topic but I like to lighten it up a bit. **We are not these intellectual people sitting behind a counter unapproachable, absolutely not the case. We are 100% approachable. Most of us have a sense of humour, we like to joke a lot so what I'm trying to get across is come in and have a chat with us – that's our job**. They say to be a doctor you need to be able to count to five, but to be a pharmacist you have to be able to count to at least 10. Most packs are in lots of 10. We are always available.

A question I get asked is "Are we shopkeepers or are we professionals?" Well I'd like to think we are professionals. We happen to work in shops. We need to be human, we need to be great listeners (which we are), we need to be compassionate because we hear everything like a doctor and we need to be accessible (which we are always**). We might be busy and ask you to wait for a few minutes, but we certainly are accessible and professional.**

The actual dispensing of medication in Australia is quite a difficult thing. It starts off when you walk in and hand your script in and a lot of people get annoyed by maybe a different front of shop lady posing a few questions and they say "It's on file." We need to have a name and address, a Medicare number, a concession number if it's available. Medicare (which is the government), insist that we see this every single time we dispense to you. That's not practical but that's what the law says. We need to know if you have reached your safety net because we don't want to overcharge you. So that's the first thing we do.

At that stage the lady will offer you generics. Do you mind? Would you accept the generic if there is one? Most people are quite happy with that. Generic medication is a big push at the moment by the government. Times are tough for everybody. The government would like everyone to use generic medications where possible.

With generic medications a lot of them are exactly the same. We are playing with names. I have a couple of examples. It is not always about cost. Take for example – Panadeine Forte. We offer Prodeine Forte. How many people say to me "Nope it doesn't work. It's not the same." We can't argue with you. All I do say is if you look at the two packs they are identical in size. Look at the tablets. They are packed identical – just the foil on the back is different.

My brother is a production pharmacist in South Africa and I visited him a year ago and I hadn't seen production in 25 years. The tablets come out of the same machine then run down the shute into the bottom part of the packet. The only thing that changes is the foil which seals it. One comes out as Prodeine Forte the other comes out as Panadeine Forte. If you have a look at the box the original is Panadeine Forte made in the UK, distributed by 'X' Laboratories, 16 Blythefield Street, North Ryde, Sydney – the generic coincidentally made in the UK, distributed by 'Y' Pharmaceuticals, 16 Blythefield Street, North Ryde, Sydney. This is the same company. They co-market. The pie is just so big. The more times you cut it up the less you get. If they bring out a generic they have got another piece of that pie. So when your pharmacist offers you generic, 9 times out of 10 it is identical.

Astrix – Asprin. If you get this on prescription there is a surcharge. The government insist on it. Losic – Asimax. These are absolutely identical. The only thing is the colour of the foil. **So when your pharmacist offers you generics don't hesitate. It is the same.**

With the NHS pricing, it's simply cost. There is an acquisition cost which is transparent, plus 10% which is my mark-up, plus a professional fee. It is government regulated.

When it gets to really expensive medications, we have to keep it in stock for whenever the customers want it, the mark-up is 2.5%, so on an acquisition cost for me of say $1400 to keep that box on the shelf, I make 2.5%. If you don't come back for your next scripts and it keeps lying in my shop and it expires, I can supply you for three years and if you miss one I make nothing, but I'm expected to have it on the shelf. This is why in a lot of cases when you walk into a pharmacy with a script we may say to you, "I actually don't have it in stock, but I'll get it in for you tomorrow". If I had to stock every item available I would have to quadruple the size of my dispensary. And there are no returns. Fridge items especially, like insulin, injectables and vaccines. You order, it arrives, and tough luck if it goes out of date.

The other thing you have to be very careful of is **the discount pharmacies** popping up all over the place. They have a place. I am dead against them – I have worked for them. **They say Australia's cheapest chemist.** Have a look at it. On the right hand side there is a little "Are we" – Are we AUSTRALIAS CHEAPEST CHEMIST. **They are not,** but by putting up a sign everybody sees it, but doesn't read, we are made to believe they are the cheapest.

