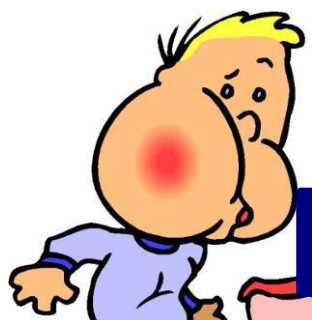


2014-15

Summer

Dec - Feb



Breath of L I F E



liwa
Lung Institute
of Western Australia Inc

Magazine of L I F E - Lung Information & Friendship for Everyone
LIWA's self help group for people with chronic lung disease, family & carers

**L I F E WISHES ALL MEMBERS, FAMILIES AND SUPPORTERS
A JOYFUL CHRISTMAS WITH FAMILY & FRIENDS, AND GOOD HEALTH IN 2015**

L I F E Christmas Party 2014



We are starting the partying early this year! Our annual L I F E Christmas Party will be on

Wednesday 26 November, 12 noon
2nd floor Interaction Area,
Perkins Institute Building (QQ)
Sir Charles Gairdner Hospital, Nedlands

There's no time to think about it! RSVP today; this is a catered event, costing you just \$10 each. Please also bring a wrapped Christmas gift for Secret Santa. More

details inside. **Your RSVP is needed straight away!**

LIWA becomes the Institute for Respiratory Health (IRH)

On 23 October the Lung Institute of Western Australia (LIWA) held a Special General Meeting to approve a change of name to the Institute for Respiratory Health to reflect its broader research interests of the whole respiratory system, not just the lungs.

L I F E remains the same. We continue to be the Institute's community group. Community members will now be called "Friends" of the Institute. That fits with our own L I F E goals of offering friendship and information to all of us living with chronic lung and other respiratory conditions. There will be a special launch of the new name and logo early in 2015.

2015 Meetings for your Diary

We'll continue to meet on the first Wed. from February

Wed 4 Feb

Wed 4 Mar

Wed 1 Apr

Wed 6 May

Wed 3 Jun

Wed 1 Jul

Wed 5 Aug

Wed 2 Sep

Wed 7 Oct

Wed 4 Nov More p28.

WHAT'S INSIDE

| | | | |
|-----------------------------|---|-------------------------------------|----|
| LIFE MEETINGS & EVENTS..... | 2 | LUNG DISEASE IN AUSTRALIA | 16 |
| LUNG LAUGHS | 3 | TREATMENT CHOICES..... | 17 |
| INSPIRATIONS..... | 4 | MUCUS AND PHLEGM | 22 |
| NEWS | 5 | VOLUNTEERING OPPORTUNITIES..... | 25 |
| RECENT MEETINGS..... | 5 | HOW TO FIND PERKINS INSTITUTE | 26 |
| RESPIRATORY RECIPES | 7 | COMING UP | 28 |
| POSITIVE+..... | 8 | | |

LIFE MEETINGS & EVENTS

L I F E's Christmas Party 2014 (continued from page 1)

Wed 26 Nov from 12 noon

2nd floor, Interaction Area, Perkins Institute Building, (QQ), Sir Charles Gairdner Hospital.



LIWA is providing the lovely room, decorating it, organising catering and subsidising our costs. Thank you Dorothy Koh! Only \$10 a person - pay on the day. BYO alcoholic beverage - if you wish. Since this is a catered event **please RSVP**; numbers are important! We also need your name to leave at the Perkins Institute security desk.

Family and friends are always very welcome, especially at our Christmas party. We are also inviting leaders from the other respiratory self help groups in Western Australia. So come and meet them - and celebrate with your mates from L I F E.

Please bring a small wrapped gift, (marked for a male or female as needed). Don't spend more than \$10. See how creative you can be! No need to bring anything else.

Getting to Perkins Institute Building

For an escorted walk or a ride on Charlie's Chariot to the Perkins Institute Building, arrive no later than 11.45am at the main hospital entrance, E block, just inside the automatic doors, and opposite the Hospital Auxiliary office. Charlie's Chariot M 0481 438 721. If you get lost on the day, ring Jenni on 0413 499 701. **More details and a map on pages 26-7.**

RSVP essential - by Monday 24 November

Raema T 9349 0617 or Mary T 9337 1286 E mvfedele@bigpond.com

LIFE Went to Spring Lunch

Well, a few of us did. After a number of apologies and some problems getting the bus to Kings Park, a few people went to lunch at Botanical Café on a glorious spring day in October. We had a short walk viewing the wonderful spring wildflowers.

In November the **L I F E working bee** sprang into action and again helped the Clinical Trials



Unit sorting medical equipment. Thanks to Sal, Shirley, June and Tom. During 2014 L I F E working bee members have whittled away the stockpile to nothing.

LUNG LAUGHS

FLIES

A woman walked into the kitchen to find her husband stalking around with a fly swatter. 'What are you doing?' she asked. 'Hunting flies,' he responded. 'Oh, getting any?' she asked. 'Yep, 3 males, 2 Females,' he replied. Intrigued, she asked, 'How can you tell them apart?' He responded, '3 were on a beer can, 2 were on the phone.'



FIRST WOMAN ON THE MOON



First woman on the moon:

"Houston, we have a problem." "What?" "Never mind" "What's the problem?" "Nothing." "Please tell us." "I'm fine."

Contributed by Mike Watteau of Bentley Bronchiatrix (Yes, it's sexist. Still funny)

RYE BREAD

Two old guys, one 80, one 87, were sitting on a bench in the park. The 87-year-old had just finished his morning jog and wasn't even short of breath. The 80-year-old was amazed at the guy's stamina and asked him what he did to have so much energy. The 87-year-old said, 'Well, I eat rye bread every day. It keeps your energy level high - and you'll have great stamina with the ladies.'



So, on the way home the 80-year-old stopped at the bakery. As he was looking around, the sales lady asked if he needed any help. He said, 'Do you have any rye bread?' She said, 'Yes, there's a whole shelf of it. Would you like some?' He said, 'I want five loaves.'

'My goodness,' she said, 'Five loaves! By the time you get to the third loaf, it'll be hard.' He replied, 'I can't believe everybody knows about this stuff except but me.'

Contributed by Jane Kirby of Clare, South Australia

INSPIRATIONS

The thought manifests as the word;
The word manifests as the deed;
The deed develops into habit;
And habit hardens into character;
So watch the thought and its ways with care,
And let it spring from love
Born out of concern for all beings...
As the shadow follows the body,
As we think, so we become.

From the Dhammapada, Sayings of the Buddha



Life is like a journey on a train - with its stations, changes of routes and accidents!

At birth, we boarded the train and met our parents. We believe they will always travel on our side. However, at some station, our parents will step down from the train, leaving us on this journey alone. As time goes by, other people will board the train; and they will be significant: our siblings, friends, children, and maybe the

love of our life. Many will step down and leave a permanent vacuum. Others will go so unnoticed that we don't realize that they vacated their seats!

This train ride will be full of joy, sorrow, fantasy, expectations, hellos, goodbyes, and farewells. Success consists of having a good relationship with all the passengers, requiring that we give the best of ourselves. The mystery to everyone is that we do not know which station we will step down.

