Autumn means it’s time for your annual flu vaccination. At the same time it’s a great opportunity to review your overall vaccination status with your GP.

There are catch-up vaccinations, such as polio, additional vaccinations (like the flu jab) and booster jabs, such as whooping cough.

Vaccination for seniors aged 65 years or over is just as important as it is for children. What you need depends on:

- whether you missed out on childhood vaccines
- if you are Aboriginal and/or Torres Strait Islander
- your job
- how old you are
- whether you plan on travelling.

Ask your doctor or vaccination provider about your specific needs.

Some recommended vaccines are funded through the National Immunisation Program (NIP), or state and territory programs, while other vaccines can be purchased privately with a prescription. For example shingles, recommended for seniors, is free when you turn 70. The flu vaccine is free for people with chronic lung conditions, among other groups. Don’t get it too early to ensure coverage into the peak flu season, usually August.

More Australian Department of Health recommendations for seniors
L I F E EVENTS

Recently

December

L I F E Summer Lunch was our Christmas Party

This year’s Christmas lunch on 5 December was partly catered with the costs be shared by L I F E and the Institute for Respiratory Health. The Institute’s Sarah Cermak became catering manager to bring us some delicious food for lunch.

We broke the ice at each table sharing our own Christmas memories and had a thoroughly great time.

We were glad a number of Institute staff could come along to join in the fun and chat with members.

1 Director of the Institute Dr Geoff Stewart (L), the Business Services Manager, Sarah Cermak (C), and the acting manager of the Clinical Trials Unit, Felicite Kensall (R).

2 Sharing a laugh a/Prof Steve Mutsaers & L I F E member Irene Reeves
Some more from the Rogues Gallery

3 (L to R) LIFE MEMBERS TOM MURNANE, HIS WIFE PAT, JUNE KEANE, SARAH KNAPP AND ROSEMARY HAWKINS

4 (L to R) LIFE MEMBERS SARAH KNAPP, ROSE HAWKINS AND INA MITCHELL

5 LIFE MEMBERS ELAINE WELLS AND TOM MURNANE

6 (L to R) JAN MAIORANA, ALEX MURRAY, MARY FedeLE, JOHNNY FedeLE, AND JOHN MAIORANA
January As usual, we didn’t meet.

February Our 6 February meeting was a social meeting, a great time to catch up, talk about the year coming up and for newer members to get to know the group.

Coming up Details of meetings in the first quarter of 2019 are listed on the back cover. The whole year’s program was distributed at the February meeting and can be found on our Facebook page, posted on 6 February.

Talking Research During 2018 key researchers at the Institute for Respiratory Health, Associate Professors Cecilia Prele and Steve Mutsaers spoke about how they would like to have our input into their research. But fear not, we don’t need to be scientists, just have a perspective on what’s important when you are living with a chronic lung condition.

This 1-2 hour session, Talking Research, will be held in March, sometime after our March meeting, at the Perkins Institute Building, near the Lions Eye Institute on the QEII Medical Campus (where Sir Charles Gairdner Hospital and Perth Children’s Hospital are located and where we usually meet). Three or four researchers will give a 5 minute consumer-friendly overview of their proposed projects and then there will be a Q&A discussion. This is the part where you can really help the researchers.

Details were not finalised before the printing deadline for Breath of LIFE. However they will be available soon on our Facebook page and at the 6 March LIFE meeting. If you would like to attend but cannot access these sources, please contact Jenni to be advised once information is available. Detailed directions to the venue will be available too.

Even if you do not usually attend our monthly meetings, you might like to come to this. We’ll be able to meet researchers and hear about and comment on their research proposals.

More

W www.facebook.com/LungInformationFriendshipForEveryone
E life@resphealth.uwa.edu.au  T 9382 4678
L I F E Autumn Lunch
This autumn we’ll be going to the Belmont Tavern, as we did in last autumn.

Belmont Tavern
Mon 15 April 12 noon-
174 Wright Street, Cloverdale, facing the Belmont Forum carpark, near the corner of Knutsford Ave. T 9277 2077 W www.belmonttavern.com.au

Getting there
Belmont Tavern is on the #998/999 bus Circle route. Map and timetable here. Alight at stop #11303 Wright St before Belmont Avenue.

Or from the Busport: Depart at 11.34am on Bus #288, from St Georges Terrace Stand C before William St (Stop #10121). Alight at 11.57am at Wright Street before Knutsford Avenue (Stop #11302).

Or phone the Transperth InfoLine on 13 62 13 for more options.

Please RSVP by Thursday 11 April to Mary E mvfedele@bigpond.com T 9337 1286

RESPIRATORY NEWS

Lung Foundation Education Day 2019 will be on Fri 17 May at Boulevarde Centre, Floreat 10am-12.30pm. Bookings are essential but were not yet open at time of going to press. The two speakers will cover:

- An overview of lung conditions
- How to manage everyday tasks with a chronic lung condition.