My pharmacy does not discount. We quote you a price. So when you come in wanting a nasal spray on prescription but its not covered by PBS and you say "But I can go to ……..and I can get it for 50% discount, how much do you discount"?, I say "zero". I'm the rip off because my price is $29.95 and their discount price is $32.

We don't give discounts and you can go to your Pharmacist and ask, "What will this cost me?" When it comes to government prescriptions there is no discounting. It is not allowed. The discount chemist will not discount them either. Therefore concession rate you pay $5, general $31.30 - no discount. If we discount we can lose our licence, so we don't.

Now the Prescription has now come in and we have offered you a generic. We can push the prices down if possible.

Another thing where you have to be very careful, some of these discount pharmacies will say to you**, now you're taking X for your blood pressure and you've got a repeat prescription which is 6 times the total - so $180 for your six month supply. Why don't you come to us and we'll give it to you all up front for $120. Wow $30 saving, yes why not. The problem with that is when you get your supply at your normal pharmacy and you pay your $31, it's coming off your safety net. When you get it in bulk at these discount places, it doesn't come off your safety net**, so you don't get onto your free list if you are a high user. We have people coming in saying "**How come I haven't hit my total?" When we look at the print out it's 00000 and they say "I got 6 month's supply". It doesn't count for your safety net and you have to wait another 2 months or so to hopefully reach it.**

Then we have the situation where people come in and say **"My doctor's changed my medication".** My blood pressure has gone up and my "X" is not good enough any more so I need a diuretic with it. No problem madam. She says, "Well **what am I going to do with these 5 boxes of medication** that I now have that I can't use**". Simple, we have a yellow bin. It's thrown in there and is incinerated.**

So we need to look at cost effectiveness as opposed to physically taking the money out of the wallet.

Now I have got the script and we've offered you a generic. We'll then have a quick scan to see if there are any interactions. Now this is where the role of the pharmacist comes in. Are there any interactions? Is there anything obvious?

We had a quick look at it and there are no interactions. We then go back to the computer and read all the data. If an interaction comes up it is up to us to decide do we want to do something about this and speak to the doctor. The problem is if you are using varied pharmacists it is not going to come up as an interaction. Try to stick to the one pharmacist and build up a relationship with them and they might find that you have been put on a drug 6 months ago and then for some reason you are put on another which could have a reaction and it will come up on his computer.

My brother is also a pharmacist and during his traineeship year he lost a patient. The guy had come in off the street and ordered a Beta-blocker. My brother dispensed it, counselled him about it, but three days later the fellow died. He was badly asthmatic. If he had gone back to his original pharmacist, who knew he was an asthmatic, he might have picked up the phone and said to the doctor "Shouldn't you rather try some other form of treatment?" We are all human and we can make a mistake.

The moment the label is printed by the machine there is a PBS component, (the government side of it), and now every pharmacy has to had a scanner and the drug gets scanned in. If the script says Panadeine Forte but we scan in Panadol Forte, it comes up wrong and you go grab the right one. Then we slap on the label.

Another thing you might have seen are little stickers over your medication saying don't do this and don't do that. There are about 47 of them available. The government wants us to use label 1 which is about not taking alcohol with particular medications, but the others also have good information, like watch out for dairy products, take before meals, take after meals, just little things that make you more compliant on how you take your medication.

So we have scanned the medication, slapped on the labels, but in the background the PBS component has been happening. Pharmacies in Australia are now "on line" pharmacies. The moment we press finish it starts printing labels and reports. We are on the internet linked up instantaneously and the reply comes back to us as to whether you are who you say you are, your Medicare is current, your healthcare card is current, your concession card is current, or you have reached your safety net and whether or not they are going to pay us.