So, we must live in the best way - love, forgive, and offer the best of who we are. It is important to do this because when the time comes for us to step down and leave our seat empty – we should leave behind beautiful memories for those who will continue to travel on the train of life.

I wish you a joyful journey on the train of life. Reap success and give lots of love. I thank you very much for being one of the passengers on my train!

Contributed by L I F E member Denise Wright

NEWS

Warm welcome to new member **Murray Anderson** of Dowerin. Murray, if you are ever in Perth on the first Wednesday of the month we'd love to meet you face to face.

Jack Fulton, loving husband and carer of Ann, is having surgery on 3 December. Good luck Jack! And to **Ann** as she has takes a "change of air" at respite care.

Welcome back **Raema, Rosie, Sarah, Sal** and **Shirl** who've been away with illness or surgery in recent months. Glad to see you again.

Farewell

L I F E farewells **Martin Rosenberg** who died recently. Martin had severe and rapidly progressing pulmonary fibrosis, but dealt with it with great acceptance and positivity. He was born in South Africa and trained as a lawyer. Later he worked providing disabled people with recreational activities, a job he enjoyed very much. When he himself became disabled with severe fibrosis he remarked that, in a very short time, he had gone from being a care provider to being the recipient of care. During 2013 L I F E made a video of Martin talking about his life and how he managed. We'll watch that some time in remembrance. Farewell, Martin.

LungNet Day 2015

What topics would you like to hear about next year at the big education day seminar at Boulevard Centre? Particular lung diseases, services, symptoms? More medical speakers, more people with lung disease speaking? Let Jenni know so she can feed your ideas back into Lung Foundation Australia's planning process with. Contact Jenni T 9382 4678 E life@liwa.uwa.edu.au

Electronic copy of Breath of L I F E

If you have the internet, you can get Breath of L I F E in full colour by email or online. You can also access all the links to websites. Contact life@liwa.uwa.edu.au to change your delivery details. (You'll also save costs and trees)

RECENT MEETINGS

At L I F E's **July** meeting Dr Lesley Silvester presented a fascinating look into life in 17th century London and the causes and impact of the Great Plague on the community and the authorities.



Medical history is a topic of interest to many members and we'll no doubt hope Lesley can return in 2015 with another interesting story from medical history. Lesley is well qualified in this role – she was a nurse and then studied palaeontology and genealogy. She and her husband Mike Murray run **Time Trackers**, a firm which conducts historical research, family history research, publishes books and makes films.

Contact

Time Trackers T 9339 8078 M 0407 669 376 E mike@timetrackers.com.au

W www.timetrackers.com.au

At the **September** meeting there was a discussion about the benefits of being a L I F E member and of L I F E being part of the Lung Institute. Some of the benefits members recognised were:

- Feel better when I leave
- Feel accepted here, like I belong
- Feel comfortable in the group, can say anything here
- People care
- Having a laugh
- Made new friends here
- People know what I mean
- Get information, e.g. through the magazine and the speakers
- Get information about clinical trials
- Enjoy the company
- Very positive group (people without health problems are sometimes less positive than this group)
- We are all involved in the group, we all have our roles and make decisions together

Do you have further ideas about what L I F E membership means to you currently - or benefits it could bring in the future? Please let Jenni know E life@liwa.org.au T 9382 4678.

At the **October** meeting Cameron Agnew, Executive Officer of LIWA discussed future directions for the Institute.

At the **November** meeting there was a change to the advertised speaker. Physiotherapist Pippa Windsor told us about breathing well. We did exercises and heard all about the diaphragm, muscles of breathing, improving breathing habits and posture, relaxation and body awareness. Thanks Pippa! Pippa practices at Darlington and Northam. Contact her at T 9299 6084

The advertised **November** speaker, Gary Smallacombe, had just returned from a long camping trip across Australia. He'll come to L I F E in 2015 to talk about living with a chronic lung disease, cystic fibrosis, from birth.



RESPIRATORY RECIPES

The traditional colour theme features here, with red and green, sweet and savoury dishes for Christmas. The salad serves 6-8 and takes only a few minutes to put together. Pour the dressing over it when it's time to serve. The dessert takes 15 minutes to make and serves 6.

CHRISTMAS CAPRESE SALAD

4 c cherry or grape tomatoes, halved. Chopped roma tomatoes will also work

1 bunch fresh basil, thinly sliced

450g fresh mozzarella pearls (or fresh mozzarella diced into bite-size pieces)

For the balsamic brown sugar reduction:

½ c aged balsamic vinegar (It's more expensive but delicious. Try a small bottle)

½ c dark brown sugar

In a saucepan over medium-low heat, add the balsamic vinegar and the brown sugar. Cook for 3-5 minutes until bubbly and thick. Once reduced, it should be able to coat the back of a spoon. Allow to cool. (Don't cook so long it becomes toffee like I did!

It was solid) Add the halved tomatoes and fresh mozzarella pearls to a bowl. Just before serving, add the fresh basil and drizzle the reduction over the salad and toss.



Source <http://nansgourmetfoods.blogspot.com.au/>

STRAWBERRY AND KIWIFRUIT CREAM CAKE

½ c mascarpone (Italian creamy cheese made with cream and food acid)

1 t vanilla extract

1½ T milk

450g rectangular unfilled double sponge

250g strawberries, thinly sliced

2 kiwifruit, halved, thinly sliced

1/3 c icing sugar

Combine the mascarpone, vanilla and 1 T of the milk in a small bowl.

Place 1 cake layer on a plate. Top with mascarpone mixture, then three-quarters of the strawberry and kiwifruit. Top with remaining cake layer.

Combine the icing sugar and remaining ½ T milk in a small bowl. Drizzle the icing over the cake. Arrange the remaining strawberry and kiwifruit on top.



Source www.taste.com.au/

POSITIVE+

Positive+ is a new column in Breath of L I F E. We'll include tips that can help you stay positive - an important part of keeping mentally healthy and living with chronic lung disease. If you have tips you'd like to share with readers, please send them in. Details below.

Check out our Inspirations column this issue for a positive piece contributed by member Denise Wright.



Our amazing brain is able to manage so many different bodily activities at once – keep you breathing, and your heart pumping, digest your breakfast, make enzymes, hold your body up, hang out the washing, notice the birds in the tree, the neighbour's radio.

But what we **attend** to is what we become conscious of. If we didn't have the ability to select what to attend to, we'd be so overwhelmed by sounds, images, sensations. A bit like when you go to a crowded Asian market. Like selecting what TV channel to watch, our attention determines what's in our consciousness. And our consciousness determines our wellbeing.

We can feed the part of us that is dismayed by the world's troubles by watching only the news broadcasts of disasters, crimes and calamities across the world. Or we can feed the part of us that recognises beauty and wonder by focussing our attention on grandchildren, good friends, a rose in the garden, our pet dog, a friend's recovery, safe return from a dangerous journey, an amazing scientific breakthrough. What's your choice? Which do you want to feed?

Take a serious newspaper. Get two different coloured highlighters. Read through the headlines and the opening paragraphs of all the articles. Highlight the headlines of each **positive** sounding article in one colour and the **negative** ones in the other colour. Don't take any notice of how big or small the headline or story is. Count how many articles are marked in each colour. Is it balanced - or are there more negative than positive?