So get on the Lung Foundation Australia mailing list T 1800 654 301 (Qld time zone) E enquiries@lungfoundation.org.au. You need to be a paid up ($30 p.a.) Lung Foundation Love Your Lungs member to receive a posted invitation. If you aren’t, you can still attend, but at a slightly higher cost.

Have A Go Day will be held on Wed 13 Nov at Burswood Park. L I F E has applied with the Institute for Respiratory Health’s Clinical Trials Unit to jointly host a booth. Your contribution of an hour or two on the booth would be great. Chat to the people about L I F E and living with a lung condition,
give away information and encourage people to join us or sign up for a clinical trial.

**National Strategic Action Plan for Lung Conditions**

Lung Foundation Australia is working with the Australian Government Department of Health to develop Australia’s first National Strategic Action Plan for Lung Conditions.

This national plan will help change the future of lung disease in Australia. It will define the priorities and actions needed to improve lung health and reduce the impact of lung disease on individuals, the community and the economy. As part of this process, an online survey was conducted recently and L I F E member David Payne took part. The community was invited to comment on a Draft of the National Strategic Action Plan for Lung Conditions. David pointed us to a report of the survey results. If you have internet access you can read it [online](#).

More [Lung Foundation Australia](#)

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**TAXIS?**

Are you considering selling your car, not renewing your driver’s licence - taking yourself off the road? Do you wonder how you’ll get around then as public transport is too difficult to manage with your level of disability? Are you reluctant to take a taxi anywhere? Like me you may have grown up in a time when taxis were considered a luxury by many families.

Don’t get miserable, sitting at home!

Get out and about. Come and join us at a meeting or a community lunch.

Here’s a great idea from pulmonary physiotherapist, Jane Stott.

Make a list of all the costs of running your car over 12 months: driver’s licence, vehicle licence and insurance, petrol, servicing and maintenance, RAC membership. Write the total on a piece of paper in large numbers and put it
on your fridge. That is the amount you would now have available to spend on taxis if you stopped riving! For example, mine came to $2,215, excluding depreciation, unexpected repair costs, and wear and tear on the tyres. That’s a lot of taxi fares.

That amount might go even further if you were eligible for the Taxi User Subsidy Scheme. The State Government subsidises 50%\(^1\) of taxi fares to eligible people. Ask your GP whether you might be eligible. There is a form that your GP needs to sign.

The guidelines say you must

- Be a permanent resident in Western Australia;
- Have a disability (mobility, vision or cognitive) that will always prevent you using conventional public transport; and
- Be over ten years of age (or less than ten years of age and use a wheelchair)


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**LUNG LAUGHS**

**CAN YOU HEAR ME?**

An older man thought his wife was losing her hearing so he stood about 6m behind her and said, Can you hear me? No reply. So he moved to 3m away and again said, Can you hear me? Not a word. At 2 m away, still no reply. Finally he whispered in her ear, Can you hear me now, honey? His wife replied, For the fourth time, Yes!

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1 Higher rate of subsidy if you have to use a wheelchair
Some more respiratory jokes, some of dubious taste

Once there was this witch doctor. He walked barefoot most of the time, giving him impressive calluses on his feet. He also ate very little and the food gave him bad breath. This made him (wait for it), A Super Callused Fragile Mystic Hexed By Halitosis.

Q: What did the lungs say to the cigarette?  A: You take my breath away...

Q: What did the elephant say to the naked man?  A: How ever do you breathe through that little thing?

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**L I F E BIRTHDAY CLUB**

Did you know that L I F E member Jan Mairorana (pic on page 3) looks after our birthday club? If you would enjoy receiving a card from us on your birthday, please let Jan know - at a meeting, T 9339 3617 or E janjohn1968@bigpond.com.

(It’s up to you whether to include your birth year. We’d just like to help you celebrate the milestones.)
And then it is winter...

You know, time has a way of moving quickly and catching you unaware of the passing years.

It seems just yesterday that I was young, just married and embarking on my new life. Yet in a way, it seems like eons ago, and I wonder where all the years went. I know that I lived them all. I have glimpses of how it was back then and of all my hopes and dreams. But, here it is... the winter of my life and it catches me by surprise...how did I get here so fast? Where did the years go and where did my youth go?

I remember well seeing older people through the years and thinking that those older people were years away from me and that winter was so far off that I could not fathom it or imagine fully what it would be like.

But, here it is...my friends are retired and getting grey - or gone...they move slower and I see an older person now. Some are in better and some worse shape than me...but, I see the great change...not like the ones that I remember who were young and vibrant...but, like me, their age is beginning to show and we are now those older folks that we used to see and never thought we’d be.

Each day now, I find that just getting a shower is a real target for the day! And taking a nap is not a treat anymore... It’s mandatory! If I don’t nap of my own free will, I just fall asleep where I sit!

And so...now I enter into this new season of my life unprepared for all the aches and pains and the loss of strength and ability to go and do things that I wish I had done but never did!

But, at least I know, that though the winter has come, and I’m not sure how long it will last. This I know - that when it’s over on this earth...it’s not over. A new adventure will begin!