What has been happening in the past, people have been seeing a doctor and if the doctor has written 30 and 5 repeats and has asked for regulation 24, this means he has authorized us to give the whole lot on the PBS at once. It is no cheaper for the patient, so if you are paying $5, you pay $5 x 6, but you get 6

months supply. Then these people get another script from another doctor, go around the corner to another pharmacist and get another 6 months supply, etc. etc. This medication gets put into a bag and sent overseas**. Heaps and heaps of medication left this country funded by our PBS for use by people all over the world. PBS "on line" has hopefully stopped a lot of that.**

Our government has this great thing about handing out **concession cards and then cancelling them**. If you have your card which is valid until 2010 but they cancelled it **tomorrow you could go around to every pharmacy in Melbourne, (who is not on line) and present your card and get your drugs at $5 when you're not entitled as you have to pay $31 for them. Now being "on line" has cut that down. There was a lot of abuse of the system. Hopefully PBS "on line" has sorted this out.**

On PBS we check that you are who you say you are, your concessions are valid and then we start working on your Safety Net component, which is very important if you are a high user of medication. For example, for a general patient it is $1191.60 per calendar year - not a financial year. For a concession patient or pensioner it's $290 which relates to 58 prescriptions within the calendar year. It started off with 52 then 54 then 56 and this year 58 and I guarantee come January it will be 60 and the $5 will go up to $5.20. It happens all the time.

Now they have brought in a 21 day rule, once again a government rule. What happened in the past Mr. or Mrs. Smith was on 6 medications and **at the end of the year he/she reaches their safety net and was entitled to free medication. We would get swamped October/November by people rushing in getting one or two of everything. Give me the lot.** Now as a pharmacists, you think if I don't, the person around the corner will do it, so all I'm doing is throwing business away, but we know they don't need it and all that's going to happen is that next year they will have enough medication (if they are still on it) to take for Jan/Feb/March which kills my business for those months and so you would give it. **December in a pharmacy was absolute hell. Scripts - if you were doing 5000 a months you would be doing 10,000 in December - you couldn't cope, so the government has brought in this rule, the 21 days rule on certain medications only. Medication such as your blood pressure medication, you are entitled to get your supply but if you come in within 21 days of getting your original supply, you can get it, you pay exactly the same for it, we get paid the same, but that supply doesn't count towards your safety net,** so you don't get on the free list. They have spread your usage and if you watch your calendar you can get up to two extra per year, if you really need it, but it has stopped this run on medications which the doctor may change.

What we have done now, we have basically got your script ready to give back to you as the finished product. That's where the role of the pharmacist comes into it. We will council you on the correct use of the medication, the safe disposal of the medication, e.g. pain relieving medication. The problem is we have a huge drug problem. We encourage you, if you are on a pain killer patch, when you take it off, make sure you stick it to itself and maybe put it into another bag so that no kid or relative or someone coming along who knows what it is can grab it out of the bin. (It sounds terrible but addicts are not opposed to going through bins to take the residue off the patches.)

Pharmacies have this yellow bin and we encourage you to go through you medicine cupboard and if there is stuff that is not being used get rid of it. Take it to the pharmacy in a bag and ask them to please dispose of it. It is a service all of us offer and there is no problem. There is no cost to us and no cost to you and stuff gets incinerated and disposed of.

We will also council you on possible side affects, like with Antibiotics – yes we all have antibiotics throughout the year, but how many times are you told that one can cause thrush, or this one can cause tummy upset, etc. That is our role. Your pharmacist should be advising you and if you are on penicillin, amoxicillin, you can actually take a little bit of yoghurt with it, twice a day or three times a day, to prevent the onset of thrush that can happen. Certainly some antibiotics should be taken half an hour before food, some with food and others after food – that's the job of the pharmacist, to be out there and inform you to do it like this or try and do it this way.

We will go through the warning labels with you. Label 1 – don't mix with alcohol. Most of this warning is because of drowsiness, so with sleeping tablets, Valium, anti-psychotics, anti-depressants, the net effect would be sedation, increased sedation, as we are taking a relaxant.