Doing this on a different day might produce a different result. This might be partly to do with what happened on that day, but it's also related to the editor's choices - the topics the editor wanted to focus on. Just like your brain, the editor chooses which story to present. Many are ignored, made smaller or published at a later date.

What do you conclude from this about keeping positive?

In future Positive columns there'll be more paper and pencil exercises, so you may like to get an exercise book or a file to keep your Positive+ Exercises in.

What do you do that helps lift your mood? Please share your tips.

Contact E life@liwa.uwa.edu.au Jenni 9382 4678

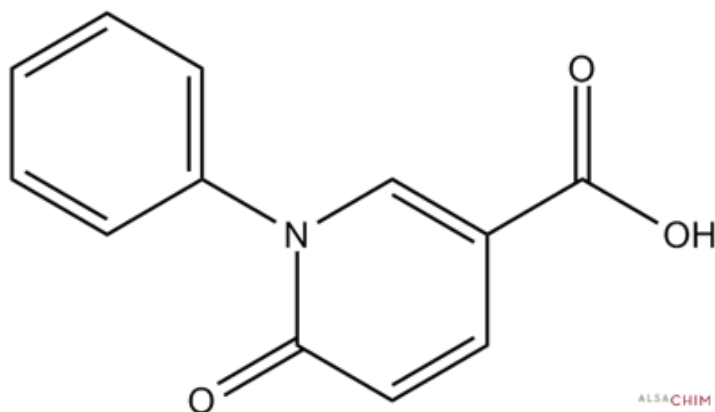
Based on Exercises for Being Positive: brain games for personal wellbeing, Yves-Alexandre Thalmann, Little Exercise Books series, Five Mile Press, 2010. Trans. P. Abbott-Charles.

SHORTS

FDA APPROVES 2 NEW DRUGS TO TREAT IDIOPATHIC PULMONARY FIBROSIS

L I F E began in 1992 because a group of people in Perth with Idiopathic Pulmonary Fibrosis wanted to share information about this disease and how to live well with it. The remaining member of that group was the late Edna Brown who died in January 2014, though not from this disease. A number of current L I F E members have Idiopathic Pulmonary Fibrosis. This is good news for them and all with this debilitating, progressive, and difficult to treat condition.

In October the US Food and Drug Administration (FDA) approved two new drugs for the treatment of idiopathic pulmonary fibrosis (IPF).



The first drug, **pirfenidone** (Esbriet), was granted fast track, priority review, orphan product, and breakthrough designations. Pirfenidone acts on multiple pathways that may be involved in the scarring of lung tissue.

Its safety and effectiveness were established in three clinical trials of 1,247 patients with IPF. The decline in forced vital capacity was significantly reduced in patients receiving pirfenidone compared with patients receiving placebo.

Pirfenidone is not recommended for patients who have severe liver problems, end-stage kidney disease, or those who require dialysis. Pirfenidone should be taken with food to minimise the potential for nausea and dizziness. Patients should avoid or minimise exposure to sunlight and sunlamps and wear sunscreen and protective clothing, as pirfenidone may cause patients to sunburn more easily.

The most common side effects of pirfenidone are nausea, rash, abdominal pain, upper respiratory tract infection, diarrhoea, fatigue, headache, dyspepsia, dizziness, vomiting, decreased/loss of appetite, gastroesophageal reflux disease, sinusitis, insomnia, decreased weight, and arthralgia.

The second drug that received approval for IPF on 15 October, **nintedanib** (Ofev) was also granted fast track, priority review, orphan product, and breakthrough designations.

Nintedanib is a kinase inhibitor that blocks multiple pathways that may be involved in the scarring of lung tissue. Its safety and effectiveness were established in 3 clinical trials of 1,231 patients with IPF. The decline in forced vital capacity was significantly reduced in patients receiving Ofev compared to patients receiving placebo.

Nintedanib is not recommended for patients who have moderate to severe liver problems. Nintedanib can cause birth defects or death to an unborn baby. Women should not become pregnant while taking nintedanib. Women who are able to get pregnant should use adequate contraception during and for at least 3 months after the last dose of nintedanib.

The most common side effects of nintedanib are diarrhoea, nausea, abdominal pain, vomiting, liver enzyme elevation, decreased appetite, headache, decreased weight, and high blood pressure.

Note: Perfenidone has been the subject of a multi nation clinical trial which included Australia. The results were published in the New England Journal of Medicine in May 2014¹. Nintedanib has also been trialled clinically in a number of countries, including Australia with promising results. The results were also reported earlier in 2014². Both are not yet available in Australia.

Source: [US Food and Drug Administration, 15 October 15, 2014, Rockville, Maryland, USA](#)

MEDICALERT

MedicAlert Foundation wants Western Australians who got their MedicAlert bracelets before July 2002 to contact them for a replacement because the telephone number on the bracelet for the 24/7 national emergency hotline is likely to become out of date soon. The number should be +61 8 8272 8822. If yours does not have this number on the back, call the MedicAlert Foundation on 1800 88 22 22 (9am-5pm CST).

SENIORS DISCOUNT ON SAFETY AND SECURITY IMPROVEMENTS

WA Seniors Card holders can apply for up to \$200 from the Western Australian Government and apply this to a personal security alarm, for example.

Safety and Security Rebate Scheme

From 1 January 2014, WA Seniors Card holders could apply for a new rebate to improve their safety and security. This includes:

- Up to \$200 for a personal safety device.



¹ www.heraldsun.com.au/news/victoria/patients-may-breath-easier-after-drugs-show-promise-in-treating-lethal-lung-condition/story-fni0fit3-1226923304559?nk=be43a86a09e71f68565a716471a66ddb

² <http://lungfoundation.com.au/new-hope-for-sufferers-of-mystery-lung-disease/>

- Up to \$200 to upgrade or replace security if you have received the previous security rebate and then experienced a break-in from 1 January 2014

This is on top of existing State Government assistance for seniors:

Cost of Living Rebate - annual payment to assist with rising living expenses.

Energy Rebates - energy subsidy payment, referred to as a Cost of Living Assistance payment.

Health Concessions - WA Department of Health subsidy for the purchase of spectacles.

Hardship Utility Grant Scheme (HUGS) - A state government scheme that provides financial assistance to people experiencing financial hardship to maintain connection to their electricity, gas or water supply.

Licence Fees - discounts on fishing, drivers' and vehicle licence fees.

Local Government Rates – rebates or deferment on their annual property rates (for eligible WA Seniors Card holders).

Public Transport- free and discounted fares for Transperth metropolitan bus, train and ferry services and TransWA regional bus services.

WA Tourist Attractions - discounts on admission fees for State tourist attractions including The Art Gallery of WA, Western Australian Museum & Maritime Museum, Perth Zoo, Rottnest Island and National Parks.

Water -discount of up to 25% on Water Corporation Bills

More

Seniors Information Service T (08) 6551 8800 (metro) Freecall: 1800 671 233 (country)

Source [Seniors Card, Department for Communities](#)

USE OF CPAP AFTER SLEEP APNOEA SURGERY

In this retrospective cohort study, researchers evaluated how well patients followed continuous positive airway treatment (CPAP) recommendations in the people, some of whom had previous surgical treatment for Obstructive Sleep Apnoea Syndrome (OSAS). Researchers studied a group of 86 consecutive patients with OSAS, working backwards to collect information about their relevant medical and surgical background and their use of their CPAP machine.