Yes, I have regrets. There are things I wish I hadn’t done, things I should have done, but indeed, there are many things I’m happy to have done. It’s all in a lifetime.
So, if you’re not in your winter yet... let me remind you, that it will be here faster than you think. So, whatever you would like to accomplish in your life please do it quickly! Don’t put things off too long!

Life goes by quickly. So, do what you can today, as you can never be sure whether this is your winter or not! You have no promise that you will see all the seasons of your life.

So live for today, and say all the things that you want your loved ones to remember, and hope that they appreciate and love you for all the things that you have done for them in all the years past!

"Life" is a gift to you. The way you live your life is your gift to those who come after. Make it a fantastic one. Live it well! Enjoy today! Do something fun! Be happy! Have a great day!

Remember, it is health that is real wealth and not pieces of gold and silver.

Consider this: today is the oldest you’ve ever been, yet the youngest you’ll ever be so - enjoy this day while it lasts.

It’s not what you gather, but what you scatter that tells what kind of life you have lived.

*Found online by Janelle Griffiths, leader of the Bunbury based support group SWILS, edited, author unknown*
REDUCING RISK OF FLARE UPS AND DEATH FROM BRONCHIECTASIS (longish)

Statins\(^2\) and mucolytics\(^3\) may lower the risk of acute exacerbations and death among people with bronchiectasis and chronic obstructive pulmonary disease (COPD), a Taiwanese study found. Bronchiectasis and COPD are two chronic respiratory diseases that a person may have at the same time, known as bronchiectasis-COPD overlap, or BCO.

Previous studies have shown that people with BCO are more likely to develop acute flare-ups when they experience a significant aggravation of their symptoms, including increased breathlessness, cough, mucus production, and extreme fatigue, compared with people with COPD alone.

BCO, a neglected area of clinical trials, is not covered by clinical practice guidelines.

In this study, researchers aimed to evaluate the effects of standard medications — statins, mucolytics and macrolides (a group of antibiotics) — on acute exacerbations in people with BCO.

Data from the National Health Insurance Research Database of Taiwan were used. Between 2000 and 2009, researchers identified newly diagnosed COPD patients with or without bronchiectasis.

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\(^2\) Statins are drugs often prescribed by doctors to help lower cholesterol levels in the blood. By lowering the levels, they help prevent heart attacks and stroke. They can also reduce lung inflammation.

\(^3\) Mucolytics are drugs which dissolve thick mucus and help relieve respiratory difficulties. Bisolvon (bromhexine hydrochloride) is an example.
After excluding people who did not meet the criteria, researchers focused on 831 people with BCO and 3,321 age-, gender-, and index year-matched people with COPD alone.

At baseline, BCO patients, compared with COPD patients, were followed for shorter periods of time (4.53 vs. 5.22 years), visited the emergency room more frequently (9.63 vs. 3.22%), had more hospitalisations (20.94 vs. 11.38%), and received more prescriptions for COPD medications (36.82 vs. 14.78%).

People with BCO also had a higher rate of stroke (19.98 vs. 15.45%), prior pneumonia (34.78 vs. 9.55%), and malignancy (21.78 vs. 10.87%), compared with patients with COPD only.

During the follow-up period and before the first acute exacerbation, people with BCO patients received more prescriptions for mucolytics and macrolides, but fewer prescriptions for statins, than COPD patients.

Importantly, researchers found that people with BCO were more susceptible to acute flare-ups, with an adjusted hazard ratio (HR) of 2.26, and had a higher risk of mortality (HR 1.46), compared with people with COPD alone. In this case, people with BCO are 2.26 times more likely to experience acute exacerbations and 1.46 times more likely to die than people with COPD.

Overall, treatment with statins (HR 0.37), macrolides (HR 0.65), and mucolytics (HR 0.68) was significantly associated with a reduction in the risk of acute pulmonary exacerbations in all people in the study. Furthermore, statins were associated with a lower risk of mortality (HR 0.32).

Among people with BCO in particular, the use of statins and mucolytic agents, but not macrolides, was linked to significantly lower risks of acute pulmonary exacerbations.

“Our study showed that the use of statins and mucolytic agents was associated with a decreased risk of acute exacerbation in the (people) with

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4 Hazard Ratio is the probability of an event in an experimental group vs the probability of the same event in a control group.
BCO. Further clinical trials are necessary to assess the effects of medications in (people) with BCO,” the researchers said.

Source Bronchiectasis News Today

TREATMENT FOR COMMUNITY-ACQUIRED PNEUMONIA

Although most people with community-acquired pneumonia (CAP) are treated as outpatients, the majority of data regarding CAP management is provided by hospitals, either from emergency department or inpatients. This was already noted in the first CAP guidelines, published in 1993, and the challenges regarding the outpatient management of CAP persist nowadays. These include the uncertainty of the initial diagnosis and risk stratification, the empirical choice of antibiotics, the overgrowing of antibiotic resistance bacteria and the relative scarcity of new antibiotics.