With alcohol it bombs us out, which is no good. The problem comes when we take a drug like Stilnox, brilliant drug, but if taken with alcohol, people have been found walking down the street saying "Why am I here?" Some even jumped off bridges, because of mixing this medication with alcohol. **When the pharmacist says don't take with alcohol, he really means**

I am a firm believer of social drinking but if you need to have a sleeping tablet, have a talk to your doctor so you don't fall asleep at 9 o'clock at night and wake up at 3 in the morning. You may have to take it later, sleep later and wake later. A glass of milk with a little honey always puts me to sleep.

You might be on a steroid for asthma and we might go through it and tell you to take it when you're well not when you're sick, because it keeps you well, doesn't make you well. It actually prevents you getting the asthma. We will warn you about rinsing your mouth out after it as otherwise you are going to get thrush in the mouth, which is unpleasant. That is actually the job of the pharmacist. If your pharmacist is not doing that, you are quite within your rights to say, "Would you mind counselling me on this medication". If he is still not doing it you need to change your pharmacy.

If you go to the discount pharmacies where I used to work, you will be told, excuse me you have come here for the price. **The pharmacy board insists that there is contact between you and the pharmacist to make sure that you are using your medication correctly. 25% of hospitalization is through incorrect use of medications. Within the hospitals they have now got a computerised system to try to get the dosing right and the amount of medication right and its working great.**

You have your prescription medication right, what else may you need. You will notice in every pharmacy a sign that says **Professional Services Area**. Behind there is where you will find your **pharmacy controlled medications; your nasal sprays, codeine, colds and flu medications, anti-fungal medications, etc. All these medications need to be sold under the guidance of a pharmacist.**

We are not trying to be difficult when you walk in and say "I would like a packet of Neurophen Plus please", and the pharmacist rushes to the front and asks "**What do you want it for?" Or if you want a cold and flu tablet, "Eh what do you want it for mate?" "I have a cold!" you answer**. We have to ask these questions. **We have to ask inappropriate questions because of abuse of medication.** There is massive abuse of codeine; there is massive abuse of pseudoephedrine. I am a scuba instructor; the best drug on the market is pseudoephedrine. I don't know where I can get some, plain pseudoephedrine for colds. Best drug around, but we can't get it, so that's why when you go to your pharmacist and you ask for anti fungal cream or whatever, the pharmacist comes out with all these inappropriate questions. "What are your symptoms? Why do you need it? Is there an abuse factor? Do you know how to use it?" they ask. It is so we can give you the smallest amount for the smallest amount of time. If you need any more, go and see your doctor. We are just trying to do our job. **That's what the board says we have to do, because of the abuse factor.**

The government is now pushing "**Home Medication Reviews**". If you are taking a lot of medications, (I think it's up to 5 medications), or if you have had a recent hospital visit, or recent changes in your regime or changes to your medications, **you can approach your doctor and ask for a medication review. It has to be instigated by your doctor. A consultant goes to the patient's home to visit and will check all your medications with you.** They ask if you take any complimentary medications, if they can see that, see where you are storing your medications, and ask you to show how you use it.

They then prepare a report which is sent back to the doctor. They do not change anything. The report will go back to the doctor and the **doctor will ask you to come in and discuss the report. He will go through all the recommendations, take you off this, and recommend that, adjust this, etc. It is a great service. It is available for everybody.**

There is a new service which we have just signed up for and it will cost I think $5, where you can be seen by a councillor in the pharmacy in a completely private area.

The last thing I want to discuss is the **dosette** which is a large part of our business. **We make them up** for nursing homes but they are **also available for the public**. Some pharmacies charge but we don't charge our regular customers for this service.