Among them, there were nine patients in the surgery group who had previously had uvulo-palato-pharyngoplasty for OSAS; another 77 non-surgical patients were assigned to the untreated group. There was no statistical difference in demographics or poly-somnographic parameters. They showed similar CPAP acceptance and air leak after the first trial. However, the surgery group (6.39 ± 1.49 h/day) used CPAP for significantly longer than the untreated group (4.73 ± 1.64 h/day;



$p = 0.007$) and was less troubled with 'waking up during night'. The present study showed that having had prior surgery for OSAS doesn't prevent people from benefitting from CPAP therapy subsequently.

Source: [Hong S, Kim H, and 4 others, Effect of uvulopalatopharyngoplasty on CPAP compliance, European Archives of Oto-Rhino-Laryngology, Aug 2014](#)

SAFE SELF-ADMINISTRATION OF INTRANASAL INFLUENZA VACCINE

Each year we go to the GP to get our flu vaccinations. What if you could vaccinate yourself by sniffing the vaccine up your nose? Nasally delivered vaccine has already been shown to be effective delivered by health workers. Here's a recent study looking at patient-administered nasally delivered vaccine.

Self-administration of the intranasal influenza vaccine appears to be as safe and effective as having the vaccine administered by healthcare professionals, researchers suggested in US's ID Week³ 2014.

The military-based study would support the idea that a single healthcare worker could instruct group of 5 to 10 individuals in how to take the vaccine, allowing for more personnel to be vaccinated in a shorter period of time, said Mary Bavaro, MD, Naval Medical Center, San Diego, California.

In discussing her poster presentation on 10 October, Dr. Bavaro said that "self-administration and healthcare worker-administration of the vaccine did not differ with regard to safety and immunogenicity endpoints."



The geometric mean titres of anti-HA antibody did not differ by sub-group, nor were there differences in reactions to the vaccine.

The study, conducted at the naval base in San Diego and the San Antonio Military Health System, San Antonio, Texas, enrolled 1,077 participants. The per-protocol analysis included 1,024 subjects -- 501 who self-

administered the vaccine and 523 who received the vaccine from a healthcare worker. The study was open to active duty military, retired personnel, and their dependents.

When the researchers tested the groups for immunogenicity by vaccine strain and by study group they found that 45.8% of those self-administered individuals raised titres that would be protective against influenza type A/H1N1 influenza compared with 48.7% of individuals vaccinated by the health care worker ($P = .43$).

³ ID Week is presented by the Infectious Diseases Society of America (IDSA), the Society for Healthcare Epidemiology of America (SHEA), the HIV Medicine Association (HIVMA), and the Pediatric Infectious Diseases Society (PIDS).

Similarly there were no differences in efficacy for vaccination against influenza A/H3N2, influenza B/Yamagata or influenza B/Brisbane.

The researchers undertook the study because of the perceived need to perform rapid vaccination in times of deployment.

“Military personnel in congregate settings are at increased risk for infectious disease,” said Dr. Bavaro. “Acute respiratory infections are among the most common. In the event of an influenza outbreak or pandemic, a rapidly deployed mass vaccination strategy would maximise health protection of military personnel.”

“Self-administration of the live attenuated influenza vaccine may be a means to achieve deployment readiness while sparing the use of human resources, especially healthcare personnel, in emergency situations,” she added.

Source: [*Presentation title: Self-Administration of Intranasal Vaccine: Immunogenicity and Volunteer Acceptance. Abstract 1162, Philadelphia, US. DGNews article by Alex Morrisson, 15 October, 2014*](#)

NON-TRADITIONAL DONOR LUNGS APPEAR SAFE FOR TRANSPLANT

Patients receiving lungs from donors whose cause of death was asphyxiation or drowning have similar outcomes and long-term survival as patients receiving lungs from traditional donors, according to a study published in the October issue of the *Annals of Thoracic Surgery*.

“For most patients with end-stage lung disease, transplant offers the only hope for survival, but there is a critical organ shortage, especially for patients on the lung transplant list,” said Bryan A. Whitson, MD, Ohio State University Wexner Medical Center, Columbus, Ohio. “Increasing the potential donor pool would help reduce the number of patients who die while on the waiting list and help expand this lifesaving treatment to those who need it.”



Dr. Whitson and colleagues searched the United Network for Organ Sharing (UNOS) Standard Transplant Analysis and Research registry for lung transplants from 1987 to 2010 and assessed the association between donor cause of death and recipient survival, focusing on asphyxiation or drowning as the cause of death.

Lungs from donors who died from asphyxiation or drowning are not routinely utilised because of potential damage sustained by the organs.

The researchers found 18,250 adult primary lung transplants, including 309 cases that involved asphyxiation or drowning. They also found that although the hospital stay was slightly longer (0.8 day) for recipients of lungs from asphyxiation or drowning deaths when compared with patients who received lungs from all other causes of donor death, survival rates were the same and there were no differences

in treatment for rejection within the first year, post-transplant dialysis, or post-transplant stroke.

“Our results show that the cause of death in an organ donor should not automatically be an exclusionary criterion for transplant consideration,” said Dr. Whitson. “The conventional criteria for organ quality and function need to be met, of course, but this adds a potential increase in the donor pool.”

“Individual transplant centres evaluate donors on a case-by-case basis and assess the risk and make the best match of donor and recipient,” he said. “Based on our results, it appears that if centres wanted to expand their individual criteria for donation, they could successfully expand their donor pool. Questions around these types of donors or even marginal lungs will be assessed by ex-vivo perfusion and we should see an increase in the number of transplants overall.”

Source: [Elsevier cited in DocGuide, 1 October, 2014](#)

WEIRD MEDICINE

This South Korean case study certainly verges on weird medicine when faecal matter (yes, poo) was used to treat a bad gut infection in a person with a severe respiratory infection who was also being treated with lots of antibiotics.

Acute respiratory distress syndrome is a life-threatening disorder caused mainly by pneumonia. *Clostridium difficile*⁴ infection (CDI) is a common hospital-acquired diarrheal disease. Disruption of normal intestinal flora by antibiotics is the main risk factor for CDI. The use of broad-spectrum antibiotics for serious medical conditions can make it difficult to treat CDI complicated by acute respiratory distress syndrome. Fecal microbiota transplantation⁵ is a highly effective treatment in patients with refractory CDI.



Successful engraftment following transplantation

Mechanical ventilation is the main supportive treatment option in patients with acute respiratory distress syndrome, which makes it difficult to perform fecal microbiota transplantation in patients with *Clostridium difficile* infection (CDI) and acute respiratory distress syndrome. This case report demonstrated that fecal microbiota transplantation can be considered as a treatment for refractory CDI infection caused by acute respiratory distress syndrome.

⁴ *Clostridium difficile* is a bacterium normally found in people's intestines (“digestive tract” or “gut”). It does not cause infection or disease by its presence alone and it can be found in healthy people. When the normal balance of bacteria in the gut is disturbed *Clostridium difficile* can multiply to levels where the toxins it produces causes illness such as diarrhoea and severe inflammation of the bowel. This is when you are said to have *Clostridium difficile* infection.

www.nhmrc.gov.au/files/nhmrc/publications/attachments/cd33_cdif_brochure.pdf

⁵ Stool transplantation.