New molecular biology methods have changed the way health professionals look at the causes of CAP, unveiling the role of virus. Diagnostic uncertainty may lead to antibiotic overuse and bacterial resistance. Novel antibiotics along with better diagnosis, using lung ultrasound and point-of-care biomarkers testing, may help to improve CAP treatment. Prevention, especially the use of anti-pneumococcal vaccine, is instrumental in reducing the burden of disease.

Most people with CAP receive care as outpatients. However, most research is focused on hospitalised severe patients. New and awaited advances might contribute to aid diagnosis, cause and assessment of patients with CAP in the community. This knowledge might prove decisive in improving outcomes, as well as to programs that maintain current antibiotics, safeguard future ones and reinforce prevention.

Source
ANTIBIOTICS & COPD

The UK National Institute for Health and Care Excellence (NICE) has published antimicrobial5 prescribing guidance recommending that antibiotics should be offered to people with chronic obstructive pulmonary disease (COPD) who have a severe flare up of symptoms.

However, other factors should be taken into account when prescribing antibiotics for an acute exacerbation that is not severe. These factors include the number and severity of symptoms.

The guidance notes that acute exacerbations of COPD can be caused by a range of factors - including viral infections and smoking. Only around half are caused by bacterial infections. So, many flare-ups will not respond to antibiotics and using them unnecessarily will increase antibiotic resistance in the community and the individual.

Paul Chrissp, NICE, said: “Evidence shows that there are limited benefits of using antibiotics for managing acute exacerbations of COPD and that it is important to take other options into account before antibiotics are prescribed.

“These recommendations will help healthcare professionals to make responsible prescribing decisions, which will not only help people manage their condition but also reduce the risk of antimicrobial resistance.”

Meanwhile, a separate update to the 2010 clinical guideline on diagnosing and managing COPD in people aged over 16 years states when to use antibiotic prophylaxis. It recommends that antibiotics used in this way should only be offered to people who are most likely to benefit from them.

Andrew Molyneux, COPD update committee, NICE, said: “COPD is a common and life-threatening illness, causing 115,000 admissions to hospital (UK) every year. For some people who have frequent flare-ups, prophylactic

5 There’s a difference between antimicrobial and antibiotic. An antimicrobial is an agent that kills microorganisms or stops their growth. Antimicrobial medicines can be grouped according to the type of microorganisms they mainly act against. For example, antibiotics are used against bacteria and antifungals are used against fungi.
“antibiotics can help to reduce the frequency of exacerbations and admissions to hospital. However, the benefits of prophylactic antibiotics need to be balanced against the potential for more antibiotic resistance.”

COPD affects approximately 3 million people in the United Kingdom, 2 million of whom are undiagnosed. It’s estimated that somewhere between 77,000 and 231,000 Western Australians have COPD.

NEW TEST FOR DIAGNOSING ANY CANCER

Queensland scientists have developed a test they hope could become the standard for diagnosing cancer.

The test has been developed by University of Queensland researchers who have discovered a unique DNA nanostructure that appears to be common to all cancers.

"We were so excited when you could see that there was a massive difference in the behaviour between one and the other," postdoctoral research fellow Dr Laura Garcia Carrascosa said.

Researcher Professor Matt Trau said this has enabled an entirely new non-invasive approach to detect cancer in any tissue type including blood, and led to the creation of inexpensive and portable detection devices.

These could eventually be used as a diagnostic tool, possibly with a mobile phone, he said.

"We certainly don’t know yet whether it’s the holy grail for all cancer diagnostics, but it looks really interesting," Prof Trau said in a statement.

"(And could become) an incredibly simple universal marker of cancer ... that doesn’t require complicated lab-based equipment."

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6 Prophylactic in this context means (not condoms, but) preventative

7 Based on Woolcock Institute report for Lung Foundation Australia (2014) and estimates for the whole of Australia, 7.7% over 40s, with WA as 10% of Australian population. Also using UK estimate of 2 undiagnosed people for every one diagnosed to estimate upper limit https://statistics.blf.org.uk/copd
Dr Abu Sina said it could be as simple as going to the doctor, and getting a test in the clinic “like a normal cholesterol test”.

The new technology has proved to be up to 90 percent accurate in tests involving 200 human cancer samples and normal DNA.

Researchers are now working to further develop the technology, and licence it with a commercial partner.

*(Suggested by member Tom Murnane who heard about it on the news)*

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**STICKING TO ALLERGY TREATMENT RECOMMENDATIONS**

Asthma and allergic rhinitis (AR, hay fever) are chronic conditions. To manage them, people need to stick to the prescribed medication correctly and regularly. This is called “treatment adherence”.

Despite the benefits of regular maintenance of asthma and AR therapy, doctors regularly see people who have not been sticking to the recommended management plan.

This review analysed recent research reports on “adherence” in asthma and AR, with a consideration of how much people stuck to their recommendations, what prevented them and what the consequences were, the effects of better education about treatment and the use of new technologies to improve the level of adherence.