If you are on a heap of medications and you are finding that you are not sure if you are taking it, or you are going overseas or you're going to respite or hubby is going to respite and they want medication packs**, go chat with your pharmacist. He can do this for you.**

It is called a Medico pack. Dosette boxes - we don't like them. The medication falls out easily and they are also hard to keep clean. **So ask your pharmacist about this new Medico pack system. They are very nice. They are 100% foiled. On the back is recorded your medication, with your name, the name of the pharmacist who packed it, what is the dosage. It is all in clear English. Four doses – breakfast/lunch/dinner/ bedtime. It can be tailor made**. **All you have to be aware of is that it starts at the bottom on Sunday.** You start at Sunday breakfast. You take it off and if you need to run to the loo it is still sealed. It has your name on it. It perforates along the dotted line.

We do 5 nursing homes at the moment and have another two coming shortly. In the homes there are division 1 nurses, endorsed division 2 nurses who can give out medication and then the carer. The carer is the scary one. They are generally untrained, a lady who is just working there because the rest of the staff are off. No idea about medication. This system makes it easy. All they have to do is take Monday breakfast and give it to Mrs. Smith and it's legal.

We picked up on this situation in a nursing home. A guy did not want to do it. He was dead against it. He didn't want his independence taken away from him. He was having increased epileptic fits. We spoke to the family. Let us pack them. We had a chat with him. Eventually he said he'd have a bash. We went back after two weeks and asked how many attacks he had over the two weeks. He hadn't had any. What had happened was he was getting his medication regularly and his fitting was stopping. Previously he thought he was taking his medication, but he was having a fit and thought he had definitely had his medication, but he hadn't. This has given him quality of life. **If you are going out for the day you just tear off your day and put it in your bag.**

There **are a great number of aids out to make your life easier.** Handrail suctions. These just slip onto tiles and it's an extra grab when you need to get out of the bath or shower. There are long handled sponges, button under-doers, shoe horns, sock aids (for if you can't get your socks on), you put the sock over the aid and they are brilliant. Key turners, holders for if you can't get things off the floor and there is an aid for when you get out of the car - a hook to hold onto which slips onto the side of the car. This is a really good gadget. They are all available at the pharmacies. The firm's name is **Make Life Easy** and there are stores throughout the country. **Look on the website www.mle.com.au.**

Our sincere thanks to Malcolm Levy for such a great talk, with humour and a genuine caring spirit.

We welcome new members **Anna Howe**, from Queensland**, Kathleen Jinnette** from country Victoria and **John De Ravin** from suburban Melbourne to the group. It has been a busy winter in our hospitals with several new cases contacting the committee.

We send our best wishes to **Val Simpson**, a long standing member, who had been hospitalized for months following a hand operation which unfortunately triggered a relapse. Val has such a wonderful outlook on life and it was a joy to share some time with her. **Peter**, her wonderful supportive husband, had heart surgery at the same time and we wish him all the best. You are very special people.

Jan and Bernie Pettit have returned from England following the sad passing of Jan's father. Bernie was not able to have treatment as regularly as required and has less strength in his hands and feet, but hopefully this will turn around with treatment at the Alfred. Bernie had plasma exchange recently and met up with **Peter Malcolm** who is also having treatment at the Alfred. Members will be pleased to know Peter has made some improvement and is looking forward to the Christmas Luncheon again this year. Peter's attendance always provides added fun to this special day. …/9

Special wishes to **our Secretary, Barbara Rivett**, who has undergone a knee operation and we hope you will be back to health very soon.

UPCOMING ARTICLE

Member, **June Cathcart**, author of the publication **A Road to Recovery A – Z**…**for the purpose and encouragement of those with Guillain-Barre` Syndrome and similar illnesses, and their carers**, will give an update of her progress in our next issue. **Thank you, June,** for your ongoing commitment to The 'IN' Group and its members. All proceeds from the publication are donated to the group.

THANK YOU TO BLOOD DONORS – FROM ANNA MELVILLE

One of our younger members, **Anna Melville**, (who because of generous donations of blood has been able to keep her CIDP at bay and achieve her life's ambition to become a pianist), arranged a "Thank You" Concert for blood donors last month. What a wonderful achievement. You are an inspiration and we appreciate your efforts in arranging this wonderful concert. **Well done Anna**