Source: [Ji Eun Kim, Tae-Geun Gweon, and 13 others, A case of Clostridium difficile infection complicated by acute respiratory distress syndrome treated with fecal microbiota transplantation, World J Gastroenterol. 2014 September 21; 20\(35\): 12687-12690.](#)

WITHDRAWAL OF INHALED GLUCOCORTICOIDS AND EXACERBATIONS OF COPD

This clinical trial looked at the effect on flare-ups of stopping inhaled glucocorticoid treatment while continuing other puffer treatments for people with COPD. Don't try this at home people, unless your doctor advises it.

Treatment with inhaled glucocorticoids (like Flixotide) in combination with long-acting bronchodilators⁶ is recommended in people with frequent flare-ups of severe chronic obstructive pulmonary disease (COPD). However, the benefit of inhaled glucocorticoids in addition to two long-acting bronchodilators has not been fully explored.



In this 12-month, double-blind, parallel-group study, 2,485 patients with a history of exacerbation of COPD received triple therapy consisting of tiotropium (Spiriva, at a dose of 18 µg once daily), salmeterol (Serevent, 50 µg twice daily), and the inhaled glucocorticoid fluticasone propionate (Flixotide, 500 µg twice daily) during a 6-week run-in period. Patients were then randomly assigned to continued triple therapy or withdrawal of fluticasone in three steps over a 12-week period. The primary end point

was the time to the first moderate or severe COPD exacerbation. Breathing test findings, health status, and breathlessness were also monitored.

In terms of when they had the next flare-up the group stopping their glucocorticoid puffers were not significantly worse off than the one who continued to use them. But at week 18, when the first group had completely stopped their glucocorticoid puffers, those still using them had a significantly better FEV1 result on their breathing test ($p < 0.001$). No change in breathlessness and minor changes in health status occurred in the glucocorticoid-withdrawal group.

In patients with severe COPD receiving tiotropium plus salmeterol, the risk of moderate or severe exacerbations was similar among those who discontinued inhaled glucocorticoids and those who continued glucocorticoid therapy. However, there was a greater decrease in lung function during the final step of glucocorticoid withdrawal.

Source: Based on [Helgo Magnussen, Bernd Disse and others](#). Funded by Boehringer Ingelheim Pharma WISDOM ClinicalTrials.gov number, [NCT00975195](#). (This company manufactures Spiriva)

⁶ like Seretide, a combination of Serevent and Pulmocort or similar combination therapy

GENETIC SUSCEPTIBILITY FOR CHRONIC BRONCHITIS IN COPD

We all know of smokers who do not seem to have got COPD, though smoking still remains the strongest risk factor for getting it. What could account for this? Our first thoughts go to genetics. Here's a study which investigates part of the genetics and COPD story.



Chronic bronchitis (CB) is one of the classic phenotypes of COPD. The aims of our study were to investigate genetic variants associated with COPD subjects with CB relative to smokers with normal spirometry, and to assess for genetic differences between subjects with CB and without CB within the COPD population.

Researchers analysed data from current and former smokers from three cohorts: the COPD Gene Study; GenKOLS (Bergen, Norway); and the Evaluation of COPD Longitudinally to Identify Predictive Surrogate Endpoints (ECLIPSE).

CB was defined as having a cough productive of phlegm on most days for at least 3 consecutive months per year for at least 2 consecutive years. CB COPD cases were defined as having both CB and at least moderate COPD based on spirometry. Primary analysis used smokers with normal spirometry as controls; secondary analysis was performed using COPD subjects without CB as controls.

Genotyping was performed on Illumina platforms; results were summarized using fixed-effect meta-analysis.

For CB COPD relative to smoking controls, researchers identified a new genome-wide significant locus on chromosome 11p15.5 as well as significant associations of known COPD SNPs within FAM13A.

This study provides further evidence that genetic variants may contribute to phenotypic heterogeneity of COPD.

Source: Based on [Genetic susceptibility for chronic bronchitis in chronic obstructive pulmonary disease, Jin Hwa Lee, Michael H Cho and others](#), Trial registration [ClinicalTrials.gov](#) NCT00608764, NCT00292552

LUNG DISEASE IN AUSTRALIA

November 19 was World COPD Day. A time to increase public awareness of all chronic lung diseases, particularly COPD, one of the most prevalent.

Even if you do not have COPD it was an opportunity to make sure those in your circle are aware of lung disease and its impact on you. In this way you can be an ambassador for lung disease. As discussed in the last issue of Breath of L I F E, chronic lung disease is fairly invisible to the wider community. Both Lung Foundation Australia and the Lung Institute



November 19, 2014

of Western Australia are committed to raising community awareness of lung disease, and we can play our parts too - by speaking up.

A new report, **Lung Disease in Australia**, prepared especially for Lung Foundation Australia by the Woolcock Institute of Medical Research highlights the impact of lung disease reveals lung disease contributes to more than 10 per cent of the overall health “burden” in Australia. The report summarises information on chronic respiratory disease (including asthma, chronic obstructive pulmonary disease and others), respiratory infections (influenza, pneumonia, etc) and respiratory neoplasms, including lung cancer and mesothelioma.

The term “burden” (of disease) is not used to mean we are a burden to anyone. It’s a public health measure assessing and comparing the relative impact of different diseases and injuries on populations by quantifying health loss due to disease and injury that remains after treatment, rehabilitation or prevention efforts of the health system and society generally.

In Breath of L I F E’s view there should be a better term than burden that sounds less stigmatising.

Some key numbers from the report

Lung disease contributes to **more than 10 per cent of the overall health “burden”** in Australia

Death due to lung disease is significant with 14%, or one in seven deaths in 2012, a result of lung disease

The report found lung disease was the cause of:

- 276,505 hospitalisations across Australia in 2011-12, representing 3% of all hospital admissions.
- more than 1.4 million hospital patient-days in 2011-12, representing 5% of all patient-days⁷

Among people with lung disease in Australia:

- Lower respiratory infections are the leading cause of hospitalisation
- Asthma represents the leading cause of disability
- Lung cancer represents the leading cause of death (40% of deaths from lung disease)
- COPD contributes one-third of the burden
- COPD contributes almost one-third of all deaths.

[Read the press release](#)

[Download the report Lung Disease in Australia](#) or ring 1800 654 304 for a copy.

TREATMENT CHOICES

Dr Fraser Brims, respiratory specialist at Sir Charles Gairdner Hospital was our featured speaker in September. He discussed advanced health care options for difficult to treat lung disease. This information should help people intending to draw

⁷ A patient-day is the equivalent of one person spending one day in hospital

up an Advanced Care Plan or and Advanced Health Directive or to appoint an Enduring Guardian.

Communication problems

It can sometimes be challenging to ensure health care staff know what types of care you want - or don't want - in the ward, emergency department or ambulance.

Sometimes your breathing can be so bad or you may be drowsy and cannot speak your mind. Emergency department staff do not have records of your medical history immediately; it takes time for your notes to arrive or appear on their screen. It would be helpful to bring a list of medications and your medical history to get the ball rolling.

Being able to tell treating health professionals what's wrong and then, later, letting them know whether you want to be actively treated - or just kept comfortable are two different issues. But in both cases good communication is vital.