Despite the extent, reasons and effects of this problem being well known, non-adherence in asthma and allergic AR remains worryingly high. Poor adherence leads to unsatisfactory health outcomes, with a negative impact on people living with these conditions and on society.

Recent literature suggests that successful programs to improve adherence should include a combination of strategies. New technologies offer promising tools to improve adherence.

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**ARTHRITIS DRUG RECALLED DUE TO CONTAMINATION!**

**OA/RA CAPSULES RECALLED**

Consumers and health professionals are advised that Blueskygreenearth, in consultation with the Australian Therapeutic Goods Administration (TGA), is recalling OA/RA capsules (batch 17098003) due to contamination with a
substance that poses an unacceptable risk to health. This product has also been withdrawn from the Australian market and will no longer be available for supply.

OA/RA is an Ayurvedic product that is indicated for temporary pain relief of osteoarthritis (OA) and rheumatoid arthritis (RA). TGA testing has found that the currently available batch of the product is contaminated with very low levels of aristolochic acid.

Aristolochic acid (found in certain plants) is included in Schedule 10 to the Poisons Standard, which lists substances considered to pose an unacceptable risk to health. There is no established safe exposure level to aristolochic acids, which have been linked to kidney problems and urinary tract cancers.

**Information for consumers**

If you, or someone you provide care for, takes OA/RA capsules, please be alert to this issue and discontinue use immediately. The product should not be consumed. If you have any OA/RA capsules, the remaining product can be returned to the place of purchase for a refund. If you have any questions or concerns about this issue, talk to your health professional or contact 1300 133 807.

*Source Arthritis WA news 23 January 2019*

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**ANAESTHETIC GAS & CANCER**

Melbourne scientists will head a global study to see whether the use of gas anaesthetics on cancer people who undergo surgery could contribute to a higher risk of the cancer recurring.

A previous study on mice linked gas anaesthesia with an increased risk of cancer relapse. People should not be concerned that anaesthetics are unsafe, the lead researcher

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* Ayurveda or Ayurvedic medicine is a system of traditional medicine native to India, which uses a range of treatments, including panchakarma (‘five actions’), yoga, massage, acupuncture and herbal medicine, to encourage health and wellbeing.
said. However, some hospitals are already choosing to use intravenous anaesthetic in favour of gas anaesthetic for cancer surgeries.

The global study, which will run for five years and include 5,700 people, is likely to shape the way cancer surgeries are managed worldwide, according to Peter MacCallum Cancer Centre’s Bernhard Riedel, who is a chief investigator on the project.

Professor Riedel said there was "mounting evidence" that gas-based anaesthetics — also known as "volatile anaesthetics" — could promote the growth of any cancer cells left in the body after surgery.

*Source ABC*

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**RIGHT HEART FAILURE & COPD**

The prognosis for people with Chronic Obstructive Pulmonary Disease (COPD) depends in large part on the frequency of flare-ups or exacerbations. Cardiovascular diseases, including heart failure, are known risk factors for exacerbations. However, the importance of heart failure type on the frequency of flare-ups in COPD people is unknown.

Right heart failure (RHF, also known as *cor pulmonale*) is the enlargement and failure of the right ventricle of the heart in response to increased vascular resistance (high blood pressure in the lungs). It’s a fairly common complication of long term COPD. Until now it has not been known whether right heart failure directly causes an increased risk of flare-ups.

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A recent Mexican study followed up 133 people with COPD from 2010 to 2016. Nearly 70% had severe flare-ups during the follow-up. People with RHF had lower FEV1⁹ and greater incidence of stroke compared with those

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⁹ A measure of breathing capacity
without RHF. Those with RHF were at a higher risk of severe exacerbations compared with people without RHF after adjusting for confounding variables. Researchers concluded that RHF independently affects the risk of severe flare-ups in people with COPD.

PROGRESSIVE PULMONARY FIBROSIS – REVIEW OF DRUGS

A proportion of people with interstitial lung diseases (ILDs) are at risk of developing a progressive-fibrosing type, associated with a deterioration in lung function and earlier mortality.

In addition to idiopathic pulmonary fibrosis (IPF), other fibrosing ILDs that are progressive include idiopathic nonspecific interstitial pneumonia, connective tissue disease-associated ILDs, hypersensitivity pneumonitis, unclassifiable idiopathic interstitial pneumonia, ILDs related to other occupational exposures and sarcoidosis.

Corticosteroids and/or immunosuppressive therapies are sometimes prescribed to people with these diseases. However, this treatment may not be effective or adequate on its own, and the side effects may not be well tolerated. This suggests that there’s a need for efficacious and better tolerated therapies. Currently, the only approved treatments to slow disease progression in people with IPF are nintedanib and pirfenidone. Similarities in patho-biological mechanisms leading to fibrosis between IPF and other ILDs that may present progressive-fibrosing type provide a rationale to suggest that nintedanib and pirfenidone may be therapeutic options for people with the latter diseases.

This review by a research group in Italy provides an overview of the therapeutic options currently available for people with fibrosing ILDs, including fibrosing ILDs that get progressively worse, and explores the status of the randomised controlled trials that are underway to determine the efficacy and safety of nintedanib and pirfenidone.

10 Efficacy is defined as the performance of an intervention under ideal and controlled circumstances, whereas effectiveness refers to its performance under real-world conditions.
USE BY WHEN?

When medicines are manufactured, by law they have to be given an expiry date. This is the date after which they are not expected to be as effective as they should.

Medicines lose their effectiveness over time because the chemicals in medicines can be broken down to inactive products by the effects of heat, light or oxygen. They can also become dangerous due to a change in their chemical composition. At worst, taking old medicines can be fatal if they’re for the treatment of serious conditions.

Expiry dates can vary widely between different medicines and forms of medicine. For example dry tablets are likely to have a later expiry date than liquids.

**Medicines to watch out for**

You need to be particularly careful with certain medicines for life-threatening conditions like:

- EpiPen® for the treatment of severe allergic reaction
- glyceryl trinitrate or GTN for angina and chest pain (such as Nitrolingual Pumpspray you apply under your tongue)
- insulin for diabetes

Eye drops are another special case. They can become contaminated with bacteria. A general rule is to never use eye drops after the expiry date, and to throw them out 28 days after you’ve opened them, even if it is before the expiry date.

*Editor: If you keep any of these vulnerable medicines in your car, just in case you need them, don’t forget how the summer heat will affect the effectiveness of the medicine so it may not be useable when you most need it.*

*It’s true the effectiveness of a drug may decrease over time, but much of the original potency still remains even a decade after the expiration date. (Apart from) nitroglycerin (spray), insulin, and liquid antibiotics, most medications are as long-lasting as the ones tested by the (US) military (1985).

Placing a medication in a cool place, such as a refrigerator, will help a drug remain potent for many years.*

*Harvard Medical School*

*Source HealthDirect*
CHATTY TABLES

If you live alone you may have sometimes wanted to have a chat but your friends are either away or busy. Have you heard of the Chatty Café Scheme? Physio Jane Stott alerted us to this new program being taken up by Sainsbury’s grocery chain and Costa’s café chain, among other cafes and restaurants in the UK. It was started in March 2017 by Alex Hoskyn who was feeling lonely for a chat.

From the website of the Chatty Table Scheme:

A Chatter & Natter table is where customers can sit if they are happy to talk to other customers.

We are looking for supermarket cafes, community cafes, large and small cafes to get involved so that just maybe we can make the Chatter & Natter table a part of everyday café culture.

A Chatter & Natter table brings people together and everyone is invited! If you’re on your own, in a couple, with a friend, if you’re a carer why not sit there with who you care for, mums and babies, dads and babies, grandparents and babies, young people, older people and anyone in between!

When you are deciding where to sit, look for the Chatter & Natter table and sit there! Stay for five minutes while you have your drink or longer. It’s not about making friends, just having good old fashioned human interaction!

On the website people can find a place near them which holds Chatty Tables, including play groups. It’s a marvellous way to decrease social isolation, and prevent loneliness and depression.

Chatty Table Scheme tells interested café owners:

It is entirely up to you when you have a Chatter & Natter table. Designating a table for as little as one hour per week to all day every day is fine. You know your customers better than anyone.

When you have decided, all you do is pop the sign on a table of your choice on that day/s and time/s. This will let customers know it is a Chatter & Natter table.

…sometimes you have to just let things be. It can take time for people to get their head around something new. All we ask is that you consistently designate a table when you say you will and let staff know what it’s all about.
I searched their UK website for Chatter and Natter Tables in Australia. I was sent to the centre of Australia, near Finke in the Northern Territory and advised there were no Chatty Tables there!!

Then I discovered that Chatty Cafe Scheme Australia had started a Facebook page in early February 2019, so it’s coming soon! They are also on Twitter (though I’m not). I contacted Alex and she’s keen to start in Australia too.

More

Chatty Café Scheme Australia and Chatty Café Scheme UK at Facebook
Chatty Café on the web
Chatty Tables, Alex Hoskyn interview with Ideas-Hub

HEALTHY EATING

Now it’s the turn of vitamin D. Most people know a bit about this.

**PLEASE READ THIS**

*We should get most of our nutrients from food, advises the federal government’s Australian Guide to Healthy Eating. Foods contain vitamins, minerals, dietary fibre, and other substances that benefit health. In some cases, fortified foods and dietary supplements may provide nutrients that otherwise may be consumed in less-than-recommended amounts.*

*If you are thinking of taking a vitamin supplement consider whether you can get adequate amounts of it in your diet, whether you have any need for extra, the dangers of taking an excess of that vitamin, and whether the vitamin interacts with other medications you are taking.*

*Your pharmacist and your GP can help you decide. A nutritionist may also be able to help.*

**Vitamin D**

Vitamin D is important for strong bones, muscles and overall health. Getting enough vitamin D is a balancing act, balancing risks and benefits.

Ultraviolet (UV) radiation from the sun is necessary for the production of vitamin D in the skin and it’s the best natural source of vitamin D. However, UV radiation from the sun is also the main cause of skin cancer.