Towards the end of your life you may or may not want certain types of treatment. It should be up to you to decide. It's best to think about this much earlier and discuss it with your closest family and friends, so they understand your views. They may not want to discuss it with you, but for your own peace of mind you may want to discuss it with them. Some information will help you in these discussions. And then you should write down your treatment wishes so that they can be provided to health care staff looking after you. More about this later.

Here are some of the treatments you might be offered if you have severe, advanced lung disease that doesn't seem to be responding to the usual management. They are listed in roughly ascending order of intervention. Warning: it's not like on TV medical dramas.

Oxygen

Often this is often the first line of treatment, but it's not a panacea for all. In fact it can be dangerous for people who retain carbon dioxide (CO₂, your exhaust fume gas). Too much oxygen can make "carbon dioxide retainers"



drowsy and slow down their breathing. This can be fatal. You need a way of warning emergency department staff and ambulance officers if you are a **carbon dioxide retainer**. Medi Alert bracelets can be used for this purpose or you can have it recorded with a health history summary and kept with your medications (which would be taken by ambulance officer). A special (Venturi) mask would be needed to use with oxygen if you are a CO₂ retainer.

Non Invasive Ventilation (NIV)

This involves a device like a CPAP or BPAP machine connected to a tight fitting mask which delivers air - or a mixture of air and extra oxygen - blown into your mouth

and nose. It feels a bit like standing in front of a fan or sticking your head out of the car window. It can give your chest muscles a rest from the effort of breathing and can help reduce CO₂ levels.

Masks must fit well and some people cannot cope well with the tight fitting mask over their face at such a time. It takes a little time to get used to. Not everyone will benefit from this treatment, but is often tried because it is relatively easy to provide - once health care professionals know who needs it.

If you already use such a machine at home, you should bring it (and your mask) to hospital along with written information about your usual settings. It's likely, however, that different settings may be required during a flare-up.

Antibiotics

If you have a severe bacterial infection in your lungs you may be treated with antibiotics delivered by intravenous drip or by mouth. The correct antibiotic group can take time to determine (by culturing your sputum), so this may not work at first.



High Dependency Unit

If you do not respond to initial treatments, you may be moved to the Respiratory High Care or the High Dependency Unit, which is staffed by nurses and doctors with special training in caring for people with respiratory disease. This is normal if you need non-invasive ventilation, as mentioned above.

If your condition deteriorates or becomes more complicated it may be suggested that you move to the Intensive Care Unit (ICU).

Intensive Care Unit

Highly trained nurses and doctors work in the ICU. Each nurse cares for just one patient at a time, round the clock, in shifts. There, your breathing might be taken over by a ventilator ("life support" machine) which provides air mixed with extra oxygen through a plastic tube inserted down your throat while you are sedated. One draw-back is that, if your lungs are already damaged, it can later be difficult to get your lungs to take over the work of breathing, once the crisis is over.

Often in the Intensive Care Unit some very difficult decisions have to be made by doctors and families - and patients, if they are able to. If you are supported on a ventilator for a long time, the bed rest and, sometimes, the medically-induced paralysis, can have long term detrimental health effects. It may be difficult for you to learn to breathe again without help from the ventilator.

If you need ventilation over a longer term (more than about 10 days), the air and oxygen mixture is delivered through a tube inserted into your trachea (wind pipe) through a small hole made below your larynx or voice box (tracheostomy). The machine does all the work of breathing for you. If you have a tracheostomy you can be awakened from the drug induced coma after the tube has been inserted.

Resuscitation

At some point in your life, you may have a view on whether you would wish to be resuscitated if the situation worsened.

Resuscitation in the real world is definitely not like on TV medical dramas. For a start, it is not necessarily the right treatment for everyone in a life or death situation.

The person must be both strong enough to withstand the process of being resuscitated and then, strong enough to recover from the underlying illness.



Only about 10% of people respond to resuscitation process and, of these, only 3-4% survive to leave hospital. Sometimes, the best health professionals and all the treatments available just cannot fight nature for too long. If people don't get any better and further treatment is futile (i.e. is bound to have no effect) doctors and nurses are not required legally or ethically to give a treatment that will not work, even if patient or family request it. Even so, when a decision is made not to resuscitate a person, it is often very traumatic for family - and for medical staff - to stand by and not be able to do anything more when a person is dying.

Your treatment choices and decisions – Advanced Care Planning

Ideally treatment choices should be based on fully informed patient decision-making. This can work well for elective surgery. However, in advanced lung disease there may not be the opportunity for this to take place. You may be too unwell to take part.

So your wishes regarding possible future treatment would need to be discussed in advance, thought out and written up into a document. The document should be kept in a place where health professionals, family and friends can easily find and use it. Other important information could be placed there too (such as your normal medicines and whether you are a CO₂ retainer or use a CPAP machine).

This can be outlined in what is commonly called an Advanced Care Plan. This is similar to an Advanced Health Directive. The Advanced Health Directive is slightly

different as it is witnessed and so, technically, has a different legal standing. Either one is extremely valuable for your health professionals in an end-of-life or emergency situation especially when you are not able to indicate your own treatment wishes.

It is best to discuss this all with your GP, respiratory physician, your family and loved ones. The kinds of things you might include would be whether, if your condition would warrant it, you would wish to have supplementary oxygen, antibiotics, nutrition, be sent to Intensive Care, have a tracheotomy or intubation, or be resuscitated. Which life-prolonging treatments would you accept, once you have reached the most serious end of lung disease?



Another option is to appoint an Enduring Guardian to make health care decisions on your behalf if you were unable to. This person could be a close friend or family member and needs to be appointed in the correct legal way. Appointing a good friend to be your enduring guardian can be helpful if you are worried

your family might not all agree, or might follow their own wishes rather than yours, when the time came.

You need to make sure that copies of your Advanced Care Plan, Advanced Health Directive or Appointment of Enduring Guardian are given to your family and close friends, your enduring guardian, if you have one, your treating health professionals and any hospital where you are regularly seen. In case an ambulance has to take you to a different hospital, you should keep another copy with your medications etc.

A L I F E member asked how doctors respond to a family member's emotional plea to do something, even if the chance of success were small and were against your documented wishes. Documented patient wishes would over-ride family wishes. If doctor were certain a treatment would be ineffective he/she is not obliged to provide it. If the family or doctor is in any doubt whether a treatment really would do no good, they may ask for a second opinion.

Research study

Dr Fraser Brims is part of a research team that have been funded by the WA Department of Health and is working with the University of Western Australia to investigate the use of Advanced Care Plans with people with advanced lung disease.

This study is based at Sir Charles Gairdner Hospital and the Albany Regional Hospital. They want to find out what is the best kind of health professional to facilitate the Advanced Care Plan discussion with patients, which is the better setting (patient's home or at hospital) and if there is an Advanced Care Plan in place, does it get used by treating health professionals, i.e. do Advanced Care Plans make a difference to the type of end of life care provided?

More

Dr Fraser Brim's team is looking to recruit people with severe, advanced lung disease into a study involving Advanced Care Plans. If you are interested and think that you may be suitable, please contact research nurse Siobhan Dormer on T 93467947 or E Siobhan.dormer@health.wa.gov.au.

[Advanced Care Planning](#) WA Health Advanced Care Planning page

[Advanced Health Directives Resources](#) at WA Health Advanced Care Planning page

[Appointing an Enduring Guardian](#) - Office of the Public Advocate T 1300 858 455 or (08) 9278 7300 at WA Office of the Public Advocate

[Getting Your Affairs in Order](#) T 1300 858 455 or (08) 9278 7300 WA Office of the Public Advocate

Further reading

Browron, Craig, [Unrealistic expectations of death](#) – an online article by an American physician

Hillman, Ken, *Vital Signs: stories from intensive care*, University of NSW Press, 2010

MUCUS AND PHLEGM

This article continues our current series about major symptoms of lung disease.

Phlegm (based on a Greek word meaning "inflammation, humour⁸ caused by heat") is a liquid secreted by the mucous membranes of mammals. It's limited to the mucus produced by the respiratory system, particularly that which is expelled by coughing (sputum) but excluding secretions from the nasal passages.

Phlegm is a water-based gel consisting of glycoproteins, immunoglobulins, lipids and other substances. Doesn't sound so bad now, does it? Its composition varies depending on climate, genetics, and state of your immune



⁸ Used here "humour" is not about being funny. It is part of an ancient Greek theory that the human body is filled with four basic substances, called the *four humours*, held in balance when a person is healthy. It is closely related to the ancient theory of the [four elements](#) and states that all diseases and disabilities result from an excess or deficit in black bile, yellow bile, phlegm, and blood.

system. Its colour can vary from transparent to pale or dark yellow and green, from light to dark brown, and even to dark grey depending on the constituents.

Contrary to popular misconception and misuse, mucus and phlegm are not always the same.

Mucus is the normal protective layering around the airway, eye, nasal turbinate (spongy bone inside your nasal passages), and urogenital tract. Mucus is an adhesive viscoelastic gel produced in the airway by sub-mucosal glands and goblet cells and is principally water. It also contains high-molecular weight mucous glycoproteins that form linear polymers. It is a type of natural lubricating layer.

Phlegm is more related to disease than is mucus. Phlegm is a secretion in the airway during disease and inflammation. Phlegm usually contains mucus with bacteria, debris, and sloughed-off inflammatory cells. Once phlegm has been coughed out it is called **sputum**.

Other words that non medical people like us use are snot (blown or “dug” from your nose), and gunk – though that has rather wider meanings than just mucus or phlegm.

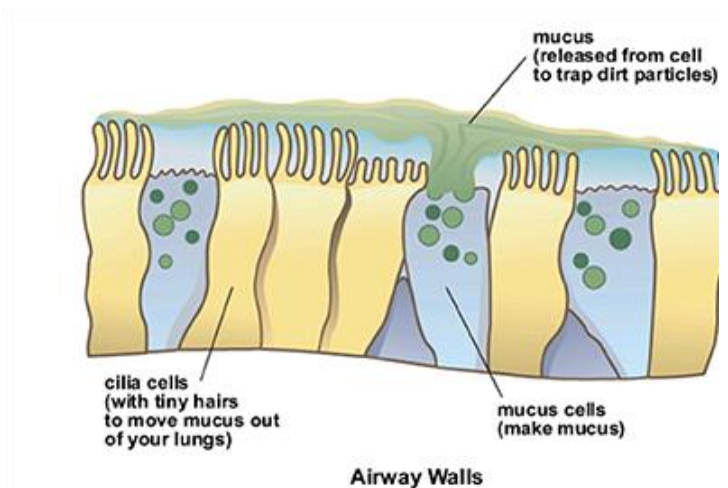
All these secretions are normal. It's usually the quantity that causes problems. What can cause too much phlegm in your throat or larynx (voice box)?

There are many possible reasons:

- Vocal abuse or the misuse or overuse of the voice in an unhealthy way such as clearing the throat, yelling, screaming, talking loudly, or singing incorrectly.
- Clearing the throat removes or loosens phlegm but the vocal cords hit together causing inflammation and therefore more phlegm.
- Yelling and screaming both cause the vocal chords to hit against each other causing inflammation and phlegm.
- Excessive yelling, screaming, and incorrect singing as well as other vocal abusive habits can cause vocal nodules.

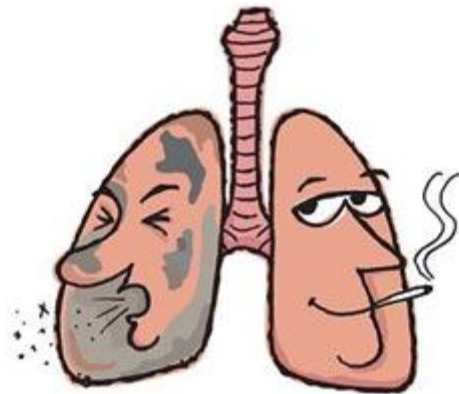
Smoke and mucus

Since smoke is hot, dry, polluted air, it dries out your vocal cords. With each in-breath of smoke, your larynx is polluted with toxins that prevent it from rehydrating for about 3 hours. The vocal cords need a fair amount of lubrication and may become swollen or inflamed when they do not have enough mucus. When the vocal



folds swell and are inflamed, phlegm is often created to attempt to ease the dryness.

A 2002 study published by the American College of Chest Physicians found that there was a correlation between smoking, coughing and phlegm. The study participants were 117 people - a mix of current smokers, ex-smokers, non-smokers; and a group who already had COPD (Chronic Obstructive Pulmonary Disease, a respiratory disease known to be related to smoking history). Researchers found a high correlation (+0.49 ($p < .001$)) between smoking and having phlegm / cough. That means that the more people smoked the more likely they were to have more phlegm and a cough, and conversely, the less they smoked the less likely they were to have phlegm or a cough.



During illness like the flu, a cold, and pneumonia, there's an increase in the quantity of phlegm as the body tries to get rid of the bacteria or viral particles in the body. A major illness associated with excess phlegm is acute bronchitis. A major symptom of acute bronchitis - usually caused by a viral infection - is an excess amount of phlegm. Bacterial infections linked with bronchitis are rarer and are usually treated with an antibiotic.

In hay fever and asthma, the inner lining in the bronchioles⁹ become inflamed and create an excess amount of phlegm that can clog up air pathways connecting the air outside and the alveoli where gas exchange¹⁰ takes place.

In studies of children, air pollutants have been found to increase phlegm by drying out and irritating parts of the throat.

Function of normal mucus

As discussed mucus is a normal lubricant in the body which prevents friction in places like the vocal cords, as they move against each other. It also keeps surface cells moist and healthy. It forms a vital part of your body's immune system. Too little mucus and you get problems with foreign organisms getting in and too much mucus interferes with some important bodily functions. It may not be just the quantity of mucus but it can be the composition of the mucus that causes problems.

For example, cystic fibrosis (CF) is a chronic inheritable condition featuring mucus that is too thick and sticky. This is a particular problem for the functioning of the lungs and the pancreas. People with CF often have digestive problems because the

⁹ Narrower airways that the air travels long to reach the alveoli, or tiny air sacs.

¹⁰ Gas exchange takes place when carbon dioxide molecules in the blood are swapped with oxygen molecules in the fresh air you breathe in.

enzymes made in the pancreas cannot get through the thick mucus layer lining the pathway to the intestine. Likewise thick mucus in the lungs is hard to cough out, impairs gas exchange and leads to frequent respiratory infections. Other functions affected by CF include reproduction and perspiration.

Airways clearance

If you have chronic mucus problem, such as in bronchiectasis, chronic bronchitis or cystic fibrosis, health professionals will probably have advised you to regularly practice certain exercises or procedures to try to expel the excess mucus and keep your airways as clear as possible. These techniques include Active Cycle of Breathing Technique, Chest Physiotherapy – and simply walking. More information about airway clearance can be found at Jenni Ibrahim's Little Blog of Phlegm or the Lung Foundation's Better Living with COPD: a patient guide.

More

[Little Blog of Phlegm](#) at Blogspot

[Lung Foundation Australia, Better Living with COPD: a patient guide, Lung Foundation Australia, Brisbane. Chapter 13: Keeping Your Lungs Clear](#), accessed 27 October 2014.

[www.webmd.com/allergies/features/the-truth-about-mucus](#)

VOLUNTEERING OPPORTUNITIES

You can help in social and medical research and training health professionals!

Take part in a clinical trial that might improve your respiratory health



LIWA's Clinical Trials Unit is the largest respiratory trials centre in Australia and is respected internationally for the high quality of its work. Participants say that not only do they appreciate having the opportunity to get access to new treatments, they also feel like they're getting great care and assistance in managing their condition from friendly LIWA staff.

If you are living with any of the following conditions and would like to know more about taking part in a trial please visit the [LIWA website](#) or contact LIWA on 9346 4964 for a confidential discussion.

LIWA Clinical Trials Unit now targeting:

[Asthma](#) | [Bronchiectasis](#) | [Cystic Fibrosis](#) | [COPD](#) | [Pulmonary Fibrosis](#)

If you need help to get to Sir Charles Gairdner Hospital for the trials, mention this when you ring up.

[illegible]

Drive and park close to Perkins Building

Turn into Aberdare Road, but don't turn down Hospital Avenue. Take the next left, just after the small lake, Gairdner Drive. Follow to the end and reach the T junction in front of the Lions Eye Institute building. Turn right and then left into the car park area. There are disabled parking spots at both front and back entrances to Perkins Building, the new dark grey building next to the PathWest Building (which covered in images of red blood cells).

Escorted

Meet at entrance to E block by 11.45am. Call and await Charlie's Chariot (M 0481 438 721) or walk with the group to Perkins Building. Meeting point is opposite the Hospital Auxiliary office and is close to the main bus stop. Walk is via E street, then left along Watling Walk following arrows on the map.

Parking

Park in car parks 4 or 4A near the Perkins building or in the multi deck car park which is accessed directly from Thomas Street, south of Aberdare Road (no access from Hospital Avenue). Parking in all bays is \$3.20 per hour or part thereof (Thanks Wilson's ☺).

Public Transport

The Hospital is served by a number of bus services including

- 23, 24, 25 Perth – Claremont
- 103 and 104 Fremantle – Salter Point, via St. Georges Terrace.
- 97 the Subiaco Shuttle, running between Subiaco Railway Station and University of Western Australia in Crawley.
- 98 and 99 Circle route, runs every 15 minutes between 6.30am and 6pm Monday through Friday, at other frequencies outside these hours.

Bus stops are located in Hospital Avenue near the entrances to C Block, E Block, J and K Blocks. Print timetables are available at E Block and G Block reception areas. Use the Transperth journey planner at www.transperth.wa.gov.au/ or call Transperth Infoline 13 62 13

Taxi Services

A taxi rank is located in Hospital Avenue. There are free taxi phones at E Block and G Block reception areas.

DISCLAIMER

The information contained in Breath of LIFE is provided in good faith and believed to be reliable and accurate at the time of publication. However, the information is provided on the basis that a reader will be solely responsible for making their own assessment of the information and its accuracy and usefulness.

LIWA shall in no way be liable, in negligence whatsoever, for any loss sustained or incurred by anyone relying on the information, even if such

information is, or turns out to be, wrong, incomplete, out of date or misleading.

LIWA is the Lung Institute of Western Australia and includes each employee or agent. Information includes information, data, representations, advice, statements and opinions, expressly or implied set out in this publication. Loss includes loss, damage, liability, cost, expense, illness and injury (including death).

L I F E

L I F E (Lung Information & Friendship for Everyone, formerly LISA) is a self help support group for people with chronic lung disease, family and carers. It is the community support group of the [Lung Institute of Western Australia](#) (LIWA). It's run by and for people with chronic lung conditions. Started in 1992 as LISA, it changed its name to **L I F E** in July 2009.



L I F E is a member of LungNet, [Lung Foundation Australia](#)'s network of respiratory support groups T 1800 654 301. **L I F E** is grateful for the continuing support of the Department of Respiratory Medicine at Sir Charles Gairdner Hospital.

Breath of L I F E magazine

Our magazine is published 4 times a year - March, June, September & December. The editor is Jenni Ibrahim. Send contributions to E life@liwa.uwa.edu.au or 7 Ruislip St, W. Leederville, WA 6007. [Read online](#). Join **L I F E** to receive a posted or emailed copy.

**Seeking information
about your lung
disease and how to
cope with it?**
**Like to meet others in
a similar situation?**
Join L I F E!

LIWA

The Lung Institute of Western Australia is a charitable organisation dedicated to the investigation and treatment of lung disease. [Donations to LIWA](#) are tax deductible. Membership is open to interested community members, as well as researchers, health professionals and medical research students. LIWA membership entitles you to join **L I F E** at the same time at no extra cost.

L I F E MEMBERSHIP

Contact LIWA for membership enquiries or application forms. T 9346 3198 or E life@liwa.uwa.edu.au or W [online](#). Membership fees are due each 30 June - \$22 or \$16.50 concession (incl. GST). Please advise us of your change of address. Members' help and ideas are welcome - magazine, speakers, social events.

CONTACTS

Phone: Coordinator **Jenni Ibrahim** T 9382 4678 M 0413 499 701
Postal: **L I F E** c/- LIWA, Ground Floor E Block, Sir Charles Gairdner Hospital, Hospital Ave, Nedlands WA 6009
Email: life@liwa.uwa.edu.au **Web:** [L I F E](#) on LIWA website [L I F E on Facebook](#)



MEETINGS

1st Wednesday of every month, 12 - 2.30pm, Feb-Nov. Speaker usually starts at 1.00pm. Respiratory Library, Department of Respiratory Medicine, 1st floor, B Block, Sir Charles Gairdner Hospital Nedlands. Wheelchair and gopher accessible. Light refreshments. If you can, please bring a plate to share.

COMING UP

| | | |
|---------------------|----------------------|--|
| Wed 26 Nov | Christmas Party | A celebratory lunch with party hats and Secret Santa |
| January 2014 | No meeting | |
| Wed 4 Feb | Social get together | No speaker. Come and catch up over a cuppa. |
| Wed 4 Mar | Meeting with speaker | Details to be advised |
| Wed 1 Apr | Meeting with speaker | Details to be advised |
| Wed 6 May | Meeting with speaker | Details to be advised |
| Wed 3 Jun | Meeting with speaker | Details to be advised |