Small amounts of the vitamin D you need can be obtained through food, only about 5 – 10%. Fish and eggs naturally have some vitamin D, while margarine and some milks have added vitamin D.
The body can only absorb a limited amount of vitamin D at a time. Spending extra time in the sun will not increase vitamin D levels – but it will increase your risk of skin cancer. Daily exercise also assists with the body’s production of vitamin D.

Health effects of low vitamin D

Vitamin D deficiency does not always have obvious symptoms, but without treatment there can be significant health effects. These can include bone and muscle pain, and softening of the bones – such as rickets (in children) and osteomalacia (in adults).

Some people are at greater risk of vitamin D deficiency, including:

- people with naturally very dark skin – this is because the pigment (melanin) in dark skin doesn’t absorb as much UV radiation
- people who avoid the sun due to previous skin cancers, immune suppression or sensitive skin and those people who have limited sun exposure, such as nightshift workers, people living in nursing homes
- people who wear covering clothing or concealing clothing
- people who spend a long time indoors – such as those who are housebound or institutionalised
- people who are obese
- people who have a disability or a disease that affects vitamin D metabolism, such as end stage liver disease, renal disease and fat malabsorption syndromes such as cystic fibrosis, coeliac disease and inflammatory bowel disease
- people who take medication that affects vitamin D metabolism
breast-fed babies of vitamin D deficient mothers (formula milk is fortified with vitamin D)

If you think you may be at risk of vitamin D deficiency, ask your GP for advice. Your GP may recommend taking a vitamin D supplement.

Overexposure to UV is never recommended, even for people who have vitamin D deficiency.

**Vitamin D and food**

There are small amounts of vitamin D in some foods such as fish, eggs and UV-irradiated mushrooms, but it is difficult to obtain enough vitamin D from diet alone.

Most people only get five to 10 per cent of their vitamin D from food. Margarine and some types of milk have added vitamin D (fortified).

**Vitamin D and safe sun exposure**

UV levels vary depending on the time of year, and the amount of sun exposure you need varies accordingly.

The ‘daily sun protection times’ reported on the weather page of the newspaper and on weather websites, indicate when the UV level is forecast to be three or above. During these times, people are recommended to use a combination of sun protection measures (sunscreen, hat, protective clothing, sunglasses and shade). Check the SunSmart app or the Bureau of Meteorology website for daily sun protection times for your location.

**Sources**

- Victorian Better Health
- Sunsmart
- US National Institutes of Health: Office of Dietary Supplements
HOW CAN I GIVE BACK?

Doing something that helps make the world a better place, feels good too. There’s always something you can do - no matter how advanced your condition.

1. **Volunteer** for L I F E - help our L I F E group. Or another community organisation near you. Help in the Breath of L I F E mail out or join the L I F E working bee which helps the Institute for Respiratory Health’s Clinical Trials Unit. Just speak to Sal at the next L I F E meeting or call her T 9331 3651 E salhyder1@gmail.com

2. **Spread the word** with family and friend. Tell them about L I F E, the Institute for Respiratory Health and respiratory conditions. Our business cards have L I F E contact details and a space for your name and phone number. Contact us for a bundle.

3. **Register with the Clinical Trials Unit** of the Institute for Respiratory Health to take part in the trial of a new respiratory medication. Call T 6457 3198

4. **Volunteer to be a research subject** in a medical research project described in Breath of L I F E or in your local paper

5. **Donate** to the work of the Institute for Respiratory Health. Call 6151 0815 or donate online. Mention the Institute’s important research into lung disease to friends and relatives who also might be interested to make a donation. Or make a bequest in your will.

SOME USEFUL CONTACTS

**Respiratory**

*Flying with Oxygen* - L I F E’s own practical guide endorsed by Prof P J Thompson, Lung Health Clinic

*Lung Foundation Australia* T 1800 654 301 (Queensland time zone)

*Connect Groups* – peak body for support groups in WA T 9364 6909

*Pulmonary Rehabilitation* programs (scroll down to WA) or T 1800 654 301

Need referral from a respiratory specialist who has admitting rights to a WA public hospital (even if you see them privately).
Pulmonary Hypertension Network Australia – a sister support group to LIFE

Asthma Foundation WA  T 1800 278 462

Bronchiectasis Toolbox for health professionals

Active Cycle of Breathing Technique (video) helps you clear your airways of phlegm

Asbestos Diseases Society of Australia (WA)  T 1800 646 690  (08) 9344 4077

National Quit line – help to quit smoking T 13 78 48

Mental Health

Act Belong Commit - activities to promote your mental health  T (08) 9266 3788

Beyond Blue  mental health support service T 1300 22 4636

Australian Mens Shed Association – find a men’s shed near you
T 1300 550 009

Lifeline 24 hour personal crisis support and suicide prevention association
T 13 11 14

General Health

Health Direct look up reliable health information or speak to a registered nurse T 1800 022 222

Cancer Council WA  T 13 11 20

Health Report with Norman Swan ABC Radio National (810 AM), listen to past programs on your computer or smartphone

ABC Health Online find reliable health news and information

Seniors

Council on the Aging (COTA) voice of older Australians T (08) 9472 0104

MyAgedCare  aged care services you may be eligible for. Speak to your GP

National Seniors  voice of older Australians T 1300 76 50 50
Better Health Channel. Victorian Government’s health information website
Seniors Services guide database of services and activities for older Australians
Seniors Recreation Council WA  T (08) 9492 9773

**Consumer and carer rights**
Carers WA supporting friends and family who care for others T 1300 227 377
Health Consumers Council an independent voice advocating for patients in WA  T 08 9221 3422 and  1800 620 780
Patient Opinion Australia  share your experience as a patient and ensure the message gets passed on to the right people T 1300 662 996

**Other**
TED Talks  watch videos of great speakers on a topic that interests you. Free
The Australian Bereavement Register  stop unwanted mail to a family member who has passed away  T 1300 887 914
Do Not Call Register – stop unwanted marketing calls to your home phone or mobile, renew every 2 years  T 1300 792 958

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**INSTITUTE FOR RESPIRATORY HEALTH**

The Institute for Respiratory Health (formerly LIWA) is a collaborative research organisation. It aims to improve the life of Australians living with respiratory conditions by bringing together world class researchers and dedicated clinicians to investigate, diagnose, treat and prevent respiratory conditions.

The Institute conducts and fosters innovative basic and clinical research and translates their work into improved treatments for people with respiratory conditions in Australia.

The Institute includes a Clinical Trials Unit and the community support group – LIFE for people living with chronic respiratory conditions.

Membership is open to community members, researchers, health professionals and research students and is due each 1 July.

Your tax deductible donation to the Institute or bequest supports respiratory research.
About Lung Information & Friendship for Everyone (LIFE)

LIFE - a group for anyone with a chronic lung condition, their family and carers. It's run by, and for, people with chronic lung conditions. Started in 1992 as LISA, our name changed to LIFE in 2009. LIFE is the community support group of the Institute for Respiratory Health. More about the Institute on page 27.

LIFE is also a member of Lung Foundation Australia's network of respiratory self help groups T 1800 654 301. LIFE is extremely thankful for the support of the Department of Respiratory Medicine at Sir Charles Gairdner Hospital.

Breath of LIFE magazine

Our magazine is published 4 times a year - March, June, September & December. It is distributed to all community members of the Institute, including LIFE members. Send your contributions to the editor, Jenni Ibrahim E  life@resphealth.uwa.edu.au  7 Ruislip St, W. Leederville, WA 6007. Read it online.

LIFE Membership

Join LIFE by becoming a community member of the Institute. Come to a meeting or contact Sarah at the Institute T 6151 0815 or E  life@resphealth.uwa.edu.au  Membership fee of $20 a year (incl. GST) is due each 1 July. Members’ help and ideas are always welcome - magazine, speakers, social events. Please be sure to tell us if you change address.

Contacts

Phone Coordinator Jenni Ibrahim T 9382 4678 M 0413 499 701
  Deputy Coordinator Sal Hyder T 0409 336 639 salhyder1@gmail.com

Postal LIFE c/- Institute for Respiratory Health, Ground Floor E Block, SCGH Hospital Ave, Nedlands WA 6009

Email  life@resphealth.uwa.edu.au Web  LIFE on the Institute website  LIFE is also on Facebook

Meetings

1st Wednesday of the month from February to November from 12 - 2.30pm. Speaker at 1.00pm.

Level 6 Meeting Room 612A, Perkins Institute Building, Queen Elizabeth II Medical Campus, Nedlands. Wheelchair and gopher accessible. Light refreshments. If you can, please bring a plate to share. Buggy pickup from the car park or bus stop call M 0481 438 731 (Mon-Fri 9am-4pm) or ask at Gairdner Voluntary Group Enquiries Desk just inside the main entrance in E block.

COMING UP

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<tr>
<th>Date</th>
<th>Event</th>
<th>Details</th>
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<tr>
<td>Wed 6 Mar</td>
<td>Succession planning</td>
<td>Workshop and discussion</td>
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<tr>
<td>XXX XX Mar</td>
<td>Talking Research - special meeting</td>
<td>Meet researchers. Details to be advised.</td>
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<tr>
<td>Wed 3 Apr</td>
<td>Writing my life story</td>
<td>Di Inglese, celebrant</td>
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<td>Mon 15 Apr</td>
<td>LIFE Autumn Lunch at Belmont Tavern</td>
<td>Details inside</td>
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<tr>
<td>Wed 1 May</td>
<td>Flying with oxygen</td>
<td>Bernie Somers, Respiratory Supplies</td>
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<tr>
<td>Fri 17 May</td>
<td>Lung Foundation Education Day</td>
<td>Floreat. RSVP. Details inside.</td>
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<tr>
<td>Wed 5 Jun</td>
<td>Talking to people about my lung condition</td>
<td>Focussed discussion</td>